

Partnering with an Aboriginal Community for Health and Education

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ABSTRACT

Cultural awareness is a concept that is gaining much attention in health and education settings across North America. This article describes how the concepts of cultural awareness shaped the process and the curriculum of an online health education project called Interprofessional Collaboration: Culturally-informed Aboriginal Health Care. The exploration focuses on the interactions among faculty members and educational developers from Laurentian University, Elders of the Anishinabek tradition, and members of the Anishinabek community known as the North Shore, an area approximately two hours northwest of Sudbury. The project's curriculum is driven by choices made by the Anishinabek Elders, with support from their cultural community and the local university.

The online module developed for this project provides health-care

RÉSUMÉ

La prise de conscience culturelle est un concept qui attire beaucoup d'attention dans les secteurs de la santé et de l'éducation partout en Amérique du Nord. Cet article décrit comment les concepts de prise de conscience culturelle ajoutent au processus et au programme d'un projet d'éducation de santé en ligne appelé Interprofessional Collaboration: Culturally-informed Aboriginal Health Care. L'exploration se concentre sur les interactions parmi les membres de la faculté et les développeurs pédagogiques de l'Université Laurentienne, les aînés de la tradition Anishinabek, et les membres de la grande communauté de Anishinabek située dans une région appelée « North Shore », environ à deux heures de route le long du lac Huron au nord-ouest de Sudbury, en Ontario. Le programme du

students at Laurentian University, with access to traditional knowledge, including the teachings of the Medicine Wheel and the Seven Grandfathers. Ideally, these teachings will lead to an increase in culturally informed care for Anishinabek clients and their families in northern Ontario. The process used by the university-based team with the Elders and the larger community of the North Shore is recommended as a possible template for university-based teams working with Aboriginal partners. Finally, the Anishinabeks of the North Shore are recognized as a cultural exemplar of a community that appreciates the intersection and potential of traditional knowledge and contemporary health education practices and technologies.

projet est mené par des choix faits par trois aînés Anishinabek, avec l'appui de leur communauté culturelle et l'université locale.

Le module en ligne développé pour ce projet fournit l'accès aux connaissances traditionnelles, y compris la doctrine de la roue médicinale et des Sept Grands-Pères. Idéalement, ces doctrines mèneront à une croissance en soins culturellement informés pour les clients Anishinabek et leurs familles dans le Nord de l'Ontario. Le processus utilisé par l'équipe universitaire en collaboration avec les aînés et la grande communauté de North Shore est recommandé comme exemple possible pour les équipes universitaires travaillant en collaboration avec des partenaires autochtones. Enfin, les Anishinabeks de North Shore sont reconnus en tant qu'exemple culturel d'une communauté qui apprécie l'intersection et le potentiel des connaissances traditionnelles et des pratiques et technologies d'éducation en matière de la santé.

INTRODUCTION

Interprofessional Collaboration: Culturally-informed Aboriginal Health Care is a project led by faculty members in the School of Nursing at Laurentian University, a mid-sized, tri-cultural (English, French, and Aboriginal) university in Sudbury, Ontario. This work is also part of a virtual learning institute supported by four Ontario universities (McMaster University, University of Ottawa, the University of Western Ontario, Laurentian University) and the Council of Ontario Universities.¹

Over a four-year period, the project teams from the universities and the council had three major goals: to foster a change in attitude toward interprofessional health education; to increase the number of health professionals prepared in interprofessional education and collaborative patient-centred care; and to develop a high-quality interprofessional health education curriculum to be available to learners through asynchronous online (Web-based) means. A more specific goal for Laurentian University was to achieve these goals through curriculum and learning activities grounded in the health needs and cultural beliefs and attitudes of Anishinabek or Anishinaabe persons living in northeastern Ontario; equally important was that this goal be achieved in culturally appropriate ways.

This article discusses the project in general and how curriculum (content and activities) and process decisions were made within a context of cultural awareness. Relevant theoretical connections to work by Leininger (2006) on health and culture and by D'Amour and Oandasan (2005) on interprofessional education are also outlined. It is proposed that the Anishinaabe community involved in this project is a cultural exemplar of a community that appreciates the intersection and potential of traditional knowledge and contemporary health education practices and technologies.

THE LITERATURE

Aboriginal Health in Canada, Cultural Sensitivity and Safety, and Interprofessional Education

Many diverse communities of Aboriginal peoples contribute to Canada's strength as a nation and to its cultural diversity. According to Statistics Canada (n.d.), Aboriginal "refers to those persons who reported identifying with at least one Aboriginal group, i.e., North American Indian, Métis, or Inuit (Eskimo), and/or those who reported being a Treaty Indian or a Registered Indian as defined by the *Indian Act* of Canada and/or who were members of an Indian Band or First Nation." Based on the 2006 Canadian census, Aboriginal people account for 3.8% of the total population of Canada, an increase from 3.3% in 2001 and from 2.8% in 1996, and an overall population increase of 45% between 1996 and 2006. The Aboriginal population is identified as the fastest-growing segment of Canada's population.

In stark contrast to this growth, Aboriginal peoples have poorer health status than other Canadians (Health Canada, 2003). In some instances, their access to health care, including disability support services, health services, specialized therapy, and health education, is either significantly restricted, consistently poor, or non-existent (Hanvey, 2002); in other cases, there may be a failure to utilize services. As a result, Health Canada has made a

commitment to Aboriginal peoples to improve their access to health-care services, prevent chronic and contagious diseases, and generally improve their overall health and well-being. Although Aboriginal peoples' life expectancy and infant mortality rates have improved in recent years, their health status remains far below that of the general population. Infectious diseases, injuries, suicide, heart disease, and diabetes affect the Aboriginal population at a higher rate than the rest of Canada's population (Health Canada, 2003). Educators, researchers, and policy-makers are actively focusing on ways not only to identify these gaps but also to develop and set in motion practical strategies to reduce these disparities in health and access to health-care services.

The World Health Organization's (1946) definition of health—"a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"—and its emphasis on wellness are especially relevant in Aboriginal contexts. For Aboriginal persons, optimum health incorporates physical, mental, social, and spiritual components and is linked to the health and well-being of the community (Lafontaine, 2006). Thus, in Aboriginal communities, health cannot be assessed or addressed separately from the community and cultural context.

The concept of cultural sensitivity refers to, above all, the value of respect—respect of self and others. A culturally sensitive person chooses to learn about self and others in ways that include knowledge of values, attitudes, and practices. By comparison, cultural safety goes beyond knowledge to the valuing of respect in relation to self and others and, thus, to culturally appropriate actions. The term "cultural safety" developed in New Zealand during the 1980s among the Maori people when they began to express discontent with the nursing care they were receiving (Papps & Ramsden, 1996). Simply stated, health professionals must recognize their own cultural beliefs and attitudes as well as those of the different populations they serve; with this recognition comes understanding, respect, and culturally appropriate attitudes and behaviours (Rukholm & Newton-Mathur, in press).

Models and Theories

The goal of the Interprofessional Collaboration: Culturally-informed Aboriginal Health Care online module is to cultivate cultural awareness and interprofessional education in the context of a unique health-care setting. Decisions about interprofessionalism were based on D'Amour and Oandasan's (2005) model, Interprofessional Education for Collaborative Patient-Centred Practice, which emphasizes the interdependence of education and health-care practice. Based on this model, undergraduate preparation of health-care professionals should include opportunities to experience interdisciplinary education, with collaborative practice modelled by health

professionals. There is also a need to help practitioners develop competence and willingness to work collaboratively (Hebert, 2005).

D'Amour and Oandasan (2005) stressed that their model is constantly evolving and that there is both an interdependence and an interplay among the factors that influence the educational and professional systems in which health-care providers study and work. They further pointed out that health-care learners sit at the centre of the health-education system while clients are at the heart of the professional setting. This positioning often leads to the creation of silos, but interprofessional education holds promise for diminishing this silo effect.

In alignment with other e-learning initiatives, the online module discussed here is grounded principally in the learning theory known as constructivism. According to constructivism, learners have an internal orientation to learning and, thus, construct knowledge and skills; importantly, the online learning setting is a place where knowledge can be co-constructed through interaction with other students and with the instructor (Murphy & Cifuentes, 2001). It is an environment where collaborative and co-operative learning can be accomplished and where learners can use their personal cognitive skills to learn from and with others (Carter, 2006; Carter & Rukholm, 2008; Hooper & Hanafin, 1991; Johnson & Johnson, 1996; Palloff & Pratt, 1999). In addition to an overall orientation to constructivism, the module includes components from transmissive learning (learning acquired through the direct transmission of information) and experiential learning (learning acquired through experience).

Working with an Aboriginal Health Partner

Leininger, a well-known nurse and cultural anthropologist, noted that "culture [is] the broadest, most comprehensive, holistic, and universal feature of human beings" (2006, p. 3). She defines culture as "patterns of learned behaviours and values which are shared among members of a designated group and usually transmitted to others of their group through time" (1975, p. 4). Leininger suggests that culture is a kind of blueprint for caring behaviours. Extrapolating from this, congruence between care delivery and cultural beliefs is identified as essential. Although Leininger's work focuses specifically on the role of culture in health care, it is invaluable when discussing "healthy" partnerships between academic institutions and Aboriginal communities, such as the relationship between Laurentian University and the Anishinaabe community of the North Shore, an area between Sudbury and Sault Ste. Marie, Ontario. Building on Leininger's (1993) sunrise model, health, caring, and partnerships may be influenced by a cross-section of elements, including technological, religious, and philo-

sophical factors, kinship and social systems, cultural values, political and legal factors, economic factors, and educational factors.

The *Practice Guideline for Culturally Sensitive Care* developed by the College of Nurses of Ontario (2005) is also relevant to this project. Although it particularly targets nurses in particular in their role as care provider, this guideline is useful when the goal is a respectful relationship. Seven principles are embedded in the guideline: 1) being culturally knowledgeable; 2) being other-centred; 3) being self-reflective; 4) recognizing potential conflict between the involved cultures; 5) facilitating the other's choice; 6) incorporating the other's cultural preferences; and 7) accommodating the other's cultural beliefs and practices. Clearly, it is impossible to be "all knowing" about a culture that is different from one's own; however, respectful relationships in all cultural situations are imperative. Self-reflection prevents us from falling into the trap of believing we know a culture when we do not; it also helps us to establish mutually agreeable goals with persons from different cultures and to resolve conflict.

REFLECTIONS ON THE LEARNING MODULE

The project's online learning module allows the traditional beliefs and values of three Anishinaabe Elders to be presented through a series of video clips housed in a WebCT™ course site. Undergraduate health-care students use a visual map and compass to experience the videos and the carefully prepared learning tools and activities. Each video clip appears on a separate Web page that links to a glossary, a case-based Cultural Learning Activity (CLA), and a Guided Listening Tool (GLT). An example of a case-based CLA and a GLT follow.

Cultural Learning Activity (CLA)

Mary is a 42-year-old mother and grandmother. She is concerned about the high risk behaviour of her two grandsons who are heavy drinkers and smokers. She has already lost a grandson and a nephew through accidents. She has come to the clinic to talk about her grandsons.

Based on your first meeting with your coursemates and/or your facilitator's guidance, contribute your thoughts and ideas about this case scenario to the Sharing Circle. Be sure to consider the teachings of the Seven Grandfathers, cultural issues, and interprofessional principles and practices as you compose your contribution.

Guided Learning Tool (GLT)

The following points and questions are offered as a means to enrich your listening experience. As you listen to Peter, be sure to keep them in mind. It is your choice whether or not you wish to make notes as you listen.

Peter tells us about tobacco. List 2-3 points Peter makes about tobacco.

What does Peter say about false beliefs?

Peter uses several personal stories in his talk; for example, he speaks about his daughter and his own head injury. What does this use of storytelling reveal about Peter and his culture? How might the idea of story be important to your work as a health professional caring for Aboriginal patients?

Peter's talk is all about the concepts of healing, values, beliefs, and teaching. In 1-2 sentences, summarize what Peter tells us about these concepts.

In the Cultural Learning Activity cited above, students share their thoughts about Mary's situation while interweaving their views and the cultural concepts of the module. Notably, students are required to consider the connectedness between Mary's personal health and her larger life situation, as it includes extended family members. Guided Listening Tools like the one included here are resources that support learners who may be new to Anishinabek culture and/or to learning through listening and narrative. Not insignificantly, each Elder uses story to teach; the listening tools help learners identify the Elders' key concepts and messages.

The Sharing Circle is a threaded bulletin board/discussion forum. In the circle, learners share their thoughts about the CLAs, a team-developed care plan, and interprofessional practice. As learners navigate the module, they are guided by a health-care professional of Anishinaabe descent. The facilitator's role is to foster thoughtful and team-focused dialogue among participants and keep learners on task in terms of experiencing interprofessionalism and teamwork.

The module also includes a Background section that presents contextual and historical information. Topics found in this section include beliefs about creation, the Medicine Wheel, the teachings of the Seven Grandfathers, and the Anishinaabe way of life. Relevant Web links and readings are provided.

During the first offering of the module, despite the dedicated efforts of the facilitator, the group did not gel as well as desired through the online discussion board. It became apparent that the learners required some

opportunities to interact with each other in synchronous ways if they were to develop as team members. Consequently, while the learning experience remains mainly asynchronous in nature, it now includes two sessions that enable real-time interaction—through teleconferencing, video conferencing, and data conferencing.

Significantly, the module's content and activities were selected through a process of discussion between the educational leads from Laurentian and the Elders. The North Shore includes seven separate First Nations: Batchawana, Garden River, Thessalon, Mississauga, Serpent River, Whitefish Lake, and Sagamok-Anishnawbek. Creating an educational module that would reflect all of these nations' beliefs and values was not possible. The Medicine Wheel and the teachings of the Seven Grandfathers, however, were agreed upon as foundational concepts of all these communities.

REFLECTIONS ON THE PROCESS

From the first planning session, members of the Laurentian University team resolved to "practice what the module teaches"—interprofessionalism in culturally appropriate ways. This commitment included an interprofessional team that, for approximately one year, consulted with respected members of the North Shore community to learn how to broach three Elders about their possible interest in sharing their beliefs on health and wellness through video. In the end, the Laurentian team worked through a trusted health-care professional from the North Shore to meet with the Elders to discuss the project. Building on this person's relationship of trust with the Elders, the project was presented as an important way of fostering cultural awareness in the health education field.

Elders typically view their life role as one of sharing and teaching, but others beyond the immediate cultural community do not always have the opportunity to learn from them; the goal of the project was to give those outside the community that opportunity. However, although the educational value of the project was easily appreciated, it had to be measured against the reality that not all Aboriginal persons believe sacred teachings should be shared beyond the Aboriginal community. There were two further variables: this sharing would be enabled through technology—a module offered through the Internet—and an assessment component would be involved. As for the sharing, the team members explained that the course, while delivered through the Internet, would be password protected, thus ensuring that the sacred teachings would not be available to the general public. They also carefully explained that the evaluation component would be focused on the students who took the module; there would be no evaluation of or research on the Elders or the community. This point was extremely

important because considerable research has been conducted in this part of Ontario in relation to Anishinaabe people, not all of which has been a positive experience.

The three Elders agreed to participate and various meetings followed, either on reserve or at locations of convenience for the Elders. Aboriginal customs, including traditional prayers and offerings of tobacco, were carried out at these sessions in order to demonstrate respect for the Elders and to affirm that the project was rooted in the values of the Anishinaabe community rather than those of the university. Establishing that this work was a community-driven educational project was critical.

Two areas of specific interest to this article are how the videos were prepared and the concept of agreement or contract. Although it would have been easier for the videographer if the Elders had travelled to Laurentian University, the videographer and others from the university travelled more than 200 kilometres to the Elders for the taping sessions. During the sessions, the Elders did not speak from scripts; rather, they were asked to share, in their own ways and in their own words, their views on health and wellness in relation to the Medicine Wheel and the teachings of the Seven Grandfathers. Aboriginal culture uses many symbols as representations of values and ideas, but the circle permeates the culture and is at the heart of understanding health and wellness. Comprised of four quadrants represented by four colours—red, yellow, black, and white—the Medicine Wheel represents “the circularity of existence.... Just as every point on a circle is equal to every other point, no place being closer to the center than any other, all created things are regarded as being of equal importance” (Bruchac, 2003, pp. 10–11). By comparison, the teachings of the Seven Grandfathers recall a time when “there were seven grandfathers who led [Aboriginal people]. Before they left to cross over into the spirit world, each of them offered teachings by which the people should live” (Bailey, 2002, p. 18). These teachings centre on honesty, humility, respect, courage, wisdom, love, and truth.

Two Elders offered very personal reflections through stories based on their life experiences. The third Elder, dressed in traditional clothes, spoke about the teachings, presenting items from his sacred bundle and demonstrating how these items are used to honour the teachings.

From a production point of view, the videos were minimally edited since it was agreed that students should experience the Elders in their own words, without the distraction of high-tech effects. Although some media experts might recommend shorter video clips—they range in length from 6 to 14 minutes—it was felt that shortening the videos would detract from their power. Students who take this module are encouraged and expected to become better listeners and to appreciate that Aboriginal culture is largely an oral culture.

As for the technicalities of the relationship between the members of the university team and the Elders, there were no signed contracts. Instead, all agreements were based on trust and were verbal in nature. Thus, when team members had a new idea they wished to explore, they took another road trip to meet with the Elders and ask for their counsel and support. This process is best described as one of ongoing and respectful negotiation.

STUDENT PERSPECTIVES

In the spring and summer of 2007, the module was piloted with six Laurentian students; the same process of piloting was carried out by the other universities involved in the larger institute. The students enrolled in the Laurentian course module represented the disciplines of nursing, medicine, health promotion, and social work. In addition to identifying certain navigational and logistical challenges in the module, these students offered a variety of insights into its impact on their appreciation of culturally informed care and interprofessionalism. The findings noted here are based on interviews, an analysis of the online discussion forum, and the administration of a tool called the Interdisciplinary Education Perception Scale. In the interviews, students reflected on culturally informed practice based on their experiences with the module. The online forum was analyzed principally for what the students shared about interprofessionalism, while the Interdisciplinary Education Perception Scale was used to generate insights into the impact of the module on students' perceptions of interprofessional education. Change is an important objective of any educational project that involves health students learning about interprofessional care (Tunstall-Pedoe, Rink, & Hilton, 2003).

During the interviews, students were asked semi-structured questions on what they had learned about culturally informed care and how this learning influenced their clinical practice. All of them reported that the module had increased their awareness of the Anishinaabe people's beliefs and attitudes about health; one student commented that what she had learned was very useful to her in the field placement she was on while taking the module. This student had been placed in a local agency where she worked regularly with Anishinaabe clients, and since she planned to stay and work in northern Ontario, the module was of great value to her future career. Another student commented on how important it is to expose students to cultural issues at the undergraduate level, before they are entrenched in the system: "It is better to be doing this kind of learning now rather than later."

A qualitative content analysis of the discussion forum enhanced the project team's understanding of what the students were discussing and sharing online. Discussions were coded as either content or process related. Content-

related themes pertained to communication, professional roles, collaborative problem solving, and teamwork. Process-related themes included information sharing, attitudes toward interprofessional education, and asking for others' perspectives.

Across all the content-theme areas, students described personal growth and increased awareness of interprofessionalism. One student commented on communication and interprofessionalism: "We all were able to focus on the importance of communication and its importance to the effectiveness of an outcome for a client." Another student, from nursing, remarked on the concept of roles:

As health professionals from different disciplines we all focus on various angles of patient care. An OT vs. a nurse in terms of what aspect they focus on for patient care is very different, yet what we have in common is the fact that we are trying to collaborate our findings/methods of patient care to provide the patient with the best possible care.

Similar positive comments were offered about problem solving, teamwork, and collaboration.

In the area of process, the analysis of the online discussion revealed that the students were learning from each other in relation to their specific professional roles. One medical student commented: "When working in an interdisciplinary setting, one should be aware of the evidence supporting clinical decisions made by other professions." In discussions of interprofessionalism, students tended to use words such as respect, honesty, and openness:

Respect: (I think we have done a good job of this so far.) As a team, we need to respect others' opinions and accept what they have to say...
Knowledge of our own and others' professions. I would love to hear a quick summary of your ideas of your profession. I think that by knowing who we are and the rest of the team will help in our communication. I can start and you can see if this will work for the group.

The same positive language and exchanges were evident when students asked for others' perspectives.

The Interdisciplinary Education Perception Scale was administered to the students before and after they took the module to determine if any of their perceptions of interprofessional education changed during the project. The pre-module data were very similar to a normative sample. The relatively small changes that did occur in the scores over time may reflect a volunteer bias in that students who participated may have been more aware of and interested in interprofessional education than others.

Although the pilot was small, it does point to the module's potential for increasing students' awareness of interprofessionalism and culturally

informed care in the context of the Anishinaabe client and community. Further work is required to determine if students who take such a module translate their learning to the clinical setting.

CONCLUSIONS

Respect, honesty, humility, acceptance, and open negotiation ensured that this government-funded project unfolded in mutually beneficial ways. As evidence of its success, members of the Laurentian project team were recently honoured to learn that the three Elders involved in the project have expressed interest in participating in further videos. The project team is also discussing the use of the module by local undergraduate students from the Northern Ontario School of Medicine, located in Sudbury and Thunder Bay. Individuals from the North Shore who were involved in the project had expressed interest in medical students being exposed to the module as preparation for their placements in the First Nations communities that comprise the North Shore. This discussion with the medical school is presently underway.

Fully recognizing that the pilot was small and that further work must be done, some theoretical observations are nonetheless offered. First, many positive interprofessional and collaborative experiences occurred and involved persons from a number of domains: faculty in the health-education sector of the university; educational and technological experts from the university; learners from a cross-section of different health sciences; and representatives from the distinct cultural community of the North Shore. According to D'Amour and Oandasan's (2005) model, if the goals of interdisciplinary education include assisting health students to develop competence and a willingness to work collaboratively and decreasing the silo-like orientation of our present approaches to health and education, the project has enhanced interprofessional attitudes and practices. As well, as the students involved in the pilot noted, the module helped to increase their understanding of team-based practice when working with Anishinaabe clients.

Second, if the goal of a project is constructivist-based learning about inter-professionalism, Web-based asynchronous learning alone is unlikely to be sufficient. This kind of learning will be further enriched when it is complemented by carefully designed synchronous discussion time and activities.

Third, although the project only scratched the surface of Leininger's (2006) model of cultural care (i.e., the provision of care that is culturally congruent), based on student feedback and the overall experiences of members of the project team, the principles and approaches that were used appear to be in line with Leininger's model. All stakeholders in the project also worked diligently to uphold and respect the principles articulated in the

Practice Guideline for Culturally Sensitive Care (CNO, 2005), and the outcomes of this commitment were positive.

Finally, because every project, project team, and cultural community is different, it is shortsighted to suggest that the approach described here is appropriate for all projects involving universities and Aboriginal communities. Such thinking is contrary to the ideas that culture is a live and an ever-changing entity and that every community possesses its own cultural identity. Instead, it is suggested that projects purposefully grounded in culturally appropriate principles and practices are more likely to be successful and beneficial to the involved stakeholders. Additionally, the Anishinaabe community of the North Shore is recognized as a cultural exemplar of a community that appreciates the intersection and potential of traditional knowledge and contemporary health education practices and technologies. The community's decision to embrace modern educational technologies and its willingness to work with the local university have given young health professionals interested in learning more about culture and health access to beliefs and understandings that are thousands of years old.

NOTE

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BIOGRAPHIES

Lorraine Carter has extensive experience in online and distributed education in remote, rural, and northern contexts. Her present research interests include culturally safe health care and inter-professional health applications, such as telehealth and telenursing. Lorraine is the present chair of the CAUCE Information and Research Committee and is a faculty member in the School of Nursing at Laurentian University.

Lorraine Carter possède de l'expérience considérable en éducation en ligne et répartie dans des contextes éloignés, ruraux et au Nord. Ses recherches actuelles portent sur les soins de santé culturellement sécuritaires et les applications en santé interprofessionnels, par exemple la télésanté et les télé-soins infirmiers. Lorraine est présidente du comité d'information et de recherches de l'AEPUC et est membre de la faculté des sciences infirmières de l'Université Laurentienne.

Ellen Rukholm is Professor Emeritus with Laurentian University's School of Nursing and the present executive director of the Canadian Association for Schools of Nursing (CASN). Among her many educational and research interests are access and flexibility for health students, cardiac health and education, inter-professionalism, and cultural safety.

Ellen Rukholm est professeure émérite à la faculté des sciences infirmières de l'Université Laurentienne et directrice exécutive de l'Association canadienne des écoles de sciences infirmières (ACESI). Parmi tous ses intérêts en éducation et en recherche se trouvent l'accessibilité et la flexibilité pour les étudiants de la santé, la santé et l'éducation cardiaque, l'interprofessionalism, et la sécurité culturelle.