

Improving aboriginal health

How can health care professionals contribute?

Ann C. Macaulay CM MD FCFP

Health is a state of complete physical, mental and social well-being, not merely the absence of disease or infirmity.¹

Well-being is associated with high self-esteem, a feeling of being at peace and being happy. This includes education. It includes employment. It includes land claims. It includes resource management. All of these lead back to wellness and well-being.

Rhea Joseph²

Health and well-being are not isolated, but inextricably linked with all aspects of living. Within this large landscape, what contributing roles can health professionals play in promoting aboriginal health?

All health care professionals can promote improved aboriginal health in Canada. This can happen daily for those caring for patients of all ages in a wide variety of settings, including rural communities, urban environments, or tertiary care centres. We also need to advocate in key areas to promote aboriginal health. These include helping all Canadians to understand the history of aboriginal peoples, with the negative legacy of colonization and the residential school system; the role of the social determinants of health; and the urgent need for increased education and employment. We must also advocate for more aboriginal health care professionals; multidisciplinary teams; increased aboriginal self-government, with control of programs including health and education; improved care for patients, families, and communities through adequate funding and relevant programs that are developed with aboriginal input and are appropriately evaluated; and research directed by or undertaken in partnership with aboriginal peoples. This is a long list but all these issues are important, interrelated, and need to be championed.

In context

Today there are approximately 3.3 million aboriginal people living in Canada, of whom about 61% are First Nations, 34% are Metis, and 5% are Inuit. These are 3 separate groups, all with unique local geographic and linguistic heritages, cultural practices, and spiritual beliefs, and it is important to avoid generalizations. Currently 55% of aboriginal people live in urban areas, some with strong ties to their communities of origin and others identifying with urban communities.³

There are striking inequities in aboriginal health outcomes, including life expectancies for both men and women approximately 5 to 10 years lower than the general population.³ This reflects the effects of history combined with the social determinants of health. Aboriginal history includes past colonization and the 1876 Indian Act, with appropriation of land and loss of traditional livelihoods, and current colonization through negative stereotyping. It also includes the residential school system established in 1892 to “civilize” aboriginal people: children were removed from their homes and placed in boarding schools funded by the federal government and operated by the churches. Children were forbidden to speak their own languages, and most were emotionally, physically, and sexually abused. This left a legacy of lost language and traditions, destroyed self-esteem, and unestablished parenting skills. As adults, many turned to alcohol and drugs to relieve the mental pain, resulting in fragmented communities and multigenerational trauma. The last residential school closed in 1996, and only in the summer of 2008 did the Canadian government finally offer an apology.

The social determinants of health include poverty, overcrowding, and unemployment. In 2001, 41% of aboriginal children under the age of 14 were living in poverty, which was 3 times the national rate; 35% of children were being raised by a single parent; and 1 in 4 single mothers reported an annual income of less than \$10000. In 2006, 11% of aboriginal people lived in overcrowded conditions (defined as greater than 1 person per room), which is 4 times higher than the general population.⁴ At the time of writing, 100 aboriginal communities needed to boil their water owing to contaminated water supplies.³

In recognition of these issues, the federal government established the Royal Commission on Aboriginal Peoples (RCAP) in 1996. The extensive final report stated the following:

Aboriginal people endure ill health, run-down and overcrowded housing, polluted water, inadequate schools, poverty and family breakdown at rates found more often in developing countries than in Canada.²

The document made many important recommendations to address health, economic development, human resources, and institution building.² Ten years later the Assembly of First Nations graded the federal

Cet article se trouve aussi en français à la page 337.

government with letter grades *A* through *F* for action taken on each RCAP recommendation. Their “report card” stated that there was “no sustained investment in meeting the basic needs of First Nations communities or in addressing key determinants of health/well being.”⁵

This is a lost decade when the federal government could have made fundamental changes recommended by their own commission. There was no recognition of the groundbreaking work of Chandler and Lalonde who have documented lower—or absent—suicide rates in aboriginal communities in British Columbia that have high rates of “cultural continuity.” Cultural continuity factors include self-government; settled land claims; women in community government; and community control of education, health, police, child welfare, and fire departments,⁶ many factors that were recommended by RCAP. Others have hypothesized that cultural continuity might also explain varying rates of chronic disease across communities.⁷

Against this negative background, health care professionals—including, of course, family physicians—can play a positive role in patient care, research, and health education, and whenever possible use their influence to advocate for wider change.

Patient care

Nonaboriginal health care professionals do best by adopting a holistic approach in offering advice and care for their patients. They should practise cultural humility by respecting local traditions and by being careful not to impose their own values. They need to understand that health encompasses physical, emotional, intellectual, and spiritual well-being, as reflected in the 4 quadrants of the medicine wheel⁸; to recognize the multigenerational legacies of colonization, the residential school system, and importance of local history; to respect traditional beliefs and healing practices; and to acknowledge the role of the social determinants of health and, in many communities, expensive foods and inadequate resources. They should work in multidisciplinary teams and include community health representatives. They must be sensitive to cross-cultural care. For example, less eye contact might be normal and patients might be very comfortable with long silences and might not answer direct questions. In self-contained communities, what happens to one individual will not only affect his or her entire family, but also the entire community. Aboriginal patients might be operating in a second language, might need an interpreter, and might not be comfortable questioning someone who is perceived to have greater power and knowledge. There are now excellent publications authored by aboriginal health care professionals and aboriginal scientists. These individuals are well positioned to understand the key issues in aboriginal health and have the greatest knowledge, deep insights, and practical recommendations.⁹

Non-Aboriginal health care professionals need to understand how Aboriginal people interpret their illness experience and respond to treatment regimens, and to respect the logic and rationale of another system of thought. They need to adapt their treatment plans and education programs to the cultural, social and economic circumstances of their Aboriginal patients and to recognize that many communities are geographically remote, with little access to specialty services.¹⁰

Some of these points are clearly illustrated in the article by Elliott and de Leeuw¹¹ included in this issue of *Canadian Family Physician* (page 443), which relates the case of a resident who was unaware that in the past aboriginal people with tuberculosis were sent away for treatment and many died without seeing their families again. The authors also raise valid concerns that health care professionals might unconsciously internalize mainstream negative perceptions of aboriginal peoples. Perhaps the general population will gain greater understanding if leading authors continue to describe the many positive attributes of aboriginal people, their many contributions to Canadian society, and the need for land claim settlements.¹²

Research

All those engaged in research—or collecting data for researchers—should ensure that the research meets high standards, uses a participatory approach in which researchers are in full partnership with aboriginal peoples and organizations,¹³ and follows the ethical guidelines of the Canadian Institutes of Health Research¹⁴ and National Aboriginal Health Organization.¹⁵ All results must be shared with communities and organizations in such a way as to benefit aboriginal peoples. In the past too much research focused on disease and dysfunction, which only served to emphasize the negative and did not add useful information to develop practical solutions. Today more research is focusing on resilience and is seeking answers to improve health. The 2 research articles in this issue of *Canadian Family Physician* are both excellent examples of positive research to investigate problems and use the results to improve future programs. The study by Kelly and colleagues¹⁶ (page 394) uses qualitative methods to better understand the needs of aboriginal patients receiving palliative care in a northern hospital; the results are being used to further improve end-of-life care in that environment. Other health care professionals can ask their aboriginal patients if the results are relevant for other locations. The SLICK study¹⁷ (page 386) uses quantitative research to evaluate many levels of diabetes care in Alberta and clearly documents that aboriginal patients are not receiving the care recommended by the Canadian Diabetes Association. The results show a reduced level

of care, inadequate screening for complications, and a lack of education from teams that include nutritionists and diabetes nurse educators. This is exactly the kind of evaluation that is needed for all programs. The results reinforce once again the glaring lack of appropriate programs needed by aboriginal peoples—in this case those with type 2 diabetes. I hope these results will have a real effect on care. The results should convince the federal government to immediately increase funding to improve programs for those with diabetes. It should also stimulate funding to develop the much needed research and health promotion programs aimed at reducing this epidemic of type 2 diabetes among aboriginal peoples.

Unraveling the mysteries of diabetes and why it is so prevalent among Aboriginal people in Canada and around the world requires a renewed exploration of indigenous “ways of knowing,” with the integration of innovative ideas derived from ancient traditional practices of Aboriginal healers with the modern scientific methods of inquiry practiced by a new generation of researchers.¹⁰

Need for more aboriginal health care professionals

In 2002 aboriginal students represented 0.9% of all first-year medical students in Canada (18 aboriginal students of 2020 total). Given that aboriginal people (First Nations, Inuit, and Metis) comprise 3.3% of the Canadian population, the number of aboriginal students in medical schools is only one-quarter of the total needed to reflect the overall population.³ The same is true for all other aboriginal health professionals, including nurses, dentists, physiotherapists, occupational therapists, nutritionists, and pharmacists. Whenever possible health care professionals can encourage aboriginal youth to complete school and consider a future in health care. In addition all health professionals should receive training in aboriginal health to better equip them for the future. To this end the Indigenous Physicians Association of Canada and the Association of Faculties of Medicine of Canada are currently collaborating to make this a reality for all medical students. In 2008 they launched *First Nations, Inuit, Métis Health. Core Competencies. A Curriculum Framework for Undergraduate Medical Education*.¹⁸ Some medical schools already have extensive curricula in place—the challenge is now for all schools (medical, nursing, etc) to implement their own courses.

Conclusion

The vision of the Indigenous Physicians Association of Canada is to have “healthy and vibrant Indigenous nations, communities, families and individuals supported by an abundance of knowledgeable, well-educated, well-supported Indigenous physicians working together with

others who share this vision.”¹⁹ This will take a concerted effort by all levels of government, working in partnership with aboriginal peoples, and support from the general public. Health care professionals—aboriginal and non-aboriginal—will be proud to contribute to this vision. 🌿

Dr Macaulay is a Professor in the Department of Family Medicine at McGill University in Montreal, QC, and Director of Participatory Research at McGill. She has been a family physician in the Kanien'kehá:ka (Mohawk) community of Kahnawake, Que, since 1970.

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Correspondence

Dr Ann C. Macaulay, Department of Family Medicine, McGill University, 515 Pine Ave W, Montreal, QC H2W 1S4; e-mail ann.macaulay@mcgill.ca

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