

## Interprofessional Collaboration and Culturally-Safe Aboriginal Health Care

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### Abstract

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The subject of this paper is the piloting of an asynchronous web-based module that delivered interprofessional health-oriented content informed by the values and beliefs of Aboriginal people to undergraduate learners. The most important finding based on the pilot is the need for a two-fold orientation before learners begin the module. First, learners need to understand that the primary goal of the module is to foster inter-professional thinking and practice and that the activities and assignments necessarily involve teamwork. On a more practical level, learners, despite the growing prevalence of online learning, continue to require orientation to web-based learning sites and their unique features and functionalities. Based on the overarching goal of interprofessionalism through teamwork, the group overseeing the pilot also perceived a number of limitations related to asynchronous learning. Facilitation of group work, particularly when enrolment is low, such as sometimes occurs in remote and northern communities can be very challenging. The role of the facilitator was also highlighted as central to a successful experience.

### Résumé

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Le sujet de cet article est le pilotage d'un module asynchrone sur le Web, pour des étudiants de premier cycle, qui livre du contenu interprofessionnel sur la santé contextualisé par les valeurs et les croyances aborigènes. Le résultat le plus important basé sur le pilotage est la nécessité d'une double orientation avant que les apprenants ne commencent le module. Premièrement, les apprenants doivent comprendre que le but premier du module est de favoriser la pensée et la pratique interprofessionnelle, et que les activités d'apprentissage et les travaux impliquent du travail d'équipe. À un niveau plus pratique, les apprenants, en dépit d'une prévalence de plus en plus grande de l'apprentissage en ligne, continuent d'avoir besoin d'orientation vers les sites d'apprentissage en ligne, ainsi que pour les fonctionnalités et caractéristiques qui leur sont propres. En se basant sur le but englobant de l'inter-professionnalisme, grâce au travail d'équipe, le groupe supervisant le pilotage a perçu un certain nombre de limitations liées à l'apprentissage asynchrone. La facilitation du travail de groupe, particulièrement lorsque le nombre d'inscriptions est bas, ce qui est fréquent dans les communautés éloignées du Nord, peut être difficile. Le rôle de facilitateur a été identifié comme crucial pour une expérience réussie.

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### Introduction

The focus of this pilot study is an online module that presents the teachings and beliefs of Aboriginal Elders and an Aboriginal physiotherapist from a geographical region north of Lake Huron in Ontario, Canada. As part of a larger Health Canada initiative called Interprofessional Education for Collaborative Patient-centered Practice, the project shares Aboriginal traditional knowledge through contemporary educational technologies. The intended educational outcome is that these traditional Aboriginal life lessons are understood and transferred to present and future health care providers who will provide culturally-safe, team-based care for Aboriginal clients and their families in northern Ontario.

The module will soon be available as a course for credit with Laurentian University in Sudbury, ON. It has also been prepared for students who wish to study in the French language.

### General Context

Interprofessional Collaboration: Culturally-informed Aboriginal Health Care is an initiative involving faculty from the School of Nursing at Laurentian University, a mid-sized, tri-cultural (English, French, and Aboriginal) university in Sudbury, Ontario, Canada. 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. Funding for the Institute was provided by Health Canada as part of a strategy called Interprofessional Education for Collaborative Patient-centered Practice.

Working over a four-year period, the Institute pursued three goals:

- to foster changes in attitude towards interprofessional education,
- to increase the number of health professionals prepared in interprofessional education and collaborative patient-centered care, and
- to develop and assess a high-quality interprofessional curriculum available to learners through asynchronous online (web-based) means.

As part of the above goals, eleven collaborative competencies for health professionals were targeted. These competencies relate to roles, teamwork, identity, evaluation, and thinking (Kearney, 2008: 25).

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

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. Given these increases, the Canadian Aboriginal population has been identified as the fastest growing segment of Canada's population, increasing by 45% between 1996 and 2006. This rate of growth is nearly six times faster than the 8% rate of growth for Canada's non-Aboriginal population over the same period.

Aboriginal people have historically had poorer health status than other Canadians (Health Canada, 2003). In some instances, access to health care, including disability support services, health services, specialized therapy, and education is significantly restricted, consistently poor, or non-existent (Hanvey, 2002); in other cases, there is failure to utilize services. As a result, Health Canada has made a commitment to Aboriginal people to improve their access to healthcare services; to prevent chronic and contagious diseases; and to improve their overall health and well-being.

The World Health Organization (WHO) defines health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (2008). Within Aboriginal culture, optimum health incorporates physical, mental, social, and spiritual components and emphasizes that the health and well-being of the community and the individual are interdependent and equally important (Lafontaine, 2006). Therefore, health within Aboriginal culture cannot be assessed or addressed separately from community and cultural context.

The term cultural safety was first developed in New Zealand during the 1980s and incorporated into nursing curricula as a response to the Maori people's discontent with nursing care. Related terms include cultural competency, cultural awareness, cultural sensitivity, and cultural appropriateness. Healthcare professionals need to learn to recognize their own cultural beliefs and attitudes as well as the cultural beliefs and attitudes of the different populations they serve; understanding and respect develop through this recognition. According to the National Aboriginal Health Organization (NAHO), culturally-safe health care “empowers people because it reinforces the idea that each person's knowledge and reality is valid and valuable” (2008).

In Canada, the Interprofessional Education for Collaborative Patient-Centred Practice initiative enhances health education programs so that healthcare providers can work effectively as members of interprofessional teams (Health Canada, n.d.). Interprofessional education is defined as the process of learning collaboratively; it includes socializing together,

mutual understanding of and respect for other disciplines, and the competencies of collaborative practice (Health Canada, n.d.).

The focus of this paper—the Interprofessional Collaboration: Culturally-informed Aboriginal Health Care initiative—blends interprofessional education for collaborative patient-centred practice and cultural safety in an asynchronous online educational module developed by Laurentian University. The theoretical framework that informed thinking and decisions regarding interprofessionalism is D'Amour and Oandasan's (2004) model called Interprofessional Education for Collaborative Patient-centered Practice. This model emphasizes the interdependence and interplay among factors influencing the educational and professional systems in which health providers study and work. With the healthcare learner at the centre of the health education system and the client at the heart of the professional setting, it is suggested that, through interprofessional education, the two systems can become less silo-like and, thus, provide better health care. By comparison, the educational theory that supported this project is principally, but not exclusively, constructivist in nature. In addition to an orientation to constructivism, the module includes components from transmissive and experiential learning. Examples of transmissive learning were video lectures given by Elders while experiential learning was represented by case studies.

### Involvement of Laurentian University

As previously noted, faculty from Laurentian University's School of Nursing led the development of a module that emphasizes cultural knowledge so that healthcare providers become sensitized to the cultural attitudes, beliefs, and values of Aboriginal clients and communities. This work is important to Laurentian University because of its dedication to serving the educational needs of Aboriginal learners and other learners wishing to better understand the Aboriginal experience. Additionally, Laurentian has a strong mandate in the health and distance education fields. Its School of Nursing offers undergraduate and graduate level programs in English and French; Laurentian also has a School of Midwifery, a School of Human Kinetics, a School of Social Work, and a School of Medicine. The university has been active in the distance education field since the 1960s and has a centralized Centre for Continuing Education that has won several national awards for its work in online distance education.

There are three main objectives for learners who enroll in Interprofessional Collaboration: Culturally-informed Health Care. These objectives include understanding how Western medicine can intersect with and promote the improved health and well-being of Aboriginal people; demonstrating knowledge of the discipline of interprofessional

practice and relevant academic and professional literature; and demonstrating awareness of the connectedness of the physical, mental, spiritual, and emotional components of health as understood by Aboriginal people.

### The Module Itself

The traditional beliefs and values found in the module are those of Aboriginal Elders and a practicing Aboriginal physiotherapist from what is called the North Shore, an area between Sudbury and Sault Ste. Marie, Ontario, Canada. Importantly, no single educational module can reflect the beliefs and values of all of Canada's Aboriginal peoples; for example, even the geographical region known as the North Shore includes several separate First Nations. These communities are Batchawana, Garden River, Thessalon, Missasauga, Whitefish Lake, and Sagamok Anishnawbek.

Laurentian University's School of Nursing faculty working with educational developers contributed various learning activities, identified relevant literature dealing with interprofessionalism and culturally-safe health care, and prepared the WebCT learning site. Emerging best practices related to instructional design in online education and more established practices from andragogy informed this work.

As a WebCT learning experience, the module is conceptualized as a journey. In contrast with using a traditional table of contents framework, the learner uses a map and compass to progress forward and backwards through the teachings and learning activities. Although the learning experience includes a facilitator, the facilitator does not provide, transmit, or interpret content. Rather, the learner has four Aboriginal teachers with whom he or she engages through professionally prepared videoclips.

Each videoclip is enhanced by carefully designed learning supports and tools. For instance, a glossary explains terms that may be unfamiliar. A Guided Listening Tool accompanies each talk so that the learner has assistance in discerning key messages. Each clip includes a case-based Cultural Learning Activity that requires contributions to the Sharing Circle; the Sharing Circle is the threaded bulletin board/discussion forum. All Cultural Learning Activities emphasize cultural awareness in a health setting that involves an Aboriginal client. Further, the module includes selected readings so that the learner is connecting his or her thinking to evidence and theory from the literature; an extensive case study that pulls together many of the concepts learners have experienced earlier in their learning journeys closes the module. These strategies help learners to gather knowledge from primary sources, learn about teamwork, and situate what they are learning about culturally-informed health care within a theoretical context.

Asynchronous web-based education holds particular benefits for health education learners. Typically, health education students—even at the undergraduate level—have very busy lives. Among today's many educational options, asynchronous online education stands out for its accessibility and flexibility. Some of the opportunities reported to be supported by asynchronous online education since its earliest days include the following: engagement and experience with high quality learning materials and activities including discipline-specific graphics, sound and audio clips, instructor-selected web links, interactive demos, simulations and so forth (Bonk & King, 1998; Harasim, Hiltz, Tele & Turoff, 1996); different kinds and levels of interaction between the instructor and the student, between the instructor and a group of students, between a member of the learning support staff and the student, between a member of the learning support staff and a group of students; between the educational interface and the student (Billings, 1999; Bonk & King, 1998; Carter & Rukholm, 2008, 2002; Cragg, 1994; Harasim et al., 1996); multimedia-based learning resources including clinical databases and simulations reflecting real-world practice (Billings, 1999); opportunities for formative and summative assessment as well as participation in high-level scholarly discourse at a physical distance (Carter & Rukholm, 2008).

### Pilot Offering

Participants in the twelve-week pilot offered in Spring-Summer 2007 were recruited through word of mouth. While 20 participants enrolled, six completed the pilot. The module continues to be offered and the facilitator is still an Aboriginal professor from the Laurentian University School of Nursing. Because of the content of the module and its goal of fostering interprofessionalism and cultural awareness in an Aboriginal health setting, it is important that the facilitator possess expertise in both health care and Aboriginal culture. While the pilot was the first online course delivered by the facilitator, she does have expertise in facilitating blended courses in which face-to-face learning sessions are complemented with online resources and tools).

The low completion rate in the pilot is attributed to several factors. Foremost, the pilot was conducted in the spring-summer when it is often difficult for learners to maintain commitment and motivation. Also problematic was the fact that the pilot was a non-credit course. Had the pilot been conducted in the autumn when students are in "study mode," this might have led to a higher completion rate. In addition, Laurentian University students are not accustomed to modules and courses that do not include university-level credits. For example, while Laurentian has a

strong history in continuing, distance, and online education, in all cases, the courses and programs offered are university-level credit courses. Learning experiences that do not include university credits may, therefore, be less appealing than credit offerings. Finally, because the module was conceptualized as a 12-week learning experience, it may have been too long to sustain engagement. While a shorter pilot might have enhanced retention, it would not have reflected what was conceptualized as necessary for the students to grow as healthcare professionals familiar with Aboriginal beliefs, attitudes, and practices in an Aboriginal context.

### Findings

Because of the small size of the participant group, it was not possible to make any generalizations based on the participants' observations. To compensate, the Laurentian University project team gathered more data from the module facilitator and other interprofessional health educators who are part of the larger Institute. Based on these data sources, three areas were noted as requiring improvement and/or adjustment: navigation, discourse, and the learning activities.

The first area of concern related to the first few web pages of the module. While, at the time of the pilot, the module provided a couple of different entry points into the main part of the module, these multiple entry points led to confusion for some participants. While the map as the table of contents was favorably received, having more than one way of getting to it was not.

The second area of major comment focused on the facilitation of discourse within the context of a small learner group. Because the expert content in the module is delivered by the four Aboriginal teachers, it follows that the facilitator must assume a different role than he or she likely assumes in other classrooms. This noted, the role of the facilitator is certainly not a lesser role. Instead, his or her first task is to support thoughtful and team-focused dialogue among participants. The facilitator's second task is to keep learners on task as per their goal of experiencing interprofessionalism and team-work. Understandably, health education students will be interested in health-related content. In this instance though, the primary focus is interprofessional teamwork. While the facilitator in the pilot demonstrated commitment to both these tasks, it is suggested that she was disadvantaged by the smallness of the learner group and the fact that the group did not meet in a synchronous way before the pilot.

The pilot's learning activities may have been insufficiently team focused. For example, for each Cultural Learning Activity, learners were

asked to respond as a health professional working alone with an Aboriginal client, and then as a health professional who is a part of an interprofessional team working with the same individual. As such, the activities did not ask the learners to work as a team in responding to cases. Although the participants reflected on teamwork, they did not participate in it.

Several modifications have since been made to the module. For example, learners are now required to attend two to three synchronous meetings offered as face-to-face meetings, teleconferences, videoconferences, and/or computer conferences. The purposes of these meetings are to negotiate roles and approaches in relation to the case studies and other activities; to interact as teams in real time; and to discuss personal and team-based growth. While these changes are regarded as valuable in facilitating teamwork and interprofessionalism, it is respectfully suggested that synchronous sessions can be logistically difficult to organize. Additionally, creation and development of teams can be challenging when the learner group is small, such as in the pilot. In northern Ontario as well as other northern, rural, and remote communities, it is conceivable that enrolments may be consistently small. Therefore, further work is required so that practical and effective ways of enabling case-based learning and interprofessional teamwork in an asynchronous web-based learning environment can be discovered.

### Conclusions

This project is important in several ways. First, it identified the good will, energy, and commitment of health educators and individuals within a specific Aboriginal community that is required to work together and foster cultural awareness in the health education field. Also important is the source of the expert content in the module. While Elders typically view their life role as a sharing and teaching one, the opportunity of learning from them is not always provided to others beyond the immediate cultural community. It was, and continues to be, a special experience to be able to sit with the Elders and take in their ideas as expressed in their own words. The module is further unique in its use of modern educational technologies to bring beliefs and understandings that are thousands of years old to young health professionals and others interested in learning more about culture and health. Finally, while one might argue that team building is best accomplished in the face-to-face setting, it is suggested that, with ongoing improvement, capable facilitation, and committed learners, this online learning experience will demonstrate that community and teamwork are more about human exchange than physical proximity.

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