"We need to raise the bar!" Exploring Indigenous patients' experiences of racism and perspectives on improving cultural safety within healthcare

Andreas Pilarinos[a,b], Shannon Field[b], Krisztina Vasarhelyi[c,d], David Hall[d,e], Elder Doris Fox[f], Elder Roberta Price[g,h], Leslie Bonshor[b], Brittany Bingham[b,e]

Affiliations:

a. Interdisciplinary Studies Graduate Program, University of British Columbia, 270-2357 Main Mall, Vancouver, BC, Canada V6T 1Z4
b. Indigenous Health, Vancouver Coastal Health Authority, 2750 East Hastings Street, Vancouver, BC, V5K 1Z9
c. Faculty of Health Sciences, Simon Fraser University, 8888 University Drive, Burnaby, BC, V5A 1S6
d. Department of Family and Community Practice, Vancouver Coastal Health, 2550 Willow Street, Vancouver, BC, V5Z 0A6
e. Faculty of Medicine, University of British Columbia, 2194 Health Sciences Mall, Vancouver, BC, V6T 1Z3
f. xʷməθkʷəy̓əm First Nation, Vancouver, BC
g. Snuneymuxw First Nation, Nanaimo, BC
h. Cowichan First Nation, Lake Cowichan, BC

Acknowledgements: We acknowledge this research was conducted on the unceded, traditional territories of the Xʷməθkwəy̓əm (Musqueam), Sḵwx̱wú7mesh (Squamish), and Səl̓ílwətaʔ (Tsleil-Waututh) Nations. We would like to express our sincere gratitude and appreciation to the participants of this study for sharing their experiences and perspectives. We also extend our gratitude to the Lu'ma Medical Centre for their support in conducting this study.

Declaration of Interest: None of the authors of this study have any conflicts of interest to declare.

Contributors Statement: All authors oversaw the conceptual design of the study as well as in data collection. Andreas Pilarinos and Shannon Field conducted data analysis, and all authors validated the findings and participated in the interpretation. All authors contributed to the drafting and critical review of the manuscript for intellectual content, provided approval for the final version of this manuscript, and have agreed to be accountable for all aspects of this work.

Send correspondence to: Brittany Bingham, PhD
Director of Indigenous Research
Indigenous Health, Vancouver Coastal Health
288-2750 East Hastings Street, Vancouver, BC, V5K 1Z9
Tel: (604) 315-8865
Email: Brittany.Bingham@vch.ca

Abstract word count: 250
Manuscript word count: 2,625

Abstract

Background: In Canada, Indigenous peoples continue to experience persistent health inequities resulting in disproportionately poorer health outcomes compared to non-Indigenous Canadians. This study engaged Indigenous patients accessing healthcare in Vancouver, Canada to learn about their healthcare experiences and perspectives on promising practices.

Methods: A Two-Eyed seeing research team, consisting of both Indigenous and non-Indigenous researchers committed to using culturally safe research approaches conducted two talking circles with 26 participants recruited from healthcare settings who self-identified as Indigenous. Talking circles were led by Indigenous Elders and thematic analysis was used to identify overarching themes.

Results: A majority of participants reported encountering Indigenous-specific discrimination or racism when accessing healthcare, which resulted in distrust towards and avoidance of the healthcare system. Nevertheless, participants were encouraged by the care they received from an urban Indigenous health clinic and suggested ways in which Indigenous peoples' healthcare experiences could be improved. In addition to emphasizing that all healthcare providers should receive Indigenous cultural safety training, participants also emphasized the importance of providing access to traditional medicines within Western healthcare settings, creating culturally safe and welcoming spaces, establishing more Indigenous-specific clinics, and improving Indigenous patients' access to Indigenous healthcare providers.

Interpretation: Despite participants' negative healthcare experiences, many credited the receipt of culturally safe care with reducing their distrust in the healthcare system and improving their well-being. The continued expansion of Indigenous cultural safety training for healthcare

providers, as well as working to recruit and retain Indigenous healthcare providers, may improve Indigenous patients' willingness to use healthcare services.

Introduction

In Canada, Indigenous peoples (First Nations, Inuit, and Métis peoples – see Appendix 1) are less likely to access healthcare, have an increased disease burden, and have higher rates of morbidity and mortality when compared to settler populations (1-6). These persistent inequities have been acknowledged through the *United Nations Declaration on the Rights of Indigenous Peoples* (UNDRIP), which calls for the provision of culturally safe health care services, resources and supports in order to improve Indigenous peoples' individual, community, and population health (7).

While UNDRIP has been enacted into law as the Declaration on the Rights of Indigenous Peoples Act (DRIPA) (8) in British Columbia, where the present study is situated, there are significant discrepancies in health care experiences between Indigenous peoples and non-Indigenous populations. This is evidenced through *In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in BC Health Care*, which found rampant anti-Indigenous racism throughout the healthcare system and highlighted the need for action to improve cultural safety for Indigenous peoples (9). It is for this reason that the provincial government has committed to addressing Indigenous-specific racism in its DRIPA Action Plan: 2022-2027 (10) by prioritizing the delivery of Indigenous cultural safety education to all health professionals.

Due to the persistent health inequities experienced by Indigenous peoples there has been a move towards self-determining and Indigenous-led approaches to the design and delivery of healthcare services. In British Columbia, this culminated in the creation of the First Nations Health Authority (FNHA), with evidence suggesting that there have been notable improvements in the health

outcomes of Indigenous peoples since the transfer of jurisdiction over First Nations healthcare services to the FNHA (11, 12). Similarly, Vancouver Coastal Health (VCH), the regional health authority encompassing the southwestern and central coast of BC, established the Indigenous Health (IH) Department, which is responsible for improving the health and well-being of urban Indigenous peoples who live in both on- and off-reserve settings within the VCH region (13). This work is seeking to enact system-wide transformation by ensuring that all Indigenous peoples in the VCH region have access to culturally safe and responsive care.

Despite some initial positive improvements in the population health of Indigenous peoples in BC, recent research indicates that the health gap between Indigenous peoples and non-Indigenous populations continues to grow (11). Although prior research has examined the healthcare experiences and needs of Indigenous patients in hospital settings (3, 14-21), similar research among Indigenous peoples' residing in urban centres is sparse. Given this knowledge gap, this study sought to better understand Indigenous patients' healthcare experiences and perspectives on culturally safe health care practices.

Methods

Study design and Sampling

This study was undertaken under the guidance of a 'Two-Eyed seeing' research team consisting of both Indigenous and non-Indigenous researchers, which is a concept coined by Mi'kmaq Elder Albert Marshall in the context of research that privileges traditional Indigenous knowledge (22-24) (see Appendix 2). Data was collected through talking circles, which are a traditional means of knowledge sharing and exchange used for millennia by Indigenous communities throughout North

America, which has previously been employed in healthcare research (25-27). Evidence has highlighted the importance of employing traditional research methodologies when conducting research with and for Indigenous populations and talking circles have demonstrated a unique ability to solicit impactful experiences from Indigenous participants (25, 27-30).

Sampling and study procedures

Participants were by recruited through convenience sampling by word-of-mouth, placing posters in health service centers frequented by Indigenous patients, and contacting local health and social service agencies with existing connections to the research team. Participation in the talking circles was limited to individuals who self-identify as Indigenous and who currently resided in the Lower Mainland. Two talking circles were conducted at two Indigenous healthcare centers in Vancouver, Canada. Participants were provided with lunch and received $25 CAD for their participation in the study. Informed consent was obtained prior to the commencement of the talking circles and participants were provided access to counseling services and Elder support during the talking circles. Additionally, participants were provided with medicine pouches and smudging supplies throughout the talking circles.

Each session was co-facilitated by an Indigenous Elder and co-author BB. Questions that were presented to participants were purposefully broad to explore participants' range of experiences with and perspectives on healthcare and health research in British Columbia (see Table 1). Each talking circle lasted approximately 2.5 hours and were audio recorded and transcript, and identifying information was removed to protect participants confidentiality. For further details on the procedures of the talking circle, please see Appendix 3.

Data analysis

Once talking circles concluded, the audio recordings were transcribed, and the research team convened to conduct a thematic analysis of the findings. This begun with co-authors AP and SF developing an initial codebook identifying broad themes, which was then refined through the addition of quotes. Themes were then presented at a health knowledge translation event in Vancouver to discuss the findings and validate the key themes.

Ethics approval

Ethical approval for this study was received from the University of British Columbia Research Ethics Board (H18-03565).

Results

Two talking circles were conducted with a total of 26 participants. Twenty-five participants self-identified as women, and one as a man. A majority of participants were adults (n=24) and two were young adults under 30 years of age. The following narratives describe participants' negative healthcare experiences and promising healthcare practices, as well as service models that have improved participants' health and engagement in care.

Experiences of racism lead to poorer care experiences and health outcomes

Racism, prejudice, and stereotypes were commonly reported by participants, with many sharing experiences that resulted in their feeling devalued, disrespected, and abandoned (Table 2). Participants discussed situations where stereotypical inferences were made that impacted their

health and found that disclosing their personal history sometimes resulted being treated poorly. As one participant noted, disclosing that they attended Residential School immediately changed the dynamic of the relationship with their physician in a negative way. In other instances, participants described how stereotypes about substance use within Indigenous communities resulted in their being labeled as 'drug-seeking', and how their safety was ignored and that they were provided with sub-standard treatment because they were Indigenous.

Discrediting of traditional medicine and Indigenous perspectives on health

Participants also shared their disappointment in many Western healthcare providers' dismissiveness of the importance of culture, ceremony, and traditional knowledge on their healing journey (Table 3). Participants explained that holistic approaches to health and well-being are reinforced by traditional knowledge around healing and wellness within their communities, but that the incorporation of traditional healing within Western healthcare settings is often frowned upon. Similarly, participants described how the Indigenous-specific healthcare services, such as the urban Indigenous health clinic where they were accessing healthcare, were also seen as lesser than in comparison to Western healthcare services, alluding to how colonization and racism are contributing to these perspectives.

In addition to the resistance towards traditional medicine that was experienced, some participants also shared their frustration that the healthcare system discredits the importance of kinship ties within Indigenous communities. Despite the central role of Indigenous women as caregivers within their communities and families, many participants highlighted that Western medicine does not place the same value on the importance of Indigenous matriarchs or the value of kinship ties during

treatment, and that the supports that many Indigenous women need in order to care for their family members are often absent. This can be seen through one participant's experience, where they were required to provide care to their family members in the absence of essential supports, including somewhere to sleep.

Indigenous-specific racism results in mistrust in the healthcare system

The plethora of negative experiences shared by participants is highly problematic, but it is also concerning that these instances of discrimination negatively impacted participants' views towards healthcare services and their overall health (Table 4). For many participants, this abuse of power and mistreatment resulted in resentment and anger towards healthcare providers and the healthcare system, while others expressed fear of the healthcare system and feeling coerced into treatment. Some participants also described how the discrimination they experienced contributed to their doubt in the intentions of the healthcare system, which added to a growing sense of distrust in the providers and services they receive. These experiences further entrenched participants' already skeptical views of the healthcare system, resulting in patients feeling alienated and ignored when access healthcare services.

Indigenous cultural safety education is necessary for all healthcare-involved staff

Despite the many negative experiences and perspectives on healthcare that were shared, participants also highlighted several positive experiences and ways that healthcare could be improved for Indigenous peoples (Table 5). A majority of patients attested to the value of culturally safe care in improving their health and well-being and indicated that such training should be mandatory for all healthcare staff. The positive impacts of culturally safe care can be seen through

one participant's recollection of an experience they had, where two nurses successfully advocated for their family to be present during the passing of their relative. Additionally, several participants shared the importance of hiring Indigenous healthcare providers to serve Indigenous peoples. This was seen as an important aspect to rebuilding trust between Indigenous communities and the healthcare system and would make many Indigenous peoples feel more comfortable when accessing healthcare services.

Culturally safe care increases healthcare engagement and improve health outcomes

Another important finding was the impact of positive healthcare experiences on perceptions towards healthcare providers and the healthcare system. More specifically, patients who had accessed services at an urban Indigenous health clinic in the study setting described feeling a stronger sense of trust in their healthcare providers and willingness to engage in healthcare (Table 6). For participants who struggled with accessing health services in the past, the aforementioned urban Indigenous health clinic represented one of the first times they felt that they had received dignified and considerate care. By placing equal weight on the importance of traditional healing and Western medicine, healthcare providers at this urban Indigenous health clinic took a holistic approach to patients' health and well-being. In one example, a participant experiencing homelessness describes how the staff not only worked to address their health concerns, but also assisted them in securing housing. In another example, a participant discussed their appreciation for how a healthcare provider intervened on their behalf following a negative experience with a specialist physician they had been referred to.

Providing welcoming, Indigenized spaces for Indigenous patients

Participants also reported that providing welcoming physical spaces that are inclusive of Indigenous cultures and traditional healing practices encourage healthcare engagement and contribute to Indigenous patients' well-being (Table 7). Some examples that were presented by participants include providing traditional medicines, smudging supplies and an accommodating space; allowing time for ceremony before or after a consultation; and providing access to Elders and other cultural supports. In one example, a participant – despite not being well connected with their culture – described the positive feeling of hearing a drumming circle in the room adjacent to the health clinic while waiting for their appointment. Nevertheless, it was also emphasized that providing welcoming, Indigenized spaces does not compensate for the absence of culturally safe care, and so relationship building was of equal importance to participants.

Interpretation

Findings from this study point to persistent discrimination, prejudice, and racism towards Indigenous patients within the healthcare system. For many Indigenous patients, these experiences resulted in significant levels of distrust and a lack of willingness to engage in the healthcare system. Despite these negative experiences, patients shared several examples of ways in which health care services could be improved, including through mandatory Indigenous cultural safety training for healthcare staff, the incorporation of traditional medicines into clinical practice, and establishing culturally safe, Indigenous-specific health clinics.

Consistent with existing evidence, racism and discrimination towards Indigenous peoples is commonplace within healthcare settings (9, 14, 19, 31), much of which is routed in the colonial history of the healthcare system. One early example of when the healthcare system was complicit

in colonization and the propagation of intergenerational trauma was through the establishment of "Indian hospitals" (32), which were segregated healthcare institutions that offered sub-standard care and that conducted experimental medical procedures on Indigenous peoples that often resulted in harm. This can also be seen in a study among Indigenous peoples who use drugs in Vancouver, Canada that found that Indigenous-specific racism in the healthcare system led to a decreased willingness to re-engage with healthcare services (14), and in a review that found that race-based stigma in healthcare is associated with negative treatment experiences and outcomes (33).

One potential solution that was discussed was the provision of mandatory cultural safety training for all healthcare staff. In the Canadian context, cultural safety training involves an overview of pre- and present-day colonial history, with specific focus on the role of colonial settler institutions in the genocide of Indigenous peoples, in turn encouraging self-reflection and attention to ways in which clinical praxis reinforce colonial perspectives and authority over Indigenous peoples (34). The promising impact of cultural safety training identified in this study is also supported within existing literature, suggesting it may change healthcare providers' perspectives and approaches and that may positively impact Indigenous peoples health and well-being (35-37). In the current study setting, efforts are underway to expand the provision of Indigenous cultural safety (please see Appendix 4 for further details).

While participants emphasized the importance of cultural safety training, they also highlighted the need for systemic changes that acknowledge the value and benefit of traditional approaches to health and well-being. For some participants, this was realized through having received healthcare services in an urban Indigenous health clinic, where traditional healing practices are incorporated

into clinical settings and the connection between culture and health is recognized and valued. For example, previous research has highlighted how strong linguistic and cultural connections are positively associated with well-being (38, 39), and that traditional healing practices and approaches have been effective at addressing the health impacts of intergenerational trauma, including substance use disorders (40). Despite potential hesitations towards the inclusion of traditional healing practices within clinical settings, research demonstrates that such initiatives are not only feasible, but essential to the health and well-being of many Indigenous patients (40-43). Given this understanding, there is a need for more Indigenous-specific and -tailored healthcare services and further exploration of ways to incorporate Indigenous ways of knowing and doing into healthcare practice.

Limitations

This study has a number of limitations. Firstly, a convenience sample was employed; therefore, this is a non-random sample and subject to selection bias. Secondly, participants were recruited through healthcare clinics throughout the study setting and may be well connected to such services; therefore, their views may not represent the views of other Indigenous peoples who may have different healthcare access patterns and needs or who live in different settings than those who participated in this study. Thirdly, this study sought to hear the perspectives of Indigenous patients and did not include healthcare providers, and future research that examines their perspectives would be valuable. Lastly, this study was restricted to an urban setting, and future research could engage Indigenous peoples living in rural and remote communities around their healthcare experiences and perspectives on promising healthcare practices.

Conclusion

While efforts are being made to reconcile the wrongdoing of the Canadian healthcare system and providers towards Indigenous peoples, findings from this study point to persistent and concerning levels of discrimination, prejudice, and racism. This is problematic given Indigenous peoples are less likely to access healthcare and continue to experience worse health outcomes in comparison to non-Indigenous populations. Nevertheless, study participants point to promising practices including the provision of cultural safety training to healthcare providers, incorporating traditional medicine into clinical settings and practice, and providing safe and welcoming spaces for Indigenous patients.

Data-Sharing Statement: Participants did not consent to their data being shared or disclosed to external researchers. Therefore, the data is not accessible and cannot be made available.

Funding statement: This study was supported through the Reach Program provided by the Michael Smith Foundation for Health Research.

Table 1. Talking circle question guide
Q1: Based on your personal healthcare experiences, what are some specific areas within the healthcare system that need to change for Indigenous peoples? Q2: What can researchers and people within the healthcare system do to support Indigenous peoples? What can be done to lift Indigenous peoples up and improve their health? Can you think of a good experience that you had, with a doctor, a nurse, in a clinic or a hospital setting that we can share with healthcare providers and researchers?

Table 2: Participants quotations about racist or prejudicial experiences in healthcare
"As soon as [my doctor] found out I was a residential school survivor, she didn't like me. She damaged my insides from a rough, careless pap smear."
"So many in the medical profession look at us like we are a number, look at us like we're not people. We're either completely invisible and get forgotten about or get on the receiving end of abuse."
"I was in a car accident and I went to the emergency. The doctor wouldn't even touch me. He wouldn't even check me physically. What he said to me was, "Ordinarily I would prescribe you some T3s, because that's what you want". And I said, "No, I want to discuss pain relief. I'm allergic to pain relievers and I take my own medicines."
"I suffered such bad physical violence, and so my partner kept me from going to hospital. But when I did get to the hospital, they told me I had to deliver [my baby] by myself. And they put me across from a lady who was giving birth and my baby passed away. And when police came and I was so badly beaten, they wouldn't help me. And when I went to the hospital the nurses would treat me so poorly, they would stitch me without anesthetic."
"*Once, [the specialist physician] was talking about Residential School and he told me 'why don't you just get over it?' I was explaining to him how much body pain I was experiencing … and he charged right at me and grabbed me and said 'what is this?... That's skin and we all have it. You need to toughen up!'"*

Table 3: Participants quotations about healthcare providers' discrediting of traditional medicine and Indigenous perspectives on health
"Although [the doctor] thought I couldn't work and I wouldn't be able to accomplish my goals, I started to gain tools from my Elders and support team. I put a care plan in place and the pain started to lift up, through ceremony, through sweat lodge, through drumming, singing songs, being around my sisters and Elders. I have one more meeting with [my doctor] and he's going to get an earful. Every time I visit him, he wonders how am I doing this, how am I staying this strong without the medicine? We need to raise the bar!"
"I had to learn how to do physio[therapy], pull catheters, and look at stool to see if [they] needed more enzymes. We lived in the hospital for 8 months and they wouldn't even give me a cot to sleep on. I slept on the floor. I wasn't even allowed to eat there because I wasn't a patient… I was responsible for all of [their] care, and got no support at all… The supports that need to be integrated into the hospitals for Aboriginal women are long overdue"
"When I got into a car accident, I was sent to get X-rays for my neck. The emergency doctor took the letter [from the urban Indigenous health clinic] and chucked it as if it was irrelevant. It's analogous to when you go to Native Education College and its seen as "lesser than a regular degree" … I've sent four letters from [the urban Indigenous health clinic] to [my insurance provider] and they've ignored all four. And so, it's not just us being ignored on the individual level, but on the organizational/systemic level as well."

Table 4: Participants quotations about how Indigenous-specific racism results in healthcare system mistrust or fear
"Of all the pain, it's pretty obvious they're just waiting for us to die. And because Canada is a colony, the survivors are the most [likely] to experience the health care system. We can go decades in horrendous conditions, and you go to get help, and you think the help is there, but it's not. It's very racist."
"I was in fear of getting older and being Indigenous in Canada – there was a lady who was being screamed at, they were shortchanging her – nobody has done anything, or tried to fix this."
"I'm told that if I don't take the medication, I will be cut financially. And so I'm told I have to take it, otherwise I fear they will come and take my grandchildren away. So I do it!"
"If we have any medical issue, and we got to get help, we don't get it – we get to see all the other [settlers] getting great help, but not us."

Table 5: Participants quotations about the importance of Indigenous Cultural Safety training and the hiring of Indigenous healthcare providers
"*If the medical system was actually listening – as part of all orientations [for] emergency, ambulance drivers, front line workers, mental health workers, for physicians, nurses – they would provide cultural competency training. Part of that is that residential schools is not our legacy, it's their legacy! They need to heal themselves and check the stereotyping of indigenous residential school survivors."*
"*For me the priority should be people-centered medical staff. People understanding people, and I think we are heading in that direction. Many of the students… are taking a cultural safety course at the Faculty of Medicine. This should be going out to everyone, even those outside of the Faculty of Medicine."*
"When we were losing my brother to leukemia, he took a bad fall and he started fading away really fast, and so we all jumped in the car and headed down. What we do is make sure that no one is alone, not even for a minute, there's always somebody there holding their hand. And [the hospital] didn't understand that. The two young nurses said they had never seen that before, but we were welcome. And we told them we needed to be there 24/7. The doctors didn't really like it, but the nurses stood by us until the end. There were two human beings who understood and respected our wishes."
"If they don't want to do it and provide the care to Indigenous peoples, then get them out of their and put some indigenous peoples in there who are willing to do it, who know what people want."

Table 6: Participants quotations about how culturally safe care improves treatment engagement and health outcomes
"I was so at the end of my rope with the medical system and didn't want anything to do with it. [This urban Indigenous health clinic] is an entirely different thing, they have a healing room, they have Elders, they have social navigators, they all help, they all care… And they do even more care, they kind of research the places that are available but also places that hear good feedback about to try to keep your experiences to be good so that you keep on wanting to be well. They really want you to be well, and I've never had that before."
"In [the urban Indigenous health clinic], they also have a social worker. She was the one that my doctor referred me to when I first came to Vancouver, and everyone knows what it's like in this city. And she went out of her way to help me locate the people I needed to find accommodation. I started in a transitional house 'cause I had my grandchildren and I expected to live with them, but that didn't work out. Then I went into two shelters, and in the meantime, they were working behind the scenes and secured me housing!"
"*[The doctor at the urban Indigenous health clinic] asked me if I wanted her help to intervene with this specialist. I've never had that support before. I've never had a doctor actually listen to me and take a positive action to help me."*
"No one gets a number at [the urban Indigenous health clinic]. We appreciate everyone that walks through this door. People tell me it feels like their home, their second home, their family."

Table 7: Participants quotations about Indigenizing healthcare spaces
"What really got me is that I hear that [this urban Indigenous health clinic] is for First Nations peoples, and I'm not by any means traditional, but I was impressed by the do-it-yourself medicine pouches they have at the doors... And every once in a while, I'm waiting to meet the doctor I hear the drumming from over [in the other room]. And I hear it and I think, "this is pretty cool, you can come in here, and you totally feel relaxed, and you totally feel like you belong."
"They need to update the [operating room] too! I used to be put asleep at the infirmary and they used to rape me, and that's why every time I get taken to surgery I start to cry. We need to not have spaces being so sterile."
"It's important to note that by 'indigenizing space', we can't expect to get more indigenous people to attend [healthcare services] if the connections and relationships aren't already there."

References

1. Adelson N. The embodiment of inequity: Health disparities in Aboriginal Canada. Canadian journal of public health. 2005;96(2):S45-S61.
2. MacMillan HL, MacMillan AB, Offord DR, Dingle JL. Aboriginal health. CMAJ: Canadian Medical Association Journal. 1996;155(11):1569.
3. Shah BR, Gunraj N, Hux JE. Markers of access to and quality of primary care for aboriginal people in Ontario, Canada. American journal of public health. 2003;93(5):798-802.
4. Marrett LD, Chaudhry M. Cancer incidence and mortality in Ontario First Nations, 1968–1991 (Canada). Cancer Causes & Control. 2003;14(3):259-68.
5. Waldram JB, Herring A, Young TK. Aboriginal health in Canada: Historical, cultural, and epidemiological perspectives: University of Toronto Press; 2006.
6. Patrick RJ. Uneven access to safe drinking water for First Nations in Canada: Connecting health and place through source water protection. Health & place. 2011;17(1):386-9.
7. UN General Assembly. United Nations declaration on the rights of indigenous peoples. UN Wash. 2007;12:1-18.
8. Declaration on the Rights of Indigenous Peoples Act, (2019).
9. Turpel-Lafond M. In plain sight: Addressing Indigenous-specific racism and discrimination in BC health care. 2020.
10. Government of British Columbia. Declaration on the Rights of Indigenous Peoples Act Action Plan: 2022-2027. 2022.
11. First Nations Health Authority. Indigenous Health and Well-being. Office of the Provincial Health Officer,. 2018.
12. Gallagher J, Mendez JK, Kehoe T, editors. The First Nations health authority: A transformation in healthcare for BC First Nations. Healthc Manage Forum; 2015: SAGE Publications Sage CA: Los Angeles, CA.
13. Aboriginal Health Department. Aboriginal Health: Year in Review. Vancouver Coastal Health [Internet]. 2018. Available from: http://www.vch.ca/Documents/Aboriginal-Health-Year-in-Review.pdf.
14. Goodman A, Fleming K, Markwick N, Morrison T, Lagimodiere L, Kerr T, et al. "They treated me like crap and I know it was because I was Native": The healthcare experiences of Aboriginal peoples living in Vancouver's inner city. Social Science & Medicine. 2017;178:87-94.
15. Wood E, Kerr T. What do you do when you hit rock bottom? Responding to drugs in the city of Vancouver. International Journal of Drug Policy. 2006;2(17):55-60.
16. Browne AJ, Fiske J-A. First Nations women's encounters with mainstream health care services. Western journal of nursing research. 2001;23(2):126-47.
17. Browne AJ, Smye VL, Rodney P, Tang SY, Mussell B, O'Neil J. Access to primary care from the perspective of Aboriginal patients at an urban emergency department. Qualitative Health Research. 2011;21(3):333-48.
18. Anne Van Herk K, Smith D, Andrew C. Identity matters: Aboriginal mothers' experiences of accessing health care. Contemporary nurse. 2011;37(1):57-68.
19. Benoit C, Carroll D, Chaudhry M. In search of a healing place: Aboriginal women in Vancouver's downtown eastside. Social science & medicine. 2003;56(4):821-33.

20. Fiske J-A, Browne AJ. Aboriginal citizen, discredited medical subject: Paradoxical constructions of Aboriginal women's subjectivity in Canadian health care policies. Policy Sciences. 2006;39(1):91-111.
21. Denison J, Varcoe C, Browne AJ. Aboriginal women's experiences of accessing health care when state apprehension of children is being threatened. Journal of advanced nursing. 2014;70(5):1105-16.
22. Bartlett C, Marshall M, Marshall A. Two-eyed seeing and other lessons learned within a co-learning journey of bringing together indigenous and mainstream knowledges and ways of knowing. Journal of Environmental Studies and Sciences. 2012;2(4):331-40.
23. McKeon M. Two-eyed seeing into environmental education: Revealing its "natural" readiness to indigenize. Canadian Journal of Environmental Education (CJEE). 2012;17:131-47.
24. Marshall M, Marshall A, Bartlett C. Two-eyed seeing in medicine. Determinants of Indigenous peoples' health in Canada: Beyond the social. 2015:16-24.
25. Drawson AS, Toombs E, Mushquash CJ. Indigenous research methods: A systematic review. International Indigenous Policy Journal. 2017;8(2).
26. Rothe P, Makokis P, Steinhauer L, Aguiar W, Makokis L, Brertton G. The role played by a former federal government residential school in a First Nation community's alcohol abuse and impaired driving: Results of a talking circle. International Journal of Circumpolar Health. 2006;65(4):347-56.
27. Becker SA, Affonso DD, Beard MBH. Talking circles: Northern Plains tribes American Indian women's views of cancer as a health issue. Public Health Nursing. 2006;23(1):27-36.
28. Conklin A, Lee R, Reading J, Humphries K. Promoting Indigenous women's heart health: lessons from gatherings with Elders and Knowledge-Holders. 2019.
29. Isaacson MJ. Addressing palliative and end-of-life care needs with Native American elders. International journal of palliative nursing. 2018;24(4):160-8.
30. Gesink D, Whiskeyjack L, Guimond T. Perspectives on restoring health shared by Cree women, Alberta, Canada. Health promotion international. 2018.
31. King M, Smith A, Gracey M. Indigenous health part 2: the underlying causes of the health gap. The lancet. 2009;374(9683):76-85.
32. Lux MK. Separate beds: A history of Indian hospitals in Canada, 1920s-1980s: University of Toronto Press; 2016.
33. Penner LA, Phelan SM, Earnshaw V, Albrecht TL, Dovidio JF. Patient stigma, medical interactions, and health care disparities: A selective review. 2018.
34. Ramsden I. Cultural safety and nursing education in Aotearoa and Te Waipounamu: Victoria University of Wellington Wellington; 2002.
35. Dell EM, Firestone M, Smylie J, Vaillancourt S. Cultural safety and providing care to Aboriginal patients in the emergency department. Canadian Journal of Emergency Medicine. 2016;18(4):301-5.
36. Peiris D, Brown A, Cass A. Addressing inequities in access to quality health care for indigenous people. Cmaj. 2008;179(10):985-6.
37. Greenwood M, Lindsay N, King J, Loewen D. Ethical spaces and places: Indigenous cultural safety in British Columbia health care. AlterNative: An International Journal of Indigenous Peoples. 2017;13(3):179-89.
38. Whalen DH, Moss M, Baldwin D. Healing through language: Positive physical health effects of indigenous language use. F1000Research. 2016;5.

39. Auger M. Cultural continuity as a determinant of Indigenous Peoples' health: A metasynthesis of qualitative research in Canada and the United States. The International Indigenous Policy Journal. 2016;7(4):3.
40. Marsh TN, Coholic D, Cote-Meek S, Najavits LM. Blending Aboriginal and Western healing methods to treat intergenerational trauma with substance use disorder in Aboriginal peoples who live in Northeastern Ontario, Canada. Harm reduction journal. 2015;12(1):14.
41. Marsh TN, Cote-Meek S, Young NL, Najavits LM, Toulouse P. Indigenous healing and seeking safety: A blended implementation project for intergenerational trauma and substance use disorders. International Indigenous Policy Journal. 2016;7(2).
42. Auger M, Howell T, Gomes T. Moving toward holistic wellness, empowerment and self-determination for Indigenous peoples in Canada: Can traditional Indigenous health care practices increase ownership over health and health care decisions? Canadian Journal of Public Health. 2016;107(4-5):e393-e8.
43. Lewis ME, Myhra LL. Integrated care with indigenous populations: a systematic review of the literature. Am Indian Alsk Native Ment Health Res. 2017;24(3):88-110.
44. Gadacz R. First Nations. The Canadian Encyclopedia: Historica Canada.; 2019.
45. Freeman MA. Inuit. The Canadian Encyclopedia: Historica Canada; 2020.
46. Gaudry A. Métis. The Canadian Encyclopedia: Historica Canada; 2019.
47. Katz A, Enns J, Kinew KA. Canada needs a holistic First Nations health strategy. CMAJ. 2017;189(31):E1006-E7.
48. Reading C, Wien F. Health inequalities and social determinants of Aboriginal people's health. Prince George: National Collaborating Centre for Aboriginal People's Health; 2008.
49. Salloum M, Warburton DE. Importance of Spiritual Wellbeing in Community-Based Health Interventions in Indigenous Peoples in BC. The Health & Fitness Journal of Canada. 2019;12(1):117-23.
50. Wright A, Gabel C, Ballantyne M, Jack S, Wahoush O. Using two-eyed seeing in research with indigenous people: An integrative review. International Journal of Qualitative Methods. 2019;18:1609406919869695.
51. Struthers R, Hodge FS, Geishirt-Cantrell B, De Cora L. Participant experiences of talking circles on type 2 diabetes in two Northern Plains American Indian tribes. Qualitative Health Research. 2003;13(8):1094-115.
52. Hodge FS, Fredericks L, Rodriguez B. American Indian women's talking circle: A cervical cancer screening and prevention project. Cancer: Interdisciplinary International Journal of the American Cancer Society. 1996;78(S7):1592-7.
53. Daley CM, James AS, Barnoskie RS, Segraves M, Schupbach R, Choi WS. "Tobacco Has a Purpose, Not Just a Past": Feasibility of Developing a Culturally Appropriate Smoking Cessation Program for a Pan‐Tribal Native Population. Medical anthropology quarterly. 2006;20(4):421-40.
54. Haozous EA, Eschiti V, Lauderdale J, Hill C, Amos C. Use of the talking circle for Comanche women's breast health education. Journal of Transcultural Nursing. 2010;21(4):377-85.

Appendix 1 – Definitions of First Nations, Inuit, and Métis

The term First Nation is used to describe Indigenous peoples who have inhabited North America before European colonization and settlement and since time immemorial, excluding those of Inuit or Metis ancestry (44). Similarly, the Inuit are the first peoples who have inhabited the Arctic region of North America since time immemorial (45). Lastly, the Métis refer to those of mixed Indigenous and European ancestry that originated from the Red and Saskatchewan River settlements in Manitoba (46).

Appendix 2 – Two-eyes seeing research and research teams

Elder Albert Marshall is credited with bringing two-eyed seeing forth. The teachings come from the late Chief Charles Labrador of Acadia First Nation, as well the work of Elder Murdena Marshall, and the Institute for Integrative Science and Health (Bartlett, Marshall, Marshall & Iwana, 2012). Existing evidence suggests that the provision of holistic care to Indigenous communities is positively associated with health care engagement and improvements in well-being (47, 48). The benefits associated with this approach, have resulted in calls for the adoption of 'two-eyed seeing' throughout the health care system in order to ensure that all Indigenous patients have access to culturally safe care (49).

There have been amplified calls for the implementation of two-eyed seeing research teams in all research disciplines that may impact Indigenous peoples, and such approaches are increasingly being employed in health research settings (24, 50). As traditional research is often structured around Western epistemological approaches and perspectives, two-eyed seeing requires that the research be meaningful and relevant to Indigenous peoples. This is done through ensuring the research mobilize Indigenous approaches to knowledge sharing and dissemination, from study conception to conclusion. For this study, the two-eyed seeing research team that was responsible for creating the study questions and questionnaire guide, organizing, and guiding the talking circle, collecting data, conducting the analysis, and presenting the study findings. This team consisted of both Indigenous and non-Indigenous men and women who have experience employing both Indigenous and Western methodologies in their work and have training in qualitative research and thematic analysis. Our roles through Indigenous Health and Vancouver Coastal Health provide us with the opportunity and privilege to explore Indigenous peoples' experiences and perspectives on healthcare, and our intent is to mobilize our collective skills and abilities to highlight Indigenous peoples' and communities' priorities in relation to healthcare service delivery.

Appendix 3 – Talking Circle Procedures

In both talking circles, participants were asked a series of questions relating to their experiences in health research and health care; ways that health care can be or has been improved in order to meet the needs of Indigenous populations; and, they were asked to provide examples of health care and health research priorities. Each round began with the introduction of the research question to the talking circle by a member of the research team, followed by a personal example that addressed the specific question. A symbolic object of power, such as a talking stick, was then circulated, which provided the object holder with the opportunity to share their stories and experiences on a given research subject. When a participant was done sharing, they would then pass the object to the next participant and this process was repeated for each of the research subject areas. As part of this process, the research team also participated in the talking circle and we had the opportunity to introduce ourselves and share our experiences, insight, and intent. This process and approach has been used and described in previous health research studies (51-54).

Appendix 4 – Status of Indigenous Cultural Safety training within the study setting

To date, the Provincial Health Services Authority of British Columbia offers an online Indigenous Cultural Safety (ICS) training program available to health care staff. Similarly, the Vancouver Coastal Health authority is committed to advancing culturally safe health care through the Aboriginal Health team. This team developed an ICS policy with the intent of supporting Indigenous patients through increased access to traditional medicines, the promotion of the inclusion of Indigenous knowledge and expertise at all levels of health service delivery, and by mandating the acknowledgement of traditional territories in all health service events. In addition to supporting patients, this team is responsible for providing in-person ICS training and workshops to health care staff with the intent of improving cultural competency and access to relevant resources. An evaluation of the ICS program is currently underway with the intent of expanding ICS training to all health care workers in the region.

While efforts are underway to expand access to such services and implement primary care networks for Indigenous patients, these services remain out-of-reach to many Indigenous patients throughout BC and Canada. As such, the promising experiences shared by participants who accessed health care services at an urban Indigenous health clinic are unlikely to represent the experiences of other Indigenous patients as a whole. Given the past and ongoing impacts of colonization on Indigenous cultural practices and the sharing of traditional knowledge, providing spaces for traditional healing practices, implementing cultural safety training for health care providers, and ensuring access to culturally safe and welcoming health care settings is critical to improving Indigenous patients' health care experiences and outcomes.