

Reflections on Indigenous health care

Building trust

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For more than 30 000 years, Indigenous peoples and their descendants have been occupying the territory of what is now known as Canada. A vivid consequence of colonization is the prevalent misconception that Indigenous peoples are one homogeneous group. Although the Constitution of Canada recognizes 3 different groups of Indigenous peoples (ie, First Nations, Metis, and Inuit), these “legal” categories comprise nearly 1.7 million people across the country, including those living on and off reserves, and those in urban, rural, or remote locations. Across the country, there are almost 100 different Indigenous nations with different histories, traditions, and cultures.¹ Such diversity points to the need for greater nuance in care.

Although we as physicians perceive ourselves as caring professionals who want to do what is best for their patients, many Indigenous people feel very differently about us. Many come from communities where their Elders tell stories of the *Sixties Scoop*² and more recent events: when babies were taken from their families by force,^{3,4} when Indigenous people were insulted and denigrated in hospitals and in other health care facilities,⁵ and when abuse by those in power was commonplace and without recourse. More recent history includes forced sterilization,⁶ being admitted to segregated underresourced hospitals, being sent to tuberculosis sanatoriums for long periods (with many never returning), and being experimented on without consent.⁷⁻¹⁰ Quite recently, children were sent alone from remote locations and reserves to stay for days in tertiary care centres^{7,11} in health care settings where cultural practices such as eating traditional food brought by relatives or ceremonies using placenta after childbirth were prohibited.

In remote communities, Indigenous health care services tend to be more underresourced than for White populations, with fewer health care providers rotating in and out of communities; as such, patients and providers rarely reach mutual understanding. In urban and suburban areas, they experience specific, and often unrecognized, barriers to culturally safe care.^{12,13} Consequently, many Indigenous people do not trust health care personnel for anything, much less for intimate examination. Moreover, when Indigenous people struggle to see a health care provider when they are symptomatic and in need of treatment, prevention remains a secondary consideration.

History needs to be understood at an emotional level to comprehend the way health care can affect Indigenous peoples, as it has had a profound impact on how patients, as well as health care providers, engage

with the modern-day system. Colonialism has lasting effects on the way health care is delivered and on how Indigenous patients perceive medical professionals and mainstream health care. One of the by-products of colonialism is implicit bias. A growing body of literature investigating the root causes of the health disparities in Canada highlights the unique contribution of racism and discrimination in health care, a legacy that cannot be separated from colonial history in which doctors and other health care professionals were complicit.^{7,10,14-18}

These issues extend beyond preventive health care and need to be considered as a fundamental framework influencing our attitudes, clinical judgment, and guidance. The probabilistic approach inherent in medical science may unconsciously conflate “being Indigenous” with “being at high risk”; that is, at a high risk of alcoholism, addiction, bad parenting, lascivious or deviant sexual behaviour, bad health or bad habits, or not following medical advice or simply not even willing to engage in their care. These are common stereotypes encountered in the general population.^{17,19,20} Such stereotypes can predispose Canadian health care professionals to act based on stereotypes rather than on facts. By wanting to do good and being driven by the professional ethos of treating everyone the same, health care professionals are often unaware of and insensitive to the cultural environment of their patients.

Medical encounters do not take place in a historical vacuum. Our attitudes, gestures, and recommendations do not stand alone. A growing body of literature now documents how they contribute to the feeling among Indigenous peoples that health care settings are not safe, and that they will, as patients, be stereotyped and shamed.^{16,17} This may promote a dynamic of exclusion and avoidance of care, as described by studies surveying the perception of health care relationships between providers and patients.²¹ Such avoidance leads to delay in consultation, missed appointments, and missed opportunities for caring; this can be followed by more severe disease at time of diagnosis, thereby reinforcing stereotypes in health care.²¹

This dynamic situation extends beyond the walls of hospitals. The Indigenous patient’s experience will resonate in their family and in their whole community, since what happens to any one of them, happens to the entire community, and—crucially—what happens in the community becomes part of the patient’s storyline. Consequently, physician-community relationships are key to understanding Indigenous health disparities and to making changes to ensure equity and safety.

What does this mean for preventive practice? Unfortunately, physicians face the cultural burden of the past. For decades, medical authorities, alongside governments, participated in the abuse of, experimentation in, and disempowering of Indigenous peoples, including the devaluing of knowledge for self-care and labeling Indigenous peoples as ill or inferior.⁷ There are memories of generations of children and babies who never made it back to their families or their communities after health care professionals “took care of them.” It is urgent to acknowledge that medical power and institutions were part of what is now recognized as a systemic genocide of Indigenous peoples in Canada, a past that continues still and disproportionately affects Indigenous women.⁴ Hence, when health care professionals approach an Indigenous patient, despite best intentions of doing good and not repeating historical mistakes, they need to recognize that, even within the walls of our best institutions, quality of care does not rest in the physician’s hands: it belongs to the patient, their family, and their community.

While this commentary speaks to Indigenous health care in general, it also provides reflections on matters related to preventive health care and screening. The development of trust is key to ending systemic violence against Indigenous peoples in medicine. Trust is an essential component for effective medical prevention. ✨

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