Aboriginal Health Care in Canada and Bioethics: Challenges & Pathways

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Challenges of Canadian Bioethics: speak truth to power

- Earlier: about the patient-professional relationship

- Now: about the relationship of underprivileged with institutions & professions

Jaro Kotalik
Aboriginal Population

- Health and longevity of Aboriginal Population of Canada is substantially worse than the rest of the population.
This persistent and severe inequality of health status is not morally acceptable and represents a moral challenge and a call to analysis and action by
1. Political organizations and health policy makers in Canada
2. Canadian Health Care system
3. Canadian bioethicists

Moral Claim
1. An inability of the Canadian health care system to provide appropriate and acceptable care to Aboriginal people and communities is to a significant degree responsible for the health inequality.

2. This inability of the system is an outcome of failed moral (ethical) relationships between health care agents (health care workers, institutions, policy makers) and Aboriginal agents (patients, families, organizations, leaders).
Using the terminology of health care quality:

The health status of the Aboriginal population would improve if the health care system could provide patients and communities with care of higher **ethical quality**, that is care which will:

- Offer all achievable benefits
- Protect them from avoidable harms and risks
- Respect their dignity, autonomy and culture
- Meet fully demands of justice

Re-statement of the hypothesis
How can bioethicists heal those relationships?

How can bioethicists improve the ethical quality of health care involving Aboriginal populations?
• Native learning, teaching others, exploring the universe, understanding of one’s self and one’s people, caring, healing and curing...all take place by sharing stories, narratives

• Stories, often shared across generations, create communities, assist in developing a moral sense, stimulate moral imagination.

Aboriginal tradition
Narrative Medicine

- says that story-making, story telling, and story comprehension are fundamental concepts for understanding and treating diseases and for addressing the health of the body ..........Narrative practice is a bridge between cultures (Mehl-Madrona 2007)
The appropriate ethical decision emerges from attention to stories of patients, other involved individuals, caregivers and community, reflecting on personal identity and character, particular events, experiences and their context and meanings.

Narrative Ethics (vs. Principalism)
1. Aboriginal tradition of telling and sharing stories
2. Narrative Medicine
3. Narrative Ethics

Could some combination of these approaches be used in clinical bioethics, especially when Aboriginal patients are involved?

Opportunity arises
Inequities, Social Determinants of Health and the Requirement for Institutional Change

Richard Matthews

Indigenous Ethics pre-conference workshop
Persistent inequalities in healthcare contribute to significantly greater morbidity and mortality among Canada’s indigenous populations. In addition to the failed moral relationships identified by Dr. Kotalik

The over-arching causal determining factors arise from:
- The impact of past and ongoing colonialism on the lives of Canada’s indigenous peoples and settler populations.
• Racism is primarily concerned with the unjust and unequal distribution of power in social, economic and institutional arrangements on grounds of ethnicity.
• Racism is above all a matter of systemic violence, of privilege and oppression.
• Only secondarily is it a matter of individual or even institutional character, choices, behaviours, policies, merit or vice.
The social determinants of health are primarily categories for assessing the ways in which inequalities arising from privilege and oppression impact the quality and possibility of human life.

Privileged groups have positive SDoH; Oppressed groups have negative SDoH.

Oppressive SDoH profoundly impact indigenous well-being in Canada at distal, intermediate and proximal levels.
A brief SDoH Impact summary

A: Proximal determinants of health include conditions that have a direct impact on physical, emotional, mental, or spiritual health.

B: Intermediate determinants of health are the causal origins of the proximal determinants.

C: Distal determinants of health are the organizing contexts of the intermediate and proximal determinants. They are the causes of the causes.
Systemic racism in the healthcare system
The Wellesley Institute 2015 report on racism in Canadian Healthcare
The Auditor General’s recent report on access to health care:
Interpersonal racism
Epistemic racism
Internalized racism

The Health Care System and health care practice as social determinant of ill health
Questions

- How might bioethicists, in their normal practice, perpetuate or intensify the racism experienced in health care by Canada’s indigenous peoples?
- How are bioethicists complicit in the healthcare inequalities experienced by Canada’s indigenous populations.
- How may we contribute to inferior health outcomes for Canada’s indigenous peoples?
Given the omnipresence of racism towards Canada’s indigenous peoples, what moral principles should guide bioethical thinking and action?

Given this racism, what practical strategies might bioethicists adopt for mitigating or eliminating racism towards Canada’s indigenous peoples in healthcare?

How do we change ourselves, our own assumptions, our own tacit acceptance of stigma, to ensure that we promote the health of indigenous people in Canadian health care?
Facilitating the Engagement of Aboriginal Elders and Healers

Jane Taylor

Indigenous Ethics pre-conference workshop
- Though Elders and Healers have been directly involved in the physical and spiritual health of their peoples for many years

- Epistemic racism abounds– that is, the imposition of western knowledge systems and particularly the use of western *science* to demonstrate the supposed inferiority of indigenous peoples and indigenous ways of knowing. This control results in continued marginalization of indigenous practices in the Canadian health care system
What role, if any, should bioethicists play in resisting epistemic racism?

What errors are possible when we assume that role?

How can bioethicists facilitate the inclusion of traditional knowledge in the healthcare system?

Can bioethicists facilitate the engagement of Aboriginal elders and healers in the current health care system?

Is this a worthy goal?

Are there successful models for such inclusion?

What can we learn from these models?

Questions?
The health markers for indigenous peoples in Canada are uniformly poorer than those of the general population:

- Life expectancy 10 years shorter; astronomical rates of suicide; a profile similar and even worse than that of people in developing countries.

Conversely, if indigenous peoples are able to benefit from their own healing knowledge and traditions, and these traditions are valued in the broader community, the health outcomes are diametrically opposite.

- Fewer infant deaths
- Improvements in longevity
- Greater political activity and social resilience
We know that we can improve health outcomes if we honor and value indigenous health traditions.

What we are uncertain of is how and in what ways we might value these traditions.

There may be many different health models to fit many different contexts.
One model that we are particularly familiar with is that employed at the Sioux Lookout Meno Ya Win Health Centre.
The comprehensive *minoyawin* model (connoting health, wellness, well-being, a state of wholeness) focuses on cross-cultural integration in five key areas:

- Odabidamageg (governance and leadership)
- Wiichi’iwewin (patient and client supports)
- Andaw’iwewin (traditional healing practices)
- Mashkiki (traditional medicines)
- Miichim (traditional foods)
The model at Meno Ya Win is based on the concept of cultural safety or transcultural care.

It is interesting to note that traditional philosophy embraces the idea of self-healing (a phenomenon written about recently by the dominant culture in the book entitled the *Brain that Heals Itself* (by Norman Doidge). Perhaps Aboriginal healers were the first to champion neuroplasticity.
One Resource that Supports the Model
The literature on this model describes a goal of establishing and reaching a cross-cultural client safety zone.

The continuum ranges from discrimination, a *them vs us* scenario, and moves to *them and us*, and finally to *us* or a state of congruence/integration.
Would the Meno Ya Win model work in your setting?

If not, are there elements of it that you could adapt?

Could traditional health models be integrated in a different way?
Culture
“the ability of systems, organizations, professions and individuals to work effectively in culturally diverse environments and situations”
Indigenous Cultural Competence

Refers to knowledge, enhanced self-awareness, and skills that enable service providers to work more respectfully and effectively with indigenous people.
supports positive health outcomes by enabling providers to deliver services that are respectful of & responsive to the health beliefs, practices and cultural and linguistic needs of diverse patients.
Local Examples - TBRHSC
AUTONOMY VS. AUTONOMY
A First Nations individual is admitted to a hospital following a traffic accident.

He is comatose and cannot currently be wakened.

The healthcare team is able to establish his identity.

The chief of his community phones and asks for an update on his status.

By virtue of being comatose, he cannot consent to the release, and there is no legally empowered designated substitute decision maker – for example, no available relative - to make the decision for him.