articulated above—perhaps because they "see" themselves in family medicine and the fit feels good.

Certainly, society benefits from having so many capable, competent, and compassionate female physicians providing exemplary care. We should be loud and proud about what we bring to the practice of medicine and the care of our patients. Indeed, we know the evidence about how health care systems are best when supported by excellent primary care. However, choosing family medicine because it is what we want is different from choosing it because other doors are not open to us. Equity in medical education will only come when we begin to address the gendered experiences of female students. Speaking out, as you have, will foster a most needed dialogue about all students feeling welcome, included, and respected for what they bring to the practice of medicine.

Thank you, Dr Dhara, for your candid comments and your willingness to put them out there.

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Competing interests
Dr Bethune was a contributing author for *Female Doctors in Canada. Experience and Culture.*

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Failure to acknowledge inequities in the social determinants of health

The article entitled "Lice infestation causing severe anemia in a 4-year-old child" in the July issue of *Canadian Family Physician* explores a case in which social determinants of health and health inequity produce severe illness in a child.[1] However, rather than highlighting these factors, the article propagates stigma that is in direct contradiction to the principles of the College of Family Physicians of Canada, namely "family physicians are cognizant of the power imbalance between doctors and patients and the potential for abuse of this power."[2]

The 4-year-old patient in the article is noted to be First Nations and living on reserve with her family.[1] She was transferred to an urban care centre for treatment. The authors explain concern for neglect given the extent of the lice infestation, for which providers contacted child protection services. The article notes that the "family complied with social services, who conducted an extensive review including home visits in conjunction with the local Aboriginal liaison team."[1] Despite this "extensive review," the team fails to acknowledge the inequities in the social determinants of health contributing to this case and instead places emphasis on the possibility of parental neglect. Furthermore, the voices of neither the parents nor the child are represented in the piece. Failure to adequately contextualize this case perpetuates societal stigma against Indigenous people.

When we as health care providers present research regarding Indigenous patients and frame it with the lens of, for instance, potential parental neglect without expressly acknowledging the contexts and oppressions that the families face we are perpetuating stigma and colonization. When we state that an "extensive review" was conducted but do not discuss the barriers and strengths that were discovered, we are failing to adequately represent and advocate for our patients.

It is well known that inequities in the social determinants of health result in an increased burden of health problems, and often restrict affected individuals, communities, and nations from accessing resources that might ameliorate the issues.[3] In this way, the individual determinants are not isolated beings, but rather threads that build a common web. Ironically, the President's Message in this same July issue of *Canadian Family Physician* explores the social determinant of health of wealth inequality, as well as the development of the Poverty Tool.[4] There is no mention of Indigenous health or the disproportionate burden of wealth inequality among Canada's Indigenous people within the President's Message.

Inequities in the social determinants of health of Indigenous people result in health disparities in early childhood development, maternal health, community health, mental health, and chronic disease, among others.[5] In order to address these disparities, it is essential to identify and understand the historical, social, political, and ethical contexts.[5]

The ancestors of the 3 Indigenous groups recognized in Canada (First Nations, Inuit, and Métis) all underwent colonization, including the imposition of colonial institutions and systems.[3,6] These processes have resulted in losses of lands, languages, and sociocultural resources for the Indigenous people of Canada.[3] The ensuing racism, discrimination, and social exclusion continue to permeate Canadian society, including the health care system.[3]

Assimilationist policies relied on measures proposed to "civilize" Indigenous children by removing them from their community, family, and culture.[6] This continues to occur in the current Canadian system, as

most rural and remote First Nations communities lack the political and structural support to provide acute care on site. Thus, people are removed from their community, family, and culture, sometimes for extended periods of time, and placed in highly colonial care facilities. A particularly chilling reflection on colonization in this case report is also present in the fact that treatment within the larger care centre involved shaving the child's head.[1] Although this is common practice in the treatment of severe lice infestation, it is also a practice well known to have occurred upon arrival to historical residential schools.

A multitude of successful Indigenous-led measures exist to address health inequities and disparities. Many First Nations communities have developed and continue to create successful health and wellness programs while battling profound social, political, and geographic challenges.[7] Some of these collaborations explore partnerships between traditional medicines and Western ones. When we fail to acknowledge the importance of traditional medicines and instead frame them as failed "treatment attempts with natural products,"[1] we perpetuate the stigma of Indigenous traditional knowledge being inferior to modern academic knowledge. Again, this is an example of modern colonization.

Dr Joshua Tepper, past President and CEO of Health Quality Ontario, states, "You can't truly have a quality health care system without having equitable opportunities for health. Equity is one of the six core dimensions of quality care."[8] In care, research, advocacy, and all other aspects of professional practice, let us always remember the modern Hippocratic oath in which we swear the following:

> I will remember that I do not treat a fever chart, a cancerous growth, but a sick human being, whose illness may affect the person's family and economic stability. My responsibility includes these related problems, if I am to care adequately for the sick.

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Competing interests
None declared

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