Building dialogue

Aboriginal health and family physicians

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A little more than a year has passed since the Canadian Broadcasting Corporation (CBC) repeatedly transmitted television images of gas-sniffing children from the Innu community of Sheshatshiu, Lab, to homes across the world. These shocking images were accompanied by a request for additional government assistance from community chief Paul Rich. Dr Jane McGillivray, a family physician who had been working solo in Sheshatshiu for 10 years, did not feel that this request would help solve the problem. In a letter to the community of Sheshatshiu, she stated: "This is a spiritual issue and no amount of money can heal the spirit."[1]

"Gathering of Nations" by Jay Bell-Redbird: *Reprinted with permission from the Aboriginal Health Issues Committee of the Society of Obstetricians and Gynaecologists of Canada.*[2]

How, as family physicians, do we respond to such challenges?

As an Aboriginal* person, I have been taught that I can speak only for myself. To speak for others, especially members of a community of which I am not a part, would be to show disrespect. As a family physician, I have a commitment to ongoing self-assessment and continuing education to better understand and communicate with patients from diverse backgrounds.

Those who are familiar with Aboriginal health in Canada know that, while the media coverage might be new, the health problems are not. Documentation of health problems among Aboriginal peoples in Canada dates back to reports of epidemics of infectious disease and famines following European contact.[2] Injuries and poisonings, including suicide, have been the leading cause of mortality for "registered Indians" every year from 1984 to 1994[3] and are the leading cause of death among the Inuit of Nunavut and the Nunavik region in Quebec.[4,5] Infant mortality rates remain two to four times higher among Aboriginal people than in the general Canadian population. Certain infectious diseases, diabetes, and other chronic disorders are also disproportionately common among Aboriginal people.[2]

Aboriginal health in day-to-day practice

As family physicians, we are key members of the team of front-line health care providers for Aboriginal people in Canada. In rural Aboriginal communities, this team can include family and community members, nurses, and nurse practitioners. Specialist support and access to tertiary care facilities sometimes requires several hours of transportation, often by plane. Rural physicians working with Aboriginal people are faced daily with decisions about whether birth, illness, and death will take place in the community or at a distant tertiary care facility. These decisions are based on information from telephone calls from nurses, physicians, or community health workers; input from patients and their extended families; locally available health care resources; policies and protocols of local (Aboriginal and non-Aboriginal), provincial, and federal governments; and the weather.

* The term Aboriginal is used as an inclusive term referring to people of First Nations, Inuit, and Métis ancestry.

Slightly more than half of Canada's Aboriginal people now live in urban areas.[6] Although access to specialists and to advanced diagnostic and treatment services is less difficult, the limited information available regarding the health status of urban Aboriginal people indicates that greater access has not translated into better health outcomes.[7] Urban practitioners working with Aboriginal people are faced with additional challenges, including appropriate identification of Aboriginal patients in the practice (who might not be readily identified by appearance) and the cultural heterogeneity of urban Aboriginal people. This might seem quite a tall order, given that Aboriginal people often make up only a small portion of an urban practitioner's total practice population.

Social, historic, and political context

The tenets of the College of Family Physicians of Canada (CFPC) hold that a family physician is a resource to a defined patient population and that family medicine is a community-based discipline.[8] Given these roles, examining the health problems of the Aboriginal populations with whom we work cannot be done without considering the community context. At first glance, the socioeconomic underpinnings of certain health issues seem obvious and straightforward. For example, the images of children involved in solvent abuse in Sheshatshiu were accompanied by reports of alcohol problems among their parents, as well as poverty and unemployment in the community.[9] At least two reports, a CBC news item (**http://cbc.ca/news/indepth/sheshatshiu/index.html**) and a newspaper article,[9] have touched on the dramatic changes in lifestyle that have occurred in this community over the past two generations and the effect these changes have had on identity and culture for some young people. They hint that an in-depth understanding of the root causes behind the presenting problems might be much more complex.

The roots of this complexity are found in the history of European colonization of the Americas. For example, government legislation that outlawed ceremonies, such as the sun dance and potlatch, and that legalized the abduction of children to residential schools have a very real effect on transmission of language and culture to today's generation of Aboriginal children—including the children of Sheshatshiu.

The process of understanding the various contexts in which clinicians encounter Aboriginal people and their health concerns is further complicated by the fact that cultural, political, historic, social, and economic considerations could be interpreted quite differently from an Aboriginal perspective. Health problems of a particular Aboriginal community are best described and analyzed by community members themselves. Regarding Sheshatshiu, one Innu woman, Mani Katnen, states this opinion (**CBC news, http://cbc.ca/news/indepth/sheshatshiu/town.html**).

> We are Innu; we are called Innu. We came from the caribou. We survived because of caribou. There was no such thing as stores. We got our clothing, tools, everything from caribou;….everything that we needed was provided for. That's why caribou is most respected within the Innu culture. We were always in the country.… Everywhere we were taken by our parents and saw all of Labrador just using snowshoes, canoes in the summer.…"
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> In the 1950s, we were taken by government and brought to this centre, Sheshatshiu, and we've been here since. Now we haven't accomplished anything with the programs. We're not happy. We're getting worse even with all the programs that we're getting.… I don't know what other people think because other people are different. Like my children are different than me. Like my children, they live differently, they think differently because they went through the school system, so they have a different mind-set because of the school process.

Fortunately, this is an era when Aboriginal people and communities are increasingly asserting a desire to recover control of their own health and health care services. As of March 1999, 78% of eligible First Nations and Inuit communities had signed health transfer agreements or were involved in planning them (**http://cbc.ca/news/indepth/sheshatshiu/town.html**). Urban areas have witnessed the opening of several new Aboriginal health centres over the past decade. The past year has also seen establishment of the National Aboriginal Health Organization[10] and the Institute of Aboriginal Peoples Health (**http://www.intoinfo.com/clients/aboriginal_health/about/board_e.htm**). Projects such as the First Nations and Inuit Regional Health Survey have highlighted the need to examine "traditional" and preventive approaches to health, while modeling a research process that is directed by Aboriginal communities (**www.cihr.ca/**).

The Society of Obstetricians and Gynaecologists of Canada's (SOGC) Aboriginal Health Issues Committee has just published a policy statement

entitled "A Guide for Health Professionals working with Aboriginal Peoples." This document examines Aboriginal health in four sections: social, historic, and political context; key health concerns; cross-cultural understanding; and Aboriginal health resources.[2,11-15] The policy statement was supported by several Aboriginal and medical organizations, including the CFPC. The entire document is available on-line (**http://www.sogc.org/SOGCnet/sogc_docs/common/guide/library_e.shtml#aboriginal**) and by request from the CFPC. It provides more in-depth information regarding many of the sociodemographic, health status, and cultural issues discussed above.

Cross-cultural relationships

As family physicians, building collaborative treatment plans based on the perspective and needs of our patients should be nothing new. Patience, experience, and some degree of skill allow for adaptation to cross-cultural settings. For example, in contrast to Western values regarding individual rights and freedoms, some Aboriginal people prioritize community and family needs over individual needs. Health care providers might need to include family and community in negotiating treatment plans. Building respectful and equitable relationships across cultures can be challenging, as they require constant evaluation of one's own cultural values and conceptions, stereotypes, and motives.

The media have brought a series of images of distressed Aboriginal children into our consciousness. For some, these images are stereotyped and imbalanced; for others they are long overdue. As human beings and as health care providers, such images invoke a strong urge to reach out. Our desire to serve others might have motivated our entry into medicine, but it was education and training that prepared us to perform tasks appropriately. The SOGC policy statement and similar educational efforts[16-18] need to be used.

I believe that the first step in working with Aboriginal people and communities is the same as in any other area of family practice: build relationships and initiate dialogue. Much of the above discussion has been about how this task can be more complex than it initially appears.

As a family physician, I will continue my efforts at ongoing self-education and assessment in order to better meet the needs of the Aboriginal people and communities who have chosen to work with me, and I encourage my colleagues to do likewise.

Initiating and sustaining a dialogue in this context can certainly be difficult. The time and effort involved might not, at first glance, appear worth the investment, especially for clinicians with only a few Aboriginal patients. I firmly believe, however, that the insights gained regarding cultural differences and holistic approaches to health will be useful throughout medical practice. It is through the success of such dialogues that I maintain hope.

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