ORIGINAL ARTICLE

'We're racially profiled as drunk Indians' – experiences of Indigenous rural British Columbians accessing health care

Terri Aldred, MD, CCFP, BHSc, GCIPH[1,2,3,4,5], Cheryl Schweizer, BEc, Med, DFMA[1], Erika Pritchard, BSc[2], Jordan Christmas, BSc[1], James Liu, BSc, MD, CCFP(EM)[1], Dana Hubler, MD, FCFP[2], Lee Yeates, MHM, CHE, RM, BA, BHSc[1,2]

[1]Department of Family Medicine, The University of British Columbia, Faculty of Medicine, Vancouver, BC, Canada, [2]The Rural Coordination Centre of British Columbia, Vancouver, BC, Canada, [3]First Nations Health Authority, West Vancouver, BC, Canada, [4]Carrier Sekani Family Services, Prince George, BC, Canada, [5]Northern Health Authority, BC, Canada

Correspondence to: Erika Pritchard, epritchard@rcebc.ca

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Abstract

Introduction: The present study examines the experiences of anti-Indigenous racism derived from the data collected across rural British Columbia (BC) through the Rural Coordination Centre of British Columbia's Rural Site Visits Project. This study aims to demonstrate how and where people are being treated inequitably in the healthcare system and to highlight racism and its negative impact on patient care.

Methods: We used an action-oriented methodology and incorporated Indigenous methods into the analysis. Participants and focus groups were identified using Boelen's Partnership Pentagon Model, and the data were collected using an appreciative inquiry approach. The data were analysed using thematic analysis.

Results: The various forms of racism appearing in health care were identified together with their impacts on patient care. Primary care providers appeared unaware of the extent of discrimination and barriers to care affecting Indigenous community members, suggesting a disconnect between provider perception and patient experience. Finally, the steps towards culturally safe health care were proposed.

Conclusions: Anti-Indigenous racism exists and adversely impacts the care Indigenous peoples receive throughout rural BC. Our study invites healthcare providers to reflect upon their practice and become more culturally aware and humble to improve Indigenous peoples' access to care, health outcomes and experiences.

Keywords: Anti-Indigenous, British Columbia, cultural safety, equity, family medicine, general practice, health care, Indigenous health, primary care patients, qualitative research, racism, rural, rural health and medicine, safety

Résumé

Introduction: Notre article examine les expériences de racisme anti-autochtone tirées des données recueillies dans les zones rurales de la Colombie-Britannique dans le cadre du Rural Coordination Centre of British Columbia's Rural Site Visits Project (projet de visites des sites ruraux). Ce document vise à démontrer comment

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et où les personnes sont traitées de manière inéquitable dans le système de santé et à mettre en évidence le racisme et son impact négatif sur les soins aux patients.
Méthodes: Nous avons utilisé une méthodologie orientée vers l'action et intégré des méthodes autochtones dans l'analyse. Les participants et les groupes de discussion ont été identifiés à l'aide du modèle Pentagone du partenariat de Boelen et les données ont été recueillies à l'aide d'une approche d'enquête appréciative. Les données ont été analysées à l'aide d'une analyse thématique.
Résultats: Les différentes formes de racisme apparaissant dans les soins de santé ont été identifiées, ainsi que leur impact sur les soins aux patients. Les prestataires de soins primaires ne semblaient pas conscients de l'ampleur de la discrimination et des obstacles aux soins qui affectaient les membres de la communauté autochtone, ce qui suggère un décalage entre la perception du prestataire et l'expérience du patient. Enfin, les étapes des soins de santé culturellement sûrs sont proposés.
Conclusions: Le racisme anti-autochtone existe et a un impact négatif sur les soins que reçoivent les populations autochtones dans les zones rurales de la Colombie-Britannique. Notre article invite les prestataires de soins de santé à réfléchir à leur pratique et à devenir plus conscients de la culture et plus humbles afin d'améliorer l'accès aux soins, les résultats en matière de santé et les expériences des populations autochtones.

Mots-clés: Anti-autochtones, colombie-britannique, equite, medecine familiale, medecine generale, patients en soins primaires, recherche qualitative, rural, sante autochtone, sante et medecine rurales, securite culturelle, securite, racisme, soins de sante

INTRODUCTION

Previous qualitative research has documented adverse healthcare experiences amongst Indigenous peoples seeking medical care.[1] Indigenous patients have observed healthcare providers shifting from pleasant demeanour to negative attitudes as the providers transition between non-Indigenous and Indigenous patients.[2] Explicit discrimination and contempt towards Indigenous approaches to health and wellness have also been documented.[3] Fear of discrimination has resulted in care avoidance.[1] The recent In Plain Sight report documents widespread, systemic anti-Indigenous stereotypes and discriminatory experiences for Indigenous peoples in British Columbia's (BC) healthcare system.[4] The downstream effects of these discriminatory experiences are significant. For example, Indigenous patients who feel the health services they receive are not culturally appropriate face greater barriers to care that can lead to reduced access to preventative care and disease management, increasing the likelihood of diabetes prevalence.[5] Furthermore, discrimination by healthcare providers is directly associated with unmet health needs.[6]

Anti-Indigenous racism regularly occurs in a variety of healthcare settings and can impact the experience of every Indigenous patient in every healthcare encounter. Our study examines the data from the Rural Coordination Centre of British Columbia (RCCbc) Rural Site Visits Project[7] (SV Project) to offer a perspective on anti-Indigenous racism from rural BC communities. It contributes to the body of literature documenting anti-Indigenous racism by bringing the data collected systematically from rural communities across BC. Our study aims to demonstrate how and where people are being treated inequitably in the healthcare system and highlight racism and its negative impact on patient care. In addition, we invite healthcare providers to reflect upon the suggested steps towards reconciliation of culturally safe health care with the aim of improving Indigenous peoples' access to care, health outcomes and experiences.

METHODS

The SV Project engaged rural BC communities to gain insight into healthcare successes, innovations and challenges, by combining an action-oriented methodology with appreciative inquiry (AI). An action-oriented methodology with AI focused on driving positive change by identifying and building on existing strengths within a system. It encouraged collaborative engagement, leveraging previous successes and envisioning an ideal future to create actionable steps for improvement.[8] While focusing specifically on cultural safety and racism was not the SV Project's intent, thematic analysis uncovered the prevalence of anti-Indigenous racism across rural BC. Consequently, this team

came together to further analyse the contributory data.

The following Indigenous methodologies[9] were used:

- An Elder participated as a co-author. Elder Cheryl provided the following example: the Elder title is one I don't take lightly but one of respect, integrity and honour. I honour the Elders and acknowledge I am a young Elder but I do not sit alone. I had my aunties bear witness and affirm like when we are in potlatch
- Indigenous methodologies often avoid traditional thematic analysis methods as it risks non-Indigenous researchers misinterpreting Indigenous experiences. Instead, complete quotes are used to authentically preserve Indigenous voices and perspectives
- As authors, we positioned ourselves as a fundamental component of how we all worked together, sharing reflections of who we are and how the work impacts us in a sharing circle format
- Authors engaged an external Indigenous review panel to ensure harm is minimised and the review identified themes for data congruency.

Recruitment

In each community, Boelen's Partnership Pentagon Model was adapted to identify participants from the following health partner groups: Indigenous leaders, Indigenous community members, health administrators, municipality members, nurse practitioners, midwives and physicians.[10] Where relevant, academics, first responders and community health groups were also included. All participants were recruited using purposeful and snowball sampling.

Data collection

After obtaining informed consent from all participants, site visitors used an AI (appreciative inquiry) approach, supported by an iteratively refined semi-structured guide, for data collection. Interviews and focus groups lasted approximately 1 h and were audio recorded, transcribed and anonymised. In keeping with First Nations Ownership, Control, Access, and Possession principles,[11] each transcript was returned to participants for verification, alteration or withdrawal prior to analysis. The data were collected between April 2018 and March 2020 from interview meetings of Indigenous and non-Indigenous participants in rural subsidiary agreement (RSA) communities across BC.

Data analysis

The research team performed iterative thematic analysis on all SV Project data and continuously revisited, compared and modified codes to accommodate incoming data. The use of NVivo 12 (QSR International) facilitated effective data organisation.

Ethics

Harmonised ethics approval from the Behavioural Research Ethics Board of the University of BC was obtained for the SV Project. Operational approval was obtained from every BC health authority.

RESULTS

There were 44 First Nations community meetings and 24 combined partner meetings that included Indigenous partners. Three hundred and eighty-two interviews with Indigenous and non-Indigenous participants were conducted in 107 RSA communities.

Theme 1: Forms of racism appearing in health care

The data analysis revealed multiple forms of racism including systemic, epistemic and interpersonal as demonstrated by the quotes in Table 1.

Failure by healthcare providers to recognise, confront and redress racism impedes Indigenous peoples' access to high-quality, culturally safe care.

Theme 2: Impacts of racism on health care

Many participants described experiences of negative interactions when seeking health care in their respective communities [Table 2]. Negative experiences impact patient care in many ways including care avoidance and leaving against medical advice as outlined in Table 3.

Table 1: How racism is experienced in health care
Examples of systemic racism
'…You're not actually saying it out loud, it's still happening…it's much more difficult to identify and define because it's so subtle, but you can still feel that it's there. It's hard to have a conversation about it because it's really hard to catch. And when it comes to language and behaviours and stuff, I deal with this all the time…and you try and explain, no, it's about the impact. 'But I didn't', 'but I didn't', 'but I didn't' – but the impact was the same.' - Health administrator meeting
'What keeps me up at night, it's the racism people suffer. The residential school for the region was right here, and that is on the surface still and a very real experience for people that I still think we're not doing a great job of caring for. There's just so much trauma that falls from that. And then people suffer here when they wouldn't suffer if they had…easier access to healthcare. And a lot of people tell me, I'd rather stick it out and suffer and, you know, die uncomfortably here.' - Indigenous community meeting
Examples of epistemic racism
'…But we're not ignorant, we're not handicapped, we just have a different way of knowing. I believe we're very intelligent, I believe everybody's an expert and it's just when you're dealing with one of us, just treat us as such. Just because we're quiet or whatever, we're not stupid…. I don't know what it is, why they do that sometimes to first nations.' – Indigenous community meeting
'Our settler population don't really appreciate the history because they've only been given it in one form. So, we have been taught history in a certain way that is the perspective of the people who wrote the books, who were also settlers. We don't get a lot of Indigenous historical material to reflect on to get the other perspective of the same events. And so you've got a lot of potential for education there, for sure.' - Health administrator meeting
Examples of interpersonal racism
'A client came struggling with addiction and his past historical trauma was never put into any consideration at all. He told me 'I went to the hospital and they told me that I was fine. The doctor didn't even listen to my chest' So I (FN health director) went with him back to the hospital and the difference he received in service was unbelievable.' - Indigenous community meeting
'It has always been hard to go to the hospital as an Indigenous person. Ever since I've gone to the hospital we have been discriminated against.' - Indigenous community meeting

Table 2: Patient experience	
Negative Experiences When Accessing Health Care	Example
Concerns around inadequate care and unmet need	*'Just over and over, people not being properly tested for certain things. Somebody came in with kidney infections and sent home, didn't even have a urine dip test, and finally the daughter had to phone the ambulance and the Elder almost died because of sepsis… I have tons of stories.'* - Indigenous community meeting
	'…I was in and out of hospitals for years, in and out of doctors, nobody knew what was wrong with me…I went to see my own doctor…and she kept saying, well, I think it's because you're drinking…I'm not a binge-drinker…And I finally saw a naturopath and she said, you're really swollen. You need to try to cut gluten out of your diet…I was fine as soon as I cut that out of my diet. My body felt different, I wasn't as sick, and I went back to my doctor and said, I've been off gluten for this amount of time, and she said, I don't know why we did n't test you for that. And I said, well, because you've been telling me for so long that I'm just a drunk Indian…it's really frustrating. That was the experience I've had, and a lot of the experiences other people have are the same, where we're racially profiled as Drunk Indians.' - Indigenous community meeting
	'...if we had that liaison in the hospital when my cousin went in there, they would've helped them… because he went in and he was in pain, the ambulance brought him in but the doctor didn't want to know, so they just sent him home and on his way home he collapsed and he passed away because he had extensive brain injury...' - Indigenous community meeting
Culturally unsafe care	*' With my experience, someone was passing away up at the hospital and the nurses kicked everybody out and told them to go somewhere else... The family members. And when it comes to First Nations people, everybody gathers. You can't shoo them away. It's their family. It's their loved ones.'* - Indigenous community meeting
	'... Elders often don't speak but it doesn't mean they don't have an opinion. They might just not show up again, their sickness is still there, their needs are not being met.' - Indigenous community meeting

Theme 3: Disconnect between physician and community perceptions

There appears to be a disconnect between how physicians and Indigenous community members perceive Indigenous patient experience [Table 4].

Theme 4: Steps towards culturally safe health care

Participants shared numerous local initiatives and recommendations for improving culturally safe and affirming health care, as outlined in Table 5.

Table 3: Impact on patient's care (what the experiences lead to)

Impact	Example
Trust in care	*'What keeps me up at night is the fear that someday one of our people is going to be turned away from that emergency department and is going to die as a result of it.'* - Indigenous community meeting
	'So all these horrible experiences happen and it's in our community, so now you hesitate, are they even going to take me seriously? Do I have to wait until I'm half dead before they'll see me, you know?' - Indigenous community meeting
Access to care	'*Many people have felt very discriminated against at the hospital, both in an emergency – they've actually left sometimes and gone to other hospitals in the area because they felt that they weren't provided services.*' - Indigenous community meeting

Table 4: Disconnect between healthcare partners and Indigenous community members

Quote
'And you know I never saw any discrimination but he would tell me that he experienced discrimination every day and I don't see discrimination of the First Nations. But if you talk to them they perceive it constantly…' - Physician meeting
In (community X) when asked if Indigenous patients were comfortable coming into the local hospital
'I think so.' - Physician 1
'I think so too. I really think so,' - Physician 2
'Some (people) go to (another town) (to see a doctor) because they don't...They don't appreciate the way they've been treated here…' - Indigenous community meeting

Drawing from Indigenous participants' numerous suggestions for reconciliatory steps [Table 5], we created a list of actionable practices for healthcare providers [Table 6], organised using an expanded four Rs Framework: Respect, Relevant, Reciprocal, Responsibility and the fifth R added for Relationship. [12,13]

DISCUSSION

Anti-Indigenous racism permeates across multiple locations and healthcare settings, impacting the care Indigenous peoples receive in rural BC. A gap exists in Indigenous-led inquiry and literature specific to rural BC. In recognising that epistemic racism influences how scholarly work is created and communicated and affects how non-Indigenous authors engage with Indigenous lived experience, maintaining epistemic awareness and actively working to decolonise our approach was essential. Participants shared experiences highlighting numerous ways interpersonal, epistemic and systemic racism negatively impact Indigenous health and wellness and how historical events (Indian hospitals, residential schools, 60's scoop, the forced removal of Indigenous peoples from traditional lands) continue to contribute to Indigenous peoples' reluctance to engage with the healthcare system.[14,15]

Many communities identified the lack of culturally safe care as a serious concern, recounting experiences of avoidable misdiagnoses that led to harm. These experiences are consistent with previously documented findings from the In Plain Sight Report[4] and through the inquest into the death of Brian Sinclair, who died waiting to be seen in the ER of a Manitoba hospital.[16] Both explicit and implicit biases (racism) can lead to Indigenous peoples feeling unsafe accessing health care; however, implicit biases that impact the care of Indigenous peoples are insidious and can be more difficult to name and address.

Racially implicit bias may lead physicians to underdiagnose, undertreat or assign more racially stereotypical diagnoses to patients based on racial or ethnic background.[4,14,17] Table 3 demonstrates how clinician biases undermine the trust and impede access to care. The impact of racial bias on patient care in Canada warrants further investigation, as the current literature is limited.

Our study joins a larger body of literature including the In Plain Sight report, First Peoples, Second Class Treatment and the Truth and Reconciliation Commission's (TRC) Report in identifying that racism is a significant barrier to, and determinant of, health for Indigenous peoples in Canada.[4,14,15] It is time to move beyond discussing the existence of racism, to identifying how it impacts Indigenous peoples' health and, most importantly, implementing change that, as Indigenous leader Dr. Caron asserts in the 2017 TEDX talk 'The Other Side of Being First', leads to healthy, thriving Indigenous peoples and communities via self-determined health care.[18] The aforementioned reports contain significant calls to action, yet almost one decade past the TRC release, the evidence of action remains limited.

It is hoped that our suggestions for culturally safe health care in Table 6 will translate the TRC's broad recommendations into practical actions that will directly benefit patient care.

Table 5: Culturally safe health care - community proposed solutions and innovations
'We budgeted for our own traditional healer to come in because there wasn't sufficient mental health services so, although, this person is not a certified clinical counselor, they are a traditional healer and they helped our people through many difficult times.' - Indigenous community meeting
'With aboriginal communities there is a lot of historical and intergenerational trauma that plays into the care as well and it takes years to see changes but you have to be forward thinking and proactive about developing the services and programs that can help reduce the effects of trauma.' - Combined partners meeting
'I think we just need someone that's going to advocate for them...To be with them during their visit to the doctor; they're having surgery and we should do to make them feel like, you know, they're safe... - Indigenous community meeting
'What is the cultural sensitivity, it has to be eyeball to eyeball in a place for them to absorb and learn what is on the ground. Instead of them just saying we have some test on the computer…' - Indigenous community meeting
'I want to address my view on cultural safety. There's a relationship between this ambulance group particularly...they provide something unusual for a first responder agency and it really has to do with cultural safety. It has to do with relationship between the people, they're like intermediaries in a way that no other first responder agency quite, quite does it. So, there's that and that's fairly innovative... you turn up for whatever, um, acute medical or trauma, and, uh, and there's a couple, uh, firefighters who are community members that show up and they're also responders, but they're also part of the community. It's as simple as that and consequently ambulance takes their lead, you know, there's a kind of a respect, right?' – Municipal/first responder meeting
'You know, we've still got a ways to go but we have come a ways with that and a couple of years ago we started a program…in which we had ER nurses volunteer to go out to some of the communities to have a visit for the day and work with the community health nurses. That changed some perspectives.' - Indigenous community meeting

While our study focuses on anti-Indigenous racism, these actions can be applied to all forms of racism. The burden of determining how to address racism frequently falls on Indigenous Elders, knowledge keepers and community members. However, as Justice Murray Sinclair, who led Canada's TRC, reminded us, reconciliation is not an Indigenous problem. It is a Canadian problem. Addressing interpersonal, systemic and epistemic racism in health care requires a top-down and bottom-up approach, with Indigenous and non-Indigenous communities and individuals working together.

Limitations

Between 2018 and 2023, the SV team visited 128 of BC's 205 RSA communities, with 77 RSA communities remaining. This means not every BC rural community is represented in the overall dataset (see RSA 2024 list[19] here: https://www2.gov.bc.ca/assets/gov/health/practitioner-pro/rrp_points.pdf). The data presented in this study draws from 44 First Nations community meetings and 24 combined partner meetings that included Indigenous partners, occurring between April 2018 and March 2020. Although participants were not required to self-identify as Indigenous, many shared their roles as Indigenous community members, Elders, health representatives and knowledge keepers during meeting introductions.

The SV Project's scope is limited to rural BC and does not represent all Canadian contexts. The ongoing SV Project encountered a 17-month delay due to COVID-19 travel restrictions, leaving some rural and Indigenous communities unvisited at the time of this analysis. Scheduling logistics prevented full partner participation in all communities, potentially omitting some perspectives, and time constraints challenged the development of deep relationships with participants, possibly affecting response quality. Moreover, few site visitors were Indigenous and the Indigeneity of the interviewer could have affected responses from Indigenous participants. To mitigate this, an ongoing cultural safety and humility program was developed early in the project and implemented for all team members. In addition, iterative revision of the interview guide incorporated more inclusive language and direct questions asking about cultural safety, humility and racism.

CONCLUSIONS

Pre-contact Indigenous peoples were in general healthy and vibrant and self-determining.[4,20] Our study illuminates the impact of colonialism and anti-Indigenous racism across the rural BC health landscape and emphasises the urgent need for local and individual provider action based on Indigenous-identified solutions. Racism emerged from SV Project data without being explicitly sought in the original framework. Our analysis revealed pervasive anti-Indigenous racism in rural BC health care, varying cultural safety and

Table 6: Culturally safe health care – examples for providers	
The 5 Rs	What providers can do
Healthcare services need to respect Indigenous cultural knowledge, core values, and traditions	Build mutually respectful relationships with local Indigenous peoples Learn about local protocol, traditions values and traditional medicines Participate in local community events Value Indigenous ways of knowing and being Read, watch, listen to Indigenous art, music, and stories Advocate for system-change Encourage healthcare leadership to review policies to address the systems that perpetuate discrimination e.g., addressing jurisdictional barriers between federally and provincially funded programs
Adopt healthcare practices that are culturally relevant and affirming of Indigenous peoples' identities and experiences	Adopt trauma-informed practice as 'universal precautions' Invest in earning trust from patients rather than expecting trust Budget for additional time in order to facilitate communication, foster trust, and make space for complex issues Be aware of how the asymmetrical power dynamics in the patient-physician relationship affect care List local trauma-trained mental health providers (i.e. EMDR, OAI therapy, somatic experiencing, etc.) Be open Discuss if and how patients use traditional medicines and ceremonies in their wellness journeys Cultivate contextual sensitivity by learning about the experiences of Indigenous peoples Review 'reclaiming power and place: The final report of the national inquiry into missing and murdered Indigenous women and girls' https://www.mmiwg-ffada.ca/final-report/and its recommendations
Develop reciprocal connections with others that situate health care as a two-way, non-authoritarian partnership between the patient and provider	Make meaningful personal connections both inside and outside of clinical settings to deepen relationships Involve Indigenous patient liaisons and peer navigators who are trained to navigate the system and provide a buffer from unsafe care Embrace opportunities to spend non-clinical time in Indigenous communities. *Elder Cheryl notes the most rewarding time she has spent with Elders is when she learned to scrape hide. Many stories are told while participating in cultural activities. Provides an opportunity to see people in their power and strengths. Other examples include berry picking, clam digging, etc.*
Responsibility means implementing healthcare practices and policies that empower Indigenous participation and leadership in health care	Be inclusive and collaborative Find ways to integrate community members, Elders, Indigenous services and organisations into the local healthcare delivery models Education Learn about and integrate local supports for Indigenous peoples into your care provision See the Truth and reconciliation calls to action document particularly 18–24 pertaining to health https://www2.gov.bc.ca/assets/gov/british-columbians-our-governments/indigenous-people/aboriginal-peoples-documents/calls_to_action_english2.pdf Develop a critical self-reflective practice to develop cultural humility
Relationship an essential 5th 'R' in health care	Develop rapport and build trust Build relationship before developing a management plan Avoid impersonal communication styles Ensure patients feel cared for, not just that they have received care Remain cognizant that only Indigenous peoples can determine if the care they receive is culturally safe

EMDR: Eye movement desensitisation and reprocessing, OAI: Observed experiential integration

humility knowledge levels and practices amongst healthcare providers and a significant discordance between non-Indigenous clinicians' perceptions of providing culturally safe care and Indigenous peoples' lived experience of receiving care in those same communities.

Our results revealed a shared vision amongst Indigenous peoples throughout rural BC, articulated as a healthcare system where Indigenous peoples feel supported in their wellness with access to a wide range of accessible, equitable health services where providers walk alongside them in their healing journeys. The time is now, and it will take every one of us.

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