Decolonizing Health Care: 
Reconciliation Roles and Responsibilities for White Settlers

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

I’m so filled with belief and hope because when I hear your voices at the table, I hear and know that the responsibilities that our ancestors carried…are still being carried…even through all of the struggles, even through all of what has been disrupted … we can still hear the voice of the land. We can hear the care and love for the children. We can hear about our law. We can hear about our stories, our governance, our feasts, [and] our medicines….We have work to do. That work we are [already] doing as [Aboriginal] peoples. Our relatives who have come from across the water [non-Aboriginal people], you still have work to do on your road….The land is made up of the dust of our ancestors’ bones. And so to reconcile with this land and everything that has happened, there is much work to be done…in order to create balance. (Anishinaabe Elder Mary Deleary speaks at Traditional Knowledge Keepers Forum, Truth and Reconciliation Commission, 2015, p. 9)

This analysis is grounded in the Truth and Reconciliation’s Commission’s (TRC) Calls to Action in Canada, and particularly the seven Calls to Action related to health. To date, less than ten of the TRC’s 94 recommendations have been taken up by settler Canadians. Here, settler generally refers to people whose ancestors came to Canada from Europe over the last few centuries. European colonizers’ Indigenous land and resource dispossession made room for settlement and
settler resource “development”. So, although settlers today may not link these original dispossession to the disenfranchisement of Indigenous peoples today, we nonetheless stand on the economic, environmental, political, and sociocultural benefits of the dispossession created by our ancestors. Health care has historically been a significant mechanism of colonization; however, it is very difficult for white settlers in health care (e.g., providers, researchers, national research-funding councils, government policy-makers, and so on) to come to grips with their ongoing participation in colonization, including their everyday micro-aggressions against Indigenous peoples, and their health-damaging, and sometimes deadly neglect, at point-of-care. In the broader context, globalization and neoliberalism are important forms of modern colonial imperialism that continue to colonize Indigenous peoples around the globe. The purpose of this paper is to enhance a nascent discussion to white settlers about how they can be active participants in reconciliation action to decolonize health care—by way of truths. I use the term Indigenous in this analysis; however, I retain the terms ‘Aboriginal’ and ‘Indian’ when they are used by sources cited.

I draw on my previous work and public presentations about white privilege, racism in health care, and critical perspectives on the social determinants of health (SDH). The paper is a reflection of where I happen to be at this particular moment. My hope is that it will be taken up and built upon, to continue to move forward with white settler reconciliation in the context of the health of Indigenous peoples. I detail some of the traumas, genocides, and related brutalities that have impacted millions of Indigenous people over time in Canada. These are the truths that need to be repeated, visited and revisited, so that white settlers can commit to following along the ethical path to know much more, and to take much more action.

I start with an examination of the genocide of Indigenous peoples in Canada, followed by evidence (truths) about the deadliness of white settler health care racism, which results in embodied oppression—oppression that is the root of Indigenous inequities in the SDH. White settler privilege is threaded throughout the analysis, including the persistent impacts of Western, Eurocentric, and biomedical knowledge dominance in health care. Although decolonization underpins this paper, I specifically analyze how white settlers can engage in ‘performing’ decolonization: decolonizing with critical perspectives on the SDH, allyship, and anti-racist, anti-oppressive health care.

It is in these truths that white settlers can often find an entry point to begin to grasp the enormity of racism’s impact on Indigenous peoples. Even a spurious analysis of curricular and public policy content reveals that health care education, practice, research and policy-making are largely devoid of these truths. Yes, there are pockets of excellence; however, these pockets lack systemic, policy-based support. I have taught thousands of students and presented to thousands of people in public venues—mostly white settlers in Canada. It is rare that many of them have heard about embodied racism, or the truths that surround its impacts. Many of our minds and hearts are indeed largely occupied by a collective mirage of neutrality, color-blindness, and happy-talk about how we are all equal in the eyes of the law, the constitution, the government, God, and many other ostensibly benevolent overseers. We cling to egalitarian notions that we are all equal, and thus have equal opportunities in life. There is a saying now in Canada about health and health care: “Let’s talk about health and not talk about health care at all”. It is a well-intentioned effort to emphasize the social, rather than medical/hospital-related, determinants of health. I have argued elsewhere that health care is indeed a powerful and highly expensive mechanism of oppression in Canada (McGibbon, 2017, 2016). Since health care is a pernicious colonizing force, it is also a strategic and ethically necessary site for decolonizing action.

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Decolonization is a contested term, due to deep embeddedness of ongoing colonialism, and relentless persistence of settlers in systematically undoing progress toward dismantling colonial power. Over a decade ago, I heard Dr. Cornell West, an African American philosopher, political activist, social critic, author, and public intellectual, speak at a Canadian conference about race and the academy. He analyzed historical progress in anti-racism work, and the impacts of the civil rights movements in the United States (US). He clearly detailed how forward steps in the fight for equality of African American people were systematically undone by white people over time. Dr. Cornell’s analysis was historically correct—white people actively create a veneer of complicity in the fight for racial equality; then, we just as deftly craft a countermove that undoes or obfuscates progress.

Here is a current Canadian example of settler undoing of progress toward anti-racist reconciliation. Although communities and non-profit organizations have successfully taken up health equity action, over the past two decades the term ‘health equity’ has more or less plodded along in hallways of government and academia. At first, one could not put the word ‘equity’ in the title of a grant proposal for the major health-related government granting agency. Reviewers claimed that this language was ‘biased’. Results would not be ‘generalizable to the Canadian population’. Terms required ‘objective definitions that could be applied across all populations’. Then came an increasing understanding of the difference between equality and equity. Equity became a political term, implying an amenable inequality in the SDH and in access to the material goods necessary for a decent quality of life—an inequality that fell along class and racial lines. This was progress. Now, almost two decades later, in a study of Canadian government documents, preliminary results indicate that the term is indeed losing its political heft, and is sometimes relegated to a catch-phrase that allows white settlers to hold the veneer of political, activist sentiments, all the while effectively stalling progress in actual public policy action for SDH equity. Leadership-oriented, health equity-focused government documents can have ‘health equity’ in the title, and not have the words ‘Indigenous’ or ‘Aboriginal’ or ‘racism’ or ‘treaty’ or ‘gender’ or ‘poverty’ in the entire document (McGibbon, Brennan, & Petrovick, 2017).

Before beginning the discussion, it is centrally important to underscore how the isms (i.e. ableism, ageism, classism, genderism, heterosexism, racism, sexism...) intersect to deepen disadvantage and oppression. My heritage is working class, Irish, and Roman Catholic. I left the church when I was fourteen years old, but that is another story. My maternal grandfather worked in Nova Scotian coalmines, and his people escaped the Irish Potato Famine when the British attempted to annihilate the Irish people. My father’s people escaped the famine for a new life in New York. They changed their name from Fitzgibbon to McGibbon in an attempt to fend off hatred and discrimination they experienced as Irish people in the new country. I grew up asking my friends’ parents to drop me off around the corner from our house because I didn’t want them to see the peeling paint and disarray—the everyday nuances of some sort of social class-related and intricate shame. As an adult, I come more and more to appreciate the richness and creativity of our (eight children, two with disabilities) upbringing with two working-class intellectuals as parents, and an intriguing, forward-thinking paternal uncle who lived with us for many years, and shared his two-inch thick copy of the New York Sunday Times each week. Although many of my people became community leaders, I know how social class potently determines our paths in life. To this day, I can pretty much pin down a person’s social class of origin, regardless of the rest of their identities. I tell these stories because I honor all these isms and their impacts on one’s chances in life—the grinding poverty and inequities in the SDH that are experienced by a growing number of
Canadians. Identities are complex. Although I had social class and gender powerfully against me in this classist and sexist/misogynist world, the truth is that I likely never would have even made it past junior high, let alone have a PhD, if I did not have the everyday privilege of whiteness on my side at every step along the way.

**Genocide of Indigenous Peoples: Settler Denial, Settler Truth-telling**

We forcibly took children from families—sometimes at gunpoint—and flew them to remote locations they could not escape—sometimes in tiny handcuffs—where they were submitted to a program of forced labour and “education” designed to destroy their cultures and civilizations. This desire to destroy cultures seems to be the reasoning for various public figures’ use of the adjective “cultural” before genocide. The other reason, I presume, is that some cling tightly—and childishly—to the idea that Canada has always been on the side of goodness and justice, and they find it very hard to accept, admit, and announce that we are a country that committed a program of genocide that lasted for many decades. (Staniforth, 2015)

Towards the end of 2017, I listened to Canadian Broadcasting Corporation’s (CBC) Michael Enright as he interviewed retiring Canada Chief Justice Beverly McLaughlin. During the interview, Enright asked Chief Justice McLaughlin to comment on the national response she received when she publicly referred to the genocide of Indigenous peoples in Canada. The two then discussed whether or not Chief Justice meant genocide in general, or was she only referring to cultural genocide. They concluded that Canada’s genocide against Indigenous peoples was limited to cultural genocide. So, how could it be that two prominent Canadian leaders were not aware that the facts of the Canadian genocide of Indigenous peoples are now a part of the official record of this country’s history? Canada’s carefully crafted and deep mirage of Indigenous genocide denial is so embedded that Canadians can publicly reassure themselves that genocide was limited to ‘cultural genocide’, not yet able to link Canadian history with Articles One and Two of the United Nations (UN) Convention on the Prevention and Punishment of the Crime of Genocide (UN, 1948). The Convention was adopted by Resolution 260 (III) A, of the UN General Assembly on December 9, 1948. Article 1 states: Contracting Parties confirm that genocide, whether committed in time of peace or in time of war, is a crime under international law, which they undertake to prevent and to punish. Article 2 states: In the present Convention, genocide means any of the following acts committed with intent to destroy, in whole or in part, a national, ethnical, racial or religious group, as such:

a) Killing members of the group;  
b) Causing serious bodily or mental harm to members of the group;  
c) Deliberately inflicting on the group conditions of life calculated to bring about its physical destruction in whole or in part;  
d) Imposing measures intended to prevent births within the group;  
e) Forcibly transferring children of the group to another group. (UN, 1948)

The most well-known instance of genocide in Canada is the Indian Residential Schools (IRS). The IRS system included industrial schools, boarding schools, homes for students, hostels, billets, residential schools, and residential schools with a majority of day students, or a
combination of any of the above (Wesley-Esiquimaux & Smolewski, 2004). Facts, in both Indigenous and settler historical accounts, tell us that at least 150,000 children were taken from their homes, often under circumstances of abduction by Indian Agents of the Canadian government. Many thousands of first-voice accounts verify that Indigenous children were subjected to physical and psychological abuse, rape, and torture (e.g. electroshocked in a small, homemade electric chair; placed in bathtubs full of snakes).

Charlie Angus’ (2015) book, Children of the Broken Treaty, traces the atrocities of IRS, the history of Treaty 9, and the intelligent and tenacious work of Shannen Koostachin, a Cree teenager who led an internationally recognized movement to bring the basic human right of childhood education to Indigenous communities. There are many facts (truths) in settler historical accounts about the Canadian government being explicitly informed of IRS abuses over time, yet taking no action. A prominent whistle-blower was Ottawa physician, Dr. Peter Bryce. A Chief Medical Officer, he was commissioned by the Department of Indian Affairs to conduct a health survey of children in IRS. He reported widespread inhumane treatment and unsanitary conditions. In a CBC interview, Dr. Cindy Blackstock stated: “Bryce found that the death rates in the schools were 25 per cent a year, and if you follow the kids over three years, it’s 48 per cent. It's horrifying…It puts a red hot poker stick into this myth that people in the period didn't know any better back then” (Canadian Broadcasting Corporation. CBC, 2017). In Bryce’s 1907 report on IRS in Manitoba and the Northwest Territories, he states:

It suffices for us to know…that of a total of 1,537 pupils reported upon nearly 25 per cent are dead, of one school with an absolutely accurate statement, 69 per cent of ex-pupils are dead, and that everywhere the almost invariable cause of death given is tuberculosis (Bryce, 1907, p.18).

This report, and Bryce’s 1922 IRS report, The Story of a National Crime (Bryce, 1922), were dismissed by Canadian government officials and medical professionals at the time, and he was soon demoted. We cannot know how many children’s lives would have been saved. The Canadian government’s deliberate suppression of the report, according to settler historical accounts at the time, and hence their knowing complicity in the deaths of thousands of children, clearly meets the UN’s genocide criteria of: (a) Killing members of the group; (b) Causing serious bodily or mental harm to members of the group; (c) Deliberately inflicting on the group conditions of life calculated to bring about its physical destruction in whole or in part. Settlers can perhaps claim that IRS church and government officials, and Christian teachers/missionaries meant well in the beginning. However, even this claim is suspect because the stated government aim of the IRS was to “kill the indian in the child” (TRC, 2015). According to Justice Murray Sinclair, TRC Chair, up to 6,000 children died in residential schools. Forty nine percent of the deaths of children in IRS had no listed cause, 43% had no listed location of death, and 32% had no listed name associated with the body (Schwartz, 2015). These dead children were literally thrown away unnamed, lost and forgotten by the settlers who killed them, intentionally and through complicit lack of action.

Relocations of Indigenous children and families correspond to violation of Article 2, section e), of the UN’s genocide criteria: Forcibly transferring children of the group to another group. The Canadian government’s Sixties Scoop was a child-welfare policy that removed 20,000 Indigenous children from their homes in British Colombia and relocated (dislocated) them to settler families in Ontario. We do not yet know the scope of health, cultural, and spiritual impacts
of these mass transfers of Indigenous children. In the Inuit High Arctic in 1953 and 1955, the Canadian government relocated eleven Inuit families from the Port Harris region, and four families from Pond Inlet, to new communities at Grise Fiord and Resolute Bay. According to McPherson-Duncan (2015), some Arctic historians claim that these relocations to the high Arctic were a strategy of the Canadian government to secure sovereignty to the Arctic via effective occupation of the Inuit during the Cold War. Despite extensive oral histories, the government failed to accurately reflect Inuit colonial experiences in official records of Canadian history. Inuit families suffered great hardship in this far north location, with traditional ways of life not possible in excessively cold temperatures. The government called the relocation a humanitarian success. It is important to note that the Inuit also survived through attempted genocides, cultural oppression, psychological and sexual abuse, and a general lack of recognition of basic human rights. Captured by Inuit vocal histories, these early interactions are pivotal in framing the contemporary Crown and Inuit relationship (McPherson-Duncan).

Germ warfare was also perpetrated on Indigenous peoples, in violation of Article 2: sections a), b), and c) of the UN Convention on Genocide. Marking a milestone of sorts, certain colonists during the French and Indian Wars resorted to trading smallpox-contaminated blankets to local tribes with immediate and devastating results (O’Connell, 1989). The first recorded use of smallpox as a biological weapon against Indigenous peoples is in the letters of Lord Jeffrey Amherst, a commanding general of British forces in North America during the final battles of the so-called French & Indian war (1754-1763). Much of what we know about smallpox and germ warfare is based in papers that were microfilmed as part of the British Manuscript Project, 1941-1945, undertaken by the US Library of Congress during World War II. The project was designed to preserve British historical documents from possible war damage. Referring to the Delaware, Shawnee, and Mingo Indians surrounding Fort Pitt, Amherst writes to Colonel Henry Briquet: “Could it not be contrived to send the Small Pox among those disaffected tribes of indians? We must on this occasion use every stratagem in our power to reduce them”. Briquet responds:

I will try to inoculate the [indians] with some blankets that may fall into their hands, and take care not to get the disease myself. As it is pity to expose good men… I wish we could make use of the Spanish method, to hunt them with English dogs, supported by rangers and some light horse, who would, I think, effectually extirpate or remove the vermin.

Amherst responded favorably on 16 July 1763: “You will do well to inoculate the indians by means of blankets, as well as every other method that can serve to extirpate this execrable race”. Fort Pitt account books make it clear that British military both sanctioned and paid for germ warfare against Indigenous peoples in the Americas. Settlers argue about whether or not the Indians already had smallpox: Did Amherst command dispersion of smallpox-inoculated blankets after the Delaware, Shawnee, and Mingo peoples already had smallpox? Which colonialist regime was the first to use biological warfare? These debates deflect settler attention from historical records (publically archived historical documents) of germ warfare. Ultimately, millions of Indigenous tribes and peoples were wiped out by smallpox epidemics in what is now known as the US and Canada, through direct inoculation (germ warfare), and through spread by infected Europeans throughout the Americas. Table 1 summarizes examples of Indigenous genocide, according to UN criteria.
**Table 1: Examples of Genocide against Indigenous Peoples in Canada**


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<tr>
<th>Article, a), b), c): Clearing the Plains</th>
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<td>Within two years of Cree negotiation of Treaty 6, between 15,000 and 20,000 people faced starvation, with the swift disappearance of the bison, and a way of life that had endured for 10,000 years (Daschuk, 2017). The I.G. Baker Company, hired by the Government of Canada to provide winter food rations, allowed food to rot in warehouses, while tuberculosis and other diseases ravaged an already weakened people. To prevent the death of their families, mothers and daughters were forced into prostitution at the hands of settler officials who controlled the food supply (Daschuk, 2013). Sir John A. MacDonald famously stated: “We are doing all we can, by refusing food until the indians are on the verge of starvation, to reduce the expense”. (Daschuk, 2013; Stote, 2012).</td>
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<th>Article, a), b), c): The Beothuk</th>
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<td>The Beothuk, Indigenous inhabitants of Newfoundland, were actively hunted and killed by British farmers, fishers and trappers who settled on the bays of the Beothuk’s summer camps. Since the island’s invasion in 1497, the Beothuk were repeatedly pushed further inland and away from their own resources. Weakened by hunger and diseases, such as smallpox, measles, influenza and tuberculosis, the population decreased from approximately 345 in 1768 to 72 in 1811 (Wesley-Esquimaux &amp; Smolewski, 2004). Indigenous historian, Dan Paul (2017) states that “as early as 1506, many of the Beothuk were being sold as slaves in Europe. Many were simply slaughtered. Also, the assault caused traditional food supplies to be cut off, which led to starvation and malnutrition and made them prime candidates for contracting European and indigenous diseases, which, because of their malnutrition state, almost always proved fatal. In time, these barbarities led to the extinction of the Tribe”.</td>
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<th>Article, a), b), c): Germ Warfare, Biological Weapons</th>
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<td>It is a matter of public record (publically archived historical documents) that germ warfare was conducted against Indigenous peoples in North America. The UN Convention on the Prohibition of the Development, Production and Stockpiling of Bacteriological (Biological) and Toxin Weapons, and on their Destruction, commonly known as the Biological Weapons Convention (BWC) or Biological and Toxin Weapons Convention (BTWC), was signed in 1975, officially recognizing biological agents as effective methods of warfare.</td>
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<th>Article 2 a): British Scalp Proclamation 1756</th>
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<td>“And, we do hereby promise, by and with the advice and consent of His Majesty's Council, a reward of 30£ for every male Indian Prisoner, above the age of sixteen years, brought in alive; or for a scalp of such male Indian twenty-five pounds, and twenty-five pounds for every Indian woman or child brought in alive: Such rewards to be paid by the Officer commanding at any of His Majesty's Forts in this Province, immediately on receiving the Prisoners or Scalps above mentioned, according to the intent and meaning of this Proclamation”. The Proclamation is still legal in Nova Scotia, despite lobbying to remove it in respect for the Mi’kmaq people in ancestral, unceded territory of Mi’kma’ki (Paul, 2017).</td>
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| Article 2, a), b), c): Indian Residential Schools; Article 2, e) Relocations. Please see text analysis. |

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<th>Article 2, b), d): Coercive Sterilization of Indigenous Women</th>
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<td>Coercive sterilization of Indigenous women occurred during the eugenics movement in the early 1900s. According to Stote (2012), evidence indicates this practice was carried out by eugenically minded doctors</td>
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in Ontario and Northern Canada, where Aboriginal women were the prime targets. No scholarship has specifically referred to, or conducted in-depth study of, this practice (Stote, 2012).

**Article 2, b): Medical Experiments on Indigenous Peoples, including Children in IRS**

Between 1942 and 1952, some of Canada’s leading nutrition experts, in cooperation with various federal departments, conducted an unprecedented series of nutritional experiments and studies on Aboriginal communities and on children in IRS. The largest study was the James Bay Survey of the Attawapiskat and Rupert’s House Cree First nations (1947-1948). There were also two separate long-term controlled experiments on malnourished Indigenous peoples in Northern Manitoba, and later in six IRS. Experiments were conducted without the “subjects” informed consent or knowledge (Mosby, 2013).

A main point here in terms of truth, reconciliation, and decolonization is that cultural genocide, and genocide that results in death and bodily harm, are inseparable. The systematic predation of Indigenous peoples at the hands of European settlers directly and indirectly caused loss of Indigenous lifeways that led to their starvation and death. It is interesting that for white settlers, there is often a distinction between cultural genocide and that other genocide that reminds us of dead people and their bodies. In order to take responsibility for reconciliation action, it is imperative that we stop clinging to notions that genocide was ‘limited’ to cultural genocide, because this thinking obfuscates and denies the hells on earth that white settlers perpetrated on Indigenous peoples across what is now known as Canada. Elder and Indigenous historian Dr. Daniel Paul has meticulously detailed these crimes in his book: We were not the savages: Collision between European and Native American civilizations (Paul, 2007), and in his extensive website documentation: We were not the savages: First Nation history (Paul, 2017).

**White Settler Health Care Racism is Deadly**

Aboriginal people never had enough time, between various sequences of new world epidemics, genocide, trauma and forced assimilation to develop tools for passing through the periodic social and cultural disintegration of their nations. Aliens in their own land, under constant siege from their oppressors and separated from their own cultures, Aboriginal people slowly subsided into despair and a hollow silence, punctuated by tragic outbursts of self-defeating behaviour. First, their elders and youth perished in the waves of epidemics that wiped out entire communities and lineages. One must remember that these diseases were not always spread by natural means. (Wesley-Esquimaux & Smolewski, 2004, p. 77)

Racism is embodied—inscribed on the body, the mind, the spirit over time and inter-generationally. Everyday racism, the relentless and grinding discriminatory actions that are experienced by racialized people, eventually take their toll on health (McGibbon & Mbugua, 2017). Camara Phyllis Jones (2002) refers to these actions as micro-aggressions—the sudden, stunning, or dispiriting transactions that mar the days of racialized peoples. These include small acts of racism that are consciously or unconsciously perpetrated, and act like water dripping on a rock, wearing away at it slowly (Jones). Everyday racism is supported by structural racism, which is created and sustained by societal structures. These are the political, economic, and social
structures of society, and the culture that informs them (e.g. law, policing, religion, health care, government) (Navarro, 2002). These structures, and the policies and practices that they create and sustain, are the root causes of racism, and they lead to the suffering, and sometimes death, associated with widespread inequities in the SDH, and resulting health inequities. Williams (1999) defines racism as “an ideology of inferiority that is used to justify unequal treatment (discrimination) of members of groups defined as inferior, by both individuals and societal institutions” (p. 176). Racism is thus the systematic practice of denying people access to rights, representation, or resources based on racial differences. White settler racism is a predominant mechanism for the continued colonization of Indigenous peoples, and hence, a decisive site for anti-racist action for health care reconciliation.

**White Settler Racism, Justice and Health**

Racism creates and perpetuates embodied struggle and suffering across all major body, mind and spirit systems and processes, producing cancer, diabetes, compromised gastrointestinal and cardiovascular outcomes; and all the related nuances of spiritual and mental health sorrows and distress. These health inequities are a result of the chronic, intergenerational stress of racism, including intergenerational trauma. Trauma is, by its nature, deeply embedded in the soul, the psyche, and the cognitive schema of those who are traumatized (McGibbon & Mbugua, 2017). Intergenerational trauma occurs when adults’ traumatic experiences and their effects are transmitted within a family system across generations. This brutal treatment, including the impacts of IRS, severely impacted Indigenous peoples’ adult lives and their parenting capacity over time (Paul, 2007; Wesley-Esquimaux & Smolewski, 2004), thus creating the context for profound stress associated with family trauma transmission. Jacobs and Williams (2008) link the current, intergenerational vulnerability of Aboriginal women and youth in particular, to the impacts of colonization, including IRS:

One of the outcomes of this history is that many Aboriginal women today continue to be challenged by fundamental issues of safety and survival...Aboriginal women have endured countless attacks on their culture, their way of life, and their persons. As a result, their traditional roles have been undermined in that they “have had to deal with dispossession of their traditional territories, disassociation with their traditional roles and responsibilities, disassociation with participation in political and social decisions in their communities ... disorientation of culture and tradition,” (Native Women’s Association of Canada, 2002), and a total societal disrespect of their roles within their communities (p. 121).

White settler Canadians’ failure to act for the rights of Indigenous women has been noted internationally. The UN Convention on the Elimination of all forms of Discrimination against Women (CEDAW) expressed concern that Indigenous women continue to suffer from multiple forms of discrimination, particularly in terms of access to employment, housing, education and health care. According to Jacobs and Williams (2008), the CEDAW Committee acknowledged programs, policies and activities in the global context that are aimed at decreasing discriminatory treatment of Indigenous women; however, they also noted with regret that Indigenous women in Canada continue to live with high rates of poverty, persistently poor and measurable physical and mental health outcomes, inadequate housing, lack of access to clean water, and low school-completion rates; and are significantly underrepresented in political and public life (Jacobs &
Williams, 2008): “They are underrepresented in all areas of the labour market, in particular in senior or decision-making positions, have higher rates of unemployment and face a greater pay gap in terms of their hourly earnings compared with men” (para. 43). In 2014, Amnesty International laid out a call to action on the rights of Indigenous women in Canada, stating that the scale and severity of violence faced by Indigenous women and girls in Canada—First Nations, Inuit and Métis—constitutes a national human rights crisis (Jacobs & Williams, 2008):

Despite the vast scale and entrenched nature of the crisis, and the many calls for action made by Indigenous peoples’ organizations, civil society groups, provincial and territorial government leaders, Parliamentarians, and international and national human rights bodies, the Canadian government has failed to implement a comprehensive and coordinated national response in keeping with the seriousness and pervasiveness of the threats faced by Indigenous women and girls. (p. 2)

One of white settlers’ pivotal roles in decolonizing health care is to literally and figuratively attach these current human rights violations to historical genocide, including cultural genocide, of Indigenous peoples. Indigenous women bear the full brunt, every day, of the legacy of colonial predation. These connections are imperative because the persistent stress of settler racism and injustice form a synergy with intergenerational Indigenous health outcomes.

**Relationships among Racism, Health, and Stress**

Each of us has built-in processes that help us handle stress. Through the body’s fight-or-flight response, the adrenal system regulates itself to give us the energy and concentration to handle everyday ups and downs of stress, such as meeting deadlines and coping with unforeseen challenges. Our adrenal system also adjusts to help us cope with crises, such as serious illness and loss of a loved one (McGibbon, 2017). However, when individuals, families, communities, and Nations live in a chronic state of stress due to the relentlessness of racism and the other isms, the adrenal system becomes fatigued. Results include immunosuppression, diabetes, heart disease, obesity, and depression. The adrenals become chronically over-burdened by the stress of everyday, and structural, racism (Etowa & McGibbon, 2012). Racialized peoples develop racism battle fatigue (Currie, Wild, Schopflocher, Laing, & Veugelers, 2012), where a military metaphor helps us understand the persistent, lifelong stressful impacts of combatting everyday racism—a racism that is never possible for settler Canadians to fully appreciate (McGibbon & Mbugua, 2017). This stress is compounded and magnified for Indigenous women through colonial, patriarchal discrimination and ongoing oppression, because Indigenous women are positioned in a particular way in terms of chronic stress, by virtue of the intersections of being women and being Indigenous women in the colonial context. According to Greenwood, de Leeuw, Lindsey, and Reading (2015), significant disparities in Indigenous women’s health are caused by historical and contemporary racist policies and practices that have shaped their lives, health and well-being, and access to health care.

The impacts of racism on health outcomes of racialized peoples, and related health care delivery practices, have been studied extensively, mostly in the US. Evidence is clear, in areas such as cardiac and cancer care, that race is a predictor of health outcomes and chances of timely referral for diagnostic testing and treatment (Brewer & Cooper, 2014; Menezes, Lavie, DeSchutter, & Milani, 2014; Tang & Browne, 2008). In a 2000-2010 review of cancer research, researchers compared lung, breast, prostate, and colorectal cancer mortality rates and mortality trends for
African Americans and whites in the US, statistically tracked cancer deaths according to race, ethnicity, and socioeconomic status (O'Keefe, Meltzer, & Bethea, 2015). Across all four cancers, even when controlling for SES, survival rates were consistently lower in African American people than in white people. The causes of these premature deaths are far-reaching; however, there is a growing body of literature that links cancer and other health disparities, among Indigenous peoples and peoples in the African diaspora, with systemic racism (Krieger, 2014). A 2017 study about heart health in Manitoba, Canada, found that, when compared to non-First-Nations people, First-Nations people are statistically significantly more likely to be younger and sicker when they receive their first angiogram to assess heart disease, and to be from a lower income quintile (Shultz, McGibbon & Fransoo, 2017).

Indigenous peoples, both women and men, are more likely to have cancers that are associated with a poor prognosis, and to be diagnosed at later stages; they are also less likely to receive adequate treatment, and are more likely to die from their disease (Kenyon, 2009). Lung and cervical cancer rates are particularly high, when compared to non-Indigenous populations (Moore et al., 2015). A 2015 Canadian study (Park, Tjepkema, Goedhuis, & Pennock, 2015) reported avoidable mortality for First Nations peoples in Canada—a measure of deaths that potentially could have been averted through effective prevention practices, public health policies, and/or provision of timely and adequate health care. Their longitudinal analysis compared avoidable mortality among First Nations and non-Aboriginal adults. First Nations women had almost 2.5 times the rate of avoidable mortality rates when compared to non-Aboriginal women (Park et al.).

Environmental racism is also implicated in Indigenous cancer rates, because toxic dumps and landfills are disproportionately, by far, located near racialized communities, regardless of region or country (Gosine & Teelucksingh, 2008; Waldron, 2018). Jacobs (2010) discusses the urgent need for environmental racism to be a central aspect of the decolonization of Indigenous peoples. In 2014, the Athabasca Chipewyan First Nation and the Mikisew Cree First Nation, in collaboration with researchers from the University of Manitoba, released a report Environmental and Human Health Implications of Athabasca Oil Sands (McLachlan, 2014). In his comments after the release of the report, Manitoba First Nations Chief Steve Courtoreille stated:

This report confirms what we have always suspected about the association between environmental contaminants from oil sands production upstream and cancer and other serious illness in our community. The Joint Oil Sands Monitoring Program has released data about the increases in these contaminants, but fails to address and monitor impacts to First Nations traditional foods. We are greatly alarmed and demand further research and studies are done to expand on the findings of this report. (Financial Post, 2014)

Results from this research demonstrated high concentrations of carcinogenic PAHs (polycyclic aromatic hydrocarbons), and the heavy metals arsenic, mercury, cadmium, and selenium in kidney and liver samples from moose, ducks, muskrats, and beavers harvested by community members. These contaminants are a result of bitumen oil extraction from oil sands. According to the report, contaminants in wildlife, as well as limited access due to declining water levels, have nearly eliminated the consumption of some traditional foods. Fish caught in Lake Athabasca and the Athabasca River are no longer trusted, while muskrat populations have
seriously declined. Compounding the impacts of environmental racism, existing healthcare services are unable to address related declines in Indigenous health (McLaughlin, 2014). These synergies among embodied racism Indigenous peoples have persistently worse health outcomes

**White Settler Racist Health Damage at Point-of-care**

Discrimination and racism continue to be part of the fabric and tradition of Canadian society, and have adversely affected racialized peoples, the health care system, and the health professions (McGibbon & Mbugua, 2017). It is difficult to understand, or come to grips with, the multifaceted pathways that lead health care providers to withhold care (racist lack of action) and to discriminate in their care (acts of racism). In the US, breast cancer patients have reported experiencing different forms of medical discrimination related to social class, race, and language, including inadequate or insufficient care based on their income levels, as well as health care practitioners making race, ethnicity, and educational assumptions that compromised quality of care (Quach et al., 2012). Even when other factors are considered equal, racial and ethnic stereotyping play a significant role in the health care that racialized patients receive (Loftin, Newman, Gilden, Bond, & Dumas, 2013). Racism in the Canadian health care system is a significant barrier in access to care (Allan & Smylie, 2015), and Indigenous women have reported consistently experiencing the structural violence of being silenced when they access health services, causing them to delay seeking services (Kurtz, Nyberg & Van Den Tillaart et al., 2008). In a qualitative study of barriers in access to health services for Aboriginal and African Canadians (McGibbon et al., 2005), results indicated that people in racialized families and communities were not offered available care, and not assessed in a timely manner when compared to their white counterparts. Although this study took place from 2004-2006, results are still timely. Table 2 provides participant contributions to the study.

<table>
<thead>
<tr>
<th>Table 2: Barriers in Access to Health Services for Rural Aboriginal and African Canadians (McGibbon et al., 2015)</th>
</tr>
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<tbody>
<tr>
<td><strong>Barriers: Health Service Providers</strong></td>
</tr>
<tr>
<td>“There is racial profiling in the health system. Aboriginal and Black people tend to be immediately treated differently and less competently. This treatment is related to systemic racism, racist attitudes of providers, and white privilege”.</td>
</tr>
<tr>
<td>“In terms of cultural literacy and health literacy, there is a lack of culturally appropriate health information, and a tendency for health workers to not take care to give available information”.</td>
</tr>
</tbody>
</table>
| “Aboriginal people are not offered available care, not assessed in a timely manner when compared to white counterparts. There is a lack of personal attention from service providers, a habit of ignoring | “There is power without accountability: “How can provincial professional organizations be held accountable for racist actions, forced to uphold a code of ethical conduct?... The current system does not provide a reliable method. In

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the concerns of Aboriginal and Black people; this leads to incompetent care, lack of assessment”.

“There needs to be cultural sensitivity/cultural competence education in the health system and in professional education of health providers: not just the learning of skills- they need to change values…This training is especially needed in rural areas where service providers become very comfortable having the privilege of ‘saying what they want’…Training needs to be anti-racist and human rights oriented”.

“Communities are used for experimentation in terms of treatments, including over-prescription; this needs to be addressed and changed”.

“The effects of the intersection of race, class and gender need to be considered in terms of how service providers treat people and respond to their needs, for example, to be a woman, a Black woman, and an ordinary Black woman. Service providers are unable or unwilling to provide proper, compassionate care unless you demonstrate some sort of privilege, such as being a professor”.

“There is a lack of accountability of professionals due to systemic racism”.

provincially funded health and social services, when something goes wrong in a person’s care, there is a one-sided investigation of complaints, often with no offer of an explanation, no accountability, no compassion”.

“Questioning people in power and authority is very difficult, takes much energy, resilience and support, yet it is so important to do because you or your family members will die if you don’t speak up. Obtaining safe care is very difficult and energy draining”.

There is tremendous stress associated with advocacy struggles and the process of overcoming these barriers; individuals and families are sometimes punished for bringing advocacy issues to light”.

“We need to become skilled at fighting a system that is prone to retaliation”.

In the first phase of a study about the heart health of First Nations peoples in Manitoba, Canada, researchers concluded that access to cardiac assessment interventions may be compromised by systemic racism (Schiltz, Dhal & McGibbon, et al., 2018). Decades of research has also found that stereotyping and racial bias mean that racialized patients are consistently less likely to be given medications for pain across all major medical specialties (Griffin, Polit, & Byrne, 2007; Meghani et al., 2012). As Matthews (2017) points out:

…a modern industrial health care system can be a determinant of ill health, especially where it is culturally unsafe. At present, Canadian health care for Indigenous peoples is not culturally safe, owing to the ways that law, health policy, and health practice continue to erode Indigenous cultural identities. (p. e78)

Many white settler health care practitioners and researchers have difficulty accepting the results of studies about racism at point-of-care—a curious paradox, since the studies are using the same mathematical/statistical analyses that are most respected by these same practitioners and researchers: How could ‘objective and unbiased science’ prove something as nebulous as racism? This is the conundrum that white settlers must confront, head on. We cannot have it both ways—claiming that our science is the only valid science, yet dismissing the results of our science when it exposes our complicity in racist oppression of Indigenous peoples.
White settlers resist truths about racist discrimination, in part because racism is embedded in our culture, and in its economic and political structures. The same holds true for unearned privileges associated with all the isms, including heterosexual orientation, being male, being white; and belonging to a Christian faith or a higher social class (McGibbon & Mbugua, 2017). White settler racist health damage has its roots in the cycle of oppression (see Figure 1), where point-of-care research has shown that when Indigenous peoples seek health care, stereotyping, prejudice, and discrimination are common (Browne, 2017; Cameron, Carmargo Plazas, Salas, Bourque Bearskin, & Hungler, 2014).

We all hold stereotypes about individuals and groups of people. Stereotypes are exaggerated, oversimplified, fixed images, where the same characteristics are attributed to all members of a group, regardless of differences. Stereotyping is based on false or incomplete information, generalizations, and misconceptions.

**Figure 1. Cycle of Oppression**


In the case of Mr. Brian Sinclair, a 45 year old Indigenous man who was also a double-amputee, racism was implicated in his death. He was referred by a community physician to the Health

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Sciences Centre in Winnipeg in 2008, complaining of abdominal pain and a catheter problem. The inquest into Mr. Sinclair’s death reported that he was ignored by staff, and that emergency room visitors repeatedly asked the nurses and the security staff to attend to him. The inquest also reported that some staff stereotyped Mr. Sinclair as ‘a drunk’ homeless person.

Stereotyping led to prejudice, preconceived opinions and ways of thinking, based on stereotypes about Mr. Sinclair as he waited for care and treatment. Prejudice led to discrimination, in this case lack of action. Mr. Sinclair was left in distress and without emergency care for 34 hours. He died in the emergency department, and was then left unattended for several more hours until rigor mortis occurred. Discrimination was backed up by institutional power (oppression), in this case a health care system with embedded allowances for clinical treatment based on discrimination, as well as a legal system that hid racism under the guise of ‘access block’ and ‘patient flow problems’ (Zbogar, 2014).

The Sinclair family, their legal counsel, and local Indigenous leaders asked the provincial Inquest into the matter to strongly consider the ways in which Mr. Sinclair’s race, disability (Mr. Sinclair was a double amputee and had suffered some cognitive impairment), and social class resulted in his lack of treatment. (Leyland, Smylie, Cole, et al., 2016, p. 4)

Oppression is also reflected in the 2016 death of Mr. Hugh Papik, a 67 year old Elder from the Northwest Territories. Staff at his care home called his daughter and told her to pick him up because he was drunk. Mr. Papik had a history of heart problems, but none of drinking. Despite these facts, staff at the local health center did not perform a physical exam. By the time his niece persuaded medical staff to fly Mr. Papik to a hospital in Yellowknife, he was declared brain dead and removed from life support. In the investigation into Mr. Papik’s death, Territorial Health Minister Glen Abernethy stated that recommendations from the investigation will help to address systemic racism in health delivery (Weber, 2016).

These narratives are examples of how the cycle of oppression can operate in the health care system, even without health care practitioners and policy-makers noticing, or being able to identify, their related thoughts, behaviors, and racial profiling. Another example of the cycle of oppression involves the missing and murdered Indigenous women and girls. The media, legal and policing systems delivered inadequate and unjust discriminatory treatment, based in a long history of stereotyping Indigenous women through the lens of Eurocentric patriarchy. In the macro or structural realm, micro-aggressions of discrimination continue to be backed up by the Canadian government. In 2017, the Native Women’s Association of Canada (NWAC) released its Report Card assessing the progress of the Commission for the National Inquiry into the Missing and Murdered Indigenous Women and Girls (NWAC, 2017). The Canadian government, through the Commissioners, received a failing grade on 10 of 15 assessment areas, and no passing grades on the remaining five areas—a troubling example of discrimination backed up by systemic, in this case, Canadian government power.

White Privilege, Settler Privilege

The cycle of racist oppression of Indigenous peoples has its base in white, settler privilege, the other side of the racism coin. A common misconception about racism is that white settlers must be able to notice and identify their racism for it to even exist. We may feel angry and offended if someone points out a racist act, because ‘we are not racist’ (McGibbon & Etowa, 2009).
care racism is very difficult to grasp for white people, unless we have examined our own privilege (McGibbon & Mbugua, 2017). Understanding white privilege is very challenging because it involves ‘nice’ people also being complicit in racism, even if they are not aware of their role (McGibbon & Etowa, 2009). This is why white privilege is described as an invisible knapsack—a set of unearned advantages, opportunities, and authorities that are based solely on having white skin, and confer life-long increased access to the resources necessary for optimal health and wellbeing (McIntosh, 1998).

In her analysis of whiteness and the nursing profession, (Puzan, 2003) stated that whiteness is also a socially constructed category of race (Caucasian), although only non-white people are viewed as belonging to a race. White people thus escape a racial designation, and occupy positions that allow them to carry on as if what they say is neutral, rather than historically situated (Puzan, 2003). White privilege is fundamental in the perpetuation of health care as a site for ongoing colonization. An understanding of the ways that white privilege operates in an everyday way is pivotal in understanding paths to address stereotyping, discrimination, and oppression in health care (Table 3).

Table 3: Everyday Privilege when White Settlers Seek Health Care

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Outcome</th>
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<tbody>
<tr>
<td>When I require pain medication after knee surgery, I can be pretty sure</td>
<td>That I will not be refused pain relief because: “Indian women have a</td>
</tr>
<tr>
<td>that I will not be refused pain relief because: “Indian women have a</td>
<td>high pain tolerance”.</td>
</tr>
<tr>
<td>I ask my community health practitioner for pain medication to treat a</td>
<td>serious workplace back injury, I can be pretty sure that I won’t be</td>
</tr>
<tr>
<td>serious workplace back injury, I can be pretty sure that I won’t be</td>
<td>accused of “drug seeking, because Natives are usually addicts and</td>
</tr>
<tr>
<td>accused of “drug seeking, because Natives are usually addicts and</td>
<td>alcoholics”.</td>
</tr>
<tr>
<td>I show up at the emergency department with dizziness and nausea, I can</td>
<td>be pretty sure that I will not be stereotyped by health care practitioners</td>
</tr>
<tr>
<td>be pretty sure that I will not be stereotyped by health care practitioners</td>
<td>as “another drunk Indian”, and receive substandard treatment or</td>
</tr>
<tr>
<td>as “another drunk Indian”, and receive substandard treatment or life-</td>
<td>threatening neglect.</td>
</tr>
<tr>
<td>threatening neglect.</td>
<td></td>
</tr>
<tr>
<td>I show up at the emergency department for urgent follow-up related to my</td>
<td>I can be pretty sure that the first question from emergency room health</td>
</tr>
<tr>
<td>cardiac surgery, I can be pretty sure that the first question from</td>
<td>care practitioners will not be: “When was your last drink?”</td>
</tr>
<tr>
<td>emergency room health care practitioners will not be: “When was your</td>
<td></td>
</tr>
<tr>
<td>last drink?”</td>
<td></td>
</tr>
<tr>
<td>I am admitted to a hospital maternity unit to give birth to my fourth</td>
<td>I won’t hear one of the nurses say: “Oh Native women are used to having</td>
</tr>
<tr>
<td>baby, I won’t hear one of the nurses say: “Oh Native women are used to</td>
<td>lots of babies. She won’t need much attention from us”.</td>
</tr>
<tr>
<td>having lots of babies. She won’t need much attention from us”.</td>
<td></td>
</tr>
<tr>
<td>I give birth to my baby, and my parents, grandparents, and children</td>
<td>I can be pretty sure that one of the health care staff will not say:</td>
</tr>
<tr>
<td>arrive with a celebration meal, I can be pretty sure that one of the</td>
<td>“There’s always so many of them. They always travel in packs and there’s</td>
</tr>
<tr>
<td>health care staff will not say: “There’s always so many of them. They</td>
<td>no room for them here”.</td>
</tr>
<tr>
<td>always travel in packs and there’s no room for them here”.</td>
<td></td>
</tr>
</tbody>
</table>

Source of Quotes: Quotes are actual, verbatim, comments heard in clinical situations by myself, my students and my colleagues in the course of our clinical practice.

Michele Fine (2004) explains the paradox of the invisibility of white privilege, on the one hand, and the powerful advantages that whiteness conveys:

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I find myself trying to understand the micromoves by which whiteness accrues privilege and status within schools; how whiteness grows surrounded by protective pillows of resources and second chances; how whiteness, of the middle class and elite variety in particular, provokes assumption of, and then insurance for being seen as ‘smart’” (p. 244).

The unearned gains that privilege bestows on white persons carries with it a logic of disadvantaging others, thus creating a duality of dominance/subordination, freedom/restriction, access to correct means/lacking access to correct means, and order/disorder (Hagey & MacKay, 2000). White privilege is foundational in the creation and maintenance of racial oppression in healthcare. Settler privilege happens in tandem with white privilege—they operate in synergy. Settler privilege confers both explicit and tacit advantages that are just as invisible to settlers as white privilege.

Settlership involves an *a priori* claim to the land and the natural resources of Canada. We assume we own them, and that we are the natural and logical stewards of land allocation, land use, and the ‘management’ of the natural world around us. We rarely question our moral, intellectual, philosophical, and creative rights to take over this stewardship. In fact, we have demonstrated that we respond swiftly, and sometimes brutally, when this stewardship is publically called into question (e.g. the Oka Crisis in Quebec; fracking in New Brunswick; Treaty violations over mining, mineral, and rainforest extraction in British Columbia; Treaty rights violations related to Nova Scotia fisheries). An examination of settler media coverage of these largely events reflects the same stereotypes heralded by Sir John A. Mac Donald and Lord Amherst over a century and a half ago: We know best, natives are violent (savage), it’s our land now, we need it for further expansion (of golf courses, etc.) and extraction (of minerals, fish, gas, old growth forests, etc.), so let us get on with our development to make this country a better place.

All health care, in what is now known as Canada, takes place on the ancestral and unceded territories of Indigenous peoples. Unceded refers to the fact that Nation-to-Nation treaties were crafted and ratified across Canada between Indigenous peoples and European, white settler officials. Settlers, including the Canadian government, eventually and illegally ignored these territorial land treaties. When we view white settler health care racism in this light, we see that the very land that health care institutions are built upon are active and symbolic sites of the perpetuation of colonization. Table 4 provides everyday examples of how white settler privilege operates in health care.
### Table 4: Everyday White Settler Privilege in Health Care

#### If I am a White Settler Health Care Provider, Teacher, or Researcher
- When I am employed in my first clinical practice position, I can be pretty sure that most of my colleagues will be of my white, settler race.
- If I ask to speak to the ‘person in charge’ when I am advocating for ethical patient /family /community care, I can be pretty sure that I will be facing a person of my own white settler race.
- If my clinical interventions include special bandages, splints or prosthesis, I can be pretty sure that the color of the materials used will reflect my white settler skin color.
- When I assess newborns with the Apgar score, I can be sure that the instrument is designed to assess white settler newborns.
- Whether I work in a hospital or in the community, I can be pretty sure that the Board of Directors, who govern my workplace, will be mostly white settlers.
- If I lobby my municipal, provincial/territorial or national political representatives about a health related issue, it is most likely that I will be talking to a person of my white, settler race.
- When I attend conferences, professional meetings, and when I search health literature, I can be nearly certain that the worldview underpinning the thinking will be aligned with my worldview— Eurocentric and biomedical.
- When I apply for research funding, I can be pretty sure that most finding decision makers, and funding agency policy-makers, will be of my white, settler race.

#### If I am a White Settler Health Care Student
- If I decide to further my education at the baccalaureate, masters, or doctoral level, I can be pretty sure that most of my professors will be persons of my race.
- When I study for my exams, my textbooks will mostly depict persons of my race.
- When I study health care theories and perspectives, I can be sure that the theorists are of my race.
- In my class about historical health influences, when I speak up about the Irish potato famine, I can be pretty sure that I won’t be accused of being stuck in the past, or taking things too seriously.
- When I learn about family and community health, I can be pretty sure that my textbooks, assignments, and class discussions largely reflect my own white settler perspective.

#### If I am a White Settler Health Care Accreditor or Policy-Maker
- When I design health care evaluation materials, I can be almost certain that the ideas and theories I use will reflect those of my white settler race.
- When I meet with my Hospital Accreditation Team, I can be almost certain that the accreditation guidelines, compliance forms and procedures, and reporting processes will reflect my Western, Eurocentric worldview about how to assess the safety and ethics of hospital care.
- When my team meets to discuss our Accreditation Report, I can be pretty sure that I won’t be asked to speak for all white, settler people when we write the health care accessibility section.
- When I design public policy intervention to reduce wait times in the emergency department, one of the first things I think about won’t be concern about how my family members are often racially profiled when they seek emergency care.
- When I evaluate health and social policy about violence against women, I won’t be thinking about how my sisters and my daughters have a far greater chance of being missing or murdered.

Adapted from McGibbon & Mbugua, 2017; McGibbon & Etowa, 2009.
Health Care, Racism, and Colonization

To the memory of my ancestors, who managed to ensure the survival of the Mi’kmaq People by their awe-inspiring tenacity and valour in the face of virtually insurmountable odds! For more than four centuries these courageous, dignified, and heroic people displayed a determination to survive the various hells on earth created for them by Europeans with a tenacity that equals any displayed in the history of mankind. May their brave accomplishment inspire the Mi’kmaq and other oppressed peoples to meet the challenges of today and tomorrow. (Daniel Paul, 2007, p. vii)

Health Care Racism is a Historical and Ongoing Colonizing Force

Colonialism refers to that form of empire building imperialism in which geographic regions outside of Europe were occupied by European countries and ‘settled’, a strategy that was justified through a racialized colonial discourse about the necessity of civilizing the world (Kim, 2016). Although most Canadians view colonialism as something that happened in the past, the term neocolonialism signifies that colonialism continues as an extension of centuries-old Treaty violations, intergenerational trauma, and new forms of colonial power. Neocolonialism is literally ‘new colonialism’, which includes “any and all forms of control of prior colonies or populations such as Indigenous people, who continue to live under conditions of internal colonialism” (Kirkham & Browne, 2006, p. 334).

The colonial experiences of Indigenous peoples around the globe have rendered them strangers in their own country. The brutal attempt at colonial annihilation of Indigenous peoples in Canada is largely kept hidden from view, in health care education and policy making, in popular culture, and in the vast literature that we call Canadian. Most Canadians do not know that when colonial government officials in South Africa sought a template of methods to subjugate, brutalize and destroy the Indigenous peoples in its nation, they came to Canada and consulted the Canadian government. White settler colonizers of Canada were recognized as international experts in the systematic processes of dispossession, relocation, and genocide of Indigenous peoples. South African apartheid was directly informed by already existing Canadian apartheid against Indigenous peoples.

In Canada, we have a complex history when it comes to race, racism, racialization, and colonization. By the 1930s, officials in the Canadian government assumed that Indigenous people were a dying race. The erroneous notion that Indigenous peoples were significantly inferior, along with economically-motivated greed, justified the Europeans’ genocide, and the colonizing of vast swathes of land and natural resources. Naturally-occurring racial differences became the basis for systems of exploitation and discrimination (McGibbon & Etowa, 2009). In analyzing the status of Indigenous people in contemporary Canada, (Patterson, 1972) identifies two viewpoints. One is that Indigenous people are treated as if they are one of the many ethnic groups which together constitute the cultural backdrop of Canada, and they should acculturate sooner to facilitate integration into the Canadian ‘norm’. Terms such as ‘cultural mosaic’ and ‘multicultural society’ reflect this viewpoint. The second view is that of a bi-cultural Canada: French and English, and everyone else, including Indigenous peoples, must assimilate to one of these two cultures (Patterson, 1972). Both of these views are grounded in the belief that colonialism is over and should be forgotten, and along with the current language of ‘vulnerable population’ in health care,
renders Indigenous worldviews of health invisible and silenced. More accurately, Indigenous peoples are a ‘population under threat’ of persistent colonial damage.

According to Thira (2006), European settler colonization of Indigenous peoples of Canada followed several waves: 1) legal—legislation to identify and control the Indigenous population through the suppression of legal rights, based on the view of Indigenous peoples and communities as savage; 2) administrative—systematic implementation of a reserve system designed to isolate Indigenous groups and claim their traditional lands, based on the view of Indigenous peoples and communities as ‘heathen’; and 3) ideological—systematic implementation of a Residential School and Foster-parent System, which were originally intended to assimilate, and later separate Indigenous peoples from the non-native mainstream, based on the view of Indigenous peoples and communities as deficient (Thira). Modern day colonization demonstrates similar kinds of predation: deadly neglect in the health care system; criminalization of Indigeneity (Razack, 2015); persistent corporate pillaging of Canada’s ecosystem, a form of modern ecocide; and government policy-based oppression in the persistent need for Indigenous peoples to prod various government jurisdictions to take action to fulfil global human rights commitments. Health care, and the health care system, are a pivotal mechanism of modern day Canadian colonization of Indigenous peoples—the fourth wave (Thira, 2006). In response to the consequences of relocation, loss of rights and criminalization of culture, and the IRS System:

…a fourth, medical, wave of colonization and genocide has been created—a social welfare industry made up of therapeutic foster homes, treatment facilities, and consulting mental health and social service professionals (not to mention researchers and academics) who have shifted the label from ‘savage’, ‘heathen’, and ‘deficient’ to ‘sick’ Indian and/or community. Aboriginal people and communities are victims who now require help form the very colonizers who harmed them. (Thira)

In the face of substantive global evidence—much of it meeting the research protocols valued by white settlers—about the relationship between racism and health, white settlers still often cling to the belief that genetic factors are responsible for these differences. With some notable exceptions, white settler health care practitioners, policy-makers, administrators, and researchers are still grounded in the rhetoric of individual causality. Limiting the medical gaze to the individual, micro sphere of causation is based in Western, Eurocentric biomedical ways of knowing. Although racism is a root cause of health inequities for Indigenous peoples, in the health fields, the dominant view is that lifestyle factors are the most important causes of illness, Indigenous peoples are to mostly to blame for their predicaments, and Indigenous people ‘don’t care enough’ about themselves to look after their health, or they ‘just don’t understand’. Daschuck (2013) states that settler views of Indigenous peoples as inherently sick or ill began with the completion of the Canadian Pacific Railway in the late 1800s. The railway brought a wave of fatal epidemics of measles, whooping cough, and influenza to a population that already had high rates of tuberculosis as a result of starvation tactics of the Canadian government and its food contractors at the time. Officials claimed that the chronic sicknesses of the Indigenous population were a condition of their race, and therefore, tuberculosis was largely hereditary. “By the early twentieth century, the notion that Indigenous people were more biologically susceptible to disease than the mainstream population was medically and politically orthodox” (Daschuck, p. 185).
White settlers’ implicit biases toward Indigenous peoples is compounded by their individualistic focus, creating a decidedly negative, and sometimes dangerous context for practice, policy-making and research, all of which contribute to racism in policy-making and at point-of-care. In this sense, however well-meaning, white settler health care providers are complicit in the perpetuation of racism in health care, and hence the perpetuation of our colonial legacy. Yes, factors such as diet and exercise do indeed cause heart disease, but these are not the root causes. No amount of patient teaching about diet and exercise will undo centuries of colonialism, racism, and slavery, and their current intergenerational impacts on the health of racialized peoples (McGibbon & Etowa, 2009). Settler health care continues to be largely based on the belief that the individual, and perhaps the family are the focus of care—that the whole can be reduced to the sum of its parts, as if families, communities or nations exist in these discrete, apolitical forms (McGibbon, 2016). If we have any doubt of the dominance Eurocentric, settler biomedicine, and its impact on Indigenous health:

…we need only think about our health system encounters. If we have a problem with one of our bones, we go to, or are referred to, the bone specialist (orthopod); if we have a problem with our skin we go to the skin specialist (dermatologist); if we have a problem with our ovaries we go to the ovary specialist (the gynecologist); if we have a problem with depression we go to the depression specialist (psychiatrist), and so on. Eurocentric thinking about health is so grounded in a focus on body parts that it is very difficult for many of us [white settlers] to even envision any other way to consider health. (p. 167)

This micro focus locates the problem, the ‘sickness’ in individual Indigenous people, while at the same time reinforcing the powerful message that microanalyses are sufficient and desirable. Colonialist, biomedically-infused thinking permeates settlers’ worldviews and the worldviews of system decision-makers in the socio-political institutions of health, justice, and education, to name a few. Colonial power and influence of these societal structures are largely invisible to most white settlers. Although these structures shape and control our ways of thinking, colonial processes and structures operate mostly without our direct observation, or any explicit, public critique. A related cornerstone of Western biomedicine is empiricism—the claim that a priori facts and truths exist and that knowledge of these facts or truths may be developed from that which is directly observable (Cruickshank, 2012). The biomedical version of empiricism is especially problematic because choices about where and how to even look for ‘facts and truths’ are filtered through the lens of colonial dominance. The relatively recent rhetoric of evidence-based practice, grounded in empiricism, also becomes open for scrutiny. Dominant evidence, by far, is based in white settler worldviews and ways of knowing. Empiricism, the dominant mode of thinking in the health fields, supports the everyday invisibility of historical and new practices of colonization. In the larger context, dominance of settler biomedicine also serves to suppress Indigenous healing practices, and inclusion of Elders in the health care of Indigenous peoples.

Performing Decolonization

Decolonizing health care is ultimately an embodied process for white settlers—embodied in the sense of movement, action, thinking, feeling, and understanding. As such, decolonizing is about everyday performing of commitments, ethical decision-making, and, solidarities with Indigenous peoples, communities, and Nations. Performance is informed and re-informed as
settlers wake up to the truths of our shared histories in Canada. Lila Watson, Murri Indigenous Elder, Activist, and visual artist in Australia underscored this solidarity: “If you have come here to help me, you are wasting your time, but if you have come because your liberation is bound up with mine, then let us work together”. Elder Watson credits this quote to Aboriginal activist groups in Queensland, Australia in the 1970s.

Canadian health care sustains colonization in many ways, including: 1) designing and delivering services that are focused on micro, individualistic and Eurocentric perspectives on the SDH; 2) denying and minimizing Indigenous ways of healing, and the insights and recommendations of Indigenous Knowledge Keepers; 3) Actively and passively engaging in racism at point-of-care, a practice that is created and sustained by health care policy makers in institutional level and public policy realms; 4) Failing to make cultural safety a national, policy-based priority in health and human services; 5) Failing to develop national standards for embedding cultural safety in the educational curriculums of health professional education programs, and 6) Failure of health-related professional licensing bodies to systematically integrate cultural safety in their professional codes of ethics, so that practice licenses are tethered to cultural safety competence. These five areas provide a clear and concrete template for important white settler roles and responsibilities in decolonizing health care. It is also necessary to emphasize that the Canadian health care context involves a long term governmental ‘carrot-and-stick’ approach where government officials promise numerous inquiries into the modern-day diseases, deaths and murders of Indigenous peoples (e.g. The Commission into Missing and Murdered Indigenous Women and Girls), provide some hope of progress, and then extend the process for decades, with limited movement on the recommendations of Indigenous peoples and their allies (NWAC, 2017).

Decolonizing involves actively seeking knowledge about postcolonial ideas and imperatives. Although postcolonial theory has differing origins (e.g., anthropology, cultural studies, nursing, sociology), it provides a framework and vocabulary for understanding the burden of history and how this history shapes present-day experiences and new forms of injustice (Browne, Smye, & Varcoe, 2005). Postcolonialism is concerned with “the unequal relations of power that are the legacy of a colonial past and neocolonial present, and the ways in which the cultures of dominant groups have redefined local meanings, and dictated social structures, including health care delivery systems” (Henderson et al., 2003, p. 197). Decolonizing perspectives involve vocabularies and analytical lenses that critique the historical origins of colonization, neo-colonialism and their imperialist underpinnings (McGibbon, Mulauodzi, & Didham et al., 2013). Colonializing practices are exposed as root causes of sustaining white settler power structures and systems, such as racism in health care.

Decolonization is an iterative process, rather than an outcome. Postcolonial scholars emphasize that colonial oppression reaches backward and forward as a persistent influence on subjugated peoples (Paul, 2007). The concept of decolonization underscores the postcolonial imperative to expose, resist and transform the continuing presence and influence of colonial processes (McGibbon, Mulauodzi, & Didham et al., 2013). For white settlers, a first step towards reconciliation in health care is to continue to learn the facts, the truths, about how Canada today is a result of racist oppression of Indigenous peoples. In his writings on curricular and pedagogical transformation, Donald (2009) argued that work dedicated to the goal of decolonization in Canada must explicitly address the colonial nature of the relationships connecting Indigenous peoples and Canadians. Donald further explains that, although the outcomes were vastly different, the process

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of colonization happened synergistically among the colonized and the colonizers, and hence, decolonization should integrate this shared history.

If colonialism is indeed a shared condition, then decolonization needs to be a shared endeavour. I am convinced that decolonization in the Canadian context can only occur when Aboriginal peoples and Canadians face each other across historic divides, deconstruct their shared past, and engage critically with the realization that their present and future is similarly tied together. (Donald, 2009, p. 5)

Wilson and Yellow Bird (2005) describe decolonizing as, ‘the intelligent, calculated, and active resistance to the forces of colonialism that perpetuate the subjugation and/or exploitation of our minds, bodies, and lands … [with] the ultimate purpose of overturning colonial structures and realizing Indigenous liberation’ (p. 223). According to Marie Battiste and Sa’ke’j Youngblood Henderson (2012), decolonization involves affirming and activating paradigms of Indigenous knowledge to reveal the wealth and richness of Indigenous languages, worldviews, healing and self-determination practices, teachings and experiences, all of which have been systematically excluded from history, from contemporary educational institutions, and from Eurocentric knowledge systems. Identifying and addressing the persistent reach of neocolonialism, and the imperialism that underpins it, is a significant aspect of decolonization (McGibbon, Mulaudzi, & Didham et al., 2013). A feminist postcolonial stance further provides the “grounds for interrupting ahistorical, generalizing, essentializing, culturalist and racializing discourses” (Anderson & McCann, 2002, p. 13). In its broad sense, decolonization is a method required to shift the current paradigm of Western dominance and colonial amnesia that constructs and maintains diminished health outcomes, and related inequities in the SDH of Indigenous peoples (Sherwood, 2009).

### Decolonizing with Critical Perspectives on the Social Determinants of Health

If settlers, including public policy-makers, persistently box themselves into an apolitical, individualistic, body-part-focused framing of human health, then there is little room for questioning the structural determinants of inequities in the SDH (McGibbon, 2017, 2009). Although the concept of SDH is now well-recognized by most white settlers in health care, there often remains a persistent denial of the structural power antecedents of inequities in the SDH. Figure 2 is an adaptation of Raphael’s (2012) critical perspectives on the SDH. It shows white settler TRC roles and responsibilities for shifting biomedical, individualistic thinking to integrate these structural or root causes of settler oppression of Indigenous peoples. White settler ‘facts’ about the SDH keep us largely stuck in the middle of the SDH spectrum, and as some would argue, many of us are stuck closer to the first area in the spectrum.
In the micro, individual area of the spectrum, SDH help us identify Indigenous people requiring health and social services. In the next area, simple identification of Indigenous people in need of services is extended to Indigenous SDH being linked to modifiable, individual medical and behavioural risks. Then, SDH are indicators of the material and living conditions that shape health, and we begin to see that these conditions are different as a function of being Indigenous. When we start to move towards acknowledging the structural roots of inequities in the SDH, we see that SDH and their distribution are different as a result of colonialist public policy. We then connect colonialist policy-making to the underlying cultural, political, economic and social structures that influence and dictate policy-making. Finally, we deliberatively flip the coin and expose the ways that SDH and their distribution are the result of racist power and influence of those who create and benefit from white privilege and Indigenous health and social inequities. An example here is Canadian government complicity in transnational corporate profit from mineral and mining extraction, and rain forest depletion on ancestral and unceded Indigenous territories, all of which severely impact Indigenous health. Overall, Figure 2 provides a summary of many of the analyses in this paper.

**Decolonizing with Allyship**

White settlers involved in health policy-making, health care practice, health research of any sort, and health care education, are particularly challenged in stepping out of our colonial amnesia and mirage of neutrality. It is exceedingly difficult for us to ‘see’ any other way of knowing because we are daily involved in enacting (performing) the principles of biomedical positivism. For many settlers in health care, put simply: We don’t know what we don’t know. This invisible, dominant stance makes it difficult for us to come to grips with a simple philosophical truth: all worldviews, including our own biomedical views, are biased according to our font of knowledge, our cultural history, our experiences of privilege and disadvantage, and our moral compasses.

The role of allyship involves a process for white settlers to make visible their cultural and epistemic domination (hegemony) in health care. Being an ally has a longstanding history in antiracist literatures and actions (Bishop, 2015), and the term ally has evolved to allyship, because antiracist practices are a process, not a static identity (McGibbon & Mbugua, 2017). Allyship is when those who experience privilege consistently strive to recognize their privileges, and to actively work within an anti-oppressive stance.

[Allyship] is a lifelong process of building relationships based on trust, consistency, and accountability with marginalized and racialized individuals and/or groups of people...it is
an active, consistent, and arduous practice of unlearning and re-evaluating, in which a person of privilege seeks to operate in solidarity with a marginalized group of people. (Anti-Oppressive Network, 2017, p. 1)

Allyship forms the center in settler action for decolonizing health care. We enter into a constantly opening and re-opening space, where white settlers actively listen, every day, to the voices of those with whom we are allying ourselves (McGibbon & Mbugua, 2017). According to Utt (2013), we cannot simply decide we are allies. “Being in solidarity is something we can strive for, but in the end, it is the choice of those we are attempting to ally ourselves with, as to whether they trust us enough to call us an ally” (p. 1).

Voice is a foundation of allyship—being constantly mindful of whose voices are considered important, or even listened to, in health care in Canada. Since we are already immersed and dominated by a Eurocentric, biomedical health care system, attending to silenced voices and recognizing how this power operates, are a primary imperatives for decolonizing health care. These forms of allyship are critically important in the path towards confronting oppression in health care. Those who act in allyship recognize that people who experience racist oppression can never take a break, the isms never go away, and they are experienced relentlessly (Anti-Oppressive Network, 2017). Those of us with privileges, including white settler privilege, also have the privilege of looking the other way. Racialized peoples “have no choice but to weather the storm of racism every single day of their lives. Women have no choice but to weather the storm of misogyny every day of their lives. Differently abled people have no choice but to deal with and respond to ableism every day of their lives” (Utt, 2013, p.1). Indigenous peoples in Canada have no choice but to weather the storm of racism, and denial of their histories, every day of their lives. Practicing allyship means that our needs are secondary to those of oppressed individuals, groups, and peoples (McGibbon & Mbugua, 2017). Bishop Desmond Tutu famously said: “If you are neutral in situations of injustice, then you have chosen the side of the oppressor. If an elephant has its foot on the tail of a mouse, and you say that you are neutral, the mouse will not appreciate your neutrality” (Tutu, 2009).

Allyship is about consistently and mindfully not taking breaks, not looking the other way, and openly talking about our own privileged positions. We build our capacity to receive criticism, to be accountable for our mistakes, and to recognize that mistakes are a turning point for us to move forward, to grow, and to do things differently (McGibbon & Mbugua, 2017; Bishop, 2015; Utt, 2013). White settlers with relative power, such as those in administrative positions in health care, and those who are higher up in professional power hierarchies, have a heightened responsibility to create specific spaces for these voices. Silence means assent—that we are complicit bystanders in the journey towards truth and reconciliation.

The TRC has already laid out specific recommendations for those of us in the health fields, and in related health and social policy making. The recommendations in Table 5 are based in a meticulous, systematic process of evidence-gathering across the country, and at all levels of governmental jurisdiction. Allies can start by deciding to promote, and insist on, using this list when we design health care and related policy (health in all policies) and programs, and curricular structures for educating health professionals. If white and settler privilege and anti-racist principles and practices are not integrated, then we are participating in an everyday sort of colonizing that is invisible, and continues to serve the dual purpose of maintaining white settler privilege and power.
Table 5: Truth and Reconciliation Calls to Action: Health

18. We call upon the federal, provincial, territorial, and Aboriginal governments to acknowledge that the current state of Aboriginal health in Canada is a direct result of previous Canadian government policies, including residential schools, and to recognize and implement the health-care rights of Aboriginal people as identified in international law, constitutional law, and under the Treaties.

19. We call upon the federal government, in consultation with Aboriginal peoples, to establish measurable goals to identify and close the gaps in health outcomes between Aboriginal and non-Aboriginal communities, and to publish annual progress reports and assess long-term trends. Such efforts would focus on indicators such as: infant mortality, maternal health, suicide, mental health, addictions, life expectancy, birth rates, infant and child health issues, chronic diseases, illness and injury incidence, and the availability of appropriate health services.

20. In order to address the jurisdictional disputes concerning Aboriginal people who do not reside on reserves, we call upon the federal government to recognize, respect, and address the distinct health needs of the Métis, Inuit, and off-reserve Aboriginal peoples.

21. We call upon the federal government to provide sustainable funding for existing and new Aboriginal healing centers to address the physical, mental, emotional, and spiritual harms caused by residential schools, and to ensure that the funding of healing centers in Nunavut and the Northwest Territories is a priority.

22. We call upon those who can effect change within the Canadian health-care system to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients.

23. We call upon all levels of government to:
   i. 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.

24. 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 residential schools, the United Nations Declaration on the Rights of Indigenous Peoples, 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.


*Decolonizing with Anti-racist, Anti-oppressive Health Care Practice*

Processes of decolonizing health care necessarily draw upon “traditions of postcolonialism and decolonial thinking, and their radical potential in unsettling and reconstituting standard processes of knowledge production” (Bhambra, 2014). The overarching role for settlers in actively participating in decolonizing health care is to unpack colonialist thinking, and shift Eurocentric, colonialist knowledge underpinnings of health care (e.g. clinical, leadership, policy-making, research, and governing practices). Anti-racism is a core settler role in reconciliation. In their book,
The colour of democracy: Racism in Canadian society, authors Frances Henry and Carol Tator (2009) described how racism operates in Canada: “Racist ideology provides the conceptual framework for the political, social, and cultural structures of inequality and systems of dominance based on race, as well as the processes of exclusion and marginalization of people of colour that characterizes Canadian society” (p. 16). When we engage in anti-racist, anti-oppressive practice, we consistently and deliberately examine and unpack these systemic structures. Understanding the white privilege that sustains racism is an important feature of anti-racist education (Dei & Calliste, 2000), along with the critique of liberal notions, such as individualism, equal opportunity, and colour-blindness (McGibbon & Etowa, 2009).

White settler racial stereotyping and profiling, and assumptions of intellectual, moral and cultural superiority, are at the heart of health care danger for Indigenous peoples. Education is important, but education alone will not likely produce lasting change and reconciliation. The structural origins of atrocities against Indigenous peoples are still present in the embedded racism of settler health care in Canada. This paper has described and analyzed many important aspects of anti-racist, anti-oppressive health care practice. Anti-racist, reconciliation action involves white settlers ’seeing’ the cycle of oppression, and how they may be participating in systemic discrimination. ‘Seeing’ their white privilege is a crucial step, and explicitly linking, or mapping, Indigenous health inequities to their root or structural causes. Indigenous inequities in the SDH did not materialize out of a weak genetic pool, or lack of ambition or intelligence, or deficits in creative capacity. Inequitable distribution of the SDH are the results of racist power and influence of those who create and benefit from white privilege, and sustained inequities for Indigenous peoples.

Anti-racist, anti-oppressive health care practice depends on dedicated and deliberative movement from actively supporting racism, white settler privilege and the supremacy of whiteness, on one end of the continuum, to naming, dismantling and preventing white settler privilege and power—exposing societal systems that create and sustain racism, white settler privilege and supremacy, and new forms of colonialism. In Figure 3, I synthesize and adapt Wijeyesinghe, Griffin and Love’s (1997) Social Change Continuum and Hesse’s (2004) Eight White Identities. The continuum is not a recipe for accomplishing reconciliation. Rather, it is a picture of an overall, ongoing process. Although the figure illustrates stages, they are overlapping and intertwined in a circular way at any given moment in time for white settlers. We move back and forth along the continuum according to our own knowledge, histories, circumstances, and commitment to change. We may actively participate in racist actions or inactions, and white settler privilege, such as laughing with our colleagues at racist stereotyping when we are designing public policy—the countless insider jokes of whiteness. We may be denying or ignoring racism and white settler privilege, and the need for cultural safety, truth, and reconciliation, with statements such as: ‘When I work with Indigenous patients, I don’t see race at all, I just see a patient in need’, or ‘Colonialism happened a long time ago. Canada is a much better place now, and it’s time for the Natives to let it go’, or ‘If we start integrating Indigenous SDH in our public policy-making at the federal level, then everyone will want special treatment’.

This thinking, along with associated privileges, renders truth and reconciliation unnecessary. Here, white settlers hold fast to their ‘neutrality’ in the face of need. On this end of the continuum, we reinforce the supremacy of whiteness. When we think of white supremacy, we most often think of disturbing and chilling historical racist contexts associated with the Ku Klux Klan in the US. In the context of Indigenous health care in Canada, the supremacy of whiteness is
writ large in the racism of our history. Here, it includes sustained control and power over public policy and other forms of decision-making, including: 1) stewardship of the land and natural resources, and decisions about protecting the environment (or not), 2) design, delivery and evaluation of health, social, legal, policing, and education systems, and their philosophical foundations, among others, 3) design and implementation of the governance and electoral processes of the nation, and 4) design and implementation of human rights instruments, along with decisions about which rights are more legal or valid than others (e.g. Treaty rights). This situation provides evidence of the supremacy of whiteness in Canada, which is largely invisible to white settlers.

The next phase of the continuum involves recognizing racism, white settler privilege, but not acting, not participating in cultural safety, truth and reconciliation. We silently benefit from assent—from holding firm as bystanders. Health care educators may recognize that colonialism impacts cardiac health, yet fail to integrate statistics about colonialism’s impact on Indigenous cardiac outcomes in our teaching about heart pathophysiology. We may recognize the need for cultural safety integration in our curriculum, yet stay silent when our colleagues lobby for more curricular inclusion. Public policy-makers may recognize that ‘centralization’ of mental health services will disproportionately impact Indigenous communities in their jurisdiction, yet stay silent during discussions to vote for centralization. As legislators, silence is a powerful way to agree with oppression. We may think, or say, ‘I don’t have an opinion because I don’t want to be biased’, or ‘One of my other colleagues always speaks up. There’s no need for me to have an opinion’, or ‘I think it’s best to be neutral when these topics come up’. The problem with these options is that silence is tacit agreement. If white settlers are ‘neutral’ or ‘objective’ or ‘unbiased’ about racism and colonialism, then we are silently agreeing, or worse, burdening Indigenous peoples and communities with the weight of speaking up (McGibbon & Mbugua, 2017).

Cultural safety, the embodied knowing and enacting of safeness, forms a powerful thread along the truth and reconciliation continuum. One of the ways that settlers have attempted to
redress the limitations of Eurocentric biomedical dominance is to integrate ethnicity, race and culture of Other people through development of the ideas of cultural awareness, cultural sensitivity, and cultural competence. These approaches all have similar and distinct limitations, including assumptions that ‘Others’ are seen as bearers of culture, or culturally exotic; and a clear lack of analysis of power. A focus on cultural diversity, diet, dancing, and dress of Others often persists, without an examination of entrenched power, privilege, and oppression. Embracing multiculturalism and diversity without an anti-racist lens serves to reinforce the privilege of dominant groups (Berman & Paradies, 2010), and a Eurocentric focus on health care knowledge development. In cultural diversity education, a focus on cultural competence, rather than societal power, racism, and white privilege, will have very different impacts on clinical relationships, and in reducing health disparities (Gustafson & Reitmanova, 2010). Enacting cultural safety provides a very real focus on the ways that historic and current intergenerational tragedies play themselves out in every health care encounter, and in every institutional decision (Aboriginal Nurses Association of Canada, 2009).

As we move from supporting to dismantling, we recognize racism, white settler privilege/supremacy and take action for cultural safety, truth and reconciliation—a complex and iterative process. Examples include systematically applying the language of white privilege; openly lobbying for more representation of Indigenous peoples in health care and educational institutions, public office, and the legal system; and publically acknowledging that we are on unceded, ancestral Indigenous territories when we teach, present, or conduct meetings—at this point we are publically ‘out’ about white settler privilege and supremacy. When we educate ourselves and our communities about racism and white settler privilege and supremacy, we commit to learning about processes such as IRS, genocide, the criminalization of Indigeneity, the Idle No More movement, Indigenous healing practices, Indigenous relationships with the land, and TRC calls to action. We openly discuss racism, privilege, supremacy with our families, and our communities of friends, colleagues and allies—organizing public meetings, classes, and so on, about historical contexts, white settler privilege, and the cycle of oppression. As we move forward, we initiate public, collective truth-telling about ruling, societal systems that sustain racism, colonialism, white settler privilege and benefit, and the supremacy of whiteness. We name, and work to dismantle and prevent, colonialism, exposing specific policies, practices, and societal systems that create and sustain racism, white settler privilege, benefit and supremacy; and new forms of colonialism.

In health care, first this means recognizing that societal structures are built, one log or brick over time, to produce a cohesive overall structure of power and privilege. In health care, the bricks include all of the events and processes, large and small, that exclude Indigenous healing practices, and make Canadian health care what it is today—Eurocentric, biomedical, individualistic models of care, and repetition of the cycle of oppression in policy-making, clinical practice, research, and legislation. The structure of health care rests on these bricks. Once we commit to opening and reopening these truths, then reconciliation is more likely, as we continue to see the truths about our complicity in colonization.
CONCLUSION

Decolonizing health care is an ongoing challenge because health field knowledge has evolved in synergy with colonial processes of racialization and domination. Racist notions of white superiority, and the inferiority of all. Others, are reflected in present-day health care knowledge and practices, professional codes of ethics, policy and position papers, and institutional policies and procedures (McGibbon, Mulaudzi, & Didham et al., 2013). It took us over 500 years to arrive at the current state of colonization. It has utterly changed who all of us are in Canada, and our health care path continues to unfold in step with this colonialist legacy. Colonial truths continue to be clouded and forgotten by intergenerational white settler amnesia—a practice that still permeates health care in Canada. Our reconciliation role is to move forward, in solidarity with Indigenous peoples, on a continuum of truth and reconciliation. Our responsibility involves sustained commitment to this movement, including commitment to bring along as many white settler people as possible.

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