

## Bill C-14 - Medically Assisted Dying

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Canadian health care systems are still just struggling to implement cultural safety models of care-learning cultural awareness and cultural sensitivity before even achieving cultural competency, a "tool kit" of skills, knowledge, protocols, attitudes, approaches, language and experiences (First Nations University of Canada [FNUC], 2015). It was found that cultural safety should "recognize the role of socioeconomic conditions, history, and politics in health" as well as "understand the power differentials inherent in health service delivery, the institutional discrimination, and the need to fix these inequities through education and system change" (Health Council of Canada, 2012, p. 5). Given the aforementioned and the fact that cultural safety is in contrast to the standard approach of nursing care which encourages nurses to deliver service irrespective of cultural differences (FNUC, 2015), would it not be prudent to assess and provide annual progress reports on how these models are performing before new and controversial legislation is introduced to health care staff and patients? Without any such progress reports and evaluations, it would seem that cultural humility, an integral component, is missing from the cultural safety model. Also when considering that cultural safety is an outcome determined by the patient, wouldn't it be even more prudent to establish whether patients feel this is achieved?

It is equally important to consider that the general institutional environment that called for cultural safety models to be implemented and training to be put in place abounds with health inequities and health inequalities. Not only are there issues of whether equitable health care is available for the high needs of many Indigenous communities as seen in Attawapiskat and Cross Lake, not only are there issues of the inequality of funding for health care services in Indigenous

communities as most recently shown in the 2016 Canada Human Rights Tribunal decision regarding the 38% shortfall in funding for the on-reserve child welfare system, there are issues about whether Indigenous people receive equal treatment in the health care system itself. The Health Council of Canada (2012) reported that Indigenous people do not feel safe from racism and stereotyping and that the health care system can be alienating and intimidating for the following reasons:

the higher value placed on Western educational credentials and a lack of respect for traditional Aboriginal approaches to healing; the power differential and different communication styles between provider and patient; the use of complicated medical terminology instead of conversational language; the rapid pace at which health care operates; and the Western focus on disease rather than on the whole person and the life circumstances that may be affecting their overall health and subsequent treatment. (p.10)

The Office of the Auditor General (2015) found that "only 1 of the 45 nurses in its sample had completed all five of Health Canada's mandatory training courses that it selected for examination" (p. 2) and that Health Canada "acknowledges that its nurses sometimes work outside their legislated scope of practice in order to provide essential health services in remote First Nations communities" (p. 3) yet it was found that "Health Canada had not put in place supporting mechanisms that would authorize the nurses to perform activities outside their legislated scope of practice, such as medical directives to allow nurses to perform specific tasks under particular circumstances" (p. 3). These findings are significant in light of the fact that Health Canada supported nurses stations are usually the first point of contact for remote First Nations communities and yet this report clearly shows that basic standards are not being met. To now introduce new controversial legislation without first ensuring that standards are being met, how can individuals and communities reasonably be assured that culturally safe protocols are

being utilized in order to ensure informed consent is being obtained of the patient let alone that the family and community understands the process of medically assisted dying.

There are more specific concerns about the legislation. First, when two medical opinions are required of patient's condition and when jurisdictional issues of funding are still present, is this feasible in the north where access to care is limited as it is and who will cover the costs of transporting patients for the second opinion? Secondly, the legislation would also ensure that where the patient could not write or sign, someone could do so on their behalf. Who decides who can do this? Thirdly, who decides who the two independent witnesses to the informed consent are? Fourthly, will there be cultural advisors/cultural brokers/Aboriginal navigators provided in remote/rural locations? If so, who will provide the training for these individuals-will it be collaborative between the federal government and First Nations Elders/Traditionalists-and who will financially provide for the training?

There are clearly significant questions that need to be answered and current issues within the health care system as it pertains to Indigenous people that need to be addressed before controversial legislation can be adequately implemented.

#### References:

An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying), First Session, Forty-second Parliament, 64-65 Elizabeth II (2015-2016). Retrieved from <http://www.parl.gc.ca/HousePublications/Publication.aspx?Language=E&Mode=1&DocId=8183660>

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