


Nurses' Experiences of Establishing Meaningful and Effective Relationships With American Indian Patients in the Cancer Care Setting

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Abstract

Introduction: The establishment of caring relationships with racial and ethnic minority populations is challenging for many cancer care nurses. Nurses serving American Indian (AI) patients frequently encounter population-specific issues, yet their experiences are largely unknown.

Objective: The purpose of this study was to describe the meaning of the AI patient–cancer care nurse relationship from nurses' perspectives. The study included three objectives: (a) to describe the immediate experiences of nurses that have engaged in cancer care relationships with AI patients, (b) to identify the underlying structures of the AI patient–cancer care nurse relationship as described by nurses, and (c) to interpret the meaning of the patient–nurse relationship within the context of AI cancer care experiences.

Methods: This was an interpretive phenomenological study using a hermeneutical process for data collection and analysis of multiple, exploratory interviews. Thematic reduction was completed to explicate the fundamental structures of this particular relationship. Reduction of individually situated themes resulted in seven shared meta-themes including from task to connection; unnerving messaging; we are one; the freedom of unconditional acceptance; attuning and opening; atoning for the past, one moment at a time; and humanizing the inhumane.

Results: Nine cancer care nurses participated. Reconstitution of data and reflective writing suggested that the essential meaning of the AI patient–cancer care nurse relationship was expressed in contradictory yet simultaneous patterns for nurses. Nurses sought synchronicity with their AI patients despite their contextual differences and similarities, yet most lacked adequate cultural safety training. Being in relationship provided nurses great purpose within the universal human context of caring.

Conclusions: Results contribute to the development of interventions designed to improve both the AI cancer care experience and the support and training of nurses. The mutually dependent nature of the patient–nurse relationship implies that strengthening and improving support for one entity may in turn positively impact the other.

Keywords

cultural competency, cancer, oncology, qualitative research, diversity

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American Indians (AIs) in the United States comprise a small but incredibly diverse ethnic-racial minority population (U.S. Department of Health and Human Services Office of Minority Health, 2015). Approximately 5 million people identify as AI alone or in combination with other races, with the vast majority residing in the lower 48 states (U.S. Census Bureau, 2012). Among numerous other persistent health inequities, AIs experience a cancer

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inequity primarily comprised of elevated morbidity and mortality despite an overall lower incidence rate compared to all other races combined (Burwell, McSwain, Frazier, & Greenway, 2014). Disproportionate cancer morbidity and mortality among AI populations are often attributed to lower screening uptake, later stage diagnosis, increased treatment complications, and worse overall outcomes (Cobb, Wingo, & Edwards, 2008; Guadagnolo et al., 2009; Vasilevska, Ross, Gesink, & Fisman, 2012; White et al., 2014).

Cancer care nurses play a pivotal role in patient experiences and outcomes. Cancer care creates scenarios where nurses act in a prominent capacity as supporters and advocates for patients (Hildebrandt, 2012; Potter et al., 2013). However, the establishment of caring relationships in the cancer care setting is particularly challenging for nurses who engage with racial-ethnic minority populations such as AIs as they contend with cultural and contextual influences different from those found in the majority population (Alpers & Hansson, 2014; Kelly & Minty, 2007; Koithan & Farrell, 2010; Murphy & Clark, 1993). Taking into account that over 80% of nurses in the United States self-identify as non-Hispanic White, the likelihood of patient-provider racial and cultural discordance occurring for minority patients such as AIs is significant and linked to poor communication and worse patient outcomes overall (Lamb et al., 2011; National Council of State Boards of Nursing, 2015; Stone & Moskowitz, 2011). How this discordance plays out for nurses and their perception of relationship with patients is largely unknown.

Literature Review

Effective cancer care requires caring patient-provider relationships, yet the literature suggests that AIs describe significant issues specifically related to providers throughout the health-care experience including ineffectual communication tactics, cultural insensitivity, perceived discrimination, and aggressive or dominating approaches to care delivery (Guadagnolo et al., 2009; Vasilevska et al., 2012; Walls, Gonzalez, Gladney, & Onello, 2015; Warne, Kaur, & Perdue, 2012). Over a third of AIs report experiencing some form of racially based microaggression from a health-care provider, resulting in chronic health condition symptom exacerbation and increased hospitalizations (Walls et al., 2015).

For providers such as nurses, care of AIs presents language and other types of nonverbal communication challenges coupled with conflict surrounding treatment philosophies and discordant interpretations of wellness and disease (Guadagnolo et al., 2009; Koithan & Farrell, 2010; Lowe & Struthers, 2001). These contextual

considerations undoubtedly impact the development of authentic, effective, and mutually beneficial patient-nurse relationships during care. Nurses may be failing to facilitate timely and culturally safe cancer care among AI populations, and thus are unintentionally contributing to the ongoing cancer care inequity (Lowe & Struthers, 2001; Warne et al., 2012). Although the underutilization, distrust, and dissatisfaction with cancer care systems and providers is well-documented for AIs, there is a dearth of literature describing nurses' interpretations or perceptions of caring for AI patients. The unique relationships that develop while providing cancer care to AI patients and the underlying meaning that nurses ascribed to these experiences remain unexplored.

Purpose and Objectives

The purpose of this study was to describe the meaning of the AI patient-cancer care nurse relationship from nurses' perspectives. The study included three objectives: (a) to describe the immediate experiences of nurses that have engaged in cancer care relationships with AI patients, (b) to identify the underlying structures of the AI patient-cancer care nurse relationship as described by nurses, and (c) to interpret the meaning of the patient-nurse relationship within the context of AI cancer experiences.

Methods

Design

The research focus was congruent with the philosophical and methodological positioning of interpretive phenomenology, an approach that seeks to uncover and find meaning in abstract yet everyday occurrences, particularly those that are the most familiar and taken for granted such as human-to-human relationships (Crotty, 1996; Van Manen, 1990, 2011). The investigation into the lived experiences and reconstituted meaning for cancer care nurses serving AI patients were guided by Van Manen's (1990) methods of phenomenological inquiry. This study used a nonlinear, iterative process during data collection and analysis. This process reflects utilization of the hermeneutic circle of data collection-reflection-analysis-meaning making that is central to the phenomenological approach and philosophy (Reiners, 2012).

Research Question

This study explored and described the unique relationships that developed while providing cancer care to AI patients and the situated meaning that nurses ascribed to these experiences utilizing the research question "what is

the meaning of the AI patient–cancer care nurse relationship from nurses’ perspectives?”

Sample

Between January and May of 2016, a convenience sample for this study consisting of 10 Registered Nurses (RNs) living in the southwestern United States and meeting the inclusion criteria agreed to participate. One participant was lost to attrition resulting in a final sample of nine RNs. Participants were recruited via e-mail and word-of-mouth using professional and academic networks and in collaboration with two research mentors, one of whom identifies as AI. Inclusion criteria were RNs (a) with at least 3 years of experience in providing cancer care to AI patients within the past decade; (b) ability to read and speak English fluently; (c) willingness and capacity to engage in repeated interview sessions over a 9-month period, including the ability to engage in self-reflection and critical dialogue; and (d) with access to a working telephone. Exclusion criteria were (a) RNs who were terminated from their work with AI patients for any reason and (b) RNs under the age of 21, who potentially lacked sufficient clinical experience to draw upon in order to engage in the exhaustive interviewing required by interpretive phenomenology.

Institutional Review Board Approval

The study received human subjects’ approval from the institutional review board of the University of Arizona (#1512281830). Participants were informed both verbally and in written form that their participation was voluntary and confidential, and that they could terminate their participation at any time without providing an explanation. Informed written consent was signed at the start of the first interview with participants retaining a signed copy. Demographic data received a numerical identifier. Participants were assured that any identifying information revealed in the course of the interviews such as patient diagnosis, place names, or tribal affiliations would be redacted or altered during transcription so as to be unrecognizable.

Data Collection and Analysis

Data collection and analysis procedures for the study intersected and were largely dependent upon one another, thus are concurrently described. An exploratory and hermeneutical interviewing strategy was utilized during repeated one-on-one interviewing with the participants. Interviews lasting approximately 1 hour were conducted in chronological order for each individual participant and not for the sample as a whole; this was both logistically convenient and in alignment with the

interpretive phenomenological method of maintaining focus on the individual experience during the first phase of data collection (Van Manen, 1990). Cross-comparison for the purposes of meaning-making did not occur until after all interviews were collected and analyzed. The setting for all in-person interviews was either a private location of the participant’s choosing, such as their home or personal office, or in a private meeting space at a public university or library. All of the interviews were digitally audio-recorded, immediately transcribed, and uploaded into ATLAS.ti (version 7.5) qualitative software (Scientific Software Development GmbH, 2016).

The first interview and exploratory analysis. The initial interview began with “what it was like” for participants providing care to AI patients with cancer to begin grasping the basic features of this particular relationship. Exploratory prompting was utilized to elicit memories, sensations, and experiential accounts such as “describe a time when you provided cancer care to an AI patient.” Although the interviews were largely participant-directed, probing throughout the interview series was based on the four phenomenological lifeworlds of corporeality (lived body), spatiality (lived space), relationality (lived human relations), and temporality (lived time) (Van Manen, 1990). Integration of the phenomenological lifeworlds into thought-provoking probes facilitated the later cocreation of meaning at the existential level (Crotty, 1996; Van Manen, 1990). Examples of life-world-based probing are as follows: (a) Spatiality: What was the environment like? How did that [described feeling/sensation/experience/relationship] impact you spiritually? (b) Temporality: How did it feel at that specific time? Describe how that [feeling/sensation/experience/relationship] changed for you over time? (c) Relationality: Describe your relationship with [a patient, family member, etc.]. Who else was there? How were they involved? and (d) Corporeality: What were you feeling physically when that happened? What was your physical response, if any?

At the conclusion of each initial interview, participants were prompted with a specific thought-provoking question or statement to contemplate during the interval between interviews (e.g., “Before our next interview, try and think more deeply about...”). This prompt emerged from the immediate data collection session and was intended to stimulate the reflective process and encourage thoughtfulness on the part of the participant prior to the next meeting (Van Manen, 1990). Following the first and all subsequent interviews, the following procedures were undertaken: (a) immediate reflective writing in a journal to capture first impressions and to note embodied responses that were not captured by the audio recording; (b) during the interim between

interviews, engagement in a period of contemplative dwelling with repeated exposure to the transcribed interviews and the creation of reflective memos exploring potential structures buried within the text; (c) tentative coding of the emic data utilizing Van Manen's (1990) wholistic/sententious, selective, and detailed approaches. For example, entire passages, short phrases, and single words were all coded for potential significance or for further exploration in future interviews; (d) conscious refrainment from assigning any meaning to the participants' recollections in an effort to remain open and accessible to their individual experiences. Instead, continued reflective journaling was employed to attenuate for the researcher's own inevitable musings; (e) regular debriefing with a research mentor in order to explore tentative coding patterns and to address assumptions and bias in an effort to prevent premature closure; and (f) preparation of the next line of questioning for each individual participant utilizing the emic coding and reflective text from each previous interview.

The second interview and thematic analysis. The second interview was conducted either in-person or via telephone depending upon the participant's location and preference. This interview revisited what was recounted previously in an attempt to encourage elaboration on any points of interest suggesting implicit meaning (Crotty, 1996; Van Manen, 1990). Examples of questions that encouraged elaboration, clarification, and deeper exploration into the nurses' experiences include the following: (a) When you say [descriptor word], what do you mean by that? (b) In the last interview, you spoke about [a described experience, feeling, relationship, etc.]. Can you talk more about that and why you felt that way? (c) You seem [descriptive or emotion-laden word] talking about it now; what were you feeling when it happened? Where do you think that feeling arises from?

Lifeworld-based probing and redirecting to *tease out* potentially buried feelings surrounding the phenomenon of interest continued; however, the interview remained open-ended and largely participant-directed. Tentative thematic abstractions for each participant were then created. This phase required a great deal of discussion and collaboration with the research mentor, as is typical of the interpretive phenomenological method in general. Despite the creation of tentative themes for each participant, continued attention was given to refraining from cross-participant comparisons. This period of analysis also attempted to move beyond what had been previously relayed in the first two interviews to explore what remained unspoken, and the next round of questioning for the third interview was created to transition from the concrete to the abstract through confirmation and exploration of the various themes and the overall potential meaning for each participant (Van Manen, 1990).

The third interview and confirmatory analysis. The third interview delved more deeply into previously described sensations, embodied perceptions, and the possible situated meaning for each participant. Compiled results from the first two interviews were presented to each participant with the opportunity for confirmation, elaboration, refinement, and discussion of themes (Parse et al., 1985; Van Manen, 1990). This approach encouraged probing of the individual variations within the phenomenon with each participant, allowing for a creative and open method of exploring consciousness and understanding (Parse et al., 1985). During this final interview, participants were encouraged to intensely reflect upon their experiences of providing cancer care to AI patients.

At this point, themes and emic coding patterns among participants became repetitive. This was further confirmed with the research mentor during debriefing sessions and during random transcript checking. When new sensations or contradictions emerged, they were viewed as relevant and integrated into the preliminary analysis. Completion of the final set of interviews resulted in multiple revisions of the individually situated themes to accurately capture the highly personal and often deeply embedded nature of nurses' relationships with AI cancer patients.

Postdata Collection Analytical Procedures

Analytical procedures for the first research aim included (a) final adjustments to the individual themes based on a period of contemplative dwelling with the data, debriefing sessions, and insight gleaned during reflective writing; and (b) considering each participant's experience as a whole and creating a wholistic/sententious description to reflect how this individual's lived experience contributed to the overall phenomenon.

No amount of codification or theme abstraction alone can produce phenomenological understanding; meaning occurs during the cocreation and transformation of text and is reflected in phenomenological tone throughout the study, especially during reflective writing (Van Manen, 1990). Thus, numerous drafts of the individually situated themes and wholistic/sententious descriptions were required to reach this level of thoughtful, contemplative text surrounding individual participant's experiences.

Analytical procedures for the second research aim entailed: (a) looking across individual participants in order to compare and contrast their experiences and to identify the underlying structures of the phenomenon, (b) reduction of a total of 36 individual themes into a set of seven thematic descriptions capturing commonalities and patterns seen across the sample, (c) composing each thematic description to begin with "Relationship

is . . .” to reflect the unique attributes of the phenomenon under investigation, (d) distilling the thematic descriptions further into seven accompanying meta-themes from which a general structural description could be created, and (e) constructing a general structural description that explicated the shared experiences across the sample at the experiential level. Although meaning occasionally subtly emerged, incorporating researcher interpretations into the text was avoided in order to authentically represent the participants’ shared experiences.

Finally, the essential meaning of the phenomenon was explicated in a phenomenologically sensitive paragraph to fulfill the third research aim of interpreting the meaning of the AI patient–cancer care nurse relationship. This process delineates interpretive phenomenology from other approaches, as it requires the integration of the researcher’s reflections into the meaning for nurses who are engaged in this unique caring relationship with AIs. It positioned the researcher at the center of the phenomenon rather than as a peripheral observer through the reconstitution of shared meaning into a universally recognizable text (Crotty, 1996; Van Manen, 1990).

Methodological Rigor

Assuring rigor in interpretive phenomenology requires that the interpretive process is conducted in a vigilant, thorough, and deliberate manner and that emergent patterns appear coherent and logical (Laverty, 2003; Van Manen, 1990). Trustworthiness for this study was established through an obvious sense of coherence between the aims and the findings with verbatim recordings, transcription, and emic quotes to support the analysis and tentative conclusions (Koch & Harrington, 1988; Van Manen, 1990). An easily traceable paper and decision trail was maintained using the debriefing notes and Atlas.ti (version 7.5) software (Scientific Software Development GmbH, 2016). To ensure reflexivity, written memos after each interview and a detailed journal were deliberately maintained. Regular debriefings with a research mentor contributed to the avoidance of premature closure and the reduction of bias (Koch & Harrington, 1988; Van Manen, 2014). Prolonged engagement and triangulation of data assisted in establishing credibility. Both typical and atypical findings were acknowledged and integrated into the findings. Regarding transferability, the results from this study should resonate with readers and appear valid, useful, and meaningful (Van Manen, 1990). Findings are not intended to be generalizable in interpretive phenomenological research (Crotty, 1996).

Researcher positioning. Prior to engaging in data collection with study participants, the researcher engaged in an extensive process of self-reflection under the guidance

of a research mentor as is consistent with the interpretive phenomenological methodology (Koch & Harrington, 1988; Laverty, 2003; Van Manen, 2014). This reflexive practice is not only required of the chosen methodology but was especially important due to the researcher’s positioning in relation to the phenomenon of focus having worked as a nurse both on and off of AI lands in the southwestern United States for approximately 8 years. During this time, regular contact with AI patients with cancer occurred, causing significant impact both personally and professionally. Systematic inequities and inimitable biases that colored the patient–nurse relationship arose that had previously been taken-for-granted. Although working with AI patients and communities was highly fulfilling in many ways, a deep-seated sense of injustice and even discomfort with the researcher’s identity as a non-Hispanic White nurse emanating from a settler colonial context and system began to emerge. Yet, close relationships with patients, fellow nurses, and other colleagues identifying as AI played a key role in providing encouragement to explore the phenomenon of focus in this study. The guided self-reflection was critical in nature, uncovering deeply held assumptions and interpretations of events. The outcome was a heightened receptivity and sensitively to later data collection and analysis procedures that were reintegrated into the findings to strengthen the overall study (Laverty, 2003).

Results

Although all nine participants self-identified as female, they represented a variety of ages and racial affiliations in addition to wide diversity in their professional cancer care nursing experiences (see Table 1).

Research Question Results

Engaging in the hermeneutical analysis process resulted in seven meta-themes: from task to connection; unnerving messaging; we are one; the freedom of unconditional acceptance; attuning and opening; atoning for the past, one moment at a time; and humanizing the inhumane. Meta-themes are explicated through a general structural description, and a meaning-infused essential description revealing the depth and complexity of this relationship phenomenon. Each meta-theme in the structural description begins with a thematic description explicating what this relationship is from the nurses’ standpoint. Emic quotes are attributed to each participant, interview, and transcript section. For example, P6-1, 237 indicates Participant 6, Interview 1, and Section 237 of the transcript.

From task to connection. Relationship is paramount for nurses to transform nursing *care* into authentic *caring*.

Table 1. Sample Characteristics.

Age	Range (in years) 25–71	Mean (in years) 45
Gender	Female	9
Self-described race and/or ethnicity	White (non-Hispanic)	6
	Native Hawaiian or Pacific Islander	1
	American Indian or Alaska Native	2
Total years in nursing	Range (in years) 3–34	Mean (in years) 18
Types of cancer care nursing ^a with regular contact ^b with AI patients	Medical-surgical oncology (inpatient)	4
	Medical-surgical oncology (outpatient)	4
	Case management/care coordination	3
Combined years of cancer care nursing with regular contact ^b with AI patients	Range (in years) 3–34	Mean (in years) 12

Note. AI = American Indian.

^aParticipants selected all types of cancer care in which they had regular contact with AI patients.

^bRegular contact was specified as caring for at least one AI patient with cancer per month.

Relationship is not necessary for engaging in the work of nursing, but it is deeply desired by cancer care nurses to feel a sense of fulfillment and purpose. When nurses establish an open, comforting, and compassionate relationship with AI patients, they feel as if they are being virtuous and ideal nurses. Once you “start the relationship, then I think they start trusting you, and then the relationship just grows,” illustrating the inter-reliance between trust and relationship, which then creates space for caring to take place (P4-3, 139). AI nurses inherently understand the centrality of relationship and also express a feeling of being appreciated within their relationship with AI patients: “I think they’ve [AI cancer patients] learned to appreciate the relationship we have . . . they’ll let me know, ‘Thank you’” (P8-2, 583).

Without relationship, nurses are relegated to engaging in surface-level conversation and only the slightest, most necessary touch. Their work as nurses has no meaning and is simply an unfulfilling “task” to be performed wherein the nurse feels like a “robot” (P5-3, 230). It is degrading, draining, and unsustainable. When relationship does not occur, nurses “feel frustrated and then sorry at the same time,” and pangs of regret and failure cling to them long after the patient has gone (P6-2, 76). It represents a missed opportunity for caring, regardless of whether the impetus to do so was professional, personal, or both.

Unnerving messaging. Relationship is thwarted by an inability to read verbal and nonverbal cues expressed by AI patients. When nurses are unable to interpret AI patients’ often subtle messaging, it causes nurses to feel disconnected from the patient and to doubt their clinical competence:

I feel more distant from the [AI cancer] patient. It’s harder for me to relate to them. I feel that when it’s harder for me to relate and connect to them, it’s harder to read their symptoms and do my job to help keep them comfortable. (P1-3, 144)

The formation of relationships partially relies on the ability to *read* the patient, but when this ability is inhibited by the patient’s muted or unexpected signals, it is unsettling and often vexing for the nurse. “If you do try talking, you’re met with silence . . . I go in with a shut-down expectation . . .” and “I just don’t seem to have any sort of way of making that connection, that spark” (P5-2, 171). When nurses encounter AI patients exhibiting “blank stares and sometimes not even acknowledging that I had spoken,” they find themselves lost in a sea of uncertainty and confusion, struggling to make sense of the situation and to regain meaning and purpose in order to reconnect with what drives them to continue caring (P1-1, 36).

For AI nurses, the messaging is familiar and decipherable. They use both verbal and nonverbal tactics to facilitate connection, hope, and partnership, and do not need to spend precious time breaking the code between patient and nurse. By “taking their hands . . . right away, they feel, as a group, you’re connected” (P2-3, 169). Their relationships with AI patients are imbued with both spoken and unspoken meaning that is understood at an almost instantaneous and intrinsic level.

We are one. Relationship deepens when nurses recognize self in the patient (and patient in nurse) regardless of contextual differences. When a nurse looks into her AI

patient's eyes and sees herself, she is able to transcend the barriers and differences between them. When nurses allow it, relationship becomes a way to honor our sacred connection to one another. Nurses imagine that patients also see themselves in their eyes, creating a sense of reciprocity, indivisibility, and exchange: "They're looking at themselves in my eyes when we look at each other . . . What's the difference? It's nothing" (P3-2, 862). This sense of oneness also creates an obligation to provide care in a manner that nurses would like to be cared for, should they ever require it. For AI nurses, recognition is immediate and infused with understanding; there is a primordial and deep connection between many AI people. When AI nurses look at their AI patients, there is a distinct sense of being in the right place, at the right time, doing the right work. Recognition contributes to the patient feeling comfortable as "they feel safe with their own people," illustrating the powerful sense of mutuality experienced by those sharing heritage and identity (P8-1, 433).

When AI patients feel unrecognizable to nurses, it creates alienation and *othering*, as if "you're taking care of someone from a different country" (P5-1, 108). There "is a wall in between me and them that you can't really—of course you can't see, but you can't even figure out really sometimes how to break it down" (P5-3, 3). This focus on separateness impedes the relationship and perpetuates a sensation of distance between patient and nurse, twisting the meaning of the relationship into something unrewarding and estranging.

The freedom of unconditional acceptance. Relationship is facilitated by removing bias, assumption, and judgment and finding neutral ground for caring to take place. Relinquishing these obstructions caused one nurse to reflect, "I noticed that I had a few judgments of my own when I first started working with the [AI] population . . . I understand that now. It's just definitely opened my mind to see my blindness" (P7-3, 12). This transformation takes time, self-awareness, and a commitment to change from nurses, but the rewards are realized in a palpable strengthening of relationships. Relationships also become exponentially more fulfilling and even freeing as inhibitions are stripped away in favor of unrestrained acceptance of the patient by the nurse. However, an inability by nurses to release assumption or bias creates stunted relationships with the potential for fallacy:

When you know you're going to have [an AI] patient I think that you have an idea or an image that forms in your mind, like a preexisting idea of how this person is going to be . . . whether or not that's true. (P5-1, 112)

The nurse enters into the relationship anticipating disappointment and irritation, and any chance for

"meeting in the middle respectfully" is dashed (P6-2, 146). Nurse and patient are closed off and isolated from one another in this scenario, like two ships passing in the night.

Attuning and opening. Relationship is a process of attuning to the AI patient in every dimension by becoming receptive to a new way of being. Attuning to patients requires that nurses speak less and listen more; mirror the patient's preferred (and often slower) pace instead of marching forward expediently with the demands of the health-care system; and relinquishing expectations in favor of honoring the patient's preferences for care. These practices often came quite easily to the AI nurses, but for non-AI nurses a unique attunement is required with AI patients due to cultural variations, calling for a heightened sensitivity and a willingness to learn. Attunement is fundamentally embedded in the ability of nurses to respond authentically and benevolently to AI patients despite their own preconceptions. This requires a conscious act of relinquishing control over both the patient and the situation, a difficult task within the often urgent and regimented cancer care world:

[AIs] don't expect things to happen quickly, or they don't expect immediate results . . . [They are] culturally different, and so that urgency isn't in them. They'll come maybe, and they'll get treated, but all in their own time, which is okay—I think something that I've learned is that it is okay. (P6-2, 142)

Being attuned to AI patients gives the relationship great meaning for nurses by creating a sense of collaboration and synchronicity. Feeling out of tune with AI patients fosters a dichotomous and superficial approach to care as if, "you're coming from this direction, they're coming from that direction" and like "you're taking care of somebody on the surface . . . you're taking care of their needs, or their problems, in that exact moment, but you haven't really made a connection or an impact" (P5-2, 145 and 127). This feels radically unsatisfying for nurses, yet they know that attunement often takes time and attention: "I think in my listening, my ability to care for her at several different times . . . we [eventually] connected because of my openness in wanting to learn, and then wanting to care for her however she wanted to be cared for" (P9-2, 63). There is an element of deference in this type of caregiving that stands out.

Atoning for the past, one moment at a time. Relationship is a means for honoring the struggles of AI peoples through the easing of suffering, even if only momentarily. The verb *honor* is derived from the Latin *honorem*, meaning to show respect or reverence. Essentially, approaching

the relationship from this perspective creates opportunities for nurses to facilitate both personal (immediate) and collective (historical) healing. “A lot of patients don’t realize that they are strong,” yet nurses are in a position to recognize this resiliency and to support it wholly (P8-2, 413). They are acutely aware of the substantial barriers and systemic complexities their AI patients’ encounter while seeking cancer care: “When you realize whatever it took to get down here [for treatment] or what they’ve been through before, it’s humbling” (P6-3, 121). Threaded throughout many of the relationships is a strong sense of past injustices committed by non-AIs against AIs; these historical violations infiltrate present interactions in subtle yet insidious ways. “It’s difficult to touch someone in an atmosphere of distrust,” and this may also mean that “you’re trying to make up for things that have happened in the past” during present-day cancer care (P9-1, 1005; P6-3, 5). Although the past is unchangeable, many nurses felt compelled to use the present time to restore trust between AI patients and cancer care systems and providers. For AI nurses, the past is implicit between themselves and their AI patients: “You understand each other and the history and your roots . . . I think most Natives have that deep understanding . . . I think that deepens the connection [between us], knowing the history” (P2-3, 31).

When relationships fall short, “it makes me sad because especially in the cancer business by the time it is figured out, it’s a lot farther than it [should] have been” (P6-1, 63). Patients may be “resentful” when they don’t feel respected, which in turn “clouds their judgment” about continuing care and perpetuates the historical pattern of disengagement from health-care services and providers (P4-3, 187). Nurses use relationship as an implement for reducing the cancer care inequity, one patient at a time; a relationship comprised of respect and parity may literally save a patient’s life. For many nurses who feel that they are often the face of a dysfunctional health-care system, relationships are the most salient tool they have to counter four centuries of inequity within AI health care.

Humanizing the inhumane. Relationship is a conduit between the biomedical cancer care and AI worlds. It serves as a channel between “crisp, clean and regimented” allopathic care and more nuanced, complex AI patterns of health and well-being (P9-2, 1029). As humans, we are always within our bodies, and nurses become the human image of cancer care through their “caring eyes” “positive” touch, and simple presence (P6-1, 239; P9-1, 1033). They often act as “the mediator, the middle person” between patients and families, physicians, and systems (P8-2, 461). Uniquely, AI nurses reside within their patients’ worlds, permitting them both a distinctive

vantage point and attenuating the taken-for-granted nature of perception: “You think about these patients who come from the reservation and they come to the cancer center and it’s a whole new environment” and “It helps me in that I understand both worlds and I don’t take anything for granted” (P8-1, 433 and 489). The enclosed sterility of the cancer care world is potentially harmful to AI patients’ healing: “It’s not good for their spirit or their emotions, just to focus on only their physical [health]” and AIs “need to touch ground, and they’re not touching the ground” in the biomedical setting (P9-1, 749 and 757). Connecting with nature is another basic feature of being human, and cancer care nurses recognize this even within their own grief process following the loss of a patient: “I kept looking outside and I wanted to see the sun . . . It feels so dark inside of you” (P2-2, 27).

When nurses feel nameless and faceless to their patients within the cancer care world, it is dehumanizing. The sheer amount of time and persistence it takes to earn the trust of AI patients and to reach a point of familiarity and ease is exhausting, and some nurses never reach that point. It is disappointing and calls into question their bearing and purpose as nurses:

I thought maybe she would even recognize my face, [but] when I have spent a significant amount of time with somebody for them to not even have facial recognition . . . I mean if they don’t remember my name that’s one thing, but that she didn’t even recognize my face was surprising. After all that time we spent together in comparison to other interactions with other patients who not only remember my face but know my name . . . (P1-3, 73)

To be human is to have a name and to be recognized by other humans. When this fails to happen, it has implications for the meaning of the relationship between AI patient and cancer care nurse as it casts shadows of doubt on the depth of their shared connection at the most fundamental level.

Essential Meaning

The nurses’ meaning of the AI patient–cancer care nurse relationship is expressed as contradictory yet simultaneous patterns of joy and sorrow, ease and difficulty, and obligation and vocation. It is challenging, often vexing, and sometimes heart wrenching; yet these relationships are also rewarding, inspiring, and humbling. From one moment to the next, nurses seek synchronicity with their patient as they dance to a life rhythm that reveals and conceals, enables and limits, and connects and separates. Being in relationship with AI patients gives cancer care nurses great purpose within the universal human experience of suffering and healing.

Discussion

Meaning for cancer care nurses serving AI patients was expressed as opposing yet coexisting experiences. These paradoxical sensations were emblematic of Parse's human becoming paradigm in which human rhythmicity allows two people to continuously move with and apart from one another over time (Parse, 2014). In many ways, the meaning for nurses in this study was located somewhere along this continuum and within this enigma, palpable yet elusive.

What these relationships meant to nurses was revealed in the "imaging and valuing" of their language (Parse, 2014, p. 37). Their words formed descriptions that exposed the multifarious and fluctuating nature of engaging in a deeply personal relationship with AI patients who felt familiar and unknown, receptive and impervious, and predictable and volatile. These contradictions may be a universal experience of nursing, part and parcel of the unpredictability of human beings that is potentially amplified during times of intense interfacing. The typically prolonged nature of cancer care adds yet another element to this nursing experience as relationships have the opportunity to become enduring yet undulating.

AI patients with cancer posed a challenge for many nurses in that their very way of being within the world felt distinctly different than the biomedical-allopathic (and mostly White) paradigm that nurses and nursing emanate from (Hall, 1999; Mohammed, 2006; National Council of State Boards of Nursing, 2015). The AI nurses and the additional racial minority nurse in this study more easily identified and named the experience of being in relationship with a fellow person of color. There was a sensed solidarity present in the recounting of their relationships with patients that was noticeably absent from the rest of the non-Hispanic White participants. Among the sampled nurses, the ability to seize upon similarities while embracing differences between self and the AI patient seemed to be deeply connected to overall fulfillment and sense of purpose within the relationship. Those nurses who were unable to envision any piece of themselves in their patients found the relationship reduced to one of task performance and superficial interactions that left them emotionally fatigued and longing for meaning.

Many of the nurses felt painfully unprepared to work with AI populations, reflecting a general absence of AI-specific cultural safety information in both their pre- and post-licensure training, which is supported in the literature (Alpers & Hanssen, 2014). The persistent dominance of White European-Anglo neo-colonial structures in nursing practice, education, and research and our failure as a nation to reconcile our uncomfortable history with AI peoples (Hall, 1999; Lowe & Struthers, 2001; Mohammed, 2006) subtly but

consistently emerged in the data. A painful historical past seemed to linger within their present-day encounters, and nearly all the nurses sought to soften and humanize cancer care as a means of honoring and even atoning for this unique aspect of their AI patients' lives. All of the nurses in this study relayed the need for adjusting and attuning their patterns of clinical practice to reflect their patients' (sometimes unfamiliar) verbal and bodily messaging. Many became more adept at this over time and came to appreciate a slower paced, quieter, and deeply respectful approach to providing cancer care. They found great meaning and purpose in relationships emergent from the confluence of patient and nurse who successfully transcended time, differences, and idiosyncrasies.

Strengths and Limitations

This study represents the first known in-depth exploration of nurses' experiences of caring for AI patients with cancer. Although the persistent cancer inequity and problematic interactions with the health-care system are well-documented among this unique population, examining the issue from the perspective of cancer care nurses is both novel as well as required to truly address the care inequity from a reconciliatory and patient-centered approach.

Although typical of the interpretive phenomenological method, a sample size of nine participants does present limitations in regard to diversity and representativeness of the phenomenon under investigation. For example, the sample for this study lacked any participants identifying as male and was largely dominated by non-Hispanic White middle-aged females, which potentially skews the perspective of what it is like to care for racial-ethnic minority cancer patients. In addition, only one of the participants in this study actually provided cancer care in an AI community, potentially skewing the essential meaning to some degree. All other participants provided care at facilities adjacent to or sometimes far removed from AI communities. Although this situation is emblematic of cancer care being centralized in more urban areas in the U.S., it is possible that the experiences of nurses who reside within AI communities may be markedly different than those who live and work in areas dominated by non-AI populations. In addition, patient-nurse relationships are comprised of a two-way exchange and certainly the AI portion of this dynamic is equally worthy of inquiry; however, a conscious decision was made to explore what was most underrepresented in the literature.

Implications for Practice

This study has several implications for cancer care nursing practice. First, illumination of the nuances of the

essential AI patient–nurse relationship embedded in the cancer care process will contribute to the development of interventions designed to improve the patient experience. This may in turn promote earlier entry into cancer prevention and screening systems for AIs and enhance treatment partnerships, resulting in decreased mortality and morbidity. Second, understanding the meaning of cancer care relationships for nurses working with AI patients and communities may assist in developing improved methods of support and training for nurses. Adequate support and training for health-care providers is associated with greater job retention, increased compassion, and the delivery of high quality and culturally safe care (Alpers & Hanssen, 2014; Hildebrandt, 2012; Kelly & Minty, 2007; Stone & Moskowitz, 2011). Although the concept of cultural safety (as opposed to cultural competency, humility, or sensitivity, for example) is still gaining traction in U.S. health-care systems, a brief foray into the training of nurses in countries with significant numbers of Indigenous patient populations such as New Zealand or Canada reveals a markedly different approach to establishing patient–nurse relationships (Aboriginal Nurses Association of Canada, 2009; Nursing Council of New Zealand, 2011). The most resolute standard emanates from the Nursing Council of New Zealand (2011, p. 7) who define culturally safe nursing care as follows:

... the effective nursing practice of a person or family from another culture, and is determined by that person or family. Culture includes, but is not restricted to, age or generation; gender; sexual orientation; occupation and socioeconomic status; ethnic origin or migrant experience; religious or spiritual belief; and disability. The nurse delivering the nursing service will have undertaken a process of reflection on his or her own cultural identity and will recognise the impact that his or her personal culture has on his or her professional practice. Unsafe cultural practice comprises any action which diminishes, demeans or disempowers the cultural identity and wellbeing of an individual.

This progressive interpretation moves beyond awareness, sensitivity, and skill sets by allowing the recipient of care to define the type of service and nature of the care relationship. This approach effectively places the power back in the realm of those who are typically disempowered through the provision of health care in colonized countries with remaining Indigenous peoples, such as the U.S. (Hall, 1999; Mohammed, 2006). Comprehensive cultural safety training for nurses who care for AI patients should be designed with this framework in mind and requires active participation from nurses and authentic collaboration with patients. At a fundamental level, the responsibility for exposing nurses to cultural safety concepts and

for supporting their endeavors to provide this type of highly compassionate and versatile care resides with nursing educators and leaders (Alpers & Hanssen, 2014). This recognized gap was a reoccurring pattern among the participants in this study.

Finally, the results of this study suggest that refinement of nursing praxis will ultimately result in improved outcomes for *both* nurses and AI patients, reflecting the inseparability of the two entities within the cancer care relationship. The complimentary and mutually dependent nature of the patient–nurse relationship implies that strengthening and improving support for one entity may in turn positively impact the other (Raingruber & Robinson, 2009).

Conclusions

As nurses fulfilled their many roles within cancer care, they formed significant and influential bonds with AI patients. From a cultural safety standpoint, the onus to improve AI cancer care both systematically and at the individual-provider level resides with the clinicians delivering the care. Yet nurses who serve AI patients face unique challenges in the formation of meaningful and effective relationships with their patients based on the deeply personal descriptions collected and interpreted in this study. The philosophy and practice of interpretive phenomenology suggests that what appears the most familiar to us is often the most elusive (Crotty, 1996; Van Manen, 1990). This study represents the first step in a program of research aimed at fully illuminating the AI–cancer care nurse relationship in an effort to improve experiences and outcomes for both this complex population and the nurses who serve them.

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