Medevac and Beyond: The Impact of Medical Travel on Nunavut Residents

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ABSTRACT

This qualitative study identifies key factors that contribute to negative psychosocial outcomes for Inuit patients using the Iqaluit, Nunavut, medevac (used for emergency transfers) and medical transfer (for non-emergency cases) programs. The study also reports on the existence and appropriateness of social and cultural supports in hospitals and communities for medically transferred patients and their families. I analyzed results from a literature review, document analysis, and 20 in-depth, semi-structured interviews with health care professionals and policy and decision makers in Iqaluit and Ottawa, Ontario. Respondents were either directly involved in medevac and medical transfer programs or were health professionals who work with those using the services. In addition, variables impacting patient speed of recovery and overall mental health were considered, including isolation, social support, and emotional stress. Findings revealed that Inuit patients do experience a lack of social supports such as escorts and translators on medical trips south. They also often encounter a lack of cultural sensitivity once in the south, and suffer from homesickness and isolation. This study demonstrates that the current medical transfer system in Nunavut does not fully meet the psychosocial needs of Inuit patients and their families, which has direct effects on patients' mental health and on medical outcomes of treatment in the south.

KEYWORDS

Inuit, medevac, medical transfer, isolation, psychosocial, Nunavut

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ᐅᓇ ᖃᐅᔨᓴᕐᓂᐅᓯᒪᔪᖅ ᐃᓚᓴᖅᓯᕗᖅ ᐱᓗᖅᑯᑕᐅᔪᓂᒃ ᑐᓂᕐᕈᑎᖃᖅᑐᓂᒃ ᐃᓅᓯᕐᒧᑦ ᐃᓯᒪᒃᑯᓪᓗ ᐃᓄᓐᓄᑦ ᐋᓐᓂᐊᕕᓕᐊᖅᐸᑦᑐᓄᑦ ᐊᑲᐃᓪᓕᐅᕈᑎᓂᒃ ᐊᖅᑯᑎᒥᓪᓗᒥᑦ ᐃᖃᓗᐃᑦ, ᓄᓇᕗᑦ ᑐᐊᕕᕐᓇᑐᒃᑯ ᐊᒻᒪᓗ ᐃᖕᒥᕐᖁᓂᒃᑯᑦ (ᑐᐊᕕᕐᓇᖕᒥᑦᑐᑯᓪᓗ ᐊᖅᑯᑕᐅᕙᑦᑐᒃᑯᑦ). ᖃᐅᔨᓴᐅᑎ ᐅᓂᒃᑲᐅᓯᖃᓇᕗᖅ ᐅᓪᓗᒥ ᐋᓐᓂᐊᕕᓐᓂ ᓄᓇᓕᓐᓂᓗ ᐊᑐᐃᓐᓇᐅᒪᔪᓂᒃ ᐊᒻᒪᓗ ᐊᑲᕐᓇᔾᔪᑕᐅᔪᓂᒃ ᐃᓅᖃᑎᒦᓐᓂᒃᑯᑦ ᐊᒻᒪᓗ ᐃᓚᖅᑯᓯᒃᑯᑦ ᐋᓐᓂᐊᕕᓕᐊᖅᓯᒪᔪᓄᑦ ᐃᓚᖕᒥᓐᓄᓪᓗ ᐃᑲᔪᖅᑐᐃᔾᔪᑕᐅᔪᓂᒃ. ᕿᒥᕐᕿᓚᐅᓇᕗᖓ ᖃᐅᔨᓴᐅᑎᒥᓂᕐᓂᒃ ᐅᖃᓕᒫᒐᓕᐊᖑᓯᒪᔪᓂᒃ, ᐅᓂᒃᑳᓪᓗ ᕿᒥᕐᕿᔭᐅᓯᒪᔪᑦ ᐊᑉᐱᑦ ᓈᔭᖅᑕᐅᓯᒪᑦᑎᐊᖅᑐᑎᒃ, ᐊᐱᖅᑯᑎᓪᓗ ᐃᓚᖓᒍᑦ ᑎᑎᕋᖅᑕᐅᓯᒪᓪᓗᑎᒃ ᐋᓐᓂᐊᖅᑐᓕᕆᔨᒃᑯᑦ ᐃᖅᑲᓇᐃᔭᖅᑎᖏᓐᓄᑦ ᐊᒻᒪᓗ ᐊᑐᐊᒐᓕᐅᖅᑎᓄᑦ ᐃᓱᒪᓕᐅᖅᑎᓄᓪᓗ ᐃᖃᓗᓐᓂ

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ᐃᓄᐃᑦ, ᑐᐊᕕᕐᓇᑐᒃᑯᑦ, ᐋᓂᐊᖅᑐᓕᕆᓂᒃᑯᑦ ᐊᐅᓪᓚᖅᑎᑕᐅᓂᖅ, ᐃᓅᑦᑐᐅᑎᓂᖅ, ᐃᓱᒪᒃᑯᑦ ᐃᓄᓕᕆᓂᒃᑯᓪᓗ ᐊᑐᐃᔾᔪᑎᑦ, ᓄᓇᕗᑦ

INTRODUCTION

In Nunavut, 58% of patients needing inpatient and outpatient hospital care are transported outside of the territory (Canadian Institute for Health Information, 2010) through medical travel in the form of "medevac" or "medical transfer." Medevac and medical transfer refer to transferring patients by air for medical treatment. While medevac refers to emergency evacuations, medical transfer denotes the practice of transporting patients on a commercial airline. In this study, I use both terms when data is specific to one program while in some cases I use the collective term "medical transfer" to characterize both programs. The medevac program is essential to the medical model of health care for very ill or high-risk Nunavut residents, or those who need complex care. Medical transfers provide patients with non-emergency transportation, such as for CT or MRI scans, to southern hospitals (Nunavut Department of Health and Social Services, 2010b).

In Iqaluit, Nunavut, patients needing critical medical treatment—such as major surgeries, complex obstetrical care, and treatment for kidney failure—are transferred to Ottawa, Ontario. In other cases, patients must extend their stay in the south for rehabilitative care after critical health incidents, such as strokes or heart attacks. Generally, patients are required to stay in Ottawa for periods ranging from a week to three months, though they may be transferred to a southern Canadian hospital for ongoing procedures such as cancer treatment or dialysis. This costly medical travel program for patients and escorts consumes 40% of Nunavut's health budget (Nunatsiaq News, 2011). However, to date there has been no evaluation of the impact of medical transfer on Inuit psychosocial health or medical outcomes in Nunavut.

This qualitative study asked for input from health care professionals and policy and decision-makers (20 participants in total) in Ottawa and Iqaluit about the various levels of social and emotional impact that a medevac or medical transfer has on patients, including their medical recovery rates. A secondary goal was to determine the existence and appropriateness of social and cultural supports in hospitals and communities for medically transferred patients and their families. For the purpose of confidentiality, all study participants have been given pseudonyms.

METHODS

Research for this study moved through four phases. It began with a review of scholarly and grey literature on the topics of medical transfer and patient isolation in Nunavut. The Nunavut Research Institute (NRI) provided a scientific research license, allowing access to grey literature through the Arctic College Library. The next step was a review of Nunavut government policies on health care, looking at whether these policies address the issues of isolation, social support, and emotional stress and, if so, to what extent and by which governmental jurisdictions. The Nunavut governmental library was the source for official documents regarding the health care system, including the financial records for medevacs. Information given to Nunavut residents travelling south for medical care also was reviewed. I then began field research in the northern community of Iqaluit. It included consulting with local social service agencies, researching local media accounts, and completing archival research. I also reviewed newspaper records and governmental pamphlets regarding health care policy and prevention programs and applied them to this research. Finally, I conducted in-depth, semi-structured interviews with 20 key informants/respondents in the health care field, including medical and administrative staff at the Qikiqtani General Hospital in Iqaluit and the Ottawa Hospital, other health care workers in Iqaluit, an employee of the Government of Nunavut, and representatives from Inuit organizations in Ottawa. Participants were recruited via word-of-mouth at relevant organizations.

Of the 25 individuals approached, 20 consented to an interview. The remaining five either declined participation or did not respond to the invitation, despite follow-up. Eleven interviews were conducted in Iqaluit and nine were held in Ottawa. There were two sets of interview questions: the first specifically for individuals involved in the logistics of the medical transfer program, and the second for health care professionals who deal with issues of social isolation. The latter were chosen because of their work with patients who have used the system. The interviews took an average of one hour to complete, with some taking as little as 30 minutes and others up to an hour and a half. In order to accommodate respondents' availability, interviews were spread over a two-month period. Of the 20 interviews, 17 were conducted face-to-face, two via telephone, and one via e-mail. To ensure confidentiality, each respondent was assigned a coded number replaced by a pseudonym in this report. Some respondents expressed an interest in receiving a copy of the study, which I provided once the study was finalized. Based on the NRI licensing agreement, respondents also received a copy of the final draft and an executive summary that was translated into Inuktitut. Lastly, the findings were brought back to the community through an interview on CBC North radio in August of 2011.

Data from the interviews led to a universal "composite description" (Creswell, 2007) of what patients experienced and how they experienced it (Moustakas, 1994). Semi-structured interviews have the dual advantage of allowing for conversational fluidity while simultaneously establishing consistency across several interviews. They involve a fixed set of questions, but the researcher may also pose new questions as issues arise during the interview (Guion, Diehl, & McDonald, 2011). I sought to clarify participant comments as needed to gain the most comprehensive understanding of the intended meaning (Glesne, 2010).

A third party transcribed all interviews and coded them for common themes or patterns based on the participants' perceptions and responses. The Coding Manual for Qualitative Researchers (Saldaña, 2009) was used to aggregate, sort, and interpret data. Three primary thematic categories emerged: challenges surrounding medical escort policies, a lack of cultural competency in primary treatment facilities, and a lack of social supports and resources for Inuit patients. These categories were then used to explain possible reasons for negative psychosocial outcomes among Inuit transported south for medical treatment.

RESULTS

The following summarizes the answers to specific questions posed to health care professionals and other respondents during interviews. Not all respondents provided full answers to all questions as some questions fell outside their area of expertise. Some data have not been collected, including information about the nature of injuries (e.g., motor vehicle accidents, slips and falls, etc.) and whether there were external factors such as drug or alcohol abuse. Because of this, there is no quantitative data provided in the results. Future research is needed to correlate these external factors with the use of medevac and medical transfers.

Respondents confirmed there were 247 medevac transfers in the 12-month period from April 2009 to March 2010. The total percentage of Qikiqtani patients requiring medevac services was unknown. Twenty-six percent of all cases (64 transfers) involved pediatric patients, and 6% (15 transfers) were obstetrical in nature.

The proportion of surgical, palliative, and other medical specialties was unknown to the respondents. Patients stayed an average of 12 days in Ottawa, with an average inpatient stay of 7.17 days, as indicated by one respondent. In most cases, patients do not require hospitalization upon their return to Nunavut, with the exception of those needing in-hospital palliative care. When asked whether some patients required repeat visits, participants responded that this depended on the type of care received. For example, three respondents noted that follow-up care could be required for cardiac and cancer patients. Respondents knew of no available data pertaining to the psychosocial impact of medical transfer on patients and their families, or responded that none existed. "Stella" added: "The government is more interested in their physical condition [than psychosocial] and not interested in the rest, and this is a real gap in the system."

It should be noted that all of the respondents felt that the medevac/medical transfer service itself was highly respected for the quality of care provided—for speed, efficiency and reliability, and the professionalism of the health care staff. Stella noted, "[The Government of] Nunavut is better than other territories in bringing more escorts down for support. NTI [Nunavut Tunngavik Incorporated] may help transfer people, but they do not pay for housing or food, leaving family members struggling for lack of resources. [The Government of] Nunavut does a better job, but it's still tough." As expected, the service is subject to adverse weather conditions and other delays.

When asked whether they had concerns associated with the medical transfer program, almost all (19 of 20) participants brought up issues related to non-medical escort policies, flight logistics, or patients' and/or escorts' social-emotional issues. The analysis of the interviews revealed three broad categories of concerns: 1) personal support for medically transferred patients, 2) cultural competency of medical staff, and 3) availability of community supports for medically transferred Inuit patients.

In terms of personal supports, the two that participants repeatedly mentioned were escorts and interpreters. In certain cases, patients can have a family member accompany them, provided they meet the escort criteria that fall under Nunavut's Health and Social Services Extended Health Benefits Policy. The medical escort (such as a doctor or nurse) or a non-medical escort (an adult accompanying a patient requiring assistance) must be deemed necessary by the referring medical practitioner (Nunavut Department of Health and Social Services, 2010a). The medical escort's duties are limited to providing care while the patient is travelling.

Questions regarding escort policies seemed to frustrate and even anger participants. One interviewee expressed irritation with the inconsistencies regarding the provision of escorts, sharing that some elderly and unilingual individuals go alone, while others who could easily manage without escorts are given one. Other respondents pointed out the difficulty of finding a last-minute escort in cases of sudden illnesses, adding to patient stress. Some interviewees talked about the financial or emotional burden placed on non-medical escorts. "Pam" stated: "For the family/escort there is the added stress of leaving home and the problems that may occur when they are away. For example, who will look after the needs of their children/own family? How will they manage financially if they are not working?" These concerns point to the problematic interruption of social assistance benefits for individuals needing to leave Nunavut. In addition, when the escort is a family provider, time away means having to budget in advance for this possibility, adding further stress. "Julie" elaborated, "For the social worker [working with these individuals] there is no way to get [social assistance funding] for them while they are staying here." Other stresses for the escort may be emotional: worrying about family members and, in particular, children. A number of respondents pointed out that the escorts were worried about the risk of physical and sexual abuse, risk of violence, and food insecurity while they are gone.

Just as escorts are important to the well-being of patients, interviewees also pointed to the necessity and value of interpreters to the program. Respondents identified the Ottawa Health Services Network Inc. (OHSNI) as an organization that helps facilitate patients' transfer and stay in southern hospitals. However, even with this resource, interpreters are often spread too thin and may only be available at the time of admission for the initial assessment and then at the time of discharge. There is no day-to-day translation for patients unless a family member with a better understanding of English is present, as was indicated by three respondents. As a result, patients feel marginalized. Without enough English knowledge, patients are unlikely to be accepted for rehabilitation programs, resulting in either their placement in long-term care—where isolation and lack of language support are again major problems—or their transfer back north, without receiving much needed rehabilitation.

The second primary area of concern was related to cultural competency or sensitivity. Respondents uniformly confirmed that traditional healing methods went unrecognized in southern patient care and pointed to the cultural gap between Inuit and the hospital medical culture in Ottawa. Some patients find it difficult or are upset to hear criticism about the medical care they received in Nunavut prior to medical transfer. Cultural differences have led to problems of adherence both in Iqaluit and in Ottawa. "Grace" pointed out that these patients are poor, come from small communities, and have little formal education, making it exceedingly difficult for them to understand and follow medical care information and directions once back home: "[Given the] poverty, abuse—lots of issues—what we are seeing is non- [adherence] or caregivers that have no clue of how to take care of [these individuals]. Patients maybe not being able to verbalize their needs. . . embarrassed or afraid of what consequences might be." Even patients with some English-speaking ability may be unable to understand what medical personnel say, and patients are often shy and do not want to ask questions, leaving them uninformed about their medical condition and unable to provide informed consent.

According to a few respondents, lack of cultural sensitivity demonstrated by staff can also be a barrier. "Meaghan" said, "In my experience [the south] is a scary place to be in, and [patients] suffer a big cultural shock. Using terms like 'social work' can cause feelings of guilt and embarrassment. For my Inuk mom at the Ottawa Hospital, everyone was talking too loudly and it was not culturally appropriate." In the hospital setting, this can lead to awkward misunderstandings. "Dina" said, "Very often the doctor will say, "go home; we will see you next week." The patient thinks that home is in the north, when the doctor means go back to Larga Home [a boarding house for patients and families], and not north." Grace observed that Inuit attach a different meaning to some common English phrases. For example, "I'm sorry," in the context of giving bad news in the hospital, is understood by Inuit as, "I'm responsible or it's my fault." Therefore, telling family about the death of a loved one can be seen as accepting blame rather than offering simple condolences. Cultural sensitivity also extends to the choice of interpreters. It is not culturally appropriate, for example, to match an elderly male Inuk with a young female interpreter.

Cultural divides not only affect Inuit patients' understanding of the medical staff, but medical staff may also find Inuit forms of communication confusing. For example, lack of facial expression or emotion is normal among Inuit, but this may be misunderstood as the patient being "not all there," said Stella, resulting in a very literal and task-oriented approach to the patient. Medical staff may express frustration with Inuit, e.g., using statements such as "Here we go again" to mean an unwelcome challenge or nuisance, said Julie. Inuit preference for "country food" (e.g., caribou, seal, and arctic char)—particularly among Elders—is also ignored. Cultural insensitivity is evident even at the level of cognitive and psychometric tests. One section of the Montreal Cognitive Assessment, also known as MoCA, shows animal pictures that patients need to identify, including a lion, a camel, and a rhinoceros (Nasreddine et al., 2005). Patient scores on such tests may be affected by cultural unfamiliarity with these animals and not represent true ability. Most important, perhaps, cultural concerns are tied to ethical decision-making regarding very ill patients. As Grace pointed out, sending very sick patients south for medical care is sometimes not recommended because of the cultural importance of being able to die at home, surrounded by family and loved ones in a familiar environment.

Several respondents described how the lack of cultural competency and demonstrated cultural sensitivity highlights the disempowerment experienced by Inuit using the system. They described how the medical transfer system itself takes away Inuit patients' control, which worsens anxieties about their illnesses. As one respondent observed, patients have no control over the

decisions about the organization and timing of flights. He added, "When individuals are sick, it is important that they feel that they have some control over things affecting them [given that they are already losing a lot of control of their illness]. Right now the system does not even give you a little control: you have to do it 'our' way." During their stay at the hospital, patients are further disempowered because of language and cultural barriers. "Chris" commented, "People need to know that they can choose the care they receive. We do not give them that option. We control the means of getting the service. Where is the individual's responsibility to take care of themselves?" Finally, unlike most patients who have the freedom to sign themselves out of a hospital (even when doctors recommend otherwise), individuals using medical transfers must receive an "okay" before being allowed to fly home.

The last area of concern that study participants unanimously observed was the lack of social supports and resulting social isolation and "homesickness" while on medical travel. "Sarah" said that it is even difficult for the patients to hear news from home because "most of them do not have a long distance [telephone plan] to call their family." Four respondents pointed out that for Inuit, homesickness is not just about missing home, but rather it means that a person feels very lost and out of place. Several respondents reported that homesick Inuit may feel so lost and depressed that they will sometimes plan to leave Ottawa before completing their treatments. Inuit patients may purposefully break rules, such as drinking alcohol, said Pam. The sense of despair resulting from homesickness can also lead to feelings of anger and hopelessness, making healing more challenging. "Heather" gave a personal example: "My mom would get depressed. She was in [the hospital] for eight months straight. It was hard on her children and it was hard on her. I also have a nephew who was getting cancer treatments and is now not working, yet it was hunting season at home. He wants to be there—on the land—and not here." According to "Jane," the psychological separation from the north, family, and friends leads to such despair that some patients may give up on getting better, dying suddenly from strokes or heart attacks. Inuit patients may feel further isolated by their condition, being unable to move around due to illness, or from the isolation units they are placed in when carrying infectious illnesses such as tuberculosis (TB) and methicillin-resistant *Staphylococcus aureus* (MRSA). Feelings of despair in this state can make a patient refuse treatment in the hope that this means they can return home. This happens because "people will not understand what they are sometimes told and not know they have to be here for six weeks," said "Debbi." Meaghan tied resistant patient behaviour not only to homesickness, but also to the Inuit historical relationship to western health care: "Historically, trauma has been associated with going into an institution and experiences in the system [of residential schools]. TB patients in the past were picked up in a ship and would not return."

As mentioned, homesickness among Inuit correlates to incidences of depressive symptoms; however, respondents seemed to disagree about its prevalence. On one hand, Grace felt that homesickness cannot be understood as true clinical depression, yet Jane reported that more than 90% of Inuit admitted to hospital in the south experienced depressive symptoms. For "Melissa," factors such as the warmer hospital temperatures, which are very uncomfortable for Inuit patients, contribute to feeling unwell and therefore to a risk of developing depression or other mental health issues.

There are no formal programs for addressing the psychosocial needs of Inuit patients in Ottawa hospitals. Jane remarked that social workers are trained to carry out psychosocial assessments, and the results could be passed along to other hospital staff, allowing them to find ways to meet the cultural needs of Inuit patients. However, Stella commented on the dilemma of addressing any pre-existing mental health issues among some of the patients arriving for care, saying, "[I]f they are here for three weeks, do you open that wound and do you help them through it and talk about it? But when there is no service up north [to continue supporting them], then what do you do? Are you causing more harm than good?"

There is limited support for patients and families in Ottawa. For example, the boarding house Larga Home is only available to Inuit from Baffin Island. Its mandate is the provision of transportation, food, and lodging (Davidson, n.d.). OHSNI offers Inuktitut/English interpreters, assists with communication among medical staff and families, and offers administrative support for appointments (Ottawa Health Services Network Inc., 2010). It gives access to nurses and social workers, as well as medical equipment and medications, and helps facilitate transfers between Nunavut and Ottawa. Once OHSNI professional staff gives clearance, Larga Home arranges air transport home.

Aside from the initial escort and a translator (if available) there are no Inuit caregiver provisions in Ottawa hospitals. Jane did, however, point out a new program at the University of Alberta Hospital (in Edmonton) where Inuit are hired to provide culturally appropriate healing practices, as well as to help educate staff about cultural norms.

To the final interview question about government agency awareness of social support problems, respondents agreed that governments have not prioritized the psychosocial needs of Inuit transferred to the south. Pam used a personal example:

> When I went back home to Pond Inlet in 2007, I approached the MLA [Member of the Legislative Assembly] about my own experience while south for cancer treatment, and [expressed] the issues that exist concerning [the lack of psychosocial support for] cancer patients and longer term care—and nothing happened. Those long-term care and cancer patients are the ones most lacking support. Inuit patients and parents of younger patients are not really comfortable about the feelings that arise from either their illness or being away for so long. It may be too much for them, and when they are in Ottawa, some do not talk at all about what is going through their minds [because there is no one there to talk to].

Highlighting similar issues, Jane stated:

> The lack of visibility of Inuit, and non-existence of political pressure has left Inuit as an invisible people. Rarely do I meet anyone outside of the hospital that even realizes that Inuit

> are sent by medevac to Ottawa for health care. I believe Inuit, like the [other] Aboriginal people of Canada, are a lost people.

DISCUSSION

The current state of health care delivery in Nunavut is built on a long history of cultural and political decisions, primarily taken outside of the territory and without input from Inuit. The present health care system in Nunavut and the poor overall health of the population is rooted in the colonial history of Inuit and the erosion of the traditional holistic understanding of health. Forced clustering, residential schools, and other threats to Inuit language and culture have led to increased psychological and social problems in the local population (Smylie, 2009). Anxiety, depression, and suicide are all serious problems, particularly among the Inuit youth of Nunavut (NTI, 2008). Additionally, social determinants of health, such as poverty, unemployment, and poor and overcrowded housing contribute to negative psychosocial outcomes including an extremely high incidence of violence in the Inuit community (NTI, 2008). Specifically, pregnant women are subject to high levels of abuse and trauma, but the risk of violence is high for all Inuit women, regardless of reproductive age (New Economy Development Group, 2006; Nunavut Department of Health and Social Services, 2007). Women and children are also vulnerable to sexual abuse (National Collaborating Centre for Aboriginal Health, 2010; Richmond & Ross, 2008). In a larger sense, health inequities, such as lower life expectancies, higher rates of infectious illnesses, and higher rates of suicide can be directly linked to these social and economic determinants of health (Creswell, 2007). Emotional and family problems have also increased due to daily hardships: food insecurity, inadequate housing, higher incidences of medical illnesses, and lower life expectancy (Smylie, 2009).

In the early years, the responsibility for Inuit health care belonged to provincial governments, religious organizations, and even the Hudson Bay Company (NTI, 2008). Since 1945, however, the Canadian federal government has been involved in the delivery of health care services to First Nations, Métis, and Inuit communities, of which medical transfer is now a key part (Aboriginal Affairs and Northern Development Canada, 2011; Health Canada, 2007). Care for Inuit was transferred wholly to the Department of Indian Affairs in 1939, but it was not until the late 1970s that there was any discussion about involving Inuit themselves in the decision-making process for their own health care (Health Canada, 2007). Currently, while Inuit are beginning to be more involved at the policy level, health care outcomes remain poor and government support for Inuit health care programs is increasingly threatened.

At the time that this study was originally conducted (2010), Health Canada was making concerted efforts to address diabetes and TB in First Nations and Inuit populations—as well as the consequences of residential schooling—through the Aboriginal Healing Foundation (Health Canada, 2007). However, due to the influence of the federal government, several Inuit-focused organizations, such as Pauktuutit Inuit Women of Canada, have had funding reduced, or eliminated entirely as in the case of the National Aboriginal Health Organization (CBC News, 2012; Fitzpatrick, 2012). The health budget for Inuit Tapiriit Kanatami (ITK), formerly Inuit Tapirisat of Canada, has also been cut by 40%. The decrease in funding, which amounts to $3 million over two years, has a significant negative impact on ITK's ability to effectively respond to health challenges facing Inuit (Inuit Tapiriit Kanatami, 2012).

These funding cuts are especially alarming in light of the gap in the health status of First Nation and Inuit communities as compared to Canadians overall, which for Inuit is largely influenced by impoverished living conditions, including food insecurity, crowded living conditions, and housing in need of major repair (Huet, Rosol, & Egeland, 2012). For example, most Canadians can expect to live 79 years on average whereas the average life expectancy for Inuit is between 64 and 67 years (Peters, 2011; Wilkins, Uppal, Finès, Senécal, & Guimond, 2008). In Nunavut, suicide rates are 11 times higher and TB incidence is 62 times greater than the Canadian average, with 100 new active cases of TB documented in 2010 (Health Canada, 2006; MacDonald, Hébert, & Stanbrook, 2011). Lower respiratory tract infections have been found to be the leading cause for the medical evacuation and hospitalization of Inuit children: rates are as high as 48.4% among infants under the age of 6 months (Banerji, 2009). Poor ventilation in overcrowded housing is a primary cause of these illnesses, with about four in 10 Inuit living in overcrowded housing—13 times more than the Canadian average (Tester, 2006).

An important finding of the present study is that most respondents perceived a negative psychosocial impact on Inuit who travel south for medical care. The interviews revealed that no official programs have yet been developed to adequately meet the psychosocial needs of Inuit patients who require medical transfer to the south and their families. Furthermore, there is little sensitivity shown for Inuit cultural practices within hospitals, which has a negative impact on the rate of recovery and points to a governmental failure to meet current Nunavut Inuit health care needs.

The respondents identified a number of shortcomings related to the medevac system and medical transfers. Organization and logistics could be improved with respect to handling of the escorts and family members that need to accompany patients. Financial supports for escorts and family are inadequate. The organization of the transport program is under the control of the medical system, which leaves patients with little to no say in the process. Overall, the biggest problem with transferring Inuit patients south—whether through medevac or medical transfers—is social isolation, which has a negative impact on both physical and mental health. On a positive note, the support and care provided by the staff at OHSNI is seen as excellent and staff is devoted to Inuit clients. One such helpful OHSNI program is the Petty Cash Fund, which allows cash supplements to a maximum of $200 per patient per visit. Additionally, Larga Home is an important source of contact with other Inuit in addition to its boarding and transportation services.

Still, the obvious systemic problems that lead to social isolation—cultural insensitivity, inadequate interpretation services, and lack of Inuit staff and cultural supports such as "country food" or visiting Inuktitut-speaking support workers—all have yet to be addressed.

LIMITATIONS

The primary shortcoming of this study is that patients and their families were not interviewed. Much more precise data with respect to psychosocial issues could be obtained by talking directly to the people affected.

Some concerns were raised about the wording of the interview questions. For example, one respondent observed that the question "In your experience do Inuit patients in southern hospitals encounter a higher incidence of depression?" was somewhat limiting. He noted that any patient who goes to a hospital with an illness would be unhappy to be there. While this question could have been worded more carefully, most respondents felt depression was a distinct and common issue for Inuit, based on cultural and language barriers.

Finally, this study may have benefited from an analysis of relevant quantitative statistical data. This could be the focus of a subsequent study.

CONCLUSIONS

This study demonstrates that the current medical transfer system in Nunavut does not fully meet the psychosocial needs of Inuit patients and their families, which has direct effects on patient mental health and on medical outcomes of treatment in the south. While this study mostly focuses on patients from Nunavut, the findings could parallel the reality of other northern Inuit regions or remote native communities internationally. Furthermore, it is hoped that this study will serve as a basis for further inquiry into the inequalities experienced by Aboriginal individuals in remote communities, and the policies surrounding health care of Inuit.

In truth, there will always be a need for medical transfer in Nunavut: the region's sparse population will hardly justify the extent of medical personnel or technology needed to meet all the demands that arise in acute care medical settings. Despite this reality, this study demonstrates several psychosocial factors that have an impact on patients and their families when they travel south for medical care. Addressing these factors with culturally sensitive and specific solutions may lessen the negative effects they have on mental health and medical outcomes.

Based on this study's findings, I propose the following recommendations to address the needs of Inuit patients who travel south for medical care. As suggested by Jane, language differences can be lessened through labelling medications and medical instructions in Inuktitut. Escort roles, and the process for getting an escort, should be better explained in a written, translated form. The government needs to provide greater moral and financial support to patients and escorts arriving in Ottawa. As one respondent noted, social assistance payments should not be interrupted for patients and escorts when they are required to leave Nunavut for medical care.

The Government of Nunavut needs to be more financially accountable to Nunavut residents in funding health care initiatives. This point refers directly to comments found in the NTI Annual Report for 2008, which notes that "NTI informed both [territorial and federal] governments that Inuit did not agree with the conversion of an Aboriginal-specific program into general funding of the public government, and instead, NTI said that Inuit have the right to review and sign off on government health funding intended for them" (NTI, 2008). Their assessment of the dispute concludes "there is no mention made of accountability to Inuit" (NTI, 2008).

Communication between northern and southern medical facilities with regard to patient transfers needs to be more reliable and consistent. As noted by several respondents, electronic medical records could improve this situation through creating a secure and dependable link among the various health care facilities.

The largest group of patients sent south for routine evaluation consists of those sent for diagnostic imaging with CT and MRI scans (Qikiqtani Hospital Medevac, 2010). Several respondents supported investing in CT and MRI scanners in Iqaluit with trained technicians on staff, and establishing a better satellite network for rapid transmission of images for interpretation by radiologists in the south. This could dramatically reduce medical transport costs for Nunavut.

Cultural sensitivity training for medical staff in southern hospitals would help health care professionals better understand Inuit norms and values, and in turn, improve medical outcomes. Many respondents said that training should include attention to verbal and non-verbal communication, awareness of Inuit connection to the land, recognition of the importance of "country food," and awareness of and sensitivity to Inuit spirituality.

Support for Inuit patients in Ottawa could be improved by hiring more interpreters and social support staff such as social workers. Ottawa does have some dedicated support services for Inuit clients, but many are underfunded and staff is overworked. Expanding these services, and collaborating with other organizations that provide patient care to Inuit in additional Canadian cities, may provide some new solutions.

One potentially cost-effective solution to the problem of isolation would be to hire Inuit visitors to attend patients in the hospitals and engage them in culturally relevant and appropriate activities. Visitors can help preserve cultural and linguistic contact, said Jane, and give much needed moral support during the hospital stay. Isolation can also be reduced by giving patients prepaid long distance phone cards to call home, perhaps funded by the Government of Nunavut or through a grant from Health Canada, as proposed by three respondents.

Findings confirm a general failure to implement a holistic approach to care for Inuit patients who are sent south. In addition, social isolation has an obvious and serious negative impact on

mental health and medical outcomes for Inuit. Homesickness and removal of cultural support contribute to a profound sense of loss, disempowerment, and depression experienced by Inuit, leading to non-adherence, early cessation of therapy, and a reduced sense of well-being. Ultimately, problems stem from the social, economic, and political determinants of health that all conspire to perpetuate conditions of poverty for Inuit of Nunavut. The larger social issues of education, housing, unemployment, substance abuse, and accidental injury still need to be addressed with greater vigour. These conditions ultimately tax the health budget and drain the medevac and medical transfer programs. Government agencies need to set priorities to address these inequalities in a timely manner. It is hoped that the conditions leading to social isolation and depression for Inuit can be lessened or eliminated with further research, and the implementation of the recommendations I have outlined in this study.

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