

What Does it Mean to be an Ally in Indigenous Healthcare?

by

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## **Abstract**

Allyship is loosely defined as the actions of an individual who works to advance the interests of marginalized groups in which they are not a member. Allyship in the healthcare field is under-studied yet is increasingly an area of interest, given Indigenous health outcomes throughout the world, and especially in countries with colonial histories, are generally poorer than the mainstream population.

This qualitative research study took place with healthcare providers in and around the Edmonton area that are community-identified allies providing care for Indigenous patients. Due to the impacts of the COVID-19 pandemic, much of the research took place virtually. Qualitative description methodology was utilized, and data was generated through semi-structured interviews with allies. The interviews were transcribed verbatim and then coded using thematic analysis. To ensure validity, generalizability, and reliability of the data, verification strategies were used throughout this study.

The results indicate that allies share common characteristics and a desire to learn and continue to improve care, while also appreciating the importance of relationships and the need for advocacy towards a systemic overhaul of all social institutions. This thesis not only demonstrates the importance of allyship in healthcare, but also shows that applying the concept of allyship to healthcare relies on a great deal of independent self-guided and ongoing work on the part of healthcare providers.

## **Preface**

This thesis is an original work by Margaux Bruno. The research project received research ethics approval from the University of Alberta Research Ethics Board, Project Name: “Understanding Allyship in Indigenous Healthcare.”, Pro00105578, 3/19/2021.

### **Dedication**

This thesis is dedicated to the Indigenous people who have been unjustly treated while accessing healthcare and to the healthcare professionals and researchers working to right these wrongs and to bring justice to the Canadian healthcare system.

## Acknowledgements

This thesis would not be possible without the love and support of my family, friends, and supervisory team. To my daughter Evelyn Anne Bruno, this thesis is for you Baby Girl. I want you to know that you can do anything that you put your mind to. I know that you are going to do amazing things in this world.

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**Abbreviations**

2SLGBTQIA	two-spirit, lesbian, gay, bisexual, transgender, queer, questioning, intersex and asexual
AHS	Alberta Health Services
APS	Aboriginal People's Survey
IRS	Indian Residential Schools
MMIWG	Missing and Murdered Indigenous Women and Girls
RCAP	Royal Commission on Aboriginal Peoples
RCPSC	Royal College of Physicians and Surgeons of Canada
SDOH	Social Determinants of Health
TRC	Truth and Reconciliation Commission
UNDRIP	United Nations Declaration of the Rights of Indigenous People
WHO	World Health Organization



## Chapter 1 - Introduction

In Canada, Indigenous health outcomes are generally poorer than the mainstream population (Kalahdooz et al., 2015; McLane et al., 2021). This is both a consequence and mechanism of colonization (McLane et al., 2021). Many academics agree that colonialism and racism have led to devastating impacts on Indigenous health (McLane et al., 2021). For example, Indigenous Canadians have a life expectancy 12 years lower than the national average and experience higher rates of preventable chronic diseases compared with non-Indigenous Canadians, while also facing barriers to accessing adequate healthcare in the face of individual and systemic racism (Kalahdooz et al., 2015).

It is important to note that the terminology associated with Indigenous people has changed several times over the last 150 years (Government of Canada, 2021). Aboriginal, First Nations, and Indian are outdated terms only used when quoted from an external source within this thesis. The term Indigenous people refers to the original people of any land around the world (Government of Canada, 2021). Within the context of this thesis, Indigenous people refers to individuals who are First Nations, Inuit, and Métis. While Indigenous people is a blanket term that is appropriate to use in some contexts, it is most appropriate to situate Indigenous people within their tribe for example, referring to someone who is Cree or Nehiyaw is most appropriate (Government of Canada, 2021).

According to 2016 census data, only 3.13% of people working in health occupations in Canada are Indigenous (Statistics Canada). *The Truth and Reconciliation Commission* (TRC) (TRC, 2015) Call to Action 23 aims to increase Indigenous people working in healthcare fields and while actions are being taken to recruit, train, and retain more Indigenous healthcare practitioners, most healthcare professionals are and will continue to be non-Indigenous. Because

healthcare providers are most likely to be non-Indigenous it is important for healthcare providers to learn how to support their Indigenous patients in order for them to receive adequate care.

This research explored the role of community identified allies in healthcare as one way to improve Indigenous people's healthcare experiences and outcomes. Allyship is a new concept in the healthcare field, and while it is an increasingly popular field of study, the role of allies in healthcare is an under-studied area (Brown, 2015; Nixon, 2019).

In 2021, Dictionary.com's word of the year was "allyship", which is defined as:

the status or role of a person who advocates and actively works for the inclusion of a marginalized or politicized group in all areas of society, not as a member of that group but in solidarity with its struggle and point of view and under its leadership.

Allyship being the word of the year in 2021 was very timely, both within my research, and within the political climate of the world. For example, I conducted this research in the middle of the COVID-19 pandemic, which has been fraught with racial disparities in morbidity and mortality (Government of Canada, 2021). Much of this can be attributed to related social determinants of health (SDOH) such as limited access to clean drinking water and access to the water required for frequent handwashing, overcrowded housing, and reduced access to healthcare services (Government of Canada, 2021).

The legacy of Indian residential schools (IRS) is another critical issue that has also been brought more into the public consciousness in the last year. This has been triggered in part, by the ongoing discoveries of unmarked grave sites at former IRS throughout the country, and specifically for the Kamloops 215. Additionally, when I started this research, the death of Joyce Echaquan drew international attention to the unjust treatment of Indigenous people Canada's healthcare system (Canadian Broadcasting Corporation, 2021).

Joyce Echaquan was a 37-year-old Atikamekw woman who was admitted to a Quebec hospital for stomach issues in September 2020. Joyce had many health concerns and had frequent negative experiences when accessing care. Joyce was not fluent in French which further complicated her ability to access proper healthcare. She often livestreamed her time in hospital to have a family member translate for her. During the livestream prior to her death, Joyce screams in distress while healthcare staff abused and mocked her in French. In addition to the abuse she faced by healthcare staff, Joyce's healthcare concerns were not considered or respected. Prior to her death, Joyce was restrained in her bed and given morphine, despite her allergy to the medication (Canadian Broadcasting Corporation, 2021).

Joyce's husband has publicly said "Joyce died because she was Indigenous" (Canadian Broadcasting Corporation, 2021). Prime Minister Justin Trudeau also called the incident "the worst form of racism" and acknowledged the deeply embedded systemic racism that led to her preventable death (Canadian Broadcasting Corporation, 2021). While Joyce's death garnered international attention, this was not the first time an Indigenous person died a preventable death through the negligence of healthcare providers in Canada (British Broadcasting Corporation, 2020; Canadian Broadcasting Corporation, 2021).

In the context of this research, Joyce's story reaffirms the need to overhaul the healthcare system to ensure that Indigenous patients are being treated with dignity. If the healthcare staff that 'cared' for her that day were allies, Joyce would not have died. The more allies the healthcare system has, to provide care for Indigenous patients, the better healthcare experiences, and outcomes that Indigenous people will have.

### **Locating Myself in the Research**

As part of reflexive, qualitative research, researchers position themselves within the research to reveal their connection, ties, and investment in a specific research project. By introducing ourselves, we attempt to build a relationship with the readers, from which the readers can contextualize the results (Kovach, 2010).

In everyday conversational practice, the onus is often on Indigenous people to locate themselves within their family ties in what we now call Canada. Settlers too are increasingly adopting this act of positioning themselves as to who they are and how they came to be in Canada. Self-location is extremely important in establishing relationships and beginning a conversation, lecture, meeting, and so on in a more equitable way and acknowledges the history of the land in which we are situated. I am fortunate enough to have been surrounded by many role models in my academic and professional career who do this well. However, I must admit that this is something that I am slowly getting more comfortable doing. In my research, I think this is especially important to understand who I am, how I found myself in this field of research, and why it matters to me.

My name is Margaux Bruno (formerly Robertson). I am an uninvited guest on Treaty 6 territory. My mother's Mennonite family settled in Canada in the early waves of colonization in Manitoba. It is my understanding that they were promised cheap, good farmland, and religious freedom. My family eventually moved westward into Saskatchewan and Alberta. They made their livelihood through farming stolen lands, and they financially benefited from colonization. While this conversation is not something we ever had over the dinner table, it is now something we can talk more openly about, especially with the younger educated generations. My grandparents raised their seven children primarily in Coaldale and Lethbridge, which is where I had my first memories of the racial conflict between Indigenous and white people. Some of my

earliest encounters with racism occurred in Lethbridge, while witnessing my grandma vehemently oppose any act of racism that she witnessed. She was a tiny lady with a big heart, and she was a strong advocate for social justice. I cannot help but smile when I think of how proud she would be of me for doing this work.

My father's family immigrated to Canada from Ireland in 1959 yet spent very little time living in Canada. While they were Canadian Citizens, they moved around for my grandfather's work as a civil engineer and lived in many developing countries with dark histories of colonization. Much of my father's family is very well educated, and many are physicians and engineers. I grew up having difficult conversations about medicine and healthcare equity and those conversations are deeply engrained in my memories and values.

My undergraduate degree is in Criminology where I learned so much about the systems that reinforce inequity, and I took special interest in learning more about the real history of Canada. During my undergraduate degree, I gained invaluable front-line experience volunteering and working as a practicum student. Through these experiences, I began to understand how deeply engrained colonialism is in every aspect of our lives and this is where my passion for social justice was ignited.

I chose to pursue my master's degree in Community Engagement because I felt that it was essential to speak with, and include, the voices of those affected by the problems that we are looking to improve or solve. This research reflects my passion for working towards systemic change by including those affected by these systems. It is my belief that in order to create sustainable and equitable solutions to problems, we must engage the experts with lived experience and create policies that reflect their voices and firsthand experiences.

I met my husband, an Indigenous Cree man, Grant, in an undergraduate Native Studies course. Through him, I have learned so much about Nehiyaw culture and the injustices that Indigenous people in Canada continue to face. I have witnessed racism towards my husband and stepsons in the healthcare system. I have never been at the receiving end of racism before but watching the people I love being mistreated because of who they are is one of the most painful things I have experienced. I am fortunate to be raising a beautiful Indigenous daughter who will one day be an Indigenous woman who deserves to live in a world that is equitable and kind to her. I hope that one day her father and I will not have to have these conversations about who is going to take her to the doctor because we know that she will be treated better when she is with her white mother than with her Cree father. For Evie, I know she will leave this world better than she found it. I am hopeful that any improvements that come from this research will be a step in the right direction towards making the world a better place for her and all Indigenous people in Canada.

I wanted to make a note about Joyce Echaquan. I feel a strong personal connection to Joyce, and I think about her often, especially as I completed this research. I feel that it is important to address my own privileges that I experience in this world in comparison to hers and how this has driven my research. The day Joyce died; I too lay dying in a hospital bed in Alberta. Joyce and I both had life threatening allergies to medications, and we shared similar experiences in trying to advocate for ourselves in the healthcare system. I cannot help but acknowledge my own privilege in the treatment that I received during that hospital stay. I was listened to and respected during my hospital stay and I believe that this is partially due to my unearned privilege of being white. I have never had to worry about being treated poorly because of the color of my skin and it is my hope that this research will draw attention to the systemic

racism that Indigenous people continue to face when accessing healthcare in Canada. I hope that this research can inform others on how to better care for and interact with Indigenous people and that Joyce's death will be a turning point in Canadian history.

It is important to note that I do not consider myself an "ally". Through my research, and personal experience, I have learned that it is up to the community to identify allies. While I would consider it an honour and a privilege to be an "ally" with the Indigenous community, that is not a word I feel comfortable applying to myself. I have used the word ally throughout my study largely due to the lack of alternative word that is easily understood and conveys all that encompasses the word ally or allyship. I use the word ally as a placeholder for now.

Whiskeyjack, Makokis, and Gesink (n.d.) suggest using language like "Relative" or "Treaty Partner". Whiskeyjack et al. state:

"Being an Ally means being a Relative committed to support one another within *nêhiyaw* Natural Laws (sharing, kindness, strength/determination, and honesty). Being a better Relative requires building and maintaining trust and co-creating a psychologically and emotionally courageous environment within which each Relative is able to grow and be their best self" (p. 31-32).

For me, this research is much more than a study. It is a way of connecting with my role as a non-Indigenous mother to Indigenous children and further understanding my role within that. For me, I am much more than an "ally" and that term just does not sit right with who I am.

### **Statement of the Problem**

International law and key reports, such as the *TRC Final Report* exist to ratify and call attention to the systemic challenges of Indigenous healthcare (TRC, 2015). They are

foundational to addressing Indigenous health disparities in Canada. *The United Nations Declaration on the Rights of Indigenous People (UNDRIP)*, Article 24.1, states, “Indigenous individuals have the right to access, without any discrimination, all social and health services” and “Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health” (2008, p.9). In 2021, *UNDRIP*, was ratified in the Canadian Senate. In 2015, *the TRC of Canada* released 94 Calls to Action. Calls to Action 18-24 relate specifically to health and healthcare:

- Acknowledge that the current state of Aboriginal health in Canada is a direct result of previous Canadian government policies,
- Establish measurable goals to identify and close the gaps in health outcomes,
- Increase the number of Aboriginal professionals working in the health-care field. ii. Ensure the retention of Aboriginal health-care providers in Aboriginal communities. iii. Provide cultural competency training for all healthcare professionals,
- Medical and nursing schools in Canada are to require all students to take a course dealing with Aboriginal health issues, including the history and legacy of IRS,, the *United Nations Declaration on the Rights of Indigenous People*, Treaties and Aboriginal rights, and Indigenous teachings and practices. This will require skills-based training in intercultural competency, conflict resolution, human rights, and anti-racism.

It has been eight years since the *TRC’s Calls to Action* were released. It remains to be seen how these calls and will be implemented into day-to-day practice. The enactment of the *TRC’s Calls to Action* and the enforcement of *UNDRIP* requires actionable steps to be developed and led by Indigenous people and communities to implement legislation that trickles down into a more equitable healthcare system that honours and respects Indigenous patients.



In settler-colonies such as Canada, Australia, New Zealand and the United States, the historical impacts of colonization on the health, social, economic, and cultural experiences of Indigenous people are well documented (Paradies, 2016). Allan and Smylie's (2015) research on racism in Indigenous healthcare asserts that colonization is "a foundational determinant of Indigenous health globally and the relationship between racism and colonization are inextricably intertwined" (p.5). Racism against Indigenous people in the healthcare system is pervasive and a major factor in substandard health among Indigenous people in Canada (Allan & Smylie, 2015). SDOH underlie the disparities between Indigenous and non-Indigenous Canadians' health and wellbeing, which are caused by "contextual (e.g. colonization, IRS, the resulting trauma, etc.) and ecological circumstances" (Kolahdooz et al., 2015, p.1). There is increasing understanding and acceptance of these factors when exploring disparities in Indigenous health in Canada, including the relationships between health and healthcare, education, housing, employment, income, food security, community infrastructure, cultural continuity, and environmental stewardship (Allan & Smylie, 2015).

The history we are taught in Canada often omits white people's responsibility for white privilege and Indigenous disadvantage. Rewriting the collective history of what is now called Canada is an essential first step for improving the deeply embedded inequity that Indigenous people face in all institutions, including health. Due to this false history, the abhorrent conditions that Indigenous people face are normalized and accepted (Kalahdooz et al., 2015). Learning the real history is an important first step towards implementing institutional anti-racism and beginning the work towards reconciliation and allyship (TRC, 2015).

One of these important steps towards reconciliation and improving Indigenous health is exemplified through the Royal College of Physicians and Surgeons of Canada (RCPSC)'s mission statement:

Create healthcare that is free of racism where every Indigenous person is treated with respect, recognized as an individual rather than a stereotype and experiences the highest level of health, and that all stakeholders understand how colonial structures and systems link to current health inequities (2019).

A promising way to improve Indigenous health is by providing healthcare providers with opportunities to better support their Indigenous patients, and one way in which this can be achieved is through allyship. It is important to recognize how allies support Indigenous people and how they react emotionally and socially to being engaged allies particularly within the hierarchies of healthcare. By understanding more about the ally experience, we can learn to educate others on allyship and Indigenous healthcare to become better facilitators of learning that encourages, supports, and critiques allyship in many areas of social justice.

### **Research Question**

The central research question of this inquiry is: “What does it mean to be an ‘ally’ to Indigenous patients in the healthcare system?” The primary objective of this research was to learn about the experiences and insights of non-Indigenous healthcare providers who were identified by the Indigenous community as being allies. Specifically, this research sought to understand non-Indigenous healthcare professionals’ perceptions on how to work as an ally in providing healthcare to Indigenous patients. As part of this, it was important to understand their successes and struggles in their roles as allied healthcare workers providing care to Indigenous patients. This research investigated how the community-identified allies’ formal and informal

learning experiences have led them to engage in work that is aimed at dismantling the colonial systems that have oppressed them and continue to create barriers for Indigenous people in accessing care.

## **Chapter 2 - Literature Review**

This literature review examines seven key themes that ground this research and provide the rationale for my research question: “What does it mean to be an “ally” to Indigenous patients in the healthcare system?” The literature review starts broadly in exploring a brief history of Indigenous people in Canada and the arrival of settlers, Indigenous health in Canada, and healthcare for Indigenous people within Edmonton, Alberta (where this research took place). Subsequently, literature on the SDOH within the context of colonial history and intergenerational trauma is explored, as well as the road to reconciliation and decolonization, and implicit biases, racism, oppression, and privilege in healthcare. Finally, Indigenous health education training is reviewed, and a rationale for this research is provided.

Before delving into the literature, it is important to note that “published literature systematically prioritizes non-Indigenous voices and perspectives” (Allan & Smylie, 2015, p. 4). While I did try to employ a strengths-based lens some of the research and statistics on Indigenous health are hard to read and accept. It was not my intention to take a negative stance, but it is important to contextualize the impacts that colonialism has had on Indigenous health.

### **Brief History of Indigenous Canada and the Arrival of Settlers**

Indigenous societies existed for thousands of years throughout what is now Canada, before the arrival of European explorers and waves of settlers (Government of Canada, 2017). These precontact societies lived relatively harmoniously and were highly sophisticated, with their own governance structures, art, and legal traditions (Government of Canada, 2017).

The term ‘settler’ refers to anyone who is not a descendant of the First people, regardless of how they came to be on this land (Nikkel, 2019). The history of settlement in Canada is well-documented through a biased and complex interpretation of history often told through the lens of

French and British fur traders. Settler colonialism is principally focused on extermination of the First people (Paradies, 2016). The first settlers came to exploit resources from what is now called Canada and justified their work through Doctrines of Discovery and *terra nullius* or ‘no one’s land’ (Garbutt, 2019; Nikkel, 2019). Indigenous people practiced a communal land relationship, had complex trade systems throughout the Americas and established sophisticated civilizations long before European contact. The European colonizers sought individual ownership and control over natural resources (Garbutt, 2019; Nikkel, 2019).

Settler colonialism is a type of colonization where colonizers or settlers arrive to other lands, stay, and exert power and possession over the lands and form a settler nation. Settler colonialism requires the dispossession and removal or assimilation of the Indigenous people of the colonized lands (Nikkel, 2019). In Canada, white European settlers arrived on Indigenous lands and created laws to take possession and to gain sovereignty. In effect, Canada is constituted as “a white, white supremacist, Christian, patriarchal, heteronormative, capitalist nation” despite the prior presence of established Indigenous occupancy on the lands (Nikkel, 2019, p. 27). Indigenous people did not willingly sign away their land, they expected this relationship of equal partnership from the earliest days of encounter with newcomers. Treaties were signed in a spirit and intent of mutual respect and reciprocity (TRC, 2015).

Early colonialism imposed on Indigenous people in Canada included: scalping bounties against Indigenous people in Eastern Canada; the deliberate introduction of disease, destruction of food sources or other means of effecting starvation and community collapse; treaty dealings marked by fraud and coercion; and failure of the Crown to fulfill treaty terms (TRC, 2015).

Colonialism also led to the *Indian Act of 1876* and with it, the creation of reserves and the confinement of Indigenous people on reserves through the pass system. It involved the forcible

removal of Indigenous children from their families and communities while subjecting them to systemic abuse and neglect. Through the IRS system, children were exposed to physical and sexual abuse, malnourishment and nutritional experimentation, long hours of hard labour, and died in very high numbers (Nikkel, 2019; RCAP, 1996; TRC, 2015).

Colonialism is not a dark patch in Canadian history, it is ongoing and deeply entrenched in the systems within Canada today. White settlers continue to be complicit in settler colonialism, they continue to be in a position of power and wealth and continue to benefit from colonialism through structures of oppression. The relationship between Indigenous and non-Indigenous people, since the time of contact, has been, and continues to be, complicated and problematic (Garbutt, 2019). While there is great diversity among Indigenous perspectives, one fact remains central—the traditional lands, practices, values, cultures, languages, systems, and understandings of Indigenous people have been systematically attacked, dismantled, and destroyed by the Canadian state (TRC, 2015).

*The TRC* has attempted to shine a light on the cultural genocide that has occurred and continues to occur in Canada. The goal of the *TRC* is to engage Canadians in truth-telling, unlearning colonialism, righting past wrongs, and forging equitable relationships (Garbutt, 2019; TRC, 2015). Scholars such as Craft and Regan (2020) and Nikkel (2019) argue that “white settler dysconsciousness” or “myths of innocence” function to protect the white settler world and the resulting structures of oppression that white settlers benefit from (Craft & Regan, 2020; Nikkel, 2019;). Craft and Regan have coined the term “myth of innocence” to explore “how and why Indigenous knowledge, cultures, languages, laws, and governance traditions have been virtually erased from mainstream history and society” (Craft & Regan, 2020, p. 26). The *TRC*

aims to unearth this dystopian view of settler innocence as a first step in achieving reconciliation between Indigenous and non-Indigenous people in Canada.

Today, the term “settler” has a negative connotation and can often make non-Indigenous people uncomfortable. This discomfort can be displayed as defensive behaviour, denial, and anger (Craft & Regan, 2020). This fear of ‘unsettling’ settlers’ innocence and merit, by acknowledging structural advantage and unfairness has the potential to upset the whole house of cards in which settler privilege precariously lives (Nikkel, 2019). Most Canadians pride themselves at a national level, as a welcoming, accepting, and inclusive place for newcomers and refugees to settle. They have turned a blind eye towards the deep injustices inflicted on the people who accepted their own ancestors to this land as newcomers and the paradox is “deeply disturbing” (Garbutt, 2019 p.28).

The fundamental impact of settler colonialism on Indigenous people is now well-recognised within public health discourses as part of recognizing the SDOH (Czyzewski, 2011). *The TRC final report, the Inquiry into Missing and Murdered Indigenous Women and Girls (MMIWG)*, the public outcry after the death of Joyce Echaquan and many other events that have shed a light on the abhorrent treatment of Indigenous people in Canada, has created opportunities to open space for more critical dialogue. Reconciliation is not possible without non-Indigenous people standing side-by-side with Indigenous people to forge a new path, together, and this concept is important within the discussion of allyship and reconciliation. Additionally, Garbutt found that “allies acting individually and together in grassroots movements are helping to change relationships between Indigenous and non-Indigenous people” (Garbutt, 2019, p. 12).

Despite the many direct and indirect efforts by colonial forces to eradicate Indigenous people in Canada, Indigenous people are thriving. Indigenous people are the fastest growing

population in Canada (Government of Canada, 2022). While there are many outstanding issues that need to be addressed, policies like *The TRC's Final Report*, and *The Inquiry into MMIWG* have drawn attention to the ongoing work that is needed in order to improve equity and the well-being of Indigenous and non-Indigenous people in Canada.

### **Indigenous Health Policy and Framework in Canada**

*The UNDRIP* was adopted in 2007 yet is not legally binding. *UNDRIP* safeguards the rights of Indigenous people throughout the world, and constitutes the minimum standards of survival, dignity, and well-being (Article 43). *UNDRIP* provides a roadmap to advance long-term reconciliation with Indigenous people, outlining the steps needed to respect, recognize, and protect Indigenous peoples' human rights and acknowledge and address the past (Government of Canada, 2021). In 2021, *UNDRIP* received royal assent and came into force (Government of Canada, 2021). The implementation of *UNDRIP*, and how it will be adopted remains to be seen. The acknowledgement of *UNDRIP* is still a positive step forward. Article 24 of the *UNDRIP* states:

Indigenous people 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, to all social and health services. 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 (UNDRIP, 2007, p.9).

Similarly, *The World Health Organization's (WHO)* mandate devotes special attention to the issues of Indigenous peoples' health around the world, which aims to protect and promote



Indigenous rights to fulfill the highest standard of health. *The WHO* highlights the fact that Indigenous health and human rights go hand in hand and aims to build the capacity of healthcare professionals by exposing health disparities of Indigenous people all over the world (WHO, 2010).

*The WHO's* constitution defines health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (WHO, 2007, p. 1). It is important to point out that the *WHO's* definition extends beyond the traditional biomedical paradigm, because it reflects a more holistic understanding of health, emphasizing harmony between individuals, communities, and the universe (WHO, 2007). For example, the *WHO* estimates that at least 80% of the global South relies on traditional healing systems as their primary source of healthcare. Importantly, traditional healing systems continue to co-exist with Western biomedical healthcare throughout the world.

In light of these considerations, overt or implicit racism is a violation of fundamental human rights and often lies at the root of poor health status around the world (WHO, 2007). Systemic marginalization of Indigenous people causes and magnifies poverty and poor health. The United Nations and the *WHO* encourages countries around the world to adopt action-oriented policies that ensure access to social services such as housing, primary education, safe and potable water, and culturally appropriate healthcare (WHO, 2007).

In 2015, *The TRC* released its final report with *94 Calls to Actions*. The *TRC* Commissioners travelled across Canada for three years to hear directly from approximately 6000 IRS survivors and their families. From these accounts, the *TRC* outlines Canada's dark history along with *94 Calls to Action* towards reconciliation. Most relevant to this research are the *Calls to Action* in numbers 18-24 that outline key recommendations to address health disparities for

Indigenous people in Canada and draws attention to the need to educate settlers on the history of Indigenous people. This includes acknowledging the unique needs of Indigenous patients as an important first step in addressing profound health inequities and informs my research into allyship in healthcare.

*The National Inquiry into MMIWG* was released in June 2019 (The National Inquiry into MMIWG, 2019). The enquiry explores the root causes of Canada's national crisis into the growing numbers of MMIWG. Firstly, the inquiry defines "health" by utilizing the *WHO*'s definition, noted above, as a human rights issue that must encompass physical, mental, emotional, and spiritual health for individuals and communities for women; girls; and two-spirit, lesbian, gay, bisexual, transgender, queer, questioning, intersex and asexual (2SLGBTQQA) people. Through interviews and stories with survivors and families, the inquiry explores Indigenous women, girls, and 2SLGBTQQA people' right to health, and how colonial violence directed towards Indigenous cultural practices, family, and community impacts physical, mental, emotional, and the spiritual health of Indigenous people. It concludes that many Indigenous people have negative experiences in accessing healthcare, and many felt that their health had diminished because of their interaction with health services (The National Inquiry into MMIWG, 2019, p. 413).

*The MMIWG Inquiry* highlights the disparities between Indigenous healthcare in Canada. Historically, Indian Hospitals and IRS were sites of abuse, neglect, and experimentation on Indigenous children (The National Inquiry into MMIWG, 2019). This began in 1904, when the federal responsibility for Indigenous health resulted in the creation of Indian hospitals. The Department of Indian Affairs began "medical programs" and developed health facilities to specifically serve only Indigenous people in Canada. Over the next couple of decades, with IRS



First Nations or communities and travel to Edmonton for healthcare, education, and for goods and services (Statistics Canada, 2021). Edmonton has the second largest urban Indigenous population in Canada, after Winnipeg.

Indigenous people are the fastest growing population in Canada (Statistics Canada, 2021). Canada's history of colonization and IRS, in addition to the pervasive underfunding of Indigenous services on and off reserve, has left many Indigenous people and communities living in poverty. At this time, 57% of those living in Edmonton and experiencing homelessness identify as Indigenous (Edmonton Community Foundation, 2019). To compound this issue, Edmonton faces a severe shortage of affordable housing, which is another factor in Indigenous health inequities (Edmonton Community Foundation, 2019, p.7).

Edmonton is a vital healthcare hub for Indigenous people and surrounding communities and is known as the gateway to the north. Many people travel to the city to access healthcare services. Additionally, there has been an increase in Indigenous, Métis and Inuit people moving to Edmonton for education, employment, healthcare, housing, and other factors that are not available outside of the urban centre (Edmonton Community Foundation, 2019).

### **Social Determinants of Health - Colonial History and Intergenerational Trauma**

It is well established that when compared with the larger Canadian population, Indigenous people endure substantially greater social, economic, and health challenges (Castleden et al., 2012). The SDOH that disproportionately affect Indigenous people (poverty, history of IRS attendance, food insecurity, etc.) have a compounding effect: the greater the number of SDOH that off-reserve First Nations people experience, the more likely they are to report poor health outcomes. Ultimately, while these are useful predictors of health, there is no one clear cause for the health disparities among First Nations, Métis, and Inuit people. Broadly

contributing to these issues are political, economic, and social circumstances, including colonialism, racism, and social exclusion (Aboriginal Peoples Survey, 2012). But the colonization of Indigenous people is a fundamental health determinant that continues to impact health and well-being and must be remedied if the health disadvantages of Indigenous people are to be overcome (Baydala et al., 2013).

The IRS system was implemented by the federal government as one of the key tools to achieve the goals of eliminating their “Indian problem” and continuing to colonize the country we now call Canada (Bombay et al, 2014). IRS ran from the 1880s until the last school closed in 1997. By 1930, roughly 75% of all First Nations children between the ages of 7 and 15 attended IRSs, as did significant numbers of Métis and Inuit children (Bombay et al, 2014). Indigenous children as young as three were forced, by law, to be removed from their families and communities to attend IRSs (Bombay et al, 2014). Estimates suggest that over 150,000+ Indigenous children in Canada attended IRSs. The traumatic legacy of these experiences continues today as abuse and neglect are passed down from one generation to the next (Bombay et al., 2014).

Intergenerational trauma is defined as a cumulative emotional and psychological wounding over the lifespan and across generations, emanating from massive group trauma (Bombay et al, 2014). Research on the intergenerational impact of trauma resulting from The *Indian Act* which includes the forcible removal of Indigenous people from their lands and onto reserves, the forcible attendance of Indigenous children in IRS, the forcible removal of children into foster care, and the ongoing marginalization of Indigenous people in Canada has become increasingly popular to researchers and is considered a social determinant of health with negative health outcomes on Indigenous people in Canada and around the world (Bombay et al., 2014).

Bombay et al (2014, p.331) also noted that, “there is consistent evidence of the enduring links between familial IRS attendance and a range of health and social outcomes among the descendants of those who attended”. Literature on the negative social and health outcomes of IRS attendance suggests that survivors are more likely to suffer a variety of mental and physical health problems compared to Indigenous adults who did not attend (Bombay et al, 2014). Additionally, IRS survivors and their descendants appear to be at greater risk for poor health and social outcomes (Bombay et al, 2014).

Given these considerations, Indigenous health must be contextualized within historical, social, and economic factors that contribute to the cumulative impacts of colonization, as well as persistent and harmful policies that continue to harm communities and individuals (National Inquiry into MMIWG, 2019). Many witnesses during the *MMIWG Inquiry* spoke about the health-related impacts of historical and ongoing colonial policies that continue to shape the health of their children and grandchildren (The National Inquiry into MMIWG, 2019). A result of Canada’s colonial history is the collapse of Indigenous traditional economies through the loss of land and self-determination. Economic variables can impact mortality, morbidity, and access to healthcare services (Manitowabi & Maar, 2018). As outlined below in *The MMIWG Inquiry* (2019):

High rates of chronic health conditions do not occur in isolation, rather health inequalities are shaped by – and rooted in – the inseparable relationship between health and generations of racist colonial policies. The effects of colonization have resulted in a legacy of environmental dispossession, degradation of the land, substandard living conditions, inadequate access to health services, social exclusion and a dislocation from

community, language, land and culture. These policies have been clearly linked to adverse health consequences for individuals and community.

*The Aboriginal People Survey (APS)* (2012) explores the relationship between SDOH and health outcomes for the off-reserve First Nations population over the age of fifteen. The survey demonstrates that SDOH were predictive of a poor health outcome (defined as reporting at least one chronic condition, or self-rating one's general or mental health as fair or poor). According to the *APS*, IRS survivors and their families are at a greater risk of daily smoking; being overweight or obese; living in a home in need of major repairs; having less than a high school education; being unemployed; having an annual household income in the lowest tercile; experiencing food insecurity; having unmet health needs; and having no one to turn to for support in a time of need. Health is heavily influenced by the social conditions in which people live, work, grow, and are born into (APS, 2012). For example, if you are a First Nations person born in Alberta, you can expect to live 11 years less than a non-Indigenous person, are twice as likely to have your infant die, women are seven times more likely to die due to assault and are three times more likely to be affected by suicide than non-First Nations people (AHS, 2018).

In 2011, Czyzewski's research introduced colonialism as a distal determinant of health in Indigenous health research. Her critical review of Indigenous health discourse emphasizes colonialism as an unfinished project with reference to the persistence of racism and assimilation (Czyzewski, 2011, p. 4). Her research highlights colonialism's history through epidemic diseases, such as smallpox, IRS, land dispossession, and separation from the mainstream economy (2011, p. 3). Colonialism creates the structural and systemic disparities that are beyond the control of the individual or community and are the "causes of unjust life situations for particular groups or people over others" (Czyzewski, 2011, p. 4).

Jacklin and Warry (2012) further Czyzewski's research as they conclude many healthcare providers do not understand colonialism as a determinant of health. Additionally, there is little awareness about the history of traumatic experiences with state authorities (like child welfare) and institutions (such as IRS or Indian hospitals) that has resulted in significant mistrust of government services by Indigenous people (Jacklin & Warry, 2012). Jacklin and Warry argue the best way to address the legacy of colonialism in Indigenous health is through decolonization of healthcare through community control, capacity building and by applying an Indigenous SDOH lens to inform future practice and government policy.

Health inequities faced by Indigenous people are widespread and persistent, and the root causes are social, political, and economic as opposed to exclusively individual, behavioral, or genetic (Jacklin & Warry, 2012). Racism, discrimination, and prejudice are major factors in health disparities which highlights a need to improve healthcare professionals' understanding of Indigenous health and allyship to ensure they get the care they need and deserve (Jacklin & Warry, 2012).

### **The Road to Reconciliation and Decolonization**

*The Royal Commission on Aboriginal People (RCAP)* was one of the first attempts at improving the relationships between Indigenous and non-Indigenous Canadians. *RCAP* was established in 1991 to investigate the relationship between Indigenous people, The Government of Canada, and Canadian society as a whole. It was launched in response to public outcries at that time. While many argue that the findings of *RCAP* were not implemented, it paved the way for the *TRC*'s impact and began the conversations towards reconciliation between Indigenous and non-Indigenous Canadians (TRC, 2015). According to the *TRC* (2015), reconciliation is an



ongoing process of establishing and maintaining respectful relationships. Truth is the first step towards reconciliation and *The TRC's Final Report* states:

Too many Canadians know little or nothing about the deep historical roots of the contemporary issues facing Indigenous people. This lack of historical knowledge has serious consequences for First Nations, Inuit, and Métis people, and for Canada as a whole. In government circles, it makes for poor public policy decisions. In the public realm, it reinforces racist attitudes and fuels civic distrust between Aboriginal people and other Canadians (2015, p. 8).

Beyond truth telling, reconciliation requires the development of a new shared vision, based on a commitment to mutual respect. The ongoing impacts of colonialism has created a divide between Indigenous and non-Indigenous Canadians, however, “reconciliation is not an Aboriginal problem; it is a Canadian one, and virtually all aspects of Canadian society may need to be reconsidered (TRC, 2015, p. VI). Reconciliation requires the decolonization of relationships between Indigenous and non-Indigenous Canadians by addressing the past wrongs and working to rebuild relationships.

Garbutt (2019) suggests that non-Indigenous Canadians may engage in reconciliation because “they may be reacting to shame or guilt, out of moral obligation, for spiritual or religious reasons, for legal or mandated agendas, or for reasons rooted in social justice” (p. 3). However, some non-Indigenous people may choose not to participate in reconciliation or decolonization for the following reasons: they may feel that it is time to move on, that racism is no longer an issue, that racism is justified, that they are not at fault for the past historical traumas, and/or enough has been done to address injustices (Garbutt, 2019). However, within the complexities of social

change, there are signs that reconciliation is slowly moving forward, “led by resilient Indigenous people and supported by non-Indigenous allies” (Garbutt, 2019, p.64).

Reconciliation is action focused, and to achieve it, education is paramount. Before being able to reconcile or build alliances, people must know what they are up against. Non-Indigenous Canadians can take the steps to educate themselves about the impacts of colonization and learn about what authentic reconciliation and allyship looks like. Reconciliation, like allyship, simply cannot be one sided and requires non-Indigenous Canadians take responsibility and make the efforts to decolonize Canada (Garbutt, 2019). Through decolonization efforts, it is believed that a new shared Canada can emerge to benefit everyone.

### **Implicit Biases, Racism, Oppression, and Privilege**

One of the main contributing factors to the oppression and racism seen in Canada’s healthcare system can be attributed to the unconscious bias or negative beliefs some healthcare providers hold. Improving health and healthcare for Indigenous people in Canada is an act of reconciliation (TRC, 2015). Allan and Smylie ‘s (2015) extensive research titled *First Peoples, Second Class Treatment* explored the role of racism in Indigenous health as told through narrative accounts with Indigenous Elders. Their research found that negative stereotypes about Indigenous people and an "unconscious, pro-white bias" among health-care workers continues to perpetuate harm. Their research found that within healthcare, unintentional racism associated with Indigenous people is alive and well. The study suggests Indigenous people experience racism from healthcare workers so frequently that they often strategize on how to deal with it before visiting emergency departments or they avoid care altogether (Allan & Smylie, 2015). The rippling effects of the trauma caused by colonial policies have served to reinforce or seemingly legitimize racist stereotypes about Indigenous people (Allan & Smylie, 2015).

Race, as a social construct, and racial stereotypes continue to influence Indigenous people accessing healthcare (Allan & Smylie, 2015). Not all Indigenous people experience racism and prejudice in the same ways. Research on implicit bias suggests that individuals may act based on prejudice and stereotypes without intending on doing so (Brownstein, 2019). For example, Brownstein's (2019) research on implicit bias suggests that what a person says is not necessarily a good representation of the whole of what she feels and thinks, nor of how she will behave. In Canada, colonization has relied on negative stereotypes around Indigenous people that are very deeply embedded into people's beliefs, and this ultimately affects the ways in which Indigenous people access care. By extension that affects their health outcomes even if the healthcare providers are unaware of their own biases towards their Indigenous patients.

Importantly, one way in which healthcare providers can recognize these implicit biases is to bring them into awareness. As Brownstein suggests, it is plausible that conscious awareness of our implicit biases is a necessary condition for moral responsibility for those biases (2019). This is important because, he suggests that people often do have awareness of their implicit biases and this needs to be considered in healthcare (Brownstein, 2019). Raising awareness of implicit biases may help to mitigate negative thoughts and behaviours that healthcare professionals may have when working with Indigenous patients and their families.

This is important in healthcare because as Brownstein suggests, policymakers and workplace managers may also be concerned with finding effective interventions, given that they are already directing tremendous public and private resources toward anti-discrimination programs in workplaces, universities, and other domains affected by intergroup conflict (2019). One strategy that helps to reduce implicit bias is interaction between members of different social groups, which can be done by increasing individuals' exposure to images, film clips, or even

mental imagery depicting members of stigmatized groups acting in stereotype-discordant ways (Brownstein, 2019). This means actively sharing meaningful and positive stories about Indigenous people.

Brownstein's research also found that explicit bias and outright prejudice are persistent and, in some places, pervasive (2019). However, critics of implicit bias research suggest that researchers should focus their attention towards systemic and institutional causes of injustice rather than biases inside the minds of individuals (Brownstein, 2019). Therefore, efforts towards change should be refocused on the social structures to improve the quality of life of people from socially stigmatized groups (Brownstein, 2019). This is important to highlight because it speaks to the systemic nature of bias, racism, and prejudice. Allyship requires an institutional shift that creates space for individual allyship to thrive. It is difficult for allies to work within the constraints of large systems, like healthcare, without addressing the explicit and implicit bias and racism that is so deeply entrenched. Brownstein's research argues that both systemic and individual change is required in order to improve the outcomes for marginalized groups.

Indigenous peoples' experience of ongoing marginalization due to the societal and systematic privileging of white people in Canadian society (Allan & Smylie, 2015) highlights the "coin model" of privilege and "critical allyship" as described by Nixon (2019). Nixon's coin model describes the "society-level norms or structures that give advantage or disadvantage regardless of whether individuals want it or are even aware of it" and this is noteworthy within the context of health equality (Nixon, 2019, p.3). Nixon argues that the health inequities affect both the unearned-privileged group (top of the coin) and the disadvantaged or oppressed group (bottom of the coin). As Nixon states, the goal is not to move people from the bottom of the coin to the top, because both are unfair, but to dismantle the system that causes these inequities.

Within the Canadian context, “it is non-Indigenous people (often referred to as settlers) who receive unearned and unfair advantage” (Nixon, 2019, p.5). Nixon (2019) explains the Coin Model below:

There are norms, patterns and structures in society that work for or against certain groups of people, which are unrelated to their individual merit or behaviour. Put another way, there are (often invisible) systemic forces at play that privilege some social groups over others, such as sexism, heterosexism, racism, ableism, settler colonialism, and classism. These unfair social structures have profound effects on health, producing inequities in morbidity and mortality (p.2).

Nixon argues that some ways in which non-Indigenous people can counteract some of this is by asking questions such as: “In which ways did I benefit from settler privilege today?” and “In what ways did my actions today reflect and thereby reinforce the coin of settler colonialism?” (Nixon, 2019, p.5). It is also significant to acknowledge that the conversations surrounding white privilege often leads to counterproductive attention on guilt, which can lead to “discomfort, distancing from the issue, denial, or intellectual paralysis” (Nixon, 2019, p.7). A more productive strategy is to recognize feelings of guilt and reframe it towards responsibility, which gives rise to actions that resist dominant norms that sustain inequality, which Nixon describes as “practicing critical allyship” (2019, p.7). As Nixon (2019) so poignantly points out “allyship is not an identity, but an ongoing practice” (p 7). Allyship requires ongoing self-reflection and action to support the cause in which the ally is aligned with.

### **Indigenous Health Education Training**

Literature on allyship and reconciliation emphasizes the need for education as an act of reconciliation. More specifically, *The TRC’s Call to Action* #24 states:

We call upon medical and nursing schools in Canada to require all students to take a course dealing with Aboriginal health issues, including the history and legacy of IRS, *The UNDRIP*, Treaties and Aboriginal rights, and Indigenous teachings and practices. This will require skills-based training in intercultural competency, conflict resolution, human rights, and anti-racism.

We have learned through various inquiries and through the literature that education is a key part of reducing biases and stereotyping which contribute to health disparities among marginalized groups, like Indigenous peoples in Canada (Allan & Smylie, 2015; TRC, 2015). One way that institutions are working to educate healthcare students and professionals is through different education and training opportunities.

For example, The RCPSC formed the Indigenous Health Committee in 2019, comprising Indigenous physicians, scholars, social workers, policy makers, and other healthcare professionals with the vision to:

Create healthcare that is free of racism where every Indigenous person is treated with respect, recognized as an individual rather than a stereotype and experiences the highest level of health, and that all stakeholders understand how colonial structures and systems link to current health inequities (RCPSC, 2019).

While this mandate is specific to physicians, these priorities can and should be brought into all health professional training. As a healthcare education concept, cultural safety “analyzes power imbalances, institutional discrimination, colonization and colonial relationships as they apply to health, care, and health education” (RCPSC, 2019, p.9). Cultural safety is another promising way to educate healthcare professionals, involving critical thinking and self-reflection

about power, privilege, and racism in educational and clinical settings. Importantly, cultural safety is determined by the patient, and their perception of safety thereby giving power back to the patient (RCPSC, 2019, p.9). Cultural safety principles and training are aligned with the principles and values of allyship such as reflexivity, empathy, open-mindedness, and education. According to the RCPSC (2019):

The healthcare of an Indigenous person reflects the dimensions of quality for patient-centred care that resonates with the culture and values of that person in all stages of his/her life. Culturally safe practices, reflexivity and anti-racism interventions should always be demonstrated by the physician, including empathy, open-mindedness and understanding of how colonialism deliberately excludes indigeneity, and how the determinants of health contribute to the patient's health status and fall short in meeting it. (p.9)

An antiracist approach recognizes the deeply rooted racist structures that perpetuate racial inequity and actively strives to undo them by redistributing power and resources. According to Kendi, “the opposite of racist isn't ‘not racist,’ it is ‘antiracist’” which involves confronting racial inequities and locating the roots of problems in power and policies (2019, p.9).

Argueza et al.'s (2021) research on anti-racism in medical training found that trainees and faculty from racial and ethnic minority backgrounds are crucial to developing informed antiracist interventions that also identify blind spots that remain unseen by white colleagues (Argueza et al., 2021). However, the “burden of change should not be placed on the people who are oppressed by the systems that they did not create” (p. 799). Institutions cannot rely on racial/ethnic minority individuals to take on *extra* responsibilities, that are often undervalued and that take away from promotion-earning activities, education, and personal wellness (Argueza et

al, 2021). One way to mediate some of these extra responsibilities often imposed on people of colour, is by dismantling systemic racism by “allowing those who have been historically excluded from positions of influence to hold and exercise power” (Argueza et al., 2021, p. 800).

Argueza et al. (2021) assert that allies are a crucial part of anti-racism work, because White people make up the majority of “trainees and faculty at medical training institutions, occupy most leadership positions, and hold immense social power” (2021, p. 800). It is critical to mobilize this influential group “to educate themselves on effective allyship and to use their privilege for positive change” (Argueza et al., 2021, p.800). White colleagues play a role in disrupting racist behaviours, uplifting the voices of people of colour, and advocating for antiracist policies. According to Argueza et al, to do this, white people must invest their discomfort, energy, and capital to acknowledge and positively leverage their privilege to practice antiracist allyship (2021, p. 800).

## **Conclusion**

Allyship in the healthcare field is a new concept that is beginning to be explored and researched. Anti-racism and cultural safety training are also increasingly popular as a healthcare intervention that helps to reduce implicit bias and racism. The principles of allyship align well with these trainings. There is much that can be learned by exploring allyship and its role in how healthcare providers care for their patients. This is particularly important given the history of maltreatment of Indigenous people in Canada and the ongoing disparities in health outcomes for Indigenous people in Canada.

Prior to contact, Indigenous people in Canada were able to satisfy all of their needs from the land. They lived relatively harmoniously and had advanced social norms and order. Upon the arrival of settlers, Indigenous peoples experienced substantial upheaval in their ways of life. This



disruption is ongoing today and is apparent in almost all of the systems in Canada, including the healthcare system. Indigenous health outcomes in Canada are a direct impact of colonization. For example, the SDOH including, poverty; food and housing insecurity, lack of access to clean drinking water, poor educational attainment, experience with the criminal justice system, and many others all impact health outcomes for Indigenous people in Canada. Additionally, Indigenous people in Canada are still subject to maltreatment when they do access care — implicit bias, racism, and oppression continue to affect the healthcare that Indigenous people receive. This has led to many calls for action towards reconciliation and improving relations between Indigenous and non-Indigenous people in Canada.

One way to improve the relations between Indigenous and non-Indigenous people in Canada is through allyship and improving the care that they receive. Being an ally means working towards improving the conditions of a marginalized group in which you are not a part. You stand beside or behind the group and advocate towards improving or removing the barriers that they face. However, there is little literature on what it means to be an ally in healthcare. Additionally, there is little research on allyship in Indigenous healthcare in particular. Therefore, this study is designed to answer the research question: What does it mean to be an “ally” to Indigenous patients in the healthcare system?”

### **Chapter 3 - Research Methodology**

This chapter outlines the research methodology, setting, recruitment and sampling, data collection, analysis, rigour, and knowledge mobilization used in this work. The research project received ethics approval from the University of Alberta Research Ethics Board.

#### **Methodology**

A qualitative description methodology was utilized. Qualitative description embraces the existence of multiple truths and the subjectivity of participant experience. This is the methodology of choice when a straight description of phenomena is desired. It is widely used for research that focuses on the who, what, and where of events or experiences and for gaining insights from participants regarding a poorly understood phenomenon. Additionally, it is amenable to obtaining straight and largely unadorned (i.e., minimally theorized or otherwise transformed or spun) answers to research questions of special relevance to practitioners and policy makers (Sandelowski, 2000).

Qualitative description was a logical choice for the research topic that explores what allyship means in Indigenous healthcare. Ultimately, I wanted to understand what made the participants good allies.

#### **Setting**

This research was conducted virtually from April-July 2021. Most of the participants were located in and around Edmonton, Alberta, Canada, as was the research team. Edmonton is located in Treaty 6 Territory.

#### **Recruitment and Sampling**

Participants were selected purposefully, based on characteristics and context that contributed to an in-depth understanding of the research topic (Mayan, 2016). To be included, research participants self-identified as non-Indigenous (some were Caucasian, and some

identified as members of other minority groups), healthcare professionals who provide care to Indigenous patients. The intention was to find participants that could provide the most and the best information about allyship in the context of Indigenous healthcare.

The participants were identified by Indigenous healthcare professionals and colleagues as being a good “ally”. The literature on allyship makes it explicit that allies are identified by the community members with which they align themselves (Smith et al., 2015). Self-identifying as an ally can be problematic as it prioritizes the ally’s identity over who they claim to be allies with. I contacted Indigenous healthcare professionals that I, or my supervisors had previous relationships with, via email. The initial email included an introduction to the research team (myself and my supervisory team), the criteria for inclusion in the study, a summary of the research project and, what to expect in the interview. The emails also asked if they would be willing to identify specific individuals, they considered allies and share the research information with them. The Indigenous healthcare providers that helped recruit allies then shared the researcher’s contact and information with those who showed interest in participating in the study. Some recruiters contacted the potential participants directly and shared their information with the researcher with their consent. An informed consent form and the research proposal were provided to participants prior to the interviews, and a date and time to conduct interviews via Zoom (a secure online video teleconferencing platform) were mutually agreed upon.

### **Data Collection**

One-on-one, qualitative, semi-structured interviews were conducted virtually between April to June 2021. Casual conversation took place prior to the formal interview process, and the research objectives and information letter were reviewed. All participants had the opportunity to ask questions. Once they agreed to proceed, the consent form was reviewed, and verbal consent was received and recorded prior to starting the interview.

The interviews, following a prepared interview guide, lasted between 20 minutes and 1.5 hours (See Appendix for Interview Guide). A semi-structured interview is a data collection method that follows a predetermined set of questions but allows some flexibility in the order and wording in which the questions are asked (Neergaard et al., 2009). The questions were open ended, which allowed participants to guide the direction of the research and to focus on what was important to them. All interviews were audio recorded and transcribed verbatim.

All participants were anonymized and given pseudonyms; their real names and any potentially identifying information were not used in the transcripts, nor the analysis. All audio recordings and transcripts were password protected and follow the requirements of the University of Alberta's Research Ethics Board.

### **Data Analysis**

Data collection and analysis occurred concurrently, using thematic analysis. ATLAS.ti (Version 9.1.3) qualitative data analysis software was used for this analysis. Thematic analysis is a way of identifying and collating the similarities to the way an idea or concept is talked about. The next step is to bring those commonalities together to make sense out of the research question (Braun & Clarke, 2012). It is the method of choice for this type of research because it systematically identifies, organizes, and offers insights into patterns of meaning (themes) across a data set. Thematic analysis allows the researcher to see and make sense of collective or shared meanings and experiences (Braun & Clarke, 2012).

Thematic analysis has six phases of reflexive analysis, an iterative process that includes: familiarization, generating codes, constructing themes, revising themes, defining themes and subthemes, and producing a report. I utilized this method to analyze the interview data by paying close attention to what the participants had said, and whether it was repeated and emphasized by participants (Braun & Clark, 2012). The next step was to code and theme within the broader

context of the research. After the first three interviews, I transcribed the interviews and began the data analysis by reading and rereading them, with the audio, to ensure accuracy and to familiarize myself with the data. Next, I began coding key words or ideas that emerged through the interviews. These words and ideas were coded into themes and organized with other related topics that shared similarities, as part of larger themes.

The codes were then grouped into three overall themes which were considered saturated when no new data emerged that was related to my research question and the themes had emerged in a clear and predictable way (i.e. participants were all saying the same or similar things).

### **Rigour**

To ensure validity, generalizability, and reliability of the data, I used the following verification strategies to ensure rigour. Verification, which is the process of “checking, confirming, disconfirming, and accounting for variability, and being certain” (Mayan, 2016, p.108). The verification activities included in this research are researcher responsiveness, methodological coherence, sampling sufficiency, developing a dynamic relationship between sampling, data collection and analysis (Mayan, 2016; Morse et al., 2002).

Ensuring rigour through researcher responsiveness includes the researcher’s “creativity, sensitivity, flexibility and skill” (Morse et al., 2002, p. 5). For this research, the study was approached through an inductive process in order to avoid being prescriptive. This requires going into the research with an open mind and thus, allowing the data to lead the research.

To ensure methodological coherence, my research question matched my method. Because my research question is focused on the meaning of allyship and its understandings, it was best answered through a qualitative descriptive methodology and qualitative interviews.

Using thematic analysis, I collected and analyzed my data concurrently, which formed a mutual interaction between what is being learned and what needs to be learned (Morse et al.,

2002). During these early stages, I reflected on the interviews through detailed journaling. I had regular check in discussions during the data collection stage with my supervisors and adjusted the interview questions for future interviews. Although no adjustments to the research questions occurred, I gained more confidence and a deeper understanding of the topic as the interviews progressed and I became a better interviewer throughout the data collection.

With referrals from Indigenous healthcare workers, the participants came from various healthcare backgrounds, and included physicians, nurses, speech language pathologists, and occupational therapists. This provides a broad sampling of Indigenous healthcare allyship. And because the data was collected and analyzed concurrently, I had the opportunity to listen to the audio recordings and compare the transcripts multiple times to ensure completeness and accuracy. Participants were given the option to review their transcripts to ensure accuracy, however, no participants made this request.

Upon completion of an interview, I transcribed, and coded the answers before continuing to recruit more participants. The themes evolving from the data closely matched the incoming data. This iterative process of interview, transcribe, code, and theme continued until my supervisory team, and I felt that saturation had been reached. I went through several iterative cycles of constructing and reviewing the codes and themes and returning to the original transcripts to ensure accuracy and to capture relevant findings.

Another critical step is the use of reflexivity, as it ensures the researcher checks in with the biases they bring into the study. Reflexivity was important in this research and therefore I also kept a journal where I recorded my thoughts and feelings before and after interviews. This activity included some of the themes that I felt were emerging from the data collection, which was reviewed regularly. To ensure rigour throughout, the research study was an iterative process

of interview, review notes, transcribe, and code. During the data collection phase, my supervisory team was kept informed on the emerging themes.

Beyond Morse et al.'s verification strategies, I conducted "participant checks" of the research findings with two participants during the final stages of coding and data analysis, to ensure accuracy and to increase academic rigor (Morse et al., 2002). We discussed the main findings, and all agreed that the findings summarized their perspectives on the topic. These conversations were not part of the data collection and therefore were not recorded or transcribed. However, their feedback was an important step in validating the research findings. I provided the research participants and the Indigenous community members who helped to recruit participants in the study a copy of my completed thesis.

### **Knowledge Mobilization**

From the very beginning of the research design, my goal was to impact and contribute to improving Indigenous healthcare. There is growing scholarship around knowledge mobilization and the connection between research, policy, and practice (Levin, 2008). While the research participants in this study were all highly educated and most actively sought new learning opportunities, it is important that the findings of this research are accessible to healthcare professionals who are interested in developing their allyship journey.

The participants who generously offered their time to open up about this topic will be provided with a final copy of this thesis and I will present my research findings to the University of Alberta' School of Public Health students. It is my hope that I will be able to present my research findings to different areas within Alberta Health Services (AHS), the University of Alberta, and for others who may be interested in learning more about allyship in Indigenous healthcare. I have plans to work with Dr. Lana Whiskeyjack on a digital story to further expand

the accessibility of this research. I have also been asked to share my research findings on a podcast that is accessed by healthcare providers throughout Canada.

I intend on writing an academic article for publication that can be accessed by healthcare professionals and anyone interested in allyship. It is my hope that the research participants and those who helped recruit for this study, will share this broadly with their networks. I hope that these findings will be shared with policy makers, AHS managers, researchers, front line healthcare staff, and post-secondary students.

Ideally this research will help to improve the education that healthcare professionals (for example, AHS mandatory training) and post-secondary students in healthcare fields receive.



## Chapter 4 - Research Findings

Participants responded to questions about allyship in Indigenous healthcare in a variety of ways and shared unique and enlightening perspectives. Some responses were explicit and to the point, while others told lengthy stories to illustrate their experiences of being allies in providing care to Indigenous patients. This chapter outlines the key findings, based on a qualitative, thematic analysis that explored what allyship in healthcare is. The findings fall into three main themes: a) the meaning of allyship, b) the experience of being an ally, and c) cultivating allyship in healthcare, which are thoroughly described below. These themes advance the understanding of allyship in Indigenous healthcare, while also eliciting participants' assessment of both the successes and struggles of being an ally. This chapter concludes with examples of further research to advance the practice of allyship in healthcare.

A total of 13 participants were needed to reach data saturation. Below is a table that outlines the demographics of the participants. The table shows the participants' pseudonym and their profession.

### Participant Demographics Table

**Table 1**

*Participant Demographic Table*

Participant Pseudonym	Profession
Sarah	Specialist Physician
Linda	Specialist Physician
Stephen	Specialist Physician
Olivia	Specialist Physician
Philip	Occupational Therapist
Veronica	Specialist Physician
Samara	Specialist Physician

Stacey	Speech Language Pathologist
Melissa	Speech Language Pathologist
Elodie	Registered Nurse
Donald	Specialist Physician
Ashley	Occupational Therapist
Joanne	Specialist Physician

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## **The Meaning of Allyship**

### ***Allyship must be Determined by the Community***

Participants were asked whether they consider themselves “allies”. Most of the participants recognized the importance of being community-identified, rather than self-identifying as an ally. One participant noted, “it has to come from the community, it’s something you earn” (Sarah). Veronica explains what allyship means to her and the importance of community within the discussion of allyship,

I think allyship to me means, that I allow myself to be held accountable by the community I work with and for, and I allow myself to take direction from them. It is waiting for opportunities in which I can speak and provide my education and some of my expertise towards the questions that they're asking. But a lot of allyship to me means walking alongside and building relationships rather than coming in with solutions.

Many participants pointed out that “ally” was not their preferred term. However, it is often used out of convenience and for lack of a better term. In some cases, participants used the terms “ally” and “advocate” interchangeably and others struggled with calling themselves allies. Many

participants used air quotations when using the term ally in their interviews. This finding highlights the participants' perceptions of the need to be identified by the community and the need to be humble.

### ***Allyship Characteristics and Working Alongside Indigenous Peoples***

Most of the participants had clear convictions about what characteristics were central to allyship work in healthcare. Participants mentioned being: “an advocate”, a “community member”, an “along-sider” or a “co-resistor”. Other key characteristics that were highlighted included: humility, trustworthiness, patience, good listening, willingness to learn, compassion, empathy, being a safe person, reciprocity, and self-reflection. Overall, participants generally agreed that the most critical aspect of allyship is “humility” or “the ability to be humble and listen” (Sarah & Elodie). Veronica explains, “I've really learned and appreciated the opportunities to just listen and just be quiet and just keep showing up. I think that it's been a hard lesson for me to learn, but allyship *is* listening”.

Echoed by the majority of participants, Stacey relates how humility can counteract anger and some of the difficulties of allyship:

As much as I am pissed, I am beyond furious about things that have happened and continue to happen. The answer is, we're not going to win people over by being angry. The approach needs to be a lot more, we need to find a way for people to come alongside in a way that people can handle... I've had to adopt this attitude of humility to be more humble and realize that they are doing their best based on their training, it's not their fault. I have become more humble and less arrogant because I have been given some gifts of learning and knowledge. I am far enough along on my journey that

I can see some of these things. I'm not better. I can't be self-righteous. I still make mistakes. I catch myself saying something stupid.

The concept of working *alongside* Indigenous people as an ally was an essential aspect of allyship. Sarah notes, "I am so cognisant about not making it about me. You can't centre the settler experience." Joanne built on Sarah's reflection as she notes,

We all have to be working for change. But those of us who have voices or a seat at the tables, [we] need to be stepping aside and bringing Indigenous people to those tables so that their voices are heard.

The concept of "working or walking alongside" meant "collaboration". For example, walking alongside for Sarah meant not imposing a "white biomedical model of healthcare to patients". Melissa also echoed what others said about the importance of "working in collaboration with patients, their families, their communities, and Indigenous healthcare professionals to ensure that Indigenous perspectives are being incorporated into their care". As mentioned by most of the participants, healthcare, and a lot of allyship work centers around the settler experience and worldviews, and there are inherent power imbalances within healthcare that favours the white male cis gender experience of health and wellness.

Some participants contend that working alongside is problematic because allyship work must be Indigenous led as Indigenous people are the experts of their own experiences and they should be leading the movement to improve health equity in Canada. As previously mentioned, Joanne suggests "stepping aside", which she says means encouraging Indigenous people to determine and take control over their health delivery.

### *Allyship is Authentic Action and Advocacy*

A feature of allyship, according to the participants, was the “important role of advocacy”. All the participants mentioned an aspect of advocacy in healthcare in relation to their roles as healthcare professionals. It implies that there is action required as a key characteristic of allyship work. Joanne explained that allyship means, “being willing to advocate for Indigenous people’s rights, including the right to health equity. Being conscious of that is especially relevant to me as a physician”.

Many participants explained that all healthcare providers should take on the role of allies or advocates. Advocacy according to Philip meant, “filling the gaps within healthcare in order to do their jobs”. Some participants expressed that they felt they could not be neutral or silent when they witnessed racism or prejudice. Instead, they wanted to be proactive against racism and prejudice, such as working to change policies and procedures and removing or reducing systemic barriers. On a larger scale, participants felt it was important for allies to call out their coworkers when they witness them being prejudice or racist towards Indigenous patients.

The story below demonstrates the lengths that some allies will go for their patients, because they understand the complexities and barriers their patients face to access care. Samara tells a story about an Indigenous patient from a northern reserve who came with her family and grandchild to Edmonton for surgery. Just before her pre-operative appointment,

I got a phone call that the patient was being turned away from the front desk screeners because she had a child with her, and with COVID children aren’t allowed in the hospital.....I feel like this is just one of so many cases where the rules seem to be so black and white. And there's no lateral thinking, as to the circumstances of the patient,

like ‘the rules are the rules’. No one at that front desk cares whatsoever about the circumstances.

Rather than turning the patient away which would mean she would not have surgery, Samara rearranged her schedule to take care of the grandson while the patient attended her appointment,

The kid and I hung out for about three hours - we coloured; we raced down the hallway. I had to sneak him in through the back. It was kind of traumatizing for both of us because of the attitude of the nurses at the front. I just don't care...I always felt like I don't care about the rules when it comes to Indigenous patients. I will do whatever I can if it's better for that patient. I've been called a reverse racist and that sort of thing, but I don't care.

Samara's story was one of many stories that participants shared about the unique situations they were put in, and where their role as allies required immediate action and advocacy. The stories that participants shared demonstrated their allyship in action. Many participants told stories about times where they had to neutralize a difficult situation or directly stand up against a co-worker who was actively mistreating an Indigenous patient. Olivia, a resident doctor, explained that for her, allyship involves “being willing to advocate for your patients when you see inequity or racism happening in front of you and being able to stand up for that”. She felt that advocating or speaking up posed a lot of challenges as a new physician in training, who also happened to be a woman.

Participants noted that within healthcare, there are hierarchies embedded within the system. For example, their profession (e.g., physician or nurse), race, gender, sexual orientation,

religion, and class, among others, played a role in their perceived ability to be advocates.

Systemic hierarchies proved to be a major barrier to advocacy as Sarah, explains,

It's an interesting tension, being a relatively young woman, and in the hierarchy of medicine. Those things don't give me a lot of privilege and a lot of voice but in being white and a specialist and cisgender and able-bodied and straight and all those things. I have all of this immense privilege and so, my constant struggle is where do I put my elbows out and say I need to take up space in this conversation? And, I have earned my space by virtue of being a physician and where do I not take up space?

Participants mentioned this internal tension between speaking up and not speaking up because they felt that they did not hold the power in a particular situation. This pressure between speaking up and not, is a key dilemma that participants mentioned in their allyship journeys and especially within the complex hierarchies within healthcare.

Participants shared concerns regarding “great white saviour” complex within allyship. For example, Elodie noted, “I have to be conscious about not being a white savior. I'm not going in there being like, ‘I want to save all these people, and I can't wait to just fix everybody!’” Linda, an experienced physician specialist, states,

*The Black Lives Matter Movement* really struck home the importance of recognizing white privilege and not being the great white savior when it comes to caring for patients and I think being an ally means that you should always be learning, taking courses, or reading or listening and promoting Indigenous people to leadership roles.

The concept of white saviourism was also mentioned within the context of different movements occurring within Indigenous communities such as *Every Child Matters* and

*#JusticeForJoyce*. For example, participants mentioned wearing an orange shirt on orange shirt day but staying silent while an Indigenous patient is being mistreated or not correcting a family member or friend when they are speaking down about Indigenous people. Most participants felt that ‘performative’ allyship was very problematic within healthcare practice. To avoid being a performative ally, participants explained that people need to “walk the talk” and need to be “action oriented”.

### ***Working to Create Positive Healthcare Experiences***

Participants expressed similar thoughts around the meaning of a positive healthcare experience which includes working to ensure Indigenous patients “feel heard,” “feel safe,” are “not being judged or shamed”. Stephen, a physician who works on a First Nations reserve, provided insightful thoughts into what a positive healthcare experience means to him and his patients. He believes this requires patients to “feel comfortable asking questions and returning for follow-up care,” and that they “believe their ailments were addressed and/or cured,” and “believe their culture, and that their experiences and needs were respected by the healthcare providers.” Elodie, a registered nurse, explained,

Allyship means understanding that me, as a white person, and my patients as Indigenous people, we are different, but that doesn't mean that I'm going to care for you differently. I'm not going to expect you to have the same views on life, the same medicines, and the same traditions as me. I think allyship is being a person that creates that environment for safe holistic healthcare.

The participants all held similar beliefs on what a positive healthcare experience looks like for Indigenous patients. According to them, what is required for a positive healthcare experience is attainable and does not require any special training. For example,



taking a few extra minutes to listen to their patients, acknowledge their concerns, and explain things to them in a safe and respectful way is a straightforward way to improve Indigenous healthcare experiences.

Additionally, when Indigenous patients do not have a positive healthcare experience, many participants mentioned the need for a streamlined complaint process to address these concerns. Many people do not feel comfortable speaking up when they are being mistreated by healthcare staff. Samara, a physician specialist, mentioned that they generally are not aware if a patient is mistreated or discriminated against by other healthcare professionals on their team. She felt that if there was a proper complaints process, some harm could be mitigated by ensuring that patients are being treated with respect in all of their healthcare interactions. As Samara states “I wish there was a way that patients felt more empowered to say if they feel like they've had a negative experience”. While participants did not have a solution on what this complaints process may look like, other than it being straightforward, ensuring patients feel safe and heard is one way that patients may feel like they can speak up when mistreated.

### **The Experience of Being an Ally**

Participants detailed the experience of being an ally, with three major foci: commitment to the allyship journey; overcoming emotions; and facing and disrupting systemic barriers.

#### ***Commitment to the Allyship Journey***

One central finding of the research is the notion that allyship is a “journey”, “a process” or “is on a spectrum”. Allyship is not simply a final destination or something you can “check-off a list”. It is ongoing and requires a lifelong commitment to learning and improving. To increase allyship, it is important to meet people where they are at on their journey. What works for one healthcare professional in one situation, may not work for another. Stacey states,

You don't want to put other people down for their journey or where they're at in their journey. We want them on the journey, we all want everyone on the journey. I would love to have a world where everybody's on that journey accepting each other. I can't be self-righteous; I *still* make mistakes.

This aspect of allyship reaffirms what participants have said about the commitment to lifelong learning and unlearning, and that mistakes are normal and are an integral part of the allyship journey.

Most participants mentioned that the fear of making mistakes is a barrier to allyship that prevents others from speaking up against injustice. They worried about saying or doing the wrong thing, making a co-worker or supervisor angry. Participants felt that because of their professions, they were used to having the answers and being an ally to Indigenous patients requires a lot learning and the openness to be wrong. Where they are in the medical hierarchy, such as their profession, years in the field, gender, and age also increased or decreased the fear of being vulnerable.

For those who articulated that allyship is a learning journey, they expressed that mistakes are a natural part of the process. To minimize the harm of mistakes, Elodie suggests that an ally can: “ask a lot of questions”, “admit your mistakes”, and “ask for forgiveness”. Some said self-reflection is key to good allyship because with reflection, mistakes can be major learning opportunities. Elodie, explained,

Learn from it. Don't do it on purpose. You likely won't repeat it. If you make a mistake – be vulnerable, own it and be sorry. Mistakes happen all the time. It's when you try to hide them that it's an issue. Look at what you're scared of – rejection? Not knowing enough? Go do research. Be vulnerable – patients are human. Ask so many

questions, annoy the people you work with you, ask them questions. The more you know, the fewer mistakes you'll make.

Most participants mentioned that mistakes happen and happened more frequently earlier on in their careers and allyship journeys. While they felt it was important to mention mistakes as an integral part of allyship, none of them felt that the fear of mistakes deterred them from their allyship journey or from continuing to support their patients.

### ***Embracing Emotions***

Most participants spoke of times when they had to be vulnerable in their emotions while being on the job. Working with and for Indigenous patients and their families can often be emotional. Indigenous people often enter healthcare having had previous negative experiences, combined with illness, vulnerability, trauma, racism, and prejudice. There are many systemic barriers that Indigenous people face prior to receiving healthcare. Allyship can be emotional, and participants spoke about the perceived uphill battles they faced within the hierarchies of the healthcare system. For example, some of the female participants struggled with their own perceived lack of power and privilege being female healthcare providers. Other participants shared about the overwhelming emotional burden they felt trying to improve Indigenous peoples' healthcare experiences.

Although some participants shared stories of negative emotions, most of the participants also shared positive and hopeful emotions and stories about their experiences. Sarah proudly told a story about her time as a new physician. Sarah and her patient had developed a relationship in her patient's previous pregnancies and prenatal care. Sarah shares,

On the day of her C Section, in the morning, she wanted to smudge, and I was still quite new at the hospital and the process of being able to smudge in a hospital was

like this very complicated thing. It's less of a big deal now and there are really appropriate policies in place for it, but I didn't know that at the time.

Sarah knew of an Indigenous clinic close to the hospital and decided to take her patient there to honour her request to smudge prior to her surgery. Sarah continued with her story, I'm helping this patient pull her IV pole through the snow! But she got to smudge before her C section. On our walk back she was like, "I am telling all of my friends to go to you for their care" I mean, not only was it like sort of this fun comical journey pushing an IV pole through the snow, but the fact that she said, "I want my friends and colleagues to come to you for care, because you are a safe, good doctor" was so rewarding to me and in fact now she works for an organization that helps to support us, which is so cool!

While Sarah's story illustrates some of the positive emotions that come with being an ally in healthcare. Sarah, and other participants, were keen to highlight that Indigenous people are not victims; they are not broken or all tragically ill. Instead, they told stories of strength and resilience. Samara shared,

I didn't have any interaction with anyone who was Indigenous until I kind of sought that out...[there is] just so much richness and culture and beauty. If you are invited to be part of that, it's such an honour and privilege. I feel like healthcare just doesn't know that or get that. We don't realize how much we can learn from our Indigenous patients.

Samara and other participants mentioned that they felt it was an honour to help their Indigenous patients and were grateful for all the learning opportunities that their patients shared with them. Participants felt that being an ally in healthcare was emotional, with both positive and negative emotions, but that the good far outweighed the bad.

Many of the participants shared feelings of anger towards colonial systems and the “ongoing structures that uphold the straight white male supremacy”. For example, Samara said, “we hear a lot, for example, about the angry black women. Indigenous people are labeled as being angry. We should, as allies, take on the anger and we should be angry”.

### ***Facing and Disrupting Systemic Barriers***

Some participants were explicit about barriers that interfere with being an ally in Indigenous healthcare, such as “time,” “hierarchy in medicine,” “leadership,” and “academic and medical markers of success that contradict what is needed for good allyship”. For example, Sarah states, “allyship is a necessary but insufficient factor or component to dismantling all of those unequal structures”. While participants felt that allyship is useful and necessary, without structural systemic changes, they will continue to fight an uphill battle. Taking the time to build relationships with their patients was important to the participants, yet the current healthcare system does not encourage this type of service delivery. For example, some participants criticized the “fee for service model” of healthcare where some felt they are pressed for time and simply cannot be the best allies in providing care under these conditions. While these concerns are specific to physicians in clinic, the same time constraints are common in most healthcare professions. This fundamentally contradicts the essential quality of relationships that participants identified as key to allyship: “patience”, “good listening”, and “learning”.

All of the participants mentioned that good allyship takes time to establish, and that the current western model of care does little to make space for this. As Sarah mentions, if healthcare professionals are “seeking financial reward” (fee for service, academic grants, career advancements, etc.) then “allyship is difficult to establish and maintain under these structures”. Stephen explains,

In medicine, time is always a challenge. Spending time with any patient is sometimes a challenge when you just have so many things to do. You don't have the time that you want to give someone, and sometimes these things just take time to do well.

Participants also identified additional systemic barriers. For example, Samara mentions the “red tape that is enforced through leadership and management who do not support allyship”. This put allies in a position of having to “break the rules” in order to provide good healthcare, for example “taking more time with a patient” or “sneaking in an unallowed visitor”. The need to make more time was echoed by most participants in the work they do as allies in healthcare.

Elodie explains, “we need to learn about the barriers so that we can get rid of the barriers”. Joanne suggests that “educating leadership, policy makers, and government officials about the barriers, in order to dismantle them” would “improve relationships between governments and communities”. Stacey takes it one step further when she says, “I need a jackhammer to break these systems,” to express the deep entrenchment of systemic barriers in healthcare. Joanne elaborates on what previous participants mentioned and offers a potential solution,

Our hierarchies are colonialist. Until our governance changes it will be hard to change. If you're in a leadership position you have power because of the position - use that power to bring people to the table - to share in it.

Participants also highlighted major upstream concerns, beyond healthcare, that negatively impact their ability to provide appropriate care, as Olivia explains, “improving the conditions that reinforce inequity and illness” such as access to “clean drinking water”, “safe affordable housing”, and “employment opportunities” are imperative. All participants identified that a step

forward must include “dismantling barriers and the systems that reinforce inadequate and inequitable access and care for Indigenous people”. Olivia added,

We need to improve a whole variety of social programs, like good education, and safe drinking water and housing is really important in terms of our health in general. Until those things are addressed, nothing is going to be fixed by making someone do an hour-long cultural sensitivity training. I think a lot of the root issues have not been resolved...a lot of inequities that we face in terms of healthcare won't be resolved until some of those things are resolved.

The participants all mentioned the importance of focusing on larger systemic changes that are needed to improve Indigenous health. Donald states “we really have a duty to educate policy makers and government stakeholders”. However, participants still felt that the small day-to-day interactions are important to Indigenous health and in cultivating allyship at an individual level. Participants also felt that to advance allyship in healthcare, and as stated by Joanne, “leadership must be involved to create a top-down system overhaul to provide more equitable healthcare to Indigenous patients”.

### **Cultivating Allyship**

Participants carefully explored how allyship may be cultivated and this is described in four central categories: building and maintaining meaningful relationships with Indigenous people; the role of the media in cultivating and expanding allyship; ongoing training and education; and advancing allyship in post-secondary education.

#### ***Cultivating Allyship through Relationships with Indigenous People***

All participants spoke about being in relationship with Indigenous people as a key aspect of fostering their growth as allies. Simply stated, getting to know an Indigenous person was

identified as a turning point in their lives in almost all of the interviews. Most of the participants identified early experiences involving positive experiences with Indigenous people, for example, through volunteering, through a faith organization, through a friendship or working relationship, or through a practicum or preceptorship in their formal education. As Joanne reflects “those positive experiences and getting to know people, as individuals, I think were quite important in my own journey”.

For some, getting to know an Indigenous person was even the catalyst to pursuing a career in the healthcare field and practicing with Indigenous people. Prior to this catalyst moment, participants mentioned times in their lives where they held deeply embedded racist stereotypes and biases. By building a meaningful relationship, these racist preconceptions were shattered. As Stacey notes,

I don't think education is the way. We all know what happened. I don't think that's going to increase allyship. Increasing allyship is going to happen through relational exchanges and creating ethical space to have those.

Stacey's statement about the importance of relationships was echoed by most participants. They spoke about many kinds of relationships, with a neighbour, a colleague, a manager, a friend, or someone they met that made them question much of what they knew and were taught about Indigenous people in Canada. Relationships are key because they are a way to humanize one another. However, participants were clear that these relationships cannot be transactional, they must be established and maintained, and reciprocal which “increases opportunities for collaboration and working together”.

Some participants mentioned the importance of the relationships they have cultivated within the communities they serve as key to their success as allies in Indigenous healthcare.



These relationships were important in creating and maintaining the relationships with their patients and for better understanding their patients and where they are coming from. For example, Samara volunteers her time in one of the surrounding Indigenous communities and she felt that this helped her to be a better ally and to better support and understand her Indigenous patients.

Stephen, a physician who works on reserve, spoke about the strong relationships he has built within the community he serves. Stephen spent the early years of his medical career living and working on a reserve, which he said blurred the lines between being an insider or an outsider in the community. In describing his experience, he says, "you're more just a member of the community". For him, he also focused much of his personal time "going to sweats for instance, participating in ceremony", which helped him to build meaningful relationships with individuals and with the community. To him, showing his commitment to the communities' traditions and values demonstrated his commitment to his patients. As Stephen explains,

My approach to working on reserve was to not being stuck in the health centre and not using a traditional clinic as your way in... but, you know, being out and about with people.

Stephen spoke a lot about the years he invested in growing and maintaining relationships in the community he works with and for. For him, this meant leaving the clinic and meeting people in the community and building relationships before they needed medical care. He felt that being a familiar face in the community helped to build trusting relationships with his patients.

Beyond relationships with Indigenous individuals, participants also explained that relationships are key to teaching and learning about allyship. Joanne explains, "allyship is best taught through role modelling or mentorship rather than teaching". Some participants felt that

the best way to learn about allyship was by watching someone else do it. For example, Joanne mentors many medical students and she felt that the best way to teach the students how to be allies was by modelling that behaviour herself. While forming and developing relationships is a key to allyship for the participants in this research, Stephen also observes that it “must be done well, which takes time and must be built on a solid foundation of trust and collaboration”.

An important consideration about establishing relationships came up in Sarah’s interview. Sarah mentioned that allies must avoid overburdening Indigenous people. She felt that this was an important caveat in her conversations around relationships and allyship. Sarah said, “we must take the burden off the Indigenous members of the group who are constantly overburdened”. Additionally, Sarah said “I think one of the big strategies is actually to increase in the number of Indigenous healthcare providers because the last thing I want is to burden those people with the duty to teach the rest of us how to be and do things”. Sarah’s comments speak to the important role that allyship plays in focusing the work on what non-Indigenous can do in order to make equitable change.

### ***The Media’s Role in Raising Awareness to Injustices***

Most participants pointed to contemporary moments in Canadian history where Indigenous people were mistreated by healthcare providers and the role that media played in raising awareness of the struggles that Indigenous people face. For example, many of these interviews for this thesis took place during the rediscovery of the mass graves in Kamloops that made international headlines. Most participants mentioned this particular issue as well as the cases of Joyce Echaquan and Brian Sinclair.

For the participants, the publicity around these atrocities helped advance their understandings of the mistreatment of Indigenous people in healthcare, drawing attention to and

providing evidence of the realities many Indigenous people face in the health system.

Participants felt that the media can, and does, play a key role in advancing allyship and understanding Indigenous issues for non-Indigenous people. Olivia explains her understanding of the significance of “stories of terrible racism” in the media when she said,

I think it is important there are inquiries...looking into this and that we listen to people's experience...I don't know the best way to fix it per se...But we need to have...a reconciliation with that.

Participants pointed out that the media can be used in a positive way to educate the general population about the ongoing injustices faced by Indigenous people and to further Indigenous equity. They felt that many of their colleagues and family members learned a lot from these more public issues – while also providing further opportunities to educate them on Indigenous issues.

### ***Ongoing Training and Education***

Participants noted specific ways they learned about Canadian history as it relates to Indigenous people and the ways they will continue to learn. Some key resources that participants found particularly helpful included the University of Alberta’s Massive Online Open Course (MOOC) Indigenous Canada, book clubs and/or reading books by Indigenous authors, watching Indigenous movies and listening to Indigenous podcasts, reading *the TRC* and *the Final Report of the Inquiry into MMIWG*, and attending virtual or in person learning opportunities or seminars that are offered by universities, non-profits, AHS, various levels of governments, and the library.

Participants also mentioned the “benefits of experiential learning”, where they learned from the communities they serve. Some examples included participating in a KAIROS blanket exercise, participating in ceremony when invited, attending a powwow or round dance, going out

to the community, and taking the time to talk to an Elder or Indigenous person. Many of the participants mentioned the importance of involving Elders in their work, and this was especially true of the healthcare providers that work in Indigenous communities. As Donald explains,

I had some wonderful mentors that have helped me kind of understand things better and we've had the opportunity, in various projects, to have many outstanding Elders involved. I've learned a great deal from them. They don't necessarily have some huge academic background, but the wisdom is there. It's incredible, their storytelling ability, their wisdom. So, I've learned a lot from them, just listening and those kinds of things, I think, have really cemented my understanding of what it means to be an ally.

These real-life interactions and experiential learning opportunities were key to participants' allyship journeys. Participants leveraged many critiques about cultural awareness or cultural competency training as not the most effective way of educating healthcare professionals and that it has the potential to be harmful, as Sarah noted:

There's no possible way you can know anything about the lives of the people that you meet. So, it's arrogant to assume that you can attain competency in some culture that's not your own. I mean, I'm not even competent in the culture of whiteness. I don't know if I have enough insight into my own privilege to be competent in it. So being competent in someone else's culture is a complete fallacy.

Sarah elaborated that it is important to avoid "pan-Indigenous tokenistic kind of lessons that some available training opportunities rely on" like some of the mandatory training that AHS employees are required to "check off a box" for their cultural awareness training. Additionally, other participants also mentioned that AHS has mandatory online training about Indigenous history, but most felt that this was insignificant and insufficient.

When it comes to training and education, many participants preferred terms and approaches other than cultural awareness, such as cultural sensitivity which implies “being aware of cultural differences and experiences”. Sarah also emphasized “cultural humility” as her preferred term because it “acknowledges that you do not know and cannot know everything about a particular culture. She also suggested cultural safety because safety is determined by the patient”. Sarah explained, “cultural safety makes some sense to me because I think that in order to provide care that is deemed culturally safe by the person receiving it, one of the most important things is humility”.

Overall, participants felt that real life experiences were a better way to learn and to advance allyship, but that learning opportunities offered by their organizations or through post-secondary institutions can provide good opportunities to educate and encourage allyship if they’re done well. For example, participants mentioned that training opportunities must be Indigenous led.

### **Summary**

This chapter provides an overview of what allyship means to participants. One of the central tenets of allyship is that allies must be community-identified. Participants also shared key characteristics that allies possess including the importance of advocacy in allyship work. Participants also delved into their personal experiences, including their journeys towards becoming allies, maintaining their allyship, and embracing the emotions involved, both good and bad.

Building and maintaining meaningful relationships with Indigenous people, patients, colleagues, Elders, and communities also helped cultivate allyship. The media’s role in raising awareness towards injustices and advancing Indigenous allyship through this awareness raising

was also highlighted by participants. Finally, participants felt passive cultural awareness training does little to advance allyship and reflected on how ongoing learning engagements and experiential learning opportunities did help to enhance and grow allyship.

## **Chapter 5 - Discussion and Conclusions**

Health disparities between Indigenous and non-Indigenous populations are well-documented and some continue to widen (Allan & Smylie, 2015; Bombay et al, 2014). The SDOH that include racism, discrimination, and implicit biases affects the overall health and the healthcare that Indigenous people receive (Allan & Smylie, 2015). These health challenges are based in-part in the intergenerational trauma from past and ongoing colonization and assimilation policies (Kolahdooz et al., 2015). Understanding how colonization and its legacy has impacted Indigenous health is essential to inform efforts to promote health equity and to improve health outcomes of Indigenous people in Canada (Kolahdooz et al., 2015). For Indigenous health and healthcare to improve, Indigenous and non-Indigenous people need to work in solidarity with the goal of breaking down systemic barriers that impact health and healthcare for Indigenous people.

Key findings from this research reiterate the critical aspect of relationships in allyship and finding opportunities to provide safe spaces for these relationships to be established and maintained. People who are considered allies by the Indigenous community share common characteristics and ways of approaching their allyship journey, such as humility, active listening, actively advocating for Indigenous issues, and prioritizing ongoing learning and relationships. The findings from this research share relevance with known literature and have implications for healthcare in Canada and are contextualized below in six main themes: characteristics and responsibilities of an ally, the allyship journey, relationships and reciprocity, education and increasing the number of Indigenous healthcare providers, avoiding the overburden of responsibility on Indigenous people, and breaking down the big(ger) barriers to health and systems change.

### **Characteristics and Responsibilities of an Ally**

Brown's (2015) research conducted a quantitative survey with 160 people of colour in the United States and found that some personal attributes and interpersonal skills of allies as identified by the participants, include "respect, curiosity, partnership, information — and resource-sharing, risk-taking, resilience, understanding, courage, support, receptivity, loyalty, honesty, investment, and willingness to make mistakes" (p.714). This highlights that allyship requires hard work, and is based in humility, respect, and commitment. The findings from Brown's study are in alignment with the findings in the current research study that found that key characteristics of allies providing care to Indigenous patients include patience, humility, trustworthiness, good listening, empathy, and compassion.

As well, key responsibilities of allyship as outlined by participants include acknowledging one's privilege and power and actively discussing them, listening more than speaking, taking direction from the oppressed community and intentionally working in the background, decentring one's self and stepping back, and being honest and accountable for one's own mistakes. Also key are: understanding feelings of discomfort and hurt, understanding that resisting oppression is a choice for oneself, but not for others, and not expecting recognition and praise for their work (Garbutt, 2019; Nixon, 2019; The Anti Oppression Network, 2019). Better understanding of what allyship entails can help people who wish to embark upon their allyship journey.

### **The Allyship Journey**

The participants in this study explored their own allyship journeys and the concept of self-identifying as an ally. Most participants felt uncomfortable calling themselves "allies". Sumerau et al. (2021) examined how people construct what it means to be an ally to marginalised groups. They conducted 70 in-depth interviews with college students who identify



as allies to one or more marginalized groups. Sumerau et al.'s research found that "current popular and activist discourses debate whether privileged group members can ever profess themselves to be allies" and those "who self-identified as allies are generally in pursuit of moral recognition" (2021, p.369). Additionally, Smith et al.'s (2015) research found that, "allyship is something that is designated by a person or community that one is aspiring to ally themselves with" (p.6). Therefore, Indigenous people are the only ones who can deem a non-Indigenous person as an ally (Sumerau, et al., 2021). This is a key aspect of allyship and shifts the power in the direction of Indigenous people and communities and drives home the importance of relationships in increasing allyship in Indigenous healthcare. Smith et al. (2015) state, "allyship is a journey that one embarks upon with the distant goal of 'being an ally' never truly in reach" (p.6).

This is further supported by Knudsgaard's (2020) research that asked Indigenous child welfare leaders to identify non-Indigenous leaders whom they consider allies. Non-Indigenous leaders were interviewed regarding their journeys to allyship, and they expressed that "allyship is not a destination that one fully arrives at. The journey to allyship is a process that allies continuously engage in" (Knudsgaard, 2020, p.44).

Understanding that allyship is a journey or a spectrum has implications for real life application in order to create opportunities for non-Indigenous people to learn from, and create safe and trusting relationships with colleagues, Elders, mentors, co-workers and their patients or clients, or communities that they serve. Whether they have committed many years towards their allyship journey or whether they are a first-year student with very little experience with Indigenous people, understanding that allyship is a journey will help address the learning needs of all healthcare professionals on their journey to being better allies to Indigenous people.

Findings from this research highlight the importance of education and training opportunities that emphasize real life interactions, that meet people where they are at on their journey, and that create opportunities for reciprocal relationships to be developed and maintained. One of the best ways to ‘learn’ about Indigenous people and their cultures is through relationships.

### **Relationships and Reciprocity**

In the current study, the significance of relationships in allyship was made clear by participants. Similarly, a review of the academic literature on allyship, also found that genuine relationships were essential to allyship (2015).

Brown’s (2015) quantitative study investigated how people of color perceive white allies. The survey findings from Brown’s research suggest that allyship occurs when an individual from the dominant group effectively advocates for equality and supports the concerns of members of non-dominant groups. In the context of that work, allyship is a verb that requires lifelong learning and relationship building that uses privilege to amplify the voices of those who are most marginalized (Brown, 2015). The findings from Brown’s study aligned with what the participants in the current study shared about allyship and the importance of relationships, action, and using their privilege in a positive way.

Allyship requires action and there is no manual on how to be an ally. It is often undefined and is generally conceived of as being in alliance with a marginalized group (The Anti Oppression Network, 2019). Allyship is not self-defined, rather, the work and efforts must be recognized by the people with whom you are in alliance (Smith et al, 2015; The Anti Oppression Network, 2019). Allies are often regarded more as friends and are more interpersonally supportive than activists (Brown, 2015).

Smith et al., state “allies offer support by establishing meaningful relationships with people and communities of the non-dominant group that they wish to ally themselves with, to ensure accountability to those people and communities” (2015, p.6). Relationship has been one of the most crucial elements of allyship in the academic literature. While crucial for all types of allyship, being an ally to Indigenous people is especially vital because relationship is a fundamental and central component of many Indigenous cultures (Wilson, 2020). Relationship development is critical to becoming an ally to Indigenous people given the need to build trust with Indigenous patients, and the history of colonization in Canada and the distrust many Indigenous people rightfully feel (McLane et al, 2021). Allies are supporters, not leaders, and to support the Indigenous community, relationships must be developed and maintained (Smith et al, 2015). Relationships also create accountability and responsibility for sustained action (Smith et al., 2015).

Participants in the current study recalled a personal connection with an Indigenous person that pushed them towards their work as an ally. Participants felt that these personal connections were key to the direction that their healthcare careers took in their work with Indigenous patients. Therefore, participants felt that creating opportunities for other healthcare providers to develop relationships with Indigenous people could be a catalyst towards increasing allyship in healthcare. Participants felt these interactions could be professional and formal or personal and informal, such as one-on-one mentorship from Elders or Indigenous colleagues/supervisors.

Dierckx et al., (2021) explored the role of allyship in community-based participatory research and critiqued the literature on allyship and reciprocity. They found that allied relationships are built on reciprocity, which means creating and maintaining a relationship that is mutually beneficial. These relationships cannot be one-sided or performative. This is a

fundamental part of Indigenous relationships because it ensures that they are *good* relationships (Dierckx et al., 2021). Participants in my study acknowledged that while healthcare professionals are often regarded as the authoritative teachers, reciprocity means creating equitable and mutually beneficial relationships which removes embedded power dynamics.

Sumerau et al's (2021) research found that "people who identify as allies generally become connected to a movement to support marginalized groups due to a personal connection to someone within the marginalized group" (p. 259). This aligns with the experiences of participants in the current study, who often mentioned a personal connection to an Indigenous person that started them on their allyship journey. Therefore, providing more opportunities to build connections with those you wish to be an ally for is necessary for individuals to become allies.

### **Education and Increasing the Number of Indigenous Healthcare Providers**

Many healthcare providers do not understand the significance of colonialism as a determinant of health for Indigenous people and require further and continued education on the legacy of colonialism and its ongoing impacts on Indigenous health today (TRC, 2015). In the current study, participants felt that for such education to be impactful, it must go beyond one-off workshops and has to be more engaging and meaningful. In addition, participants mentioned the importance of recruiting more Indigenous people into the healthcare field. Research conducted by Argueza et al (2021) drew upon their experiences as early-career physicians of color who have led and supported anti-racism efforts within their institutions. This work highlights key barriers to achieving meaningful progress. Their research on anti-racism in medical training in the United States found there were compelling benefits having a diversified physician workforce. For example, having diverse professionals in healthcare can help to address health inequities and

can improve the quality of patient–physician relationships, and patient satisfaction (Argueza et al., 2021). Their research found that having physicians from racial/ethnic minority backgrounds is also good for patient care (Argueza et al., 2021). Additionally, the increased innovation of diverse teams also has valuable implications for medical education, research, and clinical care (Argueza et al., 2021).

*The TRC's Call to Action 23* recommends prioritizing Indigenous people's admissions into healthcare streams, which is essential to improving Indigenous health and healthcare (TRC, 2015). According to some participants in the current study, in recent years many Canadian post-secondary institutions, including the University of Alberta, have created Indigenous admissions processes. Participants spoke about the importance and success of this new admissions process. However, due to many systemic barriers faced by Indigenous people, entering post-secondary can feel out of reach for many.

Murry et al's (2021) study employed Flanagan's Critical Incidents Technique to derive mentorship behaviors from the literature, from focus groups with Indigenous faculty in the health sciences. Their research found that increasing the number of Indigenous people in healthcare fields must encompass recruitment, training, retention, and the promotion of Indigenous healthcare providers. Some ways to advance Indigenous representation in healthcare fields is through career shadowing, mentorship, role- modeling, Indigenous specific admissions processes, creating safe environments for education and work and experiential learning (Murry et al., 2021).

However, simply providing the physical space for Indigenous people to enter healthcare fields is insufficient; the environment must be safe and welcoming. Windchief and Brown (2017)

reviewed and synthesized the literature addressing the role of mentorship for Indigenous Americans in science, technology, engineering, and math by considering 60 data sources that include peer-reviewed articles, personal communication with professionals working in the field, academic success, and professional training literature. Windchief and Brown (2017) propose a model of creating safe environments for Indigenous students, which includes creating an inclusive campus climate and supporting Indigenous identity, making space for Indigenous values and worldviews, and attracting mentors with interest and past success.

Argueza et al. (2021) contend that institutions must move beyond diversity and inclusion initiatives and strive towards anti-racism. They recommend implementing an anti-racism framework in medicine that includes, “advocating for holistic review, developing curricula that explores racism in medicine, and supporting mentorship and outreach programs” (p. 799). Findings from the current study support anti-racism efforts among healthcare providers, as participants cited the importance of quality education to improve allyship in healthcare. Education in this instance should involve actively exploring one’s own unconscious biases and unlearning racist thoughts and stereotypes.

Another stream of education that has promising impacts on patients is cultural humility training (Foronda, 2020). Cultural humility focuses on self-awareness which involves accepting that one will not and cannot be competent in the lived experiences of others. Foronda’s (2020) research on cultural humility was guided by Walker and Avant’s strategies, the theory was developed from a synthesis of key concepts and constructs from research and scholarly work. Foronda (2020) explains that cultural humility involves a flexible mind-set, a focus on others and self and a belief that human beings hold equal value. Cultural humility involves supportive interactions, which may include verbal and/or nonverbal communications (Foronda, 2020).

Additionally, cultural humility is a process of self-reflection and lifelong learning (Foronda, 2020). Foronda's research states that cultural humility strives to eliminate health disparities. Similarly, many participants in the current study mentioned cultural humility as a means of being an ally.

Beyond formalized training, there are other learning opportunities offered by post-secondary institutions, non-profits, health services, licensing bodies, and government agencies. Participants in this study noted some of these include attending virtual or in person speaker sessions, participating in talking circles or ceremonies when invited, starting a book club with your colleagues, taking the Indigenous Canada MOOC training, reading Indigenous literature, or having coffee with an Elder. Informal learning opportunities that privilege relationships and dialogue, and experiential learning opportunities seem to have the greatest impact on developing allyship in healthcare.

Loya and Cuevas' (2010) research explored the role of experiential learning as a means of challenging racism and social inequality in a social work course. The methodology involved a pretest and post-test survey that found statistically significant changes in racial attitudes and cultural awareness among participants. They found that "the foundation of learning resides not in schools, books, or even teachers; rather, it rests in the experience of the learner" (p.130). They also showed that learners must be able to engage in new experiences fully and openly; "reflect on, observe, and consider these experiences from various perspectives; create concepts that assimilate these experiences into sound theories; and appropriately apply these theories to their life situations" (Loya & Cuevas, 2010, p.131). Likewise, participants in the current study spoke about the importance of self-reflection and the ability to question their negative thought processes.

In contrast to Western notions of education associated with the end goal of a degree, diploma, or certificate, allyship means continuous and ongoing education, both formally and informally. Participants in the current study felt allyship requires a lifelong commitment to learning practiced with humility and listening, and suggests allies are both learners and teachers. McLane et al. (2021) held sharing circles with Elders, First Nations patients, healthcare providers and health administrators from across Alberta to better understand their experiences in accessing care in emergency departments in Alberta. Comparably, their research found “health systems should create safe spaces and time for providers to engage in collective reflection and learning. This may allow providers to self-assess and correct biases impacting the care they provide” (McLane et al, 2021, p.72). Findings from the current study suggest that moving forward, it is also important for post-secondary institutions and healthcare systems to mandate training related to Indigenous specific health and healthcare. Participants felt that required classes, as part of healthcare training, is a good first step in normalizing the need for ongoing learning on Indigenous health. Advance healthcare professionals’ understanding of Indigenous health and healthcare.

### **Avoiding the Overburden of Responsibility on Indigenous People**

Another crucial consideration, and an understudied area in relationships as an educative tool is the overburden of responsibility on Indigenous people to educate non-Indigenous people (Mensah, 2020). While many would argue that mentorship, cultivating relationships, role modeling, and increased Indigenous representation in the healthcare field are all important and a positive step forward, we need to acknowledge the burden that this places on the shoulders of Indigenous healthcare workers and scholars (Argueza et al, 2021). This was evident in the current study where participants emphasized the need to be careful not to impose the duties of



education and training on Indigenous people, and the importance of allies to acknowledging the overburden often placed on Indigenous people.

Mensah's (2020) research with Black physicians in the United States puts forth a useful concept of a "minority tax", which places additional responsibilities on minority persons to represent and advocate for their communities (Mensah, 2020, p.1). Mensah (2020) argues that one way to minimize the harm the minority tax has on non-white physicians is to charge white physicians "majority taxes," which includes "discomfort, energy, and capital" (p.1). These taxes would include "three initial steps to guide good intentions toward better impact: acknowledge your white privilege, no matter how uncomfortable; leverage privilege to highlight medical racism; and humbly and actively implement antiracist policies" (2020, p.1). This is an important aspect of allyship because allyship requires that this burden falls on the shoulders of the non-Indigenous to do what is within their power to improve inequities in healthcare with Indigenous people.

### **Breaking Down the Big(ger) Barriers to Health and Healthcare and Systems Change**

Beyond individual changes and education, participants in the current study spoke of systemic and institutional barriers, and the need for structural changes that are required to make improvements to Indigenous health and healthcare. Participants noted an important aspect of allyship is advocating for systemic changes that affect the marginalised group in which they align themselves. Some of the systemic barriers mentioned included access to clean drinking water, on reserve housing, employment, transportation, food security, addictions support, and addressing systemic racism within other institutions (child welfare system, criminal justice system, healthcare system, all levels of government). McLane et al., suggest that some of the SDOH that affect Indigenous people include "overcrowding in homes, lack of water services for

many First Nations houses, and individuals' loss of connections to culture, language and family” (2020, p. 67). Acknowledging and improving all of these interrelated systems will help to improve Indigenous health (WHO, 2010).

The systemic issues that affect Indigenous health will require institutional change at all levels of government (Lavoie et al., 2011). This means collaboration between governments must occur in order to shift public policies and formal legislation (Lavoie et al., 2011). Social institutions beyond the healthcare system also play a key role in improving Indigenous healthcare and health outcomes, including those related to access to safe and reliable housing, safety and justice, education, and child welfare (WHO, 2010).

Participants in the current study expressed the tensions that they felt in “speaking up” against systemic barriers, such as when they observe their colleagues engaging in discriminatory behaviour. Healthcare, as a system, has a hierarchical culture and participants felt that being an ally and speaking up within the constraints of these hierarchies is particularly difficult. Almost all participants expressed these tensions in their work as allies in healthcare and often grappled with when they felt it was appropriate to speak up. It is important to note that according to participants in my study, this action or advocacy that is required in allyship is what separates true allyship from performative allyship. All of these tensions and concerns highlight the need for a systemic overhaul to create a healthcare system that supports Indigenous patients and the healthcare professionals who provide their care.

McLane et al., found that one way to mitigate the racism that Indigenous people experience in the healthcare system is to understand racism as a systemic factor. This means that “rather than attempting to deal with individual instances of discrimination as they arise, addressing racism may be achieved by taking for granted that racism impacts health and

healthcare, and implementing policies and practices that support equitable care” (2021, p.72).

Participants in the current study felt that understanding colonialism as an ongoing and systemic determinant of health that impacts Indigenous people is an important first step towards addressing institutional racism and strengthening allyship.

### **Limitations of the Research**

This research study employed qualitative inquiry and used semi structured interviews for data collection. While saturation was reached, this study only scratched the surface on the topic of allyship in healthcare. One limitation of this research was that it occurred primarily in Edmonton, Alberta. However, I do think that broadening the geographic area of study would not have yielded significant differences. Embedding Indigenous perspectives and methodology into this research study would have provided greater insights into the subject matter. For example, having an Indigenous perspective within the research team could have provided deeper insights into the subject.

### **Strengths of the Research**

This research was very timely. The concept of allyship has become increasingly popular, not just within the health realm, but in other social justice movements more broadly. The key characteristics of allies, such as ongoing learning, and listening first and speaking second, can be applied to other social interactions, especially where a power imbalance is present.

This research shifted the focus away from Indigenous people and towards how others can help to improve Indigenous health and healthcare without placing the burden solely on Indigenous people. For example, the findings from this qualitative study used semi structured interviews which allowed for the participants to drive the conversation and to focus on their unique experiences and perspectives. The participants in this study were all identified by the

Indigenous community as allies and because of this they provided invaluable insights into the subject matter. Ensuring that the participants were identified by the Indigenous community is a strength of this study and is in line with the literature on allyship.

This research has the potential to positively impact how healthcare providers interact with Indigenous patients. If healthcare providers focus on taking up the key characteristics and tips outlined within this research, Indigenous patients will receive better care. On an institutional level, applying an allyship lens and focusing on education at all levels can have a profound ripple effect across the entire healthcare system.

### **Future Research**

Many more studies need to be conducted, in partnership with Indigenous people and communities, to learn more about how allyship can be applied to all fields of healthcare more broadly. More research into a broader geographic region can help to further contribute to the literature.

Future allyship research may include allyship in education, criminal justice, and social services. As Indigenous healthcare continues to grow as a field of study and practice, greater understanding of allyship is needed to move towards equity and a shared understanding of the role everyone plays in reconciliation in Canada. There are many opportunities to learn and grow as allies, and it is attainable and cost effective to educate yourself and others on allyship. Another important area of study would be on Indigenous peoples' perspectives on allyship and how that may or may not align with what allies identified in this study. Learning about Indigenous people and patients' perspectives on allyship and what they define as good allyship would greatly contribute to the subject on Indigenous allyship in healthcare.

Future research should include more non-white allies' perspectives on Indigenous allyship. Specifically, a study on newcomer perspectives on allyship would contribute to the allyship literature and help to understand how and where stereotypes and prejudices are being learned and how to begin allyship conversations with non-white allies. An additional area for consideration could be learning more from non-Indigenous healthcare providers who do not consider themselves allies.

### **Significance of Research**

Indigenous populations are over studied and much of the research efforts have remained deficit-focused (Wilson, 2020). This research helps to shift the gaze in Indigenous health research towards how non-Indigenous healthcare providers can support and improve equitable healthcare. The burden of health disparities that affect Indigenous people cannot and should not be solved solely by Indigenous people (McLane et al, 2021), and this research acknowledges non-Indigenous peoples' key role in improving Indigenous health and wellness.

There is much that can be learned in drawing from this research to adapt existing or establish new research projects and approaches to policymaking, programming, service provision and healthcare interventions. For example, the topic of allyship can be taught to various levels of government and frontline staff and is relatively easy and cost effective. This research may help inform the practices of healthcare providers who seek to provide Indigenous healthcare in an informed, culturally safe, and respectful way that aligns with the needs of their patients. One step towards allyship and reconciliation is by having these tough conversations and bringing the unconscious into consciousness. Reflecting deeply into the systemic and individual biases that exist and consciously working against deeply engrained biases and stereotypes.

### **Conclusion**

The results of this study found that healthcare providers who were identified by the Indigenous healthcare community as allies share similar characteristics and beliefs when it comes to providing care for their Indigenous patients. The semi structured interviews provided valuable insights into how allies interact with their patients within the restrictive confines of the healthcare system. The outcomes of this research can help to inform the practices of healthcare providers who seek to provide Indigenous healthcare in an informed, culturally safe, and respectful way.

### **Closing Statement**

Thank you for taking the time to read my thesis research. This project was very near and dear to my heart. I believe that it is my role and responsibility to share what I have learned in my research and in my personal journey. I will continue to grow and evolve in who I am as a mother, a wife, a daughter, a sister, a colleague, and human being on this earth. I challenge you to continue to advance your allyship journey and to continue to improve the state of the world, especially in its treatment of Indigenous people. Please share this research openly and freely and continue to make the world a better place through your interactions.

## References

- Aboriginal People Survey. (2012). *Aboriginal Peoples Survey*. Statistics Canada.  
<https://www150.statcan.gc.ca/n1/en/catalogue/89-653-X>
- Alberta Health Services. Population, Public, and Indigenous Health SCN. (2018). *Indigenous Health Transformational Roadmap*. Alberta Health Services.  
<https://www.albertahealthservices.ca/assets/about/scn/ahs-scn-ppih-ih-roadmap.pdf>
- Allan, B., & Smylie, J. (2015). *First People, second class treatment: The role of racism in the health and well-being of Indigenous people in Canada*. Toronto: Wellesley Institute. Retrieved from: <https://policycommons.net/artifacts/1204263/first-peoples-second-class-treatment/1757369/>
- Argueza, B. R., Saenz, S. R., & McBride, D. (2021). From diversity and inclusion to antiracism in medical training institutions. *Academic Medicine*, 96(6), 798–801.  
<https://doi.org/10.1097/ACM.0000000000004017>
- Baydala, L., Saylor, K., & Ruttan, L. (2013.). *Meeting standards for community-engaged Aboriginal health research*. *Paediatrics & Child Health*, 18(1), 8-9. <https://doi.org/10.1093/pch/18.1.8>
- Bombay, A., Matheson, K., & Anisman, H. (2014). The intergenerational effects of Indian Residential Schools: Implications for the concept of historical trauma. *Transcultural Psychiatry*, 51(3), 320–338. <https://doi.org/10.1177/1363461513503380>
- Braun, V., & Clarke, V. (2012). *Thematic Analysis*. Braun, V., & Clarke, V. (2012). *Thematic Analysis. APA Handbook of Research Methods in Psychology: Vol. 2. Research Designs, Research designs: Quantitative, qualitative, neuropsychological, and biological* (pp. 57–71). American Psychological Association. <https://doi.org/10.1037/13620-004>

- British Broadcasting Corporation. (2020, October 1). Trudeau decries “systemic racism” after Indigenous death. *BBC News*. <https://www.bbc.com/news/av/world-us-canada-54380645>
- Brown, K. T. (2015). Perceiving Allies from the Perspective of Non-Dominant Group Members: Comparisons to Friends and Activists. *Current Psychology*, 34(4), 713–722. <https://doi.org/10.1007/s12144-014-9284-8>
- Brownstein. (2015). *Implicit bias*. Stanford Encyclopedia of Philosophy. <https://plato.stanford.edu/entries/implicit-bias/>
- Canadian Broadcasting Corporation (2021, October 5). *If Joyce Echaquan were white, she would still be alive, Quebec coroner says* | *CBC News*. CBC. <https://www.cbc.ca/news/canada/montreal/echaquan-coroner-report-health-care-system-racism-1.6199964>
- Canadian Press, The. (2021, June 16). *Senate approves bill to implement UN Declaration on the Rights of Indigenous People* | *CBC News*. CBC. <https://www.cbc.ca/news/politics/undrip-declaration-passes-senate-1.6068524>
- Castleden, H., Morgan, V. S., & Lamb, C. (2012). “I spent the first year drinking tea”: Exploring Canadian university researchers’ perspectives on community-based participatory research involving Indigenous people: Researchers’ perspectives on CBPR. *The Canadian Geographer / Le Géographe Canadien*, 56(2), 160–179. <https://doi.org/10.1111/j.1541-0064.2012.00432.x>
- City of Edmonton. (2022). *Land acknowledgement*. City of Edmonton. Retrieved February 12, 2023, from [https://www.edmonton.ca/city\\_government/indigenous-relations-office/land-acknowledgement#:~:text=Our%20Land%20Acknowledgment&text=It%20is%20a%20welcoming%20place,for%20today%20and%20future%20generations](https://www.edmonton.ca/city_government/indigenous-relations-office/land-acknowledgement#:~:text=Our%20Land%20Acknowledgment&text=It%20is%20a%20welcoming%20place,for%20today%20and%20future%20generations).



- Craft, A., & Regan, P. (Eds.). (2020). *Pathways of reconciliation: Indigenous and settler approaches to implementing the TRC's calls to action*. University of Manitoba Press.
- Czyzewski, K. (2011). *Colonialism as a broader social determinant of health*. *International Indigenous Policy Journal*, 2(1). <https://doi.org/10.18584/iipj.2011.2.1.5>
- Dictionary.com Definition of allyship | *Dictionary.com*. (n.d.). *Www.Dictionary.Com*. Retrieved September 19, 2022, from <https://www.dictionary.com/browse/allyship>
- Dierckx, C., Hendricks, L., Coemans, S., & Hannes, K. (2021). The third sphere: Reconceptualising allyship in community-based participatory research praxis. *Qualitative Research in Psychology*, 18(4), 473-497. <https://doi.org/10.1080/14780887.2020.1854402>
- Edmonton Community Foundation. (2019). *Vital Signs*. [https://www.ecfoundation.org/wp-content/uploads/Full-Final-Vital-Signs\\_2019\\_11x22.75\\_v5.pdf](https://www.ecfoundation.org/wp-content/uploads/Full-Final-Vital-Signs_2019_11x22.75_v5.pdf)
- Foronda, C. (2020). A theory of cultural humility. *Journal of Transcultural Nursing*, 31(1), 7-12. <https://doi.org/10.1177/1043659619875184>
- Garbutt, J. (2019). *Walking Alongside: Poetic Inquiry into Allies of Indigenous Peoples in Canada*. [Master's thesis, University of Calgary, AB]. PRISM: University of Calgary's Digital Repository. <http://hdl.handle.net/1880/111025>
- Government of Canada. (2017, May 2). *First Nations in Canada*. Crown-Indigenous Relations and Northern Affairs Canada. Retrieved February 10, 2023, from <https://www.rcaanc-cirnac.gc.ca/eng/1307460755710/1536862806124>
- Government of Canada, D. of J. (2021, April 12). *The Declaration Explained*. <https://www.justice.gc.ca/eng/declaration/what-quoi.html>

- Government of Canada. (2022, August 30). *Indigenous peoples and communities*. Crown-Indigenous Relations and Northern Affairs Canada. Retrieved February 11, 2023, from <https://www.rcaanc-cirnac.gc.ca/eng/1100100013785/1529102490303>
- Indigenous and Northern Affairs Canada. (2013). *Treaty 6*. <https://www.rcaanc-cirnac.gc.ca/eng/1100100028710/1581292569426>
- Jacklin, K., & Warry, W. (2012). *Forgetting and forgotten: Dementia in Aboriginal seniors*. *Anthropology & Aging*, 33(1), 13-+.
- Kendi, I. X. (2019). How to be an Antiracist. *The New York Times*, 19.
- Knudsgaard, H. (2019). *How One Becomes What One Is: Transformative Journeys to Allyship*. [Master's thesis, University of Victoria, BC].  
[http://dspace.library.uvic.ca/bitstream/handle/1828/11480/Knudsgaard\\_Harald\\_MS\\_W\\_2019.pdf?sequence=3&isAllowed=n](http://dspace.library.uvic.ca/bitstream/handle/1828/11480/Knudsgaard_Harald_MS_W_2019.pdf?sequence=3&isAllowed=n)
- Kolahdooz, F., Nader, F., Yi, K. J., & Sharma, S. (2015). Understanding the social determinants of health among Indigenous Canadians: Priorities for health promotion policies and actions. *Global Health Action*, 8(1), 27968. <https://doi.org/10.3402/gha.v8.27968>
- Kovach, M. (2010). *Indigenous Research Methods and Interpretation*. University of Toronto Press.
- Lavoie, J., Gervais, L., Toner, J., Bergeron, O., & Thomas, G. (2011). *The Aboriginal health legislation and policy framework in Canada* (Vol. 35). Prince George, Canada: National Collaborating Centre for Aboriginal Health.
- Levin, B. (2008) *Thinking about Knowledge Mobilization: A Discussion Paper Prepared at the Request of the Canadian Council on Learning and the Social Sciences and Humanities Research Council*. Canadian Council on Learning. Accessed June, 2022. [http://www.sshrc-crsh.gc.ca/about-au\\_sujet/publications/KMb\\_-\\_LevinDiscussionPaper\\_-\\_E.pdf](http://www.sshrc-crsh.gc.ca/about-au_sujet/publications/KMb_-_LevinDiscussionPaper_-_E.pdf) [Google Scholar]

- Loya, M. A., & Cuevas, M. (2010). Teaching racism: Using experiential learning to challenge the status quo. *Journal of Teaching in Social Work, 30*(3), 288–299.  
<https://doi.org/10.1080/08841233.2010.497130>
- Manitowabi, D., & Maar, M. (2018). “We stopped sharing when we became civilized”: A Model of Colonialism as a Determinant of Indigenous Health in Canada. *Journal of Indigenous Social Development, 7*(1).
- Martinez, S., Araj, J., Reid, S., Rodriguez, J., Nguyen, M., Pinto, D. B., Young, P. Y., Ivey, A., Webber, A., & Mason, H. (2021). Allyship in residency: An introductory module on medical allyship for graduate medical trainees. *MedEdPORTAL, 11200*.  
[https://doi.org/10.15766/mep\\_2374-8265.11200](https://doi.org/10.15766/mep_2374-8265.11200)
- Mayan, M. J. (2016). *Essentials of qualitative inquiry*. Routledge, Taylor and Francis.
- McLane, P., Barnabe, C., Holroyd, B. R., Colquhoun, A., Bill, L., Fitzpatrick, K. M., Rittenbach, K., Healy, C., Healy, B., & Rosychuk, R. J. (2021). First Nations emergency care in Alberta: Descriptive results of a retrospective cohort study. *BMC Health Services Research, 21*(1), 423.  
<https://doi.org/10.1186/s12913-021-06415-2>
- McLane, P., Bill, L., & Barnabe, C. (2021). First Nations members’ emergency department experiences in Alberta: A qualitative study. *Canadian Journal of Emergency Medicine, 23*(1), 63–74. <https://doi.org/10.1007/s43678-020-00009-3>
- Mensah, M. O. (2020). Majority taxes—toward antiracist allyship in medicine. *New England Journal of Medicine, 383*(4), e23. <https://doi.org/10.1056/nejmpv2022964>
- Morse, J. M., Barrett, M., Mayan, M., Olson, K., & Spiers, J. (2002). Verification strategies for establishing reliability and validity in qualitative research. *International Journal of Qualitative Methods, 1*(2), 13–22. <https://doi.org/10.1177/160940690200100202>

- Murry, A. T., Barnabe, C., Foster, S., Taylor, A. S., Atay, E. J., Henderson, R., & Crowshoe, L. (2022). Indigenous mentorship in the health sciences: Actions and approaches of mentors. *Teaching and Learning in Medicine*, 34(3), 266-276. <https://doi.org/10.1080/10401334.2021.1912610>
- National Inquiry into Missing and Murdered Indigenous Women and Girls (Canada) (Ed.). (2019). *Reclaiming power and place: The final report of the national inquiry into missing and murdered indigenous women and girls*. National Inquiry into Missing and Murdered Indigenous Women and Girls. [https://www.mmiwg-ffada.ca/wp-content/uploads/2019/06/Final\\_Report\\_Vol\\_1a-1.pdf](https://www.mmiwg-ffada.ca/wp-content/uploads/2019/06/Final_Report_Vol_1a-1.pdf)
- Neergaard, M. A., Olesen, F., Andersen, R. S., & Sondergaard, J. (2009). Qualitative description—the poor cousin of health research?. *BMC medical research methodology*, 9(1), 1-5. <https://doi.org/10.1186/1471-2288-9-52>
- Nikkel, J. (2019). *White Settler Dysconsciousness and Ethnicity—Constructing innocence and non-complicity among Mennonites and other white settlers in Canada*. [Master's thesis, University of Alberta, AB]. <https://doi.org/10.7939/r3-y7bp-8g52>
- Nixon, S. A. (2019). The coin model of privilege and critical allyship: Implications for health. *BMC Public Health*, 19(1), 1–13. <https://doi.org/10.1186/s12889-019-7884-9>
- Paradies, Y. (2016). Colonisation, racism and indigenous health. *Journal of Population Research*, 33(1), 83–96. <https://doi.org/10.1007/s12546-016-9159-y>
- Royal College of Physicians and Surgeons of Canada. (2019a). *Indigenous health: The Royal College of Physicians and Surgeons of Canada*. <https://www.royalcollege.ca/rcsite/health-policy/indigenous-health-e>

Royal College of Physicians and Surgeons of Canada. (2019b).

<https://www.royalcollege.ca/rcsite/canmeds/framework/canmeds-role-health-advocate-e>

Sandelowski, M. (2000). Whatever happened to qualitative description? *Research in Nursing & Health*, 23(4), 334–340. [https://doi.org/10.1002/1098-240X\(200008\)23:4<334::AID-NUR9>3.0.CO;2-G](https://doi.org/10.1002/1098-240X(200008)23:4<334::AID-NUR9>3.0.CO;2-G)

Smith, J., Puckett, C., & Simon, W. (2016). *Indigenous allyship: An overview* (pp. 1-36). Waterloo, ON: Office of Aboriginal Initiatives, Wilfrid Laurier University. .[Master’s thesis, Wilfred Laurier University, ON]

Statistics Canada. (2016) *Census Profile, 2016*.

Statistics Canada. (2021). *Census Profile, 2021 Census of Population*.

<https://www12.statcan.gc.ca/census-recensement/2021/dp-pd/prof/index.cfm?Lang=E>

Sumerau, J. E., Forbes, T., Grollman, E. A., & Mathers, L. A. (2021). *Constructing allyship and the persistence of inequality*. *Social Problems*, 68(2).

The Anti Oppression Network. (2019). <https://theantioppressionnetwork.com/allyship/>

*The United Nations Declaration on The Rights of Indigenous People: A manual for national rights institutions*. (2007). United Nations.

Truth and Reconciliation Commission of Canada (TRC) (Ed.). (2015). *Final report of the Truth and Reconciliation Commission of Canada: Honouring the truth, reconciling for the future. Volume one: Summary* (Second printing). James Lorimer & Company Ltd., Publishers.

United Nations Declaration on the Rights of Indigenous People. (2007).

[https://www.un.org/development/desa/indigenouspeople/wp-content/uploads/sites/19/2018/11/UNDRIP\\_E\\_web.pdf](https://www.un.org/development/desa/indigenouspeople/wp-content/uploads/sites/19/2018/11/UNDRIP_E_web.pdf)

Wilson, S. (2020). *Research is ceremony: Indigenous research methods*. Fernwood publishing.

Windchief, S., Arouca, R., & Brown, B. (2018). Developing an Indigenous mentoring program for faculty mentoring American Indian and Alaska Native graduate students in STEM: A qualitative study. *Mentoring & Tutoring: Partnership in Learning*, 26(5), 503-52.

<https://doi.org/10.1080/13611267.2018.1561001>

World Health Organization. (2007). *The world health report 2007: a safer future*.

Whiskeyjack, L, Makokis, J, & Gesink, D. (n.d.). *Restoring Relationship to Research: Being A Better Ally*.

## Appendix

### Interview Guide

#### Preamble

Thanks, again, for agreeing to participate in this interview.

Before we start, I just want to restate the goals of this interview. We are hoping to learn about your experiences and insights as a non-Indigenous healthcare provider who provides care for Indigenous patients. The research question is “What does it mean to be an ally in providing healthcare to Indigenous patients?” This research seeks to understand non-Indigenous healthcare professionals’ perceptions on how to work as an ally in providing healthcare to Indigenous patients, as well as successes and struggles in their roles as allied healthcare workers providing care to Indigenous patients.

I have a series of questions that I would like to ask you over the next hour or so. You are not required to answer any question you do not feel comfortable answering. You will not be personally identified in any reports that we produce, nor will any comments you make be attributed to you without permission. The interview will be recorded and transcribed for later analysis.

Do you have any questions before we proceed?

### Interview Questions

1. Please tell me about your work. What are your roles and responsibilities?
2. What brought you into the healthcare field?
3. When did you realize that you were an ‘ally’? What does allyship mean to you?
4. What lessons have you learned about being an ally in healthcare?
5. What has shaped your ability to work in Indigenous healthcare well?
6. Can you recall a particular moment where your role as an ally was called into question?
7. Looking forward, what would you like to see happen to improve Indigenous healthcare strategies or activities and outcomes for Indigenous patients?
8. What specific lessons have been learned in your work that you think could be most helpful to other healthcare professionals?
9. What would you say have been the greatest successes?
10. What would you say have been the key shortcomings?
11. Looking back, would you do anything differently?