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Ethical Engagement with Indigenous Populations in Alberta and Beyond

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Ethical Engagement with Indigenous Populations in Alberta and Beyond

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An abstract of a thesis submitted to the Faculty of the Rollins School of Public Health of Emory University in partial fulfillment of the requirements for the degree of

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Abstract

Indigenous populations have long been oppressed and experience disparities in health, education, and across many sectors of socioeconomic life. Recognizing disparity in healthcare, Clare Brant wrote “Native Ethics and Rules of Behaviour” in 1990 as a guiding tool for psychotherapists. We engaged in an archaeology of knowledge search to understand how Brant’s notions of behavioural characteristics of Indigenous patients have traveled through the literature and influenced, not only medical literature, but also fields including research, social work, education, and others. In addition to the literature, we conducted focus group interviews with Indigenous patients at the Elbow River Healing Lodge in Calgary, AB to understand Indigenous patients’ experiences with communication in healthcare settings. Two candidate theories were drafted, and the results of the literature search and interviews were analyzed through the lens of those theories:

Theory 1: Present in Indigenous culture is the underlying ethical principle of community harmony and conflict suppression.

Theory 2: Western modes of communication do not acknowledge Indigenous ways of knowing, seen in various Western systems, (education, social work, and healthcare).

The results of the analysis were reported according to a realist review framework, identifying the context in which Indigenous populations are operating in healthcare and other sectors, the mechanisms acting on the context, and the outcome of that interaction. The results revealed a context in which Indigenous values differ from those of the Western medical system but are largely ignored. Though there are multiple mechanisms, or relevant behaviours that could be identified, the most salient in the

literature and focus groups interviews that were selected for this study include non-interference and sharing. These behavioural norms differ from those in the dominant Western society, and at their core, non-interference and sharing cultivate relationalism in communities. The outcome of a lack of understanding of these mechanisms of behaviour is ruptures in the healthcare relationship and reinforcement of health disparities for Indigenous populations.

Clare Brant's work has been helpful in building understanding among non-Indigenous medical professionals, but his notion that Indigenous behaviour aims to suppress conflict may be more germane if reframed. We believe that relationalism is at the core of Indigenous behaviours, and that healthcare relationships can be restored through the adoption of mechanisms like non-interference and sharing, promoting relationalism. Such restoration has the potential to transform health disparities and create a more equitable environment.

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Chapter I: Introduction

In August 1990, Mohawk psychiatrist Clare Brant published an article in the Canadian Journal of Psychiatry entitled "Native Ethics and Rules of Behaviour," (Brant, 1990) with implications reaching well beyond the medical profession. Brant aimed to articulate a more nuanced approach to inter-cultural communication, to recognize that - at least among psychiatrists in his time - behaviours commonly observed in Indigenous patients may frequently be misinterpreted by care providers. Brant noted that behaviour considered culturally appropriate in Indigenous society was deemed resistant, passive-aggressive, or depressive by clinicians. This misinterpretation, he noted, leads to misdiagnoses and exacerbates trauma. Observing communication styles and behaviour codes common across many Indigenous peoples in North America, he located the origins of "Native ethics" or principles within the pre-colonial reality of life in harsh climates, where survival "required harmonious interpersonal relationships and cooperation" (Brant, 1990, p. 534). Core ethics outlined include non-interference, non-competitiveness, sharing, and emotional restraint, which he argued together promote harmony and suppress conflict. In this exploration of the legacy of Clare Brant's original piece, we find in it the roots of a paradigm shift for guiding transformations in inter-cultural relationships. Particularly in light of directives from the 2015 release of the Truth and Reconciliation Commission of Canada's (TRC) 94 calls to action, Brant's work provides a template for navigating moments of inter-cultural discord, from inter-personal relationships to wider systems and social structures.

For Brant, these "ethics" help contextualize what is often misapprehended as the withdrawal or passivity of Indigenous children and adolescents operating within non-Indigenous contexts. Nearly 30 years since the original publication, Brant's ideas

resonate still today; in fact, they could be among psychiatry's greatest contributions to Indigenous health equity. Healthcare and social services providers still routinely speak of non-compliance with therapeutic plans designed for Indigenous patients (Jacklin, et al., 2017) while program planners and researchers are often frustrated by under-utilized investments in development or unexplained withdrawal of community partners from projects lacking in meaningful relationships (Boyd and Lorefice, 2018). Arguably, misapprehended verbal and non-verbal cues make these instances moments of inter-cultural discord. This plays out infamously in clinical encounters when a patient's nod intended to acknowledge having heard a physician's thoughts are interpreted as a sign of agreement, and in boardrooms where lack of vocalized dissent may be presumed to imply consent.

Subsequent applications of Brant's ideas in education, law, and social work, in Canada and internationally, indicate that the implications of his original piece have matured in ways that invite renewed attention. Modeling this discussion on his original article, this work contextualizes its implications in a post-TRC space in Canada and within growing attention for narrative in medicine. A need to utilize a realist approach became apparent to understand the nuances of the context and mechanisms which influence Brant's argument about behaviour, as well as the potential outcomes. With Brant's work having influence across disciplines, the realist methodology provided the tools to compare the complexity of Indigenous behavioural mechanisms acting on settler colonial contexts in various fields of study. Like Brant's, this work cautions against any universalizing applications of the Indigenous ethical principles, to avoid the tendency of Pan-Indigenous approaches to erase or overlook cultural particularities. Nevertheless, there are common values and principles that crosscut Indigenous groups

(Brant, 1990, p. 534), and common wisdom in cultures formed outside of Western capitalist structures. This work also highlights a limitation in the notion of "Native ethics," which should not be confused within a limited frame of institutional research ethics boards, but rather within a broader vision of moral principles that govern or guide one's activities in the world. Tracing the uptake of Brant's ideas, "Native ethics" and "ethical principles" have, depending on discipline, been likened to learning styles (Tippeconnic and Tippeconnic Fox, 2012), rules for inter-cultural communication (Pitama, et al., 2018), behavioural and social norms (Reeves and Stewart, 2017), and Indigenous ways of being (Castellano, 2004).

Problem Statement

As Brant noted in "Native Ethics and Rules of Behaviour," behavioural norms exhibited by Indigenous patients in medical settings are often misinterpreted by healthcare providers, leading to misdiagnoses and poor care (Brant, 1990). Miscommunication may also lead Indigenous patients to feel that their culture is undervalued, causing them to disengage from healthcare and worsening health disparities (LaFromboise, Trimble, and Mohatt,1990).

Purpose of this Research Project

The purpose of this research project is to explore how Clare Brant's notions of Indigenous behaviour have influenced the literature, and how those ideas may have changed over time. In addition to searching the literature, the project seeks to elevate the voices of Indigenous patients and their understanding of their interaction with healthcare systems, both positive and negative. Through the dual exploration, the research project aims to provide greater clarity for non-Indigenous healthcare providers regarding ethical interaction with Indigenous patients, and how they might be able to

understand cultural behaviours and engage with Indigenous patients in a meaningful and constructive way.

Chapter 2: Review of the Literature

The results from the literature review are described from the lens of the two candidate theories that developed. This review first explores how Indigenous ethical principles, such as non-interference and sharing, operate within societies and impact healthcare interactions. Next, the literature is discussed through the lens of communication, and the disconnect between Indigenous ways of knowing and values of Western systems.

A. Ethical Principles in the Literature

Unique characteristics of behavioural principles widely shared among Indigenous communities reveal differing value systems (McGrath et al., 2005), with Indigenous approaches often rooted in goals of maintaining positive, harmonious relationships despite natural adversities. Ethics, behaviours, and modes of communication emerging from this tend to value the suppression of conflict (Brant, 1990). While it is important to note that ethical principles are not overriding values that trump all other considerations (Wark, Neckoway, and Brownlee, 2017), common ethics that work toward suppressing conflict that are shared across many Indigenous communities include non-interference, sharing, non-competition, emotional restraint, relationalism, and community emphasis on identity.

The non-interference principle is a central influence on Indigenous interpersonal interaction (Wark, Neckoway, and Brownlee, 2017) and maintains harmony by promoting autonomy among all members of a community. Non-interference respects human independence and discourages any physical, verbal, or psychological coercion. Advice or instruction in a Western paradigm, can thereby be viewed as an attempt to establish dominance, leading some Indigenous people who adhere to this principle to

avoid overt, directive instruction (Brant, 1990). Instead, more subtle communication is often preferred, as means of maintaining respectful and nurturing relationships Wark, Neckoway, and Brownlee, 2017). As an extension of the non-interference principle, Indigenous communities tend to teach through modeling, demonstrating a behaviour for another person to learn as opposed to direct instruction (LaFromboise, Trimble, and Mohatt, 1990). Narratives and metaphors are also common, especially by Elders, to teach, share knowledge, and describe appropriate behaviour (Castellano, 2002), while still respecting the non-interference principle (Loppie, 2007).

Historically, Indigenous communities have survived by sharing food and other resources with each other, and the principle of sharing is still influential in modern Indigenous communities (Peterson, 2013). Traditionally, Indigenous people seldom had complete ownership over anything, making sharing common among communities. This is perhaps an origin of the value of reciprocity, as others in the community will also share resources when they are able to do so (Greer and Patel, 2000). Sharing of resources is a common theme across many Indigenous systems, and even in modern times where hunting and gathering is less the basis for livelihood, sharing remains an important cultural ethic (Peterson, 2013). Sharing ensures that no one in the community goes without, and reduces disparity, further promoting interpersonal harmony.

An emphasis on cooperation as opposed to competition is often seen in Indigenous behaviour. Non-competition avoids intra-group conflict by preventing rivalry and avoiding scenarios that create “winners” and “losers” (Brant, 1990) Research into Indigenous education has found that children learn best in contexts that foster

cooperation as opposed to competition, as those are values typically learned within cultural spheres (Pewewardy, 2002).

Indigenous communities may also adhere to a principle of emotional restraint, which seeks to ensure that any anger or negative feelings are not shown outwardly. The suppression of emotion may aim to prevent violence or ill will in a community to maintain harmony, but sometimes has the unintended consequence of psychological disturbances and strong feelings of frustration (Brant, 1990). Negative emotions that are suppressed include grief and sorrow, so as not to burden others with emotional distress. This principle may be sometimes misread by outsiders as passive acceptance (Wilson, 1996). The principle may also be referred to as "masking" feelings, particularly to fulfill familial expectations (Tiatia, 2012).

Kinship is also important in many Indigenous communities (Greer and Patel, 2000), and the role of family and community relationships are widely seen to shape Indigenous worldviews (Johnston, Vukic, and Parker, (2012). Many communities are organized by kinship and clan systems, whereby roles in rituals and day-to-day life fulfill familial or kin roles more broadly. A strong sense of relatedness within the family and community can allow individuals to know their role in society and be more effective in their activities (Greer and Patel, 2000). The defined kinship obligations ensure there is clarity in expectations, which helps to avoid miscommunication and conflict. Further, strong family ties encourage Indigenous individuals to act in accordance with their families' expectations. A study on the smoking behaviours of Indigenous women found that family is highly influential in both initiating and sustaining smoking, as well as in quitting. Smoking cessation interventions are therefore encouraged to include family dimensions to be successful (Johnston and Thomas, 2008). Family ties also impact

Indigenous entrepreneurs who, compared to their non-Indigenous counterparts, are much more impacted by cultural pressures and kinship obligations, making their business ventures more socially complex (Lindsay, 2005). In some contexts, these strong kinship ties even extend to relatives who have passed on, and Indigenous people are expected to pay respect to their ancestors (Wilson, 1996).

Kinship orders communities, so it also dictates social identity. Indigenous individuals may see themselves in relation to the community and their place within society, meaning their identity is shaped around their role in the community. An Indigenous person often gains his or her self-worth through the communal definition of self, so self-worth results from contributing value to the community (Dvorakova, 2003). Mental health research has found that community and cultural identity are among the most important factors in Indigenous narratives within counseling settings (Stewart, 2008). In a holistic view of identity, a single characteristic for an individual cannot be separated from the experience of culture and community (Wilson, 1996). This connection between identity and community promotes corporate harmony since Indigenous people are highly interconnected.

The value of living in harmony extends to relationships with nature (Turner, Ignace, and Ignace, 2000). Common among many traditional knowledge systems, all things are interconnected and have a responsibility for one another as co-creators (Cajete, 2000). The way that Indigenous communities interact with and understand nature is therefore often relational (Cajete, 2004), as all of nature is imbued with a life spirit (Aikenhead and Ogawa, 2007) and should be treated with respect to live harmoniously together. In this view of the universe, all components of the environment

are interrelated (Turner, Ignace, and Ignace, 2000), and humans have a responsibility to care for nature and be in a reciprocal relationship with it (Walker, 2004).

Western systems typically do not share this overarching value of harmonious relationships that Indigenous communities strive to achieve. The behaviours exhibited by Indigenous people to achieve that harmony may be misunderstood in Western society, and the misunderstood behaviours frequently exacerbate disparities. For example, teachers often report poor relationships with Indigenous students in their classes, not recognizing the Indigenous values that students are taught at home around conflict suppression, and how these may clash with or be incongruent within Western modes of teaching. Mainstream schools promote argumentative behaviour, competitiveness, and judgment to succeed, disadvantaging Indigenous children who are taught in other venues to avoid those behaviours (Gorman, 1999). These so-called poor relationships and culturally inappropriate models of instruction perpetuate inequities in the education and other systems (Partington, 2003). Instead, Indigenous children learn best in environments that include holistic perspectives that emphasize harmony and utilize modeling techniques for teaching (Pewewardy, 2002).

Other Western systems in addition to education fail to affirm and value harmonious relationships. Mental health services tend to emphasize individualistic approaches to care, which are incompatible with communal values present in Indigenous societies. Indigenous patients frequently leave the relationship with mental health providers because community-level factors and the value of harmony in interpersonal relationships are ignored in the care provided. This undervaluing of interpersonal harmony in healthcare leads to underutilization of resources and further exacerbates health disparities in Indigenous communities (LaFromboise, Trimble, and

Mohatt, 1990). In the Western judicial system, Indigenous cultural ethics and conflict suppression are also often at odds with the adversarial structure, leading to misinterpretations of behaviour and worse judicial outcomes for Indigenous individuals (Prowse, 2011).

B. Indigenous Knowledge in the Literature

Indigenous knowledge and wisdom shape the lives and behaviours of Indigenous communities. Culture and knowledge can be used to either empower Indigenous people, or by discounting that knowledge, further marginalize them. Unfortunately, Indigenous knowledge typically is not recognized or even misrecognized within Western systems, leading non-Indigenous people to fail to effectively communicate or provide culturally-appropriate models of care for Indigenous populations. While the contributions of Indigenous knowledge are often disregarded within settler colonial contexts, there are promising examples for how systems can partner with Indigenous communities to provide culturally appropriate services and care and help ground those systems in equity.

Across many North American groups, lives and relationships in Indigenous contexts are often shaped by ways of knowing connected to the wider environment in which people live, to the cycles of the land and life within it. The weight derived from such wisdom is that to survive on the land requires knowledge context and for human relationships to be part of wider systems of interconnection (Stewart, 2009), (Brant, 1990). Indigenous knowledge connected to land and life-giving forces is often passed from generation to generation through informal communication channels, such as storytelling, song, dance, and poetry (Mundy, 1993). Certainly, Indigenous communities are influenced by their culture and knowledge systems, and emergent experiences of the

world. Examinations of literature in the field of education have revealed that Indigenous knowledge and 'tribal values' are being used in Indigenous homes to teach values such as respect for family and community and harmonious relationships (Tippeconnic and Tippeconnic Fox, 2012). Culture strongly influences the way that Indigenous students learn, think, and communicate, so those knowledge systems might be effectively utilized in an educational setting through holistic curricula, social emphasis, and opportunities to express creativity (Pewewardy, 2002), and throughout society to best serve Indigenous populations, as well as other populations that are not entrenched in Western culture and values.

Indigenous societies represent great diversity in their geography, customs, wisdom and knowledge systems. Despite those significant differences, there might also be some commonalities which provide tools for life lived on the land and promote harmonious relationships. The collectivist values shape communication styles in ways that may differ from Western communication, founded in competition and individualism. Language barriers and cultural differences in communication styles exist between Indigenous collectivist societies that work together, trust one another, and diminish competition to survive in harsh conditions, and those who are influenced by Western individualist values, creating tension and miscommunication (Lowell, et al., 2012). The differences may be partly due to collectivist cultures and individualist cultures interpreting information differently (Aaker and Williams, 1998) and differing value systems (McGrath, et al., 2005). Some observe that there is cultural variability in both verbal and non-verbal language between Indigenous and non-Indigenous communities (Philips, 1976), and Indigenous people often prefer subtle forms of communication (Wark, Neckoway, and Brownlee, 2017). Studies have shown, for

instance, that miscommunication is pervasive throughout the healthcare sector (Cass, et al., 2002), including in palliative care (McGrath, et al., 2005) and mental health services (Tiatia, 2012). One qualitative study that used in-depth interviews with Indigenous patients and non-Indigenous medical staff found that quality communication was limited because patients and staff often did not share the same understandings of key biomedical concepts, and staff did not adequately explain them. Staff typically failed to recognize when those misunderstandings occurred, forcing patients to conform with little voice in return, highlighting that unrecognized instances of miscommunication can be pervasive in the healthcare setting (Cass, et al., 2002). Across the disciplines, miscommunication with Indigenous populations due to cultural differences also stretches into education (Pewewardy, 2002), accounting (Greer and Patel, 2000), and research (Castellano, 2004).

A major reason for breakdown in communication stems from people affirming Western principles failing to acknowledge the validity of Indigenous knowledge and cultural ways of being. This was experienced as a lack of respect and understanding of Indigenous culture and beliefs on the part of healthcare professionals and became an important barrier to quality care (Alford, et al., 2014). It was also noted that many healthcare professionals are influenced by negative stereotypes, preventing inclusive, self-determined care for Indigenous patients (Thackrah and Thompson, 2018). Biomedical knowledge is consistently given priority, and Indigenous knowledge is marginalized. This marginalization often leaves patients feeling a lack control over their healthcare (Cass, et al., 2002). Broadly, institutional racism leads to poor care, underutilization of services, and poor health outcomes for Indigenous populations. For example, a 2010 study in Australia showed that healthcare providers at a tertiary

hospital lacked cultural competency and asked Indigenous patients if they had a "GP" without explaining what a general practitioner is. Indigenous patients frequently misunderstood the question and disproportionately replied no, leading to more than 20% of Indigenous patients' files reflecting "nil GP," compared to only 6% of non-Indigenous patient files. As a result, no doctor was contacted with follow-up information about the patient's status and future care (Durey and Thompson, 2012). Overcoming communication barriers and stigma is key to improving health outcomes.

Colonialism was accompanied by policies that replaced Indigenous sovereignty on the land with a Western system and suppressed traditional healing as a legitimate contribution to wellness. The impacts of those policies and negative perceptions about traditional healing and Indigenous knowledge persist (Robbins and Dewar, 2011). Experience living on the land and oral tradition, which have also served as sources of knowledge, deteriorated under external controls and colonialism (Castellano, 2002). Negative attitudes toward Indigenous knowledge that are embedded in settler colonial society stifle the ability of Indigenous communities to maintain Indigenous knowledge and practices (Robbins and Dewar, 2011). The lack of respect for Indigenous knowledge not only impacts healthcare (Eley, et al., 2007), but systems throughout Western society. Some note that Eurocentric sciences are taught exclusively in schools, to the omission of other knowledge systems, such as understanding science through living in nature (Aikenhead and Ogawa, 2007). Indigenous children report negative schooling experiences that include racism and delegitimization of Indigenous knowledge (Madden, Higgins, and Korteweg, 2013). In conflict resolution and peacemaking efforts, Indigenous ways of knowing are silenced (Walker, 2004), despite their productive emphasis on strengthening interpersonal relationships (Walker, 2001). Social work has

been seen to ignore Indigenous worldviews (Baskin, 2003) and forms of healing (Wilson, 1996), instead basing interventions—even those pertaining to Indigenous clients—on Western notions of welfare (Gray, Coates, and Hetherington, 2007). Finally, research into Indigenous populations has long been irresponsible and overlooked the expertise of Indigenous people in knowledge about themselves and their worlds by failing to involve Indigenous community perspectives in the formulation of research projects, and the process of collecting and analyzing information. This colonial approach has led to inaccurate research and disempowering of Indigenous communities to tell their own story (Ormiston, 2010).

Western healthcare systems are filled with culturally inappropriate models due to the failure to acknowledge and validate Indigenous knowledge. Palliative care typically excludes spirituality resources, integration of a patient's family, community relationships, and Indigenous communication norms (Johnston, Vukic, and Parker, 2012). Mental health also fails to recognize a holistic approach, omitting cultural identity, community, and interdependence from care (Stewart, 2008), (Stewart, 2009). Indigenous patients of speech pathology find the care is not flexible enough in its approach, and preferred a less rigid methodology that incorporates narrative and Indigenous cultural context (Hersh, Armstrong, and Bourke, 2014).

Other systems within society beyond healthcare also fail to serve Indigenous populations in culturally appropriate ways. Even libraries omit Indigenous ways of life, cultural values, and knowledge in information literacy structures (Roy, Lilley, and Luehrsen, 2011). The adversarial nature of Western criminal justice systems clashes with Indigenous ethics, leading to worse legal outcomes for Indigenous people (Prowse, 2011) and systemic discrimination (Chartrand, et al., 1999). For example, the criminal

justice system fails to recognize the importance of non-interference in Indigenous culture and instead asserts power by soliciting responses from witnesses, victims, or the accused, who are deemed uncooperative or unreliable when they choose to remain silent in response to demands (Prowse, 2011).

The delegitimization of Indigenous knowledge, conflicting goals between Indigenous communities and Western systems, as well as the power differentials in place lead to underuse of healthcare (LaFromboise, Trimble, and Mohatt, 1990) and other public services. However, Indigenous communities and those who are sensitive to their needs are working to improve Western systems. Cancer patients are increasingly incorporating traditional Indigenous and complimentary medicines into cancer treatment to help meet their spiritual, emotional, social, and cultural needs (Gall, et al., 2018). Research involving Indigenous populations has changed drastically in recent years to include culturally appropriate mechanisms, such as sharing circles (Loppie, 2007). Educational systems are beginning to incorporate Indigenous ways of knowing into STEM education (LaFrance and Nichols, 2008). It is clear that genuine partnerships with Indigenous communities are vital in reshaping Western systems (Eley, et al., 2007). Those efforts to create culturally appropriate space to serve Indigenous communities must elevate Indigenous voices, knowledge, and perspectives (Thackrah and Thompson, 2018).

Western systems' lack of respect for Indigenous knowledge and culture creates communication barriers with Indigenous communities. Communication has the power to foster trust, strengthen engagement, and produce positive outcomes, or it can reinforce powerlessness (Jennings, Bond, and Hill, 2018). The lack of respect also means that models of healthcare, education, social work, criminal justice, etc. ignore

Indigenous knowledge and fail to properly serve Indigenous communities, and those culturally inappropriate services contribute to persistent inequity (Downing, Kowal, and Paradies, 2011). Efforts to improve communication and provide culturally appropriate services must be rooted in Indigenous knowledge and prioritize Indigenous voices, values, and concepts (Greenwood, Lindsay, and King, 2017).

Chapter III: Methods and Results from the Realist Review Lens

A. Methods

The analysis presented here builds from two sources. First, we conducted a literature review based on a search strategy inspired by Michel Foucault's notion of the archaeology of knowledge (Foucault, 1972), to trace the origins and evolution of certain core ideas related to Indigenous ethics or widely held Indigenous principles around inter-cultural communication. Second, we utilized engagement with patient voices that informed the formation of an urban Indigenous primary care clinic in Calgary, Alberta, known as the Elbow River Healing Lodge, as they related to Indigenous ethics and inter-cultural communication. Both sources of information were coded and analyzed according to a realist review framework. Realist approaches prioritize describing context(s) that frame an issue, such as ethics or inter-cultural communication within - for instance - healthcare settings, the mechanisms by which such issues may be influenced or advanced, and the outcomes of efforts to influence or integrate such mechanisms into the original contexts (Smylie, et al., 2016).

Archaeology of Knowledge in the Literature

As indicated, a literature search framed on the archaeology of knowledge is Foucauldian in that it presumes that knowledge is governed by rules operating beneath the level of consciousness, and that those rules define possibilities and determine boundaries of thought and language on a topic. As a method, it becomes a strategy for tracing memory for a particular topic and the use of terminology, allowing the researcher to understand the evolution of one or more ideas, including embedded assumptions and beliefs about them that can be observed within the literature over time.

To complete this type of exploration of the literature search, we read and considered English-language results from the major research databases listed below for each search term listed below. This topic called for a strategy more nuanced than a systematic database search, as the literature has traveled beyond Brant's field of psychology and entered into less systematically catalogued places. Each search term was paired with "Indigenous," "Aboriginal," and "Native," as multiple terms are used to identify ethnicity. For example, the results from Indigenous + conflict suppression, Aboriginal + conflict suppression, and Native + conflict suppression were each considered. Only results focusing on Indigenous peoples of North America, Australia, and New Zealand were included, as those contexts share similar settler colonial histories. Only results that sought to provide some understanding of Indigenous contexts, communication patterns, and behaviour were included. No restrictions on the year of publication were imposed. Results from various disciplines and fields of study (health, education, social work, criminal justice, etc.) were included.

Search Terms	Databases
• Conflict suppression • Communication • Communication patterns • Cultural competency • Cultural norms • Cultural respect • Emotional restraint • Ethical space of engagement • Interconnectedness • Non-competitiveness/ non-competition • Non-interference • Sharing	• PubMed • Google Scholar • Medline

A total of n=117 records released between 1976 and 2018 from a total of 7,402 sources were deemed eligible and included in the literature review (See Appendix A for literature review flow chart). Each resource meeting the search criteria was recorded in an extraction sheet table logged in a Microsoft Excel file. In addition to "inter-cultural communication," terms such as "ethics," "principles," and "rules of behaviour" were included to gain a deeper understanding of how somewhat cognate concepts relating to Indigenous behaviours in contemporary systems may have been understood across time and disciplines.

Patient Voices at the Elbow River Healing

In 2007, Dr. Lindsay Crowshoe conducted qualitative research on the topic of communication and behavioural norms among Indigenous patients accessing services at the Elbow River Healing Lodge, an urban primary care clinic specialized in serving Indigenous patients in Calgary. The data includes three verbatim focus group transcripts. Researchers analyzed and coded this data, paying particular attention to the reported communication experiences of Indigenous patients with healthcare providers.

Realist Theory-Testing

The results of this inter-cultural communications literature review produced a diversity of contexts and disciplines. While the diversity of results can create challenges for analysis, the results are no less valid due to their diversity. Realist methodologies favor such a diversity of sources and seek to describe the context, identify mechanisms for acting upon the context, and understand outcomes based on a heterogeneity in information. The benefit of this method here is the ability to identify similarities from different types of sources, especially when a singular kind of evidence like randomized-control trials is not easily replicated. By framing this within a review paradigm, we aim

to identify the core elements (context) in which Indigenous ethics are reported or affirmed, underlying mechanisms by which authors or patients understand those ethics, principles, behaviour or communication to act on that context, and the resulting outcomes. Both the literature and the interviews were coded and assessed according to this method, allowing researchers to: understand the core of the articles and patient experiences shared, identify commonalities, and compare across sources.

The process of a realist review includes identifying candidate theories around how the present mechanism produces a certain outcome within the context and then using the theory as a lens through which the information is analyzed. The validity of the theories is considered once the analysis has been performed, and modification of theories is made, as necessary. To form the candidate theories, we collaboratively considered resonant themes from Clare Brant's "Native Rules and Ethics of Behaviour." The two salient notions which emerged from that article were the behavioural principle of non-interference to maintain social cohesion, and the inherent conflict in values between Western systems and Indigenous ways of being. The analyses of the literature and the patient voices were conducted through the lens of the two candidate theories that emerged from this collaboration.

Candidate Theories:

1. Present in Indigenous culture is the underlying ethical principle of community harmony and conflict suppression.
2. Western modes of communication do not acknowledge Indigenous ways of knowing, seen in various Western systems, (education, social work, and healthcare).

B. Results from the Realist Review Lens

As the realist methodology was used to analyze the relevant literature and patient focus group interviews, the results are presented according to the context, mechanism and outcome that emerged from the realist review.

i. Context

Health disparities among Indigenous populations, including higher burden of cancers, are well-established (Mrklas, et al., 2018), and culturally inappropriate health services contribute to those inequities (Downing, Kowal, and Paradies, 2011). Failure to respond to Indigenous cultural needs (Trimble and LaFromboise, 1985) as well as devaluing Indigenous knowledge and the dominance of Western medical sciences impede quality communication between medical providers and patients, and create hesitancy of Indigenous patients to seek care (Cass, et al., 2002). There are documented cases of Indigenous cancer patients turning to complimentary medical care because Western medicine does not meet their holistic cultural needs, including spiritual, emotional and social aspects of healing (Gall, et al., 2018). The disconnect between patient needs and services provided may be partly due to the absence of Indigenous knowledge within Western systems and partly the result of differing cultural ideals, and the result of this disconnect is often that Indigenous patients choose to leave the medical relationship.

Collectivist cultures and individualist cultures have a tendency to interpret information and see the world differently (Aaker and Williams, 1998). The propensity of Western healthcare providers to emphasize individualist issues instead of community-level issues with Indigenous patients indicates cultural disconnect that reinforces health disparities, such as in the field of mental health where Indigenous populations underuse

mental health resources due to provider dismissal of cultural values (LaFromboise and Trimble, 1990). Further, core Indigenous values such as relatedness and kinship operate at a relational level, while Western values in medicine are centered on objectivity and efficiency (Greer and Patel, 2000). Medical providers are trained to believe that objectivity and impartiality are the most ethical ways to engage with health and healing. This focus on objectivism leads providers to disengage from the social context, and the elevation of medical expertise creates hierarchy and exclusion. The Indigenous ethic of collectivism, however, values inclusive and engaging environments, and devalues hierarchy in an effort toward communal harmony. Culturally appropriate healing efforts that flatten hierarchy and focus on connection and relatedness have the opportunity to provide improved health and peace (Shahid, et al., 2010).

In addition to relationships within healthcare interactions, these ethics also influence values in healing and expectations around quality of care. Medical providers' values in healing differ from those of their Indigenous patients (Kelly and Brown, 2002), impacting quality of care (Alford, et al., 2014). Interviews with Indigenous patients from the Elbow River Healing Lodge reveal that this disconnect is deeply felt. Patients reported cultural differences in how they expected the healthcare experience to be and the impact of differing cultural values. For example, Indigenous patients mentioned that many families excitedly gather at the hospital when a family member is due to give birth. The patients noted that hospital waiting rooms are typically filled with Indigenous families, but non-Indigenous groups are not represented in the same quantities. Indigenous patients feel insulted when non-Indigenous healthcare providers enforce hospital visitor policies and ask them to leave the waiting room. Indigenous patients are

operating in a medical context that does not recognize the importance of family and connectedness in the healing process.

ii. Mechanism

1. Non-Interference

According to Clare Brant, non-interference is one of the most widely accepted principles of culturally acceptable behaviour in Indigenous society. He defines this ethic as the avoidance of any attempt to direct another person's behaviour. Non-interference "discourages coercion" and promotes harmonious relationships within a community by demonstrating respect for the independence of others in their decision-making. Any attempt to influence another person's behaviour is seen as an effort to establish dominance (Brant, 1990), and is culturally inappropriate in a non-hierarchical society. Brant recognizes that barriers to effective care within the Western medical system are often the result of conflicting values expressed through failure to respect the ethic of non-interference (*A Guide for Health Professionals Working with Aboriginal Peoples*, 2001).

"I don't think they really force anything on you to learn. They just give you their wisdom for you to interpret. An elder won't make you sit there and understand what he is saying. He'll just tell you everything in his own words and in his own way that you'll get it and the rest is up to you." – Indigenous patient at the Elbow River Healing Lodge on modes of teaching in Indigenous communities

The ethic of non-interference is based in respect for the autonomy of another person, aiming for self-realization. Stories are used to teach in Indigenous culture, as opposed to direct instruction, with the goal that listeners will glean concepts from stories they can interpret and implement autonomously. This notion extends to

relationships between adults and children, and children are given greater autonomy in their decision-making than in Western society. As a result, indirect teaching methods that utilize modeling as opposed to direct instruction are more effective for Indigenous students, though rarely used in Western educational systems (Pewewardy, 2002). The relationship between a person and gaining knowledge is paramount and the notion of autonomy is held highly. When that process is interrupted by another person, the interference is considered a serious intrusion. Though the ethic of non-interference is held strongly, there is some flexibility in its implementation. If a child strays from what is expected, there are protocols that allow other family members, such as aunts and uncles, to be more direct to ensure the child adequately grasps expectations. Additionally, if a person has interrupted his or her own healing process, the Indigenous community may have an obligation to intervene.

Non-Interference in the context of healing

In Indigenous culture, healing is conceived as the direct relationship between the divine creator and the individual, and no person can interfere with the true relationship with healing and health. If a person does try to interject in the natural process of another's healing, the individual experiencing the interference is entitled to object strongly by fighting or leaving the relationship. Indigenous people have frequently left healthcare relationships because they feel that their autonomy has not been respected, and they have experienced inappropriate interference in the healing process.

The concept of non-interference is based in respecting autonomy for achieving humanity, and the patient interviews revealed that respect is central in Indigenous interaction and communication. That respect includes giving others the space to speak and express themselves, and the right to make their own decisions. According to one respondent, it is important not to be too direct with

"You know not very direct with them [Indigenous patients], so it doesn't close that door to communicating with them." – Indigenous patient at the Elbow River Healing Lodge on how healthcare providers should communicate with Indigenous patients

Indigenous people, as that risks closing the door to communicating with them. Individuals have the right to make their own decisions in achieving wellness and being direct invades their autonomy.

Understanding the ethic of non-interference sheds light on how well-intentioned directions of non-Indigenous healthcare providers can be interpreted negatively by an Indigenous patient and become problematic (*A Guide for Health Professionals Working with Aboriginal Peoples*, 2001). Direct or presumptive healthcare instruction creates power imbalances and hierarchy in the interaction that are counterproductive and fail to nurture relationships (Wark, Neckoway, and Brownlee, 2017). Healthcare providers can engage more ethically with Indigenous patients by adopting the principle of non-interference and using indirect communication. Techniques such as modeling and storytelling could be productive alternatives to direct instruction. Healthcare providers can see themselves as helpers who empower Indigenous patients to make healthy decisions for themselves and bring possibilities to the individual. Providers should enter a medical encounter after having been invited to participate, not as presumed right.

2. Sharing

Brant's piece also explores the Indigenous concept of sharing as a fundamental ethic shaping behaviour, which began as a mechanism to ensure communal survival in harsh environmental conditions. As a behavioural norm, sharing encourages the exercise of generosity among members of a community and discourages individuals from hoarding their resources. The value of sharing means that individual prosperity is not culturally valued, social cohesion is promoted because disparity and greed are diminished, and social hierarchy is flattened. Although Western culture has pressured

Indigenous communities to abandon the ethic of sharing and accept individual ambition, sharing remains an important cultural norm (Brant, 1990).

Indigenous life changed drastically after contact with the Western world, but even post-contact, where hunting and gathering are less crucial for survival, sharing remains an important facet of Indigenous social interaction. Sharing is relational in nature (Peterson, 2013) and is an expected communal behaviour (Prowse, 2011), (Greer and Patel, 2000). As such, the ethic of sharing becomes central for the understanding of self and one's place in the community (Peterson, 2013) and reveals humility in relationships.

Generosity with physical resources is still common in Indigenous societies but sharing goes beyond tangible goods. The Indigenous patients at the Elbow River Healing Lodge recognized that sharing stories is an important component of their communities, and that they value oral tradition, where wisdom is passed down through generations. Those patients also discussed the importance of sharing in familial experiences, such as illness, and the sharing of responsibilities communally, for example, in ceremony preparation. Additionally, power is shared, and though there are Elders, who are shown heightened respect, the hierarchy is less pronounced than in Western society. Researchers have found that the most ethical way to facilitate focus group discussions with Indigenous communities is through sharing circles, where all individuals are given equal opportunity to contribute (Loppie, 2007), (Madden, Higgins, and Korteweg, 2013).

Equality enacted in society is at the crux of the sharing principle. The principle, at its core, is less about the exchange of resources and more about reciprocity and relationalism. In the healthcare setting, sharing stories can be an important way that

Indigenous patients acquire knowledge about their health, and a way for healthcare providers to gain a sense of the patient's context and worldview. Healthcare providers can promote equity and model this sharing behaviour in the healthcare setting by sharing more of themselves through avenues such as stories and humor, allowing them to connect more deeply with Indigenous patients and encourage relationalism (Crowshoe, 2019).

iii. Outcome

The result of these differences in communication and cultural norms acting on the context, in which Indigenous values are not respected, is marginalization of Indigenous people. Indigenous populations experience poorer outcomes not only in healthcare, but in multiple sectors of society.

Indigenous patients experience worse end of life care due to a lack of understanding of Indigenous culture within the Western medical system, lack of Indigenous representation among healthcare providers (Bessarab, et al., 2013), and poor cross-cultural communication in palliative care. Ruptures in communication that were reported include the proper way to communicate difficult new and to whom that information should be communicated. The miscommunication causes Indigenous patients to choose not to seek end of life care or resent the care they do receive, leading to worse palliative outcomes for these populations (McGrath, et al., 2005), (Kelly, 2007). Additionally, fewer Indigenous women receive Pap test screenings due to discomfort with the Western healthcare setting, leading to worse cervical cancer outcomes (Gozu, et al., 2007). Indigenous populations also experience social and economic determinants, such as colonialism and racism, that influence health behaviours including injection drug use and increase their exposure to HIV. These

health behaviours tend to contribute to mistrust of the healthcare system, disincentivizing them from seeking treatment and creating worse HIV outcomes (Negin, 2015). With mental health services failing to adequately meet Indigenous cultural needs (Eley, et al., 2007), Indigenous populations also suffer from higher rates of youth suicide and emotional distress (Tiatia, 2012). While these numerous health disparities are well documented, they are likely an underrepresentation of the reality as biases and lack of Indigenous specific identifiers are rampant in data collection, and the data quality challenge leads to an underestimate of disparities and adverse health outcomes (Smylie and Firestone, 2015).

The education system mirrors the healthcare system in its failure to serve Indigenous populations, contributing to worse educational outcomes. Indigenous students experience lower success rates compared to non-Indigenous students, with far fewer completing Year 12 of their education. Contributing to the low success rate is that Indigenous students often do not like their non-Indigenous teachers, with 39% reporting they felt their teachers did not care about them (Partington, 2003). Negative schooling experiences for Indigenous students are pervasive and include racism and exclusion or delegitimization of Indigenous knowledge (Madden, Higgins, and Korteweg, 2013). These educational models that are unwelcoming to Indigenous students also rely on tactics such as hard rules and expectations, which is countercultural for Indigenous students. Their difficulty adhering to the Western schooling system creates feelings of shame, leading to withdrawal and failure (Gorman, 1999). Incorporating tribal values and Indigenous culture into educational curricula could benefit Indigenous students and promote better learning outcomes (Tippeconnic and Tippeconnic Fox, 2012), (Pewewardy, 2002).

A parallel outcome to poorer health and education is felt racism among Indigenous populations. The patient interviews from the Elbow River Healing Lodge revealed that communication ruptures can be experienced in a number of ways, including racist acts. Patients felt stereotyped as negligent parents and experienced doctors acting out of negative biases. One patient described an experience in which she took her young son to the hospital after a head injury. The medical staff questioned her and detained her in a waiting room while they investigated. This patient expressed feeling that she was treated poorly and that the negative experience could have been mitigated through better communication. Negative stereotyping often prevents "inclusive self-determined care for Indigenous people," (McMurray and Param, 2008) but exposure to Indigenous people and critical self-reflection for medical professionals can help dispel those negative stereotypes (Thackrah and Thompson, 2018).

Chapter 5: Discussion, Conclusions, and Implications

A. Discussion

Clare Brant's work has traveled across time to impact sectors beyond healthcare, and much of his work is still influential today. However, not all of Brant's work stands the test of time. One of the behaviours Brant explains is what he calls "emotional restraint," which he says is a suppression of all emotions, both positive and negative. The repression of emotions, Brant says, can lead to "psychological disturbances," substance abuse, and inappropriate hostility toward bystanders (Brant, 1990). New research puts this behaviour into light as unresolved grief from past traumas, such as residential schooling. A limitation of Brant's piece is that he fails to recognize "emotional restraint" as more than just a shared Indigenous behaviour, but the result of trauma and abuse (Spiwak, et al., 2012).

Brant's notion of conflict suppression as the underlying motivation behind Indigenous behaviours operates from a deficit model; perhaps he does so in an effort to effectively communicate these Indigenous behaviours to a Western audience. After completing the archaeology of knowledge and focus group interviews with Indigenous patients, we believe the motivation behind Indigenous behaviours could more accurately be described as relationalism as opposed to conflict suppression. We use relationalism as a broad principle which includes the connection between individuals, broader society, knowledge, the physical world, etc. This connection is a way to build genuine relationships that flatten hierarchy and create a harmonious society. Relationalism is the true Indigenous principle, which non-interference and sharing promote, and conflict suppression is an outcome of the relationalism ethic. At a deeper level, non-interference

is about how individuals support each other in their interactions and how they encourage each other to learn autonomously. Sharing builds relationships, connects people to one another, and reveals humility. These behaviours support and maintain the deep connections that are central in Indigenous society.

As a principle, relationalism has the potential to aid the healthcare system in overcoming its communication barriers and negative biases. Though racism is undoubtedly alive in the Western medical system, as well as other structures, simply attributing poor health outcomes to racism is too simple an approach. Sometimes the cause of felt racism is incongruent values and failing to recognize the underpinnings of what creates felt racism overlooks important nuances. The story of the Indigenous mother in the hospital feeling stereotyped as a negligent Indigenous parent may be better understood, not only as the result of implicit biases, but also incongruent ethics in the realm of healing and intervention. Attributing the scenario solely to racism ignores nuances relating to communication and differing cultural values. Genuine relationalism can promote positive communication and cultural understanding, and Indigenous ethics provide the medical system with a framework to restore the therapeutic relationship with Indigenous patients.

B. Conclusion

When the two candidate theories were tested against the literature and the focus group interviews, we found that, though they were largely consistent, candidate theory 1 needed to be adjusted. Candidate theory 1 held that "present in Indigenous culture is the underlying ethical principle of community harmony and conflict suppression." We tweaked Clare Brant's notion of conflict suppression based on this research and

redefined it as relationalism, or connection to other people and surroundings which flatten hierarchy and promote harmony. The second candidate theory still rings true after our research, and we confirmed that "Western modes of communication do not acknowledge Indigenous ways of knowing, seen in various Western systems, (education, social work, and health care."

The Truth and Reconciliation Commission of Canada calls on health systems to address the ways in which colonization has detrimentally impacted Indigenous health for centuries. This work must be done on a systematic level to have a true impact, yet the changes must also be relational. We encourage healthcare providers to recognize the ways that Western systems fail to serve Indigenous populations, and where breakdowns in communication may be occurring. We also call on healthcare providers to step out of Western cultural contexts and adopt new understanding of Indigenous worldviews, including non-interference and sharing. Healthcare providers must realize how their language and actions can be interpreted as directive and therefore, off-putting for Indigenous patients, and be willing to share more of themselves and their practice through storytelling and metaphors. Ethical interaction through the adoption of relationalism operates on an individual basis and has the power to transform healthcare interactions. However, this relationalism must also operate at the systems level and transform entire healthcare systems to create a truly culturally appropriate environment for Indigenous populations.

While problematic pan-Indigenous conclusions in research are still prevalent and a limitation we hope to avoid, we do believe that relationalism is a value widely help by cultures developed outside of capitalist societies. As a result, we hope that this research can be useful beyond Alberta, where the research was conducted, and applied in other

contexts where Indigenous populations have experienced traumatic colonial histories and resulting persistent health inequities.

C. Implications

i. Spirituality as a Necessary Element in Indigenous Healthcare

A theme that emerged from both the literature and focus group interviews is the importance of Indigenous spirituality. In many Indigenous cultures, spirituality is a central part of all of life and is highly holistic (Shahid, 2010). Though spirituality is not equivalent to organized religion, it does provide guiding principles for one's life, and a notion of connectedness beyond the physical world (Aikenhead and Ogawa, 2007). Indigenous communities typically operate under the belief that all living things have a life spirit. Blackfoot scholar Leroy Little Bear says in his tradition, everything is believed to be animate, which means all things have a life spirit. If an animal or object has a life spirit, it also carries knowledge, and holds the ability the be relational. Indigenous people largely see themselves in relationship with their surroundings through their spirit (Little Bear, 2000). If anything possessing a life spirit has knowledge, that means humans can learn from everything in the world around them, creating greater respect for one's surroundings and making it necessary to live in harmony with nature (Turner, Ignace, and Ignace, 2000). For Indigenous spirituality, the physical world and spiritual world are always interacting, leading to holistic unification between that which can be seen and that which cannot be seen (Aikenhead and Ogawa, 2007).

Spirituality and Indigenous beliefs are expressed regularly through ceremony and prayer. While Western cultures tend to compartmentalize faith and keep it separate from the secular world, Indigenous expressions of spirituality are much more

intertwined into everyday life and ceremonies and prayers will inform "secular" aspects such as processing conflict (Walker, 2001) and healing practices (Gall, et al., 2018). The medicine wheel is a commonly used resource for healing and is based on Indigenous knowledge. Though medicine wheels differ between Indigenous groups, they are commonly based on notions of relationalism. The medicine wheel recognizes that physical, mental, emotional, and spiritual needs are all connected, and must each be met for holistic health to be achieved (Graham and Martin, 2016). These cultural practices mean that Indigenous populations see spirituality as a necessary element for the healing process.

Traditional Indigenous healing practices that incorporate spirituality were repeatedly suppressed during colonization. Though colonialism itself has ceased, its impacts are still palpable and Indigenous healing practices regularly encounter obstacles in gaining legitimacy (McMurray and Param, 2008). However, the Western medical systems that have been deemed "legitimate" fail to meet the holistic health needs of Indigenous patients. The absence of spirituality in Western medical systems leads Indigenous patients to seek healing from cultural healers who can draw on belief in the interrelatedness of creation to meet holistic needs in health and wellness (Gall, et al., 2018).

Incorporating spirituality for Indigenous patients in medical settings holds great potential. The renewal of identity, including the revitalization of culture, language, and spirituality has been shown to help in building resilience in Indigenous populations (Kirmayer, et al., 2011). Spirituality influences how Indigenous patients understand and make meaning out of illnesses, and it is crucial for healthcare providers to recognize the role of spirituality in the healing process. Culturally appropriate care does not mean that

healthcare providers are expected to also provide spiritual care, but the recognition and validation of Indigenous spirituality can help foster trust in the healthcare relationship (Ypinazar, et al., 2007) and aid in building resilience (Kirmayer, et al., 2011). Medical professionals building relationships with local Indigenous healers and referring Indigenous patients to those healers in addition to biomedical treatment can go a long way in supporting relationalism.

ii. Implications for Public Health

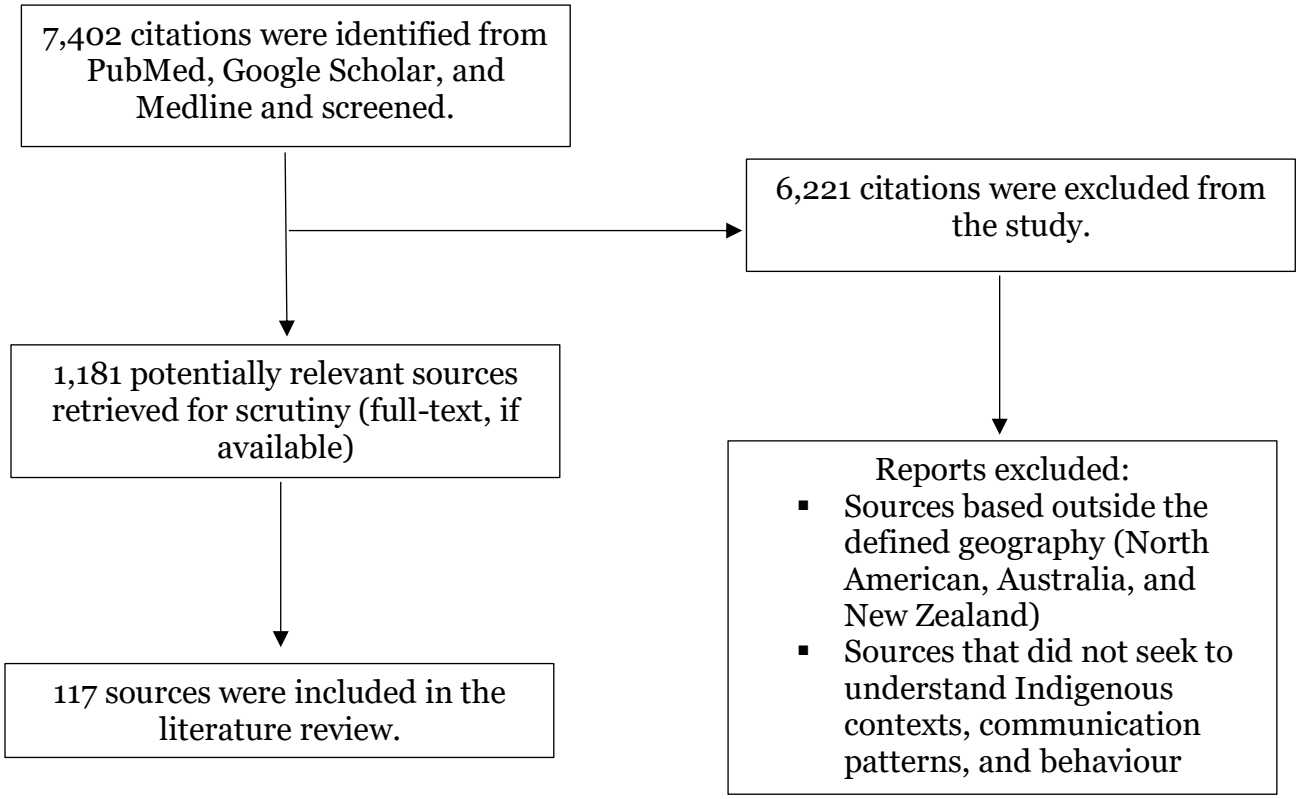
Indigenous health is a growing field in health equity and gaining attention globally (Pitama, et al., 2018). In an effort to contribute to the literature addressing those inequities, the research in this study builds off of the influential work of Clare Brant's "Native Ethics and Rules of Behaviour" through an examination of how Brant's ideas have traveled through the literature and the elevation of Indigenous voices. We argue that cultural misunderstandings and poor communication contribute to health inequities in Indigenous populations. The conclusions of this research offer ideas to healthcare providers about how to participate in respectful, culturally appropriate relationships with Indigenous patients through greater understanding of behavioural norms, such as non-interference and sharing. Through improved cultural understanding and the adoption of relationalism, the healthcare system can be transformed to serve Indigenous patients whom it currently fails to serve. If the Western medical system were to be transformed through relationalism, this shift could offer real hope to Indigenous populations who currently feel undervalued and discriminated against, and therefore, choose not to seek care or too often experience misdiagnoses and poor care. Recognizing the need for a systemic shift in medical care for Indigenous populations and embracing relationalism can improve health at a population level for Indigenous communities in

various fields of medical care including primary care, mental health, and oncology. This work stretches beyond healthcare and can be applied to the educational system, social work, research, as well as other fields.

Additional Pages

A. Appendices

Appendix A: Literature Review Flow Chart



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