

**THE ISSUES AND CONCERNS FACING ABORIGINAL PEOPLE IN HEALTHCARE
IN CANADA**

by

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Executive Summary

Within Canada, the Aboriginal population fares more poorly in almost every health determinant when compared to the rest of Canada (National Collaborating Centre for Aboriginal Health 2013). The Canadian Aboriginal population is also not as educated in comparison to the rest of Canada (Biswal 2008). It has the highest rates of addictions, chronic disease, and mental health issues in comparison to other cultures residing in Canada. This issue is worsened by the fact that many Aboriginal patients are treated poorly within healthcare due to racism, stereotypical assumptions, misunderstanding the Aboriginal culture, and having a lack of resources to adequately care for Aboriginal patients. Many healthcare providers do not have knowledge of Aboriginal experiences, culture, traditions, and the historical reasons behind their poor health outcomes and, consequently, do not treat Aboriginal patients appropriately. These challenges are troublesome because the health status of Aboriginal people is in dire need of improvement. The racism experienced by Aboriginal patients attending the Emergency Room in hospitals due to being seriously ill is a good example. Upon seeing a Physician, Aboriginal patients frequently receive improper care and a misdiagnosis because it is assumed that they are under the influence of alcohol, drugs, or suffer from addictions whereas in reality, many Aboriginal people in Canada live addiction free lifestyles (Health Council of Canada 2012).

The goal of this project was to identify the variety of issues that Aboriginal people face in Canada's healthcare system. Solutions to these issues are discussed but the main insight is the categorization of these existent issues. The challenges that Aboriginal people face in the healthcare system are complex and require further examination to determine effective resolutions.

To gather perspectives among providers and community members regarding their beliefs about areas requiring improvement in healthcare, qualitative interviews were performed.

Qualitative interviews were chosen because they provide subjective information regarding participants' beliefs, experiences, and opinions. The findings revealed that both Aboriginal and non-Aboriginal participants shared the same understandings of the leadership characteristics that an Aboriginal healthcare provider should have. These include being honest, trustworthy, having humility, an ability to communicate, the capability to build relationships, and having an understanding of the issues and culture of Aboriginal people. It was found that as a result of colonialism, healthcare professionals struggle to work with the intergenerational trauma of Aboriginal patients and Aboriginal people do not think highly of the healthcare system much of the time. Findings also revealed that important resources were lacking that could increase the quality of care to Aboriginal patients. These included medical travel, increased communication between health provider and patient, more funding for health programs, and improved living conditions. Participants had their own ideas of restorative practices to implement for the benefit of Aboriginal healthcare, which included providing more opportunities for Aboriginal healthcare graduates to obtain jobs, offering advancement prospects for Aboriginal employees working in healthcare organizations, and providing healthcare staff with increased cultural competency training.

Recommendations for improving Aboriginal healthcare are (i) to gain further information regarding participant experiences with Aboriginal healthcare providers, (ii) assist Aboriginal people in becoming more fully educated in healthcare programs, and (iii) to provide more opportunities for advancement among Aboriginal staff within healthcare organizations.

Acknowledgement and Dedication

I would like to acknowledge all of the assistance I received to complete this thesis project. Thank you to Professor Rick Colbourne for his mentorship and support throughout the whole process. I would also like to thank all of my participants who provided me with much knowledge by sharing their experiences, stories, and challenges while accessing Canada's healthcare system.

I am dedicating this research paper to my mother who has struggled with chronic disease for over 30 years. Due to diabetes complications and renal failure, my mother is now awaiting a kidney transplant. I am also dedicating this project to my Kokum who passed away from cancer difficulties in 1997. I have watched my mother, Kokum and other Aboriginal people struggle with their health and healthcare services. Somehow, I wanted to assist in making a difference to improve the health and wellbeing of Canada's Aboriginal population.

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Chapter 1: Introduction

Background of Problem

Background of Researcher

To begin with, I, Leah Karpan, am the primary researcher, I come from Aboriginal ancestry and have been working for the Vancouver Coastal Health Authority since August 2009.

My family comes from the Muscowpetung First Nation within the Fort Qu'Appelle area of Saskatchewan and I am a mixture of Ojibway, Cree and European (Croatian). My interests have always involved improving the wellbeing of Aboriginal peoples within Canada as this population has suffered many hardships that are often ignored or have become unrecognized.

Poor Health Determinants among Canada's Aboriginal Population

In Canada, the term "Aboriginal" is defined as the first people to occupy Canadian territory and refers to those with Inuit, Metis, or Indian (status and non-status) ancestry (Indigenous and Northern Affairs Canada 2012). Therefore, within Canada, the term "Aboriginal" refers to those who are of Inuit, Metis, or Indian (status and non-status) ancestry.

Aboriginal people were also the first inhabitants of Canadian territory.

Aboriginal people have the highest rates of physical and mental illness when compared to other cultural groups in Canada. For example, there are rampant cases of infancy deaths, suicide, diabetes, and malnourishment among Canadian Aboriginal groups in comparison to the rest of Canada. The social determinants of health, income and employment, for example, exhibit poorer outcomes in the Aboriginal population when compared to other cultural backgrounds in Canada (National Collaborating Centre for Aboriginal Health 2013). Other examples of poorer social determinants of health include the average income for Aboriginal people being \$10,000 less than for those who have Non-Aboriginal ancestry in Canada; the number of Aboriginal people who

are unemployed is two times higher than the rest of Canada's population; and, Aboriginal people tend to live in poorer home environments when compared to their non-Aboriginal counterparts (NCCAH 2013). In terms of education, only 68% of Aboriginal individuals between the ages of 25-34 received their high school diploma when compared to the rest of Canada where 90% completed high school (NCCAH 2013). Canada's government has largely ignored the many Canadian Aboriginal females that have disappeared without explanation or died in very suspicious circumstances leading many to believe they were murdered (Reading & Farber 2015).

Canada's Aboriginal population has high rates of mental and physical illness when compared to the rest of the country (Reading & Farber 2015). There is a notable 14 infancy deaths per 1000 births on Canadian reserves and this rate is higher when compared to other countries and, the number of deaths by suicide among young Aboriginal people in relation to suicide is 11 times higher when compared to other countries globally (Reading & Farber 2015). Among the Inuit population, in particular, there are epidemic levels of suicide and their life expectancy is approximately fifteen years shorter when compared to other cultural groups where rates are lower (Reading & Farber 2015). The number of Aboriginal people with diabetes is twice that of non-Aboriginal peoples (and Aboriginal people are three times more likely than other groups to develop Type 2 Diabetes) (Glauser, Tepper & Konkin 2016; Reading & Farber 2015). Canada's Aboriginal population suffers from being undernourished, and there are high rates of people dying accidentally (NCCAH 2013). The next section discusses Canadian Aboriginal history to provide insights into why health devastation has occurred among Aboriginal people.

Canadian Aboriginal History

There have been numerous historical factors that contributed to the ill health described above that Canada's Aboriginal population experiences today. For the purposes of this project, and for increased understanding, it is significant to mention the historical events that have created the conditions Aboriginal people are currently dealing with. The detrimental effects from these events have been passed down generationally and still require extensive healing in order for Canada's Aboriginal people to live fulfilling and healthy lives. The section that follows discusses the *Indian Act* followed by an examination of the impact of *Residential Schools* and ending with a review of the *Sixties Scoop*.

Indian Act

The *Indian Act* controls almost every aspect of First Nations peoples' lives including their land, money, assets and First Nations status. Its implementation has had detrimental effects on the wellbeing of Canada's First Nations population ((Hurley 2009; Allan & Smylie 2015). The *Indian Act* was written in 1876 with the intent of combining all regulations that applied to First Nations people into one body of law (Makarenko 2008). The Act was developed with the purpose of assimilating First Nations peoples through managing First Nations lands, and ridding traditional sources of food from the First Nations people (Allan & Smylie 2015). Furthermore, First Nations people, through the *Indian Act*, were urged to develop European practices and discontinue following their First Nations culture (Makarenko 2008). The idea of this Act was to encourage the process of colonization by stripping First Nations people of their traditional ways of life, making them increasingly reliant on Canadian authorities (Allan & Smylie 2015).

The Implementation of the *Indian Act* created many difficulties that Canada's First Nations population still struggle with today. The most prominent ill effect is that this ruling was developed for the Canadian First Nations population only, and despite amendments, it tacitly

promotes racism towards Canada's First Nations population in projecting to other Canadians that First Nations people are secondary to the general population (Monchalin 2016). Historically under this Act, if First Nations women married a non-Aboriginal male, they lost their First Nations status (Monchalin 2016). If these women had children, then this loss of status would be extended to their offspring (Monchalin 2016). Even though First Nations women and children no longer lose their status upon marrying a non-First Nations man, they are still considered second-class citizens under this Act because it is rooted in a patriarchal perspective (Monchalin 2016). The *Indian Act* forced First Nations people to be dependent on others and was a powerful tool for controlling the behaviours and activities of First Nations people and communities (Borrows 2008). It separated families, reduced the quality of healthcare for First Nations people and reduced working and educational opportunities for Canada's First Nations population (Burrows 2008).

Overall the *Indian Act* controls almost every aspect of Canadian First Nations peoples' lives and has created detrimental results from implementation. It promoted ill effects that include racism, sexism, patriarchy, First Nations people being controlled, having a reduced quality of healthcare and less career opportunities. At the same time as the Indian Act was having a negative effect on First Nations people in Canada, the implementation of residential schools resulted in First Nations peoples being subjected to additional and increased trauma and devastation.

Residential Schools

After the *Indian Act*, residential schools were implemented in Canada. The instituting of residential schools caused some of the most detrimental effects on the health and wellbeing of Canada's Aboriginal population. The Residential School era was in effect for over 100 years and

operated through churches via the Government. It was implemented with the sole purpose of removing Aboriginal culture and tradition from the lives of Aboriginal children (Truth and Reconciliation Commission of Canada 2016). Residential schools were developed all across Canada with the last one closing in the 1990s after approximately 150,000 Aboriginal children attended these schools and were separated from their parents for unconscionable amounts of time (Truth and Reconciliation Commission of Canada 2016).

The Truth and Reconciliation Commission heard many stories of mistreatment within residential schools. One survivor, who attended the Kamloops Indian Residential School in the 1930s recounted that Aboriginal children were forced to stop speaking their Aboriginal language, and that they were told that teachings from relatives were incorrect (Haig-Brown 2002). This same survivor also states that the food provided to students in residential schools was of low quality, while workers were afforded healthy nutrition (Haig-Brown 2002). Other examples of mistreatment within residential school include students developing an unstable persona, and staff using religious views to deter the practice of Aboriginal cultural and spiritual practices. Students in residential schools experienced abuse of every type including physical, mental, emotional, sexual and spiritual (Haig-Brown 2002).

Children in residential schools witnessed many deaths of other students including those of their brothers and sisters and throughout these traumatic experiences; children did not have much consolation provided to them (Partridge 2010). When Aboriginal children were taken from their families to attend residential school, their home community was also left feeling empty without offspring around for many years. As Aboriginal communities think of themselves as one living being, in removing something as important as children there was a real fear concerning the death of communities (Chidiac 2016; Julien, Wright & Zinni 2010).

As a child, my grandmother expressed many horror stories of her abuse endured while attending residential school. One horror story my grandmother mentioned was being unable to run because of a disability with plastic hip joints. But, nuns who supervised within this residential school system forced my grandmother to participate in various running sports despite her mobility difficulties. When my grandmother was unable to run, like the rest of her classmates, the supervising nuns would beat or whip her. Overall, for many Aboriginal people, these residential school experiences along, with other traumatic events such as those described above, have led to lifelong trauma for the Aboriginal population today.

The damaging results of residential schools can be traced throughout generations of the Canadian Aboriginal population today (Truth and Reconciliation Commission of Canada 2016). Aboriginal people, as a result of intergenerational trauma from residential school, now suffer from a loss of who they are, have substance abuse issues, engage in self-harm, and mistreat others (Partridge 2010). Due to assimilation within residential school, Aboriginal people frequently misunderstand their own cultural languages and many survivors are traumatized from witnessing their brothers and sisters pass away in residential school (Partridge 2010). It has been determined that healing from such detrimental effects of residential school will take a strong commitment to change from generations of Aboriginal people (Truth and Reconciliation Commission of Canada 2016).

The Sixties Scoop

The residential school era, ending in the 1950s, gave rise to Aboriginal children being taken into social service homes in the 1960s, which was called, “The Sixties Scoop.” During the Sixties Scoop, approximately one third of Aboriginal offspring were taken from their family of origin and placed mainly into Caucasian families (Milner 2001; Allan & Smylie 2015). The

actions of these child welfare agencies represented another form of assimilative practices that impacted the Aboriginal population and continues to date, as there is an overrepresentation of Aboriginal children in foster care compared to other populations in Canada (Allan & Smylie 2015).

The experiences related to the Sixties Scoop were devastating to Aboriginal peoples as children were separated from their families, communities and cultures and experienced various forms of abusive behaviour and prejudice in their foster homes (Milner 2001). As a result, later in life, those Aboriginal children who experienced the sixties scoop had difficulties attaching to others due to the trauma they suffered. Having been forcefully separated from family and many times being the only Aboriginal person in the adoptive family meant that Aboriginal children became disconnected from their language and cultural traditions (Milner 2001).

Overall, the historical events of implementing the *Indian Act*, creating residential schools and further banishing children from their families in the sixties scoop have had detrimental effects for the Canadian First Nations population. The *Indian Act* sought to control almost every aspect of First Nations peoples' lives and residential schools were implemented with the intent of banishing Aboriginal children from their culture, family and language. Aboriginal children were further assimilated in the sixties scoop when they lived in social service homes run by non-Aboriginal people. These events are significant, because as mentioned above, they enacted policies of assimilation and colonization that have led to adverse intergenerational trauma for Canadian Aboriginal people today. Canada's Aboriginal population now experiences a loss of culture, language and identity and because of these assimilation experiences, now engages in addictive behaviours, self harm and remain traumatized from, for example, witnessing their siblings die in residential school. As demonstrated above, Canada's history of enacting policies

for managing Aboriginal people have contributed directly to poor health outcomes in almost every health determinant when compared to the rest of Canada's population.

Statement of Problem

From my experience of working in the health sector of Vancouver, many Aboriginal people are challenged with a variety of issues within Canada's healthcare system. My interest is to increasingly learn about these issues because my career aspirations are to eventually work with Canada's Aboriginal community within a healthcare setting. It is therefore imperative to comprehend the challenges that Aboriginal people are faced with in healthcare so I can provide increased quality care for this population. Once there is an increased amount of knowledge about these issues, then a variety of solutions can be determined to effectively enhance the quality of care for Canada's Aboriginal population. Solutions are discussed in this project, but the main insight is to categorize the varying issues that Canada's Aboriginal people are challenged with in healthcare.

There is also a more significant reason for exploring the issues that Aboriginal people face in healthcare. As demonstrated above, there is a dire need to improve the health of Canada's Aboriginal population because this group has the poorest health determinants in Canada. The healthcare issues are complex and it is therefore imperative to focus more closely on the factors that facilitate or constrain Aboriginal access to and participation in Canadian healthcare initiatives. Consequently, I am interested in learning where improvements can be made to assist the healthcare needs of BC's Aboriginal population. Overall, my belief is that there must be increased focus on the wellbeing of Aboriginal populations in Canada and internationally because they are suffering to a large degree.

The purpose of this paper is to generate insights into how health deficiencies within the

Aboriginal population might be minimized by determining the most prominent issues that Aboriginal people are facing in healthcare today. There are four objectives, with the first one being to understand the variety of issues that Aboriginal people are currently challenged with in healthcare. Secondly, I would like to examine if racism towards Aboriginal people is existent in Canada's healthcare system, and if it is, understand the resulting impacts on Aboriginal people. Thirdly, I would like to provide the Aboriginal community with a voice to speak of their current healthcare issues. And, my last objective is to learn about community members' perceptions of the healthcare providers that they have come into contact with.

According to the Aboriginal Health Strategic Initiatives Department of Vancouver Coastal Health (Aboriginal Health Strategic Initiatives 2016), within Aboriginal communities, health focuses on harmonizing the physical, mental, emotional and spiritual aspects of an individual. My goal therefore, is to determine how to improve the physical, mental, emotional and spiritual aspects of Aboriginal patients through exploring the issues they currently face in healthcare and determining the most effective solutions to solve these challenges. I have worked in the Aboriginal Health Strategic Initiatives Department and believe the Aboriginal cultural practices and advocacy offered by this department has greatly assisted Aboriginal patients. The following research questions were chosen based on my experience of working in the Aboriginal and non-Aboriginal healthcare field and from my experiences in the Aboriginal community:

1. What are community members' perceptions of Aboriginal and non-Aboriginal healthcare providers?
2. What are non-Aboriginal perceptions of healthcare in the Aboriginal community?
3. What are the effects of different leadership styles on the experience and outcomes of healthcare for Aboriginal people?
4. Is there a difference in leadership styles between Aboriginal & non-Aboriginal healthcare providers?

5. If there are distinctions in leadership styles between Aboriginal & non-Aboriginal healthcare providers, what types of differences exist?
6. How can leadership/managerial practices be improved to increase the overall health of the Aboriginal population?

Chapter 2: Literature Review

There is a variety of literature available discussing the Canadian Aboriginal population's current health statistics, and their challenges in accessing healthcare (see for example: National Collaborating Centre for Aboriginal Health 2011 and National Collaborating Centre for Aboriginal Health 2013). There are also numerous data sets that discuss the characteristics Aboriginal leaders view as significant to being successful at guiding others (see Julien, M., Wright, B. & Zinni, D.M. 2010 and Kirmayer, L.J., Valaskakis, G.G. & Erasmus, G.H 2014). Extensive data is available that focuses on areas in Aboriginal healthcare where improvements are required and that compare Aboriginal appreciations of health with westernized views. Lastly, much research has been completed that examines restorative practices to increase the quality of medical care among the Canadian Aboriginal population (see for example: Beavis, A.S. et al. 2015 and Todd, R., Thornton, M. & Collins, D.N. 2001)

The section that follows begins with a discussion of the challenges Canadian Aboriginal people are experiencing with the current healthcare system, followed by an examination of Canadian Aboriginal leadership. It goes on to explore Aboriginal healthcare leadership and the characteristics Aboriginal people believe an individual ought to have to become a successful healthcare leader and then examines restorative practices to determine if there are reasonably demonstrable means for the improvement of the quality of healthcare delivered to Aboriginal patients.

Current Challenges in Aboriginal Healthcare

To assist Canada's Aboriginal population in receiving improved care it is important to identify the unique challenges they face in today's healthcare system. Research has shown that Aboriginal people, because of history, stereotypes, and living conditions have unique challenges within healthcare when compared to the rest of Canada. It is important for healthcare providers to take these factors into account when working with Aboriginal patients (Beavis et al. 2015). In particular, the challenges faced by Canada's Aboriginal population include racism, healthcare funding, gender, and reserve/rural access to healthcare.

Racism

One of the first challenges Canada's Aboriginal people face when accessing healthcare is racism. A primary example of racism that occurs in healthcare happens when physicians refuse to provide medicine for Aboriginal patients because of the belief that they suffer from addictions or that they may become dependent on the medication. Another example concerns Aboriginal patients who attend the Emergency room of hospitals because they are seriously ill, but are mistaken for being under the influence of alcohol and drugs because of their Aboriginal ancestry (Health Council of Canada 2012). Due to stereotypical views that exist towards Aboriginal people, quality evaluations of their health symptoms are frequently not performed and consequently, many Aboriginal people feel insecure about using healthcare services because of the mistreatment that frequently follows in healthcare settings (Health Council of Canada 2012). In reality, many Aboriginal people who do use healthcare facilities work full time, live addiction free lifestyles and really do require medical attention (Health Council of Canada 2012).

Healthcare Funding

Canadian Aboriginal people also face difficulties in healthcare today because the Federal Government has reduced funding that supports many Aboriginal health related initiatives (Webster 2012). For example, the 2012 Federal budget indicated that Governmental departments, such as Aboriginal Affairs, had decreases in funding of up to \$165 million dollars (NCCAH 2012). The Native Women's Association, which focuses on the wellbeing of Aboriginal women, has had funding decreases of up to 40% in their health initiatives, which has resulted in a loss of \$1.5 million dollars annually (National Collaborating Centre for Aboriginal Health 2016). Examples of programs where budget cuts have taken place are those related to HIV/AIDS, diabetes, mental health, addictions, suicide, fetal alcohol issues, and sexually transmitted infections (Webster 2012). With decreased funding in these departments there is less money available to provide for Aboriginal healthcare (National Collaborating Centre for Aboriginal Health 2016). These budget cuts have resulted in a decreased number of Aboriginal leaders within healthcare because many Aboriginal people are responsible for Aboriginal health related initiatives and has resulted in predominantly non-Aboriginal healthcare providers being responsible Aboriginal patient healthcare (Webster 2012).

Gender

Aboriginal women in Canada experience adverse healthcare issues in comparison to other females in Canada. For Canadian Aboriginal women, the ability to receive quality healthcare has been adversely affected by discrimination and the use of labelling (Denison, Varcoe & Browne 2014). Aboriginal women do not access healthcare as often non-Aboriginal women in Canada because of existing prejudices and because of the fear that their children will be detained so they stay away from healthcare facilities (Denison, Varcoe & Browne 2014). Additional research has found that the conditions contributing to Aboriginal women avoiding accessing healthcare relate

to their social rank, their experience of various types of abuse, prejudice, negative interactions with child welfare agencies, and in having not received quality assistance from healthcare facilities in the past (Denison, Varcoe & Browne 2014).

Reserve and Rural Access to Healthcare

Canada's Aboriginal population faces challenges accessing quality healthcare services on reserves and in rural areas. Limited access to healthcare services from these rural areas stems from the lack of mobility to and from healthcare facilities, and an inability of many Canadian rural Aboriginal people to speak the English language (NCCAH 2011). Not as many people live in rural areas in comparison to the number of individuals living in urban vicinities, which means that it is costlier for healthcare to be carried on in rural areas. On reserves and in rural areas, healthcare staff also tend to be those in predominantly nursing professions, so specialized care from physicians is frequently not available (NCCAH 2011). Furthermore, reserves and rural areas face a scarcity of healthcare staff and there is high turnover (NCCAH 2011).

There are unique, challenging and complex problems that Aboriginal people face in healthcare today when compared to the rest of Canada. As demonstrated above, budget cuts have decreased assistance to many programs related to Aboriginal health. Aboriginal women experience negativity while accessing healthcare and tend to access care less frequently when compared to other cultures in Canada. To compound these challenges even further, Aboriginal people experience issues accessing care when living in rural areas, and have communication difficulties due to language barriers. Finally, as mentioned previously, Aboriginal people fare more poorly in almost every standard of living when compared to other Canadian, cultural groups.

Canadian Aboriginal Leadership

Statistically, the Canadian Aboriginal population tends to complete educational programs at lower rates when compared to the rest of Canada and this has had a negative impact on the potential for Aboriginal leadership. Approximately 30% of Aboriginal people complete post-secondary education in comparison to 46.6% of non-Aboriginal individuals (Biswal 2008). The lack of educational completion rates among the Aboriginal population is due to the historical effects of colonization and assimilation and as a result, there are less Aboriginal graduates because they are disadvantaged monetarily, educationally and traditionally (King 2008). Aboriginal people have challenges balancing home, individual, and academic responsibilities and this prevents them from completing their educational programs (King 2008). Many Aboriginal women are largely responsible for caring for their household, while at the same time some are single mothers and these additional responsibilities create further challenges for completing education (King 2008).

A study conducted by Human Resources and Social Development Canada (2003) found that Métis people scored higher in tests of literacy when compared to those of other Aboriginal backgrounds and increased literacy scores were positively correlated with education and employment (Biswal 2008). The Canadian Inuit population fared the poorest but this outcome may have been influenced by the fact that tests were conducted in English and many Inuit people do not speak the English language (Biswal 2008). Aboriginal people as a group tend to fare more poorly than those of non-Aboriginal ancestry. But, those Aboriginal people whose outcomes were highest in the study earned an equal amount of income when compared to those of non-Aboriginal ancestry (Biswal 2008). Approximately 62% of working age Aboriginal people were employed in comparison to 73% of non-Aboriginal people in the workforce (Biswal 2008).

There are differences in views and practices when comparing Aboriginal and non-Aboriginal leadership. In particular, Aboriginal leadership is increasingly centered on community, spirituality and equality in comparison to non-Aboriginal practices. This section begins by examining the main elements of Aboriginal leadership and then concludes by discussing Aboriginal Board members' views of what constitutes successful leadership.

Aboriginal Leadership

Aboriginal beliefs about what constitutes leadership are very different in comparison to mainstream practices. Julien, Wright & Zinni (2010) have observed that Aboriginal leadership is more centered in spirituality and equality; has a communal centered focus that believes in unifying instead of separating; and focuses on the whole individual (Julien, Wright & Zinni 2010). Aboriginal leaders guide in subtle ways that include teaching through stories, visualizations, and descriptions and bonding within the community and maintaining congruence is also significant within Aboriginal leadership (Julien, Wright & Zinni 2010). Aboriginal leadership believes that spiritual practices assist community members in maintaining their ethnic distinctiveness and when making major choices, Aboriginal leaders ensure there is agreement prior to making a selection (Julien, Wright & Zinni 2010). Lastly, Aboriginal leadership focuses more on femininity, what has been taught previously, and responsibilities to children who will soon become adults and leaders within the community (Julien, Wright & Zinni 2010).

Aboriginal Leadership Characteristics

When examining the leadership characteristics of Board members in Aboriginal friendship centers throughout Canada,¹ it was found that these leaders required specific personality traits to become an effective member (Durst 2006). Characteristics required for board membership were for members to have a vision, be flexible, have a competent comprehension of the challenges Aboriginal people face, be esteemed members in their home territory, display independence, autonomy, empathy, and, most importantly, care for the wellbeing of others (Durst 2006). Aboriginal leaders must also have personality traits of truthfulness, uprightness, generousness, and practice humility to be considered into leadership roles (Julien, Wright & Zinni 2010).

Aboriginal Healthcare Leadership

Competencies

Leadership competency is defined as the personality traits and skills of an individual that increase his or her likelihood of success within their position. There is a common understanding among professionals that improvements within healthcare leadership are needed to improve the quality of care to patients in general (Baker 2003). Specifically, improvements are required at the individual, organizational and systemic levels, and Baker (2003) believes that focusing on the competency of healthcare providers will improve healthcare outcomes.

It has been discovered that university training of various healthcare programs offers little education on Aboriginal matters (Shah & Reeves 2012). A study conducted within Ontario with approximately 25 post-secondary institutions and 17,700 new health providers, concluded that only nursing and various health support programs offered training about Canada's Aboriginal

¹ Friendship centers were located in the Whitehorse of the Yukon Territory, Victoria, BC, Thunder Bay, Ontario, and Halifax, Nova Scotia and Aboriginal females and males were the participants in the age range of 25-64 years (Durst & Zimmerly 2006).

people. When Aboriginal training was offered within these health programs, non-Aboriginal professors conducted most of the teachings (Shah & Reeves 2012).

To be effective leaders in Aboriginal healthcare it has been determined that healthcare providers must have an understanding of the issues prominent within the Canadian Aboriginal community (Shah & Reeves 2012). Other healthcare leadership competencies include knowing Aboriginal backgrounds, Aboriginal traditions, and having an understanding of the Aboriginal patient themselves besides their illness. This includes knowing when to provide an Aboriginal patient with time to discuss their concerns and if needed, providing increased time in visitation sessions (Zhou et al. 2011). In developing the characteristics discussed above, healthcare leaders would be provided with the skills required to increase rapport and interaction between the healthcare provider and Aboriginal patient thereby improving Aboriginal healthcare outcomes (Zhou et al. 2011).

Traditional Healing

“Traditional healing” refers to practices used since before the occurrence of mainstream treatments, to encourage intellectual, physiological and transcendent health among Aboriginal individuals (Herring, Waldram & Young 2000). Aboriginal healthcare leaders view rituals, tradition and culture as significant to healing (Herring, Waldram & Young 2000). Traditional healing can include spiritual practices, medicines, Elder teachings, ceremonies and discussions of past or current issues (Kirmayer, Valaskakis & Erasmus 2014; Herring, Waldram & Young 2000).

Ceremonies

Within Canadian Aboriginal culture, the use of ceremony is meant to address illness, bring people together, and heal participants. Aboriginal health leaders use ceremonies that focus

on healing all aspects of the human being in patients including the mind, emotions, physiology and transcendent aspects (Health Council of Canada 2012). In most Aboriginal healing ceremonies, there is always an association between the divine and the sickness that is occurring (Kirmayer, Valaskakis & Erasmus 2014). The “Vision Quest”, for example, is a healing ceremony used by Canada’s Aboriginal population to enable individuals to realize their transcendent selves (Kirmayer, Valaskakis & Erasmus 2014). These ceremonies frequently entail the use of sacred medicines such as sweetgrass, sage, cedar, and tobacco. Many ceremonies such as a smudge ceremony, are meant to heal, purify and stabilize participants’ sense of wellbeing (Monchalin 2016). Even though healthcare facilities allow use of ceremonies, Aboriginal people who use them feel that they are frequently misinterpreted and judged as undesirable by non-Aboriginal people (Health Council of Canada 2012).

Mainstream literature has indicated that hospital facilities require increased adaptability to incorporate ceremonies into the healing and wellbeing process for Aboriginal patients. Aboriginal shamans, for example, frequently perform healing ceremonies for patients in healthcare facilities and many times, these ceremonial rituals require the use of fire and smoke which means hospital amenities need to be able to accommodate these needs (Herring, Waldram & Young 2000).

Elders

Different Aboriginal backgrounds have varying names for Elders but they are most noteworthy for being intelligent, having a rich life understanding, and assisting members in their home territory. In Aboriginal culture, most Elders are senior people in the community who are highly esteemed, are considered very knowledgeable and are traditional Aboriginal leaders who

offer residents leadership, focus and realization of the self (Monchalin 2016; Kirmayer, Valaskakis & Erasmus 2014).

Aboriginal people usually seek restoration assistance from Elders when they are struggling and require healing (Monchalin 2016). Elders are significant health leaders in that they offer ancestral guidance, storytelling, and leadership to their people when needed (Monchalin 2016). There have been examples where suicidal ideation was reduced among youth because Elders taught them their cultural traditions and this provided youth more constructive ways to deal with problems in their lives (Kirmayer, Valaskakis & Erasmus 2014).

In closing, leadership competency refers to the personality traits and skill sets an individual possesses that increases the likelihood they will be successful in their position. It was found that within healthcare, improvements are required at the individual, organizational, and systemic levels to increase the quality of care provided to patients. Competencies suggested to improve Aboriginal healthcare include having an understanding of the culture, traditions and issues that Aboriginal people deal with. Other abilities mentioned include providing lengthy visitation time with Aboriginal patients to discuss impending issues, and developing increased rapport. Hospital facilities also require increased acceptance of Aboriginal healing practices, including the use of ceremonies, and visits from Elders.

Restorative Practices

Restorative practices are designed to increase health among individuals by ridding them of illness to restore individuals back to the way they were before illness occurred (Waldram 2013). Literature has provided many suggestions as to where restorative practices can be implemented to increase the health and wellbeing of Canada's Aboriginal population. According to Warry & Robson (2000), a restorative practice should allocate responsibility for healthcare

services to the Aboriginal population themselves. The allocation of healthcare delivery to Aboriginal people is a primary stage of redesigning the healthcare system today. Warry & Robson (2000) explain that a large trial for Canada's Aboriginal population would demonstrate their ability to adequately care for their own healthcare and that the allocation of healthcare services to Aboriginal people would display Governmental approval of empowering Aboriginal people.

Measures to address the racism prevalent among healthcare providers are an important goal of restorative practices (Glauser, Tepper & Konkin 2016). Educating healthcare workers on Aboriginal history, common stereotypes that exist toward Aboriginal people and how their own biases may affect the quality of care delivered to Aboriginal patients would be a starting point to increasing the quality of care. As pointed out, racism has greatly affected the care Aboriginal people receive, in the section that follows, restorative practices that address living conditions will be discussed, followed by an examination of the issues related to geographical location and ending with a discussion of cultural competency training.

Living Conditions

Todd, Thornton & Collins (2001) suggest concentrating on restorative practices that focus on Canada's Aboriginal population's living conditions is crucial for improving healthcare outcomes. They explain that increased expenditures on prescription medication, etc., have not been effective because they are not adequately focused on the healthcare needs of the Aboriginal population. Instead, restorative practices need to consider the mindset of Canada's Aboriginal population and focus on decreasing scarcity, and improving living conditions such as the quantity of water available, cleanliness, and home accommodations (Todd, Thornton & Collins

2001). Finally, improving ecological pollutants around Canadian Aboriginal living areas would be beneficial for decreasing illness (Todd, Thornton & Collins 2001).

Geographical Location

Other restorative practices suggested to improve the health of Canada's Aboriginal population are to take into account what is required per geographical location (Newbold 1998). For example, some reserves are closer to cities than others, so it is easier to access healthcare due to proximity factors and Aboriginal people, who live in cities, tend to visit the doctor more frequently than those residing on reserves (Newbold 1998). Aboriginal people have indicated a need for more health-related training, increased access to counsellors, and easier availability of healthcare services in their place of residence (Newbold 1998).

Cultural Competency & Cultural Safety Training

A last restorative practice suggested is to introduce cultural competency and ethnic safety training among healthcare staff (Beavis et al. 2015). Cultural competency is a process that focuses on training physicians, nurses and other healthcare leaders with the education, knowledge, abilities and mindsets to properly care for patients of different ethnicities while cultural safety training focuses on the power relationship that exists between the healthcare provider and patient (Beavis et al. 2015). Cultural competency and safety training are significant to healthcare practice because this education will teach healthcare providers that focusing solely on mainstream thinking and medicine will not provide optimal care for Aboriginal patients and it will inform them about how colonization has impacted the health of Canada's Aboriginal population today. Aboriginal healthcare outcomes can be improved through introducing the historical influences of colonialism, how this colonization impacts healthcare provided to Aboriginal patients, and the ways a physicians' own life experience and understandings

influence the care they provide to Aboriginal clients (Beavis et al. 2015). This involves understanding Aboriginal worldviews and considering who trains healthcare staff, the methods of teaching, and who explains the reasoning behind why competency training is being offered. Finally, cultural competency training should be taught with and by Aboriginal people for increased legitimacy.

Canadian Aboriginal people are suffering and will continue to have the highest difficulty with healthcare unless there are revisions to Canada's healthcare system and improvements to living environments that are in the Aboriginal population's best interests. The Government, healthcare managers, Chiefs and all leaders need to work together for the improvement of healthcare delivered to Canada's Aboriginal population. It is imperative that restorative practices are implemented, and cultural competency training offered to healthcare providers.

Chapter 3: Methodology

To begin, there is a difference between the terms "Research Methodology and "Research Methods." Research Methodology consists of the theory and scientific explanation for every data collection method and it enables individuals to critically examine the development and errors that exist among research methods (Adams et al. 2007). Adams et al (2007) state that when we are able to understand the reasoning behind data gathering methods, then we are more able to critically analyze information. Research methods refers to the data collection technique used to manage and examine the research area and are the data collection techniques used to manage and present data on a research area of interest (Adams et al. 2007). The researcher must determine which technique to use to obtain the most meaningful results related to their research objectives.

Qualitative methods were chosen for this project because the research was focused on gathering subjective opinions, and perspectives on healthcare leaders. In this research,

qualitative interviews were the means used to gather this subjective information. Quantitative data gathering methods would not suffice as they are focused more on objectivity, and to get enough quantitative information would require enlisting subjects in so large a number that it would be outside the scope of this research (Health Research Funding 2015).

Qualitative Methods

Qualitative research focuses on the subjective nature of human perspectives and actions and thus was the most suitable method for this project (Adams et al. 2007). All information from interviewees in this project was subjective, therefore allowing participants to express their opinions, feelings, and leadership styles around the topic of Aboriginal healthcare. The goal of this research was to see if there were common themes that might arise amongst participant responses. This research also focused on providing participants with a voice to speak about their experiences while accessing healthcare.

Deductive Reasoning

This project chose to employ the deductive approach of methodology. There was an understanding around the topic of Aboriginal healthcare leadership prior to conducting this research therefore an outline was developed prior to analyzing the data. With deductive methodology, an individual has their own philosophies, and develops an outline prior to analysis (Burnard et al. 2008). The deductive approach is faster than using the inductive method and is most beneficial to use when researchers have knowledge of and can anticipate the types of participant replies they will receive (Burnard et al. 2008).

Choice of Methodology

Interviews

Qualitative interviews were chosen as the method of data collection because they are beneficial when gathering information based on a participant's worldview and their perspective on a specific issue (Cassell & Symon 2004). Qualitative interviews assist the researcher in determining how the participant came to view the topic of interest in this manner and, this type of research tends to have a minimal structure, asks open-ended questions and focuses on a certain topic of interest (Cassell & Symon 2004). In qualitative interviews, the interviewee is the key information provider for the project and can dynamically determine the course of the question process (Cassell & Symon 2004)

The use of qualitative interviews for data collection has many advantages. Within companies, for example, qualitative interviews assist with determining perspectives on larger matters such as those of being a male or female in an organization, cultural implications for companies, and the repercussions of joblessness (Cassell & Symon 2004). These types of interviews also assist with assigning significance to areas where quantitative methods or other forms of qualitative data collection techniques would not produce useful results. Cassell & Symon (2004) indicate that participants are more likely to participate in interview data gathering methods because most individuals are acquainted with this process from other areas of life.

Qualitative interviews were chosen because the goal of this project was to examine individual perceptions of the current healthcare system and how it could be improved to increase quality of care to Aboriginal patients. As mentioned above, the focus of this paper was to gather respondents' points of view on healthcare leadership and the experience of patients in the delivery of care to the Aboriginal population. There are also disadvantages to the qualitative interview process. For example, qualitative interviews take many hours to prepare, conduct, and examine (Cassell & Symon 2004). At times, there is also a considerable amount of time taken

from participants, and it therefore may be challenging to obtain interviewees (Cassell & Symon 2004). Cassell & Symon (2004) indicate that many times, data collectors feel overwhelmed by the number of hours it takes to conduct each step of the interview process. In this project, it would have been more beneficial to conduct an increased number of interviews, but due to time constraints, only 14 interviews were conducted.

The Researcher's Role

I was the primary researcher for this project. As mentioned previously, I am of Aboriginal ancestry and my interest has always been in improving the wellbeing of Canada's Aboriginal population. I work within the health sector of the Vancouver Coastal Health Authority. More specifically, I work within Vancouver General Hospital's Department of Vancouver Acute and Medical Affairs. I have gained much experience working directly with the Aboriginal population. For example, I have held a front-line position within an Aboriginal Women's shelter in Yellowknife, Northwest Territories. These Aboriginal women were fleeing from domestic abuse and required emergency shelter along with their children. Other occupations in which I was working directly with individuals of Aboriginal ancestry include homecare centers, the Health and Social Services Department of the Government of the Northwest Territories, an activity aide on a Psychiatry ward and lastly, a Program Assistant for an Aboriginal funding service. While growing up, the majority of my friendships came from Aboriginal ancestry and I can recall that many friends and family suffered from various dysfunctional situations within their homes. My belief is that these dysfunctions were the result of intergenerational trauma experienced from colonization.

My life and work experiences have equipped me with the tools to establish a trusting relationship with participants who may be more sensitive to the topic of Aboriginal healthcare. I

plan to share my experiences and background with all interviewees in hopes of gaining increased rapport. In light of this, I estimated that participants would share an increased amount of information with a higher level of comfort. My role as the researcher was to listen to participants' responses and request further clarification if required. I listened to my interviewees with a non-judgmental attitude and made data comparisons among participants upon completion of the interview process.

Sample

A total of 14 interviews were conducted in this project, with each lasting 40 minutes to 1 hour in length. Interviewees included 7 Aboriginal, and 7 non-Aboriginal individuals who were chosen because they came from various occupations and backgrounds (see Table 1).

Table 1 Pseudonyms for Interviewees

Pseudonym	Characteristics
Participant 1	Female, Aboriginal healthcare worker
Participant 2	Male, Aboriginal healthcare worker
Participant 3	Male, non-Aboriginal healthcare worker
Participant 4	Female, non-Aboriginal healthcare worker
Participant 5	Female, non-Aboriginal healthcare worker
Participant 6	Female, Aboriginal community member
Participant 7	Male, Aboriginal healthcare worker
Participant 8	Female, Aboriginal community member
Participant 9	Female, non-Aboriginal community member
Participant 10	Male, non-Aboriginal community member
Participant 11	Male, non-Aboriginal healthcare provider

Physicians, Aboriginal Patient Navigators and policy healthcare workers were interviewed for this research that work mainly within the Vancouver Coastal Health Authority and the First Nations Health Authority. Community members of Caucasian, Asian, and varying types of

Aboriginal ethnicities were also interviewed for this project that live around the vicinity of Vancouver. All interviews took place in a quiet, confidential area of the participant's choice and the interview process provided participants with an opportunity to voice opinions, needs, and wants from a subjective point of view. Importantly, all interview questions were open-ended to ensure answers were not biased.

It was difficult to obtain interviewees from the Reserves to participate in this project. My experience was that prospective on-Reserve participants did not return my calls or were not interested in participating. Due to time constraints, I had to proceed with this project without interviewing someone from a Reserve.

Data Collection

Participants were primarily recruited via email, phone, social media and face-to-face interactions. I asked my current supervisors if they would like to participate in my interview process, and they were useful in assisting me. As mentioned above, it was difficult to obtain participants from the Reserves despite calling, using social media, and emailing.

Informed Consent

It is important to obtain informed consent prior to the interview process for ethical reasons (Cahana, Samia & Hurst 2008). Informed consent provides participants with an opportunity to agree or disagree with participating in a research project and allows a researcher to step into a participant's boundaries of privacy (Cahana, Samia & Hurst 2008). All informed consent is voluntary and participants should never be coerced into participating in a research project if they do not wish to (Cahana, Samia & Hurst 2008).

Prior to interviews taking place, I gathered informed consent from participants to ensure they understood that I am an MBA student conducting research for my thesis project.

Participants signed an informed consent form. Participants also understood that all interviews were video-recorded and they were provided with the primary researcher's contact information if concerns arose. In the event that a participant did not wish to be recorded on camera, their preference was respected and the video camera was turned off. Lastly, participants were provided a copy of the interview questionnaire in advance of the session's commencement.

Confidentiality

I have ensured that all information collected in the interviews has remained confidential. All video-recorded interviews are stored in a secure, confidential storage space. My Supervisor, Professor Rick Colbourne, was the only other individual who viewed these results. As mentioned above, the interview location required a quiet atmosphere so voice recordings, if used, could be heard. Accordingly, all interviews took place in a quiet and confidential space of the interviewee's preference.

Ethical Considerations

Research with Aboriginal Participants

It is imperative to examine the ethics and rapport around working with Aboriginal participants because past research with Aboriginal people was conducted mainly by non-Aboriginal individuals who did not understand the culture and traditions of Aboriginal communities and, as a consequence, research has historically not benefitted the Aboriginal population (Panel on Research Ethics 2015). It is significant, therefore, to build rapport with the Aboriginal community being researched prior to conducting fieldwork (Panel on Research Ethics 2015). Researchers must ensure that their work will benefit the Aboriginal community and building rapport with Aboriginal participants includes community engagement practices, and providing information about who will view the data upon completion (Panel on Research Ethics

2015). Other forms of rapport building include obtaining consent from leaders in the community prior to selecting a participant (Panel on Research Ethics 2015).

In this project, Aboriginal people encompassed a significant portion of the study and I ensured that all areas such as their cultural background, traditions, intergenerational trauma, living conditions, and history of colonization were respected. Responses from Aboriginal participants assisted in determining how the community, as a whole, viewed healthcare leadership practices. Even though this research involved a significant portion of Aboriginal interviewees, participants were not singled out, or specific traits identified. This research with Aboriginal interviewees was collaborative in that I ensured there was a mutually respectful relationship with participants. As mentioned above, I am part of the Aboriginal population and have therefore developed an understanding of various Aboriginal customs. Throughout this project, I ensured consent from leaders prior to conducting any interviews.

My belief is that this research will benefit Canada's Aboriginal community. To begin, during the research process, Aboriginal people, whether or not they identified as members of an Aboriginal community, enjoyed freedom of expression in this project, and were free to consent in research projects that they considered of personal or social benefit. This project's research has also contributed to facilitating individual health and wellbeing because participants provided increased knowledge of how healthcare leaders can revise their practices to better care for Aboriginal patients. Aboriginal peoples are particularly concerned that research should enhance their capacity to maintain their cultures, languages and identities as First Nations, Inuit or Métis peoples. Overall, I do not believe there was a significant impact on Aboriginal communities resulting from this project's research and the belief is that this study was ultimately low risk.

I was careful to ask if there were questions or concerns before conducting interviews to confirm that all interviewees were at their maximum comfort level. I also performed check-ins throughout the interview process to ensure participant wellbeing. Respondents were not pressured to answer questions if they did not wish to. I understood that some topics may be a sensitive issue for interviewees to discuss and therefore did not probe anyone to answer questions they may have felt uncomfortable with. Assistance while conducting interviews was not required because all participants were English speakers and had full functioning capacity. Lastly, participants were offered a copy of the project when completed.

Research Limitations

While acknowledging that answers may not be found to all objectives, as much relevant data as possible was gathered. As mentioned above, interviewees may not be comfortable answering various questions and this may hinder data gathering as well. Participants cannot be forced to answer what they do not wish as this would be against ethical considerations.

Although it would have been beneficial to attain an interviewee from a reserve, due to time constraints and lack of responses, I was unable to obtain a participant from there. Results, therefore, are limited to Aboriginal leaders, non-Aboriginal leaders and community members throughout the vicinity of Vancouver. If this study were to be implemented again in the future, it would be beneficial to obtain participants from Reserves close to Vancouver.

Chapter 4: Data Analysis

The following steps guided this analysis process:

1. Interview responses were read through numerous times to search for common themes that arose among interviewee answers
2. Themes were linked to what was presented in the literature review section

3. The data was clarified using quotes from respondents, narratives and citations from the literature review section

Themes which emerged from the data were first, both Aboriginal and non-Aboriginal participants had similar characteristic expectations of a successful leader in Aboriginal healthcare. Second, the effects of colonization are a challenge when dealing with Aboriginal patients. Third, the lack of resources in healthcare and in the environment, play a significant factor in the quality of healthcare received by Aboriginal patients. Lastly, both Aboriginal and non-Aboriginal participants had their own perspective of the restorative practices required to increase the quality of healthcare to Aboriginal patients. In the section that follows, the results from the interviews will be examined with regards to themes that arose followed by an analysis of the significance of the findings and ending with recommendations.

Findings

Leadership Characteristics in Aboriginal Healthcare

The first theme arising out of interviews was that both Aboriginal and non-Aboriginal participants had similar understandings of leadership characteristics required to be successful in Aboriginal healthcare. Interviewees mentioned having quality communication skills, being respectful, having compassion, understanding the population that serving, being honest, trustworthy, and having experience working with Aboriginal people. For example, female Aboriginal, healthcare provider Participant 1 stated:

“I think that some of the best qualities or characteristics would be humility, compassion, dedication, trustworthiness, honesty, self awareness, and commitment to the work, team and themselves. Leaders must always have that transparency, that vision to always be moving forward, always having the best interests of our people in our heart.”

According to Participant 1, a quality healthcare provider for Aboriginal people would be honest, committed, is humble and would always have the best interests of Aboriginal people while working. Participant 1 works directly with Aboriginal patients on a daily basis so had extensive knowledge about Aboriginal matters.

Other examples of Aboriginal healthcare leadership characteristics included having knowledge of Aboriginal culture, excellent ethics, and being assisted by providers who were of Aboriginal ancestry. When interviewees were asked about the qualities of a successful leader in general, both Aboriginal and non-Aboriginal participants cited that all leaders should have compassion, ability to listen, capacity to understand the perspectives of others, have high ethics, a vision, humility, and a great sense of humour. For example, male Aboriginal healthcare provider Participant 2 noted:

“Healthcare leaders should have relational skills, I think its good to have management skills, you need to be able to relate to people, have communication skills, change management skills, a clear and comprehensive understanding of government processes, and also of health authority structures, roles and responsibilities.”

Participant 2 states that ensuring to stay professional and working within organizational rules is important for building relationships with Aboriginal people that lead to quality healthcare outcomes and asserts that quality communication is essential to building and sustaining relationships with Aboriginal patients. Participant 2 is an Aboriginal healthcare leader who oversees staff, so he has first hand experience of leadership within Aboriginal health.

Personality traits mentioned included the ability to identify strengths of team members, offer praise, be supportive, fair, assertive, respectful, flexible, and have an ability to assert boundaries. Important characteristics mentioned included having excellent communication,

honesty, transparency, fairness, ensuring not to micromanage, having patience, a high emotional intelligence, an ability to delegate, a willingness to make mistakes, overcoming bias, and the desire to know the individual that one is working with. One male, non-Aboriginal healthcare provider Participant 3 explained:

“...listening, being able to understand the perspectives of others, high ethical standards, I guess a relentless sort of pursuit of improvement, always pushing things forward to improve, interpersonal style and abilities. We have a lot to learn about Aboriginal communities, and their needs, how they present their needs, and how to match the services of care to their unique environments. I don’t think we can simply apply western, modern, medical treatments in a blanket way to Aboriginal individuals without thinking about their preferences, and their needs, and the environment in which they live.”

Participant 3 understands the significance of having high ethical standards while caring for Aboriginal patients. He also states that it is acceptable for Aboriginal health leaders make mistakes, as long there is follow to work on those areas requiring improvement. Participant 3 realizes that in order to provide quality care to Aboriginal people, a provider must get to know them and their needs, so they can match their care and services accordingly. He works in mainstream healthcare within Vancouver General Hospital, but still has knowledge of the characteristics required to adequately care for Aboriginal patients.

Therefore, the interviews indicate that Aboriginal healthcare leadership requires honesty, an ability to listen, high ethics, excellent communication, and building relationships. It was also mentioned that developing strong Aboriginal leadership requires getting to know the Aboriginal patient, their culture and style of communication as well as working within the policies of their healthcare organization.

Colonization

The effects of colonization emerged during the interviews as an important challenge facing Aboriginal patients and healthcare providers. For example, male Aboriginal health provider Participant 2 noted:

“It is challenging dealing with the public misunderstanding of our people in terms of not being able to connect the dots between the current health status and colonialism.”

He observes that events such as the implementation of the *Indian Act*, Residential schools, and the sixties scoop have had detrimental effects on the wellbeing of Canada’s Aboriginal population. Participant 2 believes that many non-Aboriginal people do not understand the effects that these situations caused Aboriginal peoples and he believes that the general population just sees a dysfunctional Aboriginal person while not considering the reasons why they are that way. Participant 2 notes:

“It is challenging addressing the myths, for example, that we get everything for free, that we don’t pay taxes, that we get all healthcare for free. So not true.”

According to Participant 2, there are a lot of stereotypes that affect how non-Aboriginal individuals view Aboriginal people and these biases have a negative effect on the way Aboriginal people are treated.

Aboriginal healthcare providers further indicated that dealing with the lingering effects of residential school, and colonization were challenging when working with Aboriginal patients. Intergenerational effects include addiction issues, poor physical health, mental health challenges, having difficulties attaching to others, harming self, and being violent towards others. Other

lingering effects include having an inability to trust others, dealing with racism, and being treated poorly by others, including healthcare providers. Aboriginal male provider Participant 2 noted:

“Dealing with the lingering effects of residential schools in hospitals, and colonialism is the most challenging. People are often left with complex health challenges, so the work we have to do with Aboriginal people is very complex and multijurisdictional. We’re dealing with a system that’s side looped, and fragmented, and it’s our job to bring those pieces together to create some sort of coordinated plan. And, that’s really challenging.”

He is stating that there has been extensive intergenerational trauma due to colonization and that the trauma is so devastating that it has triggered numerous health challenges on many levels including mental, emotional, physical, etc. Participant 2 believes that the mainstream healthcare system fails to consider the complexity of care required for Aboriginal patients and the constraints faced by Aboriginal healthcare providers having to work within this westernized system to provide quality services.

Another female, non-Aboriginal healthcare provider who works with Aboriginal patients indicated that because of colonialism, many Aboriginal patients do not feel comfortable or safe and there is a need to rebuild relationships so they will access care more frequently. Female, non-Aboriginal provider Participant 4 explained that:

“Due to colonization, many Aboriginal patients do not feel comfortable or protected when accessing healthcare and there is a need to rebuild relationships so they will access care more frequently.”

Her view is that many Aboriginal community members avoid accessing healthcare because they are treated poorly or frequently misunderstood. Participant 4 is non-Aboriginal but works within the First Nations Health Authority and so deals with Aboriginal patients regularly. Based on her

experience, Non-Aboriginal provider Participant 5 cited the impacts of colonization in working with all cultural groups, noting that some Aboriginal patients do not want to be associated with their culture.

“Many Aboriginal people do not want to be associated with their culture and we should not assume that they want to follow the ways of First Nation people. But we often do.”

She observes that while many healthcare providers assume that an Aboriginal person wants to include cultural healing practices in their care, many Aboriginal people are unfamiliar with their culture or do not wish to be a part of it because negative associations generated by past practices of colonization and assimilation.

An Aboriginal interviewee described a situation when she was diagnosed with Post Traumatic Stress Disorder from her brother passing away at the age of twenty-five years due to alcoholism and she was trying to receive healthcare but it was challenging. She was placed on a long waiting list of seven months and required more care than what was ultimately received. The health effects from her trauma were so complicated that she needed increased health assistance. This participant was fearful of her family being judged by the non-Aboriginal healthcare staff because her brother passed away so young from alcoholism. This female Aboriginal community member Participant 6 2016 stated:

“It really just depends on the human being, there’s very beautiful people full of compassion and understanding of the human experience but sometimes there is that disconnect, that fear of judgement from people that simply just don’t understand what its like to be a First Nations person growing up here in Canada and the different challenges we face as First Nations people. Its not the same upbringing as it is to be a middle class white person. You know my brother died at the age of twenty-five due to alcoholism. I felt the judgement. What are they thinking? What do people see when they see this?”

She was fearful that non-Aboriginal healthcare staff were judging her because her brother passed away at such a young age from alcoholism. This is an example of community members feeling unsafe and uncomfortable with mainstream healthcare services.

Therefore, within Aboriginal healthcare, due to practices of colonization and assimilation, it is challenging working with Aboriginal patients because of the residual trauma. It is also difficult for Aboriginal healthcare workers to provide care in a predominantly westernized culture that does not fully consider the needs of Aboriginal patients. In receiving care, due to the effects of colonization, Aboriginal patients sometimes do not wish to be associated with their culture, and many Aboriginal people are fearful of the mainstream westernized medical staff.

Lack of Resources

The interviews revealed that the lack of resources in healthcare plays a significant factor in the quality of care received by Aboriginal patients. For example, female, Aboriginal health provider Participant 1 noted:

“Resources in general are lacking so supporting clients can be really difficult, especially in times of crisis.”

Participant 1 works with Aboriginal patients in both rural and urban environments and she discussed not having enough resources in terms of housing, transportation, food, localized access of resources, and proper communication with other healthcare providers as being challenging especially in times of crisis. Her organization, however, strives to provide high quality care to their Aboriginal patients despite lacking these resources.

Another male provider working directly with Aboriginal patients cited lack of housing, insufficient climate resources, the absence of health transportation and insufficient health access as being challenging when providing care to this part of society. Male, Aboriginal provider

Participant 7 notes:

“I was thinking it would be beneficial to have resources linked to healthcare housed in one centre, so whether that’s Aboriginal Patient Navigators, and/or housing specialists, or community resources, having them linked together and providing additional resources for the Aboriginal community so they can access healthcare, housing, community supports. If we had a team linked all together it is possible that as Aboriginal healthcare leadership, we would feel stronger.”

According to Participant 7, because it is difficult to find accurate resources to support Aboriginal patients it would be easier to access support and crucial resources if they were all accessible through on location. He works directly with Aboriginal patients in Aboriginal healthcare so had extensive knowledge of what resources are required to improve the assistance provided to Aboriginal patients.

Other resources that are missing or challenging on Aboriginal reserves include substandard living conditions, poor quality drinking water, lack of nutrition, communication barriers such as an inability to speak English, etc. Aboriginal patient navigators listed lack of resources in terms of housing (for both urban and rural Aboriginal patients), drinking water, food access, escorts, financial resources, and parking passes as being the most difficult aspects of providing care for Aboriginal patients. Male Aboriginal provider Participant 7 notes:

“I feel, in working with clients, at the time of discharge, it is challenging searching for adequate resources, and housing in order for them to continue healing. You can say this problem exists for both urban and on Reserve patients.”

According to Participant 7, of all the resources, it is especially difficult to find adequate housing for Aboriginal patients within all areas. He notes:

“In some communities, they can’t drink the water that comes out of the taps.”

Participant 7 indicates that living conditions are so substandard in areas that Aboriginal live, that in some places they are unable to drink out of their taps at home.

Aboriginal healthcare providers indicated that economic and geographic barriers are challenging factors when caring for Aboriginal patients. Female, Aboriginal healthcare provider Participant 1 notes:

“Resources in general are lacking. Not having the financial resources, ourselves to help families with is a challenge so access to maybe food vouchers at the hospital, parking passes and that sort of thing is one of the biggest things.”

According to her, it is difficult to obtain adequate resources without the finances available to do so. Therefore, Aboriginal healthcare providers are constantly searching for vouchers for food, parking, etc. which Aboriginal patients can use.

A female, non-Aboriginal healthcare provider working with Aboriginal patients indicated that the challenges around medical travel, funding and lack of communication when a patient lives in remote areas as being “testing.” Often in remote areas, a phone or computer is unavailable for communication purposes and this creates difficulties when caring for Aboriginal patients. Female, non-Aboriginal healthcare worker Participant 4 notes:

“From community engagement work that I am a part of, many of our challenges come from transportation to appointments. Or, if Aboriginal patients are

needing to leave their region entirely to come down here to Vancouver General Hospital (VGH), medical transportation, or arrangements for funding can be challenging to navigate. And, communication can sometimes be a challenge if they're living in a rural or remote area with limited Internet services, or if you don't have a computer, or telephone, keeping up with the health provider and follow up appointments can be difficult."

According to Participant 4, it is challenging providing care for Aboriginal patients living in remote areas because there are extreme communication barriers in some areas. As mentioned above, Internet services are lacking or a phone is unavailable. These barriers make it difficult to care for Aboriginal patients living outside of the city.

Lastly, a male, non-Aboriginal, provider cited the need for increased advocacy to open communication lines with Aboriginal patients. Male, non-Aboriginal provider Participant 3 notes:

"I think first of all we should be engaging that community in a separate way. You know they are stakeholders. They have a disproportionate number of injuries, medical issues, and medical problems. And, we are not really engaging them in the planning and provision of the kind of care that they want. They have unique needs related to their Aboriginal communities and heritage, and I don't think we're very sensitive to that. So, if we had, for example, an Aboriginal liaison officer, or teaching assistant in the hospital, I think that would be very helpful."

According to Participant 3, it is essential to have Aboriginal feedback in providing quality care. An advocate would therefore be beneficial to speak on behalf of Aboriginal people regarding their unique healthcare needs.

Healthcare leaders indicated that the lack of resources was equally challenging when caring for non-Aboriginal patients. A healthcare provider cited that he had the same issues as when dealing with Aboriginal patients. Aboriginal Patient Navigators said that non-Aboriginal spouses and children were unable to receive support, transportation, and food. And, a non-

Aboriginal physician cited said access to care was similarly a significant issue for non-

Aboriginal patients. Male, non-Aboriginal provider Participant 3 noted:

“Its more than just access to care. Access to care is the big issue. But, non-Aboriginal people seem very eager to advocate for themselves. Where as Aboriginal people are less aggressive at advocating for themselves.”

Participant 3 indicates that for non-Aboriginal patients access to care is equally challenging

when compared to working with Aboriginal patients, however, the difference is that non-

Aboriginal people are more likely to speak their mind regarding their needs in comparison to

Aboriginal patients whose culture and upbringing might not support such behaviour.

Community members indicated the lack of resources as being challenging for quality healthcare. For example, referring to Aboriginal community members, a female, Aboriginal participant complained about the lack of communication between healthcare providers and patients as being challenging. She described the challenges of not receiving consistent messages of where to access proper healthcare, in not being told who will assist her with healthcare problems or who is going to follow through with her. This same participant also felt that within healthcare, many items fall through the cracks. She complained of having to search for travel assistance and was required to pay for her own healthcare at times. This same female,

Aboriginal community member Participant 8 2016 notes:

“I can’t go to First Nations Health for an issue. I have to go to Nisga’a Valley Health. One will tell me I have to talk to the other, and the other will tell me I have to speak with the other person. When trying to sign up for First Nations Health, nobody wanted to help me. It is just the communication and who will help me with this, and follow through with it. I took my application right to Health Canada and there was months of nothing. This is something that you shouldn’t have to deal with.”

Participant 8 was frustrated when applying for First Nations Health because she was receiving inconsistent messages of how to access healthcare and was forced to approach many people in order to try to receive assistance. She believes there should be improved communication of how to access care.

Another female Aboriginal participant described that she required more healthcare assistance for dealing with her Post-Traumatic Stress Disorder (PTSD) than she received.

Female, Aboriginal community member Participant 6 notes:

“I had a brother who passed away last October and I was really struggling with my mental health, so right away I contacted Vancouver Coastal Health to see what I could do to help myself. I saw a psychiatrist and she said everything I was going through is normal and that I had post-traumatic stress disorder from losing my brother. It took over 7 months to get accepted into a group she referred me to. In the meantime, I really had to struggle learning to cope and deal with my PTSD and that was really challenging because I would be on my way to work in tears, I’d be at work in tears. I think I needed more help than what I received. It took a lot out of me.”

Participant 6 complained of having to wait long periods of time to receive adequate healthcare for her PTSD. She was left on her own to fend for herself while waiting for care and felt that she should have received more thorough care instead waiting for months at a time for acceptance into a PTSD program.

Non-Aboriginal community members also complained about the lack of resources in healthcare. For example, a female, non-Aboriginal community member explained that there are long wait times when trying to access healthcare, and there is little interaction with healthcare staff much of the time. This same female, non-Aboriginal community member Participant 9 notes:

“When seeing my Family Doctor there were three hour wait times even though an appointment was made. He was at the end of his career and had a huge portfolio. I have since changed doctors.”

Participant 9 complained of long wait times to see her family doctor, even though she had made an appointment. According to her, some physicians have too big of a portfolio to adequately care for the number of patients they have.

A male, non-Aboriginal community member said that waiting long spans of time to receive healthcare, was a challenge, and that there are often difficulties finding an adequate family physician. This male, non-Aboriginal community member Participant 10 notes:

“I had to go to the children’s hospital for Penny (my daughter), and there were long wait times, but physicians were good. It also took a long time to find a family doctor because there are not many around and they’re not accepting patients.”

Participant 10 similarly complained of having to wait long periods of time at the children’s hospital for his daughter to access care.

Overall, it was found that a large increase in resources is required to improve the health conditions among Canada’s Aboriginal population. Examples of resources that are needed include increased funding, housing, transportation, communication, increased opportunities for Aboriginal healthcare graduates, decreased wait times to see physicians and perhaps having a variety of resources linked in one area. There is also access to care issues for non-Aboriginal patients.

Restorative Practices

Aboriginal and non-Aboriginal participants differed in their perspectives on the types of restorative practices required to increase the quality of care for Aboriginal patients. For example, female, non-Aboriginal provider Participant 4 states:

“I find each individual tends to have their own style and personality, that it is hard to say there is one thing that will work for everyone. When I was thinking about my workplace, I think it is important to have a strong, solidified set of core values within the team. So, it would be beneficial to offer training of how you can go about having conversations with your team, or your organization to develop those core values. Also, leading by example and role modelling is important, doing what you think should be done. Being less instructive and more demonstrative.”

According to Participant 4, a restorative practice ensures there is a set of core values among the Aboriginal healthcare team. She felt that it is imperative for Aboriginal health leaders to lead community members by setting an example through living a clean and healthy lifestyle.

Other examples of restorative practices mentioned by participants include increasing counselling services, offering more assistance for family members providing care for children, introducing Aboriginal people to mainstream healthcare processes, and providing increased job opportunities for new healthcare graduates. One non-Aboriginal healthcare provider Participant 11 notes:

“Students are graduating, but they aren’t getting jobs because they don’t have experience. There should be internships for new graduates.”

According to Participant 11, for new Aboriginal graduates to gain experience and obtain jobs, there should be internship programs available for new graduates. This would increase the number of Aboriginal employees within Aboriginal healthcare. He also states:

“There should be broad exposure for Aboriginal people to mainstream healthcare processes.”

Participant 11 believed that Aboriginal patients would more easily adapt to westernized, mainstream medical practices if they were exposed to them through job experiences and internships.

Other examples of restorative practices discussed in interviews included having comprehensive healthcare resources linked in one centre, increasing learning opportunities for healthcare staff, providing mentorship programs which would expose staff to different styles of leadership, and increasing opportunities for graduates to participate in practicums. Female, Aboriginal healthcare provider Participant 1 observes:

“There needs to be more opportunities made available for learning, for mentoring with senior staff, and leaders, and more opportunity for upward movement within an organization, instead of feeling like staff have to go somewhere else afterwards. Because often what will happen is employees will do their degree, then go somewhere else after they have gotten their Masters. And, that happens a lot.”

According to Participant 1, to retain Masters Level Aboriginal graduates, it is imperative to provide mentorship programs and room for advancement for them within Aboriginal healthcare organizations. Otherwise these newly skilled employees will be lost.

Interviewees mentioned that receiving assistance with increased quality living conditions would be beneficial. The living conditions requiring improvement included having cleaner drinking water, and more educational opportunities for Aboriginal people to create a life separate from dysfunction. Other restorative practices mentioned by participants include leading by example, participating in cultural competency training, and generating increased awareness about

intergenerational trauma that occurs among Aboriginal populations. Female, Aboriginal healthcare provider Participant 1 notes:

“One of the larger challenges of working with Aboriginal clients is working with the team that struggles to work with Aboriginal clients and family. And so, the challenge is more building that relationship with the team to help foster the relationship with the patient and family so that you can support a successful healthcare plan that is culturally safe and appropriate.”

In addition, she observes that:

“Sometimes it takes a lot of work with the team to be successful because people have those invisible backpacks. They don’t know that they have all of these things in their life that they take for granted and that Aboriginal people don’t have.”

According to Participant 1, many non-Aboriginal healthcare providers do not understand the issues, culture and traditions of Aboriginal people so there are difficulties working as a team with them. She believes that non-Aboriginal providers do not realize the benefits they have in their lives in comparison to non-Aboriginal people.

“Aboriginal people see, view and live in the world in a different way than the dominant discourse in society. Therefore, everything has to be looked at from a different perspective. It cannot be looked at from this westernized, medical kind of concept.”

Participant 1 believes it is imperative to include Aboriginal concepts of healing, culture and traditions with westernized medicine for maximum care of Aboriginal patients.

Finally, it was suggested that health information sessions should be advertised so they can become more popular with the public, and that to increase the effectiveness of healthcare, providers should engage with Aboriginal communities according to their preference.

Restorative practices mentioned by participants to improve the quality of care for Aboriginal participants include Aboriginal health leaders leading by example, having more job opportunities for new graduates and including advancement opportunities for Aboriginal healthcare employees. Other restorative practices include exposing Aboriginal patients to mainstream medical practices for them to adapt. Lastly, participants felt that it was imperative for healthcare providers to take cultural competency and safety training for improved relationships with Aboriginal patients.

Discussion

The findings indicate that characteristics considered imperative for Aboriginal healthcare leadership are respect, compassion, having an understanding Aboriginal people, being trustworthy and ethical. They also revealed that intergenerational trauma within patients is challenging for healthcare providers to work with, that Aboriginal patients do not feel comfortable accessing healthcare much of the time and that many non-Aboriginal providers misunderstand Aboriginal healing traditions and the culture. Examples of resources that are lacking to provide adequate care for Aboriginal patients include housing, funding, transportation, and communication. Restorative practices mentioned in the findings to improve Aboriginal healthcare include providing increased opportunities for new Aboriginal healthcare graduates to obtain jobs, offering advancement prospects within healthcare organizations for Aboriginal staff, and providing increased cultural competency training for healthcare providers.

Aboriginal Health Leaders

Both Aboriginal and non-Aboriginal participants had similar understandings of leadership characteristics for promoting success in Aboriginal healthcare and these included Aboriginal leaders having respect, compassion, an understanding of the population that they are

serving, being truthful, trustworthy, and having experience working with Aboriginal people.

Other examples of Aboriginal healthcare leadership characteristics mentioned in interviews included staff being humble, knowing Aboriginal traditions, having good ethics, and ensuring Aboriginal patients were assisted by providers of Aboriginal ancestry. Overall, participants identified specific characteristics they thought healthcare leaders should possess to be successful (see Table 2).

Table 2 Leadership Characteristics

Leadership Characteristics	Definition
Respect	Think highly of the Aboriginal culture
Compassion	Care for the Aboriginal patients that working with
Understand population that serving	Understand Aboriginal ways of thinking, healing, and dealing with things
Truthful	Being honest to Aboriginal patients, and healthcare team
Trustworthy	Ensuring that will keep the best interests of Aboriginal patients
Experience working with population that serving	Has worked with Aboriginal patients in similar settings previously
Humble	Does not power differentiate when working with Aboriginal patients
Ethical	Know what is right from wrong when caring for Aboriginal patients
Being Aboriginal	Provider comes from Aboriginal ancestry

These findings support the literature that mentions Aboriginal leaders must also have personality traits of truthfulness, uprightness, generousness, and practice humility to be considered into leadership roles (Julien, Wright & Zinni 2010). The findings presented here did not support the literature in that the interviews did not discuss spiritual aspects of Aboriginal healthcare. The literature mentioned that Aboriginal leaders are more focused on culture, spirituality, the whole person, and community more than mainstream providers are (Julien, Wright & Zinni 2010). The reason why spiritual aspects were not mentioned in interviews is most likely because participants are unfamiliar with Aboriginal healing practices and due to

colonization, Aboriginal ways of dealing with illness are not popular in mainstream, western society and medicine.

There is a second gap within the data in that both Aboriginal and non-Aboriginal community members interviewed had not seen Aboriginal healthcare providers in the past so could not comment on their experiences with them. These findings support King (2008) who states that due to the lack of resources, there are less Aboriginal people who become educated and because there are less educated Aboriginal people there is a limited number of Aboriginal healthcare providers to care for Aboriginal patients. Non-Aboriginal participants in particular felt that their level of knowledge was too inaccurate to comment on their perception of leadership within Aboriginal communities and because of their lack of understanding, community members could not comment on whether Aboriginal and non-Aboriginal leaders provided differential treatment or practiced differently.

The findings support the literature in that they also support the significance that understanding Aboriginal healthcare leadership, culture and communication styles of Aboriginal patients is crucial for enabling healthcare providers to provide increased quality of care. The literature mentions that to be effective leaders in Aboriginal healthcare it has been determined that providers must have an understanding of the issues prominent within the Canadian Aboriginal community (Shah & Reeves 2012). Other healthcare leadership competencies mentioned in the literature include knowing Aboriginal backgrounds, Aboriginal traditions, and having an understanding of the Aboriginal patient themselves besides their illness (Zhou et al. 2011).

The findings support the literature in revealing that if providers understood Aboriginal forms of communicating and ways of dealing with illness then it would assist them in providing

high quality caring for Aboriginal patients. Rapport would also be increased between the provider and Aboriginal patient because sensitivity would be heightened towards Aboriginal culture and traditional ways of handling illness.

Colonization

The findings support the literature in that they identified that one of the most challenging aspects of working with Aboriginal patients is dealing with the intergenerational trauma that has occurred as a result of colonization. These findings support the literature, which recognizes that the *Indian Act*, the Residential School system and the Sixties Scoop have had extremely detrimental effects on the wellbeing of Canada's Aboriginal population. As demonstrated above, the *Indian Act* made Aboriginal people dependent on others, separated families, reduced the quality of healthcare and limited working and educational opportunities for Canada's Aboriginal population (Burrows 2008). Aboriginal people today, as a result of intergenerational trauma from residential schools, suffer from a loss of identity, have substance abuse issues, engage in self-harm, and mistreat others (Partridge 2010). Aboriginal people, have interpersonal challenges due to the Sixties Scoop that result in difficulties attaching to others, and in many finding their own cultural traditions to be foreign to themselves (Milner 2001).

The findings support the literature in revealing that Aboriginal patients do have complex issues as a result of trauma from colonization and that healthcare providers have difficulties working with Aboriginal patients and the Aboriginal health care teams because patient issues are so complex that they are frequently misunderstood by non-Aboriginal healthcare workers.

Lastly, the findings support the literature in that Aboriginal patients frequently do not wish to be associated with their culture because they do not understand it or view their traditions negatively. They support the literature suggesting that colonization has negatively affected the

way Aboriginal patients are treated by healthcare providers, and that the trauma has been so devastating that Aboriginal people sometimes wish to avoid accessing care altogether. The findings indicated that because there are poor relationships with healthcare staff, Aboriginal people do not wish to access care supporting the literature that identifies how Aboriginal women, out of fear of the healthcare system, avoid accessing care more frequently than non-Aboriginal women do (Denison, Varcoe & Browne 2014).

Healthcare facilities need to be places where Aboriginal people feel safe because they are urgently needed when the health status of Canada's Aboriginal population is so dire. Overall, Aboriginal people need to feel more comfortable when accessing healthcare so they will feel access health services more frequently.

Racism

The findings support the literature in identifying that Aboriginal people are still dealing with racism in healthcare today and that stereotypes held by healthcare providers has a negative effect on the quality of care and outcomes for Aboriginal patients. For example, Aboriginal patients' experiences of racism included attending the Emergency hospital room due to being seriously ill, but not being treated properly because they were mistaken for being under the influence due to their Aboriginal ancestry, and therefore did not receive adequate healthcare (Health Council of Canada 2012). The literature also states that Aboriginal patients frequently did not receive proper medication because their attending physician stereotypically assumed that they were suffering from addictions (Health Council of Canada 2012). In reality, many Aboriginal patients who do attend healthcare services actually live addiction free lifestyles (Health Council of Canada 2012).

The findings add to the literature mentioned above where an Aboriginal community member, as cited above, stated an experience where she was caring for her brother, who was dying of alcoholism in the hospital at the age of 25, and feared being judged because of these circumstances. Overall, the results indicate that Aboriginal people do still experience racism within healthcare. These findings are significant because they indicate that stereotypical biases affect the care provided to Aboriginal patients. This racism and consequent poor quality of treatment is affecting Aboriginal patient quality of care in an adverse manner. The findings presented here indicate that relationships and rapport need to be rebuilt between Aboriginal patients and healthcare providers to improve the disastrous health problems among Canada's Aboriginal people. For example, it was noted that communication lines must be increased with Aboriginal people in a manner that they feel most comfortable with to improve their quality of care. Overall, racism in healthcare must be diminished for the benefit of all involved.

Lack of Resources

The findings support the literature identifying that there is a significant lack of resources within Aboriginal healthcare to adequately care for Aboriginal patients. Both healthcare providers and community members understood the impacts of having inadequate resources to provide adequate care for the Aboriginal population. These include cleaner drinking water, increased educational opportunities for Aboriginal people, improved medical travel, increased communication, enhanced nutrition and decreased waiting times to see physicians.

The findings of requiring cleaner drinking water and improved nutrition as mentioned by participants, support the research of Todd & Thornton (2001) who suggest a restorative practice of improving the living conditions among Aboriginal patients to improve their health status. Areas to improve on include providing increased amounts of water, increasing cleanliness, and

improving the quality of home accommodations that Aboriginal people live in (Todd & Thornton 2001). The findings also support the literature that found limited access to healthcare services in remote areas due to the lack of transportation available to and from healthcare facilities, and an inability of many Canadian rural Aboriginal people to speak the English language (NCCAH 2011). Aboriginal patient navigators, physicians and other healthcare staff all indicated that the main resources needed are increased medical services, improved living conditions, removal of communication barriers, and an increased number of housing opportunities for Aboriginal patients. These findings are significant because they shed light on the fact that healthcare leaders must increasingly improve the quality of care towards Aboriginal patients, by being more communicative and working to decrease the language barriers with Aboriginal patients. These findings are also important because they indicate providers must increasingly focus on the needs of specific communities to provide adequate care.

Restorative Practices

Participants in this project had their own perspectives on the restorative practices required to increase the quality of healthcare leadership and care provided to the Canadian Aboriginal population. The findings suggest that delivering increased counselling services to Aboriginal patients, providing more assistance for family members who are caring for children, introducing Aboriginal people to broader exposure of mainstream healthcare processes, and delivering increased job opportunities for new healthcare graduates are crucial to improving Aboriginal healthcare outcomes. These findings add new insights to the literature in that it did not mention providing increased assistance to those caring for children or offering more counselling services to Aboriginal patients. The findings of delivering increased job opportunities to new healthcare graduates adds to the literature in which Warry & Robson (2000), state that a restorative practice

would be to allocate health care services to the Aboriginal population themselves. In providing Aboriginal people with full control and authority over their healthcare resources there would be increased job opportunities and improved Aboriginal healthcare outcomes. The findings which identified having healthcare resources linked in one centre, increasing learning opportunities for providers, delivering mentorship programs which would expose healthcare workers to varying styles of leadership, increasing opportunities for graduates to participate in practicums all support the literature of Warry & Robson's (2000) recommendation of providing the allocation of healthcare delivery to Aboriginal people. There would be more mentorship opportunities for healthcare staff, and it would be similar to having healthcare resources linked in one health authority.

Of particular significance is the finding that the introduction of cultural competency training would be a significant restorative practice. The requirement of cultural competency training supports the literature review section, when Beavis et al. (2015), for example, suggest that a restorative practice would be to teach healthcare staff cultural competency and safety training to assist them in understanding the impacts of colonialism in the Aboriginal population. As mentioned above, there is much ill treatment and health inequities among Canadian Aboriginal people due to the impacts of colonization (Beavis et al. 2015) and the findings that Aboriginal healthcare providers experience difficulties working with non-Aboriginal teams support the literature that increased cultural competency training is needed. The findings indicated that Aboriginal people think, and practice healing in a different manner than westernized medicine and that non-Aboriginal providers do not understand the ways of Aboriginal people enough to provide adequate care. This supports the literature that providers need to learn about Aboriginal culture, traditions and issues to provide quality care to Canada's

Aboriginal population in order to reduce the effects of colonization towards Aboriginal people and improve the quality of Aboriginal healthcare (Beavis et al. 2015). Healthcare staff would need to be trained to pay attention to how their own biases and life experiences impact the care they provide to Canadian Aboriginal people (Beavis et al 2015).

The findings identifying the need for improved communication between healthcare staff and Aboriginal patients support the literature that states relationships between Aboriginal and non-Aboriginal people would also be improved if cultural competency training were taught in partnership with those from Aboriginal backgrounds (Beavis et al 2015). Overall, increased awareness of Aboriginal history, culture, and existing biases among healthcare staff, would assist in decreasing the adverse colonial impacts that are devastatingly prevalent in many areas of healthcare today. Therefore, participant results and the literature support a need for increased education among healthcare staff, particularly around the topics of cultural competency and cultural safety. Healthcare providers have the responsibility to increase their knowledge, and monitor their frame of mind about the cultural groups they come into contact with. A committed healthcare provider will not let racism, bias or stereotypical thinking interfere with the quality of care they provide to all patients.

Recommendations

In conclusion, both aboriginal and non-Aboriginal participants had similar ideas of what constitutes successful Aboriginal leadership in healthcare. Examples include having humility, knowing Aboriginal culture, traditions, history and ways of leading. Aboriginal leaders in healthcare should also be compassionate, ethical, have excellent communication skills and be trustworthy. Participants had not had enough experience with Aboriginal healthcare providers to comment on their experiences with them. Referring to colonization, healthcare providers found

it challenging to work with the intergenerational trauma common among Aboriginal patients as a result of colonization through the *Indian Act*, residential schools, and the Sixties Scoop.

Aboriginal people, as a result of these events, experience a loss of self and may not comprehend their culture and frequently engage in harmful activities. Many Aboriginal people do not trust the healthcare system due to the racism they experience while accessing healthcare facilities and consequently avoid them even when they are required.

It was found that many non-Aboriginal providers have biases and do not understand the culture, history or issues that Aboriginal people deal with. Referring to resources, there is a profound lack of assets to provide Aboriginal patients with adequate care. Examples of resources that are lacking include medical travel, there is miscommunication existing between healthcare providers and Aboriginal patients, housing resources are missing and finances are not available. Aboriginal people also frequently experience poor living conditions and there is a lack of cultural competency education for healthcare staff. Participants had their own idea of restorative practices required to increase the quality of care for Aboriginal patients. Examples of restorative practices mentioned by participants are to provide more counselling services, deliver increased employment opportunities for new Aboriginal healthcare graduates, provide increased mentoring options for healthcare staff, improve Aboriginal living conditions and introduce healthcare staff to increased cultural competency training. Cultural competency education is significant because it would assist healthcare staff in learning about Aboriginal culture, history, colonization, and becoming aware of their own stereotypes towards Aboriginal people.

Consequently, the following recommendations came out of the research:

1. To conduct more research to gain further information regarding participant experiences with Aboriginal healthcare providers

2. To assist Aboriginal people in becoming more fully educated in healthcare programs
3. To provide Aboriginal healthcare providers with more opportunities for advancement in healthcare organizations

My first recommendation for further improving Aboriginal healthcare leadership in Canada is to conduct increased research to ask more individuals about their experiences with Aboriginal healthcare providers. There was not enough participant experience with Aboriginal providers in this study to generate enough data. There also needs to be more information provided of experiences with Aboriginal providers to assist the Aboriginal community in refining their healthcare processes.

My second recommendation is to more fully assist Aboriginal people in becoming educated in healthcare programs. The findings revealed that there is not enough Aboriginal healthcare staff and indicated that Aboriginal people face more barriers that prevent them from becoming educated in comparison to other cultures. Therefore, Aboriginal people urgently need assistance in becoming educated in healthcare programs of interest to better serve Aboriginal patients in their community.

My third recommendation is to provide Aboriginal healthcare employees with increased opportunities for advancement in healthcare organizations. The findings indicated that Aboriginal healthcare staff frequently pursue employment elsewhere because there are not enough opportunities available within their organizations. I have first hand experience with this issue in having worked within Vancouver Coastal Health for almost 8 years and in having experienced little opportunity for advancement. Aboriginal patients will experience increased

quality of healthcare and more positive healthcare outcome through working with providers of a similar culture or with those who have an enhanced understanding of their needs. Rapport and relationships would ultimately be enhanced if more Aboriginal providers were introduced and maintained in the healthcare system.

Chapter 5: Conclusion

I have argued that Aboriginal healthcare leadership requires improvement to increase the quality of care provided to Aboriginal patients in Canada. The Canadian Aboriginal population has lower health determinants in comparison to the rest of Canada and this needs to be reversed. It appears both Aboriginal and non-Aboriginal participants cited similar characteristics of what a successful leader should entail. These personality traits included having respect, compassion, an understanding of the population that serving, being truthful, trustworthy, and having experience working with Aboriginal people. Other examples of Aboriginal healthcare leadership characteristics mentioned in interviews included healthcare staff being humble, knowing Aboriginal traditions, having ethics, and ensuring Aboriginal patients assisted by providers were of Aboriginal ancestry. There was a gap in the findings, in that literature also discovered that Aboriginal leaders are more focused on culture, spirituality, the whole person, and the community more than mainstream providers are (Julien, Wright & Zinni 2010). It is imperative that Canada's healthcare system implement Aboriginal ways of leadership and culture into their care when dealing with Aboriginal patients. Aboriginal people also become educated in healthcare programs at lower rates in comparison to the rest of Canada and this lack of education is one factor in why Aboriginal people do not have much experience with Aboriginal healthcare providers.

Colonization was meant to establish control over Aboriginal people and assimilate them. The findings demonstrate that colonization has created challenges in the quality of Aboriginal healthcare due to the on going effects of the *Indian Act*, the residential school system, and the sixties scoop. Healthcare leaders indicate that it is challenging working with the intergenerational trauma that patients have as a result of colonization and Aboriginal patients do not feel comfortable accessing care because they fear being treated poorly.

Colonization has fostered racism in healthcare providers and this has adversely affected the care they provide to Aboriginal patients in Canada. Aboriginal patients are frequently misdiagnosed, provided with improper care or medicine due to stereotypes and biases of healthcare providers leading them to assume that Aboriginal patients are under the influence of drug and alcohol and not ill.

It was concluded that there is a significant lack of resources available to adequately care for Aboriginal people. Examples of resources that are lacking for proper care of Aboriginal patients, as mentioned in findings and the literature review, include housing, transportation, and communication. Finances are also lacking and it is difficult to care for patients in rural areas because of technological barriers such as not having the Internet as mentioned, Canada's Aboriginal population fairs more poorly in almost every determinant of health when compared to other cultural groups in Canada. The Canadian Aboriginal population has high rates of diabetes, suicide, violent deaths, addictions, etc. An increased amount of resources are significantly needed to reduce the devastating health statistics among the Aboriginal population. Furthermore, resources are poor in that Aboriginal people live in substandard living conditions. There is unsanitary water, poor nutrition and less than standard housing conditions that have further contributed to the ill health status among Canada's Aboriginal population. Findings indicate that

non-Aboriginal patients also have difficulties with healthcare access but they voice their needs more than Aboriginal people do.

Restorative practices are required to reverse the effects of colonialism and improve the health among Canadian Aboriginal people and participant had their own ideas of restorative practices required to increase the quality of care provided to Aboriginal patients. Various restorative practices mentioned in the findings and literature to reverse the effects of colonization include cultural competency training where physicians are taught the history of Aboriginal people, how colonialism affects the healthcare provided to Aboriginal patients today, and are made aware of their own biases. Implications for healthcare providers are that they need to realize how their own experiences, biases and stereotypes affect the quality of care they provide to Aboriginal patients. Other restorative practices mentioned by participants include creating increased numbers of leadership positions for Aboriginal providers and new graduates. Aboriginal healthcare leaders would more likely understand the culture, traditions, communication styles, experiences, and healthcare needs of Aboriginal patients. A last restorative practice that became significant, as mentioned in the findings and literature review, was to improve the living conditions that many Aboriginal people reside in today. Resources mentioned to improve include the quality of drinking water, provide enhanced nutrition, increasing educational opportunities, providing improved housing, and easing access to healthcare.

My first recommendation for further improving Aboriginal healthcare leadership in Canada is to ask more individuals about their experiences with Aboriginal healthcare providers. There was not enough participant experience with Aboriginal providers in this study gain enough data and more information is needed. My second recommendation is to more fully assist

Aboriginal people in becoming educated in healthcare programs. And lastly, my third recommendation is to provide Aboriginal healthcare employees increasing opportunities for advancement in healthcare organizations.

Appendices

Definition of terms taken from the Government of Canada 2012, Indigenous and Northern Affairs Canada Terminology (Indigenous and Northern Affairs Canada 2012)

Table 3 Terminology

Aboriginal People	A term that describes 3 categories of Aboriginal people: First Nations, Inuit, and Metis people.
First Nations	Substituted the term “Indian” in the 1970’s after individuals felt insulted.
Inuit	A term used to describe Aboriginal individuals who live in Nunavut, the Northwest Territories, Northern Quebec and Northern Labrador.
Métis	Individuals who have both European and First Nation heritage. Origins usually come from Ojibway, Cree, Scottish and French.
Status Indian	An Aboriginal individual whose name is recorded in the Indian Act.
Indian Act	The Indian Act came into effect during 1876, and was developed to oversee “Indian” resources.
Non-status Indian	An Aboriginal Individual not recorded under the Indian Act.
Cultural Competency	Defined as increasing one’s understanding of another’s culture/tradition, and an acceptance of the large variability of ethnicities that that individuals bring forth in the workplace (Aboriginal Health Strategic Initiatives 2016).

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