Article details: 2022-0135
Title: “We need to raise the bar!”: A qualitative exploration of Indigenous patients’ experiences of racism and perspectives on improving cultural safety within healthcare
Authors: Andreas Pilarinos MPP, Shannon Field BHES, Krisztina Vasarhelyi PhD, David Hall MD, Elder Doris Fox, Elder Roberta Price, Leslie Bonshor, Brittany Bingham PhD

Reviewer 1: Carla Ginn
Institution: Faculty of Nursing, University of Calgary
General comments (author response in bold)

Thank you for your outstandingly well-written research regarding a topic of utmost importance.
I have no suggestions for revision.

Reviewer 2: Ms. Jennifer Sedgewick
Institution: University of Saskatchewan
General comments (author response in bold)

1. However, my major critical concern regards the contribution that this paper makes the literature. In the introduction of the paper, the authors outline the extant research that determined the discrepancies in health care experiences between Indigenous peoples and non-Indigenous populations. They also discuss a 2020 report that was conducted within British Columbia (“In Plain Sight...”), the province that their study is in, finding that Indigenous patients reported anti-Indigenous racism. As mentioned by the researchers, the report also discusses the need to improve cultural safety within the healthcare system. When examining the results of this paper, it is unclear what novel contribution is made, as the themes cover the findings outlined in the In Plain Sight report; specifically, it focuses on participants’ experiences with discrimination/racism and the need for improved cultural safety (through means such as Indigenous cultural safety training and Indigenizing the spaces within healthcare settings). In summary, what did this study find that In Plain Sight did not already demonstrate?
We appreciate the Reviewer’s critique of the findings of this manuscript as it relates to those already presented in the *In Plain Sight* report from British Columbia. While we understand the Reviewer’s concerns in the replication of themes, particularly in relation to experiences of racism in the healthcare system, these findings are presented here in order to ensure participants’ voices are effectively heard and understood. In doing so, we have been able to provide context on the specific experiences of the participants in this study, which provides a more nuanced understanding of the promising interventions, practices, or approaches that have been instrumental in improving the comfort and trust experienced by participants. Additionally, this study provides an understanding of how some of the Recommendations outlined in In Plain Sight can be operationalized, in turn providing direction to other researchers, clinicians, healthcare decision-makers, and others on ways to improve Indigenous cultural safety within healthcare, for which there is limited evidence on in Vancouver, Canada. (N/A)

2. Relatedly, the authors state that the previous research has examined experiences and needs of Indigenous patients in hospital settings but that “...similar research among Indigenous peoples’ residing in urban centres is sparse.” It’s unclear from the methods

how Indigenous peoples living in urban centres were specifically recruited, as it is not mentioned that this was exclusion criteria.
The Reviewer's comment regarding the confusion around the population of interest in this analysis is appreciated, and we have worked to update the 'Introduction' and 'Methods' section to indicate that we are interested in the experiences of Indigenous Peoples accessing healthcare services in Vancouver, Canada. (pp. 5, 6)

3. It is also unclear whether participants in the previous studies conducted in hospital settings were from urban, rural, or remote settings, and more importantly, if we were to specifically examine those in urban settings, why their experiences would meaningfully differ in comparison to those who had to travel for care (as those in the latter often have additional/unique barriers). Because this was not distinguished, it is again unclear what the scientific contribution is of the present study.
We have since revised the manuscript and, due to word limit restrictions, removed the section in the 'Introduction' that made reference to existing research among Indigenous Peoples in hospital-based settings. (N/A)

4. More recent literature is needed with regards to Indigenous peoples' (vs. non-Indigenous Canadians') health in Canada
We thank the Reviewer for this suggestion and have included more recent references in the 'Introduction' section. (p. 4)

5. "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..." Be careful not to generalize the practices of some Indigenous groups to all Indigenous groups. Talking Circles are within the umbrella of Indigenous research methods (vs. methods that are Nation specific) but a reference would be necessary to indicate that Circles were used for millennia by First Nations, Métis, and Inuit (and since Métis are a post-contact group, this wouldn't be the case for this group of Indigenous peoples)
We agree with the Reviewer's suggestion that we avoid generalizing the practices of some Indigenous groups to all Indigenous groups. The 'Study design and setting' sections have been updated to clarify that sharing circles were used by some Indigenous communities throughout North America. (p. 6)

6. "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." How are you sure that urban Indigenous peoples were targeted for recruitment? The introduction states that the target population was urban Indigenous peoples
The Reviewer raises and important point and we have updated the manuscript accordingly. More specifically, we have noted that participants were recruited from urban healthcare settings, which has been updated in the 'Abstract' and 'Study design and setting' section. (pp. 2, 6)

7. "Participation in the talking circles was limited to individuals who self-identify as Indigenous and who currently resided in the Lower Mainland" Unclear of the significance of the Lower Mainland in relation to what Indigenous peoples were intended to be targeted (is this an urban centre)? I understand the need to provide context but I am still

trying to understand how specifically urban Indigenous peoples were included. This will not be intuitive to those in other provinces let alone other countries
We appreciate the Reviewer noting that the inclusion criteria for this study were unclear. Additional details have since been included in the 'Participants' section of the manuscript, which emphasizes that participants were required to have been accessing healthcare services within the urban regions of Vancouver Coastal Health. (pp. 6, 7)

8. Within participant demographics, I would include a breakdown of the number of participants per Indigenous group and among those that are First Nations, the number that are status vs. non-status. These experiences would be diverse considering the barriers that status First Nations and Inuit experience from having their medical coverage is through the federal (vs. provincial) government
While we agree with the Reviewer that the inclusion of details about which Indigenous groups that participants are members of, we did not collect this information during the sharing circles and are therefore unable to provide this information. We have included this as a limitation in the 'Limitations' section. (p. 15)

9. I suggest having the themes convey a similar structure. For instance, when presenting the themes side-by-side, they are combination of stating a phenomenon, describing a process (X leads to Y), or providing a recommendation. I think there could be a combination of using phenomena and recommendations (phenomenon such as barrier/limitation that is described followed by recommendation to address the phenomenon) but that would have to be described so that it was clear to the reader.
We appreciate the Reviewer's suggestion on re-organizing the 'Results' section and alternating between phenomena followed by a recommendation. The 'Results' section has since been re-organized; however, we have refrained from alternating between phenomena and recommendations as we found it impacted the flow of the 'Results' section. (pp. 8-12)

10. Under "Discrediting of traditional medicine…" try to use more descriptive language with your findings. For instance, it is mentioned that traditional medicine is "frowned upon" within Western healthcare settings. Are there specific service providers (e.g., doctors, nurses) making these statements, or is it generalized across all types of providers? What about traditional medicine is responded to negatively? Is it that they perceive it to be illegitimate and/or have the potential to negatively interact with Western treatments? I have the same feedback for the following sentence where it describes how Indigenous-specific healthcare services (vs. Western ones) are seen as "lesser than". How did the Indigenous participants describe the experiences when they felt that service providers viewed the Indigenous-specific services as lesser than?
We thank the Reviewer for their request for additional information on how the discrediting of Indigenous traditional knowledge and perspectives on health impacted participants. We have since elaborated within the 'Results' section to indicate that this contributed to additional distrust in healthcare providers and the healthcare system. Additionally, while we understand the Reviewer requested additional details on these experiences, we have excluded additional details due to word limit restrictions. (p. 10)

11. The sentence about Indian segregated hospitals sounds somewhat out of place in this section, as it is presenting new information (this historical perspective was not

present in the literature review). I think that it is important for contextualizing the history of racism in the Canadian medical system though, and so I would include it in the introduction (either on its own or with it reiterated in the interpretation). A related comment: I would include the dates that these institutions ran for to provide context to readers who don't know about them and perhaps, highlight that although Indian hospitals no longer exist, that there are living survivors of these hospitals, and these survivors likely mistrust the Western medical system and ultimately avoid accessing care (I believe the last one closed in the 80s in Treaty 6)
We have since removed mention of Indian Hospitals from this manuscript, and have also updated the 'Introduction' section in order to meet the word limit restrictions. (N/A)

12. "...concerning levels of discrimination, prejudice, and racism..."'Levels' is a quantitative descriptive term, as it implies some kind of measurement. I would suggest changing the language here (and in other sections using this terminology) to something like "experiences" or "narratives". It does not make the findings less legitimate, but it more accurately reflects the type of data that were collected
We thank the Reviewer for noting that 'levels' is primarily used in quantitative research, and we have revised the 'Interpretation' section to reflect this. (p. 12)

13. Table 6: Participants quotations about how culturally safe care improves treatment engagement and health outcomes. The exemplars don't seem to connect with the theme, "Participants quotations about how culturally safe care improves treatment engagement and health outcomes". Specifically, they convey outcomes that are positive, but aren't necessarily connected to 'treatment engagement' and 'health outcomes'. For instance, some of these quotes demonstrate that participants experienced a more humanizing experience at the Indigenous health clinic (not being assigned a number, having service providers advocate on their behalf). Although the material (e.g., healing room) and social (e.g., Elders, social navigators) supports can intuitively contribute to improving treatment and health outcomes, the quotes do not necessarily support this. The quotes are exemplifying something else, and so I recommend taking a deeper analysis of the benefits of Indigenous-specific (vs. general) health clinics for Indigenous peoples.
We agree with the Reviewer's interpretation that the presented quotes do not align with the interpretation that Indigenous-specific services improved health outcomes. The 'Results' section has been updated to reflect this to highlight that the provision of Indigenous-specific services improved participants' trust in healthcare. (pp. 10, 11)

14. Appendix A: "The Métis refer to those of mixed Indigenous and European ancestry that originated from the Red and Saskatchewan River settlements in Manitoba (46)." The reference to the Canadian Encyclopedia describes the Métis as originating largely in Western Canada (rather than specifically talking about the Red River and Saskatchewan River settlements). There are historic and existing Métis settlements in Alberta and so I would state the generalized "Western Canada" piece that is in the Canadian Encyclopedia website
We thank the Reviewer for this suggestion. Given the importance of the Red and Saskatchewan River settlements to the Métis Nation, we have retained this an elaborated that there are other settlements located in other parts of Western Canada. (p. 4)

Reviewer 3: Dr. Kristen Jacklin
Institution: University of Minnesota Duluth
General comments (author response in bold)

1. The title should more specifically describe the study. It should make reference to the study focus on an urban Indigenous patient population in Vancouver.
Please see the Associate Editor response #4. (N/A)

2. The opening paragraph argues that persistent inequities exist for Indigenous peoples, however the references (1-6) are quite dated. This statement needs to be supported by more current literature and/or case studies that demonstrate the inequity overtime. The historical references should be retained to show that there has been evidence of systemic racism for decades yet it persists.
Please see Reviewer 1 response #4. (N/A)

3. Final paragraph of the introduction (page 5, lines 29-31) should include references to the urban studies that were identified
We thank the Reviewer for this suggestion, and we have briefly mentioned existing research that has examined the healthcare experiences and perspectives on cultural safety among Indigenous peoples in Vancouver, Canada in the 'Introduction' section. (p. 5)

4. Page 6 line 17 typo "Participants were by recruited through…"
This typo has been corrected. (p. 6)

5. Page 6 Please indicate if participants were required to be 18+ and/or if there was a target for an age range or gender distribution.
Please see Associate Editor revision #12. (N/A)

6. Page 6 lines 42-43: Include the dates that the study was conducted. Did the data collection occur pre-COVID, during or Post?
Please see Associate Editor revision #7. (N/A)

7. Page 6 line 49 typo "and were audio recorded and transcript…" (transcribed?)
This typo has been corrected. (p. 7)

8. The analysis section needs to reference the theoretical framework that guided question development and the thematic analysis.
We thank the Reviewer for this suggestion and have since updated the 'Study design and setting' and 'Data analysis' sections to indicate the patient-centered accessibility framework guided question development and thematic analysis. (pp. 6, 8)

9. The analysis needs more description overall. How as the analysis conducted? Did the researchers hand code or use software. How was the data organized, sorted and retrieved. Could you give an example of the analysis tables or procedure in a figure? Did both researchers code the data? Was the data double coded? (not necessary but should be reported). How did they check for coding reliability? Can the coding book or coding tree be included as an appendix?
Please see Associate Editor response #1. (N/A)

10. What is the significance of the themes being presented at a 'health knowledge translation event'? Who attended/who was invited and why and how were they able to 'validate' the findings? Are these individuals considered study participants and if so, how were they recruited? What was the impact of this process on the analysis?
Please see Associate Editor response #2. (N/A)

11. A general question that should be addressed in the opening paragraph is the timing of the experiences shared. The authors make the argument that racism persists therefore it is important to let the readers know the context of the stories shared. Were participants asked to reflect on current experiences? Is there any way for the authors to know if the experiences were in the recent past or historical? This is especially relevant to the first theme (table 2). This piece of information will help readers evaluate the findings and is important to the authors interpretation around the value of cultural safety training and self-determined health care in this province.
We thank the Reviewer for their recommendation on providing more context on whether participants' experiences were recent or historical. Unfortunately, we did not collect this information during the sharing circles and are unable to discern this, and we have mentioned this in the 'Limitations' section of the manuscript. (p. 15)

12. The interpretation can be strengthened. There is more to be said about these findings in relation to present day challenges and initiatives, for example, the TRC recommendations on healthcare; health care professional training/physician training; and self-determination. The interpretation could also be strengthened by delineating how these findings add to what is known (what findings from other studies do these findings also support?), and what does this study add? For example, there seems to be evidence to support the value of self-governing health care in combination with universal cultural safety approaches/training that could be implemented nationally. Participants clearly had better experiences with the Indigenous led clinics!
We thank the Reviewer for suggesting that we enrich the 'Interpretation' section, with specific emphasis on Indigenous self-determination over healthcare services. We have since updated this section in relation to other, existing literature, including on the importance of Indigenous self-determination over healthcare as outlined by the Truth and Reconciliation Commission. (pp. 12-15)

13. Page 11 lines 32-33: needs to specify that the persistent racism revealed in this study is within the healthcare system 'in lower Vancouver'.
This has been noted and updated within the 'Interpretation' section. (p. 12)

14. Second paragraph of interpretation: the transition to the historical routes (i.e., Indian hospitals) seems out of place and does not add any value to the paper.
We thank the Reviewer for noting this and have since removed mention of Indian Hospitals throughout the manuscript. (N/A)

15. Page 12 lines 21-43 in reference to cultural safety. The authors describe cultural safety in the Canadian context but reference the seminal New Zealand paper (34). It would be helpful to reference the ICS here and/or other Canadian approaches.
We agree with the Reviewer's comment regarding the reference to the seminal article from Aotearoa. We have since updated the 'Interpretation' to highlight work underway at VCH, though this is brief due to the word limit restrictions. (p. 13)

16. The information in appendix 4 is very important to the interpretation and importance of the study. Focusing lines 21-43 on the relevance of the study results in relation to the status of cultural safety training in BC and Canada as whole would make an important contribution to our understanding of the value of this approach to combating racism. It is important to acknowledge that BC has done more than most other provinces to implement and require this training.
We have since updated the 'Interpretation' section to discuss existing efforts to expand Indigenous cultural safety training in BC, as well as to discuss the importance of Indigenous self-determination over healthcare. (pp. 13-15)

17. I would suggest that the fact that this was an urban study is not a limitation, rather, it was by design to fill a gap in our knowledge. I would consider removing it as a limitation.
This has been removed from the 'Limitation' section as suggested by the Reviewer. (N/A)

18. The study has a significant gender bias that must be acknowledged and discussed. The sample is almost entirely female. How might this have affected the data and analysis?
Please see Associate Editor response #11. (N/A)

19. Page 21 – references 44-54 are not cited in the manuscript and there is a reference 85 that is blank.
We thank the Reviewer for noting this. The references that are part of the Appendix sections have since been moved to the respective Appendix, and all references located within the main 'References' section now correspond with those included in the manuscript. (pp. 21-25)

Reviewer 4: Dr. Udoka Okpalauwaekwe
Institution: University of Saskatchewan College of Medicine
General comments (author response in bold)

1. Please capitalize the term Indigenous Peoples throughout the manuscript. This is part of the elements of Indigenous writing. For more information, see Younging G. Peters M. Elements of Indigenous Style: A Guide for Writing by and about Indigenous Peoples.
We thank the Reviewer for noting this and 'Indigenous Peoples' has been capitalized throughout the 'Abstract' and manuscript. (pp. 2, 3)

2. The aim of your study in the abstract detracts from the aim and title of this work. I agree part of the study objectives were to learn about Indigenous People's healthcare experiences and perspectives on promising practices but stay focused on the specific aims which you highlighted in your title as racism and cultural safety which I believe is less ambiguous than the former.
We agree with the Reviewer's suggestion on the need to emphasize that this study examined experiences of racism in healthcare and perspectives on culturally safe healthcare, and we have updated the language in the 'Abstract' and throughout the manuscript. (pp. 2, 3)

3. I don't know that the term Two Eyed seeing research Team is the appropriate language to use. The Two Eye Seeing is an approach to research or engagement with Indigenous communities coined by Elder Marshall. The team can't be Two Eyed seeing

in itself but is comprised of persons from different worldviews working together toward a common goal. Consider rephrasing.
The Reviewer's suggestion that Two-Eyed Seeing is an approach and not a research methodology is an important consideration, and we have updated the 'Abstract', 'Study design and setting', and 'Appendix 1' sections to reflect this. (pp. 2, 3, 5, 6, 24)

4. The outlay of your findings could be better rephrased to engage your readers and not in the descriptive format you did. Point out the key findings (major themes, minor themes, etc); lessons learned and recommendations
The outlay of the 'Results' section of the 'Abstract' has been updated to reflect the Reviewer's recommendation that we avoid the descriptive format we employed in favor of a discussion of the major and minor themes we identified. (pp. 2, 3)

5. "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." Who are many in this statement? Be specific, please. [Ed's note: We would prefer that you not attempt to quantify 'many'.]
We thank the Reviewer for this suggestion. However, in accordance with the Editor's recommendation, we have refrained from quantifying these findings. (N/A)

6. Also, you identified the culture as treatment philosophy as your finding and recommendation and ended with 'may improve Indigenous patients' willingness to use healthcare services.' That sounds contradictory as a conclusion. If the study showed the solution, it is the solution and not the probable one. I will take out may improve as many studies, including the Truth and Reconciliation Commission, point to culture as the means to improve wellness among Indigenous Peoples. It is certainly not a probability.
We agree with the Reviewer's comment and have removed all references that imply that culture 'may' improve Indigenous Peoples' health in favour of language that indicates that culture is central to improving Indigenous Peoples' health. (p. 3)

7. Good start but a lot of gaps in the introduction section generally. In writing about Indigenous Peoples, it is more engaging to tell it like it happened, like a story, while acknowledging the truths of history that led to where they are now. You start with this, "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", But then skip many steps and end with the UNDRIP statement. What happened in between? What caused these inequities? How do they continue to be perpetuated in our time? What are statistics on inequities (focus on the ones relevant to your research question) Indigenous Peoples face and currently face as a result of intergenerational trauma from IRS and Sixties scoop? These narratives must be mentioned as part of the journey towards reconciliation (as proscribed by the TRC, UNDRIP, TCPS2 and so on). Glossing over them raises questions about the authenticity of your engagement proceedings.
We thank the Reviewer for this recommendation and the need to provide a historical overview of the impacts of ongoing colonialism and anti-Indigenous racism on health inequities between Indigenous Peoples and non-Indigenous populations. We have since updated the 'Introduction' section to reflect this, though due to word limitation restrictions we were unable to provide a more in-

depth, nuanced history of this relationship. Nevertheless, we have attempted to provide some context to this. (p. 4)

8. The segue into the next paragraph on racism and DRIPA lacks logical flow and skips a lot of information in between.
We agree with the Reviewer that the paragraph on racism and DRIPA lacked logical flow, and we have re-written the 'Introduction' section for clarity and to improve flow. (pp. 4, 5)

9. "Due to the persistent health inequities experienced by Indigenous peoples, there has been a move towards self-determining" you mean self-determination, not determining.
The 'Introduction' section has since been re-written and references to Indigenous self-determination have been moved to the 'Interpretation' section of the manuscript. (pp. 14, 15)

10. "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." I have a lot of questions about this statement. First, what initial positive improvements are you referring to here? Secondly, you claim recent research indicates a health gap and cite only one study. Thirdly in what direction is the gap growing in light of the improvements you mentioned?
We thank the Reviewer for noting the confusion in this statement. In order to provide more clarity, we have expanded on the findings presented by the First Nations Health Authority in the 'Interpretation' section of the manuscript. (p. 15)

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." I respectfully disagree with the last statement that similar research among Indigenous Peoples in urban centres is sparse, because you mention again in your interpretation some references which prove studies are not sparse
The Reviewer's raises and important point of contradiction regarding other research among Indigenous Peoples in urban centres. We have updated the 'Introduction' section to note that there is limited research examining experiences of racism and perspectives on culturally safe healthcare within Vancouver, Canada, and have updated the 'Introduction' section accordingly. (p. 5)

12. "Consistent with existing evidence, racism and discrimination towards Indigenous peoples is commonplace within healthcare settings (9, 14, 19, 31)" If you like I can provide you with more than 20 recent studies done between 2020 and now in this area. You should do a proper literature review before making these unfounded assertions. And it is not a knowledge gap because you can't find enough articles for similar inquiries. Indigenous communities are unique, and what is attainable for one might be different for the other; hence that could be a knowledge gap for the specific community but not a generalized knowledge gap for all and sundry
We thank the Reviewer for their comments and suggestion. The text has since been updated to indicate that this was in reference to British Columbia, where anti-Indigenous racism has been recognized as concern and challenge throughout British Columbia's healthcare system. (p. 13)

13. Your methods section needs a total overhaul. Finding the rigour and scholarship in your work with the community was difficult. I had so many questions about what you did and how it was executed in a manner that ensured transparency, credibility, reproducibility, reflexivity and rigor of your work. I think the advantage of using COREQ or other reporting guidelines is to ensure you don't miss things like these. Please kindly revise to address the following: Ethical considerations; Setting and community engagement strategies; Study design; Participant recruitment and sampling strategy (inclusion and exclusion criteria); Data collection and data collection instruments; Data processing and analysis; Data Interpretation strategies; Reflexivity or techniques used to enhance rigour (trustworthiness, credibility, confirmability, transferability, and so on)
Please see Associate Editor response #1. (N/A)

14. Again Two-Eyed seeing is a research approach subsumed in one of the following study types: qualitative or quantitative. It is not a study design in itself, so I don't understand why it is listed as one. The Tri-Council Policy Statement (TCPS) on Ethical Conduct for Research involving Humans indicates in Chapter 9, states that where research involves First Nations, Inuit, and Métis peoples and their communities, they are to have a role in shaping and co-creating research that affects them; with respect being given to the autonomy of these communities to decide to participate. So either your study design was informed by some community-based participatory form of research or other forms of collaborative inquiry, I don't see how TES is the study design. Consider revising, please
Please see Reviewer 4 response #3. (N/A)

15. Possibly, give a short definition for TES and the value it brings to community-engaged Indigenous research/projects.
Please see Reviewer 4 response #3. (N/A)

16. "Participants were provided with lunch and received $25 CAD" this is not necessary. You could rephrase it as honorarium or gift exchange, a custom in Indigenous communities. Stating this is also promoting colonizing values antithetical to the objectives of your study
We agree with the Reviewer's comment and have updated the 'Participants' section to indicate that an honorarium was provided to participants in appreciation for their time and participation. (p. 7)

17. I want to add to emphasize the importance of engagement of Indigenous patients in treatment strategies (be it western or traditional) as this promotes the UNDRIP statement to pursue self-determination. Indigenous Peoples have lost faith in healthcare not only to racism and other forms of discrimination but to the misperceptions and stereotypes that continue to perpetuate in our structural systems that fail to engage them meaningfully in promoting self-determination and decolonizing structures of oppression. As part of the journey towards reconciliation per TRC's 94 statements, Canadian health practitioners should not only learn about culturally safe practices but engage meaningfully with Indigenous Peoples to continue to learn the specific ways to enhance their wellness in a manner that ensures autonomy and self-determination is preserved. This strength-based (as opposed to the deficit-based in western epistemologies) approach enhances wellness and fulfils the commitment toward reconciliation.
We thank the Reviewer for this comment and suggestion, and have updated the 'Interpretation' section to reflect the importance and value of Indigenous self-determination over healthcare. (pp. 14, 15)

18. Your references are inconsistent throughout. Please ensure it adheres with *CMAJ* guidelines. Only words after a full stop should be capitalized as well as proper nouns. Also confirms whether journals should be abbreviated or not, with Doi or not and if web-based, include the date of last access

We thank the Reviewer for noting these inconsistencies and we have reviewed and updated the citation accordingly. (pp. 21-26)