Chapter 9
Fostering Cultural Safety in Health Care Through a Decolonizing Approach to Research with, for and by Indigenous Communities

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9.1 Introduction

On September 28, 2020, in the moments before her death at the Centre hospitalier de Lanaudière, Joyce Echaquan, an Atikamekw woman from the community of Manawan (Québec), broadcast live on social media the racist and degrading comments made towards her by the nursing staff (Kamel, 2021). This video quickly made the rounds of global media, generating shock, horror and outrage and triggering conversations about systemic racism against Indigenous peoples. The case of Joyce Echaquan is a poignant example of the racism that Indigenous peoples experience in the health system. Racism towards Indigenous peoples, whether interpersonal or systemic, is inextricably linked to colonialism, a racist ideology that presupposes the superiority of Western culture over others and permeates the structure of our public institutions (Allan & Smylie, 2015). Recently, in Canada, the Truth and Reconciliation Commission (2015), the National Inquiry into Missing and Murdered Indigenous Women and Girls (Buller et al., 2019) and the Public Inquiry Commission on relations between Indigenous peoples and certain public services (Gouvernement du Québec, 2019) have brought to light the discrimination, rights violations, trauma and harm suffered by Indigenous peoples with various institutions. These commissions have all called for actions to address the root causes of institutional violence and systemic racism through decolonization and cultural safety approaches based on respectful partnerships with Indigenous communities.

This tragic example leaves no doubt that health services are a high-level determinant of health that can increase the burdens of health inequalities for Indigenous

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populations and contribute to the systemic marginalization of minority groups. Health promotion, as a field of practice and research, has an important role to play to ensure equitable, anti-racist and culturally safe health care.

The purpose of the research discussed in this chapter is to contribute to reorienting health services by ensuring cultural safety in the provision of health care to Indigenous populations in the province of Québec (Canada). To do so, it aims to co-develop a new intervention model to ensure cultural safety for Atikamekw patients in the health system. The Atikamekw Nehirowsiw are a Nation that is part of the Algonquin cultural area and upholds values such as caring for extended family and community members, respect for Elders, equality between men and women and a close connection with the land (Atikamekw Sipi, 2019). Three Atikamekw communities are located in the traditional territory of Nitaskinan, in the Saint-Maurice River Valley (Québec): Manawan, Wemotaci and Opitciwan. These three communities together comprise around 7800 members, most of whom speak Atikamekw. The Atikamekw were traditionally a nomadic people, and many traditional activities such as fishing and hunting continue to be practised today. Like many Indigenous peoples, the Atikamekw have unique and specific cultural health practices, traditional knowledge and perspectives on health, which are central to their well-being but are often devalued or ignored by Western science and medicine (Tremblay et al., 2020). This research has been developed and implemented in full partnership with the Atikamekw communities of Manawan, Wemotaci and Opitciwan, as well as with the Atikamekw Nation Council (ANC), to address the concerns and needs that they have identified.

9.2 What Is Cultural Safety?

Indigenous peoples in Canada experience substantial health inequities, including shorter life expectancies, higher rates of suicide and greater prevalence of mental illness and chronic and infectious diseases (Hackett et al., 2016; Kolahdooz et al., 2015; Loppie Reading & Wien, 2009; Zambas & Wright, 2016). These inequities result from the continuing impact and lasting effects of colonialism on health determinants such as access to health services (Gao et al., 2008; Loppie Reading & Wien, 2009; Marrone, 2007; Peiris et al., 2008). Barriers to health services access include programmes and interventions inherently structured on the basis of dominant (Western) cultural values, principles and perspectives not relevant to Indigenous patients' needs (Jacklin et al., 2017; Kolahdooz et al., 2015; Tang & Browne, 2008). Health services built and managed in keeping with Western worldviews have reinforced Western cultural supremacy, making it possible to socially and politically disavow traditional Indigenous health practices and knowledge (Gouvernement du Québec, 2019). As a reflection of the structural racism embedded in social institutions, interactions between Indigenous patients and health providers are often characterized by stigmatization, discrimination and racism (Allan & Smylie, 2015; Gouvernement du Québec, 2019; Jacklin et al., 2017; Janzen et al., 2018; Loppie

Reading & Wien, 2009; Reading, 2009; Tang & Browne, 2008). Research has demonstrated that patients who experience racism and discrimination when receiving health care tend to anticipate such interactions with health professionals, underutilize healthcare services and under-report their symptoms to health professionals (Allan & Smylie, 2015; Tang & Browne, 2008). This increases the intensity and frequency of crisis situations and delays screening and provision of care (Allan & Smylie, 2015; Gouvernement du Québec, 2019). Along with other microaggressions and environmental stressors that diminish the capacity to manage stress, experiences of racism and discrimination in health care contribute to the allostatic load of Indigenous populations, precipitating the decline of biological functions and increasing the risk of physical illnesses (Duru et al., 2012).

Many health professionals respond to the issue of racism by aiming to be socially and culturally neutral in their practice, consequently adopting a "culture-blind" approach to service delivery (i.e. asserting that race or ethnicity should not affect treatment) (Beagan & Kumas-Tan, 2009). However, this approach wrongly assumes that neutrality is possible and desirable while hindering recognition of the substantial impact of historical and socio-cultural factors on Indigenous patients' health. Health professionals who adopt a so-called "culturally neutral" practice may ignore the significant influence of generalized social patterns on Indigenous health (Beagan & Kumas-Tan, 2009), e.g. how intergenerational trauma and frequent experiences of racism impact stress, hypertension, depression or coping behaviours. Moreover, "culture blindness" in health care is a misnomer for a practice that defaults to dominant (Western) cultural beliefs and denies the existence of specific Indigenous worldviews and health perspectives (Beagan & Kumas-Tan, 2009; McKinstry, 2017).

Cultural safety is proposed as a transformative approach to health care that draws attention to the values, needs, expectations, rights and identities of Indigenous patients (Ramsden, 1990, 1992; Smye et al., 2010; Wood & Schwass, 1993). The goal of cultural safety is to support Indigenous patients by bringing attention to, and dismantling, the colonial lens of the healthcare system. The cultural safety approach emphasizes equal partnerships between professionals and patients, the commitment and active participation of patients/professionals in the provision of health care and protection of the cultural identities of Indigenous patients (Gerlach, 2012). Cultural safety offers a way to counter "culture-blind" approaches to care by bringing the cultural and social determinants of health to the forefront of care. In keeping with this perspective, the core characteristics of culturally safe care must be defined by the communities receiving the care, in accordance with their specific needs, their own values and cultural norms (Association des Médecins Indigènes du Canada and Association des facultés de médecine du Canada, 2009; Brascoupé & Waters, 2009). This shift in the power dynamics underlying current healthcare practices, structures and policies centres the historically marginalized voices, cultures and rights of Indigenous populations in the care they receive (Gerlach, 2012).

Although recognized by many actors as a promising idea with the potential to generate significant benefits for Indigenous patients (Aboriginal Nurses Association of Canada & Canadian Association of Schools of Nursing, 2009; Indigenous Physicians Association of Canada, & Association of Faculties of Medicine of

Canada, 2009), cultural safety remains a complex concept that is difficult to grasp and translate concretely into practice (Brascoupé & Waters, 2009; Gerlach, 2012). Implementation of cultural safety cannot be reduced to applying a checklist or by offering general guidelines (Gerlach, 2012). Moreover, because cultural safety is a relative concept that is both contextual and personal, there is currently no consistent way to define or assess its application (Brascoupé & Waters, 2009).

9.3 What Are the Ontological, Epistemological, Methodological and Ethical Premises of This Research Programme?

This research builds on the premise that for Indigenous needs, rights and identities to be fully taken into consideration in a Western-based healthcare system, we need corresponding research approaches that allow for the decolonization of Western science. In a decolonization approach to research, the purpose of research goes beyond producing new knowledge; it allows the research process to refocus on the specific knowledge, worldviews and methodologies of Indigenous peoples, in order to counteract the power relationships that are inherently embedded in Western knowledge production (Martin, 2012). In this research, we build on Two-Eyed Seeing, or Etuaptmumk in Mi'kmaq, a principle of research decolonization that promotes the integration of Indigenous and Western worldviews and ways of knowing (Bartlett et al., 2012; Iwama et al., 2009; Martin, 2012). Two-Eyed Seeing fosters an open and respectful dialogue between Indigenous and Western sciences (ways of knowing), including their various ontological, epistemological and methodological dimensions (Iwama et al., 2009). Building on this decolonization approach to knowledge production, this research aims to achieve a more effective way to address power differentials and colonialism in the healthcare system.

Enabling Two-Eyed Seeing first involves implementing participation and co-learning processes in which ways of knowing and worldviews from both visions (Indigenous and Western) can be brought together, discussed and integrated into relevant co-constructed solutions (Bartlett et al., 2015). This co-construction approach requires that researchers adopt a humble attitude towards co-learning, reflexively examine their beliefs, assumptions and values in the research process and welcome alternative perspectives and Indigenous spiritual wisdom (Bartlett et al., 2015). Thus, this research is ontologically rooted in a relative conception of reality, in which reality is a relational construct that can vary from different perspectives. On an epistemological level, this research builds on subjectivism, which holds that "reality" is constructed by the multiple experiences of social actors. On a methodological level, this research builds on a dialectical approach, welcoming methods established by not only Western science but also Indigenous narratives, stories, metaphors and spirituality as significant sources of knowledge informing the problems and situations at stake (Martin, 2012). For instance, in the process of creating the model, we used talking circles as a methodology to gather specific cultural significations, values and beliefs to incorporate with other types of data. In so doing, we aim to forge a unique vision that respectfully incorporates Atikamekw knowledge and ways of knowing, with the potential to better address the barriers presently faced by Atikamekw populations in the health system.

This research complies with the Chap. 9 of the Tri-Council Policy Statement principles for research involving the First Nations, Inuit and Métis peoples of Canada (Canadian Institutes of Health Research et al., 2018). This important statement formulates ethical principles such as seeking Indigenous engagement from communities, organizations and governing authorities in research; building on participatory or collaborative approaches to research; jointly defining the level of engagement of the different entities in research; considering the views of all relevant sectors (including marginalized voices) in the research process; fostering mutual benefits in research; respecting the relevant customs and codes of research that apply in specific communities; defining an engagement plan and setting out a research agreement with the involved communities (Canadian Institutes of Health Research et al., 2018).

In line with the principles of this policy statement, in this research, we sought engagement from, and developed respectful collaboration with, the Indigenous communities and organizations involved in the project. Owing to the pilot work (described below) and preliminary exploratory meetings with potential stakeholders, the research was developed based on the needs expressed by community stakeholders, thus ensuring that the research has mutual benefits. The objective of this project was identified and defined in partnership with the Atikamekw communities of Manawan, Wemotaci and Opitciwan as well as with the Atikamekw Nation Council (Conseil de la nation Atikamekw). After preliminarily defining the objective of the project with the Indigenous partners, we also established collaborations with actors of the health system (i.e. local health and social service authorities). We wanted to give priority to Indigenous voices to discuss the problems at hand before reaching out to stakeholders in the health system.

A participatory approach is considered a gold standard in health promotion research (Tremblay & Richard, 2014), but, for this research, meaningfully involving Indigenous stakeholders was considered a moral and political imperative. In practice, adopting a participatory approach helps safeguard the political, moral and ethical principles that fight oppression and allows a repositioning of the unique knowledge, beliefs and values of Indigenous peoples in research and various social institutions of society (Martin, 2012; Bartlett et al., 2012; Iwama et al., 2009; Bartlett et al., 2015; Canadian Institutes of Health Research et al., 2018; Tremblay & Richard, 2014; Assemblée des Premières Nations du Québec et du Labrador, 2014). Such an approach ensures the self-determination and capacity building of the stakeholders and actors involved in the process, facilitates the transfer of knowledge and its application in practice and promises significant and lasting effects for the parties involved (Baum et al., 2006; Cargo & Mercer, 2008). On initiation of this research, we approached the community councils that act as the authority for each community. The research project was presented to each of these community governance bodies and agreed upon through formal collaboration agreements. In addition, this research respects and upholds the principles established by the Assembly of First Nations, which are principles accepted by the community partners. This protocol stipulates specific principles regarding the ownership, control, access and possession of data and research results by the community partners. Based on these principles, each step of the research is based on a transparent process with the partners and the communities involved. It implies that the First Nations control data collection processes in their communities and that they own, protect and control how their information is used (Cargo & Mercer, 2008; Assemblée des Premières Nations du Québec et du Labrador, 2014).

9.3.1 How Was This Research Developed?

The research was designed to build on the results of a pilot community-based participatory study. The goal of the pilot study was to identify the potential barriers to and enablers of cultural safety in the provision of health care to Atikamekw populations in the province of Québec (Canada) (Tremblay et al., 2020). The pilot study was built on a qualitative descriptive design and involved conducting talking circles with different actors (Atikamekw patients and health professionals) to seek insights into the struggles that Indigenous patients face when interacting with health organizations and to generate ideas for practical solutions that could enhance cultural safety within clinical encounters and health organizations.

The study's most important finding was that racism is a major barrier to healthcare access for Indigenous populations, with many participants reporting having directly experienced or heard other Indigenous peoples describe receiving differential treatment due to their Indigenous status, not being taken seriously by health professionals or being treated disrespectfully (Tremblay et al., 2020). In addition, the current organization of health services was pinpointed as being ill-adapted to the social organization and values of the Atikamekw culture, by discouraging community social support and the involvement of the extended family in healthcare decisions. In contrast, health professional participants underlined the fact that congestion in the healthcare system and busy schedules make it hard to implement a patient-centred approach, which takes time but would allow better consideration of the cultural diversity of the clientele. Other important barriers to culturally safe healthcare access were related to language and communication. These barriers concern the fact that many Atikamekw are unable to obtain services in their own language (i.e. Atikamekw) if consulting outside their community. In addition, the medical jargon used by health professionals further exacerbates this issue, hindering mutual understanding and trust even when patients speak French. Finally, healthcare professionals' ignorance of Atikamekw traditional practices and cultural perspectives on health was underlined as an important obstacle to culturally safe care. Health professionals expressed their desire to know more but were unsure about where to start and how to apply this knowledge in practice (Tremblay et al., 2020).

Following the pilot study, a deliberative dialogue workshop (Lavis, 2010) was organized with all stakeholders of the project to discuss the results and prioritize potential solutions to improving cultural safety. A total of 21 people attended the event, including Atikamekw patients, representatives of the Atikamekw Council of Manawan, professionals from the Native Friendship Centre, health professionals and healthcare decision-makers from the local hospital and regional health and social service authority. Before the workshop, all participants received a summary of the results in an accessible language. Through small groups and plenary discussions, participants were invited to identify and prioritize potential solutions for improving the cultural safety of care. The proposed solution consisted of developing and implementing an intervention involving a new professional role dedicated to cultural safety in healthcare organizations. Participants of the workshop suggested involving the two other Atikamekw communities (Wemotaci and Opitciwan) in future research activities. Following this workshop, the research began to take form in close partnership with these three Indigenous partners as well as with the Atikamekw Nation Council. As we wanted to prioritize Indigenous voices and concerns in the project, the roles and nature of collaboration with regional health and social service authorities (in the three involved regions) were defined a little later in the project. Formal agreements were defined with these organizations, following the submission of a new grant application for this project. A representative from each regional authority was then delegated to take part in the project research team and serve as the contact person in the project.

9.3.2 The Research Governance

This research involves partnerships with academic, Indigenous and health service actors. We decided to adopt a ternary structure of governance inside the project to facilitate dialogue between the three entities embodied by the research team, the advisory committee and the regional health and social service authorities, respectively (Fig. 19.1). Each of these distinct partners brings crucial and specific expertise to the research: scientific expertise related to cultural safety and the organization of care; lived experience of the Atikamekw culture and concepts of health; and practical experience of the particular organizational contexts and related administrative or implementation constraints of the healthcare system. To foster cultural safety in the model being developed as well as in the research approach, we have put in place an advisory committee with representation from the three Atikamekw communities in Québec and a representative of the Atikamekw Nation Council. Composed of Atikamekw health professionals and community leaders, this advisory committee oversees and takes an active role in all steps of the project, meeting once every 6 weeks. It is responsible for providing work directions for development of the model, as well as for the project more generally, and for acting as a link between the research team and the communities. The research team is responsible for liaising with the participating regional health and social service authorities to

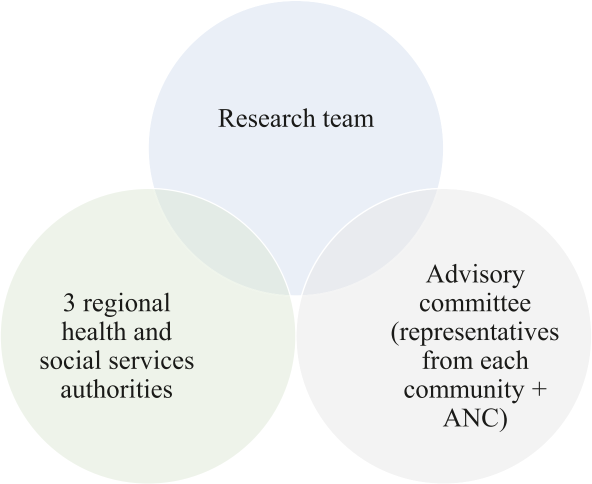

Fig. 19.1 Governance structure of the project

report on project progress, to mutually share information and to incorporate their comments, reactions and suggestions into the model. Representatives from these organizations will be invited to attend some of the advisory committee meetings, to take part in the crucial steps of the model's development and to contribute their practical knowledge of the healthcare system context. At the end of the initial development phase (1 year), a community forum will be organized to gather the perspectives of a broad base of actors from the three communities and the healthcare system sector.

For this research, we relied on different mechanisms to respectfully and meaningfully integrate Indigenous and Western ways of knowing and worldviews, following a Two-Eyed Seeing approach. These mechanisms include implementing strong, trusting relationships and formal processes of participation with Indigenous partners. This has been achieved through the engagement of the community partners since the beginning of the project and through the advisory committee. In addition, at the beginning of the project, a gathering including ceremonies was organized with all project partners and research team members, with the desire to build the communion required for this project to be successful. This gathering was supposed to be held in 2020 on the traditional lands of the Atikamekw but was finally held in 2021 due to the pandemic context. To develop a model that would weave together Indigenous and Western worldviews, we relied on different methodological traditions, such as a rapid literature reviews, to identify the fundamental components of cultural safety interventions in health care, as well as talking circles with Atikamekw Elders, healers and health professionals to identify the essential cultural elements that would inform the model (e.g. stories, narratives, values, meanings and perspectives of health). Building on all these sources of knowledge, the intervention model is being developed in full partnership with the advisory committee by weaving together Indigenous and Western perspectives and ways of knowing. A final important element to point out is the fact that many members of the advisory committee are Atikamekw health professionals and thus can more easily integrate the different forms of knowledge. Their cultural background coupled with their professional expertise nurtures rich and relevant perspectives that facilitate the articulation of diverse forms of knowledge within the model's development. So far, the main ideas for the intervention model include facilitation of bidirectional changes in healthcare organizations, i.e. changes at the interface of care that allow Indigenous patients and their families to better navigate the existing services and changes in professional and organizational practices that allow for greater openness to and consideration of Indigenous realities, value systems and practices in the healthcare system. The preliminary results of the project's development phase identified certain key elements to consider in the construction of the model, e.g. placing Indigenous staff at the centre of the intervention, supporting interprofessional collaboration within the care team and allowing the involvement of family in interventions. In addition to the community forum, later phases of the project will involve co-developing concrete modalities for intervention implementation with the advisory committee and partners.

One of the key challenges that we face in this project relates to the volatile and action-oriented nature of the health system context, especially in the aftermath of the death of Joyce Echaquan. Although this tragic event has brought public and political attention to the issue of racism against Indigenous peoples and has highlighted the need to rethink current healthcare practices, it has also meant a quickly evolving context for this project, one that requires constant adaptation to rapid changes in the political and institutional environments. At the end of 2020 and the beginning of 2021, for example, the federal (Gouvernement du Canada, 2021) and provincial governments (Gouvernement du Québec, 2020) allocated new funds to regional authorities and to the community of Manawan to foster cultural safety through training and new models of health care such as patient navigators. At around the same time, the Council of Manawan began a political process aiming to eradicate systemic racism in public institutions (see Joyce's Principle – Conseil des Atikamekw de Manawan and Conseil de la Nation Atikamekw, 2020). Although our team took part in the consultation for this brief, this was a political process carried out by the community of Manawan and the Atikamekw Nation Council. These sudden contextual transformations pose specific challenges related to adaptability as well as our position as a research team. Being a research team external to the health system, we must remain up to date and engaged in the ongoing transformations of the healthcare system via the three regional health and social service authorities participating in this project. To do so, we try to engage with high-level leadership within the different organizations as well as frequently mobilize our contact people in each organization. At the same time, to keep the trust of our Indigenous partners, it is important that we respect the inner pace and initial vision of the project by not rushing the model's development in response to external pressures or political agendas.

9.4 Conclusions

Health services are a determinant of health that play a role in increasing social health inequities and systemic marginalization of minorities such as Indigenous peoples (Allan & Smylie, 2015; Peiris et al., 2008; Tang & Browne, 2008). As such, health professionals and health organizations must be considered as key actors in the field of health promotion. This research, working at the intersection of public health and healthcare research, aims to contribute to the reorientation of health services towards ensuring culturally safe care, by building on respectful, reciprocal and equitable partnerships with Indigenous partners. To this effect, it builds on a decolonizing approach to research based on the principle of Two-Eyed Seeing, which promotes the respectful integration of Indigenous and Western knowledge and science in research. In so doing, this research centres the expertise of Indigenous communities in the development of solutions relevant to their needs and aims to elevate and integrate Indigenous conceptions of health, values and cultural practices into Canadian (Western-based) health and research systems. This research's approach and process propose useful research strategies for enacting the established values of health promotion such as participation, empowerment, social justice and equity. The major contributions of this research include advancement of the application of the principle of Two-Eyed Seeing, which is still little formalized or exemplified in the scientific literature, as well as proposing an approach to operationalize the concept of cultural safety in practice, in full partnership with local communities and healthcare stakeholders.

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