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Published in:
Indigenous Health Ethics: An Appeal to Human Rights

DOI:
10.1142/9781786348579_0007

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Recommended citation(APA):
Matthews, R. S. (2021). Some Implications of Colonialism and Indigenous Cultural Genocide for Healthcare Ethics: Reflections from Northern Ontario, Canada. In D. Zion, L. Briskman, & A. Bagheri (Eds.), *Indigenous Health Ethics: An Appeal to Human Rights* (pp. 109-128). (Intercultural Dialogue in Bioethics; Vol. 3). World Scientific Publishing. https://doi.org/10.1142/9781786348579_0007

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Some Implications of Colonialism and Indigenous cultural genocide for Healthcare Ethics

Reflections from Northern Ontario, Canada

Richard Matthews

"The federal health system is designed to ensure that we remain sick and our people continue to die. First Nations continue to suffer from the shrapnel of a foreign system imposed on us." James Cutfeet, Chief, Kitchenuhmaykoosib Inninuwug First Nation, Tuesday, February 14, 2017[1]

Introduction

Chief Cutfeet's comment is likely to strike health care workers as jarring, challenging as it does altruistic assumptions about the nature of health care systems and the people who work in them. His comment forces contemplation of the profound and yet effectively undiscussed implications of colonialism for healthcare ethics. This gap is serious, since all mainstream issues– for example concerning the role of the clinical ethicist, medical assistance in dying, consent and capacity, resource allocation, decision making in public health – are influenced and distorted by the realities of colonialism. Indeed, the implications are so profound that morally orthodox positions become, paradoxically, the vehicles for racism and injustice.

This essay explores some of the ethical consequences of colonialism and its accompanying genocides. It describes how the routine non-reflexive operations of health law, policy and individual behavior contribute to the social determinants of ill health for these communities. Health care workers, commonly inadvertently, promote the same social determinants of ill health that are causally responsible for the high levels of mortality and morbidity experienced by Indigenous peoples, and do so believing they act for the good. In doing so they promote colonialism and genocide through an uncritical regard for state law, violence and its impacts on contemporary life.

In a colonial society, every aspect of socio-economic life is underpinned by violence. Colonial societies depend on this to impose a legal, economic, social and cultural regime upon the Indigenous populations

- [1] http://www.cbc.ca/news/canada/thunder-bay/11-year-old-suicide-1.3982955?cmp=abfb

Electronic version of a chapter published in D. Zion, L. Briskman, & A. Bagheri (Eds.), Indigenous Health Ethic: An Appeal to Human Rights (pp. 109-128). https://doi.org/10.1142/q0253
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they seek to displace. Institutions such as courts, police, child welfare and health care institutions possess an ambiguous value at best for colonized populations due to the roles they play in imposing state discipline. Moreover the institutions served – the legal and economic practices of the colonial state and larger transnational institutions – require the effective marginalization and destruction of independent Indigenous identities, spiritualities, economies and laws since these of necessity conflict with the centralized dominance of a colonial state. For example, private property laws conflict with Indigenous laws concerning land use and care. In cases of conflict, the police and prison system function to suppress Indigenous laws and beliefs. The result is that cultural genocide – the elimination of a people as a distinctively identified group - sits at the heart of any colonial society.

This problem is absent from discussions in bioethics. Public health ethics is an instructive case.

Public health ethics is concerned with understanding, evaluating and making recommendations on the ethical issues that arise from population health. Above all, it explores the nature and limits of state and institutional intervention in populations.(Dawson and Verweij 2008) Standard issues include the following:

- Balancing communal and individual goods (Bayer and Fairchild 2004);
- The ethical dilemmas arising from epidemics, pandemics, terrorist acts and other states of emergency;
- Identification of appropriate normative frameworks for public health (Gostin 2001, Callahan and Jennings 2002, Goldberg and Patz 2015);
- Appropriateness of political frameworks for addressing public health, including liberal, (Radoilska 2009, Powers, Faden et al. 2012), libertarian(Menard 2010), capabilities (Venkatapuram 2009, Owens and Cribb 2013), and social justice approaches(Sreenivasan 2009)
- Human rights-based (Mann 1997, Pogge 2005, Nixon and Forman 2008, Ruger 2009) and pluralist accounts of state obligation in balancing liberty, utility and equality in the provision of public health (Selgelid 2009);
- Resolution of conflicts of laws, principles and rights in the pursuit of the common good(Kass 2004);
- Paternalist and harm-minimisation arguments for state intervention in public health (Holland 2009, Nys 2009);
- The precautionary principle in public health (Weed 2004)
- The relative priority of humanitarian, self-interested and politico-economic considerations in public health (Pogge 2001, Tolchin 2008, Bowleg 2012);

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More useful for thinking about colonization and genocide in Indigenous health are the following:

- Critiques of statist bias in public health ethics(O'Neil 2002);
- Relational, intersectional and personalist approaches (Baylis, Kenny et al. 2008, Petrini and Gainotti 2008, Bowleg 2012);;
- Fears that interventions may impose exploitative conditions on populations or otherwise exacerbate existing inequities (Bhutta 2002, Pinto and Upshur 2009, Braveman 2012, Goldberg 2012);
- gender and patriarchy in public health (Rogers 2006);
- economic inequality as a social determinant of health (Hausmann 2009);
- solidarity in bioethics (Dawson and Jennings 2012);
- The role of medical authority in exacerbating (Wear 2003)
- The distorting effects of racism on health care (Gamble 1997);

But none of these explore colonialism or specifically problematize genocide. Of the few healthcare ethics papers that explicitly mention Indigenous health, Michael Marmot addresses the need to account for structural inequalities in Indigenous lives, but challenges neither, law, economics or colonialism. Colonialism and genocide form no part of his framework. (Marmot 2012).And while McNeil, Macklin et al mention Indigenous issues in their discussion of disenfranchisement, poverty and racism in healthcare, settler colonialism and Indigenous genocide are oddly invisible. (McNeil, Macklin et al. 2005) These above papers are right to explore privilege and oppression, but a full discussion needs to integrate such theory with the social determinants of Indigenous health, colonialism, and ethnocide.

Privilege and Oppression

Privilege and oppression are concerned with unjust distributions of economic, political, social or cultural power. A group is privileged if its members get advantages from the distributions; it is oppressed if its members experience disadvantages and harms. The positioning of the groups is thus dialectically related since the power of the privileged is only possible through the disempowerment of the oppressed, a relationship which is manifest in the health indicators for populations. The improved health experienced by settler populations depends in large part on the ill health inflicted upon Indigenous peoples.

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Privilege and oppression are allocated intersectionally, i.e. across a range of overlapping categories which combine to uniquely determine the conditions of life of each individual. Individuals are members of multiple groups and may be simultaneously privileged in certain categories while oppressed in others. In a capitalist patriarchy, a woman may be oppressed in virtue of being female, yet privileged as upper class; in a white privileging capitalist society, someone may be oppressed as transgendered and poor, yet be privileged by whiteness. Comparatively few people only possess privilege markers. The number of those only possessing oppression markers depends on the levels of inequality within a society. In their case, the conditions of life are precarious and the likelihood of survival from day to day is demonstrably low.

All successful colonial societies are defined by Settler privilege and Indigenous oppression since they are founded on the non-consensual seizure of Indigenous lands. Indigenous group members are like other racialized group members, such as (in Canada) Muslims, black Canadians, Jewish people, in that they have race oppression against them. What distinguishes Indigenous groups is that their culture, economies, spiritual identities, governance systems and land are the primary targets for destruction by settler-colonial states.

Colonialism

Colonialism refers to the complex interplay of institutions of systemic violence – legal, economic, cultural and social – along with the underlying direct violence aimed at entrenching and maintaining Settler supremacy. Through violence, a Settler population aims to impose its economic, political, cultural and spiritual institutions upon one or more Indigenous populations.

Colonialism is a process that is ethnocidal by its nature. A colonial state cannot tolerate the existence of independent legal, spiritual and economic institutions within its borders and thus must suppress and eliminate these. It performs this either through physical genocide, or through the forced assimilation of Indigenous populations to the normative systems and cultural identities of the Settlers (Jones 2006, Short 2010, Palmater 2014, Benvenuto 2015), i.e. through cultural genocide or ethnocide.

The relationship between Settler and Indigenous populations in a colonial state is thereby one of opposition and conflict. It involves ongoing (Vowel 2016) struggles between the Settlers and the Indigenous population(s). One never stops being a Settler even if one's relatives have lived in the region for hundreds of years. The relation is not one of time, but of power and exploitation. An individual is a Settler if they are a beneficiary of the seizures of Indigenous lands. An Indigenous person, in contrast, is someone who

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understands themselves as tied to their land, heritage, and legal and economic traditions and who resists assimilation to settler-colonial law, economics and culture. Where Indigenous peoples are colonized, a central desire is sovereignty or, to cite Taiaiake Alfred and Jeff Corntassel, the desire to be left alone, un-interfered with by a Settler state. They thereby work, necessarily, to resist assimilation by a colonial socio-economic regime (Alfred and Corntassel 2005).

In this regard, colonialism - and ethnocide - is an ongoing process and not historical. Colonialism continues for as long as an Indigenous population resists it. If there is a single Indigenous group asserting its sovereignty and independence, the violence of colonialism remains present.

Colonialism and Indigenous ill-health

The social determinants of health, for Indigenous people in colonial societies are the causal processes – distal, intermediate and proximal - of colonization. Their impacts – the disproportionately high morbidity and mortality rates experienced by Indigenous populations - are the manifestations of oppression in their lives.

Colonialism and racism are primary distal determinants of the ill health of Indigenous peoples.(Lang 2001, Reading and Wien 2009, Czyzewski 2011) The land thefts, confinement to reserves, identity damage and resulting poverty drive the intermediate conditions of Indigenous ill health. In Canada, for example, Indigenous people disproportionately lack access to adequate sewage, housing, and water. Education is commonly poorly-resourced and they are forced to live on polluted lands. The result has been poverty imposed across multiple generations. These are the intermediate determinants of the Indigenous suicide crises in Canada, as multiple inquiries have noted (Peoples 1995, Lauwers 2011, 2016, LeFrancois 2016). The intermediate determinants of ill health in turn drive proximal causal forces such as high rates of mental health and addictions, internal conflict and other forms of suffering inflicted upon many Indigenous communities.

All of these are the product of Canadian law and economic policy and are consequences of the ethnocides. Reserve life, for example, is sharply constrained by the *Indian Act* and the constitution of Canada. Inequitable funding is determined by federal and provincial governments with neither say nor control exercised by many Indigenous populations. Control over housing, sewage and health care is exercised by the Federal government through various federal departments dedicated to Indigenous affairs, as well as through Health Canada. Laws related to resource exploitation, hunting and fishing are set by the federal or

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provincial governments. All First Nations band council budgets are established by the federal government; the resulting health care provided in the nursing stations is inequitable in comparison to equivalent rural non-Indigenous communities(Canada 2015).

Ethnocide and Indigenous suicide

In this environment, Indigenous suicide rates are disproportionately high. For example, as of 2011, the suicide rate for First Nations males aged 15-24 was five times that of Canadian males generally, and that of Indigenous females from the same demographic was seven times that of Canadian females in general (Lauwers 2011). There is considerable variation depending on whether the group is First Nations, Metis or Inuit, as well as within spatially contiguous communities and specific Indigenous groups(Kirmayer, Brass et al. 2007).

Jackie Fletcher, Elder and Commissioner with the Mushkegowuk Council People's Inquiry, correctly ties the suicide rates to Canadian policies of ethnocide or cultural genocide. All of the distal and intermediate determinants of Indigenous suicide are deliberate. They are the result of the partial success of policies aimed at "killing the Indian in the child" and are the ongoing impacts of genocide(Council 2016). They are instances of what Friedrich Engels called "social murder," (Engels 2010), the infliction of disproportionate levels of physical and mental morbidity and mortality on a population through the application of law and economic policy. Following Engels, the Indigenous suicides are not individual choices, but rather are the consequence of complex group-on-group violence with highly individual impacts. Other problems, such as high levels of mental health and addictions rates, intra-communal violence and higher rates of morbidity and mortality from a range of illnesses, are also the consequence of this violence. In colonial Settler societies, the suicides are a consequence, sometimes explicit, other times tacit, but always clearly preferred and accepted, of the choices of dominant Settler groups to pursue their interests through the dispossession of subordinated Indigenous groups. They result from the deliberate and continuing imposition of sometimes intolerable conditions of life on Indigenous communities.

Given the almost sacred status allocated to law in much bioethics literature, these considerations are significant. If the law is ethnocidal, then what moral position does the health care worker occupy? How can dialogue – the *sine qua non* of the successful bioethics consult – be possible? Health care institutions and health care workers operate within this colonial legal environment and have their choice possibilities sharply constrained by laws that Indigenous peoples often understand – correctly – to be oppressive and

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racist. To the extent that health care workers endorse those laws, they promote that racism contribute to the ill health of Indigenous peoples. The following provide some examples:

Resource allocation

The reserves are sites of marginalization and confinement of Indigenous peoples. As the Anishnaabe word for reserve - 'Ishgonigan' or 'the left overs' - suggests, they are the sections of land that, at the time of the signing of the treaties, was thought by Canadian authorities to be the least economically valuable. The rest was appropriated as crown lands and allocated for settlement building, as well as in support of resource-based activities such as mining, logging, oil extraction, hunting and fishing, as well as for needed logistical supports such as pipelines, railways, roads and power lines. These land seizures continue to determine Indigenous impoverishment as of writing this essay. Value flows away from the communities, and very little flows back in.

For example, according to the 2015 Auditor General's Report *Access to Health Services for Remote First Nations Communities*, on-reserve health care facilities are underfunded in comparison to equivalent health care facilities elsewhere in rural Canada. This underfunding extends to all aspects of health care, including racial discrimination against 163,000 First Nations children for child welfare support. (https://fncaringsociety.com/i-am-witness). What makes this a particular ethical challenge is that the underfunding – which is a major contributor to the social murder/suicide of Indigenous people - is a creature of law. Moreover, refusal to change funding levels is tied to cost-benefit calculations that repeatedly conclude that needed clinical and public health improvements are unaffordable and, in any case, outweighed by alternative obligations to fund other "more important" aspects of governance. In short, it is preferable for provincial and federal governments to leave the communities suffering as they do rather than to re-allocate funds from higher priority Settler interests.

Justice and utility discussions which fail to consider the injustice of state colonialism and the requirement for political, economic and social reconciliation inevitably skew funding and perpetuate inequities in health care systems and elsewhere. Any decisions are pre-biased by the violent and non-dialogical imposition of settler law and therefore are unjust before any discussions about resource allocation begin, i.e. are unjust *a priori*.

Beneficence

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Beneficence is likewise perverted under colonialism. It is common in bioethics to assume the state acts for the best interests of its citizens. Hard decisions get made which, sometimes, work against the interests of specific groups, but in general the assumption is that the state acts for the best. Under colonialism this assumption is incorrect. Rather, beneficence is skewed to the interests of dominant settler-colonial groups and the greater good becomes co-extensive with their needs and desires. Harm-minimization calculations are similarly distorted. The injustices in resource allocation are also examples of distortions in beneficence, since Indigenous groups count less than others and thus are correspondingly unlikely to be the recipients of beneficence. The result is that, repeatedly, needed public health and clinical interventions are denied because more benefits are routinely adjudged to lie elsewhere.

Epidemics and States of Emergency

The impacts of colonialism, racism and genocide are most apparent in in state of emergency.

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In the last 10 years, various First Nations have declared states of emergency for a wide variety of reasons including youth suicide,[2] poor water quality,[3] food,[4] fentanyl and opioid crises,[5] youth safety,[6] inequities in the provision of health services,[7] flooding, H1N1 virus,[8] and loss of power.[9] This list is not exhaustive.

In some of the cases there was no response of any kind. No government at any level responded to a declaration of state of emergency for suicide by the member communities of Mushkegowuk Council in 2011(Council 2016). In other cases the response is inadequate, such as when the federal government sent body bags instead of vaccines to Wasagamack and God's River First Nations during the H1N1 crisis[10]. Alternatively, federal or provincial governments choose short-term crisis response strategies that leave the

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[2] https://www.thestar.com/news/canada/2017/06/22/northern-ontario-first-nation-declares-state-of-emergency-on-youth-suicides.html

https://www.theglobeandmail.com/news/national/attawapiskat-four-things-to-help-understand-the-suicidecrisis/article29583059/

https://www.theglobeandmail.com/news/national/manitoba-first-nation-declares-state-of-emergency-over-suicide-epidemic/article29113402/

http://www.nan.on.ca/upload/documents/nr-neskantaga---april2013.pdf

https://www.thespec.com/news-story/6512359-28-states-of-emergency-are-in-effect-in-these-ontario-communities/

[3] http://freegrassy.net/2015/08/27/grassy-narrows-first-nation-declares-emergency-over-bad-water/

http://watercanada.net/2011/state-of-emergency-in-pikangikum/

http://www.mynorthbaynow.com/6504/dokis-first-nation-under-state-of-emergency/

http://panow.com/article/582407/muskoday-first-nation-declares-state-emergency

http://www.cjrl.ca/news/1018109957/whitedog-residents-complaining-about-lack-running-water

[4] https://canadiandimension.com/articles/view/why-arent-conditions-of-life-for-first-peoples-a-national-emergency

[5] http://shuswapnation.org/secwepemc-elders-and-chiefs-declare-state-of-emergency-over-fentanyl-crisis/

http://theargus.ca/news/2012/cat-lake-first-nation-declares-state-of-emergency/

http://calgaryherald.com/news/local-news/stoney-first-nations-facing-prescription-addiction-crisis

http://www.digitaljournal.com/article/299264

[6] https://www.tbnewswatch.com/local-news/nan-calls-for-state-of-emergency-665065

[7] http://www.chiefs-of-ontario.org/sites/default/files/community-news/NORTHERN%20ONTARIO%20ANNOUNCEMENT-%20MAY%202016.pdf

[8] http://www.montrealgazette.com/business/first+nations+calls+swine+state+emergency/1729124/story.html

[9] http://www.theprovince.com/business/quebec+first+nations+communities+declare+states+emergency/5819708/story.html

[10] http://www.cbc.ca/news/canada/manitoba/ottawa-sends-body-bags-to-manitoba-reserves-1.844427

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causes of the emergencies untouched and thereby guarantee recurrence, as in sending social workers and psychologists to council suicide survivors for a few weeks or months on the rare occasions when an emergency raises sufficient public outrage. Either way, state and private interests act to ensure emergencies are resolved incompetently or not at all.

For many of these emergencies the response does not meet the nature of the emergency. Far from being exceptional deviations from a norm, they are slow-developing, long-standing 'normal' states of affairs. They are the long-standing outcomes of colonial law, policy and economics, i.e. are ethnocidal states of affairs. Hence the causes of the crises are intermediate and distal, and single event crisis response strategies are inadequate. Effective resolution requires reconciliation and supporting long-term political, economic and legal strategies. At root, it requires the elimination of colonialism and transformations in the privilege-oppression relations that currently define colonial states like Canada. In the case of the suicide crises, these are rooted in the racism and economic practices of colonial states, as is clear in the social determinants of ill health for the afflicted communities. Effective anti-suicide strategies need to be multi-layered(Kirmayer, Brass et al. 2007), long term, and they require a transformation in the socio-economic character of the country.

Respect

Consultation failures and breakdowns are common in Indigenous health. Indigenous communities either do not get asked about their interests or needs, or they are consulted in a perfunctory manner. Under these conditions, the identity and autonomy of Indigenous peoples is de facto irrelevant, and the result is decision-making that is either of no benefit to Indigenous communities, or positively harmful. Not only are communities ignored, but the specific health knowledge and expertise of Indigenous healers and law keepers is routinely dismissed in spite of the extensive and intimate ecological and public knowledge that they possess.

An example from northern Ontario is of value here. A great deal is known about suicide prevention, and about the causes of suicides for both Settler and Indigenous populations. Successful anti-suicide programs have been instituted that are relatively cheap. Health Canada had established a successful program at Wakapeka First Nation and then cut its funding in 2016. In July of that year, the band council warned Health Canada that a suicide cluster was developing and that the funding needed to be restored. The call was rejected. Six months later, in January 2017, two 12-year-old girls died, followed by another death by suicide in May 2017 of another child, along with an attempted suicide by an additional teenager. The communities

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were not consulted on their preferences about funding, and have been dispossessed of control over the land and resources which would allow them to shape their own health care.

Respect for persons is a common failure with considerable negative health implications for the communities.

'What Should We Do?'

Commonly, well-intentioned people will ask this question. However, the question itself misunderstands the problems. Above all it is inadequate because it leaves the position, power and character of the questioner untouched. Those who pose this question fail to see how their power to act lies at the heart of Indigenous ill health. As long as the oppressive power relations remain intact, little happens other than the occasional band-aid. This is shown, for example, in more progressively oriented people who defend resource transfers – for example, extra funding for nursing stations, mental health and addictions programs, and the like – without challenging their own right unilaterally to decide on policy and resource allocation. The inequitable allocations are only possible given the suppression of the community's capacity to decide since the communities obviously would try to adequately fund their own health care. The actual obligations are about giving up power, i.e., about sharing or otherwise redistributing it and reducing control over resources.

Who Should We Be?

The central moral challenge is virtue-ethical. Health care workers and settlers generally need to stop asking what we should do and first ask who we, as a society, need to become. Successful efforts at improving Indigenous health and lives depend upon changing the relationship between settler and Indigenous populations and are thus about transforming relations of power. Consequently, transformation of the identity and behaviors of healthcare worker, the structures of health care systems and the colonial society from which they benefit is foundational. This means above all the elimination of systemic, epistemic and interpersonal racism as they manifest in the mundane operations of health care. The social determinants of Indigenous ill health implicate all of us – including health institutions and healthcare workers – as causally responsible for the high rates of mortality and morbidity in Indigenous communities. Thinking about solutions can make sense once these facts about colonialism and racism are recognized. But it means that we take seriously Chief Cutfeet's assertions about harms of colonial health care systems. It also means that health ethics has to prioritize Indigenous sovereignty and support meaningful justice-based compensation for past and present wrongs.

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The Moral Primacy of Advocacy

Work and research in clinical and public health matter for everyone. However, under conditions of colonialism and racism, any health efforts are limited or without effect because of the consequences of privilege and oppression in settler colonial societies. Under such conditions, the most effective moral work is reflective, anti-colonial social justice advocacy. Such advocacy has to focus on reconciliation and redistributions of power. Given that colonialism is fundamentally concerned with the seizure of control over resources, the real challenge is to shift the socio-economic situation so that state and corporate authorities no longer exercise unilateral decision-making power over land, resources, education and health philosophy.

The ethical healthcare worker, in working with Indigenous populations, has to advocate for land restorations, transformations in law and, ultimately, for decolonization – i.e. a transformation in the relationship between the colonial state and the Indigenous populations which it oppresses. If it is to be adequate to the ethical demands of health ethics with Indigenous peoples, bioethics has to incorporate decolonization theory. This means supporting land transfers, land rights, and reparations/reconciliation payments along with the provision of culturally safe health expertise – where requested – in support of healthcare interventions.

Conclusion

Some excellent work in Indigenous health is being done by many different players within health care. But unless the distal and intermediate determinants of ill health are transformed, the possibilities of improvement are limited and vulnerable to abandonment whenever other colonial interests dictate. Such improvements require transformations in the politics, law and economic practices of colonial societies. There may be alleviation of harm in some cases, but little likelihood of broad improvements in health. Eliminating the suicide crises and other social problems is highly unlikely without changes in macro-economic resource allocation, large scale decontamination of Indigenous lands, improvements in housing, sanitation, access to recreation, cultural and spiritual opportunities, access to and control of land, and recognition of Indigenous sovereignty and law. Colonial states like Canada continue to suppress these. This is the environment that the healthcare worker functions within, and we have to negotiate it ethically as best as we can. In this regard, the ethically minded healthcare worker has to work against the lines of colonial force. This is risky, since it can place us in opposition to interests which include our employers. It also

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means that the healthcare worker may have to act in ways which are risky, provide no reward, and which may be punished by the incentive structures of their employers and institutions. Health care workers are not entitled morally to take a neutral position on the law or policies but have to work to change them.

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