Aboriginal Health Care in Canada - Bioethics Perspective

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ABSTRACT

Health care for and among the Aboriginal population raises some unique ethical issues. Firstly, the health status of Aboriginal people in Canada, about 4% of the total population, appears to be in most aspects much worse than the health status of the rest of Canadians, leading to a significant difference in their average life span. This is a matter of social justice. The Aboriginal population needs to be recognized as a vulnerable group and Canadian society has to strive to eliminate discrepancy in health status. Secondly, Aboriginal patients living in a traditional community setting may have a set of values that may differ significantly from the values of main stream population of which the health care professional is used to accommodating. Consequently, Aboriginal patients may perceive the health services as alien and not meeting their needs. Furthermore, their values may be very important to other segments of the Canadian population, since it is composed of people of different cultural origins. A health care organization and its professionals, who understand and respect these values, will provide ethically more competent care. With some effort, it may be possible that traditional healers will become respected members of care teams and that traditional healing approaches can become available, along with evidence-based care, in our health care institutions. The attention to the ethical aspect of care for and among the Aboriginal population has a potential, not only to improve the experience of care and the quality of care for this vulnerable minority group, but also, to improve the ethical quality of health care in general.

Key Words: Aboriginal population, bioethics, culture, health status, social justice, traditional healer, values, vulnerable population

In this paper[1], I will discuss some ethical issues of health care involving the Aboriginal population in Canada. Firstly, after providing some background information, I will comment on the ethical implications of the current heath status of the Aboriginal population. Secondly, I will discuss some commonalities and differences in values and expectations between the mainstream Canadian and Aboriginal population and suggest how these could be approached in clinical care. Finally, I will comment on the ethical approach to traditional Aboriginal health practices and practitioners. The purpose of this paper is not to claim discoveries or make categorical normative statements, but rather to seek understanding and stimulate discussion of this complex topic.

Background

Some background information about the Canadian health care system and our Aboriginal people will be necessary to make the discussion intelligible. Canada is the second largest country in the world, but the population is only 32 million. The health care system is largely publicly funded and is being delivered in both public and private settings. Most physicians are in private practice, but almost all hospitals are public institutions. Federal law provides guiding principles, and the federal government provides financial support for health care, but the responsibility for health care organization and delivery is in the hands of provincial governments. Residents of Canada receive the services of hospitals, physicians and other recognized professionals for free, as long as the services are medically necessary. The system strives to combine high standards of care with high accessibility. However, crowded hospitals and emergency rooms and long waiting lists for consultations and treatments are disconcerting and periodically produce public outcry for either better services in the public system, or a demand to change the law to allow a parallel private system. However, at the present moment, it seems that most Canadians prefer to continue with a public system, disallowing a formal setup that would allow the private purchase of additional or better medical services or treatments that are not otherwise provided – there is only one standard of service(1).

[1] An earlier version of this paper was presented at the 5th International Conference on Clinical Ethics and Consultation, March 9-13, 2009, Taichung and Taipei, Taiwan.

In Canada, about 4.5 % of the population is Aboriginal, that is, North American Indians (now called First Nations), Inuits, and Métis (people of mixed racial ancestry, one of which is Native American). About 50% of First Nations members live on "reservations", tracts of land set aside for them by treaties with the Crown, signed mostly in the 18th and 19th centuries. This Aboriginal population of about 1 million is very diverse. There are approximately 50 different languages and cultural groups and 600 First Nations communities. Health care is largely under the jurisdiction of ten provincial and three territorial governments. However, the federal government, to some extent obligated by treaties with First Nations, is providing medical care for those living on the reserves and in remote communities where services by provincial governments would be very limited. In the last two decades, the federal government has been gradually transferring the governance for community programs to First Nations, as they are able and willing to accept this responsibility(2). The other half of the population lives in cities where, as other populations, they have access to medical and hospital care that is organized and funded by one of ten provincial or three territorial governments[2].

Health status of Aboriginal population and its ethical implications

In theory then, health care for Aboriginal people is well taken care of and access and quality should be at the same level as that for other non Aboriginal residents. However, the health status of the Canadian Aboriginal population is much worse than that of other Canadians. Compared to the general population, heart disease is 1.5 times higher, type 2 diabetes 3 to 5 times higher and tuberculosis 8 to 10 times higher among the Aboriginal population(3). Mortality rate for infants is 1.5 times the rate for non-Aboriginals. Potential years of life lost from injury are 3.5 times of the Canadian rate. Aboriginals require dialysis for end stage renal disease three times as often as others. As a result, the life expectancy for an Aboriginal man is 7.4 years shorter and for Aboriginal women 5.2 years shorter than that of the non-aboriginal population in general. Data are based mostly on the population of the reserves, while the data concerning urban Aboriginal people are difficult to obtain(4). Health Canada, the federal ministry of health, is formally committed to closing this health status gap, but improvements so far have been only modest.

[2] From this point on, I will use the term, Aboriginal, to largely refer to First Nations.

Recently, some organizations were created to address this issue, such as the National Aboriginal Health Organization and Institute of Aboriginal Peoples Health. This health disparity is not a unique Canadian problem. A recent comparative study of health status of Aboriginal children in Canada, US, Australia and New Zealand showed similarly elevated rates of infant mortality, suicide, accidental death, obesity and infection in all four countries(5).

The question I wish to ask deals with the ethical significance of this disparity. Specifically: Should the disparity between the health status of Aboriginal and non-Aboriginal populations within one state be considered an injustice? I am using the term injustice in the most ordinary sense as denying someone that which is due to him or her.

On first analysis, it may seem that this cannot be the case. After all, health is a complex human good and it cannot be simply provided or guaranteed by society. Health is strongly influenced by the genetic endowment of the individual and the population group, as well as lifestyle choices of people and their communities, thus placing it outside of human control. However, a critical role is played by determinants of health such as drinking water, air, nutrition, housing, education, work and leisure, which are defined by societal policies and actions(6). There is ample evidence that the living conditions of the Canadian Aboriginal population are associated with health determinants uniformly inferior to those of the majority of the population(7).

Health status is also influenced by health care delivery. The quantity and quality of health care provided to the population is largely shaped by society. How is it possible that the health care status of one segment of the population is inferior to that of another? Inadequate access to health care certainly can be a contributing factor. There is evidence that even in Canada - a country that has eliminated individual financial barriers through its universal coverage of health care - the utilization of primary health care(8) and specialist care(9) by the Aboriginal population is much lower than that of the non-Aboriginal population. Utilization may be hindered to a degree by the difficulties in accessing care because of geographical barriers, such as distance and challenging travelling conditions to and from the point of care, or communication barriers created by lack of interpreters, or residual financial barriers due to out of pocket expenses. However, a role played by less

tangible disincentives can also affect a population's access to health care. Non-tangible disincentives can emerge for a variety of reasons, among which are: the sensitivity of Aboriginal people toward their encounter with an overwhelming power-imbalance as they interact with professionals and institutions; anticipated expectation of communication challenges when presenting for care; experiences of receiving care that is not in keeping with a respect for their personal dignity, their values or their needs(10). In addition, we have to consider the lingering affect of past colonization practices that had aimed at enforcing assimilation and which resulted in multigenerational trauma.

We do not have data to show the exact contribution of various factors to these health inequalities. It was suggested that further research is needed "for greater clarity in how we conceptualize barriers, their defining characteristics and their causes"(11). Nevertheless, given this scenario, the unavoidable conclusion is that the disparity between the health status of the Aboriginal and non-Aboriginal population within one state is a social injustice. Consequently, the Aboriginal population is clearly a vulnerable group and as such it deserves the assistance necessary to put in place special measures that will help diminish the burden of disease and reduce preventable early deaths. The role of bioethics is to advocate for serious attention to this matter and make the case that the maintenance of the status quo is not morally defensible. A typical Aboriginal patient is disadvantaged by differences in language, social status, education, knowledge, social support and geography. In such a situation, the barriers to effective care and the moral aspects of patient-professional relationships necessitate careful attention. This will be the subject of the next section of this paper.

Values, needs and expectations of Aboriginal Population

One group of disincentives and non-physical barriers that cause Aboriginal populations to use health care services less than they ought to, and receive less benefit from them when they do receive care, is a cultural gap between the Aboriginal men, women and children in need of care and the largely non-Aboriginal professional care-givers, administrators, public health workers and policy-makers(12). This cultural gap between individuals, in turn, is producing institutional structures and processes which are not meeting the needs of the Aboriginal population. The cultural gap is not bottomless and

it should not be exaggerated. “We are all relatives. If you accept that we are all cut from the same genetic cloth, then all human populations share the same potential, the same raw intellectual genius”(13) and, I may add, the same moral instinct. The Aboriginal population as a minority group shares many basic values with the majority of Canadians steeped in European moral tradition. If you refer to Table #1, you will see compared some traditional First Nations values(14) to some traditional European moral virtues, of which the first five have been called focal virtues for health care professionals(15). This illustrates a remarkable degree of congruence, suggesting that the character traits of a good person, traits that an Aboriginal patient would appreciate to find in an Aboriginal traditional healer, are very much those that the European philosophical tradition considers as important to cultivate in physicians and other health professionals.

However, in the last 100 years, European medical ethics deemphasized moral virtues and instead stressed that one should act according to ethical principles, rules, rights and obligations. This trend continued with the development of contemporary bioethics during the greater part of the last 30 years. There is now a renewed interest among scholars and teachers of bioethics to see virtues as a part of a desirable, comprehensive, moral framework. This trend needs to be encouraged. Teaching and cultivating virtues among health care professionals will help to bridge the gap between Aboriginal and non-Aboriginal populations and caregivers in health care, while at the same time it has the potential to enhance the ethical quality of care for every patient or client, regardless of his or her cultural tradition.

The cultural gap we are speaking about is most apparent if we compare some elements of the worldview of an Aboriginal person immersed in traditional teaching and parallel elements in the worldview which may be commonly found among contemporary non-Aboriginal populations. At the risk of generalizing, I will list in Table 2 some values and attitudes of both population groups which will be reflected in behavior and expectations(16). This difference will have practical implications for clinical practice, whether it is in obstetrics(17) or in end of life care(18). For example, because interdependence, rather than independence, is in the Aboriginal culture understood as a reality and strength, an Aboriginal patient may prefer that decision-making about his/her health care be made by the family, even if he/she is technically capable of making decisions. On the other hand, Aboriginal families may have similar expectations about

receiving medical information and participating in decision-making as non-Aboriginal individuals, who have been brought up with the notion of personal independence and autonomy.

In addition, health, illness and care for the sick have in many Aboriginal cultures a special connection to spirituality. Picture 1 represents what 'health' means in the teaching of First Nations. Spiritual, emotional, mental and physical components of health are each occupying one quadrant of the wheel and are considered to be all equally important(19). One can hazard to guess that if non-Aboriginal persons would be asked to assign a segment to each element of health, the "physical" (including biological) section would likely occupy much more than a quadrant and may compromise greatly the other elements. The importance of spirituality is stressed even in many contemporary official documents. When Nishnawbe-Aski Nation in Ontario formulated their basic health policy, it stated that its goal is "to improve the mental, spiritual, emotional, physical and environmental well being of the membership", placing spiritual well being ahead of the physical one(20).

If these differences are indeed present, does this mean that health care professionals desiring to provide ethically appropriate care need to approach Aboriginal and non-Aboriginal patients quite differently? I will argue that this is neither necessary, nor desirable. There are three reasons for that. Firstly, Aboriginal patients and clients as a group are not homogenous. Some of them, perhaps most, will subscribe fully to the values that are on the left side of Table 2, others will choose some values from both sides, and some will even prefer all values on the right side of the table. Similarly, some non-Aboriginal patients and clients may actually prefer some values and positions which are on the left side of the table that are attributed to the Aboriginal worldview. Canada is a nation comprised of immigrants from many nations and cultures of the world. Canadians, who were brought up in an indigenous culture of Africa or Asia may actually share important understandings and preferences with Canadian Aboriginal people, such as approaching an illness from a spiritual perspective and involving the family(21). In addition, personal traits, life experiences, social and economical position, and spiritual commitments will affect how people govern their life and how they would like to be treated when seeking health care.

Finally, there is a factor of illness. A serious or life threatening illness often leads to re-evaluation and re-assignment of a person's commitment, priorities, understanding of oneself and one's needs. This may be particularly so if the person did not have an inclination, opportunity or need to question the values dominant in the society. The nature of such a shift, as influenced by illness, may be explained by a brief reference to ethical theories. The right side of Table 2 contains several values and positions which are linked to liberal individualism, whereas the left side is compatible with collectivism or communitarianism. A person, whose health is of no concern to him or her, may think and behave in a way that expresses extreme individualism and total independence. But, when an illness deprives the person of physical and emotional strength, the same person may seek shelter in the family or community, accepting restrictions on his/her personal autonomy. Affected by illnesses, an individual may be moved to trust his immediate or extended family to make health care decisions for him, and he may even have to accept a total dependence on others in order to survive. Similarly, a patient interested initially only in the cutting edge, high technology medicine, may find that this medicine utterly failed to rescue her and she may turn to an alternative therapy grounded in tradition rather than science. A wise and ethically competent physician will therefore be aware that both an Aboriginal and non-Aboriginal patient may have similar moral values and human needs and be prepared to meet the patient on his/her cultural, emotional and spiritual turf.

Traditional Aboriginal healing practice and practitioners

The existence of an Aboriginal minority in Canada (as in other countries) cannot be seen only as a challenge and a responsibility. It also can be viewed as an opportunity. The development of an ethical response to the health needs of Aboriginal people will give our health care system a chance to enrich the care provided to everyone, as well as make this care more holistic. This is because the Aboriginal population is the keeper of an ancient tradition of healing and caring that is responsive to genuine human needs and grounded in the knowledge of nature(22). Aboriginal healers and elders are sought by many Aboriginal people in their time of need. Traditional ceremonies and practices, such as sweat lodge, smudging, and herbal remedies are embraced by even those who live outside of reservations and are receiving conventional medical care. This can be seen as a parallel to many non-Aboriginal patients, who seek alternative medicine, with its many

variations. They find that if their illness is prolonged or life threatening, the evidence based, scientifically delivered medical care, however desirable and good, often does not meet all their needs. This will be true even about persons who are not ill but who are very anxious about a possible illness. Often, what they find lacking is the human touch, a caring attitude, compassion, encouragement to engage in self-help and reflection, encouragement to strive for healing of personal relationships and the clarifying of spiritual needs and commitments. University trained physicians and nurses often endeavour to provide these sorely needed elements, but the demands of their technology driven practices and the large number of patients they are expected to see, make this goal difficult to obtain. They have difficulties to combine the curative effort, based on evidence based medicine with support for healing, which is a relationship based medical art(23). A healer or elder in tune with the richness of indigenous culture may be able to provide that missing element of healing and caring.

A contemporary physician, practicing both conventional medicine and traditional indigenous healing methods observed: “In a seeming rush to separate itself from culture and tradition, conventional medicine has eliminated much of the art of healing - those elements of doctoring that may be more important than the specific medicine provided…Many of these arts can only be found now in the practices of the world indigenous cultures. Recovering these lost arts could infuse medicine with renewed vitality and effectiveness”(24). It is true that even in Europe, just a few generations ago, traditional healers without formal medical credentials were greatly relied upon, and European academic medicine, before it was re-casted as a largely practical application of the natural sciences, was esteemed because of its “art of healing”. Even contemporary patients, regardless of their culture, are pining for the lost art of healing.

On the other hand, if it becomes a reality, that contemporary health practitioners will share the care of their patients with traditional practitioners, then, conventionally trained health care professionals, besides overcoming prejudices(25), will have to have some concerns addressed. Firstly, they will want to know the ethics of traditional practitioners and especially, whether their art incorporates the commitment to the best interest of patients. Evidence for this cannot be readily provided, given that traditional healing wisdom is a part of the Aboriginal oral cultural tradition, it has not been written down, and has always been transmitted only to selected disciples. It was stated that “(a)lthough

philosophies and practices analogous to bioethics exist in Aboriginal cultures, the terms and categorical distinctions of “ethics“ and “bioethics” do not generally exist”(26). Secondly, health care professionals will be concerned about how various healer’s interventions, particularly herbal remedies, can affect the patients, because of possible interactions with diagnostic tests and prescribed drugs. Traditional practitioners, healers and elders will have to decide if it is yet time to share some elements of the indigenous knowledge with conventional institutions in the interest of making traditional care available to more patients.

In my own area of Northwestern Ontario, steps to incorporate traditional healing approaches have already been made. For example, Sioux Lookout First Nations Health Authority incorporated into their Anishnawbe Health Plan of 2006, the goal to involve traditional specialists into the primary health care system. The Sioux Lookout Meno Ya Win Health Centre has appointed an Aboriginal healer to the Board of Directors, one of two “Physician Representatives”(27).

Looking ahead.

All the levels of most educational programs for health professionals already pay some attention to the problem of culture and the special needs of Aboriginal people of the country. At minimum, some of these programs aim to provide certain cultural information in order to avoid blatant social misunderstandings. Considerable attention was recently given to the teaching of cultural competence or cultural safety(28, 29). A more radical approach is to merge the best elements of traditional healing practices, Aboriginal and others, with evidence based scientific medicine, as is being attempted by those who promote narrative medicine(30) and integrative medicine(31, 32). It will be helpful to increase the number of Aboriginal health care professionals, who will be familiar with traditional healing practices, but also trained in science- based medicine (33).

It would seem useful to pursue all of these approaches on a scholarly and research level, to see where they will lead us, and how useful they could become. Individual health care practitioners may decide to become familiar with at least one of those approaches, and cautiously test if they can be used for the benefit of their patients. Biomedical

researchers are predicting the rise of personalized medicine as it becomes possible to apply tests and treatments that are tailored to each person's genetic make-up. If we expand our horizon a bit, we can conceive of personalized medicine in another sense, such as a practice that can be tailored closely to person's psychological, social and spiritual make up, recognizing that while the genetic endowment may be fixed for a lifetime, the elements of what constitute the human spirit are constantly in the state of development and growth.

On a more general level, there are some actions which could be incorporated throughout the health care system, with the aim of providing Aboriginal patients and communities with ethically appropriate care, while at the same time expanding the horizon of health care in general:

1. Recognize that culturally competent care for Aboriginal patients is an ethical concern, and it is important to regularly engage institutional health ethics committees and professional groups in any discussions of health care that involves specific Aboriginal groups in the region that is being serviced.

2. Listen respectfully and record and consider the experiences of Aboriginal patients and their families. We need to hear these stories in order to "allow us to buy into and share our communal imaginative experience"(34). On a practical level, these activities may give us a better idea of how the professional and institutional attitudes and practices may need to be adjusted in order to provide better experiences and better outcomes for Aboriginal patients and clients.

3. Learn from Aboriginal healers, elders, and chiefs who actively care for, or accompany patients and their families, and who are willing to talk about the traditional teachings they have received, and who are prepared to share their personal experiences. These dialogues will require absolutely equal playing fields. The non-Aboriginal party has to accept the internal logic and validity of the traditional approach and appreciate that it is not inferior to the logic and validity of science-driven medicine. These stories and conversations will help to provide a better understanding of the ethos of care found in the Aboriginal tradition, as well as some appreciation of the benefits and burdens that traditional healing practices may carry.

4. Convert what has been learned into imaginative educational programs for health professionals, administrators and support staff of all institutions where Aboriginal people receive health care, in order that Aboriginal values and needs are respected, and that Aboriginal traditional practitioners may be involved in the routine care of those patients who need it or desire it.

The hope that can guide this effort of becoming fully open to the Aboriginal healing culture was best expressed by a Canadian anthropologist, Wade Davis, who states: "If you encounter another people on their terms, open to the reality that their knowledge is as deep as your own, their insights as precise, their hopes and prayers as profound, then magic happens"(35).

Conclusion

There may be those who will say that in order to be socially and economically justified, the attention which the health care system can give to a minority group, like the Aboriginal population, may have to be proportional to the percentage of these people in the population served. There are at least two reasons why this position seems indefensible. Firstly, Aboriginal people represent a vulnerable population, and this recognition creates an ethical obligation to pay special attention to this group. While society at large has to address the determinants of health, it is incumbent on health care institutions and professionals to strive to deliver more fitting health services, overcome the cultural gap, contribute to the improvement of health status, as well as appreciate the subjective experiences of Aboriginal people when they are in need of the health care system. This is a matter of fundamental justice. Secondly, I would suggest that striving for care of the highest achievable ethical standard for the Aboriginal population will have an overall positive effect on health care for all patients and all communities. Our health care will have the potential to become more culturally sensitive to all minorities and to their cultural needs; it can be more holistic, more mindful of human dignity, more realistic about the interdependence and importance of communities and families. It will more successfully meet everyone's essential human needs and become more supportive of human flourishing.

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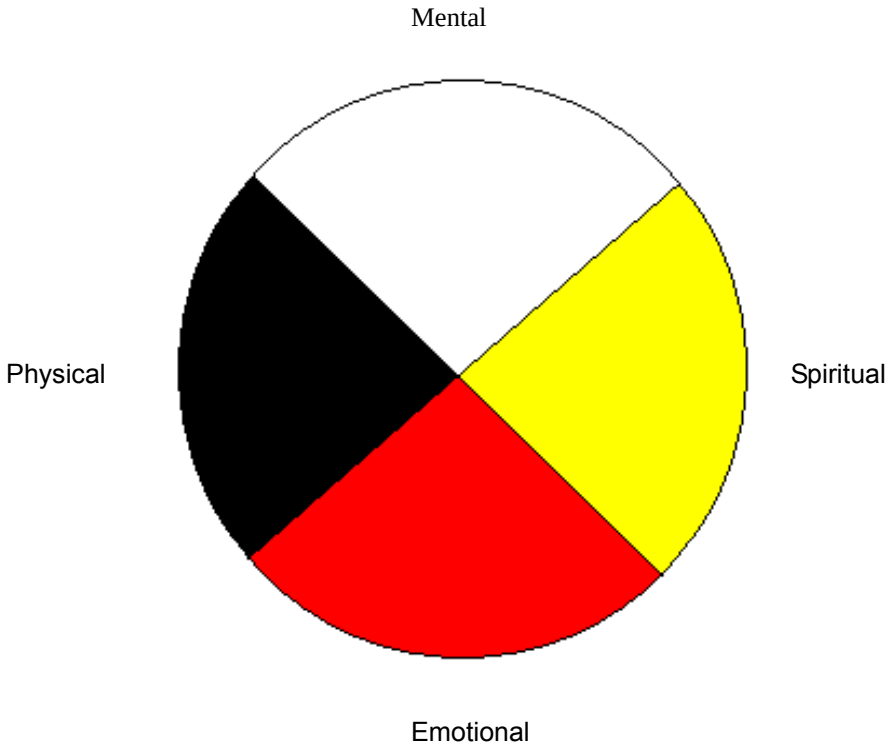
Table 1

The Seven Sacred Teachings in Canadian Aboriginal Tradition	Moral Virtues in European Tradition
Wisdom	Discernment
Love	Compassion
Respect	Respect for privacy and confidentiality
Courage	Integrity
Honesty	Trustworthiness
Humility	Consciousnesses
Truth	Veracity

Table 2

Traditional Aboriginal Values	Common Mainstream Values
Unity of all creation	Individualism is expected and promoted
Interdependence of all	Independence is treasured
Sharing with all	Distribution according to what each one deserves
Non interference	Interventionism, like promotion & persuasion, is accepted and expected
Acceptance of the creator's plan	Fight with disease or fate is admired
Seeking a balance	Celebrating excesses is common
Traditional Medicine is appreciated because it is inherited from ancestors	Medicine at the cutting edge is appreciated because it is "new & improved"
Respect for integrity of human body after death	Human body after death can be taken apart as needed

Picture 1. Health in First Nations' teachings



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