

Reconsidering the “NO SHOW” Stamp: Increasing Cultural Safety by Making Peace with a Colonial Legacy

Othmar F. Arnold

Abstract: Practising in a cross-cultural environment requires nurses to be critically aware of their personal and professional cultural attitudes and behaviours. In this article, the practice of using a “NO SHOW” stamp in primary health care settings in Canada’s North is analyzed. The aim is to examine the effects of this practice, which is embedded in nursing cultures in the North, with particular attention to the post-colonial context. A review of health disparities encountered by Aboriginal populations provides a social, cultural, and historical context. The literature review focuses also on the discourse of non-attendance of medical appointments. Observations from the author’s practice are used to describe the phenomenon of concern. A case-study approach using McLuhan’s Laws of Media is employed to examine this taken-for-granted tool, its use, and its implications. The analysis illustrates how the use of the stamp extends paternalism, obsolesces the individual story, signifies authority, and reverses caring. The analysis points to racist connotations attached to the tool and its use. The article concludes with a recommendation to discontinue the practice of using the “NO SHOW” stamp because of its discriminatory potential. Such policy change will strengthen cultural safety in nursing practice, contribute to reducing health disparities, and help create a more peaceful practice environment.

Introduction

Nursing practice in cross-cultural settings requires the same set of learned skills and clinical competencies as in any health care setting. However, working across cultural differences requires nurses to have additional cultural competencies (Anderson et al., 2003). Cultural competency is a set of behaviours, attitudes, and policies that require nurses to critically examine their own cultural behaviours and attitudes, and how they shape their practice.

Modern health care was introduced to Indigenous peoples in northern Canada through the process of colonization. Throughout the colonial period, and more so since the recognition of Aboriginal rights and land claims, Aboriginal peoples have been renegotiating their definitions of health as well as their relationships with the colonial forces (Atleo, 1997). An examination of practices within the health care system for remnants of colonial attitudes and policies and their effects on health and healing is necessary.

The purpose of this article is to initiate a discussion about a taken-for-granted practice—the use of a “NO SHOW” stamp—observed in primary health care settings in Canada’s North. The case study and analysis of this practice considers connections to covert racism and how these are linked to health disparities. It includes recommendations for improvement to cross-cultural practice and toward reduction of health disparities, as well as the proposition that eliminating colonial legacies with discriminatory connotations will help to reduce existing conflicts.

In this article, a literature review provides a background on health disparities and the discourse on attendance. Personal observations are shared to illustrate it. A framework to study the effects of technology (McLuhan & McLuhan, 1988) is introduced and employed to analyze the effects of the stamp in cross-cultural practice. Under war and peace-themed headings, various effects of the stamp as a form of structural violence, including its racist connotations, are discussed using published research findings and observations from personal practice. Finally, the retirement of the “NO SHOW” stamp is recommended as a definite step towards building peace.

Health Disparities

Health disparities are measurable differences between socially and economically different groups (Braveman, 2006). These measures provide accountability for systematic and avoidable forms of discrimination. Other definitions of health disparities, less informed by the discourses of social justice and human rights, focus more on health status as defined by clinical and epidemiological factors or on the access to services. For this article, Braveman’s definition is used because of its integrated nature. The definition facilitates a qualitative analysis and is congruent with the purpose of the analysis.

Braveman’s (2006) definition mirrors the approach underlying the assessment of the relationship between Aboriginal and non-Aboriginal people in Canada by the Royal Commission on Aboriginal Peoples (1996). Health disparities between Aboriginal peoples and the general population in Canada are widely recognized. After the 1996 publication of the *Report of the*

Royal Commission on Aboriginal Peoples, health disparities could no longer be ignored, brushed aside as isolated incidents of unfortunate circumstances, or declared as consequences of deficient individual health behaviours. The report proclaimed “the health status of Aboriginal people in Canada today [a]s both a tragedy and a crisis” (Royal Commission on Aboriginal Peoples, n.p.). Consistent with its holistic focus, the royal commission did not consider the dismal health status of many Aboriginal peoples separate from the lack of self-governance, the unequal economic opportunities, or the social and cultural effects of centuries’ old subjugation and assimilation policies and practices.

The scientific community has since increasingly embraced Aboriginal health as a critical topic. The availability of targeted government funding has led to the establishment of specific research programs. Health disparities also became newsworthy. The media uses them by sensationalizing particular aspects of Aboriginal health. For example, in a news release in a medical journal on the spread of the influenza A (H1N1) virus, Kondro (2009) emphasizes remote Aboriginal communities as the location of the first pandemic outbreak. Aboriginality is the only descriptor used as the explanation for the location of the outbreak. The author fails to name the possible underlying health disparities, such as substandard living conditions and pre-existing disease (Canadian Broadcasting Corporation, 2009, July 20). Therefore, the conclusion calls for more funding for pharmaceutical treatments. A call to address the socio-economic causes of health disparities would have equal merit.

Living in and working with Aboriginal communities can provide a unique perspective on the health status and the causes of disparities among Aboriginal peoples. For this author, no observation stands out as much as the discourse among health professionals about the honouring of medical appointments and the compliance with prescribed treatments. Many health professionals seem to be convinced that improved attendance and compliance will significantly reduce the rates of ill health in Aboriginal communities.

This attitude is rooted in the health belief model that emphasizes individual responsibility for health that can be influenced by information about personal risks and benefits (Young, 2002). These assumptions imply that irresponsible behaviours are a cause of ill health and health disparities. I have witnessed comments from nurses who use words like “those people are not able or willing to take care of themselves.” The Health Disparities Task Group (2004) extends that notion in general to correlate with a low socio-economic status. The onus for missing appointments and the perceived consequences are put on the client, effectively blaming the victim for health

disparities. Browne and Fiske (2001) state that the mechanism of victim blaming is one of the legacies of colonial ideology informing the federally sponsored health services for Aboriginal communities. The witnessed remarks seem to be acceptable as an uncontested sentiment within a health care culture.

Non-Attendance As a Source of Ill Health?

Non-attendance of medical appointments is mainly studied as an economic concern for health care providers, and health outcomes related to attendance are investigated less often. However, a study by Gruen, Weeramanthri, Knight, and Bailie (2009) found that the availability of primary health care services and specialist outreach clinics for rural, remote, and disadvantaged populations will improve attendance, but that increased attendance does not impact the health outcomes. The authors argue that it takes multifaceted interventions and a collaboration of services in order to achieve improved outcomes for disadvantaged communities.

None of the reviewed studies have explicitly controlled the influence of cultural factors, such as culturally appropriate care (Anderson, Scrimshaw, et al., 2003) or cultural safety (Ramsden, 2002), when analyzing attendance and health outcomes.

Arnold and Bruce (2005) state that differences in world views between the medical culture and diverse Aboriginal cultures require from health care providers an ability to operate in more than one paradigm in order to bridge the gaps and to avoid misunderstandings. Differences in world views can produce competing priorities and influence the attendance rates. Martin, Perfect, and Mantle (2005) illustrate that “what’s going on in [clients’] lives” (p. 640) leads to missed appointments. Izard (2005) suggests that racialization and poverty correlate with above-average non-attendance rates for medical appointments.

Rates of non-attendance for scheduled appointments in primary health care have not been studied or reported in the literature for Canada’s North or for Aboriginal communities. However, a rate of 35 percent has been observed for the Kitikmeot Health Centre in Cambridge Bay, Nunavut (Jean Conrad, personal communication, March 2009). George and Rubin (2003) report non-attendance rates in primary care between 5 and 55 percent.

While established processes of generic appointment reminders—phone messages from clerical staff or hand-delivered written notes—lack proven effectiveness, research from other primary care disciplines (Capko, 2009) has shown that improved communications strategies can reduce non-attendance rates. Studies on patients’ perceptions of non-attendance support the notion

that direct communication about purpose and timing of appointments between the clinician and the client increases attendance rates and reduces conflict (Lacy et al., 2004; Martin et al., 2005). In my own practice, I have observed that direct and specific communications between nurse and client about a plan of care and the necessary appointments, including shared decision making, have improved attendance.

The “NO SHOW” Stamp

One tool used in health centres across Canada’s North illustrates, documents, and perpetuates the core of the non-attendance discourse: The “NO SHOW” stamp. It is a rubber stamp, used with red ink, to record missed medical appointments. At the end of a clinic day, a clerk or a nurse uses the “NO SHOW” stamp in the personal health record of any client who did not attend a scheduled appointment. This is in lieu of a progress note. The same information is also collected in electronic appointment management systems.

The “NO SHOW” stamp qualifies as technology: It is both a tool (for simplifying record keeping) and a communications code (for standardizing charting entries). The message of the “NO SHOW” stamp can be summarized: This person did not show up to attend and did not cancel a scheduled appointment. The other message it produces is visual: The stamp stands out like a sign in a personal health record among handwritten entries. This visual message draws much more attention than the two words.

The use of the stamp is part of the institutional culture in health centres across Canada’s North. Yet while it makes an imprint in a patient’s health record, it has no direct effect on patient outcomes or population health. The stamp’s use raises questions about its implications for the provision of culturally safe (Ramsden, 2002; Anderson, et al., 2003) care. In the following analysis, I will examine the “NO SHOW” stamp as a tool and the implications of its use in the provision of health care services, particularly to Aboriginal communities in Canada’s North.

How to Examine the Taken-For-Granted?

The analysis is informed by Marshall McLuhan’s critique of development of technology: he postulates that humans shape their tools and in return become shaped by the same (McLuhan & McLuhan, 1988). Technologies, in this sense, are ways of encoding reality. They become media carrying messages of how the world is organized. How individuals encode the world affects cultural forms, societal structures, and the way knowledge is internalized. McLuhan understood media as working like language, with internal structures and

rules, or grammars. Those grammatical structures evolve from cultural, social, political, and economic contexts.

This inquiry is grounded in my own lived experience as a community member and nurse in Canada's North. The study is guided by the concern of how to identify factors beyond the immediate medical and epidemiologic causes that may contribute to the health disparities. The main question is: How do taken-for-granted ways in cross-cultural practice shape the experience and outcome of Aboriginal health?

The framework for uncovering the context of the particular practice of using the "NO SHOW" stamp in this case study is McLuhan's *Laws of Media: The New Science* (McLuhan & McLuhan, 1988). It is a platform for an interdisciplinary and critical analysis with a historical perspective—however, a description of the structure of health care delivery to Aboriginal peoples in Canada, its complicated historical context, the health status over time (see Waldram, Herring, & Young, 1995), and the epidemiology of the health disparities are topics that reach beyond this article.

McLuhan's Laws of Media

McLuhan's framework is designed to make explicit the deeper meaning of a wide range of media. McLuhan postulates that every technology will (1) extend some human trait or experience, (2) render obsolete an established way of doing things, (3) retrieve a long-lost method or experience, and (4) reverse into its opposite if pushed far enough (McLuhan & McLuhan, 1988). These statements were the result of the research question: "What general, verifiable (that is, testable) statements can be made about all media?" (McLuhan & McLuhan, p. 7). Because of its heuristic nature, McLuhan's proposed procedure can be applied and tested by anyone. To maintain its universality, McLuhan does not work with a specific underlying theory or paradigm.

McLuhan assumes that the figure—in this case the rubber stamp—cannot be separated from its ground—the environment in which it operates (McLuhan & McLuhan, 1988). The environment is the nursing practice in the North and its roots in a historical continuum from the European exploration of North America to the colonial promise of the medicine chest in Treaty No. 6 (1876).

Technology works through its context. For McLuhan it was important to understand that technologies influence people's attitudes and cultures (Gabriele & Stober, 2007, n.p.).

Analysis

The media effects for the “NO SHOW” stamp based on McLuhan’s framework are shown in Table 1.

Table 1. Tetrad of media effects for the “NO SHOW” stamp in Primary Health Care

<p>What does the medium/technology extend?</p> <p>Paternalism</p>		<p>What does the medium/technology reverse if pushed too far?</p> <p>Caring</p>
	<p>“NO SHOW” stamp in Primary Health Care</p>	
<p>What does the medium/technology retrieve that was made obsolete earlier?</p> <p>Seal</p>		<p>What does the medium/technology make obsolete?</p> <p>Individual story</p>

What the Technology Extends: Paternalism

Paternalism is a human experience accepted as normative in family units and some societies (Dworkin, 2009). The motive for paternalism is to prevent harm or to produce good for the other person. It occurs when a person ignores the stated or presumed wish of another human being (Miller, 2003). In child rearing, a paternalistic attitude is rarely questioned. However, in a health care context, a variety of legal and ethical concepts need to be considered. Miller provides a broad discussion thereof, focusing on questions of autonomy and beneficence, but also including responsibility, competence, freedom, agency, and equality. Elements of paternalism will be further discussed below. In a colonial context, autonomy, competence, and agency are denied. The rhetoric of responsibility is used as a cover for subjugation.

Use of the “NO SHOW” stamp on a personal health record extends paternalism by dismissing the client’s autonomy and competence to decide in personal health matters. Medical treatment needs to be for the benefit of the client or to prevent harm. A client may initially have consented to such an appointment, but subsequently decided that it is no longer necessary or feasible to attend.

Dworkin (2009) offers a test to distinguish paternalism from other forms of disagreement or refusal to co-operate:

(1) [action] Z (or its omission) interferes with the liberty or autonomy of [client] Y. (2) [provider] X does so without the consent of Y. (3) X does so just because Z will improve the welfare of Y. (Dworkin, p. 3)

Use of the “NO SHOW” stamp interferes with the client’s decision not to attend a scheduled meeting by dismissing the client’s rationale and creating a negative record. This is done without the client’s consent. Yet the scheduled meeting was intended for the benefit of the client’s health.

Use of the “NO SHOW” stamp also extends paternalism in the undertone of the message. It implies bad performance, increased risk, and liability for health consequences. Many clinicians consider non-attendance of medically necessary appointments as irrational behaviour (Buetow, 2007).

I considered and rejected several other options for traits or experiences that are extended or enhanced by the tool. Efficiency was one of them. Using the “NO SHOW” stamp is an efficient way for making repeat chart entries for frequent occurrences. However, it is the only stamp used for charting purposes in personal health records. Its significance, therefore, must be rooted in a trait or experience other than efficiency. There are numerous clinical encounters whose recording could equally be done more efficiently using a specific stamp versus a handwritten entry.

What the Technology Makes Obsolete: Individual Story

A chart entry using the “NO SHOW” stamp is very succinct so the tool meets a principle of the nursing practice standard for documentation established by the College of Registered Nurses in British Columbia (2008). The stamp is standardized and records only the need to know facts. Furthermore, it meets the standards because it communicates an observation. On the other hand, the use of the stamp renders the individual story and the context obsolete. There is no need to further investigate (1) how the scheduled appointment came to be, (2) what its medical or nursing rationale was, (3) how it was communicated between the health care provider and the client, (4) what the client’s needs, wishes, and circumstances were, or (5) how the non-attendance unfolded.

This is a significant loss of knowledge about the client. Lacy, Paulman, Reuter, and Lovejoy (2004) show that making and keeping appointments is a complex interaction between booking systems, symptoms, emotions, anticipated consequences, and the quality of relationship with the clinician. Using a standardized message to record non-attendance excludes the individual story of the event as a source of knowledge.

What the Technology Retrieves: Seal

The office stamp is a derivative of the ancient stamp seal. A seal is used to indicate the authenticity and validity of an official document and is always associated with identity, authority, and responsibility (Platt, 2006a). A “seal of approval” is a certification mark by an institution that claims to be authoritative. Platt summarizes “the seal’s philosophical appeal lays ultimately more in its social significance—as a guarantor of authenticity and marker of the self—than in its true ontological status” (2006b, n.p.). Buetow (2007) discusses how non-attendance challenges the epistemological superiority of the health professional and how important it is to maintain the disproportionate influence health culture has on shaping societal norms. Related aspects will be discussed later under the heading *Civil War: Professional Power Struggles*.

What the Technology Reverses if Pushed Too Far: Caring

The concept of caring has, at its core, attributes like relationship, action, attitude, acceptance, and variability (Brilowski & Wendler, 2005). The authors identified the benefits of caring as increased health and healing as well as a sense of solidarity and empowerment for the client and the nurse. If the use of the “NO SHOW” stamp is pushed too far, caring can be reversed through labelling and stereotyping. Labelling establishes a hierarchy (Mullaly, 2002): individuals and population groups are deemed unreliable, careless, uncooperative, and incapable in the context of the no-show debate among nurses. Labelling can lead to stereotyping and stereotyping is an essential element of racism (Mullaly).

The “pushing too far” relates to the witnessed frequency and intensity of the no-show debate among nurses in health centres across Canada’s North. The discussion of non-attendance occupies a space in meetings among health professionals that seems out of proportion in comparison to the enormous diversity of other potential discussion topics. People are often referred to as “them,” meaning the marginalized Other (Reimer Kirkham, 2003)—most often specifically referring to Aboriginal populations. Buetow (2007) requests respect for differences in belief systems and rationality related to non-attendance. He cautions about the marginalizing effects, the loss of dignity, and the escalation of conflict. Without these elements, professional care loses its healing potential. Such a loss could create a precarious line between the nurses’ contributions to health and healing, and oppressive practices, since caring and racism are in opposition.

Discussion

McLuhan's framework is applied to the stamp and its use; however, the discussion of its effects extends to its users. This discussion is grouped under three war-theme headings to emphasize hidden conflicts. Under a fourth, peace-themed heading, the discussion about the taken-for-granted leads to recommendations and a conclusion.

The response from colleagues to the phenomenon of concern for this article was disbelief and defense: There is nothing important to write about a rubber stamp. This holds true when the tool is viewed in isolation. People's being, actions, and tools—interconnected with history and the cultural, social, political, and economic contexts—makes the study of the "NO SHOW" stamp relevant. The initial response from the nurses illustrates how taken-for-granted the "NO SHOW" stamp is. The thought that the use of the tool could be interconnected with health disparities does not easily surface.

"Indian Wars": Colonial Legacy

Paternalism as a cornerstone of Aboriginal health policy in Canada has been described before (Waldram et al., 1995). Initially, the impetus for delivering health services to Aboriginal populations came from the dramatic effects of epidemics like smallpox or tuberculosis. The rendering of assistance in time of need, as promised in Treaty No. 6 (1876), was subject to "the sympathy of the Queen" (Morris, 1880, as cited in Waldram et al., p. 176). Subsequently, bureaucrats and poets like Duncan Campbell Scott painted a picture of desperation, destitution, and incompetence among Aboriginal peoples, providing justification for paternalistic intervention (Brownlie, 2003). Advances in medical sciences and the development of a comprehensive health care system in Canada's North have greatly reduced infectious disease outbreaks. However, health disparities have not disappeared. They have rather shifted to chronic non-communicable diseases and social pathologies (Waldram, Herring, and Young, 1995).

As the focus of the primary health care has shifted from acute medical emergencies to a range of comprehensive health services, the way clients engage with the system has changed accordingly. For acute illness, the client initiates contact by booking an appointment or presenting him/herself as walk-in. Preventative services and chronic disease management are by appointment only. Evidence-based guidelines require follow-up appointments to evaluate the effectiveness of treatments.

This shift from seeking medical help because of acute illness, to a system of scheduled and recurring appointments regardless whether the client feels

sick or not, is significant. Scheduling appointments occurs frequently without further consultation with the client, particularly if the client has limited health literacy. This can lead to conflicts with clients who wish to engage with the health care system on their own terms (Buetow, 2007). Furthermore, divergent world views between nurses and clients in Aboriginal communities can lead to frustrations (Arnold & Bruce, 2005), which can translate into avoidance of clinical encounters and missed appointments.

The origin of the “NO SHOW” stamp is not recorded. It appears to be a hand-me-down from the colonial administration. The stance on Aboriginal peoples by Duncan Campbell Scott, deputy superintendent for the then Department of Indian Affairs from 1913–1932, is part of the public record and Canadian literature. He laid the groundwork for a paternalistic policy approach towards Aboriginal peoples in Canada for decades to come (Brownlie, 2003). The responsibility of providing health services to First Nations and Inuit was transferred from the colonial administration of the Department of Indian Affairs to Health Canada in 1945, but it took Health Canada until 1962 to deliver direct services to Aboriginal communities through its Medical Services Branch (Health Canada, 2007). Many Aboriginal people remember those services as oppressive: “political authority was enacted through health surveillance, policy, and practice at the community level” (Waldram et al., 1995, p. 261). Some of the older records or pieces of equipment in many of health centres have a strong resemblance to military stationery and equipment of Second World War heritage.

Before the 1970s, the health services coverage in many areas of Canada’s North, particularly for the Inuit in what is now Nunavut, was sporadic. Initially, traders, missionaries, and police officers (RCMP) provided some medical services as a sideline to their businesses. Later, physicians provided travelling clinics from patrol and research vessels. Sometimes, physicians were flown into a community to respond to a particular emergency or epidemic (Waldram et al., 1995). Only with the establishment of the outpost nursing stations and health centres in select communities did nurses begin working in an expanded role to provide more continuous and comprehensive health services.

Aboriginal people had been considered unreliable and notorious no-shows long before the establishment of the permanent health centres. During early encounters, authorities who cited their lack of Western health literacy forcefully removed Aboriginal people from their communities for medical treatment. Some of these military-style round-ups during the anti-tuberculosis campaign traumatized the population and disrupted the functioning of up-to-then self-sufficient Indigenous communities (Bjerregaard and Young,

1998). The resemblance to the colonial administration's forceful removal of children from Aboriginal communities for attendance in residential schools is striking. At the time, these genocidal actions (Krebs, 2008) were justified based on epistemological superiority and for the overall well-being of the Aboriginal peoples affected. The scientific and political establishments gave their seal of approval.

"Civil War": Professional Power Struggles

Only a few of the nurses working in the health centres in Canada's North today remember the days before comprehensive health services to Aboriginal peoples. The "NO SHOW" stamp has become isolated from the collective memory and the oppressive practices of early medical services. Therefore, it is not surprising to encounter an attitude of disbelief during discussions about the tool's implications. Why then would nurses defend and maintain the use of the stamp so religiously?

The historic struggle of the nursing profession to earn its autonomy and recognition from the medical profession is one possible explanation. Illich (1976) describes how the medical profession uses the specialization of technical expertise to justify their monopolistic definition of health and health care. This one-sided attitude creates conflict among health professions, but also between professionals and clients. Particularly in the outpost setting, nurses work in an expanded role and perform medical functions—thus competing with physicians' powerful role in health care. Daiski (2004) illustrates that interdisciplinary struggle with recent evidence. The author observes that "oppressed group behaviours" include "lashing out against ... those of lesser status" (p. 44), which can include the way nurses perceive their clients. The use of the stamp feels at times like lashing out from privileged practitioners to marginalized populations in cross-cultural settings.

Personal observations in connection with the no-show discourse in nursing practice left the impression that some nurse's behaviour could be considered lashing out at persons of lesser status. As such, a stamped "NO SHOW" entry in a personal health record can be understood as a seal to mark the nurse's status in the professional hierarchy. Furthermore, it may be a subtle form of asserting power over clients.

Alternately, lashing out could be explained by current workplace issues for nurses, from constant staffing shortages to mandatory overtime, to providing around-the-clock coverage in remote primary health care settings. These and other factors reduce job satisfaction (Andrewset al., 2005) and may lead to the same "lashing out" response among nurses. A study about lateral violence among nurses documents triggers and responses along a

power gradient (Johnson, 2009). Some responses have similar characteristics as the practice of using the “NO SHOW” stamp.

Other current professional issues and discourses can be identified in conjunction with the use of the stamp. Nurses mention liability as the main argument in defense of the use of the “NO SHOW” stamp. They argue that in today’s practice climate, the nurses have to reduce the risk from litigation—“NO SHOW” entries are an indicator for continuity of care. It is sometimes the only recorded evidence of planned follow-up care. However, a widespread fear of litigation among nurses is hardly supported by available data (Worster, Sardo, Thrasher, Fernandes, & Chemeris, 2005) since, in the small number of cases, the outcome is usually favourable for the practitioner (Canadian Health Services Research Foundation, 2006).

Efficiency was not mentioned in the discussions about the stamp’s use. From a theoretical perspective, efficiency is a theme that would need further consideration since the stamp as a technology clearly embodies elements of efficiency. However, the advent of electronic health records may considerably alter the discussion around efficiency in keeping health records.

The validity of a stamped no-show entry as appropriate documentation in a personal health record remains debatable according to professional documentation standards in nursing practice. The widespread use in primary health care in Canada’s North indicates that such an assertion has not been challenged. Through documentation, “nurses communicate their observations, decisions, actions and outcomes of these actions” (College of Registered Nurses in British Columbia, 2007, p. 5). The subsequent qualifiers describe how actions taken by the nurse are the basis for documentation and not omissions by the client. The context-free message of the “NO SHOW” stamp does not sufficiently meet the criteria for a nurse-client interaction to qualify as a relevant charting entry.

“Proxy Wars”: Challenging Nurse-Client Relationships

Clients who are confronted about their non-attendance often present counterclaims. A frequently observed claim is that clients experience a considerable waiting time even when punctual for a scheduled appointment. The provider generally excuses the incidents with operational reasons. There is no way of recording or reporting such occurrences. From my observations in practice, nurses’ time management can lead to delays in service for clients who present for their appointments on time. Capko (2005) emphasizes the importance for care providers to reciprocate the honouring of appointment times to reduce conflict and increase efficiency. Lacy et al. (2004) conclude

from client interviews that mutual respect decreases the chances for provider-client conflict based on waiting times, satisfaction, and non-attendance.

In theory, nurses and clients are equal partners in decision making for an individual's health care (Canadian Nurses Association, 2005). Oudshoorn, Ward-Griffin, and McWilliam (2007) have studied the sources of power in the nurse-client relationship and the exercise thereof. The authors describe "managing the clients" as one of the mechanisms of power nurses use. "This 'managing' of clients often include[s] little negotiation with the client themselves. Examples of 'managing' clients without their input include[s] shifting the client to another nurse or moving them to another time slot" (Oudshoorn et al., p. 1439). This is a dominating practice driven by professional or systemic considerations with disrespect for relational and contextual aspects. Unilateral flexibility in uses of time gives a nurse positional power. The lack of consideration of the client's context and the insistence on professional needs (efficiency, proper procedure, risk management) appears to be a major source of conflict in the discussion about honouring scheduled appointments.

Browne and Fiske (2001) conclude in a study of First Nations women's experiences with the health care system that a variety of "invalidating encounters make evident [how] the routines of mainstream health care delivery, in myriad ways, mirror daily social encounters that marginalize First Nations women" (p. 143). However, the narratives of affirming encounters in the same study "represent unexpected exceptions to the ubiquitous forms of racism and discrimination that shape women's everyday social experiences" (Browne & Fiske, p. 143). The key elements of the affirming encounters are respect, trust, non-discrimination, and shared decision making. Negative stereotyping and labelling of a patient, such as a "no show," and the disrespect for personal circumstances, are important dimensions of invalidating the experiences of marginalized clients.

Overall, the study of affirming and invalidating encounters by Browne and Fiske (2001) underscores the importance of carefully examining taken-for-granted practices in delivering health care in Aboriginal communities from a cultural safety perspective: It depends on the attitudes of individual practitioners whether the racist connotations of the "NO SHOW" stamp have a negative impact on the client or can be neutralized. For marginalized populations, affirming encounters will decrease conflict and improve their engagement with the health care system.

“Striving for Peace”

Ramsden (2002) describes the power of attitude in cross-cultural nursing practice from a Maori perspective. She concludes in her research:

(1) That it is very possible to create active barriers to service without recourse to spoken words. (2) That there are other discourses which are unarticulated and unanalysed but inform the behaviour of patient and professional. (3) That the influence of attitude can be a powerful inhibitor, or initiator of professional interaction. (4) That it is the responsibility of the nurse as the power holder to create an environment which enables people to feel safe in the presence of the nurse. (5) That unfavourable attitudes are easily recognised by those who have been exposed to their negative effects. (6) That those who have experienced the power of attitude imposition are always vigilant to the possibility of its presence. (Ramsden, p. 62)

Ramsden’s findings form the basis for culturally safe practice, a concept that has been adopted for a Canadian context. However, cultural safety is still largely absent from professional curricula. In this analysis, the use of the “NO SHOW” stamp has been discussed as a potential barrier to culturally safe service. Paternalism, lashing-out as power display, and a risk of reduction in care have been identified in this analysis. The underlying “no-show” discourse is not articulated within the health disciplines, but it informs professional practice in subtle ways. The discourse equally affects clients’ willingness and ability to engage meaningfully with the health care system. The onus to recognize and level the power imbalances is with the professional who holds more positional power than the client. The unfavourable attitudes and racist connotations associated with the stamp are easily recognized by those negatively affected—in this case the Aboriginal populations in Canada’s North—as demonstrated more generally in Browne and Fiske’s (2001) research. On the other hand, the stamp may have little or no effect on mainstream Canadian clients using the same primary health care services. This helps explain practitioners’ reactions to my study, which confirm their widespread unawareness of the concerns raised with this analysis. I have not observed the level of vigilance among the marginalized clients as described by Ramsden.

In summary, does racism contribute to health disparities? Singling out a group of people based on a generalized characteristic (NO SHOW) is the first step towards discriminatory behaviour and racism (Mullaly, 2002). Since the use of the “NO SHOW” stamp shapes the lives of nurses as well as clients, racist implications are not dismissible even in the absence of

spectacular actions against a particular racialized group. The findings by the Royal Commission on Aboriginal Peoples (1996) establish that significant health disparities exist. The commission has also recorded strong linkages between current health disparities and the oppressive and racist government policies and practices of the colonial period. Cultural factors embodied in professional practice—such as policies and attitudes based on the superiority of one particular world view—continue those oppressive mechanisms long after the active pursuit of domination and assimilation of Aboriginal peoples. Paternalism, the element identified in this analysis that is extended by the use of the “NO SHOW” stamp, is one of these cultural factors. The use of the “NO SHOW” stamp in primary health care signifies authority, makes the individual narrative obsolete, and threatens caring.

Nurses and other health professionals need to acknowledge that oppressive practices are part of racism and that such practices lead to health disparities for the subordinate population. According to Krieger (2003), being explicit about racism is a necessity. Caring includes building strong relationships across cultural differences, reflecting on attitudes and actions from a cultural safety perspective, and accepting that questionable practices need to be changed as new insights are revealed.

As a small gesture towards reducing health disparities of Aboriginal populations in Canada’s North, I recommend retiring the “NO SHOW” stamp. This would enhance the cultural safety of daily practice. All the valid points of using the tool can be addressed in alternate ways. Statistical information about service utilization is already being collected in the appointment management database: no-shows are recorded as such. The concerns of the risk of litigation need to be addressed in a more appropriate way: Nurses need to positively record an interaction with the client; for example as a phone call to invite the client for a routine follow-up (as per guidelines), and then the client’s respective response. If the client does not honour the appointment, a lack of a corresponding entry will be sufficient documentation.

Examining and understanding the cultural, social, and historical dynamics of taken-for-granted practices is like doing a conflict analysis before there is an acute and open crisis. This will be integral to the reduction of health disparities and part of the foundation for lasting peace between the Aboriginal populations of Canada and the mainstream society.

Conclusions

In this article, I have shown that McLuhan's Laws of Media (McLuhan & McLuhan, 1988) are useful in identifying cultural factors, beyond medical and epidemiologic causes, that contribute to the health disparities encountered by Aboriginal peoples in Canada's North. The framework guided me to describe the taken-for-granted practice of using the "NO SHOW" stamp in a wider context. Through the analysis, I was able to describe how Canada's policy of assimilation, ostensibly abandoned, is still interconnected with aspects of contemporary nursing practice in primary health care. The "NO SHOW" stamp is quietly contributing to the persistence of discriminatory professional practices and individual attitudes. Many other practices may benefit from a similar analysis.

Policy changes such as the retirement of the "NO SHOW" stamp and the introduction of cultural safety as the educational foundation for nurses and other health professionals will help create a more peaceful practice environment. The more colonial legacies put to rest, the easier it will become to address health disparities. However, real change will come from individual nurses reflecting on personal attitudes, understanding how their lives are shaped by technology and history, and understanding how their profession shapes their tools—from the words they use to the technologies they embrace.

Author

Othmar F. Arnold is an advanced practice nurse and peace worker based in Whitehorse who has worked in Yukon and Nunavut communities in various capacities since 1993; more recently, he served with Doctors Without Borders in Chad.

References

- Anderson, J., Perry, J.A., Blue, C., Browne, A., Henderson, A., Khan, K., et al. (2003). "Rewriting" cultural safety within the postcolonial and postnational feminist project: Toward new epistemologies of healing. *Advances in Nursing Science*, 26(3), 196–214. Retrieved September 11, 2008 from Academic Search Premier.
- Anderson, L.M., Scrimshaw, S.C., Fullilove, M.T., Fielding, J.E., Normand, J. & Task Force on Community Preventive Services. (2003). Culturally competent healthcare systems: A systematic review. *American Journal of Preventive Medicine*, 24(3S), 68–79. Retrieved July 21, 2009 via <http://scholar.google.com>.
- Andrews, M.-E., Stewart, N.J., Pitblado, J.R., Morgan, D.G., D'Arcy, C., & Forbes, D. (2005). Registered nurses working alone in rural and remote Canada. *Canadian Journal of Nursing Research*, 37(1), 14–33. Retrieved July 31, 2009 from IngentaConnect database.

- Arnold, O.F. & Bruce, A. (2005). Nursing practice with Aboriginal communities: Expanding worldviews. *Nursing Science Quarterly*, 18(3), 259–263.
- Atleo, M.R. (1997). First Nations healing: Dominance or health. *Canadian Journal for the Study of Adult Education*, 11(2), 63–77.
- Bjerregaard, P. & Young, T.K. (1998). *The circumpolar Inuit: Health of a population in transition*. Copenhagen: Munksgaard. Retrieved July 17, 2009 from <http://books.google.com>.
- Braveman, P. (2006). Health disparities and health equity: Concepts and measurement. *Annual Review of Public Health*, 27(1), 167–194. Retrieved July 20, 2009 from <http://www.ops.org.bo/textocompleto/riarph270004.pdf>.
- Brilowski, G.A., & Wendler, M.C. (2005). An evolutionary concept analysis of caring. *Journal of Advanced Nursing*, 50(6), 641–650. Retrieved July 14, 2009 from EBSCOhost database.
- Browne, A.J. & Fiske, J.A. (2001). First Nations women's encounters with mainstream health care services. *Western Journal of Nursing Research*, 23(2), 126–147. Retrieved September 11, 2008 from CSA Sage Health Sciences database.
- Brownlie, R.J. (2003). *A fatherly eye: Indian agents, government power and aboriginal resistance in Ontario, 1918–1939*. Don Mills: Oxford University Press. Retrieved July 16, 2009 from <http://books.google.com>.
- Buetow, S. (2007). Non-attendance for health care: When rational beliefs collide. *Sociological Review*, 55(3), 592–610. Retrieved July 24, 2009 from Academic Search Complete database.
- Canadian Broadcasting Corporation. (2009, July 20). *Swine flu hits young aboriginal residents hard, expert says*. Retrieved September 19, 2009 from <http://www.cbc.ca/canada/north/story/2009/07/20/aboriginal-flu.html>.
- Canadian Health Services Research Foundation. (2006). *Myth: Medical malpractice lawsuits plague Canada*. Retrieved July 21, 2009 from http://www.chsrf.ca/mythbusters/pdf/myth21_e.pdf.
- Canadian Nurses Association. (2005). *Primary health care: A summary of the issues*. Ottawa, ON: Author. Retrieved July 17, 2009 from http://www.cna-nurses.ca/CNA/documents/pdf/publications/BG7_Primary_Health_Care_e.pdf.
- Capko, J. (2005). No-Shows cost plenty: Missed appointments mean decreased income and efficiency. *Humana's YourPractice* (Second Quarter). Retrieved August 10, 2009 from <http://www.humana.com/providers/NewsLetters/HumanaWeb2ndQ05/articles/noshows.html>.
- College of Registered Nurses of British Columbia. (2007). *Nursing documentation*. [Publication No. 151]. Vancouver: Author. Retrieved July 20, 2009 from <http://crnbc.ca/downloads/151.pdf>.
- College of Registered Nurses of British Columbia. (2008). *Documentation*. Practice Standard for Registered Nurse and Nurse Practitioners [Publication No. 334]. Vancouver: Author. Retrieved July 20, 2009 from <http://crnbc.ca/downloads/334.pdf>.

- Daiski, I. (2004). Changing nurses' dis-empowering relationship patterns. *Journal of Advanced Nursing*, 48(1), 43–50. Retrieved February 10, 2009 from Academic Search Premier database.
- Dworkin, G. (2009). Paternalism. In E. N. Zalta (Ed.), *The Stanford encyclopedia of philosophy* (Summer 2009 Edition). Retrieved July 14, 2009 from <http://plato.stanford.edu/archives/sum2009/entries/paternalism>.
- Gabriele, S., & Stober, J.A. (2007). *Old messengers, new media: The legacy of Innis and McLuhan*. Retrieved July 14, 2009 from <http://www.collectionscanada.gc.ca/innis-mcluhan/index-e.html>.
- George, A., & Rubin, G. (2003). Non-attendance in general practice: a systematic review and its implications for access to primary health care. *Family Practice*, 20(2), 178–184. Retrieved July 28, 2009 from Oxford Journals database.
- Gruen, R.L., Weeramanthri, T.S., Knight, S.S., & Bailie, R.S. (2009). Specialist outreach clinics in primary care and rural hospital settings. *Cochrane Database of Systematic Reviews*, 2009(3). Retrieved July 14, 2009 from The Cochrane Library database.
- Health Canada. (2007). History of providing health services to First Nations people and Inuit. In *About Health Canada*. Retrieved July 16, 2009 from <http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/fnihb-dgspni/services-eng.php>.
- Health Disparities Task Group of the Federal/Provincial/Territorial Advisory Committee on Population Health and Health Security. (2004). *Reducing health disparities – roles of the health sector: Discussion Paper*. Ottawa: Public Health Agency of Canada. Retrieved September 19, 2009 from http://www.phac-asp.gc.ca/ph-sp/disparities/pdf06/disparities_discussion_paper_e.pdf.
- Illich, I. (1976). *Medical Nemesis: The expropriation of health*. London: Callor and Boyars.
- Izard, T. (2005). Managing the habitual no-show patient. *Family Practice Management*, 12(2), 65–66. Retrieved September 11, 2008 from Academic Search Premier database.
- Johnson S.L. (2009). International perspectives on workplace bullying among nurses: a review. *International Nursing Review*, 56(1), 34–40. Retrieved July 31, 2009 from Wiley InterScience database.
- Kondro, W. (2009, September 17). Swine flu breaks out on Vancouver Island. *Canadian Medical Association Journal* [online report]. Retrieved September 19, 2009 from http://www.cmaj.ca/earlyreleases/17sept09_swine_flu_vancouver.shtml.
- Krebs, M. (2008). “Sorry” for genocide? Residential school apology in context. *The Dominion*, 53(August 2008). Retrieved September 2, 2009 from <http://www.dominionpaper.ca/articles/1928>.
- Krieger, N. (2003). Does racism harm health? Did child abuse exist before 1962? On explicit questions, critical science, and current controversies: An ecosocial perspective. *American Journal of Public Health*, 93(2), 194–199. Retrieved July 20, 2009 from <http://www.ajph.org/cgi/reprint/93/2/194>.
- Lacy, N.L., Paulman, A., Reuter, M.D., & Lovejoy, B. (2004). Why we don't come: Patient perspectives on no-shows. *Annals of Family Medicine*, 24(6), 541–545. Retrieved September 11, 2008 from Academic Search Premier database.

- Martin, C., Perfect, T., & Mantle, G. (2005). Non-attendance in primary care: The view of patients and practices on its causes, impact and solutions. *Family Practice*, 22(6), 638–643. Retrieved September 18, 2008 from EBSCOhost database.
- McLuhan, M., & McLuhan, E. (1988). *Laws of media: The new science*. Toronto: University of Toronto Press.
- Miller, R.B. (2003). *Children, ethics, and modern medicine*. Bloomington: Indiana University Press. Retrieved July 13, 2009 from <http://books.google.com>.
- Mullaly, B. (2002). *Challenging oppression: A critical social work approach*. Don Mills: Oxford University Press.
- Oudshoorn, A., Ward-Griffin, C., & McWilliam, C. (2007). Client–nurse relationships in home-based palliative care: a critical analysis of power relations. *Journal of Clinical Nursing*, 16, 1435–1443. Retrieved February 10, 2009 from Academic Search Premier database.
- Platt, V. (2006a). Making an impression: Replication and the ontology of the Graeco-Roman seal stone. *Art History*, 29(2), 233–257. Retrieved July 14, 2009 from Wiley InterScience database.
- Platt, V. (2006b). Making an impression: Replication and the ontology of the Graeco-Roman seal stone [Abstract]. Retrieved July 14, 2009 from Wiley InterScience database.
- Ramsden, I.M. (2002). *Cultural Safety and Nursing Education in Aotearoa and Te Waipounamu*. Wellington, Australia: Victoria University. Retrieved July 20, 2009 from <http://kawawahakaruruhau.massey.ac.nz/RAMSDEN%20THESIS.pdf>.
- Reimer Kirkham, S. (2003). The politics of belonging and intercultural health care. *Western Journal of Nursing Research*, 25(7), 762–780. Retrieved July 30, 2009 from SAGE Journals online database.
- Royal Commission on Aboriginal Peoples. (1996). *People to people, nation to nation: Highlights from the report of the Royal Commission on Aboriginal Peoples*. Retrieved July 7, 2009 from <http://www.ainc-inac.gc.ca/ap/pubs/rpt/rpt-eng.asp>.
- Treaty No. 6 between Her Majesty the Queen and the Plain and Wood Cree Indians and other Tribes of Indians at Fort Carlton, Fort Pitt and Battle River*. (1876). Retrieved October 20, 2009 from <http://www.ainc-inac.gc.ca/al/hts/tgu/pubs/t6/trty6-eng.asp>.
- Waldram, J.B., Herring, D.A., & Young, T.K. (1995). *Aboriginal health in Canada: Historical, cultural, and epidemiological perspectives*. Toronto: University of Toronto Press.
- Worster, A., Sardo, A., Thrasher, C., Fernandes, C., & Chemeris E. (2005). Understanding the role of nurse practitioners in Canada. *Canadian Journal of Rural Medicine*, 10(2), 89–94. Retrieved July 21, 2009 from http://www.cma.ca/index.cfm/ci_id/43590/la_id/1.htm.
- Young, L.E. (2002). Transforming health promotion practice: Moving toward holistic care. In L.E. Young & V. Hayes (Eds.), *Transforming health promotion practice: Concepts, issues, and applications* (pp. 3–21). Philadelphia: F.A. Davis.