Beyond window-dressing reconciliation in healthcare: A workbook for settler physicians

PLEASE NOTE: What you are reading is a *working draft*, currently being reviewed and piloted in various contexts.

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About this Workbook

This workbook was created as part of a research project, "Beyond Window-Dressing Reconciliation in Health: Settler Clinician Responsibilities," led by Cash Ahenakew, who holds a Canada Research Chair in Indigenous Peoples' Well-Being. The project was funded by a UBC Catalyzing Research Clusters grant by the same name, a SSHRC Insight Development Grant, "Towards the Ethical Integration of Different Knowledge Systems: Lessons from STEM and Health," and a SSHRC Insight Grant, "Decolonial Systems Literacy for Confronting 'Wicked' Social and Ecological Problems."

The creation of this workbook was led by Cash Ahenakew and collectively authored by Indigenous and settler members of the grant teams. Contributors to the workbook include: Cash Ahenakew, Dani Pigeau, Sharon Stein, Bjorn Stime, Vanessa Andreotti, Will Valley, and Andréa Monteiro. The workbook was reviewed by several experts in health, including: Francisco Medina, Stacey Prince, Avery Fischer, inabel uytiepo, Christine Gibson, Mariana Jimenez, and Kristine Madsen.

In these research projects, we have sought to invite deeper, more nuanced, and accountable engagements with the individual and systemic colonial patterns that continue to harm Indigenous patients in mainstream healthcare institutions (e.g., hospitals), universalize western approaches to health and well-being, and invisibilize and devalue Indigenous approaches to health and well-being (Swidrovich, 2022). The text draws from the scholarly literature in this area, as well as grey literature (e.g. reports, policies, white papers, working papers), news stories, and the lived experiences of several of the authors. Parts of this text were also adapted from previous pedagogical resources produced by some of the authors (see in particular Ahenakew, 2019; Elwood, Andreotti & Stein, 2019; Stein et al., 2021).

Although we focus on the field of medicine specifically, many elements of this workbook are likely to be relevant for other health and mental health professions. Our geographic focus is on what is currently known as Canada, where we work, but the workbook is likely to have relevance for those working in other settler colonial contexts, especially the United States. This workbook can be engaged by individuals, or collectively (e.g., as the basis of a reading group).

There are a growing number of useful resources that seek to identify and interrupt colonialism and anti-Indigenous racism in Canadian health care from various entry points. Some of these resources include: the San'yas Indigenous Cultural Safety Training Program, *Indigenous Health Primer* (2019) and the accompanying *Indigenous Health Values and Principles Statement* (2019); the *In Plain Sight* (2020) report; the NCCDH primer on Whiteness and Health Equity; the Yellowhead Institute Policy Brief, *The Failure of Federal Indigenous Healthcare Policy in Canada* (2021) by Mike Gouldhawke; *A Trauma-Informed Approach to Cultural Safety* (2022) webinar with Harley Eagle; "Unlearning and Undoing Systemic White Supremacy and Indigenous-Specific Racism within the BC Office of the Provincial Health Officer" (2023) webinar with Dr. Danièle Behn Smith and Dr. Kate Jongbloed; Lisa Richardson and Tracy Murphy's brief on *Wise Practices for Healthcare Leaders* (2018); the medical school curricula innovations of Lindsay Crowshoe, the UBC Centre for Excellence in Indigenous Health's 23 24 Indigenous Cultural Safety Program, and many, many more. These and further resources are included in the "Additional Resources" section at the end of this workbook.

This workbook is not meant to replace or supersede these important resources. Instead, it offers something very specific: **an invitation for settler physicians to deepen their intellectual, affective, and relational capacities to confront colonialism in their institutions and their clinical practice, and develop**

the stamina to do this work over the long haul. It was created for settler physicians who are committed to the process of confronting colonialism in medicine, and who have a particular interest in examining the complexities of this work, and facing up to their own complicity in harm. This workbook will ask readers to question the narratives they hold about themselves and the world, and to examine their own responses to the issues surrounding colonialism in healthcare with both criticality and compassion. Thus, this resource is not for everyone, but rather is intended for those who seek to engage in this specific kind of work, recognizing that the process may be difficult, uncomfortable, and even painful at times.

Below, we offer a disclaimer that we encourage you to read before proceeding further.

Disclaimer

Informed by decolonial critiques that emphasize how our social positions and individual and collective experiences shape the ways we experience and encounter the world, our approach to education challenges the common desire for "universal" pedagogical resources. We recognize that what is optimal for the process of learning and unlearning for one group of people can be sub-optimal or even harmful to another, and vice versa. Thus, we emphasize that this resource was produced with a settler audience in mind. However, we also recognize that Indigenous Peoples may engage with this resource. And we recognize that white and racialized settlers are likely to engage with this resource differently.

We offer more detail about the invitation offered by this workbook in Chapter 2, but we ask you to consider the following disclaimers before deciding whether or not to proceed with this resource.

> If you are an Indigenous person, some of the content of this workbook may cause you to re-experience traumatic events. We describe the systemic and interpersonal dynamics of colonial violence, and expose macro- and micro-aggressions that are invisible to many settlers. Some Indigenous people will experience this exposure as a relief and an opportunity to process and integrate the lessons of past trauma, while others may experience it as re-traumatization. Only you can decide whether it is the right context and time for you to proceed with this resource.
>
> If you are a white settler, the content of this workbook was designed to show you how what you have been socialized to think of as normal and natural can be experienced as violent and harmful by Indigenous Peoples (and other marginalized communities). Thus, you should expect to be confronted with your complicity in colonial harm. This will likely create a level of dissonance, discomfort, exasperation, displeasure, frustration, disillusionment and/or disenchantment, which are necessary for you to experience in order to be able to identify and potentially interrupt patterns of socially sanctioned harmful projections, desires and behaviours. It is up to you to decide if this is the right moment for you to proceed with this resource.
>
> If you are a racialized settler, you will likely experience ambivalent responses to this workbook. This is partly because you may be able to relate to experiences of subjugation and discrimination; while at the same time being asked to consider your implication in the subjugation and discrimination of Indigenous Peoples. This may prompt you to consider your paradoxical position of being both subject to and complicit in colonial violence. It is also up to you to decide if this is the right moment for you to proceed with this resource.

While all words are polysemic (i.e., have multiple meanings), terminology related to race, equity, and Indigeneity in particular is contested, contextual, and constantly evolving. The desire for fixed, universal meaning is part of a logocentric approach of knowledge that seeks to impose coherence and consensus on a constantly shifting, pluri-vocal world. This desire denies that the same word can mean different things to different people, and be mobilized differently depending on who is using it, when, where, and how. With this in mind, we note that the terms we use here and throughout this workbook, and the definitions that we provide in the glossary below, are partial and provisional, and were chosen based on what is most relevant for the intended audience and uses of this workbook: settler physicians in Canada. We note that preferred terminology changes over time, and thus, these terms and their definitions are neither timeless nor universal, and their uses and meanings are likely to shift and be understood differently across contexts.

Glossary

Indigenous Peoples - In what is currently known as Canada, 'Indigenous' encompasses First Nations, Inuit, and Métis peoples. Throughout this text, we refer to 'Indigenous Peoples.' Like all terms, this is imperfect and imprecise as it places different nations and communities under a single umbrella and can risk reproducing generalizations about Indigenous Peoples. Like all communities, Indigenous Peoples are diverse and heterogeneous, both within and between communities – including holding diverse perspectives about how to confront colonialism in healthcare. Hence, we emphasize that when we speak about the experiences of 'Indigenous Peoples in healthcare,' we are speaking about what commonly occurs, which does not mean this is the experience or interpretation of every Indigenous person.

Settler Colonialism - Colonialism occurs when an external power asserts authority over a group of people — their lives, lands, and "resources." While this is a basic definition, there are many ways of defining and diagnosing colonialism, and it manifests differently across different contexts. In this workbook, we focus on a specific form of colonialism known as settler colonialism, which is premised on the systemic and ongoing dispossession of Indigenous Peoples and the occupation ("settlement") of Indigenous lands by non-Indigenous people. For example, Canada and the US are both considered to be settler colonial states. Settler colonialism encompasses the forceful establishment and ongoing political control of colonial systems of government that were and are intended to replace and eliminate Indigenous Peoples. Settler colonialism was established and continues to be maintained in ways that specifically advantage white settlers over and above others. Colonialism overlaps with other forms of oppression, including racism, sexism, homophobia, transphobia, exploitation, and ecological extraction.

Settlers and Non-Indigenous people – Throughout this text, we use the terms "settlers" and "non-Indigenous people, depending on the context. "Non-Indigenous" encapsulates a heterogeneous group of people with distinct relationships to Indigenous peoples and lands. Many non-Indigenous people in what is currently known as Canada are settlers. In scholarship about settler colonialism, the term "settler" is not understood as an identity, but rather a social position of systemic and structural domination in relation to Indigenous Peoples and lands. As Flowers (2015) argues, "the category of settler is both a structural location and a product of social relations that produce privilege" (p. 34). Non-Indigenous racialized people can both benefit from *and* be harmed by the settler colonial system. Many people emphasize that not all non-Indigenous people are settlers, for instance, Black Canadians who are descended from enslaved people. Others emphasize that there are some people who came to Canada through circumstances beyond their control (e.g. refugees, transnational adoptees), or under compromised circumstances (e.g. indentured labourers), while also noting that these people and/or their descendants may now be considered settlers (following Flowers' definition). We do not offer a detailed engagement with the scholarly conversations about the important complexities that exist within and between the different non-Indigenous communities, but we encourage readers to consult this work (e.g., Dhamoon, 2015; King, 2019; Lawrence & Dua, 2005; Leroy, 2016; Patel & Nath, 2022; Mukhopadhyay, 2017). We also encourage those who engage with this workbook to consider how their social positions shape how they read and engage the text, and more broadly, how they confront colonialism in healthcare and beyond.

Whiteness – The NCCDH's Let's Talk Whiteness and Health Equity paper (2020) describes whiteness in this way: "Like all races, White is a social category, with no basis in biology…over time 'White' as a racial category has widened to include all European-descended people. White is usually seen as neutral in

White institutions and not seen as a racial category." Meanwhile, whiteness can be understood as an investment in the benefits that have been accrued over five centuries of systemic, institutionalized white supremacy, including through slavery, colonialism, imperialism, and segregation. These benefits are defended as if they were white people's rights and property, through the law, institutional practices and policies, state-sanctioned violence, as well as various forms of coercion (Harris, 1993). These property claims include at least four presumed entitlements. The entitlement to 1) epistemic and moral authority; 2) unrestricted autonomy; 3) arbitrate truth, justice, and common sense; 4) have one's wants, desires, and benevolence affirmed; and 5) continue enjoying the intergenerational social, political, and economic benefits derived from a white supremacist system. While there is a lack of race-based data to more fully characterize the racial divide among healthcare personnel in Canada, there is a strong over-representation of white healthcare leaders across the country (Sergeant et al, 2022). All non-white people are harmed by white dominance, and we emphasize the particular responsibilities of white physicians to interrupt racism in healthcare, in all its forms.

Decolonization – Like many terms referenced throughout this text and other texts that discuss colonialism, the meaning of decolonization is contested and polysemic (see Andreotti et al., 2015). Eni and colleagues (2021) describe decolonization in a healthcare context in Canada as a process that "addresses the multiple facets of disconnect between healthcare and Indigenous health outcomes, and the root of perpetual inequity itself. It is a process of [Indigenous Peoples'] reclamation of political, cultural, economic and social self-determination, including the re-development of positive individual, familial, community and nation level identities." They note that these efforts "require the active involvement of Indigenous as well as non-Indigenous peoples." They also describe decolonization in this context as requiring "the dismantling of colonialism as the dominant model upon which Canadian society, and healthcare provision, more specifically, operate" (p. 2). Indeed, many have problematized the ways that 'decolonization' efforts can be mobilized by non-Indigenous people to seek the continuity of settler colonial society and dismiss the imperative for reparation and the rematriation of Indigenous lands (Tuck & Yang, 2012).

Cultural Safety – The First Nations Health Authority in BC defines cultural safety as "an outcome based on respectful engagement that recognizes and strives to address power imbalances inherent in the health care system." While healthcare professionals might strive to offer culturally safe care to Indigenous Peoples, they should not assume that they are actually doing it. As the Canadian Institute for Health Information notes, cultural safety "can be defined only by the Indigenous person receiving care...To be culturally safe requires positive anti-racism stances, tools and approaches, and the continuous practice of cultural humility" (CIHI, 2021). Cultural humility, then, is "a process of self-reflection to understand personal and systemic biases and to develop and maintain respectful processes and relationships based on mutual trust. Cultural humility involves humbly acknowledging oneself as a learner when it comes to understanding another's experience." (FNHA, 2015). Some have noted that despite their potential importance, Indigenous cultural safety trainings may do little to interrupt the reproduction of inequity and harm if not undertaken in ways that explicitly challenge the systemic nature of racism and colonialism in health care, and interrupt stereotyped representations of Indigenous Peoples (Lavallee & Harding, 2022; Ward, Branch & Fridkin, 2016). Because of the ubiquitous nature of white supremacy and colonialism, even if a settler physician receives cultural safety training, this does not mean they are immune from reproducing white supremacy and colonialism in their practice.

Chapter 1: Introduction

Despite proud national narratives about the excellence and equity of public healthcare systems in what is currently known as Canada, Indigenous Peoples continue to experience racism and colonialism in these systems (Lavallee & Harding, 2022). This results in significant disparities in Indigenous Peoples' health outcomes compared to non-Indigenous (especially white) people, as well as persistent harmful and even deadly experiences of anti-Indigenous racism when seeking health care (Allan & Smylie, 2015; Roach et al., 2021). For instance, in a recent study of widespread racism in the BC health care system, 84% of Indigenous people reported experiencing discrimination when seeking health services (In Plain Sight, 2020). Each week, we learn about new incidents of racist treatment toward Indigenous patients in clinics and hospitals that have led to poor care, and in some cases, premature death. As Lavallee and Harding (2022) write, "Indigenous Peoples are not safe in health care systems where they can be systemically targeted and killed" (p. 52). The emphasis on *systems* here is key: colonialism and anti-Indigenous racism are systemic issues. However, individual settler doctors are trained and socialized within these colonial systems.

Increasingly, it has become more widely understood that the health disparities and the racism experienced by Indigenous Peoples in the health care system are most accurately understood as symptoms of the ongoing settler colonial system that characterizes Canadian society and its mainstream institutions. Thus, "there is a need to examine the pervasive and intervention-resistant nature of Indigenous-specific racism [in healthcare] to know what it sounds like, how it manifests and permeates health services and the problem with current accountability measures" (Lavallee & Harding, 2022, p. 51).

Lavallee and Harding (2022) observe that anti-Indigenous racism is "coached into health service practice through several processes: in post-secondary curriculum and literature; in medical residency, practical licensing and training; and through daily practice" (p. 52). The intergenerational impacts of colonial genocide and dispossession, as well as systemic discrimination in the medical system, have led to significant health disparities for Indigenous Peoples in Canada. Many Indigenous Peoples lack access to doctors and hospitals and to culturally appropriate medical care. They also experience physician negligence in diagnosis and care. Indigenous Peoples have a life expectancy 15 years less than non-Indigenous people; they experience 4 times the incidence of diabetes, infant mortality rates that are 2-3 times higher, and rates of depression and suicide up to 40 times higher (Swidrovich, 2022). These disparities are even starker in the Prairie provinces than in the rest of Canada.

While identifying and addressing these unequal health outcomes is important, efforts to simply *close* this gap do not necessarily interrupt the anti-Indigenous racism and colonialism that have *created* the gap. For instance, narrow efforts to close this gap can lead to health interventions that seek to ensure that Indigenous Peoples adopt and embrace Western approaches to health, rather than respect Indigenous health practices and support Indigenous Peoples' self-determination in health practice and governance. The persistent assertion and assumption of the supposed superiority of western health knowledge over Indigenous health knowledge is a symptom of ongoing colonialism and racism in healthcare.

Often discussions of the gap in health outcomes also focus on changing Indigenous Peoples' behaviour in ways that blame and pathologize Indigenous communities. Throughout Canadian history, colonial representations of Indigenous Peoples' health have been mobilized by settlers to justify paternalistic and often non-consensual health interventions that violate Indigenous self-determination and individual

bodily sovereignty (Ahenakew, 2011). This includes forced institutionalization in Indian hospitals, and the non-consensual sterilization of Indigenous women, which happened as recently as 2019 (Cheng, 2023).

Today, many medical interventions reproduce colonial power dynamics between settler healthcare professionals and Indigenous patients and communities, which in turn reproduce the very conditions that have led to poorer health outcomes for Indigenous Peoples. Thus, it is crucial to think carefully about how settler health professionals and scholars are trained to understand Indigenous Peoples' health, and specifically how they identify the colonial root causes of Indigenous Peoples' lower health outcomes and what they deem as the appropriate responses to support Indigenous health.

For example, health policy and scholarship often describe Indigenous Peoples as being at "higher risk" for certain diseases and poorer health outcomes. However, Indigenous and other critical health scholars challenge the common conflation of Indigeneity with risk, emphasizing that the language of risk often leads people to understand health disparities as the result of naturally occurring biological or genetic differences. This understanding of elevated risk can reify the idea of inherent racial differences, and can also invisibilize the fact that it is *colonialism* that actually creates higher health risks for Indigenous peoples. As Dr. Danièle Behn Smith, BC Aboriginal Health Physician Advisor, observes, "The exposure that confers risk on us is the socially constructed reality and experience of being subjected to Canadian practices and policies." She further notes that for many Indigenous people, it is "our Indigenous identities, who we are and where we come from, that give us strength and resilience. Those are protective factors."

Hence, as Ray, Wylie and Corrado (2022) argue, there is a need to encourage health care providers and policymakers to interrupt the tendency to pathologize Indigenous peoples and instead "to turn the gaze onto the failures of the health system" (p.2). This would require shifting the focus to "the changes health systems can make to colonial practices and structures, rather than on how Indigenous peoples can fit in and navigate their way through this hostile terrain" (p. 2). This also requires holding multiple layers of responsibility at once: turning the gaze onto settler doctors and their own roles in reproducing harm, without individualizing these systemic issues but rather seeing them as part of wider, historical patterns.

In line with critically-engaged research in this area (e.g., Czyzewski, 2011; Paradies, 2016; Reading & Wien, 2009; Stime, Laliberte, Mackie & Waters, 2018), the Truth and Reconciliation Commission (TRC) of Canada identified colonialism as a primary determinant of Indigenous Peoples' health. Six of the TRC Calls to Action (2015) are related to health. The calls seek to ensure acknowledgement of the historical and ongoing role of settler colonialism in shaping Indigenous health, and seek to secure greater commitments to close gaps in health outcomes between Indigenous and non-Indigenous communities, more support for Indigenous approaches to health and well-being, and more training and education for health care professionals regarding both Indigenous health and the impacts of colonialism in health.

The Calls for Justice issued by the National Inquiry into Missing and Murdered Indigenous Women and Girls also identify seven areas of health for ensuring well-being and respect for the rights of Indigenous women, girls, and Two-Spirit, lesbian, gay, bisexual, trans*, queer, questioning, intersex, and asexual (2SLGBTQQIA) people. Indigenous Peoples' rights to self-determination in health are also named in the UN Declaration on the Rights of Indigenous Peoples (UNDRIP, 2007), in Article 24:

> 1. Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants,

> animals and minerals. Indigenous individuals also have the right to access, without any discrimination, all social and health services.
>
> 2. Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view to achieving progressively the full realization of this right.

In September 2020, Atikamekw woman Joyce Echaquan died while in a Quebec hospital. Before her death, Echaquan filmed herself on Facebook Live, as a nurse and orderly made derogatory comments while failing to provide care as she screamed in distress. The coroner determined that her death was "directly related to the care received during her hospitalization" and identified it as an instance of "systemic racism." Following Echaquan's death, the Atikamekw Nation put forward Joyce's Principle:

> Joyce's Principle aims to guarantee to all Indigenous people the right of equitable access, without any discrimination, to all social and health services, as well as the right to enjoy the best possible physical, mental, emotional and spiritual health.
> Joyce's Principle requires the recognition and respect of Indigenous people's traditional and living knowledge in all aspects of health. (Council of the Atikamekw of Manawan and the Council de la Nation Atikamekw, 2020, p. 10)

It is in this context that the medical profession in Canada has increasingly recognized the need to identify, interrupt, and redress the impacts of colonialism on Indigenous Peoples' health and well-being, and to ensure that Indigenous Peoples have access to culturally appropriate and culturally safe medical care. These shifts have largely been the result of advocacy by Indigenous Peoples.

Doctors have an enormous amount of social and institutional power, especially in the relationship between doctor and patient. While colonialism in healthcare is a systemic problem, settler doctors are the individuals who provide direct health services, and thus they have the power to either reproduce or interrupt colonialism in the provision of healthcare to Indigenous patients and communities in Canada.

Some of the initiatives that have been undertaken thus far to confront colonialism in healthcare include: recruiting and enrolling more Indigenous students in medical school; commissioning inquiries into systemic racism in healthcare systems; increasing research about diversity and racism in health (for example, in Canada's healthcare journals such as *CMAJ* and *CJPH*); the creation of EDI ("Equity, Diversity & Inclusion") advisory committees in various academic departments; and some space being made within medical school curricula to learn about Indigenous health and about how to engage in culturally safe healthcare.

Yet, as Anderson (2018) notes, "Discussions about reconciliation are useful only in so much as they result in improved health and social outcomes for Indigenous peoples." Despite growing awareness of how anti-Indigenous racism and colonialism operate in healthcare, and growing acceptance of the basic principles of reconciliation in the medical profession (Jaworsky, 2018), much work remains to be done. For instance, according to Smylie (2022), "zero out of the seven [TRC] Calls to Action in the area of health have been completed" (p. 26 in the Yellowhead Institute Status Update on Reconciliation).

Generally speaking, settler healthcare workers – especially white healthcare workers – still tend to *underestimate* just how deeply these systems of domination are naturalized and embedded in their own minds, bodies, relationships, practice, and institutions. Settler healthcare workers also tend to *overestimate* their own capacity to identify and interrupt these systems, assuming their good intentions are sufficient to create meaningful change. Thus, in medicine, as in many other health fields, we find a significant dissonance between *where settler physicians actually are* in terms of the work of confronting colonialism in their practice and their institutions, and *where settler physicians think they are.*

In order to support but also go beyond efforts to close the "gap" of health outcomes between Indigenous and settler populations, in this workbook we focus on another gap: the gap between settler medical professionals' "good intentions" and the persistence of anti-Indigenous racism and colonialism in Canadian healthcare systems. We emphasize that while the root cause of this gap is structural and systemic, individual physicians have a responsibility to identify this gap and address it in their practice and institutions.

Here and throughout the workbook, we intentionally focus on inviting people to deepen their sense of responsibility rather than on attempting to get them to feel shame. Shame-based approaches to interrupting colonialism tend to invite responses among settlers that are short-lived and surface-level. Shame might motivate some people to act, but it generally does not provide the sustained energy that is needed in order to stay with the difficult, uncomfortable, and long-term work of confronting colonialism. Efforts to address colonial harm that are driven by shame also tend to be reactive and centred around the desire to minimize and soothe 'bad' feelings among those who have been shamed, rather than motivated by a sense of responsibility and an intention to enact material and relational repair. Settler actions motivated by shame, therefore, are transactional: there is a calculation that if I do [x] action, I will then be able to go back to feeling 'good'. By contrast, the process of enacting genuine repair may feel 'good', 'bad', and many other things to those who are responsible for the harm being repaired, but in any case, it does not centre their feelings but rather their responsibilities as well as the impacts (of colonialism itself and of the repair efforts) on those most negatively affected by colonialism, i.e., Indigenous Peoples. The implication of all this is that shame-based approaches to colonialism are unlikely to create the conditions for remaking relationships between settlers and Indigenous peoples that are grounded in trust, respect, reciprocity, consent, and accountability (Whyte, 2020).

Thus, we draw attention to the gap between where people actually are and where they think they are not to shame settler doctors for not being further along in their (un)learning process, but rather to invite them to recognize the extent to which anti-Indigenous racism and colonialism continue to shape healthcare, and thus, to recognize the considerable work that remains to be done. Failing to recognize the existence of this gap can make it harder to name the persistence of racism and colonialism, especially given the proliferation of celebrated reconciliation efforts that suggest substantive changes are already being made. This also leaves settler physicians unprepared to navigate the inevitable complexities and missteps that emerge even in well-intended efforts to interrupt racism and colonialism.

The starting point of this workbook is that settler colonialism, as an ongoing process of dispossession and domination, is the root cause of Indigenous Peoples' negative health experiences and outcomes. Thus, confronting colonialism and racism in healthcare is not just about ensuring that Indigenous Peoples receive the same quality of care as settlers and that this care is offered in culturally safe ways – which by itself is a significant challenge – but also about fundamentally reimagining existing healthcare systems and supporting Indigenous self-determination in healthcare and beyond. Throughout the workbook, we

talk about "confronting" colonialism rather than "decolonizing" healthcare. This is because we are only in the very beginning stages of a complex, non-linear, long-term process of (possible) transformation.

We suggest the first step in this direction is for settler physicians to sit with the full weight of the systemic, historical, and ongoing impacts of racism and colonialism in medicine and health more generally, and to accept that they have responsibilities as settlers to interrupt racism and colonialism. Although we invite settler physicians to deepen their intellectual engagement with systemic analyses of settler colonialism in health, we focus on inviting you to expand your affective and relational capacities to confront colonialism and anti-Indigenous racism in your own practice and institutions.

In the next section, we clarify our invitation to engage more deeply with the effects of colonialism in healthcare for Indigenous Peoples, and to accept responsibility as a settler physician to interrupt harm, so that you can make an informed decision about whether to proceed with this workbook.

Chapter 2: Invitation of this Workbook

This workbook is intended for settler physicians who are committed to learning how to responsibly engage painful truths about the enduring role of settler colonialism in Canadian healthcare, including truths about their own complicity in harm. It will invite you to practice identifying and interrupting common colonial patterns of knowing, being, and relating, including your own (conscious and unconscious) investments in the continuity of colonial business as usual. Those who accept this invitation should keep in mind that, given the nature of this work, it is often initially difficult and uncomfortable (until you begin to feel comfortable with discomfort), and will likely challenge closely held assumptions about yourself, your work, and your self-image. Confronting colonialism and racism in healthcare or in any sector of settler society entails not only intellectual work. It also entails affective and relational work. That is why one of the key elements of the invitation of this workbook is that you are not being invited to agree (or disagree) with its content. In fact, we invite you to do something that is quite counter-intuitive, which is to approach the workbook with the idea the primary "content" is not the information or materials we offer, but rather that the primary "content" is *your own multiple responses to the materials*. While we hope you might learn something from the materials we offer, the primary learning this workbook enables is learning about yourself and the work that you still need to do in order to fulfil your responsibilities as a settler physician.

In this chapter, we offer some context around the approach taken in this workbook, and clarify its invitation. If you have not engaged the "Disclaimer" at the beginning of this workbook, please do so now.

Before we further articulate the invitation of this workbook, we want to acknowledge that there are many parallel efforts that seek to contribute to the improvement of Indigenous Peoples' health access, experiences, and outcomes. We group these into two primary categories, which we outline below.

1) Indigenous health resurgence
The efforts of Indigenous Peoples to revitalize Indigenous practices and philosophies of health and well-being, and exercise self-determination and self-governance over their own healthcare (Ahenakew, 2011; Allen et al., 2020; Dennis & Robin, 2020). This also includes efforts to coordinate Indigenous health practices with western health practices in self-determined ways that serve the needs and aspirations of Indigenous communities. An important step in this direction is working to ensure Indigenous Peoples are leading their own health research, and managing their own healthcare, in partnership with settler governments, health institutions, and other collaborators (First Nations Health Council, 2011; Marsden, Star, & Smylie, 2020; McCubbin et al., 2023). Indigenous health resurgence is a response to the fact that although Indigenous Peoples have held and practiced their own holistic, evidence-based health knowledges and health practices for millennia, "Western research methodologies, knowledge dissemination and practices of health and wellness have rendered Indigenous medicines and approaches to health and wellness as inferior to Western medicines and health care service delivery" (Swidrovich, 2022, p. 194). Indigenous Peoples' efforts to exercise self-governance over their own healthcare are related to efforts to exercise self-governance in other areas, including land and education.

2) Settler responsibility towards Indigenous health and wellbeing
The efforts of settler physicians to identify and interrupt anti-Indigenous racism and colonialism in their practice and institutions. Settlers have a responsibility to identify and interrupt the ways that inherited

approaches to health care, research, and education within western medicine have been harmful to Indigenous patients and Indigenous communities more broadly. This also includes supporting Indigenous Peoples in their resurgence of Indigenous health knowledges and practices, and Indigenous health governance (e.g., advocating to increase funding for Indigenous-led health research and care; recruiting and mentoring Indigenous doctors; supporting Indigenous health governance efforts). However, settlers should not try to lead resurgence work. Indigenous Peoples have long asserted "*Nothing about us without us*," and more recently they have emphasized, "*Nothing about us that is not led by us*." Indeed, part of settler physicians' work in confronting colonialism is about interrupting the kind of socialized assumptions that often lead settlers to assert their authority and expertise, and identifying the ways settler physicians tend to reproduce conscious and unconscious colonial habits.

Both sets of efforts are important for the work of confronting colonialism in healthcare. In this workbook, we focus on the second set of efforts, understanding that the two are intimately related but also recognizing that there are different kinds of work to be done, depending on our positionalities.

Settler Responsibility

Responsibility means different things to different people and communities. Because so much of this workbook is focused on inviting settler physicians to accept and embrace responsibility for interrupting anti-Indigenous racism and colonialism in medicine, it is important to clarify what this term means in the context of this workbook. When we refer to "settler responsibility", we are referring to three different but interrelated dimensions of responsibility, which we define below.

We suggest that accepting settler responsibility means accepting all three of these dimensions:

1. *attributability*, or recognition that the accrued privileges and advantages enjoyed by settlers are rooted in historical and ongoing harm (e.g., acknowledging the colonial foundations of western medicine in Canada, and its historical and ongoing negative impacts on Indigenous communities);

2. *answerability*, or recognition of one's complicity in the systemic dimensions of colonial harm, and thus, one's responsibility to interrupt and transform systemic dimensions (e.g., supporting changes to the required competencies of health professionals; advocating for the government to fulfil its legal obligations in relation to Indigenous Peoples' health); and,

3. *accountability*, or recognition that one is both systemically culpable *and* individually complicit in colonial harm, and thus there is both an individual and collective debt to Indigenous peoples that needs to be addressed (e.g., in addition to supporting institutional and governmental changes, asking what changes are required to one's own medical practice in order to enact repair for harms done to Indigenous Peoples through colonization, and asking what settler physicians would have to give up in order to support Indigenous-led health governance).

The process of coming to terms with one's own complicity in colonial harm, and one's responsibility to interrupt and enact redress for that harm, can be unsettling and overwhelming for settler physicians. It can contradict their professional training, challenge their presumed epistemic authority, and ask them to rethink an image they might have of doctors (including themselves) as benevolent helpers. This can be especially difficult for practitioners who have not previously been asked or expected to do this work.

For this and many other reasons, having different kinds of resources for addressing the impacts of colonialism in healthcare is important. That is why this workbook was explicitly created for settler physicians. Settlers need to be able to honestly confront the realities of colonialism and their enduring investments in its continuity, and it can be difficult, painful, and retraumatizing for Indigenous Peoples to witness settlers processing their multi-layered responses to facing their own complicity in harm (e.g., naming their own naturalized colonial assumptions and investments, or describing the resistances they feel to the invitation to accept responsibility for their role in reproducing harm). This workbook provides one means through which settler physicians can do their "homework", on their own or with other settlers, without creating more emotional and relational labour for Indigenous peoples.

This homework can prepare settlers doctors to show up to their relationships with Indigenous peoples, including their medical practice, with more discernment, self-reflexivity, and accountability. When settlers do not do their own homework, they are more likely to reproduce harm in relation to their patients, and to create more (generally, uncompensated) work for Indigenous people. Doing one's homework does not eliminate the risk of difficulties or mistakes, but it can help to prepare settler physicians with more stamina and capacity to hold space for challenges, mistakes, and conflicts when they (inevitably) arise.

Deepening one's *intellectual, affective* and *relational* capacity to confront the complexities and challenges involved in interrupting colonialism can be understood as part of this "homework." This workbook will offer some practices and pathways for undertaking this homework.

Intellectual, Affective, and Relational Dimensions of Change

In many educational contexts and resources, it is assumed that colonialism is a product of ignorance that can be solved with more information (i.e., an intellectual problem). Learning about health disparities, Indigenous experiences, and the colonial history of western medicine are all indispensable. However, they are not, in themselves, sufficient for transforming settler health care systems or practitioners. Thus, although this resource does provide a fair amount of scholarly context about the role of settler colonialism in health and medicine, sharing information is not its primary intention. While having a deep understanding of colonialism and its histories and complexities is an essential element of identifying and interrupting it, in our experience having an intellectual grasp of the harmful effects of colonization is only one element of what is needed in order to enact substantive individual, institutional, and social change.

This is not only because translating knowledge into practice is by no means straightforward, but also because of the role of embodied habits and unconscious systemic patterns in reproducing settler colonialism. These patterns have been deeply imprinted onto individuals through schooling and other forms of socialization. This means that even when settlers have good intentions, they often still reproduce at least some colonial assumptions, biases, frameworks, and modes of relating. It takes significant effort to begin to identify these patterns in oneself, in one's professional context, and in wider social systems, and even more effort to learn how to actually interrupt these patterns in generative ways.

Below, we briefly describe what we mean by *intellectual*, *affective*, and *relational* capacities:

- *Intellectua*l: Developing a deeper understanding of how settler colonialism has shaped and continues to shape Canadian healthcare and negatively impacts Indigenous Peoples, even when this learning is difficult and challenges one's sense of benevolence, mastery, authority, autonomy and certainty. Recognizing that western medical knowledge is just one (indispensable and insufficient) approach to health and well-being, and that Indigenous communities hold their own, equally

valuable health knowledges. Valuing Indigenous knowledges and engaging them respectfully without asserting settler ownership over those knowledges. While this is the capacity that is often most developed among settlers who seek to understand the impacts of colonialism, it is necessary but insufficient.

- *Affective:* Acknowledging that despite a narrow focus on scientific rationality in medicine, doctors have emotional, embodied responses that shape their perception of their patients and the care that they offer. Analyzing and accepting responsibility for processing and recalibrating uncomfortable embodied and emotional responses to the tensions, conflicts, and uncertainties that arise in efforts to confront colonialism. Taking care not to reproduce harm or create more labour (affective or otherwise) for Indigenous patients and colleagues. Some of the common responses to the intense affective responses elicited through this learning process can be denial, resistance (which can manifest in multiple ways, including anger or avoidance), dissociation, numbing, shame, and guilt, which themselves can result in further harm to Indigenous patients and communities.

- *Relational:* Identifying, interrupting, redressing, and repairing the effects of the harmful, paternalistic dynamics that have characterized settler-Indigenous relations in healthcare throughout colonization. Recognizing the difficulties of this work and the need to prioritize developing relations grounded in respect, reciprocity, trust, and consent, rather than treating relationships in transactional ways.

This workbook offers resources, frameworks, and exercises to support settler physicians to deepen their intellectual, affective, and relational capacities to confront and interrupt colonialism in healthcare. Specifically, this workbook seeks to support settler physicians to:

1) Honestly confront their individual and systemic complicity in a health system that is not only unequal but often deadly for Indigenous Peoples;
2) Deepen their sense of responsibility to identify and interrupt systemic patterns of racism and colonialism in medicine, in their institutions, and in their own practice;
3) Recognize the extent of the learning and unlearning that still needs to be done in order to be able to effectively and ethically interrupt individual and institutionalized colonial harm;
4) Commit to enabling and supporting systemic, institutional transformations that can ensure Indigenous Peoples have ready access to culturally safe health care, and can govern (or move toward governing) their own health care; and,
5) Self-reflexively anticipate and navigate the range of foreseeable and unforeseeable challenges, complexities, conflicts, and mistakes that will be part of this process.

In addition to the three capacities we outlined, we also emphasize the need to develop stamina for the long-haul work of interrupting colonialism and anti-Indigenous racism in healthcare. If it is to be done well this work cannot be rushed, and there is no clear endpoint. Thus, it will require sustained efforts to go against the colonial grain, and discipline to stay with the difficulty. In particular, it will require settler physicians to persist in this work even when it feels uncomfortable and unsettling.

If at any point you feel overwhelmed by the extent and complexity of this work, it may be helpful to remember your past experiences with difficult learning. While the type of learning and unlearning invited by this workbook may be different from the kinds you are used to, everyone has persevered through some type of challenge and developed some degree of physical, emotional, or cognitive stamina. For instance, physicians have all persevered through challenging medical training programs that required

years of endurance and focus. As this workbook introduces some likely new and challenging areas of growth, remember and take courage from the fact that you have the capacity to learn, grow, and persist. It also encourages you to consider who pays the cost when you seek comfort and avoid difficult learning.

Psychodynamic Self-regulation: Holding Space for Your Internal Complexities and Contradictions

In modern societies, especially in modern systems of education, there is a strong bias towards Cartesian ways of thinking that create dichotomies between mind and body and the solid impression that we are self-transparent and coherent human beings. However, both ancient Indigenous knowledge systems and recent developments in Western psychology point to a much more complex picture of the human psyche. In the same way that we are surrounded by a cacophony of narratives around us, there is also a cacophony of narratives and affects within ourselves that is complex and paradoxical and that often gets ignored or placated. These narratives and affects are shaped by social forces and expectations, and also by internal dynamics related to unprocessed emotions and/or traumas, fears, insecurities, attachments, projections, perceived entitlements, fantasies and (self)idealizations. Therefore, our cognitive responses to difficult learning are often driven by conditioned affective patterns that manifest as different forms of resistance, such as denial, defensiveness, deflection, distraction and dismissal.

Unless we are prepared to observe and process our own cognitive, affective and relational complexity, there is no chance that we will have the capacity to observe and process the complexity around us. In this sense, psychodynamic self-regulation is one way of developing a meta-cognitive language that allows us to observe our own, complex and diverse, responses to difficult learning and to trace their trajectories in different dimensions and temporalities. We employ the term "psychodynamic self-regulation" in this workbook in recognition that our unconscious has also been colonized, therefore this use is slightly different from the use of the term in Western psychology. Psychodynamic self-regulation invites you into an ongoing self-reflexive inquiry where you develop a healthy skepticism towards your own conditioned narratives and desires, so that, instead of *reacting*, you can *respond* to difficult issues and challenges with deeper levels of sobriety, maturity, discernment and responsibility. The development of psychodynamic self-regulation is a safeguard that enables you to do the work on yourself so that you don't become work for Indigenous Peoples.

In this section, we introduce the "bus" methodology that can support psychodynamic self-regulation and enable the deepening of affective and relational capacities. As we noted above, because they are systemic, many colonial and racist patterns become habitual and unconscious for white and even racialized settlers, rather than intentionally reproduced. Thus, we need to make a significant effort to notice when these patterns are unfolding, both in ourselves and in our institutions. This requires a more general capacity to be able to sit with our own internal complexities and contradictions, especially those we might not be very proud of. These tend to become most visible when they emerge in response to being challenged by others.

To support the development of this capacity, the Gesturing Towards Decolonial Futures collective created the "bus" methodology. This methodology is premised on the notion that each of us has a metaphorical "bus" inside us that is filled with multiple different passengers. The methodology also works with other images of plural perspectives, such as a campfire, a forest, an orchestra, etc. The bus is the image that has proven to be most useful for difficult learning analogies. The methodology challenges the notion that we are or should be coherent in how we think, feel, and act. While usually there is only one "driver" at a time, different passengers make themselves known through their

thoughts, ideas, and affective responses to different stimuli. Usually, we are somewhat familiar with the passengers (and potential drivers) who are closer to the front of the bus, and less familiar with those closer to the back.

To use the bus methodology, we invite people first to learn to sit with and observe the different passengers on their bus. We tend to suppress those passengers that embody our shadow sides. The invitation of the bus methodology is to become familiar with, and accept (without endorsing), *all* of the passengers within ourselves, including "the good, the bad, the broken, and the messed up." Learning about our passengers enables us to develop self- and outward compassion, and to better consider how they impact us and others, and perhaps recalibrate them and how they express themselves (instead of either repressing them by denying their existence, or allowing them to take over the driver's seat in potentially unsafe or careless ways).

Ultimately, this practice can support us to decentre our egos, deactivate presumed entitlements and exceptionalisms, disarm our often unconscious defenses, and de-amplify harmful desires and projections. This, in turn, can enable us to develop more space and stamina to hold the tensions, dissensus, plurality and conflict that tend to arise in the work of confronting colonialism, and address these in more generative ways.

Throughout the workbook, especially when you start to feel affectively overwhelmed (e.g., uncomfortable, defensive, angry), we invite you to pause and observe which passengers are emerging and how they are responding to the situation—accepting their presence and their responses without judgement, endorsement, or attachment. In these moments, you can ask: *Which passengers are making themselves known right now?* Then subsequent questions: *What are they saying, thinking and feeling? Are they responding from a place of fragility, trauma, or insecurity? What are they projecting onto others? How old are they? How comfortable are they with uncertainty? How do the passengers relate to each other? What does each passenger need (and does this differ from what they want)?*

You can also ask more general questions about the state of your "bus." For instance: *Is the bus processing, or is there something 'burning' that needs to be expressed, or even 'vomited' (when roads get rough)? If so, how and with whom is it appropriate to vent or vomit (who can 'hold the bucket' without being harmed in the process)? What processing can be done on one's own?*

People might also find it useful to ask questions about the landscape that the bus is navigating, such as: *What is the current weather like? What are the conditions of the roads you are travelling on? Do you know which direction you are going, and who on the bus is deciding that direction?*

You can learn more about the bus metaphor here: https://decolonialfutures.net/portfolio/the-bus/

Before we proceed, we want to provide an opportunity for you to practice using the bus methodology. Remember, this is intended as a practice of *accepting without endorsing* different passengers' responses. As you read the text below, try to identify at least three different passengers who emerge in response to the text below. After you read, we will invite you to look more closely at these passengers.

Practicing the Bus Methodology: Beyond Window-Dressing Reconciliation

Depending on how they are implemented, efforts enacted by settlers under the umbrella of "reconciliation" can reproduce rather than interrupt harmful dynamics that leave untouched the root causes of Indigenous Peoples' health disparities, discriminatory experiences in the mainstream health care system, and barriers to self-determination in health and well-being.

In our research and practice, we have identified several common patterns that emerge when settlers try to respond to calls for reconciliation but end up reproducing colonial dynamics in health. We encourage people to be aware of these patterns and how they might be playing out in their own contexts.

These patterns include:

- Prioritizing quick, easy, and inconsequential changes that make a healthcare organization or individual "look good" but ultimately allow for the reproduction of colonial business as usual, leaving root causes of Indigenous Peoples' disparate health access and outcomes untouched (**reconciliation as window-dressing**) (Daigle, 2019; Jimmy, Andreotti & Stein, 2019)

- Prioritizing the maintenance of settler comfort and advantages by resisting deeper, more difficult, and uncomfortable engagements with settler complicity in the systemic, historical, and ongoing colonial harm enacted against Indigenous Peoples through the settler healthcare system (**reconciliation as a feel-good exercise**) (Stein, 2020; Tuck & Yang, 2012)

- Imposing settler priorities, sensibilities, and imaginaries of health, well-being, and responsibility onto the process of transforming health care systems, thereby ignoring the priorities, needs, and perspectives of Indigenous communities (**reconciliation as settler paternalism**) (Ansloos & Peltier, 2022; Dennis & Robin, 2020; Indigenous Health Writing Group of the Royal College, 2019)

- Reproducing accounts of Indigenous health in ways that pathologize and deficit-theorize Indigenous communities, position settler clinicians as benevolent helpers, and ignore accounts that address settler complicity in harm (**reconciliation as saviourism**) (Tuck, 2009)

- Expecting Indigenous peoples to shoulder the bulk of the (intellectual, affective, and relational) labour of institutional change, and expecting them to do it in a way that prioritizes settlers' comfort (**reconciliation as Indigenous Peoples' responsibility**) (Ahenakew & Naepi, 2015)

- Addressing systemic marginalization in non-specific ways that flatten the experience of different marginalized communities, thereby failing to address the specific impacts of settler colonization on Indigenous Peoples' health and well-being (**reconciliation as an extension of existing EDI**)

- Engaging Indigenous health knowledges without Indigenous Peoples' consent, involvement and leadership, resulting in engagements that are selective, extractive, tokenistic, and appropriative ways that fail to respect Indigenous Peoples' sovereignty over their knowledges (**reconciliation as consumption**) (Jimmy & Andreotti, 2021; Schmidt et al., 2021; Smylie et al., 2020)

Having read the text above, we invite you to begin to ask some basic questions about the bus passengers that emerged for you when you were reading. For instance: *What are these passengers saying, thinking, and feeling? Did any of these responses surprise or disappoint me? What am I learning about myself and my level of preparedness for the work of confronting colonialism by observing their responses?*

In the next chapter, we will invite you to work with your bus as you engage with a letter that was written by an Indigenous person to settler physicians.

Chapter 3: Letter from an Indigenous Person to a Settler Physician

The following letter was written by Stó:lō educator Dani Pigeau, with support from fellow Indigenous and non-Indigenous members of the "Beyond window-dressing reconciliation in health" research team. The letter reflects Dani's own experiences in the healthcare system within what is currently known as Canada, as well as the documented experiences of many other Indigenous Peoples within this system. Racism in Canadian healthcare stems from the ongoing, intergenerational legacies of settler colonialism. This letter was written as an invitation to settler clinicians to begin to confront the historical and continued ways that their professions have reproduced harm in the healthcare system. This is not an easy invitation to accept, because it asks physicians to honestly consider their own role in individual and systemic violence, even when they have good intentions and have committed to "do no harm." However, given the health outcomes and experiences of Indigenous Peoples, this difficult and uncomfortable work is not only necessary but also part of the professional responsibility of settler physicians.

By now, many settler clinicians are likely aware of at least some of the concerns that are articulated in the letter below, from increasing coverage in the news of colonial racism against Indigenous patients and growing efforts to respond to the TRC Calls to Action related to health (#18-24). More people have acknowledged that it is the responsibility of settler physicians to identify and interrupt the impacts of racism and colonialism on Indigenous Peoples' health and well-being, and to ensure that Indigenous Peoples have access to culturally appropriate and culturally safe health care. However, understanding and affirming these things intellectually does not always translate into changes in behaviour, due in part to the pressures of time, the strong forces of habit that shape clinical practice, and the desire to have one's benevolence affirmed. This often means that settler clinicians overestimate how advanced they are in the work of unsettling colonialism in healthcare, and underestimate how complex and challenging this work will be. This letter is an invitation to recognize this gap and indicate the work that lies ahead.

Confronting the dissonance between ethical commitments and professional standards on the one hand, and the impacts of prevailing colonial patterns of clinical practice on Indigenous Peoples on the other, often causes feelings of discomfort and even resistance for settler physicians. That is normal, and it is definitely not a reason *not* to do this work. In fact, those feelings generally indicate there is a lot of work still left to do. Thus, as you read this letter, we invite you to observe the responses that emerge on your bus. Specifically, we invite you to consider: *What are your bus passengers thinking, feeling, and feeling compelled to say in response to the letter? Where are these responses coming from in terms of your own socialization, education, and personal history? What are these responses teaching you about your investments, insecurities, fears, and what do you still have to learn and unlearn in order to take and support substantive action toward Indigenous health equity and self-determination?* After the letter, we offer some additional questions that can prompt deeper self-reflexive engagement and generative conversations about this topic.

Dear Settler Physician,

As a Stó:lō woman, this is not an easy letter for me to write. Part of me is frustrated that I even need to write it, but my own experiences have shown me how deeply racism and colonialism are embedded in our healthcare system, and that recent "reconciliation" efforts have not necessarily done much to change this. I have seen the way that settlers dismiss our Indigenous knowledges, experiences, laws, and

leadership; some even dismiss the work of their settler colleagues who seek to draw attention to racist and colonial patterns in health. So, I know it will not be a simple task to interrupt these patterns, and that my invitation for you to sit with these realities might be received with some resistance.

Rather than ask you to suppress this resistance, I will ask you to sit with and hold space for it long enough to get through this letter so that you can confront the individual and institutional work that still needs to be done in order to uproot racism and colonialism in the healthcare systems of what is currently known as Canada. In fact, by treating your own resistance as a teacher, you may also get a better sense of the work that you still need to do. This letter is not intended as an accusation, but rather as an invitation to relational accountability, with the intention of deepening your capacity as a clinician to manage your own discomfort when addressing these issues, and activating a sense of responsibility to identify and interrupt harmful patterns in the provision of health services for Indigenous Peoples. Developing this ethical capacity is not only increasingly expected as part of your job, but it will also make you a better physician. And it will make us as Indigenous Peoples more willing to seek western medical care when we need it.

I will first take a moment to re-examine some of the national stories we have been told about Canada's origins and history as a nation-state, to begin to come to terms with the truth of what Canada is all about. We will then look a bit more specifically at the origins and history of health care in Canada and the ways it has been delivered to Indigenous Peoples, before considering some of the ways that the current practice of healthcare and health services delivery can, despite its good intentions, continue Canada's dispossession and elimination of my people. The reality is that racism is deadly.

At certain points throughout the letter, I will share some of my own experiences with the healthcare system. Although some of these stories are painful to recount, I know it is important for them to be told. I will also share some of the things I have observed when settlers are faced with your complicity in harm, and I'll invite you to attend to these interactions differently, from a state of heart, guts, and mind that is oriented in the service of: providing culturally safe care that respects the dignity and bodily autonomy of your Indigenous patients; improving Indigenous health access and outcomes; and working to support Indigenous self-determination in health care – that is, our "ability to exercise authority, participate in decision-making practices, possess control over health, and to play an active role in health service planning, design, and delivery" (Webb, Mashford-Pringle, Allin & Mauer-Vakil, 2022, p. 5).

Although there is no checklist or formula for this work, I will present you with some specific tasks that can help you to start this shift. However, please keep in mind that transforming centuries of colonial 'common sense' will not happen overnight, and we will need to develop stamina for the long-haul.

Historical context

While you may hold particular ideas about yourself, your country, and your profession, if you want to challenge settler colonialism in health care, you will have to challenge the inherited narratives we have been told. It will be important for you to open yourself to considering other perspectives on these narratives, especially the perspectives of Indigenous Peoples. We have had our lands stolen and polluted, our children taken away and killed, our governing structures demeaned, our cultures scorned, our bodies disrespected and defiled, and our sacred spiritual practices demonized and outlawed such that at one time our people were incarcerated if they practiced them. And this is not just in the past – much of this is still happening today, so that you can enjoy the comforts and benefits offered by settler society.

Canada has allowed a few formal inquiries to take place, aimed at documenting and coming to terms with a historically accurate depiction of the nature of the country's relationship with Indigenous Peoples, such as the Royal Commission on Aboriginal Peoples (RCAP), the Truth and Reconciliation Commission (TRC), and the National Inquiry into Missing and Murdered Indigenous Women and Girls (MMIWG). The TRC, for example, identified the origins of Canadian 'rule of law' – of Canada's unaccountable assertion of sovereignty over Indigenous lands – as being based on the notions of *terra nullius* and the Doctrine of Discovery. These are essentially beliefs that the land was empty of sufficiently-human beings, supposedly justifying the seizure and occupation of the region and supposedly justifying white settler domination over anyone and anything already present in the region. The TRC called for the repudiation of all laws based on these principles that sought to undermine the existence and worth of Indigenous Peoples. The Vatican recently repudiated the Doctrine of Discovery, which they said "did not adequately reflect the equal dignity and rights of Indigenous peoples." So far Canada's laws that are based on and justified by presumptions of my inferiority or sub-human status have not yet been repudiated. We can flag that as an outstanding or incomplete responsibility that we need to continue to check up on. In fact, very few of the Calls to Action have been fulfilled in the years that have passed since the time the TRC finalized its report and made the Calls in 2015. The Yellowhead Institute formally tracks progress toward completing those calls. As of 2021, they found, "Canada has not completed a single Health Call to Action."

Now let's back up a bit to the origins of health care in Canada, particularly care provided by the state to Indigenous Peoples. Many Canadians find great pride in the universality of the Canadian healthcare system. And settler Canadian health professionals often understand themselves as champions, in a global context, of advocating health equity by advocating for universal health care. I could tell you some facts that point to how this "universality" is more universal to some people in Canada than others, especially Indigenous communities. The teacher in me wants to lay out the basics of the history of the health care system's complicity with colonialism, such as its role in residential schools, TB sanatoriums, Indian Hospitals, weaponizing smallpox for land theft, medical experimentation, and genocidal policies and practices such as forced sterilization (which was still happening as recently as 2019). But I'll leave it to you to learn about that elsewhere as it is all well-documented and readily available to those who are interested. I also encourage you to learn about the long history of Indigenous Peoples who have fought for health equity and for Indigenous Nations to be able to govern and manage our own health decisions.

However, it's important to note that these issues aren't only in the past. You can find numerous reports and news stories about how racism within the health system has led to Indigenous patients' neglect and death. You can also trace the failure of federal, provincial, and territorial governments to meet their stated commitments to improve Indigenous health, and their refusal to accept the proposals offered by Indigenous Nations for how to address anti-Indigenous racism in the healthcare system.

Speaking just from my own experience and the experiences of people in my extended family, physicians have questioned whether I'm "really" in pain, or if I am just pretending in order to get access to painkillers. I have had serious illnesses misdiagnosed for months before I had someone take my symptoms seriously. I have had physicians stare and ask inappropriate questions about my ceremonial markings during routine exams. I have had my son's doctors question my parenting abilities. I have had doctors dismiss and minimize the critical symptoms of medical emergencies of my family members, and fail to provide the necessary referrals to specialists that would have provided crucial health support. I have had doctors blame me for illnesses that are the result of systemic inequities and violences.

Unfortunately, anti-Indigenous bias is internalized by settlers of all backgrounds, not just white Canadians. In one experience, a recently arrived racialized immigrant doctor accused me of faking a disability. As an Indigenous woman, my initial step in seeking to ensure my mental, physical, emotional, and spiritual wellness was to prioritize traditional medicines, ceremonial practices, and cultural support, and then to turn to western medicine as needed. Because the doctor assumed that the only valid way to treat medical illness is through western medicine, and because I didn't meet her expected image of Indigenous person experiencing a severe health condition, she concluded in her report that I was trying to exploit the benefits system. Apparently, from her perspective, Indigenous Peoples are only worthy of support if we appear weak, helpless, and grateful for the "charity" of non-Indigenous people.

Overall, through my experiences in Canadian healthcare, I have been made to feel like I am less worthy of care than other patients, like I am trying to "cheat the system," or that my health issues are a result of personal failings rather than the result of systemic and intergenerational inequities. Many of my family members simply avoid seeking healthcare altogether because of negative past experiences, worried they will be disbelieved, neglected, or institutionalized against their own will. When I have to seek care, I feel extremely anxious and reluctant, and I often now ask a white friend to accompany me to the hospital or a doctor's office, knowing that I am likely to receive better treatment if they are present. Each time I feel the need to seek western medical care, I have to make a difficult choice: either prepare myself to experience (and relive) medical trauma by receiving racist, dismissive, and neglectful responses from physicians, or endanger my health by not seeking care. In both cases, I am at risk of harm as a direct result of ongoing systemic discrimination.

De-exceptionalizing Western medical expertise

Canadians also take pride in the excellence of the medical expertise in the Canadian health system. By many measures, Canadian medical expertise is great; but it is not the only health knowledge and practice that exists, or that has value. The presumed exceptionalism of Western ways of knowing and doing has been central to rationalizing settler colonialism, including *terra nullius* and the Doctrine of Discovery, the legal justifications for white settlers to ignore Indigenous sovereignty and take over Indigenous land and resources. This same presumed exceptionalism of western knowledge and practice has characterized medical care by settlers in Canada from the very beginning, and it has been accompanied by the dismissal and even demonization of our Indigenous health knowledges and practices.

That same knowledge-system arrogance continues to this day. Despite being a comparatively young and evolving field of study, the language commonly deployed in the settler health care system (e.g., "evidence-based medicine", "best practices", etc.) is steeped in an ongoing claim of superiority that dominates and systematically marginalizes any non-western ways of understanding and practicing health and wellbeing. The supposedly exceptional nature of Canadian western health care is also mobilized in the false, paternalistic, and racist narrative that Indigenous Peoples are "fortunate" and should be "grateful" that European colonizers came to bring us western medicine and in so doing supposedly lifted us out of our misery to save us from ourselves and our "backwards" ways.

I'm not saying there is no value in western medicine – it is extremely important and has saved the lives of many people, including me and people in my family. But I have been taught to understand medicine from a place of deep reciprocity and respect, and western medicine has always been presented to me from a place of authority and force. I have also been taught that when a medicine is not offered in respectful and relationally appropriate ways, it can become a poison. Because western medicine has

been a source of harm for me and many people in my family, it has compromised our trust in the western medical system. Perhaps now you can understand a more bit about why so many Indigenous people are hesitant to seek medical care from settler clinicians – and thus, why I'm writing this letter.

Beyond good intentions

It is also important to discuss the notion of Canada as a champion of health equity, such as in the work done to advance the social determinants of health. Canada only adopted its "universal" Medicare insurance system a few decades back, and it did so with the economic rationale of keeping the Canadian workforce healthy to support the growth of Canadian economic development. 'Well, economic development is generally good for population health,' you might say. 'Employment is the most important determinant of health,' you might add. That might have some truth in certain contexts, and for certain communities. But for Indigenous Peoples in Canada, the advancement of economic development has often taken place in a way that is premised on the appropriation of our land. And appropriation of my people's land is premised on my people's eventual assimilation or elimination.

The capitalist pursuits of unfettered economic growth and extractivism are premised on land theft and come at the direct expense of my people's wellbeing. We can see this, for instance, not only in the ways that resource extraction projects deny Indigenous sovereignty and displace Indigenous peoples, but also in how these projects lead to many negative health impacts through a number of complex social and ecological pathways beyond any direct toxic exposures (Brisbois et al., 2019), including increased incidence of violence against Indigenous women, girls, and gender-diverse people. Thus, Canada's pride in the universality of health care here is not a pure, innocent or wholesome pride. It has often been contingent on supporting a colonial, capitalist logic that continues to harm my people and our lands.

Our people have had a more holistic and collective understanding of what determines a community's wellbeing for a very long time. For instance, Cree scholar Cash Ahenakew writes (2019) that for many Indigenous Peoples, "well-being is about steadiness, resilience, and smoothness of physical and spiritual relations in order to enable reciprocity, generosity, compassion, and gratitude within an environment where everything is interwoven" (p. 21). Our health is not just about physical well-being but also mental, emotional, and spiritual, and is also intimately intertwined with the health and well-being of our territories. However, our systems of knowledge and expertise have been consistently dismissed and made invisible in settler society. We can see this type of erasure happening even in Western science's proud claims that they discovered how to achieve "health equity." The Canadian healthcare system's work to achieve any of its measures of health equity must be understood in context. The important context for present-day advances in health equity by the colonial healthcare professionals is often dismissed: that health equity advances are happening only after settlers initially came to this land with colonial systems, as well as new diseases, that decimated the pre-existing levels of health equity that Indigenous Peoples had already established through our own health knowledges.

Canadian pediatrician and medical researcher Dr. Frederick Tisdall serves as an illustrative example of this pattern: First, cause death and ill-health through nutrition-deprivation research experiments on captive Indigenous children. Then, claim that this was necessary for inventing your Pablum formula that saves children's lives. Get awards, career advancement, statues and buildings named in your honour.

I explain the problem of this partial accounting of Canadian advances in health equity not to say that the healthcare system should not pursue health equity. Indeed, we desperately need greater equity to help ensure the well-being of communities like mine. But I remind you of a fuller accounting of health equity

in Canada in order to encourage you to have some humility in it, to be more aware of the historical context of this pursuit, and aware that it often positions settler people and your knowledges as superior to Indigenous Peoples and our knowledges. That positioning is both untrue and harmful to my people. I invite you to find a way to separate the gifts of Western medicine and healthcare from the arrogance of believing it is superior to other health knowledges and practices. And to be more accountable for the harms that Western medicine has caused and is still causing for Indigenous Peoples. This might enable you to better address the limits of Western medicine and healthcare, as well, and appreciate both the gifts and limitations of health knowledges and practices that are different from your own.

Interrupting colonial patterns

From the idea of settler Canada's health care exceptionalism, to its universal accessibility, to the celebratory framing of more recent commitments to advance health equity, many settler Canadian health professionals and your workplaces are steeped in beliefs that settler people are exceptional helpers and that Indigenous people benefit from that help. The evidence does not actually support those beliefs. And each time new evidence is presented that demonstrates how wrong that story is, the reaction from settler Canada is an emotional apology and a promise of 'doing it better next time' for Indigenous Peoples. In some cases, this is even followed by new funding streams and initiatives to support Indigenous health. Yet despite all of this, examples of the harm that we experience by and through the health care system continue to repeat. A cyclical pattern emerges; it's exhausting.

Only once you are able to start to identify this pattern, and attune to the harm that it causes, will we have a chance of stopping it. And stopping it will also require you to accept your specific responsibilities as a settler and as a physician who is living and working within this ongoing colonial context.

I'll take a moment here to remind you that not all Indigenous people think the same. There is no one "Indigenous culture", or Indigenous viewpoint. There is a lot of heterogeneity both within and across the over 630 First Nations, as well as Inuit and Metis communities. Other Indigenous people in Canada can certainly speak for themselves. You may come across some who have adopted western approaches to health and are content with them. Others depend on western health systems but do so under duress with no other viable options for seeking medical care. Many speak out critically, although those people often receive a backlash for doing so. Others, like me, try out different ways of engaging with settlers in the hopes that these efforts might result in opening cracks in settler structures and institutions that could interrupt the centuries-long colonial dynamic that continues to hurt and kill Indigenous Peoples.

While I speak of "settlers" in general terms here, I recognize that not all settlers have the same identities and positionalities as each other and thus the nature of responsibilities can differ. For example, a recently immigrated female Asian Canadian physician has a different position than a white male Canadian physician whose ancestors have been here for centuries. Both are settler physicians, but they would have different experiences and different degrees of power, privilege, and responsibility within a predominantly white and patriarchal settler Canadian health system. The ways that people are situated within multiple, interlocking systems of oppression (e.g., race, class, gender, ability) is termed intersectionality. In some contexts and conversations, it's really important to emphasize how these different systems of power operate within the broad category of "settlers." In this text, however, I have emphasized settlers in general in order to emphasize the settler colonial dynamics of healthcare, and to remind us that it is not only white settler physicians that can reproduce harm.

I should also note that when I talk about settlers, I am talking about your structural position of domination in relation to Indigenous Peoples and our lands. This is not about being "good" or "bad" people. I know many different kinds of settlers, including some that stand alongside me in this fight for health equity, some that have tried to stand in my way, and everything in between. But at the end of the day, you all have responsibilities that come with the fact that you benefit from colonialism.

Fundamentally changing course

I dream of a future when Indigenous communities have access to the best available health care, from both Indigenous and western health traditions. I dream of a future where our communities are actively involved in the design, management, and governance of our own health systems. I dream of a future where it is easy and affordable for us to access Indigenous doctors, nurses, midwives, pharmacists, and dentists, and where we can receive culturally safe care from settler doctors, nurses, midwives, pharmacists, and dentists as well. [Inspired by the visioning of the First Nations Health Council, 2011.]

Indigenous health practitioners, including those trained in both western and Indigenous health traditions, are already leading us into these futures. But in order for these futures to become possible, we need settlers to do their part as well, especially settler healthcare professionals. We need you to recognize that settler colonialism is real and ongoing in what is currently known as Canada, and that your professions have a long and still-unreckoned-with role in propagating and sustaining it. Because of the wider context of reconciliation and movements for Indigenous rights, settler clinicians are expected to be aware of this and be actively working toward changing and redressing it. Increasingly, it is considered unprofessional to deny the historical and ongoing impacts of racism and colonialism in health.

Questioning the foundations of a system that you have personally invested a lot into, and that gives you a lot of benefits, can be hard. I don't know exactly what you feel as settlers when these foundations of yours are shaken. But I know that it must be very difficult, and can activate many different types of reactions among settler people. I know this, in part, because I have seen these reactions and often people take out their defensiveness on me. I want to acknowledge that this is difficult for you, but I also want to name the fact that this difficulty does not compare to the pain Indigenous Peoples have experienced at the hands of many settler healthcare professionals throughout Canadian history. When you prioritize your feelings instead of your responsibility, efforts toward Indigenous health equity stall.

By reading this letter, you may have started to identify your own position of systemic advantage within a settler colonial healthcare system. You may have also identified some of your own assumptions or behaviours that are also part of the problem that I am pointing to. Noticing the harmful implications of your own behaviour to date, as you look back at it with a new perspective, may make you feel ashamed or embarrassed or even angry. But remember that these patterns are naturalized and normalized by settler society and institutions, and that's why they are so common. You're not a "villain" if you identify yourself and your healthcare institutions as part of the problem. In fact, this is a prerequisite for systemic change. Confronting colonialism in the health care system and in yourselves is only the first step for settlers in a long-haul process of change that will require you to:

1) identify and interrupt the structures, practices, and attitudes that continue to reproduce racist and colonial dynamics in mainstream healthcare systems;
2) mobilize support (materially and otherwise) for the resurgence of Indigenous health care knowledges and practices (without attempting to claim ownership of them); and,

3) advocate for changes to existing policies and funding structures that would enable Indigenous communities to make our own healthcare decisions that are more aligned with our political rights, cultural values, and health needs (Webb et al., 2022).

Apologies that are not followed up by substantive, systemic change will likely be called out by Indigenous people and our allies as being hollow and performative. However, real change cannot begin until settlers first accept responsibility for your individual and collective complicity in colonial harm.

You might already be good at identifying and challenging overt racism from other settlers who say that Indigenous Peoples should be thankful to settlers and need to "get over it," etc. But you need to know that it may not be those people who are the biggest problem. The people who use the benevolent language of "helping Indigenous people" are actually a lot more numerous and have a lot more traction in public discourse and institutions. Settler paternalism is more insidious than overt racism as it demeans Indigenous Peoples while recentering settlers as caring helpers. Settler colonialism has, from the very beginning, been premised on notions of good intentions and care. Thus, settlers' good intentions are not enough, and in many cases, they are a significant part of the problem.

In short, the problem of settler colonialism is a relational problem, in that it results from a denial of settlers' responsibilities to Indigenous Peoples and our lands. This includes the responsibility to repair colonial harms done through rebuilding respectful relationships as well as enacting material forms of restitution. This will require respecting our bodily sovereignty in terms of making personal health decisions, as well as respecting our political sovereignty to make decisions about our healthcare as Nations. While you may be accustomed to seeing Canadian healthcare policy as benevolent, it is important to try and understand from our perspective how it treats us in unequal and paternalistic ways. And while you may be accustomed to seeing yourself as a benevolent healer, and as someone who holds the moral and epistemic authority to decide what is best for our health, you will need to interrupt presumptions of your own exceptionalism and innocence, and respect our right to decide.

If you really want to resolve this relational mess, we will need to learn to move and breathe together very differently, toward different possible futures. That means respecting each other's different paths while also fulfilling your professional duties and your duties as settler citizens of Canada to advocate for your government to respect the Treaty and inherent rights of Indigenous Nations. Instead of paternalism and pathologization, you will need to learn to develop relationships with Indigenous Peoples grounded in trust, respect, reciprocity, consent, and accountability, so that you can support us to make our own self-determined health decisions and to access culturally relevant and culturally safe forms of health care.

Things to take with you from this letter

I know I've covered a lot of ground here, so I will leave you with some key takeaways that summarize this letter and can support you to begin, or continue, this (un)learning process:

- The health care system in Canada has been shaped by centuries of settler colonialism, and the experiences of Indigenous peoples within that system are also shaped by colonialism. It is important for settler physicians to educate themselves about the impacts of colonialism on Indigenous health.
- Indigenous Peoples' health outcomes are not just individual, they are also systemic – negatively shaped by the settler colonial dispossession of their traditional lands, livelihoods, and food systems as well as by unequal access to care and other health resources, a lack of respect for Indigenous

Peoples' self-determination, and the harm and neglect of settler doctors (whether intentional or not).

- Recognize that when Indigenous patients come to you, on top of the general power differential between doctor and patient, your relationship is shaped by the long history of settler-Indigenous relations, including Indigenous peoples' negative experience in the health care system. This isn't personal, it's systemic, but it is likely to affect the relational dynamic with Indigenous patients.
- Colonial racism against Indigenous peoples is also not about 'bad' individuals – it is systemic; but this also means that individuals that are part of these systems have a responsibility to change them.
- Harm has often been done by settler physicians with "good intentions", which is why it is important to emphasize the impact of your actions rather than your intention, and to listen to your Indigenous patients when they tell you about their medical issues or when they indicate their discomfort. Remember that it is up to your Indigenous patient to decide whether or not they have received culturally safe healthcare – so if you are not sure, ask – and then listen, even when it is hard to hear (while also recognizing that some people might not feel comfortable to share even when asked).
- Like all patients, Indigenous Peoples deserve culturally safe and culturally relevant healthcare. If you received standard graduate training in Western medicine, you may not yet be equipped to provide this. Although you are used to being the expert, it is ok and in fact important to have the humility to admit there are some things you don't know and still need to learn. A similar principle applies to Indigenous medicine – as a settler, this is not and will not be your area of expertise, but you have a responsibility to respect the choices of patients who are also seeing Indigenous practitioners.
- There is considerable work that settler physicians will need to do in order to repair the violences already done by the health professions to Indigenous Peoples, and build good relations with Indigenous patients. This work includes regularly asking yourself (with honesty and humility):
    1. How did I mess up, how can I make things right, and what can I learn from that mistake?
    2. How can I adjust my own practice to ensure more culturally relevant and culturally safe care for Indigenous patients?
    3. How can I advocate for systemic and institutional changes to help ensure Indigenous patients are better served in my context of work (hospital, practice, etc.)?
    4. How can I better support and mentor emerging Indigenous medical students and interns without reproducing paternalistic dynamics?
    5. How can I identify opportunities to engage with Indigenous doctors, healers, and knowledge holders to learn more about their approaches to health, medicine, and wellbeing in reciprocal and respectful (i.e., non-extractive and non-exploitative) ways?
    6. How can I identify further opportunities to educate myself about settler colonialism in general, and in healthcare specifically?
    7. How can I support Indigenous Nations seeking resources and respect for their rights to determine their own health systems?

    This work will not be quick or easy; it requires a long-haul commitment (and increasingly, it is not optional – you will be expected to do this work as part of your job and professional standards).

Thank you for taking the time to read this letter, and consider its implications for your life and work.

Sincerely,

Dani Pigeau

Questions to consider after reading the letter

- Can you identify three passengers that emerged on your bus when you were reading the letter? What were they each saying? Thinking? Feeling? Did you manage to observe these passengers' responses without investing in them? What did you learn from observing them?
- Did you witness a desire in yourself for quick fixes or for seeing yourself outside of the problem (e.g., as a "good settler/good doctor")? How could these desires reproduce harm?
- Did you witness yourself getting impatient or annoyed with the letter (or the letter writer)? At which parts? Where did this impatience or annoyance come from? What is it teaching you?
- To what extent do you feel you are able to honestly confront the aspects of yourself, and your profession, that you or other people would not consider flattering or desirable?
- How much time and energy do you invest in seeking and/or demanding validation for your knowledge, work, innocence, authority, or your positive self-image? Why is this important to you? What do you (and others) gain and/or lose from this investment? What insecurities could be driving this behavioral pattern? What sensations have arisen in your body when engaging with these questions?
- How prepared are you to hold space for difficult (painful, overwhelming, irritating) issues and conversations without demanding affirmation or quick fixes? How can you expand your capacity for holding discomfort? From whom, or what, might you need to learn to do that?
- What is the next, most responsible, small thing you can do to deepen your engagement with the complexities and complicities raised in the letter? What do you need to commit to doing in the long-term?

Chapter 4: A Brief History of Colonialism in Western Medicine in Canada

In this section, we offer a brief history of the effects of colonialism on Indigenous health in Canada, drawing heavily from the work of Eng Stime (2022). We review the Canadian state's egregious record regarding Indigenous health, informed by sobering and well-documented historical events and policies. We also consider the Canadian healthcare profession's record regarding Indigenous health. We do so not to incite feelings of guilt or shame in settler clinicians, but rather to more accurately and accountably situate the current pursuit of health equity within a longer temporality. Through this approach, we seek to centre the responsibility of settler physicians in addressing the contemporary impacts of the accumulated intergenerational harms inflicted on Indigenous Peoples by the settler health profession.

As you read, we encourage you to pay attention to what is happening on your bus – what are the different passengers saying/thinking/feeling in response to the history that is being reviewed? Remember that the invitation is to accept that these responses are present within you, without necessarily endorsing those responses. After we review the history, we will invite you to do an exercise that makes these passengers present so that you can ask what you are being taught by their responses.

Origins of the settler health system and its impact on Indigenous peoples

Before European colonization, Indigenous Peoples had their own sophisticated governance systems. Europeans, intent on expanding their reign into Indigenous territories, forced Indigenous Peoples off of their lands and into colonial power structures. These structures or systems of governance and imposed 'rule of law' were specifically designed to serve the European people's own interests and goals. Hierarchies of cultural, social, and racial superiority were invented as they were needed to justify these systems imposed by European colonizers. The European colonizers also self-affirmed their colonial project with religious arguments that further justified a supposed 'God-given' right to rule over Indigenous Peoples. European nations consciously chose a relationship of colonialism in interacting with Indigenous Nations. Other alternative relationships, including relationships that were respectful of all people's dignity, were possible at the time, but these were not chosen by the colonizers.

The initial health impacts of colonization arrived through numerous new infectious diseases European settlers brought with them, and to which Indigenous Peoples had no biological defenses or cultural adaptations (First Nations Health Council, 2011). This included smallpox, influenza, typhoid, measles, whooping cough, Tuberculosis, and venereal diseases. The impact of these diseases on the Indigenous population decline was staggering, with a population loss of up to 90% following European arrival (First Nations Health Council, 2011). These deaths significantly weakened the physical, political, and social strength of Indigenous communities and thereby facilitated the taking of land by white settlers.

As settler colonialism began to dominate the geography of the continent that came to be known as Canada, and as the emerging nation's health system's origins were being established, the attempts at annihilation or extermination of Indigenous Peoples involved, at times, the intentional spread of these diseases, including smallpox, the most devastating of the European-introduced diseases (Boyd, 1999; Lange, 2003; Monchalin, 2016; Townsend, 2009). Starting in the 18th century, Indigenous Peoples suffered a heavy death toll from smallpox, despite the existence of a smallpox vaccine and familiarity with how to use quarantine to stop the spread. By withholding these, settler public health policies facilitated the genocidal spread of this disease. The death toll resulted in settlers viewing Indigenous Peoples as a 'dying race,' while the population of white settlers surged with the gold rush (Ostroff, 2017).

In this setting of Indigenous communities recently devastated by disease, the Canadian state was established in 1867 and the Indian Act was passed in 1876 by the Canadian government. Among other objectives, the Indian Act was a piece of legislation that was operative in "destroying […] traditional practices of health and healing" (Mawani, 2020, p.3). Soon after, in the late 19th century, settlers sought to "clear the plains" and enact treaty negotiations on favourable terms by withholding food from Indigenous Peoples suffering from famine and malnutrition, especially as bison populations shrunk due to bovine diseases introduced by settlers' domesticated cattle, as well the intense slaughter of bison driven by demands for buffalo hides. Lack of access to adequate food also made Indigenous Peoples more vulnerable to further illnesses like tuberculosis (McCallum, 2017).

The settler Canadian health care profession at the time generally aligned with presumed superiority of Western knowledge systems over Indigenous knowledge systems, and failed to guard against vicious misapplication of the knowledge that it did have (as in the weaponization of smallpox). Under a Western medical paradigm that shaped health care delivery and practice in Canada, the preservation or improvement of health was seen as largely dependent on the invention and use of new Western medical techniques or technologies. This arrangement subordinated Indigenous Peoples beneath the authority of settler Canadian so-called 'experts,' and framed them as inherently unhealthy rather than as Peoples suffering from ill-health as a direct result of colonial practices and policies. Further, traditional Indigenous practices of health and well-being were not just devalued and denigrated, in many cases, they were also criminalized. As a result, many Indigenous survivors of genocide have lacked access to these practices, and thus, lacked access to the appropriate means of mourning and healing.

Not surprisingly, the measured health status figures for Indigenous populations began to contrast sharply with settler populations', a contrast that remains sharp through to present times. However, as historian Mary-Ellen Kelm (1998) illustrates, discourses about such measures of health have been contested by Indigenous Peoples for the ways they have regularly cast Indigenous Peoples as embodying inequity, as being on the verge of "dying out," and as "essentially pathetic, pathological, and powerless" (p.xvii). It was not until recent decades that state-funded health professionals would begin to more systematically attend to the population-level health inequity between communities, with health measurement and surveillance attention focused also on the social aspects of health.

However, as health information scholar Keith Denny (1999) describes, medical discourse in Canada is not historically neutral, but rather is designed to protect its own established authority within a cultural and political context. In fact, as settler public health scholar John O'Neil (1993) has articulated, when the actual drivers of health disparity are ignored (such as colonialism) "public health surveillance systems perform disciplinary and regulatory functions in society independent of their overt purposes of tracking health conditions." He adds, too, that "an image of sick, disorganized communities can be used to justify paternalism and dependency" (p.15). So even when the settler health profession has finally begun to attend to some of the measures that might indicate a problem when it comes to health equity in Canada, our measurements tend to be framed in ways that ignore the underlying processes of colonialism and instead point to more intervention from the presumably benevolent health system.

Situating Canadian health equity

As the Canadian state consolidated its coast-to-coast-to-coast control, regularly engendering health inequities and violences through processes of colonization, it often enlisted or implicated various health professionals in its policies. While we might imagine that in Canada there is a clear separation between

political power structures and medical knowledge or medical practice, health information scholars have described how medical authority is intimately linked to political power structures (Denny, 1999).

In other words, the practice of Western medical care in Canada has been deeply shaped by the Canadian state. The influence of the state on medical practice includes funding (or absence of funding), commissioning of reports, and surveillance and measurement that supports particular framings and courses of intervention (and discredits others). Through this influence, the practice of medicine in Canada has and continues to facilitate the political assertion of settler authority and the ongoing dismissal of any challenges to the state's authority. Consider this non-exhaustive list of examples of how the Western medical profession in Canada has, over the course of Canada's history, supported policies that favoured the state's control over the land and over Indigenous Peoples:

- Mid-19th century: Supporting a germ theory that grafted well onto colonial routines that cast Indigenous Peoples as being inherently ill (suspectable to infectious diseases) because of their own deficiencies (framed as filthiness, squalor, poverty) (Anderson, 1998),
- Late-19th century & Early-20th century: Supporting efforts to boost white/British/'right-sort' population growth by becoming increasingly preferentially concerned with white maternal and infant mortality (Cassel, 1994),
- Late-19th century: Supporting a eugenicist "economic prosperity" discourse that allowed sterilization policies, denying Indigenous Peoples' humanity, dignity, and bodily autonomy while diverting attention away from the oppression of the settler state, and carrying out the surgical work of those policies (Stote, 2015),
- 1862: Participating in selective policies of vaccination, quarantine, and forced expulsion that intentionally spread deadly disease through vast expanses and among numerous Indigenous Nations, effectively securing the settlers' ability to assume political control over those regions (Boyd, 1999; Lange, 2003; Monchalin, 2016; Townsend, 2009),
- 1867-1929: Organizing the medical profession's associations and its internal governance in ways that catered preferentially to the needs and interests of white upper- and middle-class men (Cassel, 1994),
- Late-19th century & early-20th century: Accepting and repeating the discourse that ill health results essentially from poor personal decisions (Cassel, 1994), which would further justify the state's treatment of Indigenous Peoples in ways that did not uphold their dignity,
- 1930s – 1960s: Focusing on curative medicines rather than on prevention (Cassel, 1994), which exacerbated existing colonization-induced conditions of poverty and disease,
- 1930s – 1990s: Operating Indian Hospitals – with medical experimentation, physical restraints, and disregard for consent refusals – as hospitals designed in response to fears from the white Canadian population that Indigenous people embodied an epidemiological threat (Kelm, 1998),
- 1942-1952: Participating in, and adding to, the horrors of residential schools by conducting nutrition-deprivation medical experimentation on more than 1000 captive children (Mosby, 2013),
- 1974: Shifting to an interest in non-medical determinants of health only once there was an economic rationale for the state to do so (Lalonde, 1974),
- 1979: Working within a state-imposed framework (i.e., the Indian Health Policy) that framed the problem of poor Indigenous health as being a matter of Indigenous Peoples' inherent personal, cultural, and moral failings and deficiencies (Crombie, 1979),

- 1986; Championing calls for social justice and equity as a prerequisite for "Health for All" while largely ignoring Canada's ongoing colonization and land occupation as the biggest driver of social injustice and inequity in Canada (Epp, 1986; WHO, Health Canada, & CPHA, 1986),
- Early-21st century: Continuing to celebrate Canada's commitment to health equity (e.g., MacDougall, 2007; Martin et al., 2018), while failing to fully grasp or directly address the ongoing colonization that the healthcare system is embedded in and facilitates,
- Early-21st century: And continuing to claim that, given the supposedly superior or exceptional Western medical expertise that flows from Western education and training programmes, "We're the ones building the future" (UBC Faculty of Medicine, 2021).

Whitewashed and unaccountable narratives about the evolution of Canada's Medicare system and of its equity-oriented public health approach are commonly repeated (e.g., Butler-Jones, 2009). Such narratives fail to consider the implications of the fact that there were contemporaneous attempts at genocide taking place even as these 'equitable' systems were being conceived and elaborated.

Indeed, in their movements to recognize the importance of health equity and advocate for it, the healthcare professions in Canada seem to, with some exceptions, invisibilize or minimize the impacts of the most notable cause of health *in*equity that would signal the need for a focal shift: ongoing colonization of Indigenous lands and of a population dispossessed and subordinated by settlers. This overview of how foundational processes determining health have paradoxically invisibilized systemic inequity, even within systems of vocal public advocacy for health equity, can guide our outlook and positional-awareness while engaging with this workbook's subsequent material.

Invitation to a debriefing exercise

Read the following 'clusters' of possible responses from fellow settler physicians to the history we've just reviewed. As you read, see if you can identify what the grouping of responses was based on – how would you 'categorize' or summarize each cluster?

Cluster 1

- "If Indigenous people don't want our 'colonial' medicine, then they don't need to come to our hospitals."
- "I get that systemic issues matter, but a lot of my Indigenous patients clearly just don't care about their own health. Changing our behaviors as doctors won't change that."
- "So, when we don't provide care, we're being 'neglectful'; but then, when we do provide care, we're being 'paternalistic' and harmful. We can't win! What do they want from us?"
- "The person who wrote this obviously has never dealt with an unruly Indigenous patient who was clearly just looking for their next opioid fix."

Cluster 2

- "This offers a very ugly history of our profession. It kind of makes me wish I had gone into a different line of work, like engineering, or teaching. Then we wouldn't have to deal with all this baggage."
- "It's a shame what happened, but what am I supposed to do about the past? It was a different time back then, and we can't judge it by the morals of the present."
- "This is all important stuff, but at the end of the day, western medicine has done more good than harm."

- "I agree with fighting back against oppression. But my own story also involves fighting against other layers of systemic oppression to get to the place I am as a physician, so I'm not going to let 'making space for' the Indigenous struggle supersede my own gains in the medical hierarchy."

Cluster 3

- "I want to support my Indigenous patients to access traditional Indigenous health practices, but I don't know how. I'm afraid I'll say the wrong thing, so I often end up doing nothing."
- "I'm trying to educate myself about these things, but it's hard when we have so much other continuing education to keep up with. There are a lot of competing priorities"
- "I find it hard to balance the call for humility with the professional expectation that we should make healthcare decisions based on our medical training and expertise."
- "I don't want to repeat the paternalistic mistakes of the past, but I feel really conflicted when an Indigenous patient doesn't follow my medical advice, especially when I know that their health will likely suffer as a result."

Cluster 4

- "This stuff is pretty hard on my ego, but I also know that facing it can make me a better doctor, especially for my Indigenous patients."
- "I'm realizing just how much I don't know about the history of my own field, and how much I need to learn so that we don't repeat the same mistakes as in the past."
- "I am learning to trust my Indigenous patients to make their own healthcare decisions – which has required unlearning my own arrogance. It's not easy, but it's important."
- "I can see how in my practice I have reproduced harm. I think if I continue to pay attention, I will keep finding more of these harmful patterns in my practice that I will need to change."

Read the clusters a second time. This time, pay attention to what is going on inside your bus. For instance, are there passengers responding especially strongly to any of the statements? Take note of both strong identification/agreement and strong dis-identification/disagreement. Are there responses to the history review that are present on your bus, but were absent from these clusters? What are they?

Consider the questions below in order to identify what you are learning from processing in this way.

Basic questions

1. What other responses do you think are likely to emerge amongst settlers in response to the history (or the workbook in general), but are missing from the list above?
2. Have you heard comments like these before? If so, how did you respond? Would you respond differently now?
3. How would this history likely be received by other settler physicians in your workplace?
4. What do you think is the most likely distribution of responses (e.g., which are more or less likely to emerge amongst settler physicians and have wide support)?
5. Did some of the responses listed bother or resonate with you more than the others? If so, which ones and why? Were there some you felt ambivalent about?

Advanced questions

1. What responses emerged on your bus during the exercise? What did different passengers think/feel/say? Did you feel the urge to share the thoughts/feelings/narratives of certain passengers with others (e.g., seeking outside reassurance that you are a 'good' healthcare provider)? Which passengers were the 'loudest' or most activated? Which passengers' responses surprised you the most?
2. What sensations did you notice in your body while completing the exercise, and this chapter overall? Did you notice tightness or constriction? Temperature changes - places that felt hot or cold? How did your gut feel? Changes in your breathing or heart rate? Places that felt numb? Or hypersensitive?
3. How did you feel toward the workbook/its authors while reading this? Were there moments when you were tempted to stop reading or found yourself distracted? Did you find yourself immediately doubting the facts recounted in the history? If so, where did this/these response(s) come from?
4. How did this exercise differ from usual exercises where you are asked to either agree or disagree with what has been presented to you (rather than ask what you are learning from engaging with it)?
5. What did you learn from observing these different responses on your bus/in your body?

Chapter 5: Learning to Show Up Differently with Indigenous Clients, Colleagues, and Communities

Because the settler colonial system has prioritized the rights and comforts of settlers – in particular, white settlers – at the expense of Indigenous Peoples, often when they are asked to confront colonialism, settlers can experience feelings of defensiveness, discomfort, and resistance.

For instance, settlers often expect to be made to feel comfortable and affirmed. This can lead them to prioritize the maintenance of their own 'good' feelings rather than prioritizing their responsibility to identify and interrupt harmful colonial systems and desires, or consider the feelings of Indigenous colleagues or patients. This can also lead Indigenous people to feel pressured to use a "filter" to appease settlers.

This section offers frameworks and exercises that can prepare settler physicians to stay with and be taught by their own discomfort, sit with their complicity in harm without seeking affirmation or absolution, and learn to accept the inevitable challenges and complexities of confronting colonialism in medicine. Working through these resources, observing and being taught by the responses on your bus, can prepare you to have difficult conversations in more generative, generous, and accountable ways.

Why I Can't Hold Space for You

The first exercise in this section is centered around a poem, authored by members of the Gesturing Towards Decolonial Futures Collective, that was written from the perspective of an Indigenous colleague – in this case, an Indigenous physician – who is frustrated by the demands and the labour placed on them by their settler colleagues. This includes the labour of both educating settlers about colonialism, and being expected to do so in a way that does not activate their settler colleagues' negative emotions (and their subsequent resistance, which is often then projected back onto the Indigenous person).
To engage the exercise, first read the poem once all the way through. As you read, please pay attention to the different kinds of responses that it evokes in you (or in the passengers on your "bus"). After you have read the poem once, read the instructions that follow for the second part of the exercise.

Do You Really Want to Know Why I Can't Hold Space for You Anymore?

Because
You see my body as an extension of your entitlements

Because
I have held space for you before
and every time, the same thing happens
You take up all the space
and expect me to use my time, energy and emotion
in service of fulfilling your desires:
to perform my trauma
to affirm your innocence
to celebrate your self-image

to centre your feelings
to absolve you from guilt
to be always generous and generative
to filter what I say in order not to make you feel uncomfortable
to validate you as someone who is good and innocent
to be the appreciative audience for your self-expression
to provide the content of a transformative learning experience
to make you feel loved, important, special and safe
and you don't even realize you are doing it
and you don't even realize you are doing it
AND YOU DON'T EVEN REALIZE YOU ARE DOING IT

Because your support is always conditional
On whether it aligns with your agenda
On whether it is requested in a gentle way
On whether I perform a politics that is convenient for you
On whether it fits your personal brand
On whether it contributes to your legacy
On whether you will get rewarded for doing it
On whether it feels good
Or makes you look good
Or gives you the sense that we are 'moving forward'

Because when you 'give' me space to speak
It comes with strings attached about
what I can and cannot say
and about how I can say it
You want an easy way out
A quick checklist or one-day workshop
on how to avoid being criticized
while you carry out business as usual

And even when I say what I want to say anyway
You can't hear it
Or you listen selectively
And when you think you hear it
You consume it
You look for a way to say 'that's not me'
'I'm one of the good ones'
and use what I say to criticize someone else
Or you nod empathetically and emphatically to my face and then
The next thing you do shows that while you can repeat my words
Your perceived entitlements remain exactly the same

And when I put my foot down or show how deeply angry or frustrated I am
You read me as ungrateful, incompetent, unreliable and betraying your confidence
You complain behind my back that I'm creating a hostile environment

You say I'm being unprofessional, emotional, oversensitive
That I need to get over it
That I'm blocking progress
That I shouldn't be so angry
That I have a chip on my shoulder
That my ancestors lost the battle
That not everything is about colonialism or racism or whiteness
That aren't we all just people, in the end?
That we are all indigenous to some place
That you feel really connected to the earth, too
That you have an Indigenous friend/colleague/girlfriend that really likes you…
You minimize and further invisibilize my pain

Your learning
your self-actualization
your credibility
your security
and your social mobility
always come at my expense.
That is why I can't hold space for you anymore.

After you read the poem once, we invite you to read it a second time, this time focusing on observing your embodied responses, perhaps trying to identify the different responses from passengers on your bus.

Finally, we invite you to read the poem a third time, and to use a psychological narrative to focus your attention on the responses of your amygdala, which is the part of the brain that stores information about emotional events and that manages situations of perceived threat.

In modern societies, our brain is trained to minimize threat and maximize reward. If something is perceived as a threat to one's self-image, status, autonomy, or security, the amygdala is triggered, prompting responses of fight, flight, freeze and/or fawn (i.e., to please). As you read the poem again, identify the parts of yourself that are engaged in these patterns of response:

Mapping patterns of response to perceived threats

fight (defensiveness)	flight (avoidance)	freeze (feeling lost and helpless)	fawn (trying to please)
● denying ● arguing ● explaining ● dominating discussion	● withdrawing ● getting distracted (intentionally or unconsciously)	● crying ● numbing ● deflecting ● exiting	● seeking absolution ● self-flagellation ● martyrdom ● over-complimenting

● delegitimizing/ discrediting ● claim of being attacked ● claim of objectivity (only you see the truth) ● insistence that it does not apply to you since you have Indigenous friends or family members that can attest that you are a nice person	● focusing on your intentions ● insisting you are misunderstood ● arguing over words meanings or other details ● offering counterexamples ● bringing up other forms of oppression (e.g., class, sexism, cis-heteronormativity) to minimize the importance of race and colonialism	● getting distracted ● changing the subject ● distancing ● detaching ● divesting ● despairing ● disconnecting	Indigenous people ● seeking proximity to Indigenous Peoples ● seeking immediate forgiveness/absolution ● seeking praise ● virtue-signalling ● demanding attention ● demanding validation (e.g., "I am one of the good ones") ● pretending to go along to get along (or to protect your image/interests)

As you identify these responses in yourself (or in the passengers on your bus), try to document (in writing, drawing, recording, etc) how they manifest. Next, consider the fears, insecurities, and desires that could be behind these responses, and how these fears, insecurities, and desires could be unconsciously driving your actions and relationship building with Indigenous persons and communities.

Pause to consider:

- The costs of these patterns in the long run both for the well-being of Indigenous Peoples and for the depth and sustainability of the relationships you build together;
- What you would need to unlearn to enable healthier and more generative relationships with Indigenous people and communities;
- How you might be expecting Indigenous colleagues to hold space for your (un)learning and have patience with your inevitable mistakes;
- How this expectation places a demand on Indigenous colleagues' time, labour, and generosity, and requires them to re-live painful and traumatic experiences and frustrations;
- How the labour that is expected of Indigenous peoples could be better acknowledged, compensated, and better yet, (re)distributed in your institutional context.

Layers of Settler Responsibility

In this section, we offer a set of basic questions that can prompt deepened self-examinations or discussions amongst settler physicians about different layers of settler responsibility in relation to medicine in Canada. In addition to the intellectual, affective, and relational layers that we have previously named, we also gesture toward historical, political, and economic layers as well. Keep in mind that these are only a handful of the possible questions that could be asked about each layer.

In healthcare contexts, it tends to be intellectual accountability that is most commonly invoked (to varying degrees of depth and commitment), often to the exclusion or marginalization of others. Most efforts to address colonialism in health will focus on one or two of these layers of responsibility, at most. Indeed, although the layers intersect, it is difficult if not impossible to address all of them at once.

One way to approach these questions is by trying to actually answer them and thereby amass more "information" about individual and institutional responsibility at an intellectual level. However, another way of approaching these questions is to consider how your bus passengers are responding to them - using a psychodynamic approach. Both approaches are valuable in their own ways, and not mutually exclusive. The former approach can leave you better informed about the ways that settler colonialism shapes medicine. The latter approach can support you to better understand how you respond when faced with difficult questions, which in turn might enable you to respond in more generative, less defensive ways when you receive similar questions, especially when they come from Indigenous colleagues or patients. In both cases, by committing to "doing your homework," you can hopefully create less work for Indigenous people.

Whichever approach you take, consider that there are many more questions that could be added to the list for each layer. As you read, consider what additional questions are coming up for you/your bus passengers. These questions might be more general, or they might be specific to your own social positionalities, past experiences, and the communities with whom, and context within which, you work.

Intellectual responsibility

- How does western medical knowledge continue to shape most healthcare education, research, practice, and administrative organization? How do these western foundations affect the reception of, and resources allocated to, Indigenous Peoples and knowledges?
- What individual and institutional white middle-class sensibilities and norms might be preventing Indigenous health knowledges and practices from being respected in the Canadian health care system (e.g., in existing standards and clinical guidelines)? How might these sensibilities and norms be interrupted in order to affirm the equality and integrity of Indigenous health knowledges?
- How are Indigenous and other de-/anti-colonial critiques of Eurocentrism in healthcare policies, curriculum, and research generally received in your context of work (e.g., ignored; attended to in earnest; engaged in selective and instrumentalizing ways; deeply engaged)?
- For the questions in this exercise that you don't feel like you have the answers to, why not? How might this be something more than just an intellectual or informational problem?
- What other questions about intellectual responsibility are emerging for you?

Affective responsibility

- How do you react when someone suggests that your ideas or actions reproduce racism or colonialism? Are you defensive? Are you open to receiving feedback about (inevitable) mistakes?
- Do you know how to sit with the implications of your individual and institutional complicity in colonial violence without feeling overwhelmed, running away, disidentifying, or seeking immediate absolution? How could you deepen your capacity to sit with these implications?
- How might your desires for control, authority, certainty, security, and/or innocence get in the way of developing the humility, patience, and stamina required to confront colonialism in medicine?
- Are you willing to put in the difficult, uncomfortable work that is required in order to do this work?
- What other questions about affective responsibility are emerging for you?

Relational responsibility

- Is there a relationship between your healthcare system and/or institution, and local Indigenous community/communities? If so, what is the quality of that relationship? Who sets the terms of that relationship? How is power distributed within that relationship?

- Is the system/institution prepared to offer support (financial and otherwise) to, and collaborate with, Indigenous health practitioners and healers?
- Are you and your settler colleagues expecting Indigenous colleagues or patients to engage in (intellectual, emotional, and pedagogical) labour that should be your own responsibility? How are you seeking out the education you need in order a better physician to your Indigenous patients?
- What do you expect to hear when Indigenous colleagues or patients speak, and why? Are you able to 'hear' Indigenous people when they deviate from that script?
- What other questions about relational responsibility are emerging for you?

Historical responsibility

- What has been the historical relationship between the Canadian healthcare systems and institutions, and Indigenous Peoples and knowledges, and how has this relationship shifted across time (or not)?
- How does the historical development of healthcare systems in Canada relate to the development and dominance of a settler society?
- How do the colonial foundations of settler healthcare in Canada shape contemporary healthcare? How do these foundations shape your own practice
- Who benefits from forgetting certain histories, and foregrounding others? What are the common responses when people bring up systemically marginalized histories?
- What other questions about historical responsibility are emerging for you?

Political responsibility

- What responses emerge within you when you hear the suggestion that Indigenous Peoples should be able to govern their own healthcare and manage their own health systems if they choose to do so (as indicated in Section 35 of the Canadian constitution)? Where are these responses coming from?
- What *legal* responsibilities do non-Indigenous healthcare institutions have to local Indigenous Nations? What *ethical* responsibilities do non-Indigenous healthcare institutions have to local Indigenous Nations?
- To what extent are local Indigenous Nations a genuine (non-tokenistic) part of decision-making related to issues of land at your institution (e.g., construction projects for new hospitals)?
- Do institutional engagements with questions of colonialism name and seek to interrupt ongoing unequal power between Indigenous and white settler individuals and communities?
- What other questions about political responsibility are emerging for you?

Economic responsibility

- How are private *and* public sources of funding for Canadian healthcare institutions derived (directly and indirectly) through a colonial economic system that is premised on ongoing dispossession?
- What are the origins of the wealth from which your healthcare system's/institution's endowments, foundations, and other forms of wealth emerge? In what are endowments, staff pensions, *et cetera* currently invested?
- How can healthcare institutions and systems engage in forms of reparative redistribution to support Indigenous health and well-being, especially through Indigenous-led health and well-being initiatives?
- How can healthcare-funding bodies and insurance companies ensure that Indigenous Peoples can use their health coverage to pay for the cost of Indigenous medicines and Indigenous healthcare?
- What other questions about economic responsibility are emerging for you?

Fast-Tracking Lessons Already Learned: 10 Propositions

To conclude this section, we share some of what we have learned from engaging this work thus far, and from the colonial desires and assumptions that tend to arise amongst settler physicians. This summarizes some of what has been shared in this workbook, as well as our previous work in the area of Indigenous-settler relations. We have tried to map what, educationally, could help ground settlers in their learning and unlearning journeys, considering the common circularities that tend to emerge and the high costs of this learning for Indigenous Peoples. We offer 10 propositions that can accelerate the process for settlers to confront their complicity in colonialism, and expand their capacity to interrupt harm in health practice.

These propositions are framed as "fast-tracking lessons already learned" that can help prevent settler physicians from repeating mistakes that have already been made several times, usually at the expense of Indigenous peoples. The sooner you accept these lessons, the sooner you will be able to show up in more generative ways to serve Indigenous patients and work with Indigenous colleagues and communities.

As you read these propositions, we invite you to observe how different passengers on your bus are responding. Ask where these responses are coming from, and the implications that each response would have for your ability to weave different kinds of relationships with Indigenous peoples.

1) **Western medicine is rooted in colonial foundations.** As was summarized in Chapter 3 of this workbook, Western medicine in Canada has many roots in settler colonization. These foundations continue to shape Canadian healthcare today, and their ongoing impacts must be considered as part of any effort to confronting colonialism in medicine. Historically there has been a lack of education around these foundations. Although this is changing for medical students who are increasingly exposed to courses focused on these issues, most practicing physicians do not have extensive knowledge of these histories and ongoing legacies of harm. Nonetheless, this knowledge is available in many resources produced by both settlers and Indigenous peoples.

2) **Colonialism is a matter of expense, not just exclusion.** In many cases, settlers frame the primary harm of colonization as the fact that Indigenous Peoples have been excluded from the "progress" and prosperity of settler colonial society – including high quality social and public services like health care. What this framing ignores is that it is not simply that Indigenous Peoples have been *excluded* from these benefits (though they often have), but also that these benefits have been secured at their *expense*. The very existence, as well as the funding, of western health care systems in Canada are dependent on the historical and ongoing dispossession and commodification of Indigenous Peoples' ancestral territories, as well as their brutal treatment in non-consensual medical experiments conducted by settler individuals and institutions (see Recognition 1). In this sense interrupting and redressing colonialism in health care and other social institutions is not about simply "including" more Indigenous Peoples and knowledges into existing systems, but asking how those systems can be transformed not only to better serve Indigenous Peoples but also in ways that do not reproduce, or depend on the reproduction of, colonial relationships and dynamics.

3) **The most important determinant of ill-health for Indigenous Peoples is colonialism.** There is no way of improving Indigenous Peoples' health and well-being without addressing settler colonialism as the primary driving force in processes that determine Indigenous ill-health. Indigenous Peoples have been saying for a long time that interrupting settler colonialism is foundational for wellbeing. Unfortunately, white health professionals have consistently dismissed or downplayed the role of

ongoing colonization on Indigenous Peoples' health. In recent decades, language about the "social determinants of health" has become almost a marker of progressive public health thinking, sparked by the 1974 Lalonde Report with its focus on non-medical determinants of health and further invigorated in the 1986 Ottawa Charter for Health Promotion and its socially attuned aim of "Health for All." However, in present-day health practice, "social determinants of health" are generally treated essentially the same as conventional risk factors are, slotting them into a reductionist and individualist paradigm of health causation rather than refocusing on the social systems and intergenerational processes of domination and dispossession that are causing ill-health and health inequities in the first place. As a result, income is often cited as "the most important determinant of health," which both erases the specific impacts of settler colonialism on Indigenous Peoples and imposes a white capitalist paradigm of health and well-being onto Indigenous Peoples. Instead, settler health professionals can come to understand and account for how the foundational and ongoing processes of colonization continue to affect every aspect of health and well-being for Indigenous Peoples.

4) **The indifference and arrogance of settler healthcare professionals kill Indigenous peoples**. Some Indigenous people suffer or even die at the hands of settler healthcare professionals because of neglect and poor levels of care, such as receiving less rigorous, less timely, or inappropriate medical treatments. Indigenous patients' concerns are often dismissed because of anti-Indigenous racism, either because they are not taken seriously, they are suspected of "faking" or exaggerating pain, or because the settler health professional has failed to listen to the patient and understand their needs. Other Indigenous people avoid seeking medical care altogether, in an effort to avoid demeaning and humiliating experiences in the healthcare system. This avoidance is based on their own past negative experiences with that system, and/or that of their family members. Even filling out medical forms can be a difficult and traumatic experience for some Indigenous people. Indigenous Peoples have the right to access information about their health and the health of their communities, which should be communicated in ways that are accessible and non-judgemental. This will also require settler healthcare professionals to accept Indigenous patients' self-determined health choices (and support policy changes that support Indigenous self-determination in health). This is a matter of life and death.

5) **Many Indigenous people have different ideas of health and well-being than settlers and the settler health system.** Many Indigenous approaches to health and well-being are more collective and holistic than settler approaches to health and well-being. Indigenous approaches tend to prioritize the need for balanced relationships between different parts of the individual self, as well as balanced relationships with others, including not only other humans, but also other-than-human-beings, and the land itself, as well as ancestors. These approaches have been dismissed, pathologized, and even demonized by the settler health system. Settler physicians will likely never fully understand Indigenous approaches to health and well-being, not having been raised or educated in those systems. However, in order to interrupt harm, settler physicians will need to not only understand the impacts of colonialism, but also understand that Indigenous Peoples have their own practices for health and well-being that need to be respected.

6) **Indigenous Peoples have the right to access both Indigenous and non-Indigenous health systems, and to make their own health care decisions.** Settler physicians often assume that they know what is best for their Indigenous patients, a dynamic that reproduces paternalism and ignores the patient's right to determine their own healthcare and approach their health on their own terms. Some

Indigenous people embrace western healthcare wholesale, some Indigenous people reject western medicine and prefer to only seek Indigenous healthcare, and many Indigenous people are in-between. If you encounter an Indigenous patient who is reluctant to follow your medical advice, accept that, rather than become defensive. You were trained in western medical knowledge, not in any of the many other systems of health knowledge that exist. Your own medical expertise is typically restricted to one specific knowledge system. Support your Indigenous patients in their efforts to seek out health experts from relevant knowledge systems.

7) **Indigenous Peoples are diverse.** While it is pedagogically important to make broad distinctions between Indigenous and Western approaches to health and well-being, there is also a lot of heterogeneity *within* both approaches. There is no singular, pan-Indigenous perspective that represents all Indigenous Peoples and their health knowledges. Further, as in all complex communities (including settler communities), there are conflicts within Indigenous communities over power and authority. Projections, idealizations, and stereotypes about Indigenous Peoples held by settler physicians can get in the way of the latter's ability to offer quality healthcare to Indigenous patients that is appropriate and responsive to their individual and cultural needs and choices.

8) **Both individual and systemic change are hard, and require a long-haul commitment.** It will take a lot of time and work to interrupt colonial patterns within the Canadian healthcare system, and create the possibility of more ethical relationships of trust between settler physicians and Indigenous patients and communities. Although there are many useful resources available to support settler physicians in this learning and unlearning process, there is no checklist or formula. It will unfold over many years, and likely involve many mistakes and failures. When you make a mistake, try and repair the negative impacts, learn from those mistakes, and develop the stamina to continue the work over the long-haul and through the ups and downs. Relationships that are sustainable in the long term are built on respect, reciprocity, consent, and accountability, but different communities have different understanding of these terms. No one approach to relationship building works across all contexts. The colonial desire for quick fixes, formulas, and universal solutions is one of the greatest obstacles to being able to weave relations between settlers and Indigenous Peoples in ways that account for the weight of historical harms and the complexities and challenges of interrupting (often unconscious) colonial patterns.

9) **Practicing critical self-reflexivity is key to confronting colonialism.** One way to critically self-reflect is to be attentive to your own social positionalities, including your position of power in relation to others – such as your positions as a settler and as a physician. Take the time to consider how differently positioned people could be "reading" you in any given context. Conversely, consider how you are "reading" different people in that context as well. By making this a regular practice, you can learn to more deeply scan a situation and discern the naturalized intellectual, affective, and relational patterns that are present in yourself and in others, especially when those patterns are harmful. Attuning to the perspectives and affects of people from different positionalities can also support a practice of interrupting harmful patterns. Here are a few questions that can prompt self-reflexivity: *How wide is the gap between where you think you are at, and where you are actually at? How might you be prioritizing your own comfort at the expense of deeper learning and more accountable clinical practice? How might you be making more work for other people (especially Indigenous colleagues and collaborators) without realizing it? What unconscious attachments, fears, projections, and desires may be directing your thinking, actions and relationships as a physician? How do these impact your relationships with patients? What cultural ignorances do you continue to*

embody and what social tensions are you failing to recognize? To what extent are you aware of how you are being 'read' by different communities, especially Indigenous communities? How can you respond with humility, honesty, and hyper-self-reflexivity when your work or self-image are challenged?

10) **Tokenism and a desire for "quick fixes" wastes valuable time and resources.** Indigenous peoples and communities can recognize when settlers are focused on the optics rather than the substance of engagement. Forms of engagement/reconciliation that seek quick resolution and the continuity of "business-as-usual" generally backfire with reputational and relational costs for settlers and/or their organization, wasting time and resources that could otherwise be spent addressing complex challenges. The desires of settlers to restore their sense of innocence and benevolence, to achieve (superficial) harmony or consensus with Indigenous Peoples, often end up suppressing or flattening conflicts, paradoxes, and complexities. This can also deflect accountability for the systemic, historical, and ongoing violences that enable the comforts, opportunities, and security that are secured through colonialism. These approaches tend to center the comfort of settlers, at the expense of doing the difficult work of addressing tensions and conflicts that are actually impeding the possibility of healthy, reciprocal relationships between settlers and Indigenous Peoples.

Chapter 7: Wrapping Up

As we conclude this workbook, we recognize that this is one small piece of a complex, multi-layered, long-term inquiry into the question of how to confront colonialism in healthcare. We also wish to indicate some future areas of inquiry that are orienting the work of members of our research team.

Systemic trauma-informed health education

Cash Ahenakew (2023) has proposed a "systemic trauma-informed approach to education" (STIE). He writes, "This approach to education, like individual trauma-informed care, is based on choice and consent. However, unlike individual trauma-informed care, it focuses on the interruption of systemic trauma, which involves inviting people to sit with their complicity and implication in systemic harm." STIE is based on the understanding that educators have an ethical responsibility to critically examine the knowledge and systems in which we are embedded in order to identify and interrupt historical, systemic and ongoing social and ecological violence. STIE focuses on the collective trauma and impact of historical, systemic and ongoing violence and of systems of unsustainability that characterize modern/colonial societies. It requires participants to be ready and willing to question their narratives about the world and about themselves, to examine their emotional responses to difficult issues and to evaluate and expand their capacity to build and repair relationships in accountable ways. Because of this, it is important for participants to assess whether it is the best time and context for them to engage in education informed by this approach so that they can grant or refuse consent. This workbook was inspired by the notion of systemic trauma-informed health education; however, further work remains to be done to develop this approach and accompanying pedagogical practices and curricular resources.

Supporting Indigenous self-governance in health

While we have emphasized the importance of supporting Indigenous self-governance in health throughout this workbook, this is an area of increased focus and interest amongst many Indigenous Peoples. We suggest that in order for settlers to support Indigenous self-governance in health, they might consider the following guiding principles: recognizing that self-governance is not something settlers benevolently "grant" to Indigenous Peoples but rather is part of their inherent rights, recognized by the Canadian constitution but not always upheld or respected by the government; challenging assumptions of settler benevolence and the idea that settlers "know better", in terms of health care and the overall process of systemic change; and actively reflecting on how individual settler behaviours and systemic policies and practices repeat colonial dynamics that ultimately stand in the way of strong Indigenous health governance (Richardson & Murphy, 2018). For example, layers of colonial bureaucracy based on ongoing paternalistic attitudes about Indigenous people can impede Indigenous health systems' access to adequate resources (Halseth & Murdock, 2020; Webb et al, 2022).

Expanding the conversation to include other health professions

While this workbook has focused on doctors specifically, it is likely to have resonance in other health professions and adjacent professions, including nurses, dentists, public health officials, mental health workers, social workers, physical therapists, home health aides, etc. If you are a settler healthcare worker in one of these other health fields, we invite you to consider the following questions in relation to this workbook: To what extent and in what ways do the patterns, dynamics, and histories identified in the settler physician workbook found in your own profession? How did your bus respond to hearing about another, adjacent profession's complicity in colonialism – did it make it easier or harder to consider similar dynamics within your own field? In what ways are people within your profession being asked or

expected to attend to the profession's historical and ongoing colonial entanglements? What are the complexities and challenges that have emerged within these efforts? What might be the essential elements of a similar workbook or learning and unlearning resource or process in your field?

Postscript: Expanding the conversation to include nurses and other healthcare disciplines

By Andréa Monteiro

While the focus of this workbook has been on physicians, its relevance extends to various other health and related disciplines. These include nurses, dentists, public health officials, mental health workers, social workers, physical therapists, healthcare assistants, and more. As someone who identifies as a racialized settler, scholar, and nurse, I found this workbook highly relatable to the nursing profession.

Like the medical field, my experience within nursing academia reveals a predominant influence of Western knowledge in shaping nursing education, research, and practice. This workbook deeply resonated with me because I have grappled with unlearning colonial aspects ingrained through my nursing education, and this process continues in my role as a researcher and educator.

During my graduate studies, I delved into the experiences of racialized nurses within nursing education programs in the context of the white settler nation-state known as Canada (Monteiro, 2018). Here, I share a glimpse of how Eurocentric education impacts the lives of IBPOC (Indigenous, Black, and People of Color) nurses, with a particular focus on the experiences of Indigenous nurses.

Canadian nursing schools promote multiculturalism, equity, and diversity as part of their mandates. However, research within the Canadian and US contexts reveals a disconnect between these stated aims and the actual realities. Studies suggest that nursing schools often function as spaces dominated by white hegemony. In my research, I sought to challenge this prevailing white hegemony and the predominantly Eurocentric curriculum. I did so by examining the experiences of racialized nurses, shedding light on how they navigated the complexities of learning within environments where systemic racism was pervasive.

The narratives provided by IBPOC nurses unveil intricate experiences characterized by several recurring themes. These themes include "Othering," where participants experienced discrimination; the "white gaze" through which they were perceived; the challenges of navigating spaces primarily designed for white individuals; the identification of accents as markers of difference; the perpetual need to “prove” oneself; and the overarching impact of racism on health. Participants identified that they were seen through a white gaze while in nursing school and engaged with the study as an avenue for challenging and resisting the systemic racism woven into the fabric of their educational environments.

The accounts of racism shared by participants demonstrate colonization’s historical and deeply entrenched influences in nursing. These influences are inherent to the foundation of the white settler nation-state and continue to shape the landscape of nursing education. One instance involving an Indigenous nurse illustrates the pervasive nature of racism within the classroom setting:

> During class if we were talking about Indigenous issues or topics, sometimes they were positive, but most of the time they were negative. It would always be the stereotypes, or assumptions, all the things you see in the news about Indigenous people, like the poverty, or there is no running water in communities. I felt that we, myself, and other Indigenous students, we always get approached, the teacher would look at us, briefly, and you would feel that you needed to speak up, or you need to speak up to clarify and kind of say no, that is not how it is. That is not the way we live and that is not how all Indigenous people are. In those times when I did speak up, sometimes I felt “oh, should I do this or should I not,” like, I don’t want to make a scene. Because people always say, “oh, you need to let that stuff go.” You’ll see numerous comments, or people constantly

> saying, "oh you need to let that history go" or "you need to let the past go," and it is like, but we haven't been able to deal with it, at all. Any trauma that myself or my family or my grandparents have faced, hasn't been something that any of us have ever been able to deal with at all, so we can't let this stuff go, when you haven't been able to address it yourself, and to ask a whole group of people to let it go, it's really hard and difficult to see how it's presented out in the world, and in class.

This nurse also recounted instances where she constantly heard remarks suggesting that, as an Indigenous student, everything was provided to her without cost, implying that things were handed to her and other Indigenous students due to their ethnicity. She also encountered the misconception that Indigenous individuals don't pay taxes. These statements often originated from white students who would casually ask, "Oh you don't have to pay for your school, it's free, right?" The Indigenous student expressed how frequently she faced this question from her peers, an inquiry that made her uncomfortable. She highlighted the irony of this situation by pointing out that she would never inquire about others' personal finances in the same manner. These interactions, far from being harmless inquiries from naïve white students, served to silence and demean her. They underscored the presence of deeply ingrained, unquestioned racism within nursing schools and society at large, permitting such derogatory remarks to persist. From her perspective, nursing school seemed tailored for white nursing students and failed to acknowledge or incorporate her traditional ways of being:

> Yes, [nursing school] caters to that population [white]. Even the teaching style and method is catered in that way. [For me] growing up I have always been taught, you know, we'll sit and listen to family members, and my grandmother, and we never would write down any history, we don't write down any stories or teachings, or learning. That's not something that we've ever done. I've never seen my grandmother write down stuff she's learnt, anything. So, to go from that type of dynamic, being really close, to going to a classroom where you're expected to write everything down and to be able to do a test, it's different, I find. We have to adapt to that learning style, which is different to what I have been brought up to learning, and how I was brought up being taught. So, I find that's hard.

The educational experience of the Indigenous nurse highlights that contemporary nursing students are obliged to assimilate into a Eurocentric and predominantly white milieu. This assimilation can potentially be re-traumatizing, mimicking the education and health care system's complicity with residential schools' legacy of colonialism. The student shares this advice with nursing teachers, which we can expand to physicians and other healthcare professionals:

> Sometimes I think it's hard to teach people who are already set in their ways. It is hard to let everything go that they know and open up their minds and hearts to learn about Indigenous people and their experiences because they may not see how they came off or they may not see how hurtful things can be during class and in clinical, and I hope that they can learn what it is to be an instructor to an Indigenous student and teaching this content in class, because it is not easy. And it is very traumatic, if you're talking about colonization and residential school and all the stuff that has happened to Indigenous people in a class with Indigenous students it is hard… they need to be reminded that this is still going on… and they need to be part of the change and not the problem…it is frustrating how stuck people seem to be.

Although this research was completed in 2018, every time I engage in classroom or conference presentations, many IBPOC students, nurses, and healthcare professionals express that they continue to encounter multiple instances of racism within educational settings. They often disclose, sometimes for the first time as if given permission, their experiences of racism originating from instructors, peers, patients, and coworkers (including physicians, social workers, fellow nurses, etc.). Consequently, this

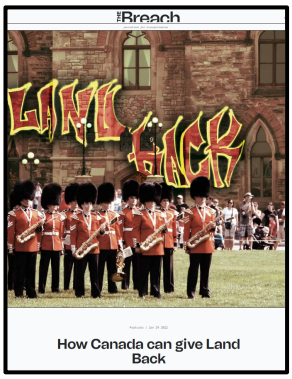
workbook provides an avenue for us to actively reflect and confront our personal complicity and our profession's role in perpetuating systemic harm. To look beyond ourselves and our disciplinary biases and limitations.

As Gustafson (2007) highlighted, examining racism within nursing education can be perceived as a challenging or unnecessary pursuit within predominantly white spaces. This is due to the contrast between the negative concept of racism and the positive image associated with the caring nature of the nursing profession. I concur with Gustafson that the premise that nursing is a caring profession (the same goes for physicians, social workers, etc.) tends to preclude us from examining the ways that racism is central to our educational practices. After all, Florence Nightingale remains an enduring symbol of nursing, embodying ideals of care, purity, religiosity, and whiteness. Thus, it is important for nursing educators to interrupt taken-for-granted assumptions of innocence, naiveté, and benevolence and to hold Canadian nursing schools accountable to their colonial past and present.

If you are a settler nurse or healthcare worker in one of these other health fields, we invite you to consider the following questions about this workbook:

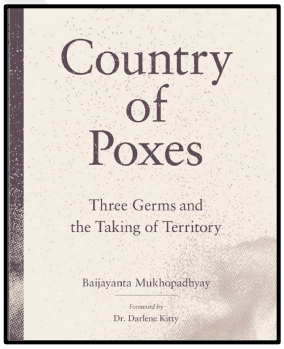
- To what extent and in what ways do the patterns, dynamics, and histories identified in the settler physician workbook found in your own profession?
- How did your bus respond to hearing about another, adjacent profession's complicity in colonialism – did it make it easier or harder to consider similar dynamics within your disciplinary field?
- In what ways are people within your profession being asked or expected to attend to the profession's historical and ongoing colonial entanglements? What are the complexities and challenges that have emerged within these efforts?
- What might be the essential elements of a similar workbook or learning and unlearning resource or process in your field?

Brief Annotated Bibliography



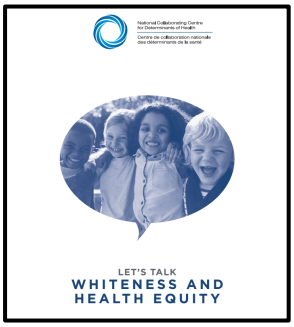
How Canada can give Land Back: As Indigenous rights continue to gain support, what would a policy agenda for land restitution look like? by Justin Brake, 29 Jan 2022.
https://breachmedia.ca/how-canada-can-give-land-back/
This article about the return of land (and the legal pathway to doing so) may be a helpful article for beginning to imagine a parallel process for the return of authority to Indigenous Nations of the healthcare systems in Canada. Return of the authority over healthcare systems in Canada may sound like an impossibility. But when we consider the negative impacts that settler health systems have had on Indigenous Peoples, returning governing authority over healthcare to Indigenous governments may begin to seem like less of an impossibility and more of a complex, but not impossible, future horizon.

Country of Poxes: Three Germs and the Taking of Territory by Baijayanta Mukhopadhyay, 2022.
https://fernwoodpublishing.ca/book/country-of-poxes



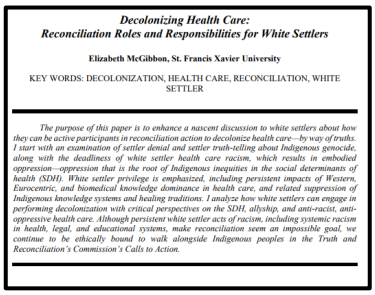
The author reminds readers that each time we step into a healthcare setting, "we step into a system that has come from stealing land." He says, "For me, this remembering cannot come down to a brief land acknowledgement at the beginning of each meeting. It comes through an exploration of my place within this process, of learning and unpacking that history, and working to repair the damages it has wrought." He tells the stories of syphilis, smallpox and tuberculosis in Canada, and how these three particular diseases transformed and were transformed by processes of colonization.

NCCDH's Let's Talk: Whiteness and Heath Equity by Nancy Laliberté, Alycia Fridkin and Sume Ndumbe-Eyoh, 2020
https://nccdh.ca/resources/entry/lets-talk-whiteness-and-health-equity



This short resource provides a quick introduction to the concept of whiteness and the importance of identifying and naming it, while also providing an overview of the ways that whiteness - as a set of practices, policies and perspectives - is damaging to the health and wellbeing of everyone, and especially to Indigenous, Black, and other racialized people. The paper offers some ideas for how to think about health professionals' roles in disrupting whiteness at both an individual and systemic level.

Decolonizing Health Care: Reconciliation Roles and Responsibilities for White Settlers by Elizabeth McGibbon, 2018 https://ojs.scholarsportal.info/ontariotechu/index.php/cs/article/view/127



Decolonizing Health Care:
Reconciliation Roles and Responsibilities for White Settlers

Elizabeth McGibbon, St. Francis Xavier University

KEY WORDS: DECOLONIZATION, HEALTH CARE, RECONCILIATION, WHITE SETTLER

The purpose of this paper is to enhance a nascent discussion to white settlers about how they can be active participants in reconciliation action to decolonize health care—by way of truths. I start with an examination of settler denial and settler truth-telling about Indigenous genocide, along with the deadliness of white settler health care racism, which results in embodied oppression—oppression that is the root of Indigenous inequities in the social determinants of health (SDH). White settler privilege is emphasized, including persistent impacts of Western, Eurocentric, and biomedical knowledge dominance in health care, and related suppression of Indigenous knowledge systems and healing traditions. I analyze how white settlers can engage in performing decolonization with critical perspectives on the SDH, allyship, and anti-racist, anti-oppressive health care. Although persistent white settler acts of racism, including systemic racism in health, legal, and educational systems, make reconciliation seem an impossible goal, we continue to be ethically bound to walk alongside Indigenous peoples in the Truth and Reconciliation's Commission's Calls to Action.

This paper aims to enhance discussion about how white settlers in health care can actively participate in reconciliation. In analyzing how white settlers can engage in tangible ways, McGibbon details a number of specific simple examples of how white settlers' dominance and systemic advantages manifest in healthcare settings, which provide some small practical starting points for where we can begin to disrupt those systems of privilege in daily practice.

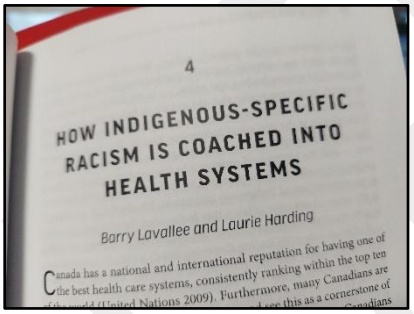
White supremacy culture – Still here curated by Tema Okun, 2021.
https://www.whitesupremacyculture.info/
This document lists a number of characteristics (e.g., perfectionism, individualism, defensiveness) that we can often value and protect, but that can be linked to processes that can ultimately sustain white supremacy in our places of work and in our daily habits. We encourage you to read this text alongside recent discussions about the impacts and complexities of the idea of 'white supremacy culture' for different communities, such as: https://forgeorganizing.org/article/how-not-dismantle-white-supremacy

White Supremacy Culture – Still Here

Tema Okun | May 2021

For a more extensive exploration of this article, go to http://www.whitesupremacyculture.info/

How Indigenous-specific racism is coached into health systems by Barry Lavallee & Laurie Harding, 2022.
https://fernwoodpublishing.ca/book/white-benevolence



4

HOW INDIGENOUS-SPECIFIC RACISM IS COACHED INTO HEALTH SYSTEMS

Barry Lavallee and Laurie Harding

Canada has a national and international reputation for having one of the best health care systems, consistently ranking within the top ten

This paper, published in the book *White benevolence: Racism and colonial violence in the helping professions*, edited by A. Gebhard, S. McLean, & V. St. Denis, makes the case that anti-Indigenous racism is in fact coached or taught in both subtle and overt ways within health systems in Canada. The authors provide examples of how this type of racism functions, how and where the coaching happens, and in this way offers insights for anti-racism intervention in this context.

Insights from the NCCDH's racial equity journey by Sume Ndumbe-Eyoh, 2019.
https://nccdh.ca/blog/entry/insights-from-the-nccdhs-racial-equity-journey#Reference%209
This blog post uniquely provides an example of some of the reflexivity needed in a health institution's journey of decolonization. This example demonstrates some of the rarely admitted messiness of the process along the way, with all the setbacks and miss-steps. Seeing a documented example like this can help to do away with expectations of a polished version of what it will look like when a primarily white-populated health institution begins on this journey.

Additional Resources

Truth and Reconciliation Commission of Canada Calls for Action (2015):
https://www2.gov.bc.ca/assets/gov/british-columbians-our-governments/indigenous-people/aboriginal-peoples-documents/calls_to_action_english2.pdf

National Inquiry in Missing and Murdered Indigenous Women and Girls Calls for Justice (2019):
https://www.mmiwg-ffada.ca/wp-content/uploads/2019/06/Calls_for_Justice.pdf

Towards Braiding by Elwood Jimmy, Vanessa Andreotti, and Sharon Stein (2019):
https://decolonialfuturesnet.files.wordpress.com/2019/05/braiding_reader.pdf

Towards Scarring Our Collective Soul Wound by Cash Ahenakew: (2019)
https://musagetes.ca/document/towards-scarring/

San'yas Indigenous Cultural Safety Training Program: https://sanyas.ca

Indigenous Health Primer (2019):
https://www.royalcollege.ca/ca/en/health-policy/indigenous-health.html

Indigenous Health Values and Principles Statement (2019):
https://www.royalcollege.ca/rcsite/health-policy/indigenous-health-e

In Plain Sight (2020):
https://engage.gov.bc.ca/app/uploads/sites/613/2020/11/In-Plain-Sight-Summary-Report.pdf

The Failure of Federal Indigenous Healthcare Policy in Canada (2021) by Mike Gouldhawke:
https://yellowheadinstitute.org/wp-content/uploads/2021/02/m-goldhawke-health-policy-yi-brief-2.2021.pdf

A Trauma-Informed Approach to Cultural Safety (2022) by Harley Eagle:
https://www.youtube.com/watch?v=py4GHmD3-m4

Unlearning and Undoing Systemic White Supremacy and Indigenous-Specific Racism within the BC Office of the Provincial Health Officer (2023) by Dr. Danièle Behn Smith and Dr. Kate Jongbloed,
https://youtu.be/NlAIZbZrZdo

Bringing Reconciliation to Healthcare in Canada – Wise Practices for Healthcare Leaders (2018):
https://www.healthcarecan.ca/wp-content/themes/camyno/assets/document/Reports/2018/HCC/EN/TRCC_EN.pdf

Fighting for a Hand to Hold: Confronting Medical Colonialism Against Indigenous Children in Canada (2021) by Samir Shaheen-Hussain: https://fightingforahandtohold.ca/

Stories of Care and Control: A Timeline of the Medical Industrial Complex:
www.mictimeline.com/?fbclid=IwAR1j7vud9UPEQ5Y2P1Wiw1aUiPHCl3fhpNsNnv5JbFeH3zeDPtvNfiDvO9A

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