Bad medicine: A critique of health care discourse on Aboriginal populations in Canada

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Introduction

For many years, voices from Aboriginal populations living in Canada have called attention to the fact that significant challenges exist to their pursuit of good health and well-being. Unsurprisingly, perhaps, this trend is not unique to the boundaries of Canada, but is instead reproduced in other parts of the world by different indigenous peoples. In Canada, Aboriginal peoples endure poorer health outcomes in a majority of measures when compared with figures for the overall population. In some instances, these differences are profound.

Interestingly, these challenges are visible elsewhere in the Canadian context, in other arenas where Aboriginal peoples come into contact with dominant societal institutions. These challenges have been most clearly documented with respect to the entire edifice of justice (for a compelling overview of the relationship between the justice system see, for instance, Ross, 1992, Report of the Aboriginal Justice Inquiry, 1991 and the Royal Commission on Aboriginal Peoples [RCAP], 1996).

There have been no shortage of calls from within the health care establishment to address this situation and efforts have been made to reform curricula and even institutions to the end of rectifying the problem, largely under the guise of the multicultural paradigm

Canada so proudly espouses. These efforts have focused on improving relations between Aboriginal and non-Aboriginal communities through increased tolerance, understanding, and so on.

Such approaches, which fit under the general heading of 'cultural sensitivity', now officially dominate the discourse on 'Aboriginal health'. However, I argue that the health care system and indeed, Canadian society as a whole, engage with the Aboriginal population in a much more complex and less favourable manner than is accepted by these approaches. This paper posits that, instead of focusing on the Aboriginal population and their health issues, the light should be shone back onto the health care system and the mainstream society. Inherent in this proposition is the notion that transformation must occur on the level of the dominant institutions for it to be significant. The too-common approach of examining deficits and flaws within Aboriginal populations deflects attention away from this very basic idea, and in fact, as I shall argue, represents a process of ongoing colonization.

I adopt a postcolonial framework through which to analyze Canadian health care discourse with respect to the Aboriginal population. The adoption of this approach is not without difficulties and some of these will be touched upon in this paper at a later section. However, at the outset, it is important to note that this paper deliberately avoids many of the internal debates in this body of literature. This is not a 'glossing over' but rather an effort not to become bogged down in an academic morass that serves little to further thinking vis-à-vis the specific problem at hand.

Public health theory and practice is positioned in a unique location within the health care field to adopt a postcolonial approach in reference to subjugated groups, including Aboriginal peoples. Its moral underpinning rooted in social justice would seemingly allow it to move naturally in this direction. Until now, however, this has not been the case; it would be informative to look to discourse emerging from the nursing field, segments of which have been remarkably progressive on this issue, for further guidance.

In this critical literature review, I begin by looking briefly at the European encroachment into the continent. This is not meant to be an exhaustive examination of the historical processes of this period. The goals are instead two-fold. Firstly, it seeks to examine the formulation and evolution of the European –and later Canadian – discourse on Aboriginal peoples. Secondly, by highlighting efforts by non-Aboriginal interests to establish control on the northern part of the continent, I illustrate the dislocating effects colonization has had on Aboriginal populations which have led to detrimental consequences on health and well-being.

From there, I turn to a comparative overview of broad Canadian and Aboriginal health outcomes. Again, this is not meant to be exhaustive, but merely to illuminate the disparities between Aboriginal and non-Aboriginal populations. Following theses statistics, I raise several problems inherent in data generation itself, illustrative of the notion of health care research as a component of the broader and ongoing colonization process.

After broadly sketching the backdrop to the current context, I enter into a discussion of health care discourse 'on' Aboriginal people, examining how the health care sector understands 'Aboriginal health' through a 'cultural sensitivity' approach.

I then delineate the postcolonial approach and its particular application to indigenous populations, including Aboriginal peoples on this continent. From there, I turn to a discussion of culture and the problems that emerge when narrow conceptualizations are adopted without factoring in the social, economic, political and historical contexts which surround it.

Finally, I examine the role that non-Aboriginal people can play in research and provision of health care to Aboriginal peoples. I argue that any efforts should begin by self-examination of the role of 'non-Aboriginal professional' (whether researcher or practitioner) in the creation and upholding of the dominant discourse as understood in the postcolonial context.

Before entering into the body of text, it is important to highlight the problems of labels and of naming. For the purposes of clarity, the term 'Aboriginal' in this paper refers to all Indigenous inhabitants within Canada's political boundaries, including First Nations, Metis, Inuit people, status and non-status Indians, and all those who self-identify as Aboriginal, Indigenist, or other variants therein. These will be used unless otherwise stated (as in certain instances when statistics referring to a specific group are used). In doing so I am following the leads set out by many, though not all, voices within the groups represented by this label today. In addition, where 'Canada' or 'Canadian' is used, the terms refer to the broader society found within Canadian territory and are taken to be 'outside' of Aboriginal.

I acknowledge that these labels, as with all labels, contain considerable, if not fundamental built-in difficulties, especially in those instances involving vast disparities in power between groups. However, in a sense, the issue of the label lies near the crux of this paper, and instead of shying away from it, it should be noted for what it is. I return to this issue at the termination of the section on Aboriginal health outcomes.

Historical background

Non-Aboriginal history within boundaries currently defined as Canada is a history of conquest and settlement. It recounts the colonization project as undertaken by the arriving non-Aboriginal population to a land already occupied by diverse peoples. This section examines the evolution of European/Canadian discourse vis-à-vis Aboriginal peoples, discourse that necessarily underpinned the colonizing process and simultaneously created conditions which engendered mechanisms and apparatuses promoting the intended dislocation of Aboriginal people from their way of life, with dramatic ramifications for health and well-being.

By focusing critically on the non-Aboriginal role in this colonizing process, the intention is to expose the mechanisms by which the process compromised the health and well-being of the first inhabitants of the region. This is not to say that scholarship which pays mention of the epochs prior to the arrival of the newcomers does not exist, or that it is not important. Quite the opposite. However, the intention of this paper is to examine the role of the non-Aboriginal populations in creating the discursive conditions which have fostered the environment which we see today.

What's more, the very concept of Aboriginal 'history' was (and remains) an oral endeavour (Castellano, 2000) and in the past was rarely recorded by non-Aboriginals, except in stilted representations when it suited the latter's purposes, as with depictions of the cigar store Indian, or Sitting Bull safely relegated to the confines of Buffalo Bill's circus. Furthermore, when non-Aboriginal scholarship writes Aboriginal history, it is susceptible to the pitfalls of writing history *for* someone else, for 'the Other', a notion to which I shall return at a later juncture.

We have nonetheless been provided glimpses into knowledge systems on health and well-being prior to European arrival on the continent and we know that these conceptualizations of health and wellness lay at the heart of many Aboriginal societies' worldviews in a theme consistent with the holism embraced by many of these populations (see, for instance, Kelm, 1999 and Tuhiwai-Smith, 1999). Much Aboriginal teaching today continues to emphasize notions of interconnectedness, harmony and well-being (Regnier, 1995). I highlight these generalities at the outset simply to provide a contrast to difficulties faced during subsequent centuries.

Despite repeated, and, in many cases, ongoing efforts at resistance, colonization has been a largely dislocating process, just as it has been for other populations in other parts of the globe (Ashcroft et al., 2007). This dislocation has had profound implications for the health and well-being of these affected populations.

Europeans arrived in the location now referred to as Canada to find a country populated by numerous different societies. Jean Cabot, who arrived in present-day Newfoundland in 1497, was instructed by King Henry VII of England to seize the territories in the 'new' land and to subdue any population centres encountered in the course of the expedition (Hakluyt in Green and Dickason, 1989). Over the coming centuries, the people inhabiting these regions came to be regarded as-less-than human and this provided the normative framework for which to push across the continent.

Colonization in North America had several different phases. It would be overly simplistic to understand the early relations as completely unequal and coercive. Initially, European expansion and exploration (and what turned out to be ultimately a misguided effort to find passage westward to India) provided the motivation for 'exploration'. Recognition of the bounty-filled land, principally in the form of fur brought back to Europe to feed a seemingly insatiable appetite of a fashion-conscious public, resulted in a concrete economic impetus for trade and expansion. Notwithstanding many hostile encounters and relationships during these initial phases (the tragic demise of the Beothuk in contemporary Newfoundland is one such example), the European-Aboriginal relationship was, more often than not, based on cooperation (Miller, 2000). This arrangement was produced for a variety of reasons from the point of view of the Europeans: these included their being relatively few in number, the requirement of Aboriginal knowledge and expertise, the need for military alliances to counter rival interests from other European powers, and so on.

As is highlighted in the RCAP (1996), these early relations were based on mutual interests and were welcomed in many cases by parties on both sides. Nonetheless, the acknowledgement of mutual interest should not be taken as a view towards equality. This cooperative spirit was likely, in most cases, a marriage of convenience and whether dominant European discourse actually viewed Aboriginal people with similar esteem as compared with their European counterparts has been a matter of some debate. Certainly, European scholarship and religious thinking during this early phase was quite clear on its view of the 'primitive' and this understanding formed the backdrop. Many took a pragmatic view based on political economic interests as outlined in the RCAP. In other cases, the *sauvage noble* was seen as closer to God's 'original man', but such romanticism hardly approximated a representation of equality between peoples despite its apparent curious benevolence (Binnema and Hutchings, 2005).

Having said that, it must also be acknowledged that those Europeans of more 'common stock' came to integrate to one degree or another into Aboriginal communities, adopting food, survival methods and forming intimate relationships (RCAP, 1996). With respect to the latter point, the Metis nation remains living proof of these intertwined worlds.

The eighteenth century witnessed further expansion of the colonial enterprise. The conflict between British and French reached a culmination with the takeover of New France by England, formalized by the *Treaty of Paris* in 1763. That same year, the British negotiated the *Royal Proclamation.*

The *Royal Proclamation* is a seemingly paradoxical document in its view of Aboriginal peoples. On one hand, it recommends a certain degree of autonomy to the Aboriginal population, as well as stating that Aboriginal territories should remain under Aboriginal control unless ceded or purchased (RCAP, 1996). Some have argued that the *Royal Proclamation* is an illustration of the agency of the Aboriginal populations involved in 1763 discussion, and indeed it has remained a focal point in many court decisions over land rights in more recent times.

However, in the same document, it refers to Aboriginal lands as part of the British dominions and territories and "...asserts that full underlying title vests in the Crown." (Switlo, 2002: 106). For many commentators, the *Royal Proclamation*, read in that light, is yet another negotiation of convenience (Dickason, 2002). The apparent paradox, then, very much depends on the reading of the text, and may well be, in and of itself, in keeping with empire-building, where indigenous 'subjects' were granted some autonomy but always against that backdrop that the Crown had the ultimate say in her dominion. As Switlo argues, this trend has remained a guiding current throughout the history of treaty-making in Canada to the present day.

Treaties prior to Confederation were frequently military alliances, but the understanding of the process as well as the very content of the treaties was often clearly different for the Europeans as compared with their Aboriginal counterparts (RCAP, 1996). The situation continued on this uneasy and shifting ground into the Confederation period, but by then significant changes had occurred in the relationship. The continent was being flooded by European arrivals and the European view of Aboriginal peoples shifted to one of coercion with the gradual emergence of assimilation as the underlying theme (Miller, 2000). This reflects a shift in the needs of the Europeans, who no longer needed Aboriginal people in the same way that they had previously.

The Dominion of Canada came into being in 1867 and in 1870, the Canadian government assumed sovereignty from the monolithic Hudson Bay Company over the Northwest Territories, a vast tract of land stretching from the Great Lakes to the Rockies and northward to the Arctic. With that came the so-called 'numbered' treaties.

Of these, *Treaty Six* is of particular interest with respect to health care delivery to Aboriginal people. *Treaty Six* represents an area found in the central part of Saskatchewan and Alberta, where the majority of the population was made up of Cree inhabitants, but also some Saulteaux, Chipewyan, and Assiniboine. At the time of its signing in 1876, there was already significant unease among these Aboriginal populations (Taylor, 1985). By this point, it was clear that there was something critically wrong with the buffalo herds that had all but disappeared, meaning that starvation was a very real, if not imminent, proposition, and, no less importantly cosmologically-speaking, an entire way of life was under threat. Furthermore, other health issues, most significantly small pox, were adding to the concern. These difficulties served to create an even more unequal ground on which treaties were negotiated.

These concerns led to the inclusion of a health care provision into the Treaty, the only treaty which specifically mentions health care. It is cited by Waldram et al. as follows: "That in the events hereafter of the Indians comprised within this treaty being overtaken by any pestilence or by a general famine, the Queen, on being satisfied and certified thereof, by her Indian Agent or Agents, will grant to the Indians , assistance of such character as to extent as here chief Superintendent of Indian affairs shall deem necessary and sufficient to relieve the Indians of the calamity that shall have befallen them. And, that a Medicine chest shall be kept at the house of the Indian agent for the use and benefit of the Indians at the discretion of the Agent" (1995: 143). The notion of the "Medicine chest" has been referred to over the years as denoting the relationship between the federal state and the "Treaty Indians".

As was mentioned above, the nature of the relationship between the Europeans and the Aboriginal population had changed by the nineteenth century. Not surprisingly, so too had the discourse justifying policy on the ground as the Europeanization of the continent continued. Enlightenment thought had begun replacing purely religious explanations and forms of inquiry. These developments transformed conceptions and representations in the so-called New World, but naturally they never challenged the underlying view of the inferiority of the Native. Europe, for all its diversity and differences, was remarkably cohesive when it came to the view of those outside its borders: "No single category, classificatory scheme or set of explanations of cultural difference was hegemonic in the manner that racial typologies of non-European peoples." (Muthu, 2003: 279). Such unity of thought was useful to the project of colonization. A passage from the RCAP is succinct: "To justify their actions, the non-Aboriginal settler society was well served by a belief system that judged Aboriginal people to be inferior. Based originally on religious and philosophical grounds, this sense of cultural and moral superiority would be buttressed by additional, pseudo-scientific theories, developed during the nineteenth century that rested ultimately on ethnocentric and racist premises." (RCAP, 1996).

The counterparts to such discursive justifications were the assimilationist and protective elements the Canadian state promoted towards Aboriginal peoples. The foundations of such policy likewise could locate support in Enlightenment thought which had been discussing concepts of civilization—and its absence—with obvious conclusions (Buchan, 2005). Much like the older civilizing missions of the Church, the secular nineteenth century approach was promoted in almost compassionate language, with a clearly paternalistic bent. The underlying motivation was to 'enfranchise' Aboriginal people into the European society, as was clearly laid out in the 1857 document, *An Act to Encourage the Gradual Civilization of Indian Tribes in this Province, and to Amend the Laws Relating to Indians,* which articulated, as a goal, that the potential British subject would "no longer be deemed an Indian." The *Gradual Civilization Act* built on earlier efforts to legally define "an Indian", most notably the *Act for the Protection of the Indians in Upper Canada* of 1839. These efforts informed later policy and the issues of classification remain very much of consequence today.

Perhaps the best embodiment of this paternalism came in the form of the *Indian Act* of 1876, a piece of legislation which remains with us even now (remarkably so, given the very name of the document, let alone its contents). As a document, its impact was profound: "European worldviews, including their medical systems, have achieved social, economic and political dominance over Aboriginal people through enactment of [the Indian Act's] policies. This piece of legislation, passed in 1876, delved into every facet of Native life." (Smye, 2004). A further amendment to the *Act*, Section 114 in 1895, criminalized many of the ceremonies of different Aboriginal peoples, many of which lay at the core of Aboriginal belief systems.

The treaties and the broader *Indian Act* represented European efforts to dislocate Aboriginal peoples from the land. However, as I briefly discussed, there was also a cultural edge to this dislocation, initially in the form of the missionary presence and later in government legislation. These attempts to modify or destroy culture were, in essence, direct assaults on the well-being of Aboriginal people everywhere. Efforts at dislocation came to the fore with the widespread adoption of the residential school as the masthead of federal assimilationist policy.

In the most organized effort to 'civilize' the Aboriginal populations, the Canadian government, in tandem with religious institutions, established boarding schools with the intention of surrounding Aboriginal children with the civilizing influence of European/Canadian authorities (RCAP, 1996).

The results have been well-documented. Suffice to say the schools' legacy has been widespread and profound, affecting virtually all dimensions of Aboriginal societies. Dislocation –from family, from language, from spirituality, from wellness, from practical day-to-day skills –translated into a deep malaise among many Aboriginal people that is still strongly evident today. As Grand Chief Edward John stated in a 1992 letter to the federal minister of justice: "We are hurt, devastated and outraged. The effect of the Indian residential school system is like a disease ripping through our communities." (John in RCAP, 1996).

Reference in the previous citation to the residential school legacy as a "disease", and indeed repeated referral to the need for healing the wounds caused by colonization speaks to the centrality of health and well-being in Aboriginal worldviews. The notion of an upset balance affecting wellness is a theme revisited again and again in testimony by Aboriginal residential school survivors, testimonials which were compiled for the RCAP (Chrisjohn and Young, 2006).

Over the years, various different justifications were used to defend the behaviour and policies that formed the colonization project. At the outset, Aboriginals were considered savages in need of a salvation that could only be attained through Christiendom, supplied through divinity's labourers on Earth. This was transformed into a more general civilizing mission, to be accomplished through assimilationist policies. In the current context, they need 'help', often in a medicalized sense. In all cases, Aboriginal people are 'them', providing the necessary linguistic backdrop.

While the tendency is to view colonization as an historical entity with demarcated start and end points (and this remains the case in the brief mention of colonization in the health care curricula), analysts have pointed out that colonization refers to a process that may be ongoing (Razack, 2002). In the postcolonial framework which I shall discuss momentarily, the key feature rests on subjugation of one group by another, whether on the level of material conditions in a social, economic, or political sense, or through the underpinning discourse.

Health in the context of colonization

From an epidemiological perspective, the health status of the inhabitants of the North American continent prior to European arrival has been difficult to ascertain with any sort of meaningful precision (Widmer and Perzigion, 1981). However, according to the archeological record, it appears that there was considerable disease prevalence amongst the populations on the continent (Waldham et al., 1995). In terms of epistemology, as noted above, oral histories suggest, broadly-speaking, conceptualizations of health that favoured holism and harmony.

Following the arrival of European populations, epidemics of infectious diseases, first slowly and then with increasing speed, ravaged the Aboriginal populations across the continent (see, for instance, Hackett, 2002, for his discussion of waves of epidemic diseases in the Petit Nord, the region north and west of Lake Superior to Hudson's Bay). The speed at which these diseases spread is evidenced by the fact that they outpaced the physical expansion of Europeans across the continent. Regardless of what the health status of Aboriginal populations prior to European arrival, it does seem clear that disease led to a depopulation across the Americas (Churchill, 1998).

As disease ravaged the peoples of the continent more effectively than any forged weapon, it enabled the colonization process to continue, likely tempering resistance efforts. It also lay the groundwork for the emerging Canadian mindset, which represented (and continues to represent) the Aboriginal person as 'sick' (O'Neil, 1998), a further extension of the notion of requiring 'help' or protection alluded to in the previous section. Much as with religious and later pseudoscientific justifications of the past, the representation of 'sick' (as opposed to 'well') fit nicely within the oppositional framework that served further to entrench the notion that the construction of the Aboriginal is 'not us', or, in other words, 'them'. This creation of 'the Other' will be explored in detail in later sections when I introduce the postcolonial framework as a lens through which to examine these representations.

The destruction wrought by disease formed a grim backdrop against which contrasting conceptualizations of health and well-being can be viewed. The differences lie at the fundamental level of epistemology; Aboriginal peoples have conventionally understood health as central to their cosmology, a drastic difference from the compartmentalization of different knowledge sets seen in the highly specialized European worldview. Given the threats to the vitality of entire societies, maintenance of Aboriginal conceptions of health became an act of resistance (O'Neil et al., 1998).

I now turn to an examination of current health care figures and trends. It becomes immediately apparent that, while epidemics of infectious diseases remain present, they are being surpassed by two new kinds of epidemics, those of chronic disease and despair. Research, firmly rooted in the Western-based model of medical knowledge production, ensures to entrench to Aboriginal people in the 'sick' role. The representation of Aboriginal bodies as sick bodies shields the role of colonization itself in the ongoing destruction of the fabric of entire societies (Razack, 2008). The 'Aboriginal' shifts from being fundamentally immoral (as in the early phases of colonization) to fundamentally sick and, not coincidentally, self-destructive, which neatly locates the blame for the sickness.

Statistics on Aboriginal health

The literature on Aboriginal health in the contemporary Canadian setting reveals a disconcerting picture. With some exceptions, the Aboriginal populations in Canada fare significantly more poorly than the Canadian population on important health outcome measures.

In 2001, life expectancy at birth for the so-called Registered Indian population was estimated at 70.4 years for men and 75.5 years for women, as compared with 77.0 years and 82.1 years respectively for the overall Canadian life expectancy as determined from the 2001 census (Indian and Northern Affairs [INAC], 2005; Statistics Canada, 2001). While the gap between the Canadian and Aboriginal populations has decreased over recent decades, it remains significant. The following tables (Table 1 and Table 2) represent the gaps between the two groups for both males and females:

Table 1: Life expectancy at birth (males)

Year	Registered Indians	All Canadians
1980	60.9	71.7
1985	63.9	73.1
1990	66.9	74.4
1995	68.0	75.1
2000	70.2	76.7
2001	70.4	77.0

Source: INAC, 2005.

Table 2: Life expectancy at birth (females)

Year	Registered Indians	All Canadians
1980	68.0	78.9
1985	71.0	79.9
1990	74.0	80.8
1995	75.7	81.1
2000	75.2	81.9
2001	75.5	82.1

Source: INAC, 2005.

In certain causes of death, the Aboriginal population experiences significantly more years of life lost as compared with the Canadian population (see Table 3).

Table 3: Potential years of life lost by cause of death (per 100,000)

Disease classification	First Nations	Canada
Injury	4297	1223
Circulatory	1219	1016
Cancer	813	161
Digestive	536	198
Endocrine (incl. diabetes)	363	179
Respiratory	358	230
Perinatal	349	122
Infectious	327	193
Nervous system	326	169
Musculoskeletal	103	27

Source: Health Canada. *First Nations and Inuit Health Branch in-house statistics.* (Figures for Canada are from 2000, for First Nations from 2001).

The incidence and prevalence of type 2 diabetes has prompted a great deal of attention.

Type 2 diabetes is seen in considerably younger age groups in the Aboriginal population and at a much higher prevalence than in the Canadian population; the age-standardized prevalence of diabetes for First Nations people is between 3 and 5 times that of the Canadian population (First Nations and Inuit Regional Health Survey National Steering Committee, 1999). Studies suggest that the transition to a sedentary lifestyle and a conversion to a non-traditional diet have played significant roles in the rise of diabetes in Aboriginal communities (Health Canada, 2000). Unfortunately, the effects of this epidemic have not been fully realized as of yet, since diabetes causes significant co-morbidity, increasing, for instance, the likelihood of cardiovascular disease, renal disease, neurological disease, and so on. Given that, the burden of illness is likely to continue to increase.

Tuberculosis remains a significant problem amongst the Aboriginal population. Of the 1,600 active tuberculosis cases reported in Canada in 2005, 19% of the patients were Aboriginal peoples, while 13% were non-Aboriginal Canadian-born. In 2005, the tuberculosis rate was 27 active cases per 100,000 in Aboriginal peoples compared with 5 active cases per 100,000 in the Canadian population. This is down from 34 per 100,000 for the Aboriginal populations in 2000 and 82.1 in 1990. Table 4 depicts comparative rates of incidence:

Table 4: Incidence of tuberculosis infection per 100,000

Year	First Nations	Canada
1990	82.1	7.2
1995	57.0	6.5
2000	34.0	5.5
2005	27.0	5.0

Source: Health Canada. *First Nations Inuit Health Branch.*

The spectre of HIV/AIDS has risen alarmingly in the Aboriginal community over the past decade. In 1998, 18.8% of positive HIV tests reported were among Aboriginal peoples. This increased to 25.3% in 2003. Furthermore, data shows that before 1993, 1.2% of reported AIDS cases were among the Aboriginal population, but by 2003 this had increased to 13.4%. Injection drug use continues to be the prime mode of transmission. More women and younger people are being affected among Aboriginal peoples in comparison to data for the Canadian population (Public Health Agency of Canada, 2004).

Intentional and unintentional trauma is a major cause of death, contributing to one third of all deaths among Aboriginal people and resulting in four and a half times the number of potential years of life lost of the Canadian population (Young, 2003; Health Canada, 2001). An observational study out of Alberta revealed that among 'status Aboriginals', severe trauma occurred almost four times more frequently than among the reference population (as defined by all trauma patients in the Calgary Health Authority) for both women and men. Moreover, differences in rates for specific causes, including assault, traumatic suicide, and motor vehicle crashes were substantial (Karmali et al., 2005).

Suicide rates remain drastically elevated; in 2000, suicide accounted for approximately 1,079.91 potential years of life lost per 100,000 population among the Aboriginal population. This is nearly three times the 2001 Canadian rate. In the two Inuit territories, Nunavut and Nunavik, the potential years of life lost due to suicide in 2001 was an astounding 4,883 and 7,665 per 100,000 respectively. For the Inuit in Nunavut, this translated into a rate of death by suicide of more than eleven times the average in Canada in 2003 and means that between the years 1999 and 2003, twenty seven percent of *all* deaths were by suicide (Hicks, 2006).

Beyond the raw statistics, there is also more direct evidence of a failure to engage with the system. Studies have shown that Aboriginal women, for example, are thirty percent less likely to undergo cervical cancer screening (Hislop et al., 1992). This discrepancy is often linked to 'dysfunctional' and 'risky' health behaviour. I return to this problematic conceptualization in a later section.

While merely an overview, these statistics illustrate the stark difference between the Aboriginal and Canadian populations in terms of the disparity among health outcomes. Gains have been made in many health outcome measures, but these gains have in most cases been made in both populations, meaning that the gap remains.

A note on data generation

Beyond the data itself, it is instructive to examine how these statistics are compiled and presented. Terms like 'Registered Indian' remain prevalent and there is often a loose and careless mixture of terms such as that one, as well as First Nations, Aboriginal, Status Indian, and so on. Indeed, the use of currently 'politically correct' terms (as Aboriginal is used in the context of this paper), while attempting to move beyond discriminatory language of the past, generally neglects to understand these terms as social constructs in and of themselves (Smylie, 2005). Moreover, using broad categorizations fails to acknowledge the diversity and heterogeneity of the peoples it professes to understand. Research can be colonizing process and health care research is no exception (Tuhiwai Smith, 1999). In the reductionism of the politically correct, people lose their own identities; Cree, Ojibwe, Iroquois, and so on, all are brought under the umbrella term of Aboriginal.

This is not to say that the classification system, however, confusing, contradictory, and at times, offensive, is not without real and practical implications for care delivery. Whether someone is a 'Status' or 'Non-Status' Indian deeply impacts upon the administration of care provision. That notwithstanding, the taxonomy should be seen for what it is: a collection of constructions emerging from a specific set of interests and largely imposed from the outside. As the political climate has changed, so too has the language, thereby deepening the sense of confusion and, often, 'otherness'.

However, perhaps more important than the interaction that takes place against the backdrop of the classification system is the interaction which takes place in the normative sphere, those day-to-day encounters between non-Aboriginal people and those people perceived as 'Aboriginal', regardless of the latter's official state designation as Status, non-Status, Inuit (or, for that matter, the white person who lives in a space associated with the typified Aboriginal). To borrow a term from Razack (2008), the person becomes racialized. In doing so, s/he takes on the all stereotyped characteristics of the socially constructed type, in this case 'the Aboriginal'.

The confusion related to state efforts at classification has practical implications for research as well. Young notes that "[t]he research fails to reflect the demographic composition of Canadian Aboriginal people, with severe under-representation of Metis, urban residents, and First Nations people not living on reserves." (2003: 421). He notes further that health needs of women and children have not been sufficiently studied. Young's study fails to propose a reason behind these gaps, but the consequences are clear on a practical level for a field bent on generating 'evidence'. As the results from research in the communities becomes evidence under the general heading of 'Aboriginal health' the reality is that entire groups may fall under that umbrella without having any reasonable link to the populations actually studied.

Finally, it is important to note as well that, beyond language used to describe the subject, data generated in Canada use the categories and phrases such as 'Canadian population', 'all Canadians', 'the overall Canadian population', with the implication that Aboriginal populations are a constituent of a whole. This encapsulation by the nation state (or, put another way, by the settler society), is, in essence, evidence of the ongoing process of colonization. These points will continue to resurface in the following sections.

Health care discourse 'on' all things Aboriginal

Discourse is an inherently elusive concept to define. For Foucault, discourse referred to a way of "...constituting knowledge, together with the social practices, forms of subjectivity and power relations which inhere in such knowledges and relations between them." (Weedon, 1987: 108). Discourse becomes, then, the glue which informs both research and praxis.

Despite this, knowledge production and its application to clinical practice in the health care field in the contemporary setting is heralded as 'evidence-based'. Such an approach clearly has its merits and there is little need to elucidate these further in this paper. However, it also engenders significant problems, many of which are rarely acknowledged. In her discussion of nursing discourse (and the argument can be equally applied to the medical field), Racine (2003) argues that research and practice is assumed to be neutral and apolitical. Such a view undoubtedly stems from the notion that research and practice are based on 'evidence', facts that are beyond dispute and therefore do not require a critical approach. This lies in stark contrast with Foucault's conceptualization of discourse and a plurality of knowledge.

Recognizing significant disparities in health outcomes by reflecting on figures such as those shown in the previous section, the health care sector responded by incorporating 'Aboriginal health' onto the agenda (as it were) as a new forum for which to address issues pertinent to the Aboriginal populations (see, for instance, MacMillan et al., 1996 for a discussion of the importance of understanding the health needs of the Aboriginal peoples).

This realization impacted on the field of health care education, and 'Aboriginal health' was introduced into the curriculum, although in a somewhat piecemeal fashion and not entirely satisfactorily, even for its proponents. Inclusions came at different times and progressed at different paces and to a range of extents, depending on the fields and the institutions. For instance, a major Canada-wide study examined the issue as it pertained to medical education (Redwood-Campbell et al., 1999). The objective was "to determine whether Canadian family medicine residency programs currently have objectives, staff, and clinical experiences for adequately exposing residents to Aboriginal health issues." (p.325). The authors concluded that "many Canadian family medicine programs give residents some exposure to Aboriginal health issues, but most need more expertise and direction on these issues." (p.329)

Health care professionals had realized for some time the strictly biomedical problems of the Aboriginal population (as an example, see Burrows, 2004, for a discussion of health care delivery in British Columbia at the end of the nineteenth century and into the twentieth). The recognition of health outcome disparities between Aboriginal and non-Aboriginal populations was descriptive, however, and did not provide an adequate explanatory model (beyond the crudest race-based theories of inferiority which simply did not stand up to scrutiny by the latter half of the twentieth century). Beyond the simple figures reflecting the poorer outcomes among the Aboriginal populations, the new champions of Aboriginal health care found themselves face-to-face with the realization that there was a disconnect between Aboriginal people and the health care system. Having arrived at this uncomfortable discursive juncture, a response was required.

The assumption underlying the 'problem' of Aboriginal health morphed into a new view, one that lay in the normative sphere; that is, the roots of this disconnect originate in cultural differences, variously explained as differences in communication styles, in worldview, in conceptions of health and healing and so on. It was observed that health care delivery to individuals of diverse cultural backgrounds posed unique challenges, but challenges that should be faced, even embraced (in a strictly pluralist sense), and eventually overcome (Hamilton, 1996). Indeed, the approach grows quite naturally from the multiculturalist paradigm formally and discursively embraced in the broader Canadian context.

Because a key tenet of the Aboriginal health field has been that cultural differences play a fundamental role in the problems encountered, the solution has been to introduce 'cultural sensitivity' into the curricula for incoming trainees. The incorporation of this development has been widespread. In both medical and nursing training, for instance, education on cultural sensitivity is, in many cases, taken as requisite element accepted as a given that requires no further debate or justification (for examples of this, see Geiger, 2001 and Ruddock and Turner, 2007).

The underlying assumption to cultural sensitivity in health care (or in justice, for that matter), rests on the idea that problems in communication, in engagement, and therefore in health status itself, are based on differences in culture, defined as the languages, behavioral practices, and beliefs that define a particular group. Likewise, "...the main determinant of social relations is [understood to be] culture..." Swendson and Windsor, 1995: 3). As such, culture becomes the central, underpinning focus.

As a consequence to this, Aboriginal health and the promotion of cultural sensitivity in medical and nursing schools involve discussions of Aboriginal conceptions of health (for instance, introduction to the notion of holism as manifested through the medicine wheel), participation or observation of activities of a ritualistic nature (such as a sweat lodge or healing ceremony), and direct encounters with members of an Aboriginal community.

(There is something quite telling that formal encounters need to be planned for non-Aboriginal professionals or trainees to meet Aboriginal people). Increasingly curricula across Canada also involve mandatory or elective periods in a rural community deemed 'Aboriginal', such as a reserve or a community in the Northern territories.

While there is little doubt that 'sensitivity' towards cultures different from one's own is important, just as it is important to be sensitive towards any condition or situation that does not share the same circumstances as one's own, it does not, I argue, adequately contextualize the experience of a given group. Just as the environment of political correctness has (fortunately) eliminated much of the overt racism seen commonly in language, both formal and informal, only a few decades ago (although the persistence of the term 'Indian' in official government language in Canada indicates that even this primordial struggle has not been won), it would nevertheless be ludicrous to suggest that issues of race no longer matter, just as strides made by women do not mean that matters of gender disparity have been resolved.

To understand the persistent gaps, I now turn to a wholly different paradigm, that of postcolonialism.

An overview of postcolonial thought

Postcolonialist approaches emerge from the realization that the dominant ideology is but one testimony of the experience of colonization, albeit one that functions to buttress the status quo and to legitimate the history of colonization from the perspective of the colonizer.

Instead of accepting this dominant discourse, postcolonialism shifts the focus to other locations and experiences within the process. By doing so, it is able to cast light back on the dominant voice, thereby exposing it as only one way, out of many, of telling a story. 'Postcolonial', in this sense, does not mean 'after' colonization, but instead refers to discourse that moves through the colonizing process (McConaghy, 1998). Nonetheless, a clear definition remains elusive. In the interests of clarity, it is useful, then, to trace the evolution of postcolonial thought.

Postcolonialist thought, most commentators agree, stems directly from the works of Edward Said, most notably his writings on Orientalism in a book by the same name (1979). In its crudest form, Orientalism describes the process whereby one part of the world –the West/North –extends domination over 'the Other', namely the East/South. While this process in part lies in the political mechanism of colonization, Said's analysis extends to the domination by Western culture over subjugated non-European cultures. Under this one-sided relationship, the dominant culture not only propagates its influence, but, more importantly for Said, it generates knowledge production *on* non-Western cultures and peoples, generating representations of the colonial population in contrast to its own conceptions, thereby creating 'the Other'. This process is dehumanizing and lays the discourse through which acts of oppression, exploitation, and so on are possible on economic, social, and political levels.

The concept of 'the Other' is important because it lies at the heart of postcolonialism's understanding of the world. For Said, the 'Oriental' was the West's construction of another part of the world, and one which it knew nothing about. This ignorance proved useful, in a sense, because it allowed the construction of the Orient in exactly the form that suited the West's purposes, specifically vis-à-vis the colonizing enterprise.

In this construct, the world is seen in entirely in binary opposition and so everything is neatly divided and reduced into mutually exclusive categories: Black-White, East-West and so on, so that one is the opposite of the other. If the West is ordered, rational and good, the Orient is necessarily chaotic, irrational and evil (JanMohamed, 1983). African novelist Chinua Achebe's reading of Joseph Conrad's *Heart of Darkness* highlights the colonizer's worldview of a dark, mysterious, frightening Africa where madness is the normal state of affairs and the savage is everything the colonizer is not. In addition to being all that Conrad sees as 'not Good', the savage's role is to form the background through which the European strides forth (Achebe,, 2001). This 'going forth' is, even if for the European's own ends, perfectly justifiable for the European, given the subhuman status of the Native. If a civilizing mission is thrown into the fray, so much the more righteous the endeavour.

On a fundamental level, health care discourse fits this oppositional, binary analysis well. Ideas like sick-well and physician-patient are two such dichotomies. Beyond these larger constructs lies a language based on opposition (the Latin terms hypo- and hyper- predominate a great deal of the vernacular in medico-speak). The world is neatly divided into these simple oppositions.

Postcolonialism was initially applied by analysts examining relations between dominant and subjugated parts of the world, along some approximation of Said's West/North and East/South dialectic. As was mentioned at the outset of this section, the 'post' in 'postcolonialism' is difficult to apprehend, even as postcolonial thinking was in its more embryonic stages; its applicability lies in the notion that the traditional phase of colonization, complete with defined imperial states and their peripheral colonies has largely ended. It nonetheless accepts that neocolonialism –new patterns of dominance but with more or less static nexuses of power –ensures that colonization and subjugation of one form or another are ongoing. In this sense, postcolonialism is less a chronological conceptualization and more a description of a historical condition (Ashcroft, 1996). Nonetheless, the elasticity of the concept has become a source of frustration, to some degree, for proponents in search of common ground (Moore-Gilbert, 1997).

The term appears to become even more problematic in the context of indigenous peoples in newly emerging states such as Canada, Australia, New Zealand, South Africa, and the United States (known as settler states), where the colonial phase, in the traditional sense of the word, never ended. Some analysts have argued that the postcolonial framework should not be applied at all in these settings; see, for example, Miguel Vale de Almeida (2004) for a discussion of this. Vale de Almeida is quite particular in his argument, suggesting that postcolonial is not only a period that follows the departure of colonizers, but furthermore pertains to the experience of nation states specifically following the decolonization phase.

Others have shied away from such a rigid definition, which essentially reverts to a sort of historical chronicity rejected by many postcolonial scholars. Furthermore, scholars have noted that colonization can occur within the boundaries of an encircling state. Certainly, few can deny the presence of the colonization process in North America or Oceania.

Simply because there has been no formal period of decolonization does not mean the postcolonial framework is not applicable, especially since postcolonialists of all stripes acknowledge ongoing neocolonialism, not to mention outright occupation, in other parts of the world.

The notion of 'internal colonialism', first applied in mainstream scholarship by Lenin (1964), has been widely applied in discussions of colonization processes outside of the conventional definition involving a centre-periphery relationship of, for instance, France and Indochina. The term has proved particularly useful in describing the experience of indigenous populations within settler states, and has been used specifically with respect to Aboriginal peoples within Canada (O'Neil et al., 1993)

Delineating the process of internal colonialism allows the experiences of Aboriginal peoples to be contoured by postcolonial discourse. Indeed, postcolonial writing has flourished in other social contexts and particularly within feminist analysis. In essence, this is possible because postcolonialism's application has been broadened so that now "...the postcolonial approach is directed at uncovering the exclusionary effects of dominant ideologies in 'Othering' other forms of knowledge — the subjugated knowledge." (Racine, 2003: 95).

The requisite lynchpin to the application of a postcolonial approach lies in this dominant-subjugated relationship. This is underpinned by the social, economic, and political contexts generated over the course of colonization, and legitimated through the dominant discourse. Discourse in this context, as understood by Browne and Smye, refers to the alignment of ideas from which ideologies emerge, as well as "patterns of thinking" that are overlapping and reinforcing while functioning to close off "alternative avenues of thinking." (Browne and Smye, 2002: 30; the authors borrowed heavily from the writings of Shore and Wright, 1997, as well as Seidel and Vidal, 1997 for this conceptualization of "discourse"). This follows roughly from Foucault's broader conceptualization.

As becomes apparent with the above discussion, for most, there is no single postcolonial approach, just as there is no single voice (Anderson, 2002). This has contributed to the problem of elasticity cited at the outset. However, the problem is perhaps a necessary one; while there is no single postcolonial approach, this merely reflects the fact that there is no single postcolonial context. The setting in which colonization transforms culture(s) is both a transnational and translational process (Hall, 1996; Bhabha, 1994). The result is something new, something 'postcolonial' (perhaps for want of a better term); this is the notion of 'hybridity' to which I shall return presently.

The assertion of the presence of a plethora of voices is consistent with the overall project, which notes that 'voice' is too often appropriated or silenced by the more dominant. Borrowing heavily from the school of standpoint feminism, postcolonial scholarship attempts to restore a space where the experience of the subjugated can be recounted, relived even, in its own intrinsic richness, in spite of the conditions imposed upon it.

There is, of course, an obvious problem to this: To what degree does the sheer oppression of material conditions silence the subjugated voice (perhaps to the point of muting it entirely) while raising the decibel level of the dominant to a deafening level? In her seminal essay, "Can the subaltern speak?" Spivak (1988) poses this precise question and the conclusion is far from utopian. She argues that the voices of the subjugated are homogenized and essentialized, even in the postcolonial narrative, and, in essence, do not represent the heterogeneity of experience. However, Spivak is not so much claiming that the subjugated do not have voices, but that even in the supposedly sympathetic paradigm of postcolonialism, there is not space for these voices. In other words, space must be continually struggled for.

Pertinent pitfalls in postcolonialism

Postcolonialism is frequently criticized for being obtuse, unnecessarily verbose, and inaccessible (Jacoby, 1999). Certainly this charge is difficult to deny. However, such a criticism, while perhaps valid, does not discount the paradigm *quid pro quo.* While there may be difficulty in engagement, this does not by definition discredit the theory. Furthermore, the complexity of the discussion, it has been argued, only mirrors the complexity of the social world. Oversimplified arguments and explanations, while perhaps elegant, can be problematic in their implications. Nevertheless, however, a tension remains.

A corollary to this criticism lies in the fact that such scholarship, if difficult to access for the educated classes, becomes wholly inaccessible to the oppressed who do not have the means to engage with the subject matter. Indeed, if Spivak concludes that the subaltern can't speak, one could also posit that neither can she read Spivak. Dirlik (2005) alludes to this in his criticism of postcolonialism, where he posits that the arguments made by the postcolonial camp emerge from Western ways of thinking much more than such commentators would suggest, and moreover, differ significantly from the attitudes, views and interests of those colonized, many of whom are actively demanding modernity as a means of survival.

Dirlik's point is difficult to refute in its entirety. However, postcolonialism's value lies in highlighting the very fact that there are alternate discourses (hidden or not), or, in another sense, the *acts* of discourse by the subjugated, the same people who find themselves represented in the status quo by the dominant discourse about them and for them, but never by them or with them. If there is indeed a call for modernity (and as Dirlik suggests there may well be), it almost certainly does not come in the same form or from the same location as the dominant one. Again, the twin notions of space and position provide the differentiation.

Furthermore, postcolonialism's value also lies in elucidating the very existence of a dominant discourse that presides over subjugated experiences, the former being taken by the mainstream as objective, and therefore unassailable. In other words, by exposing something as dominant, there is also a simultaneous (however implicit) exposure of non-dominant forms; otherwise it wouldn't be dominant, it would be singular and unitary. There is value in laying bare this simple point for society at large. In this sense, postcolonial scholarship is an act of resistance against the status quo, as it challenges neutrality and deliberately takes sides (postcolonialists, of course, note that all scholarship 'takes sides' and that knowledge production of any kind cannot be neutral and is by definition political, as earlier feminist thought articulated). Postcolonialism deliberately challenges dominant intellectual discourses (Anderson, 2002)

Finally, a postcolonial approach has the potential to promote a more humanist agenda, simply because its intention is to lay social relations, replete with power, bare, thereby exposing the inequalities and injustices of the societal enterprise. Indeed, much to the chagrin of the postmodernist camp, Said preferred the term humanism in describing his lifelong project (Said, 2003). Moreover, the practice of promoting the elaboration of different points of view has its own inherent value. Black feminist Barbara Smith observes: "Third World feminism has enriched not just the women it applies to, but also political practice in general." (Smith 1984: 27).

The fluidity of culture

Postcolonialism, in a sense, at once embraces and shuns 'culture'. Owing to its Marxist roots of long ago (and to the pedigree of many of its current intellectual proponents), it accepts that underlying material structures are critical. But, in a Gramscian twist, it understands that discourse is much closer to the matter than Marx's ghost would like to admit.

Health care discourse also identifies the concept of culture as a crucial one. The focus on culture in the sense defined by health care discourse (such a 'cultural sensitivity' approach has been termed 'culturalist' by some scholars) is a double-edged sword. Firstly, under a Eurocentric model of knowledge production, in the representation of cultures there is great risk in objectifying the subject (in essence creating 'the Other'), in this case

Aboriginal peoples, and contributing to further marginalization (Weedon, 2002). Secondly, adopting a culturalist approach deflects attention away from other important forces which ultimately act as significant determinants of health. In this section, I shall present a critical approach to culture and its location in the colonization process.

As noted above, health care discourse does pay some lip service to notions of culture and history. However, while "...the concept of culture has been widely applied as an explanatory concept within health care," too often it is within a "framework representing culture as a fixed, reified entity, with cultural groups existing in a binary sense vis-à-vis mainstream culture." (Kirkham et al., 2002: 222). In this process, the Other is essentialized and unified (Bannerji, 1995). The latter point made by Bannerji is readily apparent in health care discourse and cultural sensitivity training for health care professionals which adopt a homogenous representation of 'Aboriginal', ignoring the wealth of cultures found among First Nations. Further, this functions to eradicate the often very different historical experiences amongst different groups and sequesters the differences in current realities.

If culture is not fixed and if cultural groups do not exist in binary opposition, how then should culture be conceptualized? Bhabha (1994) provides us with the notion of hybridization. He argues that under the process of colonization, culture ever hybridizes;

this is not merely assimilation, nor does it take the form of a purely repressed entity, but instead engages in a sort of negotiation under the shadow of the power relations of domination and subjugation. However, such a transformative understanding of culture embedded within structures of power is rarely articulated within the health care environment.

There are very real implications. Browne's (2005) observations on this in nursing practice are insightful. In her study, she noted that nurses understood culture (and in particular Aboriginal culture) as an object or 'thing' that could be identified or located during routine health care. These conceptualizations of culture were rigid and fixed and in fact functioned to reinforce the stereotypes that the culturalist approach purports to break down. Moreover, and of vital importance to the argument, the nurses were not simply espousing personal values; instead these are discourses that form the fabric of 'multicultural mosaic' that lies behind the idea of Canada.

Surveys of Aboriginal women in clinical encounter settings reveal that there are consequences to such discourse for the very people to which the care is supposedly directed (Browne and Fiske, 2001). Already existing barriers are reinforced and mistrust is actually deepened rather than being alleviated. O'Neil (1989) notes that while problems with non-Aboriginal practitioners and Aboriginal peoples are thought to be due to deficiencies in communication, they instead reflect deeper misunderstandings.

In Swendson and Windsor's critique of cultural sensitivity, they argue that: "In defining difference as predominantly a cultural phenomenon, a cultural approach ignores problems long associated with colonization and immigration...Contemporary practices of multiculturalism transcend the political and economic context and thus obscure our understanding of the way in which cultural relations are embedded in, and are a manifestation of, capitalism." (1996: 4). Likewise, within health care discourse, health problems are regarded as arising from lifestyle and behavioral problems, informed by cultural differences, in addition to biomedical and genetic predisposition; social and economic circumstances and marginalization (which, in turn, are part and parcel of the process of ongoing colonization) are largely downplayed (O'Neil, 1989). Yet, as the extensive body of literature arising from certain strains within public health informs us, social determinants of health are absolutely central to health outcomes. Moreover, behaviour is determined by conditioning and this conditioning is shaped by the social forces that act to generate it.

This is not to discount culture, nor is it to pretend that culture does not exist. Rather, it must be understood within a complex of intersecting forces which include race, class and gender and their manifestation with historical, social, economic, and political forces

(Anderson and Kirkham, 1999). Furthermore, culture is fluid, negotiating and morphing as forces external to it act.

With the focus on a fixed Aboriginal culture, there is a simple inability for either practitioners or researchers to even approximate an understanding of the context in which Aboriginal peoples exist. It is this terrain, I argue, on which the disconnection takes place.

The reality is not only about sweat lodges and medicine wheels and other symbols that have come to be identified in the fixed Aboriginal culture. It is strongly informed by elements not only of ethnicity, but also of class and gender. Because the focus lies purely on nurturing cultural sensitivity, the reality fashioned by these other forces remains effectively hidden. The inclusion of 'culture' alone as a key component to understanding the non-biomedical sphere serves to divert attention from social, economic and political elements which act as determinants of health and health care delivery (Browne and Syme 2002). A fixed understanding of colonization as something that 'happened' and is now finished, even within a more sophisticated analysis involving structures beyond culture, nevertheless results in a blinding to these forces acting in the present (and, of course, having repercussions for the future). In essence, in this culture-based approach, 'culture' appropriates the influences of all other social forces at play, thus obscuring the effects of colonization on all but one level (Browne and Smye, 2002).

And these forces are significant. Again, it is instructive to examine the figures. When using the United Nations Development Index to assess Aboriginal communities located in Canada, as a conglomerate they rank seventy-sixth among nations. Canada ranks eighth. (Assembly of First Nations, 2006). Overall, the unemployment rate is fifty percent, though on many reserves, unemployment approaches a remarkable one hundred percent. Graduation from secondary school and the post-secondary education attainment rate are substantially lower than that of the Canadian population (INAC, 2005; Statistics Canada, 2001). Far more Aboriginal people are on income assistance than among the Canadian population (INAC, 2005). Aboriginal people are vastly over-represented in correctional institutions; though Aboriginal people form four percent of the Canadian population, more than twenty percent of those in custody are of Aboriginal descent (Landry and Sinha, 2006).

Currently, against the backdrop of liberalism's cultural sensitivity, research and education that touches upon issues related to Aboriginal health is required to refer to the damaging historical legacy. Certain key elements are invariably raised, such as the tragedy of residential schools, among others. However, even a cursory survey of research and curricula on Aboriginal health reveals that rarely are issues of colonization (as an ongoing process) placed at the fore. Instead, they serve as part of the stage for which biomedical problems are discussed. Yet biomedical factors alone are not nearly sufficient to explain the vast differences in health outcomes between Aboriginal people and the larger Canadian society which surrounds them.

Lastly, it must be acknowledged that the process described above neither originated in the health care realm nor is restricted to that specific area. This point is perhaps obvious, in that health care ideology does not exist in a void, but, as I have argued, emerges from the dominant discourse. To make this palatable, the overarching narrative has embraced pluralism as the façade by which to present itself. Through it, culture is understood as a primary defining feature of a given group, to the exclusion of other criteria. The emphasis, then, has been on embracing cultural differences.

In Canada, multiculturalism has been the face placed on this discourse, and has in fact been portrayed as a panacea for all woes Canadian. Marginalization (on any level) is seen as a cultural problem, with, therefore, a cultural solution, which is broadly articulated as the promotion of tolerance between cultures.

The need for a contextual approach

The need to contextualize health and illness within the various forces that are woven together to form our social being is a critical step for the researcher as well as the practitioner. Browne and Smye (2002) provide a compelling analysis of the discourse surrounding cervical cancer among Aboriginal people. In their analysis, they note that epidemiologists and other researchers identify much higher rates of cervical cancer among Aboriginal women. Several risk factors have been identified for the development of this form of malignancy. These include such lifestyle choices as early sexual activity (generally cited in the medical literature as below eighteen, although this is likely an arbitrary figure), multiple partners, and tobacco use.

However, this is where the analysis ends. There is no linkage made between these 'risky' behaviours and the context under which they emerge. Even in instances where epidemiological studies include poor socioeconomic status as a risk factor for a given disease, it is not within the context of the oppressive mechanisms of colonization. Poverty can, after all, be characterized in a different light. Bluntly put, under neoliberalism, poverty is the individual's responsibility, reflecting the inability to generate income in the face of ample opportunity.

This decontextualization from social, historical, political and economic contexts, Browne and Smye note, can then generate negative and damaging representations about Aboriginal women. Even if the researcher or clinician has been exposed to cultural sensitivity training, the smoking, lascivious woman who presents with cervical cancer 'did it to herself'. She becomes a far cry from the idealized representation of the Aboriginal woman performing a healing ceremony in a sweat lodge. This is not to say that the latter doesn't exist, or in fact cannot be the same woman. But that is not the point.

To take the argument further, these negative representations may result in an unwillingness by the subjugated to engage the system, thereby accounting for the lower rate of cervical cancer screening among Aboriginal women.

Like cervical cancer screening, mental health is another area in which context is critical. As noted above, high rates of suicide are common in Aboriginal populations. From a medical perspective, suicide is a manifestation of a mental disorder, such as depression. Depression, while it may have a circumstantial trigger, is understood in the medical literature to be caused by biochemical imbalances within the brain (and hence the general approach to treatment is by pharmacological preparations which seek to alter these biochemical levels by one means or another). However, testimony at the RCAP by an Aboriginal psychiatrist specifically identified poverty, despair, poor housing and political alienation as root causes of mental health problems and its corollary, suicide (O'Neil, 1993; Brant, 1993).

Psychiatry, as a discipline, has been criticized in the past for downplaying the social environment (Szasz, 1974). In light of the history of subjugation and dislocation, as well as the ongoing problems, it would be reasonable to assume that significant emotional and psychological distress would be present. The suicide rates appear to be evidence of this. In such an instance, to not place the social context at the fore is to fail to understand, on even a superficial level, the difficulties faced by people in many Aboriginal communities.

Likewise, Caron (2005) points out that emergency trauma presentations must be contextualized. Much of the trauma seen in Emergency Departments should be understood as a symptom of a deeper social malaise. For instance, nineteen percent of Aboriginal trauma patients in a Canadian study were victims of assault (including homicide), and an additional ten percent were due to suicide (Karmali et al., 2005). As a comparison, Aboriginal people in the study were ten times more likely than the Canadian population to present with an injury following an assault.

Trauma is closely linked with alcohol, a relationship especially evident in the Emergency Department setting. An American study noted that somewhere between twenty and thirty-seven percent of trauma presenting to hospitals involved the use of alcohol (Roizen, 1988), and a substantial body of literature has emerged elaborating on this link, as well as the associations between trauma and other mind-altering substances.

Because of the immediate circumstances which contour trauma presentations, the root causes underlying these events are often articulated as behavioral problems – 'poor choices' – and dismissed as such. Under the blinding glare of the Emergency Department lights, the context which led the individual lying on the stretcher through a specific string of events is impossible to see.

The issue of context is critical, although perhaps not for the reasons primarily highlighted in health care discourse. Often the need for context in the health care setting is to allow practitioners to 'comprehend' why the people they are ostensibly charged with serving make 'bad decisions' or 'poor choices', a process delineated by Browne and Smye. The problem here is that the context never involves the non-Aboriginal portion of this historical and contemporary relationship, and so there is no acknowledgement of the very existence of a settler society and the internal colonialism that it continues to engender. There is something heavily ironic about this; Fanon's (1967) observations, though made in the African context, are applicable elsewhere. He points out that the European, having dispossessed the indigenous population and created obstacles wherever possible to self-determination, then speaks righteously of liberty, humanism, rights, and democracy.

The same could be said of destroying a social fabric and then turning around and preaching health, healing, and well-being. The difference between Fanon's observation and the Canadian context is one of degree and not kind.

A plea to turn the gaze inwards

The thrust of the argument made here is two-fold. Firstly, it is vital that health care discourse contextualize the experience of those pushed to the margins. Secondly, and equally critically, the health care sector, from practitioners to researchers, must understand the role they play in the generation of the dominant discourse. To understand this, those in health care must understand that the medical institution itself is a profound symbol of colonization (O'Neil, 1989).

As Kirkham et al. argue, "If our scholarship is to generate knowledge that addresses longstanding patterns of inclusion and exclusion along lines such as race, ethnicity, class, and gender, interpretive frames are needed that account for culture as embedded in fields of power relations; as mediated by social forces such as economics, politics, and historical patterns of oppression and colonization; and as being constantly renegotiated" (2002: 225). In other words, the role played by non-Aboriginal actors should be an active one, but one that looks not to Aboriginal people as the main focus, but to themselves. The project should be to shine the light back at the production of knowledge in the West, to examine how the West sees/constructs/comprehends Aboriginal peoples. It should not be so much about Aboriginal peoples as it should be about health care (in this instance) and its discourse.

Health care discourse, as with all discourse, must be first understood as political (Browne and Smye, 2002). Moreover, when discourse emerges from an institution firmly buttressed by the status quo –a dominant institution, as in the case of health care – this discourse comes to be dominant. In essence, what emerges from research, policy and practice becomes 'Truth'.

The issue of voice becomes very problematic for anyone engaged in research involving other human beings, and especially when any form of significant power dynamic is implicated. The case of Aboriginal health is a useful lens through which to understand this. Even apparently well-intentioned work can be problematic. For instance, as Lux (2004) points out in her criticism of Hackett's discussion of historical epidemics in

Canada (cited earlier in this paper), Aboriginal people are silent in Western scholarship.

Does this mean there is no role for those emerging from the status quo? Spivak discusses the issue of voice and the voiceless, and despite her conclusions regarding the subaltern and the question of voice, she is remarkably optimistic regarding the role of those in the privileged position: "In learning to speak to (rather than listen to or speak for) the historically muted subject of the subaltern woman, the postcolonial intellectual systematically unlearns female privilege. This systematic unlearning involves learning to critique postcolonial discourse with the best tools it can provide and not simply substituting the lost figure of the colonized" (1988: 295). As Weedon (2002) argues "All postcolonial feminists, wherever they are located, can contribute to making the existing social relations that produce hierarchical difference visible." Both Spivak and Wheedon are writing with the postcolonial feminist context, but, though coloured by the overshadowing spectre of patriarchy, their points can be applied to all postcolonial scholarship. This is not to say that the tensions underlying postcolonialism are resolved by such assertions, but they do leave room for manoeuvering.

Conclusion

As was noted at the outset, the relationship between Aboriginal peoples and the various institutions that form the dominant structures on which Canadian society rests has been dysfunctional. Health care is but one example, but nevertheless an important one. However, it should come as no surprise that it is not simply one area where the relationship is poor, but is instead societal-wide; a post-colonial reading of the past, as well as the present suggests that such a situation is virtually inevitable. In the face of ongoing colonization, it would be astounding if it were otherwise.

For non-Aboriginal health care researchers and practitioners there is an important role in to be played in all of this, whether as bulwarks of the status quo, or, in a more progressive position, as agents acting to dismantle impediments to the decolonization process. Such a process begins by real, genuine efforts to appreciate people and the experiences they encounter on an everyday basis. It is also about looking inwards to understand one's own role in the dominant structure of the society. It is about understanding the artifice of representations of the 'the Other', which, despite the fact that these are constructions, nonetheless serve a specific agenda.

This paper has been critical of the cultural sensitivity approach taken under the umbrella of 'Aboriginal health'. All of this is not to say that 'Aboriginal health' should be dropped from the curriculum, or that non-Aboriginal practitioners cannot deliver care to Aboriginal peoples (although certainly efforts in training Aboriginal people in health care should continue to be enhanced). Quite the opposite: for a meaningful understanding of the current context, a deeper inquiry is required.

The point here is that in order to understand the health care system's failure to engage and adequately address the needs of the Aboriginal population, the analysis must focus on the discursive level and specifically on those who occupy a position which grants them (whether they are aware of it or not) the role of formulating this discourse.. While there is little doubt that negative attitudes by health care providers towards Aboriginal people play a detrimental role (and certainly there is evidence to suggest that such attitudes, as well as overt racism has and continues to exist in the field of health care; see, for example, Silversides, 2008), to rest the case at that juncture is overly simplistic and fails to understand that these attitudes form part of a continuum that originates at the level of the dominant discourse. As the postcolonial perspective informs, the dominant discourse negates the experience of Aboriginal peoples and replaces it with simplistic culturalist explanations.

Perhaps this is a tall order. Perhaps one could argue that challenging underlying structures of thought is not a realistic demand to make on health care professionals. However, I believe that within a sector which seeks first and foremost to provide care and promote health, such a revolution in thinking is required. Clearly the status quo is not functioning.

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