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Indigenous Spirituality is an Inherent Part of Palliative Care

How Can Spirituality Be Integrated with Palliative Services in Northwest Saskatchewan?

Gail Noltcho-Clarke

Master thesis in Governance and Entrepreneurship in Northern and Indigenous Areas
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Abstract

Indigenous people in northwest Saskatchewan rely on a health care system that does not meet the spiritual needs during end-of-life care. Research indicates there is important relevance to spiritual care during end of life, for Indigenous people ceremonies are important to help the individual cross into the spirit world. This paper provides the reader with insight from a First Nations perspective of the inequalities Indigenous people of northwest Saskatchewan cope with within the current health programs. I will provide insight on how the current policies impact the inequalities Indigenous people adhere too to receive palliative care. In general, the paper provides an overview of services rendered to Indigenous people in northwest Saskatchewan compared to services offered to Indigenous people in other parts of Canada. The sources are based on documented research with various sources like the Government of Canada, Saskatchewan Health Authority, and other individual reports completed by numerous scholars.

The people of northwest Saskatchewan live in a large geographical area and services are provided by two levels of governments that make it difficult to receive equal or equitable services to Indigenous people. Based on the research conducted, the current health care system discriminates towards Indigenous health care and lacks appropriate spiritual care in northwest Saskatchewan. The current health system requires an overhaul of services and supports in northwest Saskatchewan to respect First Nations inherit right to health care.

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1. Introduction

For Indigenous people, spiritual, emotional, physical, mental, and psychological wellbeing are important factors during end of life care because all areas are interconnected to each other. During this time, health professionals can maintain the dignity of First Nation patients during their final days and respect their traditional practices. Like many Canadians, Indigenous people in northwest Saskatchewan would like to remain at home to die but there are limited resources to support the physical and medical needs during end-of-life care. So, it is imperative hospital settings provide a respectful environment to meet the needs of the patient and family during the last remaining days of the patient's life.

The current practice by medical professionals is to address the physical symptoms of the illness and manage pain, leaving families to address the spiritual needs of the patient. The medical approach to addressing the physical needs of patient comes from a western philosophy that does not address the four elements of the medicine wheel. This paper will provide insight from a First Nations perspective into the inherent right of Indigenous peoples to practice their spirituality individually and collectively during end-of-life care. First Nations should have the right to spiritual rooms within proximity of the patient to practice traditional ceremonies and comfort to the patient.

1.1 Situating the Researcher: Personal Background

I do not claim to be an expert in spiritual practices because each person views their spiritual practices differently. I grew up in a community of Dene First Nations who were influenced by the Roman Catholic Church. I did not know my traditional ceremonies because I conformed to a Christian upbringing introduced through colonization. I did not question the practice; like many Indigenous families I got up every Sunday and went to church with my parents. I would sit in church and wonder why people would indulge in standing and kneeling

for over an hour and sing in a language I did not understand. Through my curiosity I asked my parents what the purpose is of going to church. I was basically told that I had to go to church and pray every Sunday to find salvation or face damnation. As a child, I felt if I did not conform to the Catholic teachings I would be punished.

Later, into my adult years, I started to learn and understand my spirituality as a way of life to everything the Creator created and blessed us with. I was taught we begin with the Creator and end with the Creator; all living things are to be respected and provided by the Creator. I took it upon myself to learn the different ceremonies to honour the Creator through the sweat lodge, smudging, moon ceremonies and healing circles. I began to educate myself and learnt Indigenous people were split between two cultural paradigms: a dominant colonial culture and First Nations culture. For many years, colonialism continues to infringe on Indigenous rights through legislated policies that marginalized Indigenous people into a colonial society.

This western culture is evident in the policies and practices implemented in the health services I received and witnessed. Upon my hospital arrival, health care professionals would ask what religion I prefer but never ask what my spiritual preference is. This question always made me feel uncomfortable because I self identified as a Dene person foremost and I did not clearly identify with any religious order. I was taught the Dene people are spiritual people with a close connection to the creator not a specific religion. I recall a time I attended the hospital dressed in my sweats and a sweater. The staff were rude and made me feel uncomfortable, so I left untreated. If they took the time to listen, the staff would realize I am educated person with a serious medical concern. But I was judged for the colour of my skin, treated disrespectfully, and asked if I even spoke English before given the opportunity to clarify my medical need. The colonial approach and lack of culture awareness led to stereotyping resulting in poor medical support and treatment.

Living in northwest Saskatchewan, I have experienced on one or more occasion the provision of end-of-life care within a hospital and home setting. As my loved one passed into the spirit world, I sat by their bedside in the hospital like many of my relatives, but I would feel empty. Thinking, “I know I have to do something” I would begin to pray, reciting the prayers learned from the Church, but the words felt meaningless. Again, I approached my grandparents for advice about the Dene way of life. It was then I learned that the Creator was a loving entity that provided for all we have; we should honour death as we honour life in ceremony. My grandparents reminded that we are all connected to the Creator, and everything we do in life is a ceremony. The sweat lodge provided a place to connect with our grandfather and grandmothers in the spirit world and provided healing of ailments. Smudging with sweetgrass or sage allowed our prayers to be heard by the Creator and cleanse the area from negative energies. It is these teachings from my grandmother I continue to practice daily.

Since then, I have observed the services within the health care system excluding the importance of culture and spirituality during the end-of-life care. Within my Dene community, people tend to gather in large groups during end-of-life care. A large room is necessary to accommodate both immediate and extended family members who provide emotional, mental, and spiritual support while the hospital staff address the physical needs of the patient. When my loved one was in end-of-life care, I felt the current arrangement within the hospital did not address the immediate spiritual services for our family needs. If I wanted to participate in a traditional ceremony using spiritual items, I would have to leave the building, or find a ventilated spiritual room to burn sweet grass, sage or perform a pipe ceremony away from the patient’s room. This approach allowed for a disconnection with my loved one to experience his journey into the spirit world through ceremony.

In a home environment, families are free to practice their religious or spiritual beliefs, ceremonies can be conducted with our loved one. Unfortunately, the home environment lacks adequate medical care to accommodate palliative care. If a ventilator is needed to care for the patient one be admitted into the hospital. Yet, oxygen tanks are provided to the patient at home. I recall a time when I stayed with a loved one at home. It was difficult staying by his side and watching him go through his final days. Due to the distance of the hospital from my community, we did not have medical care daily. On occasion the local nurse would come by and check his vitals and visit with family. We were left without medical support majority of the time, but we were together as a family, through prayer and ceremony my loved one passed into the spirit world peacefully.

1.2 Regional overview and definition of terms

For this thesis, "Indigenous" and "Aboriginal" (used interchangeably here) respectfully refer to the First Nations, Inuit, and Metis in Canada. The Constitution of Canada, section 35 defines Indigenous people as First Nations, Metis, and Inuit. In Canada, particular legal rights are afforded to First Nations people with recognized "status" according to the Indian Act of 1867. A status First Nations person is identified under the Indian Act as either a 6.1 or a 6.2 category. A non status First nations person does not have the same recognition as status First Nations as defined in the Indian Act. In this paper, the term "First Nations" refers to both status and non-status people. The focus will be on increased spiritual services for Indigenous people during end of life care with the amalgamation of health regions in northwest Saskatchewan. In Canada, status First Nations receive medical care differently than the general society including Metis and non-status First Nations. Health care programs are funded by Indigenous Service Canada (ISC) to provide health care services in First Nations communities. The health programs are funded by the Provincial Government in the Metis settlements.

End-of-life care or palliative care (used interchangeably in this paper) are offered during the final stages of a person's life suffering from terminal illness (usually weeks to months) within an institutionalized setting like a hospital or hospice facility. During this time, the goal is to provide the best possible quality of life for the dying person and their families, regardless of the setting of care (The Yukon Health and Social Services, 2015).

Hospice palliative care is a facility that provides "whole-person health care that aims to relieve suffering and improve the quality of living and dying" (Canadian Hospice Palliative Care Association, 2014, pg1). Hospice care improves the condition of life as they get closer to death and provides an environment to maintain patient decisions in care. Hospice care programs focus on giving support to individuals to die painlessly with self-respect, support families and grief support post death. Hospice care is generally provided in hospice foundations, hospitals, and other long-term care facilities (National Hospice and Palliative Care Organization, n.d.). Depending on where you reside, hospice care can be provided in a person's home. Hospice care personal will help the patient develop a care plan to manage the symptoms and pain. The hospice plan will consist of support for emotional, psychological, and spiritual care. The hospice plan outlines the short-term impatient care when the pain becomes unmanageable at home. The final stage of the hospice plan is to provide bereavement support and counseling to the surviving family and friends (National Hospice and Palliative Care Organization, n.d.).

In February 2017, the Provincial Government implemented one health authority within Saskatchewan and amalgamated all the health regions except for the Athabasca Health Region. With the merger of health services, the Saskatchewan Health Authority now oversees the health programming in northwest Saskatchewan. Keewatin Yathe Regional Health (KYRH) continues to provide services with the amalgamation under the Saskatchewan Health Authority. KYRH provides hospital care, physician care, emergency services, primary

care, homecare, and long-term care within the Métis communities. The surrounding First Nation communities receive medical care under the supervision of doctors affiliated with provincial health region. The Saskatchewan Health Authority offers end-of-life care through home care, hospice, and hospital settings.

There are five First Nation bands located in northwest Saskatchewan: English River Dene Nation, Canoe Lake Cree Nation, Buffalo River Dene Nation, Birch Narrows Dene Nation and Clearwater Dene Nation. Meadow Lake Tribal Council provides community health programming to all five First Nations under a joint agreement with the Federal and Provincial Governments. There are eight Métis settlements in this area: Beauval, Ile a la Crosse, Jan's Bay, St George's Hill, Michel Village, Buffalo Narrows, Turnor Lake and La Loche. These thirteen communities rely on the two hospitals in northwest Saskatchewan (St. Joseph's hospital in Ile a La Crosse and the La Loche hospital) for all medical services including palliative care. With the advancement in technology equipment, La Loche and Ile a la Crosse hospitals utilizes online consultations with specialists. The La Loche and Ile a la a Crosse hospitals provide long term care for the elderly but limited palliative services. The area for palliative patients is placed in a general location of the hospital for all patients with no designated palliative beds. If St. Joseph's hospital or La Loche hospital cannot provide appropriate medical treatment to address patient needs, he/she is transported to receive treatment in Saskatoon Saskatchewan or Fort McMurray Alberta. By utilizing a distance calculator, the air flying distance to Saskatoon is 516.04 km from La Loche and 378.69 km from Ile a la Crosse. The driving distance is much longer so both hospitals utilize medical air transportation. The flying distance from La Loche to Fort McMurray, Alberta is 122.04 km. There is no direct highway from La Loche to Fort Mc Murray. In the wintertime, there is limited availability with the winter road. In the summer, people drive on average 12 hours to

reach Fort McMurray. Family members must arrange their own transportation and drive by land to Saskatoon or Fort McMurray to provide support to their family member.

Indigenous spirituality refers to spiritual beliefs and practices Indigenous people identify as being traditional or customary among Indigenous people (Ontario Human Rights Commission, n.d.). Spiritual services refer to access of First Nations traditional ceremonies, Elders, and traditional medicines. Indigenous ceremonies are conducted to communicate with the Creator. There are different types of ceremonies for healing, celebrations, and spiritual growth/balance like sweat lodges, cedar baths, smudging, moon ceremonies, pipe ceremony, shaking tent, sun dance, and the ghost dance. Ceremony practices vary between communities. They can consist purely of First Nations spirituality or a combination of Christianity and First Nations ceremonial practices. For example, during end-of-life care an Elder will conduct a smudging ceremony with the patient to prepare for their journey into the spirit world. The use of sage and cedar help purify the air and remove negative spirits to allow the patient to cross over into the spirit world in peace.

An Elder is a person held in high esteem within the Indigenous community who have a respectable place in Indigenous cultures. The Elder performs the ceremony with family members upon request of the family with an offering of tobacco and cloth. Monetary funds are not exchange. Elders can be traditional healers because they understand traditional values and share their knowledge with community members.

The medicines include rat root, chaga, bear root, wild mint, sweet grass, sage, tobacco and other plants and herbs provided by mother earth. The medicines gathered are used in different ceremonies for healing, health, and the passing of loved ones. Aboriginal traditional healing refers to the many healing traditions/ceremonies within First Nations cultures that were used for centuries prior to and after the arrival of European groups. In northwest Saskatchewan, traditional medicines and ceremonies would normally be practiced within a

sweat lodge, or the privacy of one's residence. Medicine bundle is a term used in the signing of Treaty Six to provide health coverage to First Nations in Canada. However, the medicine bundle is used by First Nations consisting of herbs, medicines picked from the land and cloth to perform ceremony. This medicine bundle is kept in a safe place away from others and treated with respect. If you are blessed with a pipe, the pipe becomes part of your bundle.

1.3 Methodology

The data for this paper will be gathered using documentary research to review information on end-of-life care services and how First Nations spirituality is implemented. This information provides a needs assessment for access to spirituality in palliative care in northwest Saskatchewan. The research gathered will look at related legislation affecting Indigenous people, and policies affecting the delivery of services related to cultural practices within palliative care, and various other grey literature.

The research will evaluate statistical data related to end-of-life care and the implications this will have on First Nations. I will review sections of the Indian Act and how this act discriminates against First Nations' inherent right to practice their spirituality within hospital care. I will review Federal Government utilization of the Indian Act to transfer jurisdiction of health services to the provincial government of Saskatchewan. I will review the lack of Provincial responsibility to provide end-of-life care to First Nations according to section 88 of the Indian Act. I will further review the United Nations Declaration of Rights of Indigenous people in relation to the recommendations to address the inequalities First Nations encounter within the health care system such as: cultural genocide of Indigenous people historically and currently. I will review section 35 of Constitution of Canada that recognizes the rights of Indigenous people and what this means for First Nations dealing with end of life care. I will review how the levels of government have failed in relation to Indigenous people within the current health system.

I will review gaps in spiritual services for patients in northwest Saskatchewan and how other health regions have taken steps to address spiritual practices. I will review palliative care at St. Joseph's and La Loche hospitals in northwest Saskatchewan and compare this data with other spiritual services offered in health care facilities in and around Saskatchewan and other Canadian provinces.

2. Indigenous People will Require Access to End-of-Life Care

First Nations do not have adequate palliative services in northwest Saskatchewan and rural areas. There is a growing population of First Nations that continue to face marginalize care due to racism in the health field that affects the overall care of Indigenous families. There were no statistical data on access palliative care services in Canada, but other statistics help illustrate the growing need for such access. Firstly, rates of chronic illness among elderly Indigenous people show a trend suggesting more palliative care will soon be necessary. Chronic illnesses are progressing and evolve over time with lasting effects such as heart disease, strokes, cancer, diabetes, obesity, or arthritis that can lead to a health disability or death (Ontario Ministry of Health Framework, 2007). In 2012, 88% of Aboriginal senior women in Canadian population centers reported having been diagnosed with at least one chronic condition. This was slightly higher than for men, at 86%. Not surprisingly, as age increases, having at least one chronic condition increases, with similar patterns between men and women (O'Donnell, 2017). This statistical data demonstrates a growing trend of Indigenous population who will require hospital care due to aging and chronic/ terminal illness. Canadian statistics does show there will be a growing need to address palliative care in northwest Saskatchewan because Indigenous population continues to increase in Saskatchewan yearly. For example, aboriginal population in 2011 was estimated at 14.9% in

the province of Saskatchewan. Within this population 9.6% are First Nations and 5% Metis people. It is further estimated that the Aboriginal population of Saskatchewan will make up about 35% of the total population of Saskatchewan by 2045 (World Population Review, 2019). Based on this prediction it only makes sense to address palliative support for Indigenous people especially in vulnerable locations like northwest Saskatchewan.

As chronic illness increases in the aging population of Canada's, palliative services will be impacted. CHPCA indicated in 2009, "Canada had 4.7 million persons aged 65 years or over, twice the number recorded in 1981" (CHPCA, 2014). It is estimated these projections will excel into the near future. By 2061, there will be between "11.9 million and 15.0 million persons aged 65 years or older" (CHPCA, 2014). Basically, Canada's aging group of senior citizens will require appropriate end-of-life care

Aside from the future problems associated with an aging population, Canadians already lack sufficient access to appropriate end of life care. CHPCA states that "only 16 percent to 30 percent of Canadians who die currently have access to or receive hospice palliative care and end of life services" (CHPCA, 2014, pg1). This gap of palliative services creates a disservice to many other Canadians. For example, in Saskatchewan there are large areas of rural communities that do not have access palliative services. The commute for family members to support their loved one causes strain and hardship (Saskatchewan Medical Association, 2020). End-of-life care should be a priority in Canada but 73% of Canadians feel that the provincial governments minimize end-of-life care, and 35% stress there is far too little end-of-life care programs (CHPCA, 2014, pg3). There is a growing concern to restructuring healthcare for palliative care and so is the demand to address spiritual support for patients.

Wheatley and Baker (2007) indicated that "up to seventy percent of patients receiving palliative or end-of-life care would like to be at home to die surrounded by family members"

(Wheatley and Baker,2007, pg. 647). Unfortunately, this is not always possible. For example, when my family members were faced with an end-of-life scenario they had to decide whether to remain at home with family or go into a hospital setting. Due to the lack of appropriate medical care at home they went into the hospital. Annette Brown (n.d.) indicated "northern and rural areas of British Columbia, residents are faced with geographic distance, a limited range of services, hospital downsizing, and cultural differences which create barriers to accessing health services (Brown, n.d.)." This is relevant to Métis, status First Nations and non-status First Nations in northwest Saskatchewan because the residents are faced with similar circumstances that affect end of life support well as many other determinants such as: the general costs of hiring trained professionals, accommodating health staff and lower concentrations of residents means all services inevitably cost more per person to provide end of life support. It is obvious with the statistical data there is a need to address palliative care for all people in Canada, but there is a particular need among Indigenous people in northwest Saskatchewan with inadequate services.

3. First Nation Spirituality and End-of-Life Care

When a person faces a terminal illness, the patient is struggling emotionally and mentally with the realization that their life is will end. The ability to be independent decisions deteriorates both physically and mentally (Horst, 2017). During this time, it is imperative to respect the wishes and privacy of the terminally ill person with dignity.

Indigenous people turn to their spiritual faith in the Creator to reflect on their current situation to seek peace and prepare for their journey into the spirit world. According to survey conducted with Elders, First Nations identified the importance of kinship, Elder / Healer supports and handling of ceremonial items during end-of-life care (Bourassa et al. 2016). Family members will discuss with Elders about protocols in preparation for the patient to travel into the spirit world. Elders prepare a ceremony before the loved one crosses over to

the spirit world. Each family member plays a role in the preparation which allows for family unity, healing, and comfort for each other.

Research has shown that people with life-limiting illnesses who reflect on their quality of life improved when their spiritual needs are addressed and valued (Horst 2017). For families facing end-of-life care, spirituality is a vital component to addressing healthcare along with the physical, and mental wellbeing of the patient. Palliative care provides a temporary placement for patients facing the end-of-life care with dignity. Palliative care is formally committed to physical, social, psychological, and spiritual care of the dying person and family (Walter, 2002, p133).

There is some evidence that patients expect religious or spiritual services as a complimentary service in hospitals. In Australia, the Prince of Wales Hospital (POWH) conducted a survey on spiritual needs and healthcare services during end of life care. 74% of patients agreed on the importance of spirituality during end-of-life care. Patients stressed health professional should be cognizance of Indigenous practices. 81.6% felt spirituality/religion customs were valued during patient care. 81.1% of people considered the significance of having a traditional ceremony during times of suffering or illness. Finally, 73.7% felt professionals should understand patient's beliefs and 72.8% felt professionals can freely ask about patient beliefs (Haynes, et al. 2007). Although this data is from Australia, it seems reasonable to believe Indigenous people in Saskatchewan can relate to the data because of the similarities Indigenous people in Canada continue to endure.

Saskatchewan Elders interviewed by Bourassa et al. discuss the importance of kinship, the use of Elders and healers, handling of sacred items, support, and guidance to community members during their time of need. Elders clarified they have a role in providing support to families. Elders advised that "ceremonies and healing are special gifts given by the Creator and, like languages, there are also many different healing methods used among

Aboriginal peoples' (Bourassa et al. 2016) that continue within Indigenous cultures. There are Indigenous people who practice the ceremonies, who teach others and pass on their knowledge so the traditional knowledge continues to future generations. Through the ceremonies performed, healers, medicine men, and medicine women facilitate communication between the ill person and spirit world through prayer. During this time, the patient finds solace and acceptance. The "sacred and ceremonial items are integral parts for many people" (Bourassa et al. 2016) during their healing process. The sacred items may include feathers, tobacco, sweetgrass, cloth, special stones, sage, and cedar as well as "medicines in the form of teas" to assist the traditional healer in prayer (Bourassa et al. 2016). During the end of life of care, Elders explained "that even though a person may be dying, s/he may be doing the most mental, emotional and spiritual healing that s/he has ever done" and Elders or healers perform ceremonies essential to healing" (Bourassa et al. 2016).

The sacred items are treated with respect and used when one needs to smudge or perform a ceremony. Elders have stress that items must not be moved by anyone without permission. If a health care practitioner or hospital staff member needs to move an item, s/he should discuss this with the patient and/or family members to respect their spiritual beliefs (Bourassa et al. 2016). The sacred items are considered blessed and use to perform ceremonies in prayer to the Creator and people should refrain from handing the items if they are unaware of the Indigenous beliefs. For many Indigenous groups, women do not handle sacred items when they are on their menstrual cycle because women already have the gift to cleanse oneself during this time. The only item that women will use is sage or cedar for smudging purposes. For this reason, when attending the bedside of a family member, Elders will use sage to smudge the room or ceremonial room, so all can participate. The Elders interviewed by Bourassa et al. provided a strong argument to recognize and respect the values

and practices of Indigenous groups who choose to honor their loved ones using traditional practices during end-of-life care.

3.1 Examples of Spiritual Services During End-of-Life Care Elsewhere in Canada

Spirituality is an intricate part of palliative care in northwest Saskatchewan. Bourassa et al. indicated in their research that Elders stress the importance of "decision making" because the person determines the supports and plan of care for their loved one. The person's spiritual beliefs can affect decisions to stop treatments. "If the person or their substitute decision-maker, family, and health care workers can talk about these beliefs, it may cut down on misunderstandings and conflict at the end of life and provide comfort to the person and family" (Bourassa et al., 2016). The Canadian Hospice Palliative Care Association indicated, they asked where they preferred to die, and many respondents stated at home surrounded by loved ones. "Yet, almost 70% of Canadian deaths occur in a hospital (Canadian Hospice Palliative Care Association, 2014)."

Supports and information related to end-of-life care best practices can be culturally sensitive to First Nation people. A study completed by Kelly, et al. (2009) on "Palliative care of First Nations people, a qualitative study of bereaved family members" reviewed what First Nation in Ontario identified to likes and dislikes during the end-of-life care. "Respect, music, and spirituality" were all perceived to be part of good caregiving (Kelly, et al, 2007)." Kelly et al further learned that "spiritual care was important by most families with prayer and singing were often synonymous (Kelly, et al. 2017)." In particular, the Meno Ya Win Health Center in northwestern Ontario, the Whitehorse Hospital in Yukon, and the Chinook Regional Hospital in Lethbridge, Alberta provide good examples of how they have implemented traditional practices. The Provincial and Territorial governments worked with

Indigenous groups to promote culturally appropriate programming within hospital settings to address end-of-life care.

Ontario has developed the Aboriginal Health Organization (AHO) that addresses Indigenous health programming. The Ontario Human Rights Commission have taken an active role of recognizing the importance of Aboriginal health care and implementing Indigenous practices. The Meno Ya Win Health Centre in Sioux Lookout, Ontario is designated as a Centre of Excellence for Aboriginal Care. The hospital's mission is culturally responsive to First Nations values, providing traditional healing options, interpreter services, and traditional foods. This facility includes a smudge room and a palliative care area large enough for extended family (Kelly, et al. 2007). Traditional services offered at the Meno Ya Win Health Centre provide support on traditional healing, medicine, traditional foods, and support programs for First Nations.

The Yukon Government has made strides to incorporate traditional knowledge and practices into the health care delivery for Indigenous people. In Whitehorse, the territorial government in partnership with First Nation leaders implemented a holistic model in the 1990s where traditional practices and ceremonies were part of the healing process. Whitehorse hospital takes a traditional approach to program delivery specific to Indigenous healthcare. The Yukon Hospice team supports patients in a hospital setting, private care, and other facilities as needed. Yukon Hospice provides emotional and spiritual support to palliative care patients from a holistic approach.

Chinook Regional hospital provides an Indigenous liaison program that supports First Nations and Metis people seeking support. The program offers support for cultural teachings and patient advocacy among other supports. The ceremonial room is part of a new wing in the hospital for the use of people of various faiths. The room is ventilated to allow burning of sacred plants in First Nations ceremonies (Government of Alberta, 2016).

4. Legislation/ Jurisdictional Policies

The Federal Government's paternalistic approach to health care through the Treaties, Indian Act, and other federal legislation places legal responsibility on the Federal Government to coordinate services at all levels of government. Yet, First Nations continue to face many disparities and inequalities. Since contact with European settlers, Legislation dictated what services such as health care Indigenous people qualified for, generating discriminatory policies that affected their wellbeing. The Indian Act of 1867 and the Constitution of Canada (evolved from the British North American Act) legislated policies affecting control over Indigenous people for over 150 years. The British Crown (Canada) and First Nations have struggled to coexist alongside each other due to the lack of recognition by the Federal Government over Indigenous peoples' inherent rights.

The Canadian Constitution was established in 1867 formally known as the British North American Act was amended in 1982 recognizing the equality of all Canadians and the rights of Indigenous people. Section 15.1 of the Constitution reaffirms that all Canadians have equal rights without discrimination including Indigenous groups within Canada. Section 35(1) of the Constitution provides a "constitutional framework that aboriginals lived on the land in distinctive societies, with their own practices, traditions and cultures (McNeil 2010)". Yet the Indian Act was created to colonize the Indigenous people and assimilate status First Nations into mainstream society by controlling and regulating policies directly affecting their well-being.

According to the Indian Act, the Federal Government of Canada is compelled under section 73(1) to provide health services to the status First Nations. Although the Indian Act indicates a clause to provide medical treatment this can be interpreted as vague and leaves it open for scrutiny because the Indian Act does not provide clear directions. The British Crown (Canada) negotiated number treaties with many First Nation groups. Cardinal and

Hilderbrandt interviewed Elders from Saskatchewan for his book, *Treaty Elders from Saskatchewan,* and they emphasize that the medicine bundle was agreed throughout all numbered treaties but the text of Treaty Six is the only one that stipulates the medicine chest clause (Cardinal, Hilderbrandt, 2002). Loyer and Small Legs (2014) indicated Treaty Six includes a clause for a medicine chest to be held at the Indian agent's home and it offers emergency help, for example, during epidemics. Loyer and Small Legs (2014) state these clauses have been interpreted in various ways, particularly around the extent of health care. However, the Supreme Court reaffirmed that the terms of treaties are not limited to the text in the treaty, but rather include the actual agreements between the parties (Loyer, Small Legs, 2014).

Indigenous Elders have indicated that the Federal Government has a legal responsibility to honor the treaties (Cardinal, Hilderbrandt, 2002, pg.25). Unfortunately, the Indian Act appears to supersede the treaties because the act regulates how health services are rendered to status First Nations with little regard to treaty obligations. For example, the First Nations Non-Insured Health Benefit (FNIHB) policy is derived from the Indian Act. FNIHB program is limited to the type of supports offered like Indigenous spirituality during end-of-life care. The program provides services for medical coverage, travel, meals, accommodations, medical equipment, and other medical needs. The Federal Government recognized they have a responsibility under the Indian Act to provide healthcare services to Indigenous groups, but Métis and non-status First Nations are exempt from FNIHB program. In 1962 numerous field services merged with the Indian Health and Northern Health Services. FNIHB continue to evolve from the "Indian Health Policy" because of the unique affiliation between the status First Nations and the Federal Government of Canada (Loyer, Small Legs, 2014). The Federal Government constructed the Health Transfer policy in 1989 to determine health services provided to status First Nations and Inuit. The Health Transfer

Policy allowed First Nation groups to manage their own health services on reserves. The objective of the policy was to promote community-based health services (Loyer, Small Legs, 2014). The FNIHB specifies what services, supplies and equipment are included within FNIHB policy and which services are excluded. First Nations assert that health benefits are an inherent aboriginal and treaty right and are constitutionally protected (Government of Canada, 2020).

The 1984 Canada Health Act the Federal Government have a legal responsibility to provide services to all First Nations and Inuit people that involves "primary care and emergency services on remote and isolated reserves where provincial services are not available (Government of Canada, 2020). First Nations have argued that program delivery contains systemic racism and infringes on the constitutional rights of Indigenous people related to spiritual practices. Although both levels of government and Tribal councils are working together to integrate the delivery of these services (Government of Canada 2020). For example, the Canada Health Act allows the Federal Government the ability to provide financial support for Provincial governments and regional health services to provide palliative care for Indigenous groups off reserve. If located on reserve, the Federal government provides limited funding to community clinics to provide this support.

Browne (n.d.) identifies the social inequalities First Nations address daily in British Columbia like northwest Saskatchewan. First Nations experience many social inequalities like the lack of spiritual support in a marginalized society. Language barriers, foreignness of the health system, discrimination and power imbalances between health professionals and First Nations clients can affect the level of care First Nations people receive. Due to many hardships like financial burdens, dislocation of patient care, language barriers, and exposure to a different culture, First Nations patients and their loved ones can experience feelings of isolation (Browne, n.d.) First Nations may choose to not burden others with caring for their

needs nor speak up due fear of inadequate care or racism, this can affect the person seeking spiritual support.

The Government of Canada received royal assent by the senate on Marilyn Gladue private member's bill (Bill C-277), "Framework on Palliative Care in Canada Development and Implementation" because the Federal Government wanted to use assisted suicide as the last alternative if palliative care services could not be met. Nevertheless, this bill provides an opportunity to further explore the legal rights of Indigenous people to improve the delivery of palliative care.

Duty to consult is a long-standing issue for Aboriginal groups in Canada because legislation, policy and service delivery continues to infringe on the rights of Indigenous people. In 1990 the Sparrow case was the first Supreme Court case to address the Government's responsibility on the duty to consult with Aboriginal groups (Brideau, n.d.). The Tsilhoqot'in ruling in 2014 further supports the importance of the consultation process with First Nations.

The Truth and Reconciliation Commission (TRC) report originated from the abuses that Indigenous people endured during the residential school era. The TRC report had ninety-three recommendations addressing many areas affecting Indigenous people, including seven recommendations surrounding the health and well-being of Indigenous groups. The TRC report clearly states, "We call upon those who can effect change within the Canadian health-care system to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients" (Truth Reconciliation Commission Report, 2015, pg3). The TRC report is a great example of how this inquiry identified the need to change the current government system. It provides another avenue to address the spirituality and end-of-life care by implementing the recommendations to honor the reconciliation process.

UNDRIP is recognized by international countries including Canada to address Indigenous rights. Articles 21, 24, and 25 of the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) relate to Indigenous rights to healthcare acknowledged the importance Indigenous practices. Article 21 states Indigenous people have a right without discrimination to the improvement of their social conditions, including the area of health. Moreover, the state is obligated to "take effective measures and, where appropriate, special measures to ensure continuing improvement" of these conditions and that attention should be paid to the "special needs of indigenous elders" (UNDRIP 2018). Article 24 states "Indigenous have a right to their traditional medicines and a right to practice their traditional health practices without discrimination to health service" (UNDRIP 2018). Article 25 states "Indigenous people have the right to maintain and strengthen their distinctive spiritual relationships within their traditional territories for future generations" (UNDRIP 2018). These three articles clearly state traditional practices are inherent rights of Indigenous people and the different levels of Government have an obligation to ensure Indigenous people are not discriminated against within the health field.

5. Current Programs of the Saskatchewan Health Authority (SHA)

Within this section, I will provide a brief overview of services offered in northwestern Saskatchewan through Keewatin Yathe Regional Health and compare to other palliative care providers in southern Saskatchewan. This comparison analysis will address the different types of services available and how jurisdictional issues and policy development affect the quality of care for Indigenous people depending where the person resides.

5.1 Home Care

Home care services are provided through the provincial healthcare system in Saskatchewan. In Saskatchewan, the home care program is available to patients who choose to remain at home. This home care program delivers limited support for palliative patients such as completing home visits to provide support, completing errands, grocery shopping and cleaning the patient's home. Home care workers do not provide spiritual services. Family members are the primary care providers and provide the financial, emotional, mental, physical, and spiritual support to their loved one.

In northwest Saskatchewan, Keewatin Yathe Regional Health home care services are provided in Métis communities not in First Nations communities. KYRH provides home care services to families who choose to remain at home with a terminal illness or require elder care. The home care program is provided by locally employed community members by the health region who resided in local communities.

5.2 Hospice Care in Keewatin Yathe Regional Health (KYRH)

Hospice care resources are not available in northwest Saskatchewan. Hospice care can be beneficial to decrease anxiety on families caring for a terminally ill family member and an opportunity to develop traditional programming for First Nation patients Unfortunately, northwest Saskatchewan does not have hospice facilities. Like many other health care services people who require such care must relocate to another community away from family and friends.

In northwest Saskatchewan, Keewatin Yatthe Regional Health provides health services to Indigenous people (Dene, Cree, and Métis). In February of 2017, the provincial government announced the amalgamation of all the regions to be more cost efficient and provide consistent approach to health delivery. This region have two health facilities in northwest Saskatchewan, in La Loche and Ile-a-la-Crosse, both provide regional long-term care services. KYRH states the region utilizes the medicine wheel concept in their principal

statement but spiritual services are not immediate to the patient or family members receiving palliative care. The patient and family cannot access a spiritual room, sweat lodge, church, traditional healers, Elders or spiritual items to practice their way of life because the location of the spiritual room is not within proximity of the patient care.

St Joseph's hospital does not have a palliative care unit. If a patient requires palliative care at St. Joseph's Hospital, the person is placed in a private room near the end of the hall. Although the health center provides long-term care for elderly patients who require medical support, the palliative care is handled separately. The private room is utilized for palliative care consisting of a hospital bed, television, private washroom, and a sitting area for family members. This area is located down from the nurses' station. The room is large enough for a patient and eight people in sitting positions. The compact room is too small to accommodate larger groups of family members that come to visit. For example, when my family gathered with my stepson, the room could not accommodate the large group of people and we filtered out into the hallway. We departed to the hall in silent prayer, or used the sitting area provided. I had to leave the building to smudge in prayer within my vehicle because the hospital policy states that smudging ceremonies are conducted on the second floor. This ventilated spiritual room is not within proximity of the patient and not accessible in the evenings. If the family wanted to recite the rosary, everyone could not come into the patients' room but trickled into the hallway. For families, this type of practice is inappropriate for patient care and family support.

The La Loche hospital does not have palliative care unit but a long-term care program that provides services to patients within the community including elder care. Like St. Joseph's Hospital, the patient and families have limited space to gather in the patient room to support their loved one and the hospital is unequipped to host large gatherings of family

members. The hospital has a spiritual room where they can smudge but not in proximity of the patient which makes it difficult for the patient to participate.

5.3 Saskatoon Health Region

The Saskatoon Health region located in southern Saskatchewan provides a wide range of medical supports to all residents of Saskatchewan. In 2016, the Saskatchewan Heath Region implemented policy directing health facilities to accommodate smudging ceremonies in ventilated areas (Saskatchewan Health Region 2016). Unlike, KYRH, Saskatoon facilities are better equipped to meet the needs of palliative patients. Unlike the two hospitals in northwest Saskatchewan, palliative services are provided in a hospital setting at the St Paul's Hospital in Saskatoon.

First Nations and Métis volunteers provide culturally appropriate services at the three hospitals in Saskatoon. The First Nation and Métis health services uses an integrated approach with other health care professionals to provide care to Indigenous people. The First Nation and Métis Health services in Saskatoon provide Elders on site for families who are seeking direction and support to perform ceremonies or comfort. This type of Elder service is not available in northwest Saskatchewan.

St. Paul's Hospital is a public hospital located in Saskatoon. St. Paul's has an interdependent partnership with Saskatchewan Health Authority. According to literature provided by Saskatoon Health Authority, St. Paul's Hospital is the only hospital in Saskatoon that provides 12 beds located in the A wing of the hospital to care for palliative patients. St. Paul's hospital has a multifaith room located on the 5th floor of the hospital. The ventilated multifaith room can be utilized for Elders to perform ceremonies. Other religious faiths can utilize the room too (Gardiner, .2007). St. Paul's Hospital further provides a chapel, a First Nations spiritual/ sanctuary ceremonial room and other quiet rooms for families to reflect and find refuge in prayer.

University Hospital provides health care for families from northern communities. The University Hospital does not have designated beds for palliative care according to the Saskatoon Health Region. There is a multifaith room located on the fourth floor in the University hospital for families who choose to practice traditional ceremonies which is inadequate for patients who are bedridden and cannot make the trip for the ceremonies. The Saskatoon City Hospital does not have palliative beds but offer a multifaith room for families in need of spiritual or religious comfort. The City hospital offer smudging ceremonies in the multifaith room by the Elder. The sacred space may also be used for private smudging upon request (Saskatoon Health Region, 2017). In rural settings in southern Saskatchewan palliative care is available.

6. Analysis

6.1 Potential reasons for the lack of service

According to the study complete by Bourassa et al. (2016), health caregivers did not know what First Nations people required when faced with end-of-life care. Many hospital personnel did not understand the importance the historical factors affecting Indigenous people, their traditional background, and their connection to the Creator. The Indigenous beliefs and values are different to mainstream society, they believe "the heart and spirit were the most important factors during end of life care; comfort for the heart; and spirit took precedence at the person's end of life (Hampton et al 2010)." For the dominant society, this concept maybe difficult to understand. Indigenous spirituality is a practice that Indigenous people take very seriously throughout their life especially when faced with end-of-life decisions and joining the spirit world. Protecting the spirit is important to Indigenous people during preparation into the spirit world. Many Indigenous people will not talk about the illness but concentrate on the person. Indigenous ceremonies and the meanings of sacred items is difficult to understand unless you have personally experienced the beauty of

connecting with mother earth and the Creator through Indigenous practice. “Healthcare professionals rely on knowledge learned from medical textbooks and hospital care policies. Traditional knowledge is not taught in textbooks but passed down from generations and not recognized within western teachings (Bourassa et al., 2017).”

According to Bourassa et al’s, previous research shows that cultural barriers can discourage ethnic minority patients from using services based on a palliative care philosophy. Bourassa et al. argue that health care professionals have an obligation to respect the different beliefs of Indigenous people and their ceremonial practices. “It is important to respect whatever the person and family believe and find comforting. Sometimes the person and other family members do not have the same spiritual or religious beliefs like other health professionals (Bourassa et al., 2016).”

7. Potential Solutions

7.1 End-of-Life Spiritual Care in Hospitals Through Political Advocacy

The Federal and Provincial governments along with Indigenous leaders need to work in partnership to address the health service delivery for Indigenous patients especially in relation to spirituality and end-of-life care. Aboriginal people in Canada receive healthcare through a system of services provided by the federal and provincial or territorial governments, as well as Aboriginal organizations that continues to promote systemic racism. This complicated system is based on a mix of jurisdictional concerns, legal interpretations, policies, and established practices. (Minore, Katt, 2007) that fail to meet the needs of Indigenous people in northwest Saskatchewan.

The Assembly of First Nations (AFN) represents the First Nation groups in Canada to ensure there is equality and self-determination. The AFN has a role advocating on behalf of

the First Nation people to ensure they receive adequate healthcare and programming. The Federation of Sovereign Indigenous Nations (FSIN) represents 74 First Nation communities in Saskatchewan to advocate for the inherit and treaty rights of First Nations people. FSIN relies on the numbered treaties to ensure the medicine bundle is protected and followed as agreed by Indigenous forefathers. Meadow Lake Tribal Council (MLTC) represents nine First Nations in central and northwest Saskatchewan. MLTC currently provides health services in partnership with the Provincial and Federal Government. The Metis Nation represents the all the Metis people in northwest Saskatchewan. Currently the Federal Government provides the funding necessary to promote the delivery of services adhering to the current Federal policies. The AFN, FSIN, MLTC, Metis Nation and First Nation leaders need to work with the local communities addressing spiritual services and palliative care in hospitals or communities.

MLTC should advocate for services for First Nations people in northwest Saskatchewan because of the current health agreements in place with the Federal and Provincial Governments. The agreements allow for MLTC to deliver health care services within the nine First Nation communities. Currently, many clinics have limited space to develop palliative care units resulting in limited end of life care within a patient's home. For this reason, reconciliation can mean taking a proactive approach to improve end of life care and create ceremonial rooms within proximity of the patient.

Currently, Saskatchewan Health Authority has many gaps in providing palliative services throughout Saskatchewan. Palliative services are provided in many southern urban settings, but this service is lacking in northwest Saskatchewan. Many First Nations in northwest Saskatchewan do not have knowledge of available services due to the geographical area, and lack of communication of available services. It is important Indigenous people in northwest Saskatchewan are made aware of services in urban settings to offer options for end of life care. Utilizing FSIN to advocate and provide education awareness to the Provincial

and Federal governments will assist in narrowing the gap of understanding cultural practices during end of life care.

Caregiver should be educated about the importance of spiritual services during end of life care because Indigenous people in the northwest area practice both Christianity and traditional ceremonies. Providing education and cultural competency training for health professionals will allow for a better understanding of spiritual services for indigenous people because many indigenous people are returning to their traditional way of life. This approach is the beginning to understanding the importance of how Indigenous people deal with spirituality, end of life care, grief and loss.

Continued palliative care research is imminent to advocate for improved health support in northwest Saskatchewan and resolve the current inequalities. The AFN can use their position to review current health programs for First Nations communities within Canada and advocate at a national level to develop sustainable services. Sullivan, K., and Associates (2003) wrote an article on "National Indigenous Palliative Care Needs Study" that can provided a blueprint to assist with this research. This study was conducted out of Australia but provides a bases to address services related to First Nation culture and palliative care many Indigenous groups in Canada experience.

7.2 End-of-life Care at Home

An alternative to improving spiritual care in hospitals is to improve homecare and nursing services to avoid unnecessary hospital and emergency usage in northwest Saskatchewan. By improving home care, the geographically dispersed and culturally disparate Indigenous peoples within northwest Saskatchewan can provide end of care and practice their spirituality with family members. The Saskatoon Health Region and MLTC should provide qualified trained health professional to provided quality care at home.

7.3 Individual professional steps

Healthcare professionals require cultural awareness training to understand the importance of how racist attitudes affect First Nations spirituality during end-of-life care. Racism in healthcare continues to plague the care of First Nations whether you reside in northwest Saskatchewan or any other part of Canada. First Nations have an inherent right to practice their ceremonies without discrimination. By providing a cultural component to professional development, sensitivity training and knowledge of historical inequalities can alleviate the disparities of First Nations. Indigenous people are awfully familiar with feeling this disparity in hospital settings due to stereotyping by health staff.

Bedside etiquette from healthcare professionals should be improved to engage and develop empathic relationships with First Nations patients. Health care professionals should be aware of their own biases because it affects the level of care a First Nations person receives. Good listening skills and awareness of their non-verbal body language can address discrimination and stereotyping attitudes, for this reason it is imperative health professionals communicate openly to First Nations about their beliefs and traditions. Respectful bedside manners can create positive relationship building with the patient and allow the healthcare professional to develop a better understanding of the patient's beliefs, cultural preference, decision making, and manage care of the patient without discrimination. "The caring of health staff implicates the fundamental attitude towards patients, and the ability to convey kindness, compassion and respect. Yet, all too often, patients and families experience health care as impersonal, mechanical; and quickly discover that patient-hood trumps personhood (Chochinov, 2013)."

Indigenous people continue to struggle with lack of understanding of western approaches resulting in non-First Nations infringing their believes on First Nations people. First Nations need compassionate health staff who speak a First Nation language to communicate with health professionals. KYRH can implement, like identified in the

southern region of Saskatchewan, hiring Indigenous Elders and traditional healers to provide traditional counselling and ceremonies for Indigenous People. KYRH can provide access to a First Nations ceremonial areas for the patient and family members to perform ceremonies in prayer. KYRH can implement a First Nations Liaison worker to advocate for patient services and develop awareness of KYRH health programming for patients.

First Nations should feel free to seek knowledge from appropriate professionals and organize any spiritual support without judgement of their cultural background. Health professionals can work jointly with First Nations as a circle of care team focusing on the wellbeing of the patient in a respectful manner. Health professionals may not appreciate First Nations people. but they should behave respectfully towards First Nations people.

8. Conclusion

In the beginning of my thesis I indicated that I do not claim to be an expert in spirituality but to me, spirituality is the essence to life and death. Practicing and living spirituality honors the Creator by respecting all living things. Life and death are interchangeable and interconnected to the Creator. In northwest Saskatchewan, Indigenous groups practice Christianity or First Nations traditions. Some people will turn to Christianity for a church service, prayer or blessing for healing. While others will call upon Elders or traditional healer to perform cultural and traditional ceremonies to support the patient and family members.

Northwest Saskatchewan does have a multifaith room within their two hospitals, but unfortunately the services are inadequate to address spiritual ceremonies. First Nations do not have access to a large spiritual room, traditional Elders, or healers on staff. First Nations have faced marginalization and racism from healthcare professionals who are not trained or familiar with First Nations cultures. Although there are legislation policies in place to provide

services to Indigenous people free of discrimination, Indigenous people do not receive appropriate spiritual support and end of life care services.

Over the years the Supreme Court has dealt with many court cases in respect to Indigenous rights and the duty to consult. With the recent developments, the door to communication and partnership between Indigenous groups and the Federal Government are opportunities to create palliative services respecting traditional practices. The Framework on Palliative Care in Canada is an opportunity for Indigenous groups to address end-of-life care and improve the spiritual services. The Truth and Reconciliation Commission report calls upon all levels of Government to acknowledge "the current state of Aboriginal health in Canada and the direct result of previous Canadian government policies. The TRC recognizes the impacts of healthcare, rights of Aboriginal people as identified in international law, constitutional law, and Treaties (Truth Reconciliation Commission Report, 2015, pg2). The TRC report calls upon governments to collaborate with Indigenous groups when it comes to addressing spiritual ceremonies within health. The United Nations have encouraged the Federal Government of Canada to adopt the United Nations Declaration Rights of Indigenous people to ensure Indigenous people are treated with fairness, respect, and equality. There are "well-documented disparities in aboriginal and non-aboriginal health rooted in colonial government policies, such as segregation and Indian residential schools (McCue, 2015)" that support an overhaul of healthcare such as palliative care.

Essential changes have occurred in policies guiding and structuring the delivery of health care for Indigenous people. The momentum to address health care has escalated over the past decade as the principle that Indigenous people must develop, plan, manage and control their own health services. Indigenous people should be the decision-makers. It is now generally recognized that First Nations, Métis, and Inuit people have unique knowledge that can make the services offered more culturally appropriate (Minore, Katt, 200, pg. 9-11).

Restructuring end-of-life care and reviewing current services on spirituality for the patient and family is a start to acknowledging the reconciliation process and the inherent rights of First Nations.

Bibliography

Blackstock, C. (2012). Jordan's Principle: Canada's broken promise to First Nations children? *Paediatrics & Child Health*, 17(7), 368–370. Retrieved from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3448536/

Bourassa, C. Hampton, M. Baydala, A. Goodwill, K. McKenna, B. McKay-McNabb, K. Saul, G. Clarke, V. Christiansen, J. Jackson, M. Novik, N. Millman, C. (2016). Completing the Circle: End of Life Care with Aboriginal Families. Canadian Virtual Hospice. Retrieved from http://www.virtualhospice.ca/en_US/Main+Site+Navigation/Home/For+Professionals/For+Professionals/The+Exchange/Current/Completing+the+Circle_++End+of+Life+Care+with+Aboriginal+Families.aspx

Brideau, I. (n.d.) The Duty to Consult Indigenous Peoples. Legal and Social Affairs Division. Library of Parliament. Retrieved from: https://lop.parl.ca/sites/PublicWebsite/default/en_CA/ResearchPublications/201917E

Brown, A (n.d.) Issues Affecting Access to Health Services in Northern, Rural and Remote Regions of Canada. Retrieved from: https://www.unbc.ca/sites/default/files/sections/northern-studies/issuesaffectingaccesstohealthservicesinnorthern.pdf

Canadian Hospice Palliative Care Association (2014). CHPCA Fact Sheet- Hospice Palliative Care in Canada (pg1-15) Retrieved from http://www.chpca.net/media/330558/Fact_Sheet_HPC_in_Canada%20Spring%202014%20Final.pdf

Cardinal, H. and Hilderbrandt, W. (2002). *Treaty Elders of Saskatchewan. Our Dream is That Our Peoples Will One Day Be Clearly Recognized as Nations*, Publisher?

Chochinov, M. (2013) Dignity in Care: Time to take Action. *Journal of Pain and Management*. Retrieved from: https://www.jpsmjournal.com/article/S0885-3924(13)00452-1/pdf

Department of Justice Canada (2013). The Constitution Acts 1867 to 1982. (pg56) Retrieved from: http://www.laws-lois.justice.gc.ca/PDF/CONST_E.pdf

Derzko, M. (2014). Physicians lead the conversation on end-of-life care. Saskatchewan Medical Association. Retrieved from: http://www.sma.sk.ca/inner/49/physicians-lead-the-conversation-on-end-of-life-care.html

Government of Alberta (2016) Chinook Regional Hospital Expansion provides greater health care delivery to southern Alberta. Retrieved from: https://www.alberta.ca/release.cfm?xID=42976F1BB5ECF-9075-B41F-8E94BA830DF5BF9F

Government of Canada. (2012) Canada's Health Care System. Retrieved from: https://www.canada.ca/en/health-canada/services/health-care-system/reports-publications/health-care-system/canada.html#a3

Government of Canada (2018) EI compassionate care benefit – Overview. Retrieved from: https://www.canada.ca/en/services/benefits/ei/ei-compassionate.html

Government of Canada (2019) Framework on Palliative Care in Canada. Retrieved from: https://www.canada.ca/en/health-canada/services/health-care-system/reports-publications/palliative-care/framework-palliative-care-canada.html#p.1.4.3

Government of Canada (2017) House of Commons of Canada. Bill C-277: An Act providing for the development of a framework on palliative care in Canada. Retrieved from: http://www.parl.ca/DocumentViewer/en/42-1/bill/C-277/third-reading

Government of Canada (20180. Medical Assistance in Dying. Retrieved from: https://www.canada.ca/en/health-canada/services/medical-assistance-dying.html#a2

Government of Canada (2017) Canadian Institute of Health Research. Community-Based Primary Health Care: Research profiles. Retrieved from; http://www.cihr-irsc.gc.ca/e/50370.html

Government of Canada (2017) Constitution Acts, 1867 to 1982. Part II Rights of the Aboriginal Peoples of Canada. Justice Laws Website. Retrieved from: http://laws-lois.justice.gc.ca/eng/Const/page-16.html#h-52

Government of Canada (2020) Non-insured health benefits for First Nations and Inuit. Retrieved from: https://www.canada.ca/en/health-canada/services/non-insured-health-benefits-first-nations-inuit.html?_ga=2.186575406.64469216.1511630516-1007089515.1511630516

Government of Canada (2015) Public Health Agency of Canada. Chronic Disease Risk Factors. Retrieved from: https://www.canada.ca/en/public-health/services/chronic-diseases.html

Government of Canada (2005) Ten Years of Health Transfer First Nation and Inuit Control. Retrieved from: https://www.canada.ca/en/indigenous-services-canada/services/first-nations-inuit-health/reports-publications/funding/years-health-transfer-first-nation-inuit-control-health-canada-1999.html#transfer_of

Government of Ontario Newsroom. (2016). Ontario Launches $222 Million First Nations Health Action Plan Province Supporting Indigenous Health Care. Retrieved from: https://news.ontario.ca/mohltc/en/2016/05/ontario-launches-222-million-first-nations-health-action-plan.html

Government of Saskatchewan (2016). Home Care Policy Manual Retrieved from: http://publications.gov.sk.ca/documents/13/29232Home%20Care%20Policy%20Manual%202016.pdf

Government of Saskatchewan (2016). Individualized Funding for Home Care Retrieved from: https://www.saskatchewan.ca/residents/health/accessing-health-care-services/care-at-home-and-outside-the-hospital/individualized-funding-for-home-care#step-2

Haynes, A. Hilbers, J. Kivikko, J. Ratnavuyha, D. (2007). Multicultural Health Unit. Spirituality and Religion in Health Care Practice. A person-centred resource for staff at the Prince of Wales Hospital. South Eastern Sydney Illawarra Retrieved from: https://www.rch.org.au/uploadedFiles/Main/Content/cultural_services/Spirituality_Staff_Resource.pdf

Health Canada (2012). *Your Health Benefits: A Guide for First Nations to Access Non-insured Health Benefits.* Retrieved from: http://publications.gc.ca/collections/collection_2012/sc-hc/H34-230-1-2011-eng.pdf

Hildebrante, A. (2014) Supreme Court's Tsilhoqot'in First Nation ruling a game-changer for all. CBC News. Retrieved from: http://www.cbc.ca/news/indigenous/supreme-court-s-tsilhqot-in-first-nation-ruling-a-game-changer-for-all-1.2689140

Hilbers Julianne, Haynes Abby S., Kivikko Jennifer G. (2010) Spirituality and health: an exploratory study of hospital patients' perspectives. Australian Health Review 34, 3-10. Retrieved from: https://doi.org/10.1071/AH09655

Horst, G. (2017) Information and Support on Palliative and end of life care, loss, and grief. Spiritual and Life Limiting Illnesses. Canadian Virtual Hospice. Retrieved from http://virtualhospice.ca/en_US/Main+Site+Navigation/Home/Support/Support/Meet+the+Team/CVH+Team+Members+/Ask+a+Professional+Team/Glen+R_+Horst+MDiv_+DMin_+BA.aspx

Indigenous and Northern Affairs Canada. (2013) *The Numbered Treaties (1871-1921.* Retrieved from: https://www.aadncaandc.gc.ca/eng/1360948213124/1360948312708

Joseph, B. (2013) Working Effectively with Indigenous People. Indigenous Corporate Training. Retrieved from: https://www.ictinc.ca/the-potlatch-ban-abolishment-of-first-nations-ceremonies

Justice Law (2017) Indian Act R.S.C., 1985, c. I-5. Regulations: Section 73 (1) Justice Law Website. Retrieved from: http://laws-lois.justice.gc.ca/eng/acts/I-5/page-10.html#h-32

Kelly, L. (2009) Palliative care of First Nations people A qualitative study of bereaved family members. Retrieved from: file:///C:/Users/Gail/Desktop/GENI%20info/Palliative_care_of_First_Nations_people_a_qualitat.pdf

Loyer, J. and Small Legs, M. (2014) Non-insured Health Benefits for First Nations and Inuit People: An Overview or Information Providers. *JCHLA / JABSC* Vol. 35 Retrieved from: https://journals.library.ualberta.ca/jchla/index.php/jchla/article/viewFile/22390/16620

McCue, D. (2015) Racism against aboriginal people in health-care system 'pervasive': study Discrimination called a major factor in aboriginal health disparities. CBC News. Retrieved from: https://www.cbc.ca/news/indigenous/racism-against-aboriginal-people-in-health-care-system-pervasive-study-1.2942644

Minore, B. and Katt, M. (2007) Aboriginal Health Care in Northern Ontario Impacts of Self-Determination and Culture. Institute of Research on public policy. Retrieved from: http://irpp.org/wp-content/uploads/assets/research/aboriginal-quality-of-life/aboriginal-health-care-in-northern-ontario/vol13no6.pdf

Morellato, M. (2008). The Crown's Constitutional Duty to Consult and Accommodate Aboriginal and Treaty Rights. The National Centre for First Nations Governance. Retrieved from: http://fngovernance.org/resources_docs/Crown_Duty_to_Consult__Accommodate.

Narine, S. (2017). Indigenous patients, families have cultural, spiritual needs met in hospital. *Wind Speaker*. Retrieved from: http://www.windspeaker.com/news/windspeaker-news/indigenous-patients-families-have-cultural-spiritual-needs-met-in-hospital/

National Hospice and Palliative Care Organization. (n.d.) Hospice. Retrieved from https://www.nhpco.org/about/hospice-care

Northern Education Centre for Aging and Health Kenora Chiefs Advisory Home and Community Care Pain & Symptom Management Team (2003). First Nations Caring for the Terminally ill honoring the choices of the People (Person/Family/Community) (pg10-140). Retrieved from http://cerah.lakeheadu.ca/uploads/Caring_for_the_Terminally_Ill.pdf

O'Donnell, V., Wendt, M., and the National Association of Friendship Centres (2017). Aboriginal seniors in population centres in Canada. Aboriginal Peoples Survey 2012. Retrieved from: https://www150.statcan.gc.ca/n1/en/pub/89-653-x/89-653-x2017013-eng.pdf?st=gngF-0U1

Ontario's Aboriginal Health Access Centres (2015). Ontario's Aboriginal Health Access Centres Report. Our Health, Our Seventh Generation, Our Future. Retrieved from: www.aohc.org/aboriginal-health-access-centres

Ontario Human Rights Commission. (n.d.) Indigenous Spiritual practices. Policy on Preventing Discrimination based on Creed. Retrieved from: http://www.ohrc.on.ca/en/policy-preventing-discrimination-based-creed/11-indigenous-spiritual-practices

Ontario Ministry of Health (2007) Long Term Care. Preventing and Managing Chronic Disease: Ontario's Framework. Retrieved from: (http://www.health.gov.on.ca/en/pro/programs/cdpm/pdf/framework_full.pdf)

Parliament of Canada (2017). House of Commons Canada, Bill C227. An Act providing for the development of a framework on palliative care in Canada. Retrieved from http://www.parl.ca/DocumentViewer/en/42-1/bill/C-277/third-reading

Saskatchewan Health Authority (2017) Palliative Care. Retrieved from: https://www.saskatoonhealthregion.ca/locationsservices/Services/Palliative-Care

Saskatchewan Health Authority (2019) Retrieved from: https://kyrha.ca/our-communities/

Saskatoon Health Region (2017) Spiritual and Cultural Care St. Paul's Hospital. Retrieved from: https://www.saskatoonhealthregion.ca/locations_services/Services/Palliative-Care

Saskatoon Health Region (2017) The First Nations and Métis Health Services. Retrieved from: https://www.saskatoonhealthregion.ca/locations_services/Services/fnmh/service/Pages/Resources.aspx

Saskatchewan Health Region. (2016) Facilitation of Smudging Ceremonies. Retrieved from: https://www.saskatoonhealthregion.ca/about/RWPolicies/7311-20-004.pdf

Saskatchewan Medical Association (2020) Palliative and End of Life Care. Retrieve from: https://www.sma.sk.ca/resources/59/palliative-and-end-of-life-care.html

Sullivan, K., Johnston, L., Colyer, C., Beale, J., Willis, J., Harrison. J, and Welsh, K (2003) *National Indigenous Palliative Care Needs Study.* The National Palliative Care Program. Retrieved from: http://ksaco.com.au/files/PC%20Needs%20Study.pdf

Tasker, J.P. (2017) Liberal government backs bill that demands full implementation of UN Indigenous rights declaration. CBC News. Retrieved from: http://www.cbc.ca/news/politics/wilson-raybould-backs-undrip-bill-1.4412037

The Chronicle Herald. (2017). Supreme court ruling 'big victory' for Métis, non-status aboriginal people. Retrieved from: http://thechronicleherald.ca/novascotia/1357017-supreme-court-ruling-big-victory-for-metis-non-status-aboriginal-people

The Truth and Reconciliation Commission of Canada. (2015) *Truth and Reconciliation*

Commission of Canada: Calls to Action. Retrieved from: http://www.trc.ca/websites/trcinstitution/File/2015/Findings/Calls_to_Action_English2.pdf

The United Nations. (2008). United Nations Declaration on the Rights of Indigenous People. Article 21, 24 and 25. Retrieved from: http://www.un.org/esa/socdev/unpfii/documents/DRIPS_en.pdf

The World Population Review (2019). Saskatchewan Population 2019. Retrieved from: http://worldpopulationreview.com/canadian-provinces/saskatchewan-population/

Walter, T. (2002). Spirituality in palliative care: opportunity or burden? Palliative Medicine, 16(2), 133–139. Retrieve from: https://doi.org/10.1191/0269216302pm516oa

Wheatley, V. Baker, J. (2007). "Please I want to go home": ethical issues raised when considering choice of place of care in palliative care. *Palliative Care.* (pg643-647) Retrieved from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2600129/

Yukon Health and Social Services (2015). Yukon Palliative Framework (pg1-11). Retrieved from; http://www.hss.gov.yk.ca/pdf/palliativecareframework.pdf