Colonial State of Mind

EXAMINING THE CULTURE OF HEALING AND THE POTENTIAL FOR WHOLENESS

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Abstract

Prior to European contact, Indigenous peoples had complex and intricate medical systems that demonstrated high levels of efficacy in preventing and treating a plethora of historically specific health-related issues. Since contact, Indigenous groups in Canada have experienced severe and prolonged effects of colonization by European Settlers on their communities, lands and belief-systems. Consequently, European occupation of traditional Indigenous territories has had a dramatic impact on the lived realities of Indigenous peoples, including significant effects on their health and wellness. Multiple studies indicate that the health and wellness of Canada's Indigenous population is lower than the general population in almost every health indicator. Various correlating factors have been advanced to help elucidate factors linking the multifarious aspects of colonialism to the maintenance of this health gap. Among these explanations, scholars have investigated how the introduction and imposition of foreign political and economic structures has resulted in the alienation and disconnection of Indigenous peoples from their own cultural practices and healing methods. In response, health care scholars and providers have begun designing unique strategies to meet the specific needs of Indigenous groups. The explicit recognition and incorporation of Indigenous healing systems within the biomedical model has been linked to improving the health and wellness of Indigenous peoples in Canada.

This paper adapts the popular LEARN transcultural communication guide into a 5-part analytic framework investigating the emergence and maintenance of power imbalances vested in the dominant Western health care system. This paper deploys the LEARN analytic framework to examine how the colonial encounter has resulted in a severe disruption of traditional approaches to health and healing. As an analytic framework, LEARN has broad applications in assisting health care scholars in considering the various complexities of the Indigenous-Settler interface, including examining the implications of colonial contact for Indigenous health and wellness, a look at emergent recommendations to ameliorate poor health outcomes and strategies to resolve power disparities at an institutional and individual level.

Key Words: Holism, Ceremony, Balance, Colonization, Biomedicine, Indigeneity, LEARN, Cultural Safety, Wellness.

Background

The Canadian constitution formally recognizes three groups of Indigenous[1] peoples: Indians (commonly referred to as First Nations), Metis and Inuit (Indigenous and Northern

[1] This essay employs the term 'Indigenous' to refer to the original inhabitants of the land and mobilizes the notion of the 'Settler' to denaturalize non-indigenous peoples' status and claims to the land, thereby emphasizing its relational and political attributes. Additionally, the terms Indigenous and Settler serve to underline our continued participation in an unrelenting colonial process.

Affairs Canada, 2015). While these groups represent three distinct peoples with unique worldviews, histories, languages and meaning-making systems, there is also great heterogeneity *within* these populations. For example, there are over six-hundred recognized First Nations governments or bands with distinctive languages, traditions, and beliefs. According to the 2011 Census of Population, there are over 60 Indigenous languages in Canada - a more accurate indication of the immense diversity of Aboriginal communities (Statistics Canada, 2011). The outright and explicit recognition and acknowledgement of the diversity within and between Indigenous peoples primarily serves two purposes: first, to dispel the harmful misconception that Indigenous peoples are one homogenous group that share a singular culture, history, traditions, language, and philosophies and, second, to recognize the fluidity of Indigeneity and to dislodge the historical belief of static Indigenous identities. Taken together, these insights suggest Indigenous realities that deviate from popular Western historical and contemporary representation. Drawing from lessons learned during my coursework in classes such as Introduction to Indigenous Health and Theorizing Social Inequities as well as the community consultation undertaken in my Practicum at Fraser Health Authority - Aboriginal Health, I will endeavor to faithfully represent the diversity, strength and complexity of Indigenous realities, albeit at a conceptual level.

Introduction

The provision of low-level health care services for Indigenous peoples in Canada has historically been underpinned by two harmful fallacies. The first fallacy suggested that the declining health conditions of Indigenous peoples were inevitable and reflected the ostensibly natural decline of a simple and decaying Indigenous civilization. The second fallacy suggested that non-Indigenous health care providers did not need to elicit the views of Indigenous peoples

as they did not possess methods of healing conducive to or compatible with Euro-centric conceptions of health (Klein, 1998). In conjunction, these assumptions have continued to inform the prevailing attitudes, beliefs and values of the dominant Western healthcare system and the practice of health care professionals (Klein, 1998).

Several studies investigating Indigenous patient experiences in primary health centers have demonstrated how negative assumptions about Indigenous peoples vested within the dominant health care system have unfavorably impacted the health and wellness of Indigenous patients. Continuous interaction with this system has resulted in a series of adverse outcomes for Indigenous peoples, including a deep distrust of health care providers, the incremental erosion of Indigenous personhood and community, the development of significant apprehension challenges, a lack of adherence to suggested treatment plans and a rejection of longstanding and culturally rooted Indigenous medical systems (Sookraj, Hutchinson, Evans, Murphy, The Okanagan Urban Aboriginal Health Research Collection, 2010; Wardman, Clement, Quantz, 2005; Bhattacharyya, Estey, Rasooly, Haris, Zwarenstein, Barnsley, 2011). While these power disparities have significantly inhibited Indigenous peoples' ability to attain an equitable standard of health care, Indigenous and non-Indigenous scholars as well as health care practitioners have responded by developing innovative cross-cultural health care practices to name and consequently challenge the various manifestations of power relations (Browne, 2005; Downing & Kowal, 2011; Foster 2006). One strategy aimed at the service provision level is focused on advancing basic teaching frameworks for cross-cultural health care that empower Indigenous clients to transition from passive receivers of care to active participants in their healing journeys (Cass et al., 2002; Browne, 2005; Coffin, 2007). The goal of such strategies has been to support and build the capacity of individuals, families and communities to take greater control and responsibility for their own health and wellness (Hammond & Collins, 2007).

The LEARN framework was first developed to facilitate this transition through the advancement of physician-client encounters predicated upon respect, dialogue and an exchange of ideas and beliefs (Berlin, Fowkes, 1983). During my practicum experience at Fraser Health-Aboriginal Health, I conducted a preliminary environmental scan on current organizational anti-racism and cultural safety initiatives on a local, national and global level. Through this environmental scan, I was introduced to the LEARN mnemonic and its uptake at the service provider level. Building on the knowledge acquired during my Practicum experience, I will adapt the LEARN transcultural communication model as an analytical framework to organize and investigate the following broader themes: advancing Indigenous conceptions of healing, wellness and disease[2], identifying various factors that determine the accessibility and quality of care for Indigenous peoples, and identifying appropriate partners in addressing the poor health status of Indigenous peoples.

I will begin by introducing and unpacking the LEARN model and its application as an investigative framework. I will then proceed to present Indigenous and Western systems of healthcare. Following this introduction, I will juxtapose these models to illustrate the underlying tensions in reconciling Indigenous and Western approaches to health and well-being. Lastly, I will provide a series of recommendations including identifying appropriate partners in addressing this public health issue and moving towards a more integrated method of care.

Methodology

[2] Wellness has been conceptualized in numerous ways by distinct Indigenous groups. Numerous studies have posited wellness as the coalescence of culture, land and language. This paper will advance a Wholistic vision of wellness consistent with the First Nations Health Authority that espouses core values for traditional wellness including: respect, wisdom, responsibility, and relationships.

For my Master's Project I set out to develop an innovative analytical framework modeled after the LEARN transcultural communication guide. My decision to develop a new analytical framework instead of employing a pre-existing framework to guide my thinking around this subject was primarily derived from my experiences in the MPH program at Simon Fraser University. Over the course of the previous two years, I have been repeatedly introduced to and employed several analytical frameworks commonly used in public health discourse. My professors defended the utility of a durable and robust analytical framework to organize research, conduct a systematic and rigorous investigation of a chosen topic, and to posit operational strategies to resolve the public health issue in question.

The frameworks I had initially considered to apply to my topic included path dependency, Roberts et al.'s control knobs, and the 3 I's – Ideas, Interests and Institutions. Each framework offered a unique opportunity to undertake a robust analysis of various aspects of the health system. However, I felt that none of these frameworks could adequately capture or investigate the multidimensional effects of the underlying power dynamics, the complex interaction between institutional arrangements and communities and the cultural nature of health care. Furthermore, I wanted to employ a framework that embedded the notion of reconciliation into its structure. I believe that the LEARN analytical framework addresses all these aspects and can be a useful tool in undertaking a systematic analysis of public health issues. Furthermore, the use of the LEARN analytical framework allowed for greater flexibility in the design of my analysis along with the central components by which to frame and address this public health problem.

Method - The LEARN Model

The LEARN mnemonic presented in this paper is derived from the Family Practice Residency at San Jose Health Center which was supported by the South Bay Area Health

Education Center in San Jose, California (Berlin, Fowkes, 1983). The mnemonic was created as a practical guide to assist health care providers in serving an increasingly multicultural patient population. At the time, health care providers were experiencing significant challenges in responding to a diverse population with varied languages and socioeconomic conditions. In addition, there was an increasing awareness of the impact of diverse health and disease belief systems on the physician-patient encounter (Berlin, Fowkes, 1983). LEARN stands for:

L – Listen to your Client's perspective

E – Explain your own perspective

A – Acknowledge differences and similarities between these two perspectives

R – Recommend a plan of action

N – Negotiate mutual agreement

Since its inception in the early 1980s, the LEARN model has been adapted to a variety of contexts including the Indigenous health care arena by Cultural Competency and Cultural Safety theorists (Browne et al., 2012). In the context of Indigenous health, the model contributes to scholarship that has opened debates regarding the re-centering of Indigenous conceptions of health, healing and illness, the challenging of biomedical monologues, the focus on subjective experiences accompanying disease, and the promotion of self-reflexive practice in service of deconstructing power and privilege (Downing & Kowal, 2011; Waters, 2009; Koptie, 2009). The emergence of the LEARN model exemplifies salient efforts by pockets of the medical community to create affirmative health care encounters.

As a basic guide, the LEARN model assists health care practitioners to find strategies to reconcile varied approaches to healing with Indigenous clients. However, as an investigative

framework, the LEARN model offers health care providers a dynamic opportunity to identify, address and challenge the hegemony of Western health care concepts and practices.

LEARN Framework	Capstone Integration
Listen to the perspective of the client	Conceptual examination of recurring themes in Indigenous health systems; the impact of colonial contact on the health systems, beliefs and values.
Explain your own perspective	Critique of the biomedical healthcare paradigm and its dominance over Indigenous models of care.
Acknowledge Differences and Similarities between These Two Perspectives	Compare and Contrast two health care systems.
Recommend A Plan of Action	Outline structural interventions and strategies developed by Non-Indigenous health care providers working with Indigenous clients.
Negotiate Mutual Agreement	Outline structural interventions and strategies developed by Indigenous health care providers working with Indigenous clients. Examining the changing governmental landscape and the movement towards First Nations peoples reclaiming greater control over the design, provision and evaluation of health care services.

Application of LEARN analytical framework

As a method of investigation, the LEARN Analytical Framework offers several positive outcomes. However, there are also limitations that need to be considered here. The LEARN Analytical Framework has not been previously tested for its ability to plan and organize information. Furthermore, as is common amongst all analytical frames, a LEARN analysis cannot adequately speak to the tremendous complexity of social processes. While these limitations restrict the utility of the LEARN analytic framework as a method of analysis, I strongly believe the framework offers intriguing historical and contemporary insights into the Indigenous – Settler health care interface and the existence of power inequities embedded within the health care system.

Listen to your Client's Perspective – Indigenous conceptions of health, healing and illness

The World Health Organization (WHO) defines traditional[3] medicine as "the sum total of knowledge, skills and practices based on the theories, beliefs, and experiences indigenous to different cultures that are used to maintain health, as well as to prevent, diagnose, improve or treat physical and mental illnesses" (World Health Organization, 2000, 1). While this definition provides a fairly sound foundation to begin our inquiry, the definition developed by Velimirovic (1990) and amended by the Royal Commission on Aboriginal Peoples (RCAP, 1996) provides a more robust and contextualized description. According to this definition, traditional healing refers to "practices designed to promote mental, physical and spiritual well-being that are based on beliefs that go back to the time before the spread of western scientific bio-medicine" (Velimirovic, 1990; RCAP, 1996, 348).

Prior to European contact, Indigenous peoples had complex and intricate medical systems that demonstrated high levels of efficacy in preventing and treating a plethora of health-related issues (Robbins & Dewar, 2011; First Nations Health Council, 2011). Similar to contemporary Western medical knowledge, these systems were in a constant state of flux, adapting to encompass emergent knowledges and understandings of body, disease and medicine. Contrary to conventional Western thought, these complex systems did not simply cease to adapt with the arrival of European settlers, but continued to develop and find expression, although within increasingly nominal spaces. Many of the medicines employed in contemporary biomedical treatments are predicated upon Indigenous knowledges of plants and herbs (Robbins & Dewar, 2011; First Nations Health Council, 2011; Kelm, 1998). According to renowned physician Dr.

[3] The term 'traditional' is a colonial concept introduced to Indigenous peoples in English speaking parts of the world. Most Indigenous healing practitioners may prefer to reference the complex practices associated with healing as simply medicine. Thus, traditional becomes a nebulous term that does not fully engage with the complexity and variety of healing practices and medicines.

Gary Goldthorpe, "Enough of our medicine in modern western medicine came from Indian people's remedies to start with that I have no doubt there are more there that we just haven't investigated" (Kelm, 1998, 97). However, through systemic oppression, forced assimilation, cultural denigration and epistemic colonization, representations of Indigenous perspectives on health and healing have been largely disparaged within health care institutions. Within these multifarious colonial processes, Indigenous peoples became alienated from their traditional health systems, which significantly impacted the medical choices made by Indigenous peoples (Alfred, 2009; Burnett, 1996; Reading, 2009).

The division between Indigenous and Settler health systems continues to locate the stories, identities and epistemologies of Indigenous peoples in spaces of marginality. Thus, the number of people who relied on Indigenous healers and traditional healing methods steadily declined since the arrival of European settlers. However, this was not a uniform or totalizing process (Robbins & Dewar, 2011; First Nations Health Council, 2011). Many Indigenous healers continued to practice medicine and provide their community with essential services. This can be seen in the mission of the National Aboriginal Council of Midwives (NACM) to "advocate for the restoration of midwifery education, the provision of midwifery services, and choice of birthplace for all Aboriginal communities consistent with the U.N. Declaration on the Rights of Indigenous Peoples" (NACM, 2012). The continued provision of Indigenous midwife services illustrates Indigenous communities' desire to draw on rich traditions of language, knowledge, and cultural practices to restore health to Indigenous individuals, families and communities and reclaim greater control over their health and wellness.

Indigenous Approaches to Health and Healing

It is challenging to develop a comprehensive definition of Indigenous healing approaches for multiple reasons, including the diversity of Indigenous perspectives, and the fact that Indigenous cultures are noted for orally passing on knowledges of healing. Nonetheless, this paper presents three conceptual commonalities in approaches to Indigenous health to demonstrate how Indigenous health systems diverge from the dominant biomedical system: balance & belongingness, ceremony, and connection to the land[4] (First Nations Health Council, 2011; Kelm, 1998; King, Smith, Gracey, 2009; Martin-Hill, 2009; Robbins & Dewar, 2011).

Contrary to Cartesian perspectives on health predicated on the rigid polarities of 'natural' and 'spiritual' or 'body' and 'mind,' Indigenous medical systems traditionally blurred these boundaries. For many Indigenous peoples, the body occupied a balanced space between the human and non-human world[5] (Kelm, 1998). The notion of balance and harmony are a recurring feature of Indigenous medical systems (King, Smith, Gracey, 2009; Martin-Hill, 2003; Robbins & Dewar, 2011). The medicine wheel metaphor illustrates the importance of attaining and maintaining balance between all four dimensions of the self: the physical, emotional, mental and spiritual (First Nations Health Council, 2011; King, Smith, Gracey, 2009). For example, imbalances in these dimensions resulting from a loss of traditions due to negative experiences in residential schooling can adversely affect the health of Indigenous individuals, families and communities.

The notion of balance is also integral for maintaining positive *social* relations with the family and community. For example, the Kwakwaka'wakw believe that good health lies in the

[4] These notions in no way represent an exhaustive consideration of the complexity of Indigenous health systems, but are offered to assist the reader who may wish to explore these ideas in greater detail.
[5] The human realm was the place of everyday practices in the world of humans. The non-human realm was the place beyond the village, both geographically and cosmically, and it was inhabited by animals, spirits, souls and ghosts.

strength of a person which, consequentially, relies on the strength of a harmonious community (Speck, 1987, 69). The linkages between the individual, family and community must also be accounted when discussing Indigenous perspectives on the healing process. Willie Ermine, a Cree scholar and ethicist, also expresses the importance of these social linkages through a lens he describes as "community mind and thought" (Ermine, 2009). According to Ermine, traditional medicine and healing comes from belonging to a community mind. Belonging is to attain and maintain a resilient connection with myriad sources of significance and guidance beyond the self, such as family, community, culture, nation, the natural realm and the spiritual realm (Canadian Institute for Health Information, 2009).

Another integral aspect that permeates several aspects of Indigenous wellness is ceremony. Ceremonies such as the Potlatch, the Sundance and brushing/smoking ceremonies are integral for multiple aspects of Indigenous life, including healing. The four sacred traditional medicines of cedar, sage, sweetgrass, and tobacco are used in ceremonial healing. A report by the Canadian Institute for Health Information entitled *Mentally Healthy Communities: Aboriginal perspectives* describes how gathering cedar boughs, red fabric strips and blankets and asking a matriarch to perform the smoking ceremony assisted individuals with suicidal ideation in regaining a spiritual balance and moving towards respecting life and the self (Canadian Institute for Health Information, 2009).

Lastly, Indigenous perspectives on health and wellness also stem from a profound understanding and connection to the land. The link between Indigenous healing and the connection that a human being has to the earth informs multiple diverse Indigenous medical systems. According to Arvol Looking Horse, Indigenous health systems "view the earth as a source of life rather than a resource" (Looking Horse, 2009). Several Indigenous communities

hold a strong belief that continued association and stewardship of the local environment is a key aspect to maintaining positive health and wellness. Engagement with land-based activities offers multiple opportunities for Indigenous peoples to improve their health and wellness outcomes through increased physical activity, improved diet and greater autonomy and self-esteem (Burgess, Johnston, Bowman & Whitehead, 2007). The importance of the earth to the health and wellness of Indigenous groups in Canada was made explicit by medical anthropologist C.F. Newcombe, who noted in his field notes from interactions with the Haida that bark and pulp of black twinberry was a highly effective pain-killer for several maladies including toothache, ophthalmia, and burns. Resource management activities are an essential component to the maintenance of Indigenous heritage and represent a significant aspect of health and wellness. The importance of balance & belongingness, ceremony and connection to the land also illustrates the immense complexity of Indigenous perspectives of healing that are often not accounted for in the dominant health care arena.

Impact of Colonial Contact

After colonial contact, oppressive Indigenous health policy and legislature explicitly denied Indigenous peoples the right to engage in traditional healing practices.[6] In 1884, the Indian Act was amended to include regulations denying Indigenous peoples from engaging in or facilitating particular healing methods such as practicing the Pacific Northwest First Nations' Sundance or the Potlatch ceremony (Facing History and Ourselves, 2015). First Nations people caught practicing or using traditional healing methods were imprisoned (Assembly of Manitoba Chiefs, n.d.). Fear of prosecution resulted in the gradual suppression of Indigenous culture and

[6] There are numerous interlocking pathways through which colonial policies and practices have led to the loss of culture, language, heritage, identity, land, and self-determination. However, in this essay I explicitly focus on the Impact of the Indian Act on ceremonies.

healing practices as well as the loss of the knowledge necessary to perform them (Assembly of First Nations, n.d.; Robbins & Dewar, 2011). The widespread restriction of Indigenous healing in Canada was supported via deliberate initiatives by influential government individuals such as Duncan Campbell-Scott, the Deputy Superintendent of the Department of Indian Affairs from 1913 to 1932. Campbell-Scott's attitude towards Indigenous healing practices typify the prevailing government approaches to Indigenous peoples at the time. In a letter addressed to Indian Agents across the country, Campbell-Scott states, "it is observed with alarm that the holding of dances by the Indians on their reserve is on the increase, and that these practices tend to disorganize the efforts the Department is putting forth to make them self-supporting" (Campbell-Scott, 1921). In the same letter, Campbell-Scott instructs the Indian Agents to "dissuade the Indians from excessive indulgence in the practice of dancing" and describes First Nations healing practices as "demoralizing amusements" (Campbell-Scott, 1921).

Indigenous communities have only recently reclaimed the ability to practice traditional approaches to healing without fear of persecution. Maria Napoli powerfully articulates the importance of these practices on the wellness of Indigenous peoples in a 2002 study of integrated care models for native women:

> An understanding of Native traditions, such as prayer, storytelling, and ceremonies, along with an understanding of the importance of body, mind, spirit, are integral components of treatment. We cannot separate ourselves into parts; we are part of a whole and, from a health perspective, need to be treated as a whole person (Napoli, 2002, 1575).

Understanding Indigenous perspectives on healing requires health care providers to recognize how Indigenous medical system may diverge from the Western medical practices and also to situate current health and wellness trends within the context of large-scale cultural suppression.

Explain your own Perspective – Examining the biomedical health paradigm

A Western Scientific epistemology has historically informed Canada's dominant biomedical health care paradigm. The biomedical health care system is typically characterized by an emphasis on locating pathology, isolating the individual in diagnosis, seeking biological causes for illness and acutely focusing on cures rather than on disease prevention (Cash, 2011; Kapsalis, 1997; Ratcliff, 2002; Rothman, 1991; Warshaw, 1989). Furthermore, several scholars, health professionals and health activists have charged this dominant paradigm with demonstrating technological favoritism in society, science, and medicine that promotes invasive solutions and medical procedures.

Indigenous clients interacting with the biomedical health care system often find themselves at odds with this model of health as it deeply conflicts with Indigenous perspectives on health, healing and illness. The prevalence of Settler-centered assumptions about Indigenous peoples, the relative inferior social position of Indigenous peoples, and the longstanding patterns of racism and other intersecting systems of oppression exacerbate Indigenous peoples' experiences of health care in unique ways. For example, conclusions regarding safe and successful treatment plans are consistently patterned on Settler populations, omitting determinants that uniquely impact Indigenous peoples (King, Smith, Gracey, 2009; Reading & Wein, 2009). Indigenous peoples are regularly excluded from these discourses and are positioned as 'the Other,' thereby producing inaccurate knowledge that imbricates representations of Indigenous peoples and the daily reality of their existence.

The biomedical model has been the leading paradigm in medical science and practices over the past five centuries. Adherence to this model has shaped popular Western narratives about the body, disease, and health care. This model primarily defines health as the absence of disease. Thus, to promote health, the biomedical model works to eliminate disease in the body of the patient. This definition of health informs health care providers to screen bodies, diagnose

disease, and prescribe an appropriate treatment. These treatments have often taken the form of pharmaceutical prescriptions or invasive surgical solutions. An acute focus on screening, diagnosis, and cure, means that less time and money is dedicated to prevention strategies and structural initiatives that address the relatively poor structural condition and colonial legacies that uniquely impact Indigenous peoples.

This de-contextualization of Indigenous peoples' care has led to two intertwining process, the pathologizing of Indigeneity and the medicalization of natural processes. Pathologizing Indigenous people occurs when the significant health disparities experienced by Indigenous peoples are attributed to perceived weaknesses and inadequacies of their culture. Thus, identifying as Indigenous implicitly becomes their diagnosis (Ellison-Loschmann, 2003; Koptie, 2009). Several prejudicial fallacies typically underpin this practice: the notion that Indigenous peoples are victims of Western socio-economic progress and that chronic cycles of poverty are inherent features of Indigenous cultures. Furthermore, until recently, little consideration was given to how the traumatic effects of colonization directly and indirectly influenced the present conditions of Indigenous peoples (Ellison-Loschmann, 2003; Koptie, 2009). Additionally, Western trained physicians have historically tended to pathologize certain behaviors as individual deficiencies as opposed to practices introduced by colonizers and reinscribed through multigenerational discriminatory practices. This imbrication often serves as a political tool to construct Indigenous health images and marginalize Indigenous peoples' experiences in a settler-colonial context and ensure that the current structural conditions remain immune to scrutiny and destabilization (Ahenakew, 2011). Shields, Bishop and Mazawi discuss how the process of pathologizing Indigenous peoples was used as a mode of colonization to "govern, regulate, manage, marginalize, or minoritize, primarily through hegemonic discourses" (Sheilds, Bishop, Mazawi, 2005, x).

The last feature of the biomedical model that I will investigate is the technical emphasis on treating the body as a machine. According to medical sociologist, Barbara Rothman:

> The Cartesian model of the body as a machine operates to make the physician a technician, or mechanic. The body breaks down and needs repair; it can be repaired in the hospital as a car is in the shop; once 'fixed,' a person can be returned to the community. The earliest models in medicine were largely mechanical; later models worked more with chemistry, and newer, more sophisticated medical writing described computer like programming, but the basic point remains the same. Problems in the body are technical problems requiring technical solutions, whether it is a mechanical repair, a chemical rebalancing, or a "debugging" of the system (Rothman, 1991:34-35).

The Cartesian model of the body largely serves to emphasize the technical aspect of health issues, while concurrently neglecting other critical aspects such as the subjective experiences accompanying diseases or the psychological and environmental aspects of illness. Thus, an Indigenous person who has diabetes grapples with not only the physical challenges associated with the disease but may also be experiencing individual or community disharmony that may be integral to their sense of self. The body-as-a-machine metaphor also has significant implications for physicians setting up parochial parameters around disease etiology and treatment (Ratcliff, 2002). The role of the family and broader community in successful treatment is often ignored, as is the context of the disease. For Indigenous peoples, this requires situating health and wellbeing within broader historical, economic, and social contexts. By situating the contemporary health status of Indigenous groups within broader socio-historical phenomena, practitioners may better appreciate the intergenerational impacts of defining features of colonialism, such as the residential school system and 'Indian hospitals' as experienced by Indigenous peoples today (Downing & Kowal, 2011).

Acknowledge differences and similarities between these two perspectives

The ascendency of the biomedical model as the dominant perspective of healthcare since the seventeenth century did not supplant Indigenous medicine. Indigenous healing perspectives

continued to permeate Indigenous communities in clandestine spaces. Kristin Burnett, an Associate Professor in the Department of Indigenous Learning at Lakehead University, states in her description of the state of Indigenous midwives in early twentieth century Alberta:

> Biomedicine did not replace Aboriginal medicine; instead, medical pluralism was practiced. The treatments that were chosen depended on a variety of factors: in some situations, Western medicine was more effective, while in others, Aboriginal medicine was superior. In spite of – or perhaps because of – the state's best efforts, Aboriginal women continued to operate as midwives, healers, and caregivers in southern Alberta.

Beyond presenting a historical precedent for pluralistic treatment styles, Burnett's work also contributes to a grander project of reclaiming Aboriginal medicine and ways of practicing health.

The notion of medical pluralism espoused by Burnett heavily informs emergent strategies for advancing integrative care. Integrative care can be conceived as simply providing care congruent with the beliefs and values held by the patient and allowing for diverse treatment options. Typical approaches to integrated care have traditionally been either formal or informal. Formal approaches include, but are not limited to, a governance structure that mobilizes an integrative lens to service provision and organizational practices. Informal approaches can include advancing an ethic of openness and inclusiveness, and employing ceremony as a foundation for dialogue (Indigenous Physicians Association of Canada, 2009). However, several scholars and health care providers have strongly recommended an integrative approach that includes structural changes that embrace both formal and informal mechanisms to ensure relationships between staff as well as health practitioners and patients from different traditions are equitable, respectful and grounded in a foundation of understanding and regard for each other's unique positions and strengths (Shahid et al., 2003; Smylie, 2001; Indigenous Physicians Association of Canada, 2009; Purden, 2005). An example of a structural initiative that reflect formal integrated care practices is the newly formed Sacred Space at Fraser Canyon Hospital in

the Fraser-Salish Region. The Sacred Space is an indoor area in which the ventilation system has been fitted to allow for smudges and various ceremonies (n.a, 2014).

While integrative care and medical pluralism is being more closely considered by health care providers across the country, the challenges involved with reconciling two varying approaches to health, healing and illness, still present formidable barriers that primarily rely on small-scale innovations and incremental changes. These differences include how health is defined, how interventions are conceived, the dominant characteristics of each respective health model, as well as the assumptions underpinning these individual systems (see **Figure 1** for a more detailed consideration of these differences). While the differences indicated in Figure 1 illustrate the barriers to medical pluralism and integrative care, there are also areas of overlap where the distinctions are blurred.

Recommend a plan of action- Non-Indigenous providers working with Indigenous individuals, families and communities.

In this section, I address how the emergent tensions between conflicting worldviews underlying Indigenous and Western approaches to health and well-being may be mitigated or resolved by Non-Indigenous health care providers. A major theme outlined in the research literature is the importance of practicing self-reflexivity among Non-indigenous health care providers. The strategy is meant to illuminate their own beliefs and assumptions as well as to reflect on the new perspectives they develop through interactions with Indigenous peoples.

	Dominant Biomedical health paradigm	Indigenous perspectives on health and wellness
Defining Health	The biomedical health paradigm advances health as the absence of disease. This definition omits crucial elements such as the impact of proximal, intermediate and distal determinants of health as well as the role of larger financial and political institutions.	Indigenous perspectives on health and wellness often highlight the importance of attaining and maintaining balance. Wellbeing comes from a balance between the spiritual, physical, mental, and emotional dimensions of the self. This balance extends beyond the self and incorporates the health of the environment and a social dimension that includes the family, community and spirit world.
Health Interventions	Solutions to disease often involve pharmaceutical prescriptions or invasive surgical procedures – thus attention to prevention is neglected. The mechanistic view of the human body and the interventionist mentality of science encourage technological solutions.	Healing is a dynamic process that can involve ceremony, family and community involvement to regain balance. Multiple studies have identified the need for holistic healing and programs that address all the components of health.
Dominant Characteristics	**Pathology:** The acute focus on screening and diagnosing disease prioritizes pathology. **Medicalization:** The medicalization of a natural process such as birthing often results in control being taken away from women and placed in the hands of the doctor. Thus what was once "women birthing" babies has become "doctors delivering" babies. **Body as a machine:** The body is regarded as a **machine** consisting of finely tuned interdependent parts working in harmony. **Universalism**: Disease signs, symptoms, and other manifestations are viewed as consistent across cultures. **Specific Etiology**: Disease is caused by a specific agent (Germ, Virus, Parasite).	**Wholistic** conceptions of health that include the spiritual, physical, mental and emotional wellbeing, with a strong focus on spiritual healing. **Traditional medicine** is intricately connected to land, language, and culture. Traditional medicine constitutes an entire way of life. **Relationality** with nature, family and community. Between past, present, and future. In teaching and learning between Elders and youth. Between Western and Traditional health providers. **Interconnectedness and Interdependence** of the land, water, plants, animals, and peoples.
Example of Care	Under the biomedical health paradigm, childbirth has gone from the unfolding of the natural process of pregnancy to what is often represented as the most dangerous day in the mother's and baby's life. Physicians are often trained to distrust the natural process and anticipate that something might go wrong.	Indigenous models of health view childbirth as a sacred event. Ceremony often plays a large role in the event of childbirth. For example, some traditional Metis ceremonial practices incorporate a drummer, holding a smudging ceremony before and after the birth, and giving the new baby a cedar bath (Metis Centre of NAHO, 2010).
Assumptions	Indigenous societies and peoples lacked systematic health beliefs and therapies until the arrival of European Biomedicine. Indigenous ways of knowing, health beliefs and worldviews are recognized but deemed inferior and not a viable alternative to biomedicine. Non-Indigenous health care providers do not need to elicit the views of Indigenous peoples when designing heath care. Locates the cause and cure of disease as solely within the individual.	Healing is an ongoing journey and should not be reduced to a single moment. Traditional medicines have an intricate and reciprocal relationship to land, language and culture. Maintaining wellness includes carrying out traditional Indigenous practices such as fishing, hunting, drumming, participating in healing circles, and learning from language.

Figure 1: Comparisons between Biomedical and Indigenous Health Care Systems

Many of the misconceptions held by physicians and other health care providers stem from the limited hospital interactions. Levin & Herbert (2004) discuss how health care providers interacting with Indigenous peoples in hospitals contribute to negative and harmful misconceptions:

> Unfortunately, many health care providers have encountered Aboriginal people only when they are in the most difficult situations and are most vulnerable. As a result, negative stereotypes have become firm attitudes. Others, who have actually worked in Aboriginal communities, may have had the opportunity to know many healthy and happy Aboriginal people, so will bring a somewhat different perspective (Levin and Herbert, 2004, 176).

Levin & Herbert's observations were reflected in Larson et al.'s 2011 cross-sectional survey of an urban cohort of family medicine residents. According to this study, inadequate knowledge of Indigenous cultures was one of the primary barriers residents experienced when working with Indigenous peoples. These findings have resulted in several recommendations by and for health care providers to improve the relationship between non-Indigenous health care providers and Indigenous communities (Larson et al. 2011). These recommendations include:

- Training in cultural competency and cultural safety
- Involvement in the community (i.e. attending cultural gatherings and events)
- Encouraging inter-professional and multi-disciplinary teams within Indigenous Health Care Settings (i.e. working on teams with Indigenous health workers).
- Non-Indigenous health care providers need to recognize their practice with Indigenous communities as a personal and professional journey of lifelong learning.
- Health care providers do not isolate physical and mental issues but consider the whole person including history, culture, language, emotions and spirituality.

Negotiate a Plan of Action – Indigenous Strategies for Moving towards Integrated Care

Various studies investigating the attitudes, beliefs and perspectives of Indigenous peoples using both Western and Indigenous models of healthcare have identified a lack of trust between physicians and Indigenous patients (Cook, 2005). In a study of traditional Mi'kmaq medicine, the majority of Mi'kmaq patients indicated previous use of Indigenous medicine in conjunction with Western medicine. These patients elected not to discuss this course of action with their physicians (Cook, 2005). Multiple scholars have attributed this recurring tendency to the belief that

Indigenous clients feel uncomfortable discussing traditional healing options with non-Aboriginal providers or feel the physician may reject or not comprehend these options (Cook, 2005; Maar & Shawande, 2010). These sentiments were echoed in a study of Anishinabe healers who felt that non-Indigenous health care providers did not understand or respect the methods of traditional healers (Struthers et al., 2008). These studies indicate the continued dominance of the Western model of healthcare and the resistance by healthcare providers to incorporate Indigenous medical beliefs. In an attempt to facilitate the use of these beliefs and transition to an integrated care method, the Indigenous Physicians Association of Canada (2009) prepared a number of recommendations:

- Place equal value on Indigenous knowledge and traditional medicines in statements and policies
- Recognize Indigenous understandings of health
- Doctors should build personal relationships with elders and healers
- Make reference to elders and healers as much as possible, and make an effort to be aware and informed on their patients' openness to, and use of, traditional healing practices and medicines.

While these strategies and recommendations provide unique and helpful strategies to foster collaboration and alliances, there are major structural challenges that require further focus. These concerns are well articulated by medical anthropologist Marion Maar:

> Provision of traditional healing services in the new cultural setting of a health centre requires much groundwork… It is important to understand that each community and each individual is unique with respect to their expectations, familiarity, and level of comfort with traditional Aboriginal medicine… Challenges include strain on staff and high staff turn-over rates; fitting intergenerational trauma, cultural identity and language loss into a biomedical model of illness; some staff being unfamiliar with the community and culture; demand for Aboriginal health professionals heavily outweighing their availability; unrealistically high community expectations of Aboriginal staff; and regulation of traditional healers. (Maar, 2004)

Several health centres across North America have taken up these challenges and are making a concerted effort to provide integrative practices and programming for the betterment of

Indigenous communities.[7] British Columbia has made significant strides in laying the groundwork for transformative change. On October 13, 2011, the federal Minister of Health, the provincial Minister of Health, the BC First Nations Health Council, and the BC First Nations Health Society signed the British Columbia Tripartite Framework Agreement on First Nations Health Governance (NCCAH, 2011). As a result, British Columbia has gained a new health governance structure operated by BC First Nations. The structure includes the First Nations Health Council, First Nations Health Directors Association, Tripartite Committee on First Nations Health, and the First Nations Health Authority. The emergence of the First Nations Health Authority (FNHA) represents the B.C. First Nations' successful efforts to determine the design and delivery of First Nations health care in the province. British Columbia is the first province whose First Nations communities have decided to take control over their health services and care. The new health governance structure has already made important advances in mobilizing Health Authorities to provide more responsive, sustainable, and strength-based care.

FNHA has led the charge for investigating how the existence of multiple power differentials results in structural disadvantages for Indigenous peoples. This investigation includes some of the issues outlined in this essay, including the perceived superiority of the biomedical model over Indigenous knowledges and medical systems as well as Indigenous patients' experiences with non-Indigenous health care providers who perpetuate racist attitudes. A primary goal for FNHA is to transform poor structural conditions for Indigenous peoples by embedding cultural safety and cultural humility into health services in British Columbia. In July 2015, the

[7] Examples include the Nisga'a Valley Health Authority (New Aiyansh, B.C), Anishnawbe Mushkiki Thunder Bay Aboriginal Health Centre (Thunder Bay, ON), Wabano Centre (Ottawa, ON), and the Southcentral Foundation (Anchorage, Alaska).

provincial Deputy Minister of Health and the CEOs of the seven Health Authorities signed on to the Declaration of Commitment on Cultural Safety and Humility in Health Services for First Nations and Aboriginal people in British Columbia. The declaration includes a Framework for Action at the system, organization and individual level to be launched on June 21st, 2016, the 20th anniversary of National Aboriginal Day (First Nations Health Authority, 2015).

Health care practitioners, researchers and Indigenous communities have recognized cultural safety as a significant determinant of health care accessibility for Indigenous peoples in Canada. Cultural Safety is founded on the notion that what creates safety is not just an emphasis on culture, but also an emphasis on power relationships that are rooted in culture as well as other aspects of a person's identity, including gender, sexuality, age and socioeconomic status (Baba, 2013). As an ongoing process, Cultural safety fundamentally challenges historically specific power inequities embedded in health services and health care relationships that potentially deter Indigenous peoples from accessing necessary health care services (Indigenous Physician Association of Canada & Association of Faculties of Medicine of Canada, 2009). Furthermore, Cultural Safety actively contests the perpetuation of racist assumptions, sexual abuse, and the de-legitimization of Indigenous knowledge through a more explicit confrontation with Canada's legacy of colonialism. The implementation of culturally safe healthcare practices by health organizations has demonstrated significant improvement in the health of Indigenous peoples (Walker et al. 2010; Skye, 2010).

Finally, central to the concept of cultural safety is the explicit recognition of how micro-level interactions between patients and practitioners are imbued with historically specific power disparities, which typify macro-level structural conditions (Browne, 2007). For example, the belief that the mind and body are separate entities is a culturally held belief that has become normalized

within Settler society. These attitudes are shared modes of thinking, and to the extent that they are mental constructs, can be classified as cultural. At the same time, the fact the majority of medical approaches view disease in physical terms, ignoring the psychological and subjective aspects of illness may be considered structural. It is a pattern of social behavior, existing primarily at a level of lived experiences. The fact that this pattern exists in our society is a structural feature of our society. Thus, dominant health care systems must seek out structural interventions that engage the complex social, economic, political, and cultural determinants of health as a way of influencing proximal, downstream outcomes. By engaging these structural conditions, health care providers may be able to create transformative change that results in an attitudinal adjustment and the shaping of new norms, behaviors, and health outcomes in the population as a whole (Pronyk et al. 2013).

Conclusion

In this essay, I adapted and mobilized the LEARN transcultural model to critically investigate the following four areas: first, to illustrate how Indigenous methods of care and healing have adapted and been transformed in response to the multifarious colonization process that banned and disparaged Indigenous medical systems for centuries; second, to critique the dominant characteristics of the biomedical health care system; third, to illustrate salient differences between the two models that make integrated care a challenging endeavor; and lastly to provide an overview of the recommendations and interventions by Indigenous and non-Indigenous health care providers to integrate both medical systems to deliver the best care for Indigenous peoples in Canada.

The successful integration of Indigenous and Western biomedical approaches to improve the health of communities is predicated on the explicit recognition of the profound significance of

Indigenous knowledges, traditions, and epistemologies of health. However, addressing methods to restructure health care to benefit two radically different traditions and conflicting worldview poses a serious challenge for health care professionals moving forward. While the division between Indigenous and Settler health care systems has historically located the histories, stories, identities and epistemologies of Indigenous peoples in spaces of marginality, the emergence of new governmental structures in British Columbia provide a solid foundation for the resurgence of Indigenous medical systems in the health arena. The recent adoption of cultural safety by Health Authorities in British Columbia, and the gradual shift towards greater patient-centered care all point towards an exciting opportunity for Indigenous individuals, families and communities to reclaim their health and fulfill their potential for holism.

As future public health workers, it falls upon us to continue to facilitate the resurgence of Indigenous medical systems in the health arena. Through my two-year journey as a MPH candidate, I regularly focused my academic gaze towards concerns relating to Indigenous groups in Canada with a particular emphasis on complicating Settler cultural conventions. As a new member of Fraser Health Authority's Aboriginal Health Team, I intend on working towards investigating how the cultural nature of Western health care adversely affects Indigenous groups in Canada through surreptitious and intricate institutional pathways. Through this new role, I also plan on advancing a critical disposition towards my work and endeavoring towards structural initiatives for transformative change and healthcare reform. Through the coordination and the full implementation of Fraser Health's Cultural Safety Framework, I have been offered the rare and valuable opportunity to use my knowledge and insight to effect meaningful and sustained change – a challenge I intend to embrace.

Critical Reflection

According to the Master's Project Guidelines, the capstone is intended to be a "culminating experience where students synthesize and integrate the knowledge they have acquired in coursework and other learning experiences throughout the Program" (Faculty of Health Science, 2011, 2). My intention at the inception of the capstone was to develop a project that extended the invigorating line of reasoning I embarked on during my practicum experience through the mobilization of the valuable lessons acquired from my course work. Additionally, I wanted to illustrate the utility of public health frameworks, theories and practices in illuminating the development, maintenance and potential deconstruction of power inequities experienced by Indigenous peoples in Canada, thereby reconciling my professional pursuits and academic gaze. However, over the course of developing this project, I gradually understood the immense difficulty of this endeavor. What follows is a critical reflection on how to use the tools I have acquired as an Academic at SFU towards navigating the complexities of working as a Public Health professional.

Project Limitations and Key Considerations

This paper has been written with the explicit understanding of the author's limitations in conducting this Master's project. There are several key limitations that require further thought and consideration. As a current Masters of Public Health Candidate and public health professional, I am not removed from my own specific positionality in relation to the broader context of colonial power relations and the ongoing struggles for autonomy by Indigenous peoples in British Columbia. Through my recent professional experiences working in the Indigenous-non-Indigenous interface at Fraser Health, I have become more cognizant of the long and turbulent colonial history of non-Indigenous peoples producing distorted representations of Indigenous peoples (a project that I have found myself inadvertently a part of at times).

My Master's Project has been written with the explicit recognition that the author is embedded within and has been shaped by the colonial discourses and master narratives that are being challenged in this paper. These discourses continue to permeate and influence, in often distorting ways, alternative epistemological and ontological values. Such recognition represents a reflexive turn in identifying how colonial power relations are entrenched in contemporary knowledge production and are often complicit in the development of oppressive and subjugating endeavors. Thus, I hope to demonstrate the ways that I, as a student in the Academy, am fixed within power relations that shape society on a local, national, and global level, thereby illustrating that power relations are not solely done to us, but also through us and, perhaps most importantly, by us.

Doing Your Homework: A Decolonial State of Mind

Navigating the dynamics discussed above is a complicated and ongoing challenge that I am perpetually grappling with. However, as a Western academic, my role in contributing to the deconstruction and resistance of dominant historical narratives is clear. A deep understanding of the multifarious processes of colonization and their impact upon Indigenous peoples' realities is essential to any process that seeks to undo the parochial teachings in our history and to promote social and political change (Kelm 1998). In this regard, I draw upon the work of renowned post-colonial scholar Gayatri Spivak who suggests:

> …if you make it your task not only to learn what is going on there through language, through specific programmes of study, but also at the same time through a historical critique of your position as the investigating person, then you will see that you have earned the right to criticize, and to be heard (Spivak, 1990, 62).

Spivak proposes that without 'doing your homework' we may end up reproducing the racist teachings in our history and stifle transformative change processes that problematize and challenge

the status quo. Therefore, the right to critique the dominance of oppressive regimes is predicated upon my ability, as the investigating person, to position myself within broader structures of power and legacies of sustained marginalization. To do so requires that I engage in reflexivity as a continuous and relational exercise.

The process of engaging in this form of reflexivity and acknowledging one's privilege is a complex undertaking that envelopes significant challenges and tribulations. As renowned scholar and social worker Barbara Heron states,

> Admitting one's privilege does not necessarily unsettle its operation. For this is a concept that has the potential to leave those who name it in a place of double comfort: the comfort of demonstrating that one is critically aware, and the comfort of not needing to act to undo privilege. For individuals on the other side of the privilege coin, the citing of privilege by those in dominance amounts, however inadvertently, to a reinscription of marginalization. (Heron, 2005, 343)

Heron points to a common phenomenon among Settler academics who, in an attempt to somehow absolve themselves from implication, inadvertently position Indigenous identities, stories, and experiences in spaces of marginality. Challenging and disrupting the comfortability of my subject position requires undertaking reflexivity as a starting point for a relational investigation in critical analysis. Neglecting to study up - that is to do our homework - and interrogate our own subject position has historically resulted in the perpetuation of colonial power dynamics that continue to disempower Indigenous individuals, families and communities.

As I move on to work in the public health arena, I intend to advance reflexivity as social critique in service of disrupting the dominant culture of healthcare that has historically resulted in hearing Indigenous stories without listening, listening to stories without acting, and acting without listening (Kelm, 1998). Spivak's notion of 'doing your homework' has deeply resonated with me and reflects a personal and professional ethic that I will continue to engage with on a deep and meaningful level (Spivak, 1990).

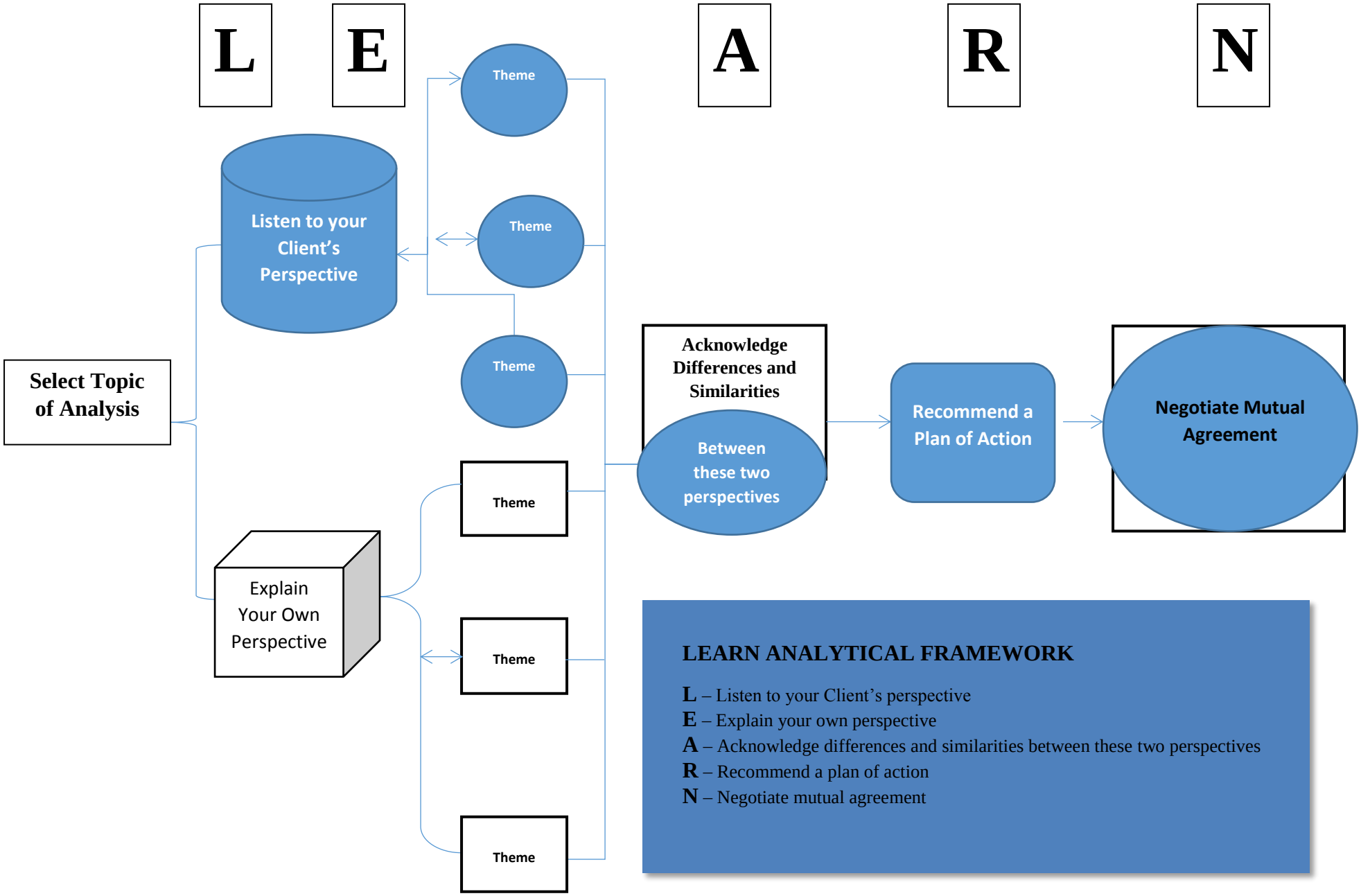
How we resembled One another
Conscripted into Complacency
Indoctrinated into Silence
generations adrift

Welcome to Monoculture 101
so much to conceal
a distilled history, instilled in the mind

these are the wounds of a colonial state of mind
that mystify
that dominate
that control…

But not totalizing
not uniform
not forever…

Colonial State of Mind by Vishal Jain



LEARN ANALYTICAL FRAMEWORK

L – Listen to your Client's perspective
E – Explain your own perspective
A – Acknowledge differences and similarities between these two perspectives
R – Recommend a plan of action
N – Negotiate mutual agreement

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