Indigenous Healthcare Providers: Voices from the Field

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Abstract

Clinical transactions between Indigenous healthcare professionals working with Indigenous patients are thought to be at the apex of an improved Indigenous health experience, yet little is known about these professionals. The Government of Canada and the Truth and Reconciliation Commission have stated explicit goals to increase the number of Indigenous health professionals, and, currently, universities across the country are working with schools of nursing and medicine to attract and retain Indigenous students. Currently, most healthcare professionals working with Indigenous People are non-Indigenous Healthcare professionals, and this environment comprises the primary point of contact between formal health services in Canada and Indigenous community members. This thesis is a qualitative study using constructivist grounded theory and Indigenous research methodologies with 10 Indigenous healthcare professionals. Respondents described their experiences as adverse learning and professional environments at best. Research findings provided a synopsis of healthcare training, educational institutions, and the medical field encountered by Indigenous healthcare professionals. Respondent data describes challenges and discussions about how they foster patient engagement, which may also be of relevance for all professionals working with Indigenous Peoples.

Résumé

PRESTATAIRES DE SOINS DE SANTÉ AUTOCHTONES : VOIX DE TERRAIN

Les transactions cliniques entre les professionnel(le)s de la santé autochtones et les patient(e)s autochtones sont considérées comme étant au cœur d'une expérience améliorée en matière de santé autochtone. Pourtant, nous disposons de peu de données sur ces professionnel(le)s. Le gouvernement du Canada et la Commission de vérité et réconciliation du Canada ont défini des objectifs précis pour augmenter le nombre de professionnel(le)s de la santé autochtones. À l'heure actuelle, les universités du pays collaborent avec les écoles des sciences infirmières et de médecine pour recruter et retenir des étudiant(e)s autochtones. Pour l'instant, la majorité des professionnel(le)s de la santé qui travaillent auprès des peuples autochtones sont des professionnel(le)s de la santé non autochtones. Pourtant, cet environnement représente le principal point de contact avec des services de santé officiels au Canada pour les membres des communautés autochtones. Cette thèse est une étude qualitative axée sur la théorie ancrée constructiviste et des méthodologies de recherche autochtones menée auprès de dix professionnel(le)s de la santé autochtones. Les sujets interrogés décrivent tout au mieux leurs expériences comme un environnement pédagogique et professionnel défavorable. Les résultats de recherche donnent un aperçu de la formation en santé, des établissements d'enseignement et du domaine médical auxquels se heurtent les professionnel(le)s de la santé autochtones. Les données de recherche font état de difficultés et de discussions sur leur façon d'encourager la participation des patient(e)s, ce qui peut également être pertinent pour l'ensemble des professionnel(le)s qui travaillent auprès des peuples autochtones.

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Chapter One

I begin by introducing the reasons for this study. Next, I review an Indigenous land acknowledgment offered by the First Peoples' House at McGill and review key terms. Then, I discuss my own reasons for wanting to learn more about Indigenous healthcare professionals as well as my own location as an Indigenous researcher. I review the relevance to Social Work, policy, practice, and health science literature. I briefly review interviewing Indigenous healthcare professionals. Lastly, I provide a summary of activities and descriptive listing of chapters.

This dissertation focuses on listening to the perspectives of Indigenous healthcare professionals and their stories about education and work. Respondents shared perspectives and experiences as Indigenous community members raised multifaceted questions about the operations of medical educational programs and healthcare institutions. The Truth and Reconciliation Commission of Canada (TRC) Calls to Action (2015) offer an opportunity to review and compare the experiences reported by Indigenous healthcare professionals, who sometimes described difficult engagements. I am hoping this dissertation promotes discourse about the need for improvement of curricula in medical programs as well as improvement of training provided in healthcare institutions to benefit Indigenous Peoples. At the same time, I hope findings from this dissertation might be of service for all People who face discrimination or exclusion in healthcare education and training programs based on gender, race, religious beliefs, legal status, ethnic origin, or disability. This knowledge gap is considerable. Yet, to me, the voices of respondent Indigenous healthcare professionals represent great resiliency and a desire for improved health for Indigenous community members everywhere. TRC Calls to Action highlight the need for healthcare systems to respect and include healing traditions from

Indigenous communities and support the use of Indigenous elders for consultation and assistance in helping other Indigenous community members.

The beautiful picture below (Figure 1) by Métis artist Christi Belcourt, for me, represents a desire for health by depicting medicinal plants used by some Indigenous communities. This is how I am personally seeking to enact the TRC Calls to Action (2015). I believe these images of medicinal plants and the rendering of the natural environment is beautiful, and the artistic portrayal of traditional medicines depicted in the painting presents a key opportunity to recognize substantial histories of traditional Indigenous healing knowledges in Indigenous communities across Canada. One sees the powerful strawberry, berries of many sorts, sage-like leaf figures as well as a design seemly presented in a balanced mirror image of herbal medicines.

Figure 1: Christi Belcourt, (2014). Wisdom of the Universe [Painting]

Paintings from Indigenous artists represent unique histories shared across many Indigenous communities while also illustrating important individual perspectives. I chose this image because of how the spectacular floral designs reminded me of pow wow season. I have attended many pow wows and seen Indigenous dancers gather in traditional regalia featuring beadwork representations just like the ones in the painting. The depiction of these plants reminds me personally of how important it is to acknowledge a larger field of traditional Indigenous knowledge still in use in many Indigenous communities across Canada. I have participated in traditional Indigenous ceremonies and rituals such as the Wiwacipi or Sundance. I also have practiced burning sage, tobacco, sweetgrass, and cedar in prayer as part of a group practice and in individual ceremony. The TRC Calls to Action (2015) support Indigenous use of traditional medicines in modern health centres to support healthcare treatment. I call on Indigenous Peoples to use traditional medicines and knowledges everywhere and to seek out instruction on how to access these resources or even to revive lost knowledges.

These Indigenous medicines and knowledges depicted in Figure 1 are old and validate how Indigenous Peoples have always sought out health and wellbeing long before the advent of modern healthcare delivery systems. Indigenous Elders visiting McGill have also told me about other traditional healing ceremonies specific to local communities conducted in longhouses, shaking tents, or in natural settings. Indigenous Elders taught me that each Indigenous group may practice specific healing ceremonies, and these might be shared with other groups or be only for community members of a certain group, and some are only reserved for certain individuals. Elders spoke to me about the importance of listening to Indigenous communities in order to learn what each community does. I have also come to know through discussion with other Indigenous community members that there are also Indigenous communities where traditional Indigenous spiritual practices are not used. The historical importance and contemporary utilization of traditional Indigenous health knowledges, spirituality and traditional herbal medicines found in Indigenous communities is essential. It illustrates an Indigenous desire for health.

The reader will hear directly from Indigenous healthcare professionals in this dissertation calling for greater incorporation of Indigenous spiritual and traditional medicine in healthcare training and service provision. Indigenous community members continue to attain poor health and social status; this study focuses on the Indigenous individuals who seek to reverse this by answering the call as credentialed medical service providers.

Land Acknowledgement

I was deeply moved when I first heard a land acknowledgment provided at the beginning of a workshop at McGill University First Peoples' House in 2019 during a workshop provided by a visiting Indigenous elder. It felt so powerful to me because we were a group of Indigenous students, staff, and faculty who had gathered to hear an Indigenous elder discuss the value of Indigenous community connections. I worked previously with the Indigenous faculty, students, and staff at McGill who crafted this statement but had not experienced hearing it before then and in an all-Indigenous group setting. The statement is as follows:

> McGill University is located on land which has long served as a site of meeting and exchange amongst Indigenous Peoples, including the Haudenosaunee and Anishinabeg nations. McGill honours, recognizes and respects these nations as the traditional stewards of the lands and waters on which we meet today (McGill University First Peoples' House, 2020).
>
> "L'Université McGill est sur un emplacement qui a longtemps servi de lieu de rencontre et d'échange entre les peuples autochtones, y compris les nations Haudenosaunee et

> Anishinabeg. McGill honore, reconnaît et respecte ces nations à titre d'intendant traditionnel des terres et de l'eau sur lesquelles nous nous réunissions aujourd'hui (McGill University First Peoples' House, 2020).

I worked for several years on ways to increase Indigenous student enrollment as a member of First Peoples' House and Indigenous Access McGill at the School of Social Work, which unfortunately remains low. Hearing this read out loud inspired me and, I felt, was very profound. I believe Indigenous land acknowledgements are an important protocol for McGill University and hope all academic institutions embrace this practice. Though it must be noted that the practice has also been criticized during an interview with Indigenous journalist Rosanna Deerchild (2019) by Anishinaabe author Hayden King at Ryerson University who originated the practice. He described with regret how land acknowledgements had not evolved into meaningful reconciliatory action (Deerchild, 2019). I personally feel land acknowledgement practices are needed everywhere and everyone should participate, and that their consistent use illustrates how respecting Indigenous communities is not a one-time event. I feel bringing Indigenous words in spoken and printed use creates visibility and endorses institutions to honor Indigenous Peoples. McGill Equity Committee (2020) has described the practice as honoring Indigenous identity and connection to land, and the University directs People to think critically about using words that evoke meaningful reconciliation when developing land acknowledgements. It must be noted that this land acknowledgement does not make mention of Métis Peoples or Inuit, though both Indigenous groups have long histories in Montréal. The Métis connection is especially prominent as Indigenous advocate Professor Cindy Blackstock noted how little reference to Louis Riel there is at McGill given that he resided in Montréal for long periods of time. Blackstock called for greater recognition of Métis history in Quebec (personal communication, November 12, 2019).

Inuit Peoples are very visible in Montréal and represent approximately half of the Indigenous homeless People (Savoie, 2012). The omission of both Métis Peoples and Inuit community members in the acknowledgement above speak to challenges Indigenous Peoples face even thought this land acknowledgments was enacted by other Indigenous Peoples.

Opening with a land acknowledgement is important for this dissertation because the work was conceived and in large part carried out at McGill and around Montréal, where I am a newcomer. I would also add that I wish to welcome the reader and acknowledge this study was conducted via telephone and in face-to-face interviews on urban and rural Indigenous lands of First Nations, Métis, and Inuit communities across Canada. Pidamiya, or thank you in Dakota, for sharing the bounty of this place.

Though I opened this thesis with a land acknowledgment, I also recognize that land acknowledgements represent only one small aspect of reconciliation. The Truth and Reconciliation Commission of Canada, TRC, (2015) describes a greater depth and extent of activities needed to begin to promote equity and reconciliation on many levels with Indigenous Peoples. The 94 Calls to Action of the TRC (2015) illustrates how a path towards engagement around reconciliation is a comprehensive and ongoing process and not merely an end goal or single statement. I hope questions about the completeness of engagements with Indigenous communities will motivate institutions and individuals toward more meaningful land acknowledgements as a pathway toward enacting comprehensive TRC Calls to Action (2015).

Key Terms

I have provided a glossary below to important terms that I used throughout the dissertation. These conceptualizations have been gathered from my own experience as well as the literature.

Indigenous refers to People who are members of First Nations, Métis Peoples, and Inuit communities, which are collectively referred to as Indigenous Peoples and communities (Government of Canada, 2017).

Indigenous Healthcare professionals refer to Indigenous nurses and doctors working in healthcare settings including some who participated in the dissertation interviews.

Respondents refers to Indigenous healthcare professionals who participated in interviews conducted during dissertation research.

Traditional Indigenous health knowledges refer to Indigenous spirituality, traditional herbal medicines which might include the identification and use of specific plants, animal parts, and mineral or rock components to promote health status (Redvers & Blondin, 2020; United Nations, 2019).

Traditional Indigenous ceremonies and rituals refers to Indigenous community activities and events that are known or conducted confidentially or in secret to promote health and wellbeing (Redvers & Blondin, 2020; United Nations, 2019). In in my own community of origin of Dakota Peoples, Ceremony is required to fulfill connection to Wakan Tankan, also known as the Mystery Great or Creator. Our Dakota communities also call on connections to the natural environment, meaning all living things in the natural environment including rock, river, and sky as well as animal and plant life, spiritual world connections and connections to other members in our communities and connection to other Indigenous and non-Indigenous community members outside of our community.

The Study of Indigenous Health Professionals

In this section, I provide a short overview of study components. First, I review the study rationale, beginning with an introduction of myself as the researcher as an Indigenous person, and then review researcher location. Briefly, I discuss my motivations for interviewing Indigenous health professionals. Next, I summarize activities used in this study to learn more about the experiences of Indigenous healthcare professionals. I conclude this chapter by providing a concise listing of chapters that comprise the study.

I remember being at an Indigenous research conference in Auckland and hearing Professor Linda Tuhiwai Smith (2016) lament that Indigenous students are using the word 'colonialism' without specificity. It occurred to me then that specific descriptions of problems often require specific solutions. Research frames issues that might be described as arising from an overwhelming non-Indigenous environment. But I believe it is not the entire world that must be examined to inquire about a specific problem. I hope to provide insight into one aspect of Indigenous healthcare professional experience by engaging and listening to respondents, while recognizing there are many other facets of their experiences that are not included. I hope to prioritize their reported experiences by using both constructivist grounded theory and Indigenous research methods. One work cannot define everything, and Indigenous methodologies represent diverse aspects of Indigenous experience (Kovach, 2009).

It is my hope that by listening to Indigenous healthcare providers as an Indigenous researcher I will help everyone learn more about the challenges these individuals face as Indigenous healthcare professionals. Research scholars have noted how relationships in research are greatly impacted by researchers who are empowered by their positions or intuitions and ascribe their own abilities to be both objective and neutral while objectifying those being researched (Fine, 1998; Fine, Weiss, Wesen, & Wong, 2003; Smith, 1999; Strega & Brown, 2015). Scholars such as Adale Sholock (2012) contest the legitimacy of the dual role occupied by many white researchers who assume they are empowered to gather and interpret research participant data while not belonging to community under scrutiny (Strega & Brown, 2015).

Researcher as an Indigenous Person and Researcher Location

I think that it is important that I am Indigenous and am doing research with other Indigenous People. Much of the research on marginalized groups has been conducted by researchers who are neither marginalized or from the communities they study (Strega & Brown, 2015, p. 4). I am motivated as an Indigenous researcher to begin the process of conducting research with Indigenous community members for a dissertation. I do not believe that I automatically possess the ability to be more effective with other Indigenous People because of my own identity and rely on the guidance of established Indigenous and non-Indigenous researchers to help me hone my own research abilities. However, I do believe being Indigenous is helpful in talking with other Indigenous People. Academic researchers Susan Strega and Leslie Brown (2015) discuss how many Indigenous scholars such as Shawn Wilson (2008) have voiced how Indigenous communities need "relationally accountable" (p. 3) engagements in research because of the long and continuing marginalization they endure. I want to share how I believe my being Indigenous helps forge that accountability because I have experienced marginalization as an Indigenous person. I also have worked in the field of community-based urban programs focused on improving Indigenous health status in New York City, and I have worked in many larger platforms as an Indigenous community advocate.

I am an enrolled member of the Yankton Sioux Tribe of South Dakota and grew up on the Rosebud Sioux Reservation, also in South Dakota. My dad was an educator and helped start Sinte Gleska University as well serving as superintendent of the local high school and several American Indian boarding schools, including Haskell Indian Nations University. His career culminated with a position in the Office of Indian Education Programs at the Bureau of Indian Affairs in Washington, D.C. He was descended from the Tiospaye Wakankdiduta or family unit Redlightning. We are of the Dakota oyate or Dakota Peoples and allied with the Great Sioux Nation of Dakota-, Lakota- and Nakota-speaking Indigenous Nations. Our particular community is called Yankton or Ihanktowan and means ‘those who camp at the end’ of a great gathering. We have historical ties with the Canupawaka, or Pipestone, Dakota First Nation just south of Brandon, Manitoba. My Great Grandfather Homer Redlightning, a minister, was often there for pow-wows. My mom worked for many years as head nurse at the Indian Health Service Rosebud Hospital on the Rosebud Sioux Reservation. My mom is descended from Norwegians who settled in South Dakota near Dupree on the Standing Rock Sioux Reservation.

My mom’s family came from Tysnes and Andalsnes on the coast of Norway before settling in South Dakota on illegally taken Indigenous land. This point is divisive and remains unresolved in our larger families. Both my parents, however, were very supportive of our Indigenous heritage, and we often went to pow wows every weekend as well as attended many ceremonies. Years later my mom shared with me proudly that both Russell Means and Denis Banks, leaders of the American Indian Movement (A.I.M.), knew my dad and hid out with us for a few days during the Wounded Knee uprising in Pine Ridge. Also, my dad went to boarding school with Floyd Red Crow Westerman, a well-known Lakota actor and musician. I also attended Indian Boarding schools and went to Haskell Indian Nations University where I was featured in the St. Martin’s Press anthology *Living the Spirit* under the name Ben The Dancer, which was edited by Will Roscoe and a community organization called Gay American Indians (1988). I then went to New York City to pursue fine arts and had a short modern dance career with a Canadian First Nation ballet production created by Mohawk composer John Kim Bell called *In The Land of Spirits* in the early 1990s (Native Drum, 2019). Soon after returning to New York City, I became involved in the HIV/AIDS advocacy movements in the early 1990s and attended one of the first Indigenous LGBT gatherings in Beausejour, Manitoba; the term Two Spirit was created by Indigenous community member Dr. Myra Laramee at the gathering (Albert McLeod, personal communication, July 18, 2020). I then helped organize one of the first Indigenous HIV/AIDS conferences in New York City at the American Indian Community House, Inc. (AICH). Importantly, AICH serves as a gathering place for Indigenous Peoples in New York City and is where I began to realize my calling to become a social worker.

I started out as a Community Health Representative (CHR) at AICH serving many American Indians and Jay Treaty Canadian First Nation community members, who exercise their right to live and work in the United States due to a treaty signed between Britain and the United States in 1794 (Pine Tree Legal Assistance, 2020). AICH was founded by many Mohawk community members from Kahnawake and Akwesasne living in New York City and doing iron work on construction sites across the City. I heard many stories of how iron workers would toss red hot iron rivets many stories up and use them to forge joints between iron beams. These families were later joined by Indigenous Peoples from all over the United States and Canada and formed the AICH in 1969 (AICH, 2020).

I developed a curiosity about Indigenous healthcare professionals during these early experiences at AICH. I was exposed to health issues early on that involved helping People navigate systems in both urban settings as well as on Native American Reservations and in Canadian First Nations, Inuit, and Métis communities. I would often work to help Indigenous People request assistance from their communities of origin and liaison with several Indigenous community health programs to get a prescription renewed or get copies of medical documentation, for example. Additionally, AICH participated in many Indigenous social justice activities and provided support to Indigenous communities in Kahnawake during the OKA crisis in 1990 and to Indigenous protests seeking to draw attention to the James Bay hydroelectricity projects in northern Quebec. Most recently I have been serving on the board of the International Indigenous Working Group on HIV & AIDS (IIWGHA) coordinated by the Canadian Aboriginal AIDS Network (CAAN) in Toronto.

I have also worked in many non-Indigenous professional organizations. I supervised quality improvement projects in many medical departments at the New York City Health and Hospitals Corporation (NYCHHC, 2016), which provided me with a in depth familiarity of hospital operations. NYCHHC (2020) all together represents the largest public hospital system in the United States and is the main provider for patients regardless of their ability to pay. It was during my tenure in this system that I also became very involved with non-Indigenous nurses and doctors in administrative and clinical settings. At the same time, I continued to serve as the local Indigenous resource for medical care and directly assisted about 50 Indigenous community members obtain needed medical information or services. I believe my professional work in non-Indigenous settings is important in this study because I am familiar with formal medical operations in hospitals and clinics. However, I specifically chose not to focus on evaluating the systematic and administrative healthcare structures in favor of listening to how Indigenous healthcare professionals describe experiencing their work.

The first glimpse I had of how different things are for Indigenous health professionals occurred during an Indian Health Service training in the 1990s. Curriculum focused on reviewing and upholding confidentiality standards. There were several Indigenous participants who voiced concern that confidentiality practices for Indigenous healthcare providers is more difficult than non-Indigenous Peoples because of small community sizes and interrelated Indigenous family structures. I became intrigued about what else Indigenous providers might know or relate to based on their experiences of being Indigenous and a healthcare provider.

I also had the experience of working with distant relatives and non-related community members from my own Reservation in South Dakota. Sometimes we burned sage or ingested it by chewing the raw dried leaves in prayer. This also made me curious to learn how or if traditional Indigenous knowledges might arise in other treatment scenarios with Indigenous healthcare providers. I tried carefully at AICH to craft individual treatment plans that took enmeshed community settings into account to protect confidentiality; however, as soon as someone would see me talking to clients, talking notions of privacy evaporated. I believe I found an effective tool to help Indigenous community members in need by simply offering encouragement. I recognized how Indigenous community members trust of outsiders seemed to be particularly fleeting and listened carefully as many patients recounted numerous system failures. My work was never easy but was always meaningful to me personally. I felt my role was essential as an Indigenous professional. However, I was not able to say if this was also the case with other Indigenous healthcare workers.

I think about my background and relate to how Cowessess First Nation scholar Robert Innes identifies traditional kinship systems as vital resources by helping to build Indigenous collective identities, and through creating a foundation for Indigenous sovereignty through these connections (Innes, 2017). I hope learning more about the experiences of Indigenous healthcare professionals in this dissertation will help health education and training as well as healthcare organizations and institutions find out more about complex health and social issues facing

Indigenous communities across Canada. I want to hear perspectives directly from Indigenous healthcare professionals working with Indigenous community members.

I have included another painting with the reader. I interpret this artwork by Kent Monkman (Figure 2) as both an illustration of how Indigenous communities intimately know low health and social status and as how Indigenous healthcare providers might witness their own experiences. I see Indigenous family members and Indigenous community members mourning at a hospital bedside. I personally have heard the cry of Indigenous patients, Indigenous community members, Indigenous and non-Indigenous healthcare professionals and advocates seeking immediate change in this very scenario. I have seen Indigenous and non-Indigenous professionals scramble to meet the urgent healthcare needs of Indigenous community members, yet Indigenous community health status is slow to change. I have listened to Indigenous leaders, advocates and community members describe how they are pained to see community members live with unbalanced health outcomes and witness great privation in highly developed countries such as Canada.

Figure 2: Kent Monkman, (2016). Death of the Virgin (After Caravaggio). [Painting]

The reasons for this study are not only personal or solely based on my own community experiences but also due to the increased interest in promoting Indigenous healthcare professionals in Canada. The Royal Commission on Aboriginal Peoples in 1996 made the education of Indigenous healthcare professionals an explicit goal for Canada (RCAP, 1996). The Truth and Reconciliation Commission additionally highlights several historical wrongs perpetuated on Indigenous Peoples and supports Indigenous revitalization in 94 Calls to Action (TRC, 2015). The TRC recommendations highlight incorporating Indigenous content in education, increasing educational opportunities and retention of Indigenous health providers

(TRC, 2015). This goal for more Indigenous healthcare providers is being met by universities and training programs. Interest in the recruitment and training of Indigenous Peoples across provinces and territories is high. I have worked as a coordinator for Indigenous Access McGill at the School of Social Work to recruit Indigenous students. I have also participated in several recruitment meetings seeking to increase Indigenous student representation in medicine, engineering, nursing, education, and other programs at McGill. I am also working with other Indigenous students at McGill to start a social enterprise called Indigirecruit, which seeks to help Indigenous community members gather application materials before they apply for post-secondary educational programs at universities, colleges, and technical training institutes across Canada. Indigirecruit also provides these institutions with an overview of Indigenous candidates and seeks to coordinate more timely recruitment of applicants. These activities have motivated me to try to learn more about Indigenous respondents' experiences in this dissertation, and what they say as members of an Indigenous cohort of the larger field of healthcare professionals.

I specifically chose to review reported experiences of participants using Qualitative Grounded Theory espoused by Charmaz (2014) in hopes of gaining information that can be used to support Indigenous nursing and medical students, improve health professions' training programs, and identify salient perspectives of Indigenous health professionals. The following questions guided my research:

1. What are the successes, challenges, and anecdotal experiences of Indigenous providers working in the field with Indigenous patients?
2. How do Indigenous healthcare providers conduct clinical evaluation, treatment, or referral for Indigenous patients?

3. How do Indigenous healthcare providers experience clinical contacts with Indigenous patients?

(See Appendix A. Application for Ethics Approval for Research Involving Human Participants).

I formulated these questions as a way to introduce the topic of learning more about the experiences of Indigenous healthcare professionals, but Constructivist Grounded Theory directs researchers to incorporate participant identified data (Charmaz, 2014). Charmaz also directs researchers to incorporate a literature review and data interpretation based on participant data, which is accomplished after data collection is conducted as a way to uphold and validate participant contributions as research findings. For this reason, Indigenous research methodologies emerge more prominently in the Methodology, Literature Review, and Results chapters.

I started incorporating Indigenous methodologies during data collection. Indigenous researcher Shawn Wilson (2008) talks about using tools from Indigenous communities such as giving a gift as appropriate practice. I began face-to-face interviews with a small feather fluff, which is a traditional practice in my community of origin when one speaks to another person asking advice or discussing community issues. I explained to respondents the importance of this practice to me as an Indigenous researcher. Wilson (2008) discusses how impactful and epistemically aligned identifying one's location as a researcher is for Indigenous communities because it embodies relationality and connection. I intuitively approached interviews by introducing myself as an Indigenous community member and talked about my community of origin and work at the American Indian Community House in New York City. Numerous scholars have described the importance of Indigenous researchers informing others about their own connectedness to Indigenous communities (Absolon & Willett, 2005; Martin, 2003; Nicholls, 2009; Smith, 1999; Smith, 2012; Strega & Brown, 2015).

Linda Tuhiwai Smith (2012) discusses how her experience of her role as an Indigenous researcher impacted her connection to members of the same Indigenous community; she saw differences in her own higher income compared to the women with whom she was working. I wondered how my own affiliation with McGill University might impact the respondents because of prestige associated with some of the University programs. Strega and Brown (2015) discuss how research negotiations around location are inherent in the formal role of gathering and analyzing data and the "formal connotations" (p. 23) of research. I thought about how being Indigenous at McGill impacted me as a student. I felt so fortunate to be accepted by McGill but also worried that it would distance me from other Indigenous People. I found this to be partially true for myself. I intentionally connected with Indigenous community members at the Native Friendship Centre of Montréal in community gatherings as well as local pow wows. Though respondents did not mention my affiliation with McGill, I do wonder how it might have affected their choice to participate.

I chose Constructivist Grounded Theory because this method prioritizes participant contributions as a defining aspect of research (Charmaz, 2014). I started out hoping this approach might better support Indigenous research methodologies in analysis by directing respondent contributions to drive the literature review. I felt that it was more likely that this approach would include discourse about Indigenous methodologies as respondents related to their own communities of origin and identities as Indigenous healthcare professionals. I worried about my ability to use only Indigenous methodologies in a research project that does not focus on a single Indigenous community but rather a cohort of dispersed Indigenous healthcare professionals. Next, I will describe the relevance of this research study for social work practice and policy and health sciences practice and policy.

Relevance to Social Work

I believe the theoretical implications of this study are to be found by providing examples of how social workers might examine other professional fields; for example, in this case healthcare professionals. The TRC (2015) calls for efforts to increase retention of Indigenous healthcare professionals. Scholars also call for increasing engagement strategies with Indigenous community members and leaders to enhance healthcare equity (Browne et al., 2016). Theoretical implications for social work also relate to increasing the amount of information available to learn more about reported experiences of Indigenous healthcare providers.

Policy Relevance

I believe healthcare education and training institutions need more opportunities to hear from Indigenous healthcare professionals for policy development. Scholars have identified many challenges facing Indigenous community members in post-secondary educational settings. Specifically, researchers Kirkness and Barnhard (1991) identify desirable qualities needed to support Indigenous students, termed “four R’s – Respect, Relevance, Reciprocity, Responsibility” (p.1). These scholars have helped identify how educational systems fail to recognize, support Indigenous student needs, and advocate for educational systems to “respect” Indigenous students as they are. These researchers also prioritize the need for recognizing relevancy of the educational process from the Indigenous student viewpoint, and the need for supporting systematic reciprocity in relationships as well as empowering Indigenous students to “exercise responsibility over their own lives” (Kirkness & Barnhard, 1991, p. 1).

Indigenous healthcare workforce deployment presents another key area impacting policy development as health systems seek ways to promote and retain Indigenous staff. Listening to Indigenous healthcare professionals has presented a key learning opportunity for me as an

Indigenous social work graduate student. Though I have some exposure to their professional roles and a connection to their Indigenous community affiliation, I feel it is my responsibility to undertake research to learn more about their reported experiences, concerns and recommendations. I hope to use research to work toward better health outcomes for Indigenous community members, and in this case my research seeks to hear and analyze what Indigenous healthcare professionals say about their experiences. I am hoping that health policy outcomes might include a call for more formal research-based assessments of all Indigenous professionals in all fields.

Practice Relevance

I believe the theoretical implications of social work practice this dissertation relate to increasing the emphasis of Indigenous academic research and increasing social justice. Strega and Brown (2015) identify a call for intellectual development of ways of knowing that focus on “cognitive justice” (p. 2), which supports social justice (Strega & Brown, 2015). Scholars describe the development of Indigenous research methodologies as being in alignment with earlier calls for recognizing “racialized epistemologies” (p. 2) and draw from many scholars (Strega & Brown, 2015). Strega and Brown (2015) highlight an example being scholar Gloria Ladson-Billings identification of African American writers such as Carter Woodson and W.E. B. du Bois, who previously critically examined accepted epistemologies (Ladson-Billings, 2000). I am hoping this research contributes to the larger discourse in social work about social justice for Indigenous healthcare professionals in professional settings. Strega and Brown (2015) review how feminist writers also advanced identified “women’s historical ways of knowing” (p. 2) and list several authors espousing critical reviews (see also: Mary Daly, 1978, Ehrenreich & English, 1973; Lorraine Code, 1991; Wendy Holoway, 1989; Sandra Harding, 1991). I believe academic inquiry about oppression described through the perspectives of diverse groups will empower Indigenous social work academics to use research to better understand the deleterious effects of discrimination and exclusion. I hope this study also contributes to the increase of Indigenous researcher methodologies. Strega and Brown (2015) also highlight the development of Indigenous worldviews, knowledges, and research methodologies by many diverse scholars (see also: Absolon, 2011; Chilisa & Ntseane, 2010; Dana-Sacco, 2010; Kovach, 2010; Minde, 2008; Nichols, 2009; Smith 2012; Wilson 2008).

Health Sciences Relevance

Writer Margaret D. Jacobs (2017) describes an environment of academic research focused on the education of Indigenous Peoples as a “contested space of education in Indigenous histories” (p. 266) and describes how scholarship espouses many different approaches (Andersen & O’Brien, 2017). Her cumulative review of research on Indigenous education describes how non-Indigenous authors primarily document oppressive educational mandates perpetrated on Indigenous individuals, while Indigenous scholars focus on survival and the emergence of Indigenous control over education as an extension of Indigenous sovereignty (Andersen & O’Brien, 2017). My study is in alignment with this view. I am hoping the qualitative data provided by Indigenous healthcare professionals presents a novel opportunity for exploring how reconciliatory actions can be enacted in formal disciplines such as health and social services.

Descriptive Listing of Chapters

In Chapter two, I describe how and why Constructivist Grounded Theory was used as a methodological approach. I review how Indigenous theory and epistemology was instrumental to underpin the research study’s conceptual foundations and provide detailed descriptions of data collection and analysis.

Chapter three consists of a literature review providing an overview of Indigenous health and social settings and current trends across Canada. The contexts of Indigenous healthcare systems were reviewed, and descriptions of Indigenous community members receiving care in these settings as well as, more typically, in public health institutions in urban settings was also explored. Research descriptions and health study findings are used to provide a concise and formal introduction to the field of Indigenous healthcare, including descriptive literature and health studies that focus many health and social deficits experienced by Indigenous community members.

In the fourth chapter, I review findings from participants. I describe and explore respondent data further to learn more about respondent experiences as Indigenous individuals in schools and workplaces. A summary of how these formal educational and work environments impacted Indigenous health provider identities is used to analyze their roles.

In the fifth chapter, I discuss study implications, and broadly reference findings arising from analysis of interview data. Findings derived during the data collection process are described in relation to the larger fields of health and social service, as well as the specialized field of Indigenous healthcare. I provide a critical analysis of study limitations.

In Chapter six, I review study outcomes and summarize recommendations for social work and the health sciences.

Chapter Two Methodology

I begin the second chapter by briefly introducing some key terms. Then, I describe Indigenous research contexts which leads to presenting the three research questions. Next, I explain why I use constructivist grounded theory and Indigenous research methodologies for the doctoral study. From there, I establish my researcher lens while emphasizing that the respondents' experiences drive the inquiry. In the following sub-section, I re-emphasize the importance of the respondents' individual professional experiences by explaining how ethics must be prominent even though the doctoral study required neither community engagement nor an institutional setting. Included is a detailed description of the sampling and data collection methods to give the reader an overview of how Indigenous professionals were recruited and engaged during data collection and how the evaluation of respondent data guided the journey toward definitive findings and recommendations discussed in subsequent chapters. I follow the method section with a discussion of Indigenous relationality described by several Indigenous authors. Finally, I review how respondent experiences were analyzed using constructivist grounded theory methodology and highlight the importance and incorporation of Indigenous methodologies during analysis. To do this, I circle back to my reliance on constructivist grounded theory in tandem with Indigenous research methodologies.

Key Terms

- **Indigenous methodologies** refers to Indigenous-authored methodological approaches that arise from academic examination of Indigenous identity and Indigenous experiences by Indigenous researchers (Archibald et al., 2019; Kovach, 2015; Smith, 1999; Strega & Brown, 2015; Wilson, 2008).

- **Constructivist Grounded Theory** refers to qualitative research methods originated by Strauss and Glazer (1967) and further developed by Charmaz (2014).
- **Respondent** is the term I used to refer to Indigenous healthcare professionals participating in the research.
- **Research Ethics Board II** (REB II) is the institutional ethics review board at McGill University that examines and approves applications meeting REB standards. The Category II refers to research projects advanced by the School of Social Work (McGill University, 2020).

Describing the Indigenous Context

Browne, McDonald and Elliott (2009) assert that Canadian government policies enact continuous, ongoing, deliberate subordination of Indigenous Peoples and create indelible and systematic colonial domination. They point out that Indigenous communities struggle to change economic conditions, create opportunities and address health and social inequality. These struggles indicate that colonialism does not include an equitable engagement between the State and their communities. These scholars and others (Czyzewski, 2011; Lornie, 2011; O'Sullivan, 2012) ascribe the colonial framework to be the largest contributing factor causing health and social inequality for Indigenous Peoples in Canada. Along with Jai (2014), Browne, McDonald and Elliot argue that Indigenous communities currently experience the continuation of the Indian Act and restrictions on sovereignty, which diminish their ability to create economic development and resolve contested land claims. As a result, this oppressive environment greatly limits the ability of Indigenous communities to influence control and improve access to health services provision (Browne, McDonald & Elliot). Dion Stout (2012) explains that historical barriers to health services were created by colonial domination perpetrated through Residential Schools and the administration of Indigenous reserve systems, which constituted structural violence directly impacting health. She discusses how this domination caused poor health status compounded by lasting and multilayered negative effects of loss and unresolved grief, which continues today. As an example, Dion Stout describes negative encounters in healthcare settings across Canada that greatly reduce the ability of Indigenous patients to participate in their own care. Amplified by historical injustices, she insists that adverse encounters in contemporary healthcare settings solidify a complacent fatalistic dynamic of illness for patients. Dion Stout argues that, historically, government policies have created a reality where the sole health outcome for Indigenous Peoples seems to be death. According to the Canadian Nurses Association (2014), currently, across Canada, systematic government programs continue to be the main vehicle that provide health services. Currently, Indigenous communities and their allies, who must use these government programs, are seeking to create different outcomes.

Research Questions and Approaches

Both the Royal Commission on Aboriginal Peoples (RCAP; 1996) and the Truth and Reconciliation Commission of Canada (TRC; 2015) identified Indigenous healthcare professionals as an essential part of the effort to improve the current Indigenous health crisis. The RCAP call to educate more Indigenous healthcare professionals has had a fundamental effect on the field of Indigenous healthcare providers because it increases attention given to Indigenous student recruitment by the educational institutions training them. For example, nursing and physician professional organizations identify the promotion of Indigenous professionals as an essential activity to transform the medical field (CNA, 2010a; IPAC, 2009). Integrating practice and research, the TRC calls for increasing the number and amount of support available to educate and retain Indigenous healthcare professionals and underscores the need for creating reconciliation through funded research (McGregor, Restoule & Johnston, 2018). Thus, hearing directly from Indigenous healthcare professionals represents a significant opportunity to learn about challenges they face in an expanding field. This background motivated me to formulate three questions that could shed light on the experiences of Indigenous healthcare providers, which are listed below.

1. What are your successes, challenges and anecdotal experiences as an Indigenous provider in the healthcare field with Indigenous patients?
2. How do you provide clinical physical evaluation, treatment or referral for treatment as an Indigenous healthcare provider for Indigenous patients?
3. How do you experience clinical contacts as an Indigenous healthcare provider with Indigenous patients?

   (See Appendix A)

The TRC's inclusion of funded research as part of the reconciliation process meant seeking answers to these questions would involve an ethical approach unlike research into health professionals from dominant social groups (e.g., able-bodied, heterosexual, white).

Among other procedures, my REB II proposal (Appendix I) described two major points concerned with participant recruitment and contribution. First, I chose to use constructivist grounded theory espoused by Charmaz (2014) based on the work of Strauss and Glazer (1967). Second, this methodology would be used to analyze respondent interviews to identify the experiences of Indigenous Canadian healthcare professionals. The proposal centered the work of Maori researcher and academic Linda Tuhiwai Smith (2012) who describes how Indigenous methodologies represent a response to historical colonial research methodologies in academic literature seeking to subjugate Indigenous communities. Smith's methodologies would be essential when accounting for barriers to respondent participation in my study. Initially, I relied heavily on Margaret Kovach's (2009) research to support an Indigenous methodological approach, which I felt aligned with constructivist grounded theory. Subsequently, during the thesis review, I was given the opportunity to incorporate a wider array of Indigenous methodological sources. Both constructivist grounded theory and the diverse array of Indigenous methodologies reviewed later in this chapter highlight the validity of participation and contribution of respondents.

The REB II (Appendix 1) proposal described the constructivist grounded theory guidelines that were used to collect and synthesize data. These analytical processes constructed theories using participant data (Charmaz, 2014). For example, I described how interviews would be employed to gather data from respondents. Then, I would analyze the information they supplied to identify individual and collective patterns associated with their reported experiences. Constructivist grounded theory methodology uses flexible analysis during all phases of the dissertation. For this reason, questions which arise during an analysis phase are used to form theory. In turn, this emerging theory can be used to construct concepts about respondent contributions (Charmaz). After interviews are completed, constructivist grounded theory directs literature reviews and program documentation reviews as well as uses observations from the field to help inform the research process (Charmaz). The task of using Indigenous knowledge to help transform Indigenous realities is both promising and emergent (Kovach, 2009; Smith, 2012; Wilson, 2008). Smith (1991) reviews how Indigenous knowledge must be centered and correlate to community mandates originating within Indigenous community identity and experience.

Thus, analytical interpretation of Indigenous healthcare provider experiences that ignore Indigenous research methodologies might fail to accurately describe data due to a lack of understanding or community familiarity. This doctoral study derives support from Indigenous theory by providing parameters for a more comprehensive review of Indigenous healthcare professionals and their experiences in the field. Also, it seeks to use both constructivist grounded theory and Indigenous methodologies equally to glean learning from Indigenous professionals working in the current healthcare systems to treat Indigenous patients.

At the same time, this study is informed by my own worldview and assumptions as an Indigenous graduate student, healthcare professional and Indigenous community member with many years of experience working as a social worker in healthcare settings with Indigenous People. The field of Indigenous research methodology is expanding rapidly, and this requires many Indigenous researchers to learn how tribal community paradigms are used in diverse applications (Kovach, 2009; Strega & Brown, 2015). This aligns with Indigenous scholar Shawn Wilson's (2008) discussion that Indigenous methodologies espouse terminology that materializes from Indigenous identity. Wilson asserts that these particular terminologies are both a defining aspect of Indigenous methodologies and of Indigenous identity itself. Along with Indigenous researchers, I seek to engage diverse world views rooted in dynamic Indigenous communities while contributing to western knowledge, which is described succinctly by Sto:lo First Nation researcher Q'um Q'um Xiiem OC, also known as Jo-Ann Archibald (2008; whose work I discuss later in the section entitled "Indigenous Relationality") as well as other Indigenous researchers (Archibald et al., 2019;Lambert, 2014; Kovach, 2009; Wilson, 2008). Archibald (2008) worked for many years with Indigenous Salish/Stó:lō Elders, a coastal community in British Columbia, and began to use storytelling as a way to incorporate Indigenous traditions and life experiences in educational settings.

Researcher Lens

Scholars Creswell and Miller (2000) discuss the importance of researchers demonstrating the validity of qualitative work and review procedures used in the qualitative process. I established validity by using the “lens of the researcher” (p.125) to guide the length of time spent in the field recruiting respondents, beginning in 2015 and ending in 2019. During this period, I canvased agencies and sought respondents across Canada. I screened and interviewed respondents. I wrote memos in reference to the work I was doing as an Indigenous researcher and thought about what I was hearing while listening to experiences shared by respondents. I provided respondents with the transcripts for their review, a protection stipulated by the Tri Council Guidelines for Indigenous community members participating in research projects (CIHR, 2014). I incorporated changes respondents discussed and reviewed with them any emerging themes and new questions, specifically those relating to their experiences in healthcare education and training programs as well as in their professional fields. I determined data saturation by the depth of information respondents provided, which is part of the lens described by Creswell and Miller (2000) that informs the researcher about findings. They highlight this practice to validate qualitative work. Patton (1980) directs researchers to return to the data several times to confirm how “constructs, categories, explanations, and interpretations make sense” (p. 339). I reviewed transcripts with respondents and incorporated additions and confirmation of content.

Respondents were curious about the research. Thus, I described how the study grew from my original questions to include rich descriptions of respondent experiences in healthcare educational training and work settings. During interpretation, I sought to reaffirm the construction of the categories and themes with respondents. Qualitative scholars describe the importance of revisiting and comparing respondent data, memos and interpretation to practice as reflexive work, which is described as means of further validating interpretation (Altheide & Johnson, 1994; Charmaz, 2014; Creswell & Miller, 2000). At the same time, I thought about how my work relates to discussions about Guba and Lincoln's (1994) argument that researchers' assumptions motivate them to determine procedures that validate work (Creswell & Miller, 2000). I talked about my research with many Indigenous students and community members at McGill and while attending Indigenous community gatherings in Montréal. I discussed my work with respondents as well as spent time reflecting on my own experiences, beliefs, bias and assumptions which aligns with "researcher reflexivity" (p. 127) described by Creswell and Miller (2000). These authors describe how this helps "bracket or suspend" (p. 127) researcher bias, which I sought to do through identifying my experiences, background and beliefs in the introduction (Creswell & Miller, 2000). I used rich and thick descriptions from respondent data to inform my analysis and as a way to establish credibility, which is also described as an important activity by Creswell and Miller to provide opportunity for readers to be "transported into a setting or situation" (p. 129) through voluminous respondent data (2000). Guba and Lincoln (1994) describe three main paradigm assumptions as postpositivist, constructivist and critical. These three provide researchers with relevant paradigm assumptions used to define approaches (Creswell & Miller, 2000). Creswell and Miller describe qualitative validity through the use of nine procedures, which are categorized within a framework that connects the researcher's lens and paradigm assumptions (2000). My work corresponds to the first category of postpositivist paradigm assumptions, which entails relying on specific protocols to validate works related to systematic and rigorous methods (Creswell & Miller, 2000; Denzin & Lincoln, 1994). This resource highlights validation approaches through the practice of member checking, described as paramount methods for establishing validity (Creswell & Miller, 2000). Constructivist grounded theory also directs researchers to engage respondents with questions that arise from the data and require revisiting respondent data (Charmaz, 2014). Additionally, the Tri Council guidelines support robust member checking because they mandate Indigenous participants' right to review, approve, redact and add to data (Canadian Institutes of Health Research [CIHR], 2014). Creswell and Miller (2000) explain that member checking supports researchers who aspire to work where "validity procedures shifts from the researchers to participants in the study" (p. 127) and how this focus aligns the researcher with respondent data.

I do not feel my research orientation relates to the constructivist paradigm assumptions, which is described by Creswell and Miller (2000) as embracing a "pluralistic, interpretive, open-ended, and contextualized (e.g., sensitive to place and situation) perspectives" (p 125). I also do not think my work relates to the third critical paradigm assumption described by Denzin and Lincoln (1994), which relates to how "researchers should uncover the hidden assumptions about how narrative accounts are constructed, read, and interpreted" (p. 126), and how the importance of self-reflection is stressed (Creswell & Miller, 2000). This paradigm assumption focuses on seeking to learn more about how interpretation is affected by researcher "historical situatedness of inquiry", governs researcher perspectives and directs researchers "to be reflexive and disclose what they bring to a narrative" (Creswell & Miller, 2000, p. 126). I do discuss my own story and identity as an Indigenous person as it relates to research and especially as the work relates to Indigenous research methodologies. However, I believe that respondent experiences, and not my own, are central driving reason for the inquiry.

Ethics are Prominent

Issues around unethical research practices have been so alarming and prominent that a large body of work has resulted to protect Indigenous Peoples from further victimization (CIHR, 2014; Strega & Brown, 2015; TRC, 2015). Presently, ethical research violations form the largest segment of limitations affecting studies that involve Indigenous individuals, communities and nations. For example, medical scholars have described how nutrition experiments done on residential school children lacked consent and created harm for Indigenous children causing malnutrition and death, and long-term health problems (McDonald, 2014). Many Indigenous communities have sophisticated discourse about the need for academic researchers to enact protections that guard against rampant disrespectful engagement during research projects such as the Kahnawake Diabetes Prevention Project which oversees community review of Participatory Action Research (PAR) projects (Macaulay et al., 1998;1997). For most Indigenous communities, ethical change did not occur in research approaches due to the lack of institutional impetus. Indigenous community members realized they could no longer wait for these changes and began to create their own research protections (e.g., Macaulay et al., 1998). For this reason, Indigenous political and community organizations directly impact western institutions' ability to do research that involves Indigenous issues and interests. Indigenous communities did not say “don't do research.” Instead, they said, “do it this way.” Ideally, this directive fosters an environment based on social justice principles so we can remove the yoke of colonial oppression (Strega & Brown, 2015).

Most researchers and Indigenous communities use the Royal Commission on Aboriginal Peoples' (1996) Ethical Guidelines for Research (Brandt-Castellano, 2004; Kovach, 2009). Kovach had identified six Canadian protocols created to prevent ethics violations in Indigenous community research, which includes the landmark Ownership, Control, Access and Possession (OCAP; The First Nations Information Governance Center, 2014; Schnarach, 2004). Additionally, the *United Nations Declaration on the Rights of Indigenous Peoples* (UNDRIP) describes community permission as voluntary community consent and informed engagement, referred to as Free Informed Prior Consent (FPIC; General Assembly United Nations, 2007). These guidelines, protocols and descriptions seek to prevent what Martin and Frost (1996) previously identified as “smash and grab” (p. 606), a term used for “quick in and out interview sessions” (Kovach, 2009, p. 28) performed by ethnographers. Many scholars view this type of approach to research to be misrepresentative and exploitative (Kovach, 2009; Smith, 2012; Strega & Brown, 2015).

Although I was well aware of the guidelines, protocols and descriptions mentioned above, they did not apply to my doctoral study because of the way they conceptualize Free, Informed Prior Consent (FIPC), for example, when work with Indigenous communities focuses around land-based agreements (United Nations, 2016). Instead, I observed the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS; hereafter referred to as the Policy). After consulting chapter 9 of the Policy, Research Involving the First Nations, Inuit and Métis People of Canada, specifically, Article 9.2, it became clear that my doctoral study did not require community engagement because respondents’ involvement was unlikely to directly affect their own identified communities. Further, respondents are at liberty to participate in research projects they consider beneficial to themselves or society; additionally, their participation upholds freedom to express individual viewpoints as citizens. I determined the study to be low risk because the study questions concentrate on respondents’ individual professional experiences. As detailed in my REB II-approved consent form, respondents read there were no identified risks expected throughout their entire interview and review process. However, if they experienced distress when discussing traumatic experiences from the field of healthcare service, the consent form provided them with contact information for the Canadian Nurses Association and the Canadian Medical Association. If they had any concerns about my conduct, the interview and review process, or the doctoral study as a whole, the consent form also provided contact information for my doctoral supervisor and McGill's Ethics Officer. Finally, I wanted to keep the focus on the experiences of Indigenous healthcare professionals rather than on institutions or organizations where they work. I did not choose to conduct this study in a clinical or healthcare institution. Although respondents did discuss their professional experiences in schools and workplaces, their responses centered how they felt about what happened to them in those spaces as opposed to descriptions of the spaces themselves.

Grounded Theory and Indigenous Methodologies

I begin with a few words about how I approached this study. Although constructivist grounded theory represents one of the methodological approaches used in this doctoral study, it does not represent the only way I attempted to access and formulate respondent data. In subsequent sections, I review how some Indigenous research methodologies appear in my work. Later in the chapter, I return to this discussion to offer concrete examples that demonstrate how they were used simultaneously to complete the description of study findings.

Qualitative methodology positions the informant, or in the context of my doctoral study, the respondent, as a crucial source of knowledge (Charmaz, 2014; Glazer & Strauss, 1967). Constructivist ground theory provided a direct route to methodological tools that helped me better understand the respondents' reported experiences and knowledge. I included an introduction to two respondents by quoting from their interviews here and will provide a more detailed description of them later. I felt that talking to Indigenous healthcare professionals presents a crucial opportunity to learn more about their experiences. For example, Maureen said, “Before taking part in this study, no one had ever asked me about my own experiences and participating forced me to think about it.” Additionally, Pat, the second respondent, said:

> …what I had done in the previous times, saying like ‘if you look at this group of old People, these are the last ones, the last generation of People that have, um, “native language” is their first language, and there is barely any left now. And now we are in a cultural revolution of young People going back to language schools or like my kids are fluent because I choose to send them to immersion school.

Because the respondents work in hospitals and community clinic settings where primary physical healthcare is provided, I hoped they might share what they understand about Indigenous patient care. I hoped they would be able to describe, from their unique professional perspectives, what they thought as workers helping Indigenous patients. I believed studying the respondents’ interviews would provide an in-depth understanding of their perceptions of these types of professional experiences. Broadly, respondents shared their interactions with various health and social problems that seem to affect their particular Indigenous communities. Therefore, my doctoral project seeks to define the barriers and opportunities in their professional experiences in relation to their Indigenous background.

Using Constructivist Grounded Theory

Constructivist grounded theory provided the necessary guidelines to help me collect and synthesize data using an analytical process. This process enabled me to construct theories from respondent data, which is a primary goal of constructivist grounded theory (Charmaz, 2014). It entailed interviewing respondents to gather word data and then analyzing these data to identify information and themes. This qualitative methodology uses flexible analysis during all phases of the study to allow for the creation of new generations of questions that arise from the data. As Charmaz explains, these questions inform the evolving theory which is used to construct concepts about participant contributions. For the analysis needed to effectively utilize constructivist grounded theory, I relied on tasks such as separating, sorting and synthesizing. For example, these tasks enabled me to use coding to extrapolate information which revealed data segments that aligned with the Indigenous respondents' experiences. Ultimately, following this process, I returned to data sources repeatedly to identify more information.

Clarke (as cited in Creswell, 2013) defines a proactive approach that strengthens grounded theory methodology by focusing on data gained primarily from social situation categories. Clarke (as cited in Creswell, 2013) sorts data into "situational, social work/arenas and positional cartographic maps" (p.84) to create categories for analysis while relying less on positivist methodologies. Initially, my primary focus when collecting data was to review the respondents' clinical interactions with Indigenous community members. This focus changed as I spoke to more respondents and gathered more data. Also, my initial research questions were formulated from information gleaned from an exhaustive literature review on Canadian Indigenous professional experiences in healthcare during the Comprehensive Exam process. Initial interview questions evolved as interviews were reviewed, sorted and used to synthesize new questions (Charmaz, 2014). Again, following Charmaz (2014) during data collection, these methods directed me to use comparative coding of data segments, which required me to return to participants as subsequent questions were generated to further inform the evolving theory. Additional components of analysis that informed the research process included literature and program documentation from medical practice settings and observations from the field. I added memo writing to this documentation, which is also described as a “memoing process.” Specifically, during the analysis phase, I used memos about the open-coding process to compare these notes with each other (Charmaz, 2014; Creswell, 2018). In other words, I wrote memos to document my observations, which were compared to ideas about the data; this comparison added to my interpretation of data categories.

In summary, Charmaz’s (2014) work on constructivist grounded theory provided essential resources for thorough qualitative analysis. Experts stress evaluating qualitative data using established procedures refined through reiterative application (Charmaz; Creswell, 2018; Glaser & Strauss, 1967; Saldana, 2016). For example, Saldana’s work on qualitative analysis procedures conveyed a helpful and in-depth description and review of analysis techniques. Saldana linked research activities such as reasoning to theoretical foundations. Additionally, I employed “process coding,” (also described by grounded theory authors as “action coding”) which involves employing verbs with “ing” endings to describe action-oriented data (Bogdan & Biklen, 2007; Charmaz, 2002, 2008; Corbin & Strauss, 2015; Strauss & Corbin, 1998; Saldana). Because grounded theory creates opportunities for data to drive theory creation and to motivate formulation of conceptual information gained from respondent contributions, I was able to increase proximity to respondents as a researcher (Charmaz, 2014). Charmaz’s methodology also helped illustrate how respondents’ contributions were used to formulate data. Further, grounded theory enabled me to formulate a credible foundation for research findings, partly because theories were derived from interviewing Indigenous health professionals instead of being imposed from outside sources. As I interfaced with the respondents and subject matter, flexible and structured analysis methods facilitated my role as a researcher. Following Charmaz, this role helped me during data collection through repeated engagement and comparison.

Indigenous Research Methodologies

Ninomiya and Pollock (2017) state that the exclusion of Indigenous methodological development in Western academia is a barrier for most Indigenous researchers, which inhibits both the growth and the formulation of new methods deemed appropriate by many Indigenous communities. These issues are profound, particularly when research-based policy fails to improve Indigenous communities' low social and health status (Brascoupé, 2009). Western academic systems found in Canada and the USA represent a formal arena that has only recently begun to support inquiry into Indigenous research methodologies and ways of knowing (Strega & Brown, 2015). Indigenous experiences and realities must be more fully integrated into academic work and, overall, research of this nature must increase (Archibald et al., 2019; Strega & Brown). Increasingly, many researchers are developing a richer engagement in diverse Indigenous community cultures and practice settings, which can transform homogenous Western approaches to research (Archibald et al.; Strega & Brown). Yet, despite a growing number of research findings that support increased use of Indigenous methodologies, it must be noted that academic systems can simultaneously represent a foundational barrier toward, for example, recognition of Indigenous oral histories while regarding these histories as below par when compared with peer-reviewed academic literature (Kovach, 2009; Strega & Brown). Another example comes from the editors McGregor, Restoule and Johnston (2018) who, along with editors Strega and Brown (2015), correlate in their introductions some of the open and diverse approaches found in Indigenous research with a respect for the diversity of traditions found in Indigenous communities. However, they note that these approaches can represent uncomfortable experiences for some mainstream researchers unfamiliar with Indigenous communities and or divergent approaches.

Archibald and colleagues (2019), Strega and Brown (2015), and Kovach (2009) characterize methodologies rooted in “resistance research” as a prominent aspect of self-location, also found in anti-oppressive literature (Potts & Brown, 2015). Métis scholar Adam Gaudry (2015) describes this as “resurgence or insurgent” (p. 306) Indigenous research methods. Adding to self-location, Deborah McGregor (2018) upholds the need for research to “empower and give ‘voice’” (p. 302) as opposed to solely relying on researchers’ interpretations. She highlights that this empowered voice serves as an opportunity to recast aspects of Indigenous research methodologies in ways that naturally allow for the prioritization of goals and aspirations defined by Indigenous communities. They call on researchers to contribute to western methodologies with Indigenous methodologies that enrich access to information. At the same time, they join Pelletier and Sinclair (2003) who describe Indigenous research methodological approaches as subject to continuous prescriptive revision and development. Additionally, McGregor, Restoule and Johnston (2018) cite the absence of a unified or systematic approach to Indigenous methodologies in the introduction of their work about Indigenous research methodologies.

In her work *Indigenous Methodologies*, Kovach (2009) offers a close look at the limitations of western methodologies, the inclusion of Indigenous voice, perspective and leadership and the ongoing need to refine and diversify Indigenous methodologies. In agreement with Deloria (1999), Kovach (2009) asserts that many western researchers, in hopes of accessing Indigenous ways of knowing, have improvised methodological approaches during studies focused on Indigenous People or communities. This improvisation may have occurred because these researchers lacked tools available to a specific Indigenous community or they lacked experience with the community.

Kovach argues that the colonial cloak of identity presents a fundamental crisis for Indigenous individuals and communities, which requires specialized scholarship and inquiry. She references Indigenous scholar Marlene Brandt-Castellano's call for Indigenous initiatives at the annual Aboriginal Education Research Forum Shawane Dagosiwin in Winnipeg in 2005 (Kovach, 2010). Going further, seven years later Brandt-Castellano (2012) called for more Aboriginal research from everyone. Indigenous scholar Smith (2012) provided a ground-breaking argument where she described how research as a tool of oppression used against Indigenous People by Western researchers who make them the object of study without implementing a method of engagement for them or their communities. Because Western research historically supports oppressive goals of assimilation, Smith views the Western paradigm of research methods used in Indigenous communities as misaligned with Indigenous priorities. Smith's argument builds on Said's (1978) argument that in Western spheres the goal of research upholds domination of Indigenous Peoples by using research to know about them to better combat their independence. In fact, both Kovach and Smith discuss their fears that their research contributions might be used to exploit vulnerable Indigenous communities. For them and Said (1978), the fear that contributing to academic research could become detrimental to Indigenous communities puts more pressure on Indigenous researchers.

I ask, where is the middle ground? Kovach (2012), in her retelling of the Brandt-Castellano address, highlights Brandt-Castellano's idea that "Indigenous People must suspend distrust and non-Indigenous People must suspend disbelief" (p. 156). In other words, Western research institutions are invited to espouse "critical examination" and "the potential for re-invention" as a way forward for supporting Indigenous methodologies (p. 156). To this end, Kovach (2009) demonstrates that some Western methods such as Participatory Action Research were found to align with Indigenous community practice. She adds that this alignment has contributed to the multifaceted development of Indigenous-based research. Over time, other qualitative methods such as grounded theory were also used to advance Indigenous inquiry. Recently, Indigenous researchers and others have gone further to create Indigenous community-originated research methodologies. In summary, for Kovach (2009) and Smith (2012), Indigenous methodologies align with Indigenous community experiences and perspectives. When everything is considered, Indigenous methodologies have arisen from Indigenous researcher thought and advocacy.

Sampling and Data Collection Methods

In this section, I identify the selection process used to include participants in the doctoral study. Then, I list in sequential order the phases involved in recruiting respondents, interviewing them and reviewing their interviews with them. These last two methods enabled me to collect data for the study. Before turning to these two topics, first I briefly provide the delimiting factors that influenced which respondents were sought. Inclusion criteria were (a) identity affiliation with a recognized First Nation, Métis or Inuit community; (b) completion of credentialed healthcare program for nurses and physicians; and (c) willingness to participate in an initial interview as well as a second member checking interview. Exclusion criteria were (a) No reported affiliation with a First Nation, Métis or Inuit community and (b) Lacking professional credentials to qualify as a healthcare professional. In other words, I included only Indigenous nurses and doctors because I felt they would provide insightful contributions based on their professional roles in clinical medical care and they are the most consistent provider of medical services to Indigenous communities. Later in the literature review, I discuss the important roles nurses and doctors have in Indigenous healthcare programs and I describe Indigenous representation in this profession. Indigenous scholars consider Indigenous inclusion and participation in research as a way to "take back control of our destinies" (Archibald et al, 2019; Smith, 2012, p. 142). For this reason, I felt it imperative to focus strictly on interviewing Indigenous credentialed nurses and physicians who were affiliated with recognized communities and to exclude nurses and physicians who were Indigenous yet non-credentialed, who self-identified as Indigenous but were not affiliated with an Indigenous community recognized by the Canadian Government (2020) as Métis, First Nation or Inuit, as well as any non-Indigenous healthcare professionals. In general, some Indigenous scholars helped me see how important it was to use Indigenous-centric guidance to prioritize respondent contributions. Ultimately, I viewed this category of Indigenous healthcare workers as both a credentialed cohort of professionals and a community of legitimate/authenticate/reliable Indigenous professionals in a western field.

Description of Sampling Activities

Overall, this study employed purposeful sampling methods (Creswell, 2018; Patton, 1990) to recruit interested Indigenous nurses and physicians in Canada who have worked with Indigenous patients. Also, theoretical sampling in the data collection process (Creswell, 2018; Strauss & Corbin, 1990) was used to inform theory creation derived from Indigenous healthcare respondent data. I used a cluster procedure where I identified organizations to locate potential participants in those clusters (see detailed description in REB II application in Appendix A). Qualitative researchers describe how sample size for large or small studies focuses on saturation of the data for validity (Creswell, 2018; Strauss & Corbin, 1998). Therefore, I sought to engage approximately 20-30 Indigenous healthcare professionals in order to solicit participation in the study with a goal of 10-15 respondents. They would include Indigenous physicians and nurses working in the McGill University Health Centre and Indigenous professionals working in Indigenous clinics, community-based health organizations and urban health centres across Quebec and other parts of Canada.

Identifying and Contacting Potential Respondents

The McGill First Peoples' House, an entity that provides Indigenous students with myriad resources to support their academic journey, helped to identify potential respondents connected to the McGill University Health Centre (MUHC) and assisted in contacting prospective Indigenous participants from other organizations (Appendix 1, Attachment 4). I also recruited from Indigenous clinics, community-based health organizations and urban health centres across Québec and the rest of Canada as well as health-focused conferences, training or educational engagements, described below. All prospective respondents, individuals or organizations contacted about this study were told it was focused on Indigenous physicians and registered nurses working in health settings in Québec and across Canada as detailed above. I emailed a letter of introduction approved by the REB II process (Appendix 1, Attachment 3) to 25 healthcare centres on First Nation Reserves across Canada and to specific staff at the health centres in three First Nation Reserves located in Québec: Kahnawake, Kanesatake, and Lustiguj where staff from the McGill First Peoples' House had professional contacts. Additionally, I emailed the Manitoba Métis Federation, Métis Nation of Alberta, Métis Nation of Saskatchewan, Nunavik Regional Board of Health and Social Services and the Nunavut Department of Health. I also contacted several schools of medicine and nursing programs by sending an email solicitation to their faculties of medicine (Dalhousie University, University of Ottawa, University of Toronto, University of British Columbia, University of Manitoba, University of Alberta and

University of Saskatchewan). I requested assistance via email solicitation from the 16 organizations listed below:

- Canadian Indigenous Nurses Association, Canadian Association of Nurses, Indigenous Physician Association of Canada, Canadian Medical Association;
- McGill's School of Social Work, School of Nursing and the Faculty of Medicine, including their Indigenous Health Professions Program;
- 10 Friendship Centres: Brandon, Calgary, Edmonton, Halifax, Montréal, Ottawa, Regina, Toronto, Vancouver, and Winnipeg.

As a student at McGill who is part of the Indigenous Health Professions Program, I emailed colleagues in this program, providing them with information about the study and requesting participation as well as referrals to individuals in their networks.

My recruitment efforts also included outreach at health-focused conferences. I met a Canadian Indigenous nurse and a non-Indigenous Canadian physician at the 17th International Congress on Circumpolar Health in Copenhagen, Denmark. They shared information about my study through their networks in Northwest Territories and Manitoba. Because of my long-standing volunteer engagement with the Native Friendship Centre of Montréal, I asked my professional and community contacts there if they knew of healthcare professionals working in social service programs serving Indigenous community members who might be interested in participating.

Once potential participants were identified, they were asked to participate via email and telephone. Interested participants who met the inclusion criteria were provided with a letter of invitation (Appendix A, Attachment 1) via email which explained the scope and purpose of the study and the interview protocol (Appendix A, Attachment 2). An informed consent form was also provided in the email (Appendix A, Attachment 3).

Respondent Selection

The final sample size consisted of 10 Indigenous respondents from a total of 39 potential respondents screened during the initial recruitment period. Strauss and Corbin (1998) use theoretical saturation to determine whether the respondent sample size is sufficient to collect adequate data that saturates and informs each category or theme that emerges from the data. Therefore, after reviewing these 10 respondents' interviews, I determined theoretical saturation had been reached.

The remaining 29 respondents were not included for the following reasons, as described below in Table 1.:

Table 1: Reasons why 29 respondents did not join or were not included.

Number	**Reason for not being interviewed or included**
4	Indigenous health professionals who did not return calls after expressing initial interest in participating.
1	Indigenous health professional cited reasons for not wanting to participate due to lack of time.
1	Indigenous health professional cited reasons for not wanting to participate because of concern about relevance of their professional experience.
2	Indigenous health professionals did not participate without explanation.
4	Indigenous health professionals did not answer calls or emails about participating.
5	Professionals were not affiliated with First Nation, Métis or Inuit community although they identified as being Indigenous
6	Indigenous professionals were working in paraprofessional healthcare professional roles such as EMS drivers, nursing aides, medical case managers, Community Health Representatives (CHRs) or substance use counselors.
6	Indigenous healthcare professionals were still in academic training and had not yet started working with patients.
TOTAL	29

The following table and graph introduce the 10 respondents which consisted of 9 nurses and 1 physician; among this group, 6 were both trained and worked in an Indigenous community and 4 worked in an Indigenous community but had received their training elsewhere. I used the Canadian Government guidelines defining recognized community affiliation for Métis, First

Nations and Inuit community affiliation (Government of Canada, 2020), and respondents were asked if they belonged to a recognized Indigenous community. Regarding their community affiliation, the sample was composed of 1 Inuk (note, "Inuit" is plural, while one person is "Inuk"), 3 Métis, and 6 First Nations healthcare professionals as depicted below in Figure 3. Respondent Community Affiliation.

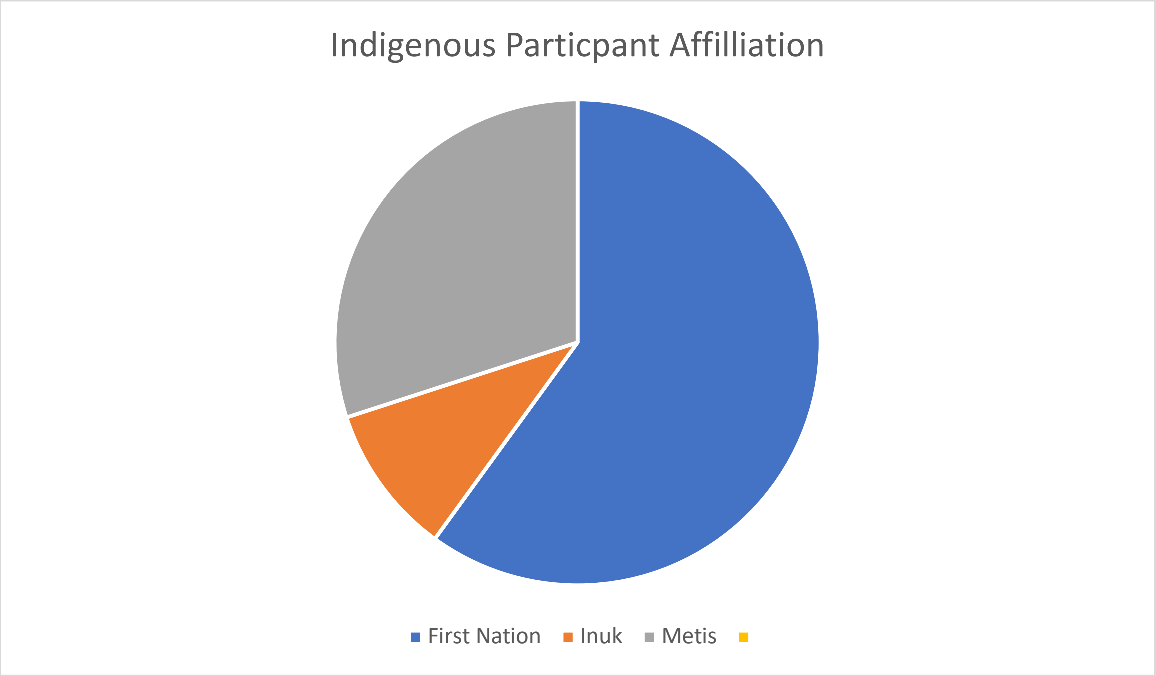


Figure 3: Graph showing respondent community affiliation.

Before turning to the next section about data collection, I pause briefly to bring attention to Indigenous diversity. There are over 630 recognized Indigenous groups in Canada and community members are found in rural and urban community settings (AANDC, 2013; Indigenous and Northern Affairs Canada, 2019). Constructivist grounded theory presents an essential opportunity to integrate this diversity and to uphold Indigenous theory as it emerges from respondent data in such a diverse environment. Here, I purposefully included data from interviews to highlight the kinds of diverse backgrounds respondents discussed. In general, they identified differently from one another. For example, Maureen shared that “We have a very diverse unit, but I am the only Indigenous person that I work with.” Alternatively, Twila explained, “I identify as an Indigenous woman and this is a strong part of my identity.” Twila continued, “But even with support it [nursing school] put a lot of stress and strain on my husband because he was very traditional.” Another respondent, Pat, compared a past and present observation about language loss and revitalization:

> … in the previous times [I would say] If you look at this group of old People, these are the last ones, the last generation of People that have, um, native language, as their first language, and there is barely any left now. And now we are in a cultural revolution of young people going back to language schools or like my kids are fluent because I choose to send them to immersion school.

Overall, respondents provided rich and deeply diverse descriptions of their backgrounds. These descriptions frame how they experience and talk about Indigenous identity. It is my hope and desire that identifying Indigenous diversity though qualitative inquiry in this study helps the reader how the larger Indigenous communities in Canada are made up of many different groups. The reader will be provided with the opportunity to hear many of these divergent descriptions, which are then united by respondent Indigenous identity and respondent experiences in school and at work. Table 2 below shows respondent reported work environment and interview format.

Table 2: Table of respondent interview profiles.

Profession	Works On Reserve Currently (Yes or No)	Trained or Worked in Indigenous Community	Interview Face to Face or via Telephone
Nurse	Yes	Trained and Worked	Face to Face
Nurse	Yes	Trained and Worked	Face to Face
Nurse	No	Worked	Telephone
Nurse	No	Trained and Worked	Telephone
Nurse	Yes	Worked	Telephone
Nurse	No	Worked	Face to Face
Nurse	No	Worked	Telephone
Nurse	Yes	Trained and Worked	Face to Face
Nurse	Yes	Trained and Worked	Telephone
Doctor	No	Trained and Worked	Telephone
TOTALS Nurses: 9 Doctor: 1	TOTALS Yes: 5 No: 5	TOTALS Trained:6 Worked: 10 Both: 6	TOTALS Face to Face: 4 Telephone: 6

Data Collection Phases in Sequential Order

Here, I offer a concise description of the types of research settings offered to and chosen by the respondents. I proposed interviews be conducted in person, by telephone or using web-based conference calling such as Skype. Overall, respondent interviews were conducted face-to-face or by phone; no one requested a web-based video call. The in-person interviews where the respondent and I were in the same location were conducted in settings according to respondent preference (e.g., McGill offices, coffee shops, libraries, etc.). Although I offered interviews in a private setting, three participants chose to meet in cafes, one in a McGill office at the School of Social Work and another chose her home. Regardless of whether the interviews were face-to-face or by phone, all interviewees were asked if the interview could be audiorecorded for transcription purposes. If they declined, I explained that I would use pen and paper to take notes during their interview. All respondents consented to be digitally audiorecorded.

At the outset of the interviews, I verified that respondents had received and had time to review the study's informed consent form (Appendix A, Attachment 3) that outlined the parameters of the study and the purpose of the interview. I discussed how the consent form would be reviewed and read at the beginning of the interview in English to ensure the respondent understood the objective of the study. I reviewed in the REB II application how there are no identified ethical concerns noted. I informed respondents how their participation was voluntary and how respondents might choose to participate or not, and withdraw from the interview at any time and refuse to answer any question. Respondents were informed that their participation or refusal would be kept confidential and would not affect any their professional position in any way. I described how data would be destroyed for participants who wished to withdraw.

Voluntary written consent for audiorecordings was collected prior to starting the interview. To ensure confidentiality as much as possible, I described both in the consent forms and verbally to respondents how their names would never be revealed in written or oral presentations and no record would be kept beyond the parameters described below (Appendix A, Attachment 1). I informed respondents how their identity would be safeguarded by ensuring that transcripts would not contain participant names, location, age, or place of work. I also explained that all identifying information from the interview would not be included in the transcript, such as patient information, including names, diagnosis, location, Indigenous affiliation, place of treatment or age. Regarding access to the interview recordings and transcripts, I explained that I would be the only person who had access. Any paper consent forms would be stored in a locked file cabinet in a locked office of Indigenous Access McGill (IAM) in the School of Social Work where I work, located on the McGill University campus. Additionally, electronic information would be kept on a password-protected computer in the secure IAM office. From there, I described how participants would have the opportunity to review and revise the transcript and the digital audiotape of their initial and subsequent interviews would be destroyed after the transcription of their interviews had been completed. Further, regarding the scanned and stored electronic files of original paper documents, I informed respondents that these electronic files would be destroyed seven years after the doctoral study had been completed as per McGill's REB guidelines. Again, I emphasized the privacy and confidentiality of their data because I was the only person who have access.

Regarding the interview and review process, I outlined how interviews would be analyzed and formulated in a final thesis as well as possible publications to be shared with Indigenous communities. I informed respondents that in the next two weeks I would email them a transcript of their interview; they had one month to review and amend information, then return it to me. I informed respondents that their signature served as agreement to participate in the study.

I reviewed with respondents how there were no anticipated ethical concerns that might arise during the course of the research. These concerns included potential psychological, physical, emotional, social, legal, economic, or political harms identified as risks or expected throughout the interview and review process. I did discuss however, how respondents might experience distress when discussing experiences from the healthcare field. I informed respondents that if they required counselling or other related professional services, I would refer them to the Canadian Nurses Association or Canadian Medical Association that have individual helplines available for no cost which can be accessed on their website. I talked about the steps I would take to reduce or eliminate these risks. I described how I would stop recording if, at some pointn during the interview, the respondent felt distressed and ask if the respondent would like to continue or stop the interview; further, I would remind them of their right to withdraw from interviews without penalty. I assessed the risks as acceptable given the value the research would bring to the fields of medical education and Indigenous healthcare services. None of the respondents requested services or withdrew from interviews.

Finally, I discussed how the benefit of conducting this study might help others better understand the experience of Indigenous healthcare professionals and support Indigenous healthcare professionals as well as non-Indigenous healthcare professionals who desired to be more effective in the healthcare field. I reviewed how interviews might provide resources for future administrators to create policies and services more aligned with the specific needs of these professionals and Indigenous communities and discussed how I anticipated disseminating the results, which would be made available to the public as an academic dissertation as well as academic publications about Indigenous professional experiences.

In addition to relying on the interview and review process to collect data, I engaged in the reflexive practice of memo writing. This practice provided an important opportunity to review and contemplate how respondent data coalesced into categories. I noted how the original questions I started out with (Appendix A) did not encompass the vast array of respondent viewpoints shared during data collection. I thought about specific respondent contributions and realized the prioritization of data was related to their experiences in school and at work, and thematically exploring these data was key to engaging respondent points of view. The original interview questions I framed the proposal evolved into facets of experience respondents discussed and expanded.

Indigenous Relationality

I think special attention has to be given to how McGregor, Restoule and Johnston (2018) join Wilson (2008) to discuss relational accountability and how this accountability forms primal connections to self, others, community, natural and spiritual realms. They describe these realms as an essential component of research involving Indigenous communities. McGregor, Restoule and Johnston in particular describe how Western approaches focus on removing relational accountability from research contexts; this removal denies validity of Indigenous concepts and knowledges. For them, making “explicit” reference to “research subjectivity” (p.10) is a key opportunity for Indigenous research methodologies. For Wilson (2008), relationality plays a vital role in data interpretation and is a term used by many Indigenous researchers. However, these expansive multilayered connections can be ambiguous. Sisseton Wahpeton Oyate scholar Kim TallBear (2017) nuances relational accountability when she reviews how being Indigenous and working with other Indigenous People presents challenges arising from personal affiliation and reciprocity with our own communities. Similar questions arising from insider belonging have been identified by many scholars (Andersen & O’Brien, 2017; Chipps, 2004; Innes, 2009; Jacobs-Heuy, 2002; Medicine, 2001; Narayan, 1993; Ohmuki-Tierney, 1984; Simpson, 2007; Todorova-Pirgova, 1999).

Regardless of the degrees of complexity that arise when practicing relational accountability, Archibald and colleagues (2019) highlight how Indigenous scholars uphold the importance of community context in order to better understand Indigenous “reality” (1999, p.

xvi). Archibald points out that when Indigenous involvement is respected, powerful aspects are gained because community engagement has been validated through this inclusion (Archibald, Lee-Morgan, De Santolo, & Smith). They issue a call for Indigenous research to expand beyond the constriction of the Western academy and to use storywork as a way to "make meaning in the community" (p. 11) and to draw upon Indigenous experiences. Archibald, Lee-Morgan, De Santolo, and Smith describe how the focus on expanding Indigenous research provides a pathway for Indigenous communities to create Indigenous connections with community, land, traditional knowledges and "ceremony of living relational knowledge" (2019. p. 11).

My own Indigenous community affiliation and professional experiences as an Indigenous social worker working with other Indigenous healthcare professionals aligns with the call for Indigenous People to conduct research in their own communities. As described below, I engaged with respondents and their data by drawing on my own relationship with Indigenous experience and knowledges; further, I drew upon my own Indigenous knowledge during the analysis phase.

The powerful connection of relational accountability is described as using respect for all relationships in the process of research (McGregor, Restoule & Johnston, 2018; Wilson, 2008). I feel my own identity as an Indigenous community member who worked many years with Indigenous healthcare professionals illustrates a key aspect of relational accountability in healthcare contexts. When working as a Community Health Representative at the American Indian Community House in New York City, I sought to go to school to help my own community. At Columbia University, I was the only Indigenous student in the social work program. In this role, I worked to bring visibility to Indigenous community issues in classes and in student organizations. While I felt my own motivations were clear, I realized the systematic oppression of Indigenous People would not be addressed by my work in mainstream non-

Indigenous institutions or by using non-Indigenous scholarship. This realization motivated me to return to school and enter the PhD program at the McGill School of Social Work for the purpose of conducting research and writing this thesis to advance knowledge about the experiences of Indigenous healthcare professionals. I found being Indigenous was helpful during the recruitment and screening process for respondents. When I engaged respondents, I sought to address relational accountability by disclosing my own Indigenous background growing up on the Yankton Sioux Reservation in South Dakota and sharing about annual visits with distant relatives in Brandon, Manitoba for the Dakota Winterfest. I also shared about my own experiences working with Canadian Indigenous community members as a Community Health Representative, Social Worker and Executive Director of the American Indian Community House in New York City. I talked about how these experiences provided me with exposure to a wide array of Indigenous healthcare professionals as well as diverse Indigenous communities.

Further, I was able to hear aspects of respondent data that might otherwise be unexplored because we shared similar stories. For example, respondents discussed their own desire to become Indigenous healthcare professionals and to work with their own community members which was very much a part of my own story. Additionally, over the years, I have worked with many different Indigenous community members, which has provided me with an appreciation for diverse Indigenous traditions, languages, and cultural beliefs. I link this appreciation to TallBear's (2017) discussion about the divide between Indigenous community knowledges and formal academic tools and words used to engage Indigenous communities in research. Tallbear identifies the relevance of both. I observed Tallbear's applicability when, during data collection, respondents referenced traditional Indigenous practices and identity in their interpersonal experiences and related to the formal medical setting where they trained and worked. It may seem ironic how Indigenous respondents discussed the importance of Indigenous healing in spite of barriers that encountered in the field of healthcare services. This is a huge gap that Indigenous respondents referenced through anecdotes and discussion. TallBear (2017) talks about the importance of using academic methods and developed technical terms while recognizing "imperfect translations" (p. 79). She shares a viewpoint about how a personal mandate of Indigenous relation-keeping with our own communities and academic development pose a great opportunity, especially for Indigenous researchers (TallBear, 2017).

Along with acknowledging Indigenous Relationality between respondents and me, I also looked to different settings in which Indigenous research occurs. Often, urban settings provide a rich context to learn about Indigenous People's multifaceted experiences. For example, McGregor, Restoule and Johnston (2018) note that Indigenous health research about urban diabetes prevention upholds "Indigenous relationism" as a key ingredient because this ingredient ensures that both the researcher and participant communities achieve "broader decolonizing healing purposes" (p. 278). Smith (2016) offers another example when she voices the need for an environment of decolonization at all levels of inquiry that goes far beyond single or repeated community consultation. Andersen and O'Brien (2017) emphasize in their anthology of Indigenous research the importance of diversity and question the idea one Indigenous paradigm by providing articles from Indigenous authors around the world. Author Coll Thrush (2017a; 2017b) also draws attention to scholarship on Indigenous Peoples in urban settings and provides descriptions of contemporary and historical Indigenous presence in Seattle, which is jampacked with diverse Indigenous communities and geographic legacies. Further Thrush (2017b) discusses how Indigenous urban experiences are framed as by-products of colonial actions and devoid of Indigenous legacy. Thrush (2017b) describes in his writing the importance of recognizing

Indigenous identity in urban areas. He discusses how aspects of transformative change and descriptions of Indigenous urban places have a “shared vitality, cultural empowerment, and broadening political and economic engagement” (p. 113), and represent valid components of Indigenous experience (Thrush, 2017b). Similar to Smith (2016), both Andersen and O’Brien go beyond focusing on a single point of geographic origin or historical reference.

Many studies that describe urban Indigenous experience have provided a way for me to see the importance of accessing Indigenous knowledge and experiences regardless of the setting. This study responds to Thrush’s call to validate “urban places and spaces” (p. 114) provides an example for investigating Indigenous identity in diverse places (Thrush, 2017b). It focuses on listening to Indigenous community members who are receiving specialist medical technical educational and training and listening to their experiences in the field from their own perspectives as Indigenous Peoples. In fact, respondents’ Indigenous identity shines through during data collection and emerged as a validation of Indigenous survival even in the most formal western environments found in hospitals and clinics. I feel this is an important connection to make: to conduct research that seeks to validate Indigenous experiences in many different kinds of modern environments, such as, in this case, in healthcare education, training and professional workplaces. I believe the aspect of authentic Indigenous identity is not limited to a single place or time; when respondents validated the importance of their Indigenous identity throughout their educational and professional journey, they also validated this belief.

Finally, relational accountability guided me to use the Indigenous concepts of the Naming Ceremony and the Vision Quest in data interpretation as a way to highlight Indigenous concepts and viewpoints. These two ceremonies, described shortly, were not just references to historical practices. Instead, the ceremonies support respondents’ experiences as they discussed the importance of their Indigenous identities throughout their experiences of formal healthcare education and work. Before turning to the two ceremonies, I highlight Indigenous stories to link aspects of my Indigenous identity to the data interpretation phase of my study.

Indigenous Vision Quests are described as a ceremonial rite of passage for Indigenous community members who go on a journey alone and often forgo food and water in order to prepare for dreams or visions (Robinson, 2018). Sleep deprivation is described as a common experience employed to help participants access dreams or visions (Dahl, 2013). Indigenous communities have diverse traditions and many ceremonies were lost due to residential schools and colonization, however the vision quest is described as having been a part of many Indigenous communities, and remains in use (Robinson, 2018). Métis communities also access Indigenous ceremonies; however, many Métis communities are described as also practicing Christianity and experienced prohibitions of Indigenous identity (Préfontaine et al., 2003).

Naming Ceremonies are also described as being conducted in different ways by different Indigenous communities, and may involve using a name of an ancestor or experiences gained during ceremonies (Centennial College, 2018). My own community often used what occurred during the Vision Quest to help determine a name, however a person might also get a name for other reasons such as showing bravery or generosity. Historians describe how Métis community members were often historically given French Catholic names but also had names influenced by trade and connections with First Nations and European immigrants (Préfontaine et al., 2003). I choose the Vision Quest and Naming Ceremony as a way to create a story about respondent data and Indigenous resilience.

Smith (1999) discusses how Indigenous stories shared from Indigenous perspectives is an important and defining aspect of Indigenous research methodology (Archibald, Lee-Morgan, De

Santolo, & Smith, 2019). Indigenous Australian scholar Larissa Behrendt (2019) shares her identity as being an “Eualeyai and Gamillaroi woman” (p.175) and further shares her “personal totem is the dinewan (emu), my clan totem is the long-necked turtle (girrabirrii)” (p. 175). Behrendt (2019) emphasizes how Indigenous storywork gives voice to Indigenous efforts to counteract colonial oppression and violence. Archibald and colleagues highlight the importance of engaging "Indigenous storywork" to gain knowledge about Indigenous cultures and traditional practices from an Indigenous perspective (2019). For this reason, Archibald created seven principles that guide Indigenous research, especially research focused on developing frameworks for the application of theoretical, methodological and pedagogical approaches: “respect, relevance, reciprocity, responsibility, holism, interrelatedness and synergy” (Archibald, Lee-Morgan, De Santolo, & Smith, p. 1). Kirkness and Barnhardt’s (1991) Four Rs comprised of respect, responsibility, reverence and reciprocity provided an important foundation and these were further expanded. Archibald and colleagues discussed the need to create an enriched approach to help researchers and others “pay better attention to and engage with Indigenous stories” (2019, p. 1). Their ability to integrate a prescriptive approach (which both draws from Indigenous knowledge and intentionally enriches Indigenous contributions) helps researchers to create a “deep interpretational understanding of story, people and place” (Archibald et al., 2019, p. 8; Archibald, 2008).

Archibald and colleagues (2019) offer an example of these seven principles of Indigenous engagement when they highlight a coyote story shared by Indigenous community member Eber Hampton from the Chickasaw Nation. Hampton’s rich description of wisdom rooted in allegory exposes vital information needed to see the teaching story embedded in folklore wisdom. The story illustrates how Old Man Coyote looks for an old bone needle previously lost. By using

Archibald ’s seven principles, researchers might be able to make connections to the lived experience of Indigenous Peoples. The quest for tools to recover or repair Indigenous learning requires understanding. In Hampton’s (Archibald, 2019) retelling, Old Man Coyote did not take care of the lost bone needle and goes around in circles hoping to find it. Archibald and colleagues link this search to the lesson to either revere Indigenous learning or profoundly mourn its loss. The seven principles helped Archibald and her colleagues demonstrate a powerful path towards restorative learning where Indigenous Peoples can draw upon their own wisdom to find better ways to connect with Indigenous needs. In doing so provides a holistic, respectful response grounded in integrity to RCAP’s call for formulation of new relationships that contribute to Indigenous Peoples and reverses the devaluation of Indigenous Peoples in research (Archibald et al., 2019).

Regarding storywork, Lambert (2014) offers an example when she discusses the medicine wheel as a way to integrate Indigenous methods into the academic research process. Using the four quadrants of the medicine wheel, she analyzed her own research data. For this reason, Lambert calls for Indigenous researchers to explore and develop unique Indigenous conceptual frameworks. She also upholds the practice of relying on knowledge that is relational and connected to the informant as well as all aspects of their own Indigenous worldview including the natural world, ancestors and creation itself. Like Lambert, during the data analysis phase, I began to draw upon my own experiences with Indigenous storywork or conceptual frameworks. I recalled talking to my dad about our Indigenous community of origin and about our ceremonies and community traditions. One ceremony, the vision quest, was of great interest to me and my dad described a ritualized approach where one would fast while sitting in a location for four days and nights. It was described that during this time, the person on the vision quest would experience the natural and spiritual world and in retelling their experience to the medicine person, sometimes a name would emerge. However, the vision quest's primary purpose was not to obtain a name, but to connect with what one experienced and to share it with others. My dad then spoke about the naming ceremony. In this traditional practice, the person who participated in the vision quest would be given a name based on what they experienced. It might also be, my dad continued, that a person could inherit a name or get a name from a relative, but he emphasized that often, for Yankton Sioux, the traditional way to receive a name would be to complete the vision quest and then the naming ceremony. I clearly recall thinking of my dad during data analysis and realized that analyzing respondent data was more akin to this tradition of going on a vision quest, reflecting on one's experience, and sharing what one experienced. These early childhood discussions with my dad motivated me to use a spiritual and culturally relevant way to describe what I heard and witnessed during the interviews with Indigenous healthcare professionals.

Dichotomy for Indigenous Healthcare Professionals

The Truth and Reconciliation Commission of Canada (2015) documents many forms of trauma enacted during the era of the Residential School system. The pain and anguish caused by Residential schooling affects both survivors and their children thereby passing on trauma through subsequent generations. Archibald et al. (2019) emphasize the importance of listening completely to all these Indigenous narratives. They led me to think a lot about the dichotomy for Indigenous healthcare professionals: Dare we go to the very place that was charged with our total annihilation in order to get education and training to help save our own People? Indigenous approaches to research, using Indigenous "holistic meaning-making process" (Archibald et al., p. 9) can help reduce the pain and trauma inflicted in Residential Schools and during the Sixties

Scoop when Indigenous children were separated from their families and communities (RCAP, 1996; TRC, 2015).

In addition to serving as a source for healing historical trauma, Indigenous research approaches can adapt Western research approaches to better meet the needs of an Indigenous community. Archibald and colleagues (2019) state that constrictive Western research activities do not honor Indigenous storywork and have a horrible legacy of misuse with the goal to elevate oppression and increase subjugation of Indigenous communities. Linda Tuwahi Smith's (1999) seminal work on decolonizing methodological approaches starts to frame dynamic Indigenous opportunities. Both Smith and Archibald describe about how Indigenous researchers can approach research processes in two ways. First, we can use our Indigenous experiences to create Indigenous research methods. Second, we can bring a new more reliable focus to historical methods, an Indigenous point of view that prioritizes “our own purposes” (Archibald et al., p. 39). Thus, prioritizing our own purposes creates a powerful stance that directs Indigenous researchers to rely more on Indigenous alignment with Indigenous knowledges and relational engagement to reveal perspectives either missed or actively excluded by Western research methods.

As noted by Archibald and colleagues (2019), Smith (2012) does not call for a complete rejection of Western knowledge, but for an alignment with Indigenous knowledges and wisdom. Archibald and her colleagues point out that Indigenous stories reveal foundational principals that emerge when information is “shared, respected and treasured” (p. 6). When researchers examine these stories, they are provided with valid resources. Indigenous research neither comprises standardized approaches nor requires a sole approach; instead, it directs researchers to be wary or suspicious of methods that suppress or exclude Indigenous contributions (Archibald et al.;

Swadener & Mutua, 2008). Archibald and colleagues (2019) highlight the need for Indigenous researchers to cherish and use our own Indigenous knowledges as a tenet of our pursuit for social justice. I draw upon this tenet by using my own experience as an Indigenous person to interpret data in an Indigenous way familiar to me.

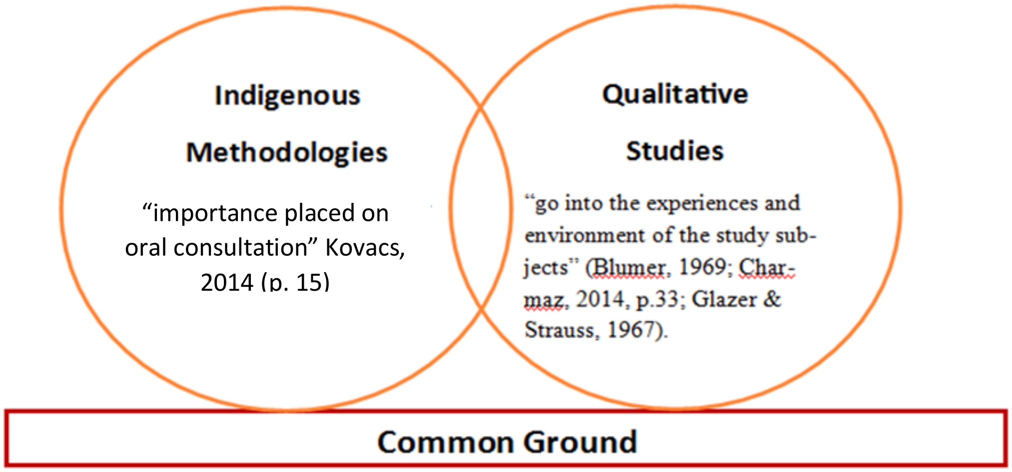
Constructivist Grounded Theory in Tandem with Indigenous Research Methodologies.

Indigenous writer Margaret D. Jacobs (2017) provides a cumulative review of research on Indigenous education. She describes how non-Indigenous authors primarily document oppressive educational mandates perpetrated on Indigenous individuals, while Indigenous scholars focus on survival and the emergence of Indigenous control over education as an extension of Indigenous sovereignty (Jacobs, 2017). In contrast, some scholars argue that a binary review does not support the depth of community engagement espoused by many Indigenous research methodologies (McGregor, Restoule & Johnston, 2018; Watts, 2013). Therefore, they seek to limit comparing mainstream practices to Indigenous research methodologies. Many scholars have described research on Indigenous Peoples as deficient; they call for the incorporation of Indigenous research methods to support a more robust engagement between researchers and community respondents (Kovach, 2009, Smith, 2012; Strega & Brown, 2015). As presented earlier in this chapter, several Indigenous theorists identify the closeness between Indigenous and qualitative research methods (Cajete, 1999; Deloria, 2002; Henderson, 2000; Kovach, 2009; Little Bear, 2000) which Creswell (2018) describes as providing an “interpretive, naturalistic approach” (p.7). In fact, many Indigenous and non-Indigenous scholars state that current qualitative research practices can be inclusive and supportive of Indigenous research methodological approaches (Kovach; Smith; Strega & Brown). Several Indigenous authors have illustrated how Indigenous knowledge is accessed through interpretive inquiry (Cajete; Deloria; Henderson; Kovach; Little Bear).

Overall, researchers may value qualitative methods because they are more apt to capture and describe actions over time, which provide an opportunity to understand complex aspects of reported respondent experiences (Hennink, Hutter, & Bailey, 2011; Saldana, 2016). Kovach (2009) specifically identifies grounded theory as an important way to make Indigenous knowledge accessible and to establish the importance of incorporating Indigenous research methodologies. As mentioned in the section "Sampling and Data Collection," the REB II (Appendix 1) proposal described constructivist grounded theory guidelines that were used to collect and synthesize data. These analytical processes constructed theories using participant data (Charmaz, 2014). For example, I described how interviews would be employed to gather data from respondents. Then, I would analyze the information they supplied to identify individual and collective patterns associated with their reported experiences. Constructivist grounded theory methodology uses flexible analysis during all phases of the dissertation. For this reason, questions which arise during an analysis phase are used to form theory. In turn, according to Charmaz (2014), this emerging theory can be used to construct concepts about respondent contributions. She explains that once interviews are completed, constructivist grounded theory directs literature and program documentation reviews as well as uses observations from the field to help inform the research process. Further, she insists, comparative actions identified during data collection and memo writing enhance interpretation opportunities, and the researcher's ability to formulate categories grows as the pace of research activities increases. The findings become clearer through these analysis activities and this motivates the creation of theory and rich findings that are based on the data. For Charmaz, grounded theory ensures the field of social research has a methodology for theory creation and ways to describe human studies that might otherwise be considered inaccessible due to the abstract nature of information housed in conceptual ideas.

To conduct meaningful and informative data collection, constructivist grounded theory supports engaging and prioritizing respondent data over pre-established questions (Charmaz, 2014). Thus, respondent data is the guiding force in analysis. Instead of solely relying on fixed questions formulated beforehand, themes arise from respondent data. For example, as respondents shared their own stories, my original interview questions naturally developed based on facets of respondent interviews rather than remain static. This development relates to my motivations for wanting to interview Indigenous healthcare professionals and why I chose Constructivist Grounded Theory. It also demonstrates some of the ways that the theory aligns with Indigenous scholars who direct researchers to uphold Indigenous data as valid and essential. Put differently, I was able to reprioritize respondent data over initial interview questions. This priority enabled me to align data analysis with respondents' key experiences, especially experiences they wanted to talk about. In the original interview questions, I asked about their experiences with Indigenous patients. However, they uniformly related their experiences in healthcare education and training as well as their issues in professional practice settings. These Indigenous healthcare professionals were able to provide a more accurate response to the general aim of this inquiry by focusing on their own stories. The combination of constructivist grounded theory with Indigenous methodologies represent a key component of the study process as it unfolds. Constructivist grounded theory directs researchers to include respondent information regardless whether it relates to the initial research questions or whether it provides an alternative viewpoint (Charmaz). I interpret this to mean that respondent content is validated as essential components of theory development. Indigenous researchers also discuss the need to prioritize Indigenous viewpoints as valid and urge researchers to incorporate Indigenous methodologies in the face of resistance from the western academy (Kovach; 2014, Smith, 2012; Strega & Brown, 2015).

I included an illustration below showing overlapping circles representing how qualitative works and Indigenous methodologies have shared strengths. I found this to be paramount during all aspects of the thesis and especially prominent during data analysis.



Overlapping circles illustration idea from Dr. Janine Metallic presentation on February 29, 2019 at Thompson House, titled "Highlights of Indigenous Research at McGill", based on Kavach (J. Metallic, personal communication, February 28, 2019; Kovach, 2009, p 31).

Figure 4: Graph illustrating methodology correlation.

Analysis of Respondent's Data: Some Examples

The strength constructivist grounded theory offered me was a way to access the many different viewpoints and contexts contained in the respondents' data. This multiplicity helped create an analysis that remained central to their stories. Many Indigenous researchers demand that respondent data be validated and prioritized, however for distinctly different reasons (Smith, 1999; Smith, 2012; Strega & Brown, 2015). Some direct the prioritization of Indigenous respondent content as an essential method that reinforces Indigenous survival and sovereignty (Smith, 1999; Smith, 2012; Strega & Brown, 2015). For my doctoral study, constructivist grounded theory and Indigenous methodologies were equally important resources because they insist that respondent data inform theories formulated by researchers. I offer three examples below to demonstrate my assertion.

The first example comes from a respondent for whom I provided a pseudonym, Pat, in order to protect her identity. She provides a description of how Indigenous languages used in clinical practice with elders from her community made a powerful impact in the care delivery. This aspect of care, using Indigenous language, was not a part of my original area of focus. However, its relevance emerged because constructivist grounded theory directs research themes to arise through respondent contributions. The respondent described the importance of an elder asking for water in their original Indigenous language and the provider giving them exactly what they want, instead of asking to be addressed in English. Also, the respondent shared experiences of working with patients regressing due to memory loss. She explained how these patients will often revert to languages and words used in their childhood. Through memo writing I discussed how Indigenous languages was emphasized again in Respondent data analysis. In Memoing 3.1.1, I noted: “It felt so amazing to hear her discourse about working in the community and using the language to provide appropriate care to elders.” Kovach (2009) describes using grounded theory to analyze interviews; as a result, her analysis highlighted Indigenous language as an opportunity to explore a “layered endeavor” (p. 25) of Indigenous experiences. She explains that the individual and deeply imbued nuances found in tribal languages contain contextual knowledge and locations not readily accessible to researchers. Therefore, western research methods can be ineffective as the sole source of data interpretation when analyzing data derived from respondents using their Indigenous languages.

The second example deals with transmitting information. In general, Indigenous knowledge holds oral consultation as both a defining trait and prominent source of information, which posits a markedly different pathway for transmission of information (Kovach, 2009; Strega & Brown, 2015). Critical discourse of data interpretation and the incorporation of Indigenous identities distinguishes Indigenous methodologies from mainstream or western methodologies (Kovach, 2009; McGregor, Restoule & Johnston, 2018). Specific examples of dichotomies emerged early as exemplified when respondent Pat commented, “Yeah, so you can, I actually really got to see firsthand like the experiences [trauma], that like not all of it might have been a direct result of Residential schooling and things like that and cultural genocide.” The ability of researchers to discern what data elements specifically relate to the Indigenous experience is challenging. Indigenous theory relates to the inclusion of all findings as Indigenous regardless of the lack of stereotypical association.

My third example connects to Indigenous relationality. Including respondent voices supports the overall goal of the doctoral study, which was to focus intently on Indigenous healthcare professionals as both Indigenous individuals and as healthcare professionals. During one interview, Rhonda claimed that “because, so often I find, perhaps if they are seeing individuals who are not First Nations or don't have that Indigenous background, they are just very ‘treat, treat, treat’.” Following this interview, my memoing reflections showed alignment: “I liked how she began by asking ‘How do you know my sister?’ as a way to get us started and also to let me know, I think, that we are both Native so you come with a ‘good referral.’” I feel

Rhonda complemented my experience of gathering and formulating data as an Indigenous researcher using my own Indigenous identity.

Although I do not provide a direct example, another strength grounded theory offered me was the delayed literature review. Charmaz (2014) informs us that employing a delayed literature review optimizes a researcher's ability to see data through analytical eyes instead of being influenced solely by preconceived ideas. Literature reviews done after data collection support the conceptual framework in ground theory which is "developing theories" (p.6) from information gathered earlier in the study. Charmaz further describes studies which use literature to frame data as "deducing testable hypotheses from existing theories" (p. 6) as she discusses approaches to using constructivist grounded theory employing a literature review after data collection (2014). In this study respondent data indicated colonial legacy of oppression present in professional settings. Describing circumstances of oppression requires the researcher to look at literature beyond limited social and health literatures.

In this chapter, I reviewed why I found the discussion of how to incorporate Indigenous methodology and epistemology key to supporting the incorporation of Indigenous perspectives. Highlighting the experiences of Indigenous healthcare professionals can provide a contextual background to those professional health training and certification programs seeking to increase Indigenous enrolment. This contextual background is informed by data that describe both the education and work environments and paint an essential picture of respondents and the contexts where they were trained and work. Finally, this chapter documented the inquiry process including a critical analysis of the methodologies used for the doctoral study.

Chapter Three Literature Review

Specialized knowledge is required to help the reader better understand the professional environment where healthcare institutions, government policies, Indigenous communities, and urban health centres interact. This review provides a synopsis of the fields of Indigenous health education and work. The task of describing Indigenous healthcare is as daunting as it is necessary in order to introduce a remarkably unique field of practice.

Literature is organized into two components. The first component provides an overview of Indigenous health services in general and offers a broad description of the field from many disciplines. Issues identified in Indigenous Health Literature relate to many settings where Indigenous healthcare professionals work. A wide range of topics in the first component are used to describe how services are provided to Indigenous communities and show a pronounced lack of coordination and engagement. Included also is a description of Indigenous community health and social issues. The second component contains literature related to respondent reported experiences presented later in chapter four. Literature intentionally relates to study results which are organized primarily around respondent interviews, analytic memos, and data analysis. Constructivist grounded theory directs researchers to review literature derived primarily from respondent contributions (Charmaz, 2014). Data gathered during interviews seeks to help establish a connection between academic literature and individual descriptions provided by Indigenous respondents. 'Discrete Areas' outlined below are derived directly from descriptive frameworks used in chapter four and are used to organize literature.

Discrete Area One: Educational Training; Descriptions open with a general introduction describing the field of Indigenous nursing and medicine education.

Discrete Area Two: Experience Working; Literature focuses on describing the current environments experienced by Indigenous healthcare professionals.

Discrete Area Three: Challenging Environment; Articles review discussions about the adverse learning and working environment experienced by Indigenous students and professionals.

Discrete Area Four: Making Recommendations; Literature explores the recommendations of Indigenous healthcare professionals and advocates.

I conclude this chapter by summarizing literature contained in components one and two. Topics found in the literature review are briefly listed for comparison and to refresh the reader with numerous issues identified by academics and researchers.

Component One: Indigenous Health Services and Complex Environment of Service Provision

The Truth and Reconciliation Commission (2015) provides a definitive mandate of improvement of healthcare services through Indigenous community engagement. Indigenous healthcare professionals work in a complex administrative environment. Canadian healthcare researchers have long described how equity can be increased in healthcare services that are created in collaboration with Indigenous Peoples and require change on many levels including systems, healthcare organizations and individual interactions between patients and healthcare professionals (Browne, et al., 2016). These scholars describe how a multifaceted approach to create healthcare that is both equitable and responsive to Indigenous People's needs (Browne, et al., 2016). Health services in Indigenous communities are provided through a diverse array of funders such as federal departments, provincial ministries as well as Indigenous community governments (Assembly of First Nations, [AFN] 2018; Lavoie & Gervais, 2009; Wigmore & Conn, 2003). Scholars have described the need for a governing structure and leadership to increase Indigenous community engagement which would improve informed decision making, healthcare services, increased access to healthcare providers and better approaches for chronic disease management (Tompkins et al., 2018).

Canadian health research and policy scholars have over the years highlighted the way health services are provided in Indigenous communities being fragmented and confusing for patients and professionals, who are affected by uncoordinated programs and complex government policies (Government of Canada, 1997; Lavoie & Gervais, 2009; National Advisory committee on SARS and Public health, 2003; Romanow, 2002; Tompkins et al., 2018). Indigenous communities are heavily impacted by local, regional, provincial, and federal boundaries (Lavoie et al., 2016). Understanding complex institutional systems requires health planners to know how legislation and policies vary according to geographic location and district (Lavoie et al., 2016). The Assembly of First Nations (AFN) recognizes how jurisdictional boundaries across Canada represent a formidable barrier inhibiting decision making and cooperation between Indigenous communities, local, provincial, and federal departments (AFN, 2018). Researchers have described how coordination of health services in this environment creates poor quality healthcare services due to uncoordinated institutional systems (Lavoie & Gervais, 2009; Marchildon, 2005; Richmond & Cook, 2016). Indigenous advocacy groups, non-Indigenous advocacy groups and individual scholars have also highlighted how a chaotic care environment affects the consistency and quality of medical care, and Indigenous communities have issued several calls for change and improvement (AFN, 2018; AFN, 2006; Canada, 2005; Inuit Tapiriit Kanatami, 2004). Overall, an environment of bureaucratic disorganization inhibits access to care and contributes to the problems Indigenous communities face accessing care (AFN, 2018; Lavoie & Gervais, 2009).

Policy Lacking Engagement

The historic TRC Calls to Action highlight increased healthcare providers and services as primary goals for governments and instructions serving Indigenous Peoples (2015). Historically Indigenous health policy is created within institutional bureaucratic structures housed in federal government departments and does not originate through a process of community engagement, which many scholars have identified as a continuing trend (Lavoie et al., 2011; Richmond & Cook, 2016). Indigenous leaders have highlighted how Indigenous participation in healthcare planning and governance is neither equitable nor focused on Indigenous priorities (AFN, 2018). Scholars describe how the same government colonial institutions administering programs have remained in operation since inception (Czyzewski, 2011). Government policies are not enforceable as laws, which allows for flexible applications of these policies over time (Leenan, 1998). This allows for the provision of services to continue to be misaligned with community needs even when deemed ineffective because of low-quality outcomes (Lavoie et al., 2011). The nonbinding nature of government department policy creates an environment where the responsiveness to local needs is not prioritized over the service delivery model, and healthcare services remain unchanged in spite of crisis levels of illness (Lavoie et al., 2011). Available services for Indigenous communities are deemed ineffective compared to care provided to other Canadians (AFN, 2018, February 13; OAGC, 2011). For example, in 2018, the death of Ina Matawapit, an Indigenous woman brought to the North Caribou Lake clinic in Ontario, revealed that Indigenous northern healthcare services manage care poorly and routinely jail patients who present intoxicated (Martell, 2019). The inquest into her death revealed a disorganized fragmented care system which makes tracking poor outcomes difficult if not impossible (Martell, 2019). Health policy researchers describe how long history of inequity experienced by

Indigenous community members continue unabated and recommend stronger collaboration and leadership with Indigenous communities to improve social and health standings (Richmond & Cook, 2016).

Researchers, for example, have identified the basic inability to access services and a lack of equitable services as serious barriers facing Indigenous communities (Gone, 2014; NCCAH, 2011). Racism has been described by researchers as a serious deterrent for Indigenous Peoples accessing healthcare, and scholars call for increase cultural safety training and increased retention of Indigenous healthcare professionals (Bourassa, 2018). Calls for increased Indigenous leadership and improved capacity to develop and oversee Indigenous health services has been identified as a primary goal to improve Indigenous health services (AFN, 2018).

Situations like this have been identified as indicating a deep lack of understanding of Indigenous communities and the institutions that are charged with providing them care (Lavoie et al., 2011; Romanov, 2002). Policy objectives enacted as a part of legislation make application less flexible and more consistent across institutional services (Legemaate, 2002). However, the inability of Indigenous community members to enforce policy is lacking as evidenced by the issues described in the reviews of Jordan’s Principle (Blackstock, 2012; Britten & Blackstock, 2015). Professional assessments have defined the need for greater government coordination and provision of comprehensive health services, not simply relying on historical medical models that only target the treatment of disease (Chenier, 2002; Lavoie et al., 2011). AFN calls for health services to include Indigenous cultures and languages as essential components, which are often not integrated into western medical services (AFN, 2018). This requires prioritizing service strategies that address treatment modalities as well as many health and social issues (Chenier, 2002; Lavoie et al., 2011). Indigenous health issues are exacerbated by the reduction of government funded community-based health services, which are further impacted by social issues such as inadequate housing options (Browne et al., 2011).

Canadian health researchers such as Fridkin (2012) discuss how involvement of Indigenous Peoples in health policy and program development is key to supporting valid discourse which recognizes the imbalances of power Indigenous Peoples face. Fridkin talks about how studies reviewing colonialism impacting Indigenous Peoples provide a platform to address inequities and help healthcare advocates and Indigenous community members become more involved in all levels of health policy formulation. The TRC Calls to Action (2015) also discuss incorporation of Indigenous collaboration on all levels of health education and training, as well as in the provision of services. Researchers have described how educational institutions can incorporate a post-colonial viewpoint in order to help identify systematic failures to engage and help Indigenous community members instead of blaming them for ill health and disability (Hojjati et al., 2018). They describe, for example, how a rehabilitation professional training program identified the need to examine the very foundations of educational training used in their programs (Hojjati et al., 2018). These researchers highlighted this example as a way other schools might address curriculum that undermines equitable treatment of Indigenous Peoples and supports low health attainment (Hojjati et al., 2018).

Diversity of Indigenous Communities

Indigenous communities comprise of many distinct groups across Canada and local diversity is lost in health studies combining different groups of People living in different geographic locations. Additionally, Indigenous communities are described in health literature as one singular population. Descriptive data do not capture Indigenous community identity but rather describe how groups of Indigenous Peoples are categorized by Crown relations with

Canada. There are 630 Indigenous communities in Canada, most of which are found in the Prairie Provinces of Alberta, Manitoba, and Saskatchewan (AANDC, 2013; Government of Canada, 2017). Statistics Canada reported Winnipeg, Manitoba, as having the most Indigenous population of any city in Canada with 92,812 Indigenous community members. Statistics Canada (2017) group tabulations described Indigenous communities in 2016 as: 977,230 People who reported being Registered Indian/First Nation (including status and non-status People); 587,545 reported being Métis and 65,025 reported being Inuit. Combined, these communities represent 4.9% of Canada's population (Statistics Canada, 2017). Census reports describe how Indigenous communities represent the fastest growing population in Canada as well as the youngest population with 44% of Indigenous community members under the age of 25 (Statistics Canada, 2017). These data present an important context of diversity within Indigenous communities across Canada (Gracey & King, 2009).

Health Indicators Studies are Available

Indigenous research, utilizing multiple methods, is mainly categorized into three main domains focusing on social science, health policy and biomedical health (Wilson & Kue Young, 2008). The higher burden of Indigenous mortality and morbidity compared to the general population of Canada is widely studied (Adelson, 2005; Richmond & Big-Canoe, 2009; Park et al., 2015). Health studies rely primarily on geographic location to define the parameters of community physical health status and either focus on describing on-reserve communities or off-reserve communities, however scholars have found studies fail to describe the Indigenous communities in general (Cardinal, 2006; Minore et al., 2009; Tjepkema, 2002). Several scholars describe how Indigenous Peoples have been profoundly impacted by long periods of privation caused by forced location on reserve lands with little resources and assistance, and the mandated removal of Indigenous children into residential schools and later foster homes (Allan & Smylie, 2015; Anaya, 2014; Browne et al., 2016; Coulthard, 2014). Researchers identify how Indigenous community members continue to be impacted by low employment, poverty, low educational attainment and poor and inadequate housing (Browne et al, 2016; Patrick, 2014; Peters & Andersen, 2013). Indigenous scholar Dion Stout (2012) discusses how Indigenous Peoples have been resilient in spite of barriers to effective healthcare services by relying on Indigenous knowledges and spiritual practices.

Lower Health Status

Researchers have identified for many years how Indigenous community members have low health status and less access to healthcare than non-Indigenous Canadians (MacMillan et al., 2003; Mian et al., 2019; Shah et al., 2003). Indigenous Peoples in Canada are described in health literature as having more health problems compared to other Canadians due to chronic diseases like diabetes for example, which is related to disproportionate poverty and high substance use (NCCAH, 2013). The Highlights from the Report of the Royal Commission on Aboriginal Peoples describes seven health indicators found to be above or below national benchmarks lower including, infant, child and maternal health status, higher incidence of infectious diseases, higher incidence of chronic diseases, higher accident and injury rates, higher disability rates, higher alcohol abuse rates, and lower community health status related to poverty, poor living conditions and high levels of environmental hazards (AANDC, 2013; Adelson, 2005; Park, et al., 2015). The impact of this study has been profound and has led health researchers toward investigating root causes of poor social and economic conditions and how they affect physical health outcomes (Rose, 1992). Recent research has confirmed that the health status of Indigenous Peoples in Canada continues to be disproportionately poor (Dion Stout, 2012).

Social Determinants of Health (SDOH)

Factors that have a lasting impact on health and wellbeing and arise from a wide range of interdependent systemic problems related to education status, employment opportunity and attainment, income levels and social exclusion, represent the main components of SDOH categories (Browne, 2009). Identifying high-risk activities or social and economic environments that contribute toward the progression of non-communicable diseases through unhealthy acts such as drinking or smoking, and how these forces create stressful lives is key for researchers to frame studies using this methodology (Marmot, 2004). Increased access to social and economic resources enable individuals and groups to avoid health risks or reduce the impact of diseases that affect those in lower social economic groups more strongly (Link & Phelan, 1995; Wilson et al., 2008). The same dynamic holds true even in developed countries where more resources are conceivably accessible to help individuals and communities attain wellness (Marmot & Wilkinson, 2003). A framework developed for the World Health Organization defined 10 primary SDOH: addiction, social exclusion, food, social support, transport, social gradient, work, stress, unemployment, and early life (Marmot & Wilkinson, 1998; Richmond & Big-Canoe, 2009; World Health Organization, 2020). These areas of study have been used prominently in research describing the Indigenous community and children (Greenwood & de Leeuw, 2012; Richmond & Big Canoe, 2009).

The definition of health in the SDOH framework is not solely focused on physical outcomes but is inclusive of wellbeing on many levels including mentally, socially and emotionally, and focuses on helping individuals attain wellness and implement environmental changes that would better support wellness. Scholars have used SDOH as an effective framework to unify the diverse and oppressive forces impacting Indigenous communities that otherwise would remain disconnected in discussions of policy, biomedical or social science research (Pulla, 2013; Richmond & Ross, 2008).

The focus of Indigenous health research has primarily been on analysis of disease categories and population specific mortality rates and is not inclusive of social and economic trends affecting health status (Richmond & Big-Canoe, 2009). Understanding how inequality adversely and disproportionately affects social determinants of health in Indigenous communities compared to Canadian society remains less established (Loppie & Wein, 2009; Richmond & Ross, 2008; Richmond & Big-Canoe, 2009). Another barrier to understanding the health of Indigenous communities is how research describes on-reserve populations but excludes the growing urban Indigenous communities (Richmond & Big-Canoe, 2009). Studies found Indigenous community members living in urban areas reported high levels of anxiety and researchers call for more analysis of the relationships between Indigenous specific determinants of health, mental health and anxiety disorders (Nasreen et al., 2018). Researchers advocate for the inclusion of determinates such as Status Indian, history of attending a residential school, Indigenous language knowledge and individual involvement in traditional activities (Nasreen et al., 2018).

Service Delivery Issues Impact Indigenous Communities

The opportunity to incorporate Indigenous-specific geographic, economic, biological, and social status in social determinants of health frameworks is largely unrealized in health studies, and markedly absent in discussion of government administration and policy (Greenwood et al., 2015). Advocates point out that Indigenous Peoples are often blamed for conditions of poverty, which is exacerbated though negative stereotypes in mainstream media and government reporting (Allan & Smylie, 2015; Britten & Blackstock, 2015; Palmater, 2011). These stereotypes highlight cases of ineptitude that are then associated with all Indigenous communities and shift the focus away from government inaction (Allan & Smylie, 2015; Britten & Blackstock, 2015). The complexity of Indigenous community settings presents unique social determinants of health (SDOH) that profoundly impact Indigenous health status as it relates to Indigenous identity, history, and diverse living conditions (Raphael, 2009).

Component Two: Discrete Areas Related to Respondent Data

Research compiled and matched with 'Discrete Areas' described in Chapter 4 anchors Indigenous health literature as it relates to respondent findings. Respondent data used to formulate literature reviews is a primary goal of constructivist grounded methodology. Sections relate to wide ranging descriptions of Indigenous health literature. Information relating specifically to fields of nursing or physicians is listed separately in each of the four 'Discrete Areas' listed below: Educational Training, Experience Working, Challenging Environment and Making Recommendations.

Indigenous communities experience a notable lack of primary medical care services. This is caused by a smaller number of physicians available in Indigenous communities; this in turn reduces community access to primary care services requiring medical supervision (Health Canada, 2016; CNA, 2014).

Indigenous nurses are especially important because they are a professional majority and represent 77% of all Indigenous healthcare professionals working in Indigenous communities (NHS, 2011; Exner Pirot, 2014). This is key because it shows high Indigenous professional representation in spite of the fact that most of the medical care provided in Indigenous communities are currently provided by non-Indigenous professionals (CNA, 2014; Exner Pirot, 2014; IPAC; 2009; King, n.d.).

The vast underrepresentation of Indigenous providers is seen as a contributing factor to the low social and health outcomes experienced by Indigenous communities (Anderson, 2009). Healthcare delivery for Indigenous People is mainly provided under the medical authority of both nurses and doctors (Exner Pirot, 2014). Doctors have government-sanctioned rights provided by medical education and licensing processes to provide medical care services regardless of the setting, that is, hospital, clinic, home, community, school, and so forth. In this way, nurses and doctors embody medical systems as professional and credentialed individuals.

Discrete Area One: Educational Training

Health professions are undergoing tremendous change as professional training, education and credentialing is focused more on helping Indigenous professionals advance, and more importantly, for all professionals to become more effective when working with Indigenous Peoples (JSOGC, 2000; CNA 2014; Canadian Institute for Health Information [CIHI] 2020; CMA, 2002). Researchers have issued the call for increased numbers of Indigenous healthcare professionals for many years and identified the need for increased cultural safety training in healthcare curriculum (Anderson & Lavallee, 2007). Scholars have found more evaluation is needed of Indigenous content in medical training programs in order to improve students' ability to identify and meet the needs of Indigenous patients (Spencer et al., 2005). Researchers have found that healthcare professionals do not have an in depth understanding of low health literacy, and how this lack of professional knowledge creates barriers for Indigenous community members as they seek healthcare services (Lambert et al., 2014). This study also noted concern about the lack of awareness low health literacy might have on Indigenous community members seeking to manage health conditions, and furthermore how healthcare professionals may not know how to help Indigenous community members improve health literacy skills (Lambert et al., 2014).

Indigenous Nurse Barriers to Education

Indigenous advocates have voiced concern in a survey by the Canadian Nursing Association (CNA; 2014) that Indigenous students do not receive adequate math and science in elementary and secondary schools, which puts them at a disadvantage when applying for admission to training programs (CNA 2014; Rowan et al., 2013). Many Indigenous nurses also have identified inadequate funding and few supportive resources for Indigenous nurses as a barrier to program completion, because these women often start programs with children and return to the workforce after many years of taking care of families (CNA, 2014). Scholars also identified how older Indigenous students often return to school after raising a family or working in less professionalized fields for a long time and they need special support to successfully complete programs (CNA, 2014). Health education programs are not geared toward supporting mature nursing students who need greater flexibility and supportive services (O'Brien, Keogh & Neenan, 2009). Many women who return to school after raising families still maintain their role at home as well as trying to find a balance in school, which is unlike mature male students who are better able to enjoy academic freedom (O'Brien, Keogh & Neenan, 2009). The provision of childcare services and counseling support are two resources nursing schools can offer to help Indigenous students achieve a stronger sense of self-esteem and confidence (CNA, 2006; Minore et al., 2013). Allowing Indigenous students time to work by creating flexible program models and using distance learning curriculum to support older students living in rural and geographically isolated Indigenous communities also support student success (CNA, 2014; Minore et al., 2013). The Association of Aboriginal Nurses in Canada (ANAC) has described best practices for Indigenous nursing education to include assistance getting into a program, support completing the program, preparation for graduation, and employment in the field (ANAC, 2006b). Indigenous students who are able to define their role in nursing practice are more able to help the profession adapt better methods of engaging with Indigenous Peoples (ANAC, 2006b). Moreover, Indigenous nursing students learn better from staff who practice cultural competency and cultural safety (ANAC., 2002a, 2005a, 2006b, 2011b; Minore et al., 2013).

Indigenous Nurse Student Experience

Indigenous nurse education has been examined by researchers who found the need for nurse training programs across Canada to incorporate more effective engagement strategies in order to increase Indigenous student enrolment and retention (Lane & Petrovic, 2018). Nursing program enrollment has, in general, increased, and schools have admitted between 13,392 students in 2001 to 15,125 in 2011, with the most programs offered in Ontario and Quebec (CAN, 2014; CASN, 2013). There is a total of 104 Canadian Association of University Schools of Nursing (CASN)-accredited nursing programs in Canada in 50 universities (CASN, 2020). The number of CASN programs in each Province: 8 in Alberta; 17 in British Columbia; 1 in Manitoba; 5 in New Brunswick; 3 in Newfoundland and Labrador; 1 Northwest Territories; 11 in Nova Scotia; 38 in Ontario; 5 in Prince Edward Island; 13 in Quebec and 2 in Saskatchewan (CASN, 2020). Yukon and Nunavut have no accredited CASN programs (CASN, 2020).

The recruitment of Indigenous nurses is seen as a key opportunity to foster much needed leadership as well as to educate other professionals about the impact of racism and colonial oppression (CNA, 2014). Canadian Institute for Health Information reported that RN graduates in 2018 increased to 12,837, which represents the highest increase in the past five years (CIHI, 2019; CNA, 2019). The number of Indigenous nursing students is currently unknown; however, nursing programs have been found to have low Indigenous representation (ANAC, 2006a; 2006b, 2011b; CNA, 2010b). A recent survey of Canadian schools of nursing found Indigenous students were estimated to represent only 1-10 percent of students in the programs surveyed, and these programs reported even fewer Indigenous faculty and few Indigenous recruitment policies (Rowan et al., 2013).

This has motivated professional organizations to place emphasis on the need for increasing recruitment and training opportunities. A task force to explore these issues was convened by the Canadian Association of University Schools of Nursing (CASN), which conducted a literature view and survey of nursing programs across the country in 2002 (Gregory et al., 2008). This survey, requested by Health Canada to help the nursing field better understand obstacles in nurse recruitment and retention practices of Indigenous nurses specifically, found there was need to inform nursing schools and educational training centers about best practices with Indigenous communities (Gregory et al., 2008).

CASN partnered with the Canadian Indigenous Nurses Association (CINA) in 2020 to advance the TRC calls to action (CASN, 2020). CASN and CINA specifically focused on Action 24, which calls on schools of nursing and medicine to “require all students to take a course dealing with Aboriginal health issues, including the history and legacy of residential schools, the United Nations Declaration on the Rights of Indigenous Peoples, Treaties and Aboriginal rights and Indigenous teachings and practices” (CASN, 2020; TRC, p.2, 2015). Skills-based training on intercultural competency, conflict resolution, human rights, and anti-racism will be required to help schools improve (CASN, 2020). The nursing framework approach for implementing TRC Calls to Action includes a three-pronged approach of foundational strategies focused on reconciliation, recruitment and retention strategies, curricular strategies and (CASN, 2020). CASN and CINA Leadership, and CASN schools provided unanimous approval for this initiative and, empowered a TRC taskforce to clearly outline areas needing improvement in order to foster meaningful change (CASN, 2020).

Indigenous Doctors Barriers to Education

Statistics Canada lists 760 Indigenous physicians who self-identify as Indigenous out of 93,985 physicians in Canada, which represent less than one percent of physicians (Ohler, 2018; Statistics Canada, 2017). The Indigenous Physicians Association of Canada and the Association of Faculties of Medicine of Canada (AFMC) have been actively working to increase the number of Indigenous physicians to 2,000 (AFMC, 2012; IPAC, 2013; Morrison, 2008). There are 17 medical schools in Canada: two in Alberta, one in British Columbia, one in Manitoba, one in Newfoundland and Labrador, one in Nova Scotia, six in Ontario, four in Quebec and one in Saskatchewan (AFMC, 2019). These schools graduate approximately 2,700 students each year (AFMC, 2019).

Healthcare schools and educational training programs across the country are seeking to increase Indigenous enrolment to heed the Truth and Reconciliation Commission calling for more healthcare providers (Ohler, 2018; TRC 2015). Researchers have identified how the number of Indigenous students in medical schools is as much as six times below what might be achieved in relation to the Indigenous community population size (Dhalla et al., 2002; Mian et al., 2019). The AFMC announced how 17 deans of medicine gave unanimous support for a roadmap outlining 10 actions promoting Indigenous students by focusing on; increasing the number of Indigenous doctors; creating a better experience for Indigenous learners and creating an Indigenous health curriculum (AFMC, 2019). Lower numbers of Indigenous applicants, lower grades and lower rates of graduations represent some of the many barriers affecting Indigenous enrolment in medical school programs (Mian et al, 2019; Petch et al, 2013; Reiter et al., 2012; Statistics Canada, 2019). The inability of medical schools to recruit and train and deploy Indigenous physicians quickly is related to the amount of time it takes to train and graduate students (AFMC, 2012; IPAC, 2014). The effort to recruit and train Indigenous physicians is seen as an essential activity that will increase the availability of culturally competent physicians and increase the integration of Indigenous cultures and Western medicine (Morrison, 2008).

The TRC provides a paramount call for change which has motivated some medical training programs, such as the Cumming School of Medicine in Calgary for example, to conduct a collaborative review of five schools of medicine and an in-depth examination of TRC mandates (Crowshoe et al., 2020). Authors of this review describe how TRC Calls to Action provide an essential opportunity to help educational institutions identify ways to address Indigenous social and health disparities and increase the quality of Indigenous health training programs (Crowshoe et al., 2020).

Academics describe the importance of medical student exposure to the impact of colonial oppression and inequities (Yeung et al., 2018). Increased learning and exposure to Indigenous communities also provide an important opportunity to improve medical education curriculum and create a foundation for improved physician and Indigenous patient relations (Yeung et al., 2018). A health study focusing on Indigenous diabetes care found physicians adapting care to support Indigenous patients improved patient care quality, however researchers also recommend more examination of healthcare system issues in order to increase competency (Crowshoe et al., 2018).

Cost and academic preparation are two specific barriers identified as deterrents to recruiting Indigenous medical students (Mian et al., 2019). The Dean of the University of Manitoba Medical School emphasized how expensive academic preparation and exams such as the MCAT can create barriers for students from low-income communities; thus, schools should provide supportive services for students who do not have access to higher quality preparatory education (CBC, 2015). Intense recruitment efforts by medical schools is hampered by inadequate science and math resources available to young Indigenous scholars, which is also referenced as a barrier for Indigenous nursing students (ANAC, 2011). The Northern Ontario School of Medicine identified how most Indigenous applicants in their programs to be female and mature (Mian et al., 2019). The School describes how Indigenous students encounter numerous barriers to admissions in post-secondary institutions and, recommends socially accountable admissions (Mian et al., 2019). This includes assessing many factors for admission such as schools service region and targeting northern and Indigenous applicants (Mian et al., 2019).

Indigenous Doctor Medical Education Experience

The 1996 Royal Commission on Aboriginal Peoples goal of educating 10,000 Indigenous health professionals in twenty years (RCAP, 1996) provided a measurable target for the medical field to reach. The Truth and Reconciliation Commission (TRC; 2015) also has issued a direct call for institutions and governments to increase the amount of Indigenous healthcare professionals. Concerns from Indigenous advocates point out that Indigenous doctors are employed primarily in urban settings, however, the emphasis on educational training is to recruit students who will return to their community of origin to practice (Aboriginal Human Resource Council [AHRC], 2006). Physicians are educated in urban settings but either travel periodically to provide services in remote and rural Indigenous communities or provide services via long distance government programs (AHRC, 2006). Reframing concepts of wellness to incorporate Indigenous orientation requires providers to take into consideration the spiritual and emotional elements as well as physical and mental health (Pulla, 2013). However, this is not included in formal medical training programs (IPAC, 2014).

Discrete Area Two: Experience Working

Literature reviewed provides descriptions focused on two geographic areas of service delivery. The first description entails issues found in urban settings. The second description focuses on issues related to services provided in traditional First Nation Reserves and in Indigenous communities. The federal government is the primary funder and provider of health services for Status Indians on reserves and Inuit living on traditional lands (Health Canada, 2003; 2008; Lavoie et al., 2011). Health Canada oversees the Regional Offices of the First Nations and Inuit Health Branch (FNIHB), which operates 77 nursing stations, 217 health centers and 4 small hospitals across Canada (Health Canada, 2016). Concerns about the effectiveness of this system have come under scrutiny due to poor documentation and reporting systems, which make comparisons with mainstream Canadian healthcare systems impossible (Martell, 2019). Government funding in 2017 in the amount of $828.2 million dollars was pledged to support increased Indigenous health status and specifically identified the need to support Indigenous mental health, maternal and child heal as well as primary care services (Ohler, 2018). Furthermore, the government pledged an additional $97.5 million per year in 2018 for critical medical care and 24/7 nursing services in 79 Indigenous communities located in remote areas (Ohler, 2018). Indigenous nurses are most represented in these service settings working alongside non-Indigenous nurses. Services are provided to help rural and remote Indigenous communities on-reserve lands or in treaty areas receive health services where provincial care is not accessible via nursing stations and health centres (Health Canada, 2016; Kirby 2001). Indigenous communities south of the 60th parallel, who constitute about 46% of First Nations, have relied on a Health Transfer program since the 1980s to provide services (NAHO, 2002). This has given communities limited control over some health services previously provided by Health Canada but does not constitute health planning or service delivery restructuring needed to address community needs (NAHO, 2002). Indigenous communities may also choose health service delivery via the government Integrated Community-Based Health Services program that provides supportive administrative assistance in healthcare service planning and delivery, which provides communities with more input in service provision (NAHO, 2002).

Indigenous Urban Settings

Currently it is estimated that up to half of Indigenous People in Canada live in urban settings, but do not fare better because of closer proximity to services (NCCAH, n.d.; Tjepkema, 2002). Challenges facing Indigenous People in urban settings are many. Barriers include unfunded transportation costs for Indigenous patients, experiencing loneliness and a lack of affordable housing which requires Indigenous patients to travel far using extensive urban transportation schemes (Lavoie, 2008). Urban Indigenous issues are not well represented in health and social literature (IPAC, 2014)

There is limited data available to study Indigenous communities in urban areas in terms of health status and scholars must rely on diverse sources of information in order to analyze how poor access to health services affects communities and individuals in urban settings (Place, 2012). Information is often anecdotal or specific to one health issue. For example, Indigenous Peoples living off reserve are likely to have higher incidence of arthritis, diabetes and high blood pressure compared to on-reserve communities (Statistics Canada, 2016; Tjepkema, 2002). One of the reasons why Indigenous community members relocate to urban areas is to have better access to healthcare services (Tjepkema, 2002). Urban Indigenous Peoples have reported having more unmet healthcare needs due to healthcare services deemed to be poor quality (Tjepkema, 2002).

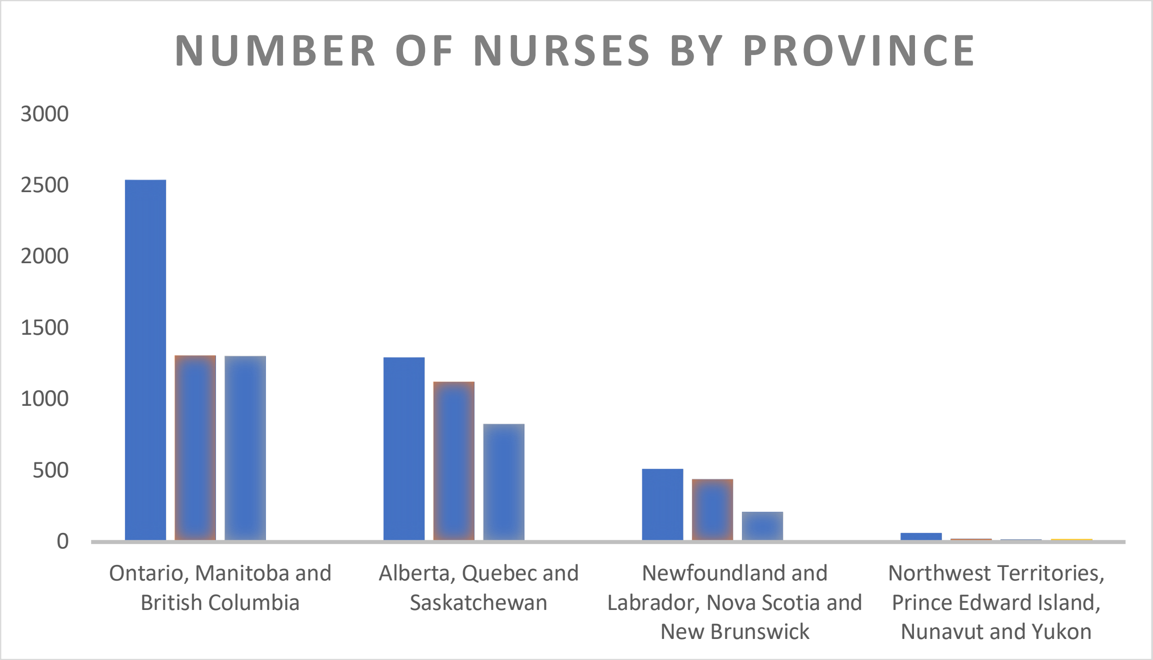
Settings on Reserves and in Indigenous Communities

Most health studies have focused on individuals living on reserves or on traditional territories, and research has described how these communities have lower health status than Indigenous Peoples living elsewhere (Tjepkema, 2002; Urban Aboriginal Knowledge Network, 2012). Off-reserve Indigenous communities can also reside in rural areas and have different challenges than Indigenous communities in urban areas (Tjepkema, 2002).

Indigenous Nurse Work Setting

Nurses represent the largest and most important group of Indigenous healthcare professionals. There are currently 9,695 Indigenous nurses in Canada of 327,780 nurses and they comprise approximately 3. % of the nurse workforce based on the 2016 census in Canada (Statistics Canada, 2016; University of Saskatchewan, 2018). Identification and percentage of Indigenous nurses by community affiliation is: 51.5% Métis, 51.5% First Nations, 3.9% Multiple and other and 1.3% Inuit (Statistics Canada, 2016; University of Saskatchewan, 2018).

Table 3: Indigenous Nurse Workforce listed in order by Province.



Ontario has the most nurses at 2,540 which represents the largest number of nurses of all provinces followed by Manitoba with 1,310, British Columbia with 1,305, Alberta with 1,295, Quebec with 1,125, Saskatchewan with 830, Newfoundland and Labrador with 515, Nova Scotia with 440, New Brunswick with 210, Northwest Territories with 65, Prince Edward Island with 25, Nunavut with 20 and Yukon with 20 (Statistics Canada, 2016; University of Saskatchewan, 2018).

The four largest percentages of Indigenous nurses were found in Northwest Territories with 15.9% and Nunavut with 14.3%, Manitoba with 9.2% and Saskatchewan with 7.0% (Statistics Canada, 2016; University of Saskatchewan, 2018). The government-run Office of Nursing Services (ONS) oversees the operational services delivered on reserves by recruiting nurses and providing orientation training (Health Canada, 2016). Nursing guidelines are maintained by ONS, which also develops standards of care, maintains policies, and incorporates national health initiatives (Health Canada, 2016).

Nurses provide more intensive services in these communities and require special medical knowledge, advanced skills and clinical judgement that is beyond nurses working in mainstream settings (Health Canada, 2016). The number of Indigenous nurses in Canada has been found to be insufficient to meet the current staffing requirements of Indigenous healthcare centers and nursing stations (Gregory et al., 2008). Indigenous communities rely more heavily on nurses to provide healthcare compared mainstream settings, especially in remote communities in the North. There are few resources available for comprehensive care and nurses perform pre-natal monitoring, diabetes management, immunizations and healthy baby monitoring for communities ranging from 200 to approximately 5,000 individuals (Government of Canada, 2015).

Indigenous Doctor Work Setting

The reasons for promoting Indigenous doctors have been described by health advocates as their ability to related to Indigenous patients during clinical interactions, and these professionals also have higher retention rate than non-Indigenous physicians (King, n.d.). Indigenous academic Tibetha Kemble (Stonechild), the Director of Indigenous Health at the University of Alberta describes how Indigenous doctors might better understand the life experiences of Indigenous Peoples, and also be more aware of traditional healing (Ohler, 2018). Doctors and specialists are available anywhere from 2 to 12 days each month and coverage at other times is provided by telephone (Government of Canada, 2015). Isolation and autonomy can be more stressful for the healthcare professionals who rely on limited multidisciplinary teams (Government of Canada, 2015). Long distance hospitalizations and specialty consultations such as Urology, Mammography, Radiology, Computerized Tomography Scan, Obstetrics and Gynecology services also require patient travel and require physician monitoring and coordination (National Expert Commission, 2012).

Indigenous Doctors Experience Geographic Constraints

Indigenous doctors are employed primarily in urban settings, however the emphasis on educational training is to recruit students who will return to their community of origin to practice (AHRC, 2006). Physicians either travel periodically to provide services in remote and rural Indigenous communities or provide services via long distance government programs (AHRC, 2006). Long distance medicine and telephone medical services are a reality for many physicians working with rural and remote Indigenous communities that have little opportunity for professional advancement because there are fewer patients and few medical diagnostic and treatment infrastructures available in rural and remote areas. This infrastructure is needed to support physician professional development and opportunities to increase income (Buxton et al., 2007; Tollinsky, 2011).

Primary medical care services are heavily focused on prevention of chronic disease such as diabetes and obesity for example, which occur at a younger age and lead to disability compared to non-Indigenous patients (McGibbon et al., 2008). Researchers have defined the need for primary healthcare providers to be better educated about the colonial history of oppression and privation experienced by Indigenous Peoples (Beavis et al., 2015). Healthcare students should be taught about how inequality and in equity experienced by Indigenous Peoples is sustained by colonial contexts, and this education is essential for helping them be better equipped to recognize and challenge oppressive medical practices (Beavis et al., 2015). Researchers discuss how the Western world view must be critically examined in order to acknowledge harms and pursue social justice for Indigenous Peoples, as well as other oppressed groups (Beavis et al., 2015).

Prenatal care is a prominent medical service in Indigenous communities compared to other clinical services offered, which require travelling for services (JSOGC, 2000; Starkes et al., 2014). Geographic isolation of many Indigenous communities presents a serious barrier for service delivery that make medical care markedly different than medical care provided in mainstream settings (AFN, 2018; Webster, 2006). For example, palliative care where Indigenous patients in end stage illness are only connected by telephone to family back home is markedly different than what is found in mainstream care schemes (IPAC, 2009).

Discrete Area Three: Challenging Environment

Indigenous Peoples' experiences of conquest and forced government policies of assimilation describe the foundational dynamic between the Canadian government and Indigenous Peoples (Allan & Smylie, 2015; Palmater, 2011). Indigenous health research has developed into a priority in Canadian health and social science fields (Adelson, 2005; Reading & Nowgesic, 2002). The inadequacy of western health service models to address Indigenous health problems has been described as stemming directly from historical delivery systems using oppressive colonial operational frameworks (Commission on Social Determinants of Health, 2007; Dyck, et al., 2010; Pearce et al., 2008).

Understanding how colonialism is central to the Indigenous experience is essential because this framework continues play a contributing role in diminishing the access and quality of health services (Allan & Smylie, 2015; Browne et al., 2005; Browne, & Varcoe, 2007; Kelm, 1998). Scholars have identified colonialism as the largest contributing factor to poverty, which consists of historical and contemporary activities to force acculturation of Indigenous Peoples into mainstream societies along with fostering the continual disenfranchisement of rights and property (Alfred, 2009, Bennett & Blackstock, 2007; Blackstock, Clarke et al., 2003; Briggs &Lee, 2012; Loxley, 2010; Palmater, 2011; Sterritt, 2007).

Racism has been described as avoidable and unfair actions that cause an environment of disadvantage or advance the advantage of one group over another (Paradies et al., 2008). A racist environment is created through the promulgation of racist beliefs by stereotyping People and supporting racist emotions by acting in a prejudicial way, or by discrimination which is a combination of racist behavior and race-motivated practices (Paradies et al., 2008). Systemic institutional care provision schemes are prone to racist constructs and may even be unintentional or so subtle that is difficult to see how this perpetuates inequities for Indigenous patients (McGibbon & Etowa, 2009). Mental health clinicians influenced by racism and racial profiling of Indigenous patients might fail to provide an appropriate assessment, resulting in misdiagnosis which then produces misaligned treatment regimens (Bui, 2002; Fernando, 1991; Kafele, 2003; Wilson, 1997). These issues are ongoing and prominent. The Indigenous Physicians Association of Canada (IPAC) provided a policy statement condemning the death of Indigenous patients in care in response to the tragic mistreatment and death of Joyce Echaquan. (IPAC, 2020, September 30). Additionally, structural racism may create a scenario where treatment opportunities are missed, and entire communities are misdiagnosed. Misdiagnosis has been suggested by researchers analyzing Indigenous communities with low Post Traumatic Stress Disorder (PTSD) diagnosis rates and high incidences of mental health problems stemming from Residential School experiences and long histories of colonial oppression (Gone et al., 2019; Beals et al., 2005). Healthcare workers do more than provide direct medical services and have been deployed to the Indigenous communities struggling with high levels of attempted suicide, for example, in the Attawapiskat First Nation and Nishnawbe Aski Nation organization of First

Nations in northern Ontario (Dyer, 2016). Adverse environments created by ongoing colonial domination and racism are so important that the Indigenous Physicians Association of Canada (IPAC) is actively organizing discussion about racism against Indigenous community members as patients and healthcare providers (IPAC, 2020).

Indigenous Nurses' Challenges

A report detailing the perspective of Indigenous nurses in the field identified how racism and conflicts with instructors was an inhibiting factor in the field (CNA, 2014; Etowa et al. 2011). Nursing advocates recommend greater investigation into racism in the field and the incorporation for more Indigenous knowledge (CNA, 2014). Indigenous nurses assume a new role in their community while maintaining family and social relationships and simultaneously being exposed to traumatic situations arising from historical oppression (CNA, 2014).

Scholars have identified how cultural safety and cultural competence trainings are needed to address the lack of diversity training in nursing educational programs, which also harbor systematic racism in training practices (Vukic et al., 2012). Scholars describe cultural competency as an approach focused on being informed about cultural differences as a provider of services (Curtis et al., 2019). Cultural safety by contrast requires service providers to be aware of how dynamics such as power and equity impact work with People, and focuses on providers developing skill sets to recognize stereotypes and address bias (Curtis et al., 2019).

Programs are recommended to identify a designated leader in the school to promote policy compliance with cultural competency and safety practices using dedicated resources and funding (Rowan et al., 2013). Calls for increased cultural competency and cultural safety in the field of nursing education are currently derived from standards and frameworks from international practice as well as provincial and federal Canadian government healthcare agencies (ANAC, 2009a; Douglas et al., 2011; Doutrich et al, 2012; Mahara et al., 2011; NAHO, 2008). Nurses without specialized training are likely to continue to reinforce misaligned clinical practices that create barriers to care with patients; this is especially relevant when medical staff engaged in care have not received specialized training (CNA, 2014).

Institutional structures creating systematic barriers for Indigenous patients include persistent racism in the clinical setting, which is exacerbated by the lack of support for cultural competence and cultural safety in professional settings (CNA, 2014). Organizations have described how training and tools aimed at increasing professional competency for nurses are minimal (A.N.A.C 2009a; CASN 2013; CNA 2014), which raises the question of how much an impact these initiatives will have on improving the delivery of nursing care for Indigenous communities.

Indigenous Doctors' Challenges

Many Indigenous physicians have voiced the concern about the lack of cultural safety as both patients and as professionals working in clinical settings (Lesyk, 2013). Physicians are expected to recognize how relationships are affected by power differential dynamics during treatment and to increase effective connections with Indigenous patients. The emphasis on redesign of service delivery methods includes highlighting ways to improve communication by being more familiar with Indigenous community norms and experiences. Professional organizations outline how services should include engagement of communities and individuals and not just be concerned with providing clinical services focused on medical treatments (Allan & Smylie, 2015; Browne, et al., 2011; JSOGC, 2000). The Northern Ontario School of Medicine describes how they focused on better preparing medical students to successfully engage with Indigenous community members by partnering with Indigenous community members to collaborate with students during classroom training sessions (Hudson & Maar, 2014). Scholars discussed how beneficial using structured Indigenous community cultural immersion activities are, and how building these kinds of activities in curriculum supports students to become more effective professionals (Hudson & Maar, 2014). However, increased study is recommended by researchers in order to effective engagement programs with Indigenous communities (Hudson & Maar, 2014). Additionally, scholars have noted how the geographic isolation of many Indigenous communities presents a serious barrier for service delivery and makes the kind medical services needed for this environment markedly different than medical care provided in mainstream settings (Mian et al., 2019; Webster, 2006).

Discrete Area Four: Making Recommendations

Canadian health researchers describe how Indigenous health status is impacted by long standing oppressive forces found in structural violence, which represents an amalgamation of racism embedded throughout institutional mandates, which perpetuate Indigenous inequality and inequity. (Browne et al., 2016). These scholars highlight how growing awareness about the inequities found in healthcare provision schemes have not been addressed and continue to affect Indigenous Peoples (Browne et al, 2016). Scholars describe how structural violence stems from continuation of “structures, policies and institutional practices that are innately unjust” how this greatly impacts Indigenous Peoples (Browne et al., 2016, p.2). Health researchers identified how broad-based government programs serving Indigenous communities have not resulted in a formal Indigenous policy framework that can be used across Canada, and advocate for national framework for First Nation, Inuit, and Métis policy development (Lavoie, 2013). Researchers describe how low health attainment of Indigenous Peoples is directly connected to how they experience exclusion and oppression in “everyday social patterns” (Browne et al., 2016, p. 2) which reinforces inequity and escalates poor service delivery outcomes (Farmer et al., Kim, Kleinman & Basilico, 2013). Scholars discuss how poor social attitudes about Indigenous Peoples are in turn imbedded in institutional health service delivery, and consequently low health attainment may appear to be falsely attributed to interpretations that Indigenous People face these issues because they are Indigenous (Browne et al., 2016; Taylor, 2013). That Indigenous health failures can be caused by the perpetuation of structural violence by the very systems meant to aid them is alarming (Browne et al., 2016; Farmer, 2013).

Scholars have voiced how changes to repair deficient physical and mental health delivery systems must entail actions focused on correcting harms caused to individuals, communities and families through a holistic approach (Barron, 2009). Healthcare delivery redesign in these settings is pressing, especially since the inequalities of social determinants of health make Indigenous community members more prone to physical illness and mental health problems (Allan & Smylie, 2015; National Expert Commission, 2012).

Need for Indigenous Engagement

Researchers advocate for the Truth and Reconciliation Commission Calls to Action (2015) be embraced by all government and healthcare institutions across Canada and be incorporated as a proactive tool to improve Indigenous health and social services (McNally, & Martin, 2017). Authors have described loosely coordinated healthcare strategies as insufficient, and underscore how this will diminish Indigenous ability to access health services because the provision of services are driven from outside mandates lacking alignment with community needs (Adelson, 2005; Lavoie & Gervais, 2009) To bolster community engagement, many Indigenous organizations are now focusing on community participation in defining key components for establishing operational services (Wabano Centre for Aboriginal Health [WCAH], 2015).

Wabano Centre for Aboriginal Health in Ottawa, for example, conducted a comprehensive impact evaluation process with Indigenous community members to guide services while establishing a new health centre (WCAH, 2014.) Researchers recommend inclusion of Indigenous community members to influence and improve structural and systemic healthcare services and call on all healthcare institutions to show leadership as service providers and network advocates to foster change (McGibbon, 2019).

Indigenous Nurses

Indigenous nurses may be able to incorporate more traditional concepts into western medicine, though more must be done to recognize how tensions between Indigenous belonging and nursing mandates create unique challenges (Aboriginal Nurses Association of Canada, 2013; CNA, 2014). Research has also shown that improved health status of Indigenous individuals and communities is associated with increased access to Indigenous nurses (Health Canada, 2002; Kulig et al, 2010). This could be due to the idea that Indigenous professionals may be able to better relate to clients with regard to (a) the poverty experienced by Indigenous Peoples, (b) how poverty fosters poor health and (c) how poverty inhibits productivity and the ability to act independently, which, in turn, can cause trauma and confusion (Dion Stout, 2012). Researchers call on examining stereotypes about Indigenous Peoples to find ways to reduce the negative impact of how stereotypes support racism and health inequities (Ly & Crowshoe, 2015).

Social Determinants of Health

Understanding how Indigenous communities experience unique social determinants of health is essential for de-colonizing Nursing practice (CNA, 2014). Nursing organizations expect professionals to understand more about how these determinants profoundly influence well-being and life opportunity in Indigenous communities (Browne et al, 2009; CNA, 2014).

Indigenous Doctors, Connection is Important

Research has supported how healthcare professionals can improve treatment outcomes when they are sensitive to cultural issues and responsive to community norms (Kirmayer, 2012). Health literature supports an increased effectiveness of Indigenous professionals compared to non-Indigenous professionals with regard to patient retention and improved health outcomes (Kirmayer et al., 2009). Researchers have identified how some Indigenous individuals value respectful relationships as well as strong family and community ties more than medical services, which is important for clinicians to know (Brant, 1990; Ellerby et al., 2000; Hotson, Jennings, 1994; Macdonald & McDonal, 2004). Additionally, some Indigenous community members emphasize how professionals listening to Indigenous patients and accepting patient decisions is an important component of meaningful engagement (Brant, 1990). One study found Indigenous patient value trust over medical competence (Kelly & Brown, 2002). A Mohawk psychiatrist identified how some Indigenous patients devalue physician advice or recommendations that detract from individual choices (Brant, 1990).

Indigenous Professional Training Opportunities

Cultural safety skills will help nursing leadership focus on how care delivery impacts the social inequality inherent patient in interactions (Browne et al., 2005; CASN, 2013). Cultural safety training incorporated in college and university science programs showed how curriculum improved student behaviors and attitudes when working with Indigenous patients (Kurtz et al., 2018). Researchers advocate for curriculum in health science program to focus more on understanding relationships between oppression and low Indigenous health attainment (Yeung et al., 2018). Scholars stress how students should know the history of colonial oppression perpetrated on Indigenous Peoples and recommend accomplishing this by working experientially with Indigenous community members (Yeung et al., 2018). The TRC (2015) 24th Call to Action recommends healthcare educational institutions expose healthcare workers to Indigenous histories including racism and oppression which would create more meaningful Indigenous educational training.

Without this focus institutions are likely to maintain practices that create inequities and degrade the ability of professionals to provide services in a way that supports cultural safety (Browne et al., 2005; CASN, 2013). This intersects in a profound way with the promotion of anti-racism practices (Browne et al., 2009; CASN, 2013).

Summary

It must be noted that the literature assembled above is very generalized and broad. Similarly, one might also see how the work environment described in the results chapter four is difficult to encapsulate in a unified and cohesive description. Literature reviews provide an essential descriptive background emphasizing the complexity of this study. Though it may do little to explain many operational issues confronting Indigenous healthcare providers in the field in detail.

Each component offers different findings and describes vast operational environments that illustrate an overwhelming professional reality. Several of these descriptions are also provided by Indigenous healthcare professionals in different locations and during different points in their careers collectively.

Component One provides an overview of service coordination and highlights an environment governed by many unconnected funders who are profoundly disconnected from Indigenous communities. Literature describing low Indigenous community health status and SDOH follow. Lastly, a review of service delivery issues is provided.

Component Two is aligned with Discrete Areas in chapter four and provides a review of literature related to responded data and study analysis. Discrete Area One details literature about Indigenous nurse and doctor education and training programs. Discrete Area Two provides an overview of literature that describes the work environment experienced by Indigenous nurses and doctors. Discrete Area Three focuses on how challenges faced by Indigenous nurses and doctors is represented in the literature. Finally, Discrete Area Four provides a short overview of recommendations for the field as it pertains to literature describing nurses and doctors

The next chapter provides an overview of the methodology used to garner and analyze information provided by Indigenous healthcare professionals about this field. Respondents represent dissimilar Indigenous community affiliations and work histories. However, they are united by Individual Indigenous identity and complicated work environments. The next chapter describes how these voices were garnered and analyzed collectively.

Chapter Four Results

Healthcare Provider Roles Examined by Indigenous Healthcare Workers

Descriptive interviews provided by Indigenous healthcare professionals offer an insightful introduction to their domains in schools, at clinics and hospitals. The descriptive table below provides and introduction to the respondents, and a few details about their backgrounds. However, great care was taken to protect identifying information and so Indigenous affiliation, geographic location as well as workplaces are described in a general. The table 4 below describes Indigenous respondents and provides a summary background and pseudonym.

Table 4: Respondent Name and Background.

Respondent Name	Background (All Indigenous Respondents)
Joan	Involved for many years in direct care and has experience auditing First Nation programs, provided many sage insights about care systems and the importance of culture.
Rhonda	Works in community health center serving different First Nation patients, has experience in community research.
Pat	Provides care to First Nations elders, returned home to work in community.
Maureen	Works inpatient setting in urban hospital, also worked on First Nation reserves.
Twila	Works in a rural nonprofit focusing on education and advocacy in an Indigenous rural area, has interest in First Nation policy and rural health management.
Merna	Helps Indigenous patients with substance use issues and in early recovery in a First Nation, works with local community members and affiliated institutions.
Geri	Provides inpatient medical care, returned to Indigenous home area to get experience during training.
Pamela	Worked for a short time in inpatient pediatrics serving mostly Indigenous children from the North, now in school, worked in urban and rural settings.
Eloise	Involved in First Nation policy and community liaison, strong advocate for increasing Indigenous curriculum and training.
Mary	Involved in administration and has many years of experience in community care, natural leadership skills and advocates for community-based education programs.

This chapter shares their views on key healthcare areas and is divided into two main sections. Stories garnered from their personal and professional lives provided an opportunity to create two operational frameworks. The first operational framework is entitled Vision Quest (discussed below in Figure 5), which serves as both an analytic tool that organizes information and as a roadmap for readers. A second operational framework entitled Naming Ceremony (discussed at the end of the Chapter, see Figure 6) provides readers with a summary of how these educational and professional experiences impact Indigenous healthcare providers.

Ceremony: A Foundation for Academic Pursuits

Vision Quest, the first operational framework (Figure 5), houses data in an Indigenous way. The Vision Quest is known in my community as a profound coming-of-age ceremony where individuals live alone in the wilderness for a number of days. Before they depart, they are instructed to find a spot where they will stay put to experience the world around them devoid of familiar places, friends and family. When they return to the community, individuals relate what they experienced to a medicine person and a name is created out of their retelling. This idea of leaving the familiar to gain experience is analogous to what Indigenous People must do to become credentialed healthcare providers. Naming Ceremony, the second framework (Figure 6), describes how Indigenous respondents were impacted by participating in the educational process and the professional work environment. Traditionally, the Naming Ceremony encapsulates experiences of discovery individuals gained during their Vision Quest ceremony. This second framework highlights what respondents identified as impacting them during their academic and professional careers. The Yankton Sioux Tribe of South Dakota, my community of origin, practices both ceremonies. Many relatives and friends talk about these two ceremonies when they explain the different kinds of traditional names in my community. Both ceremonies instruct community members to remain open to new things and to incorporate these experiences in a positive manner into their worldview. Several Indigenous and non-Indigenous scholars have highlighted the value of Indigenous researchers relating to their own Indigenous experiences and identity in research (Absolon & Willett, 2005; Martin, 2003; Nicholls, 2009; Smith, 1999; Strega & Brown, 2015; Wilson 2008). I seek to relate a similar storyline to readers as a way to encourage them to stay hopeful as they learn about the respondents' many challenges.

Introduction to the Vision Quest Framework

This chapter starts by laying out the operational description of the Vision Quest framework which was created by diagramming or modeling data to illustrate findings (Figure 5). Relationships between data were obtained by analyzing 10 respondent interviews. Interviews were rich and provided a dynamic opportunity to review Indigenous healthcare professionals' perspectives through the lens of a traditional Indigenous methodology. Overall, the Vision Quest framework represents a visual description of information that respondents shared with me I thought of how Indigenous education scholars discussed the concepts of resistance by using Indigenous storytelling as a way to validate and utilize Indigenous experiences (Cardinal, 2010). I felt this related to my own analysis of respondent data and how I saw respondent data as describing what one might have seen on a journey or in this case a Vision Quest. I reviewed vivid details in discussions with respondents which imparted distinct details about their experiences at school and work and how I incorporated this information into a remade story of an Indigenous vision quest ceremony, retold using respondent data. Graphic illustrations provide a complete diagram of data. Component parts describe the respondents' discussions during their interviews and also represent the respondents' data.

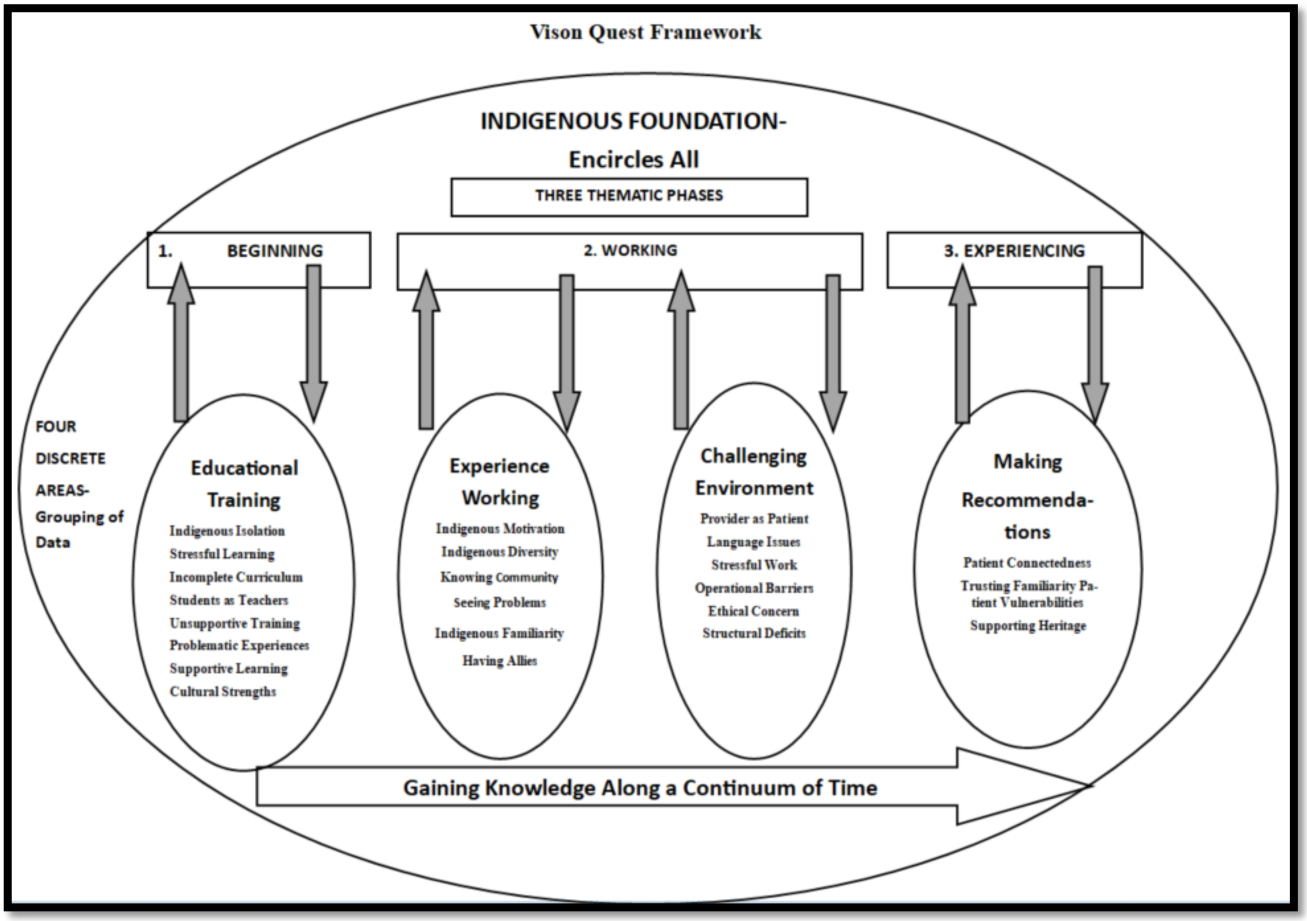


Figure 5: Vision Quest Framework Components.

Vision Quest Framework Components relate to experiences of entering and working in mainstream health professions as an Indigenous healthcare provider and are derived directly from codes, categories and analytic memos. Categories are described in the Discrete Areas. Analytic memos that arose during synthesis were integrated into the Vision Quest framework in order to create a centralized format to organize data during analysis. The Vision Quest framework began to take shape while using the concept of an Indigenous Foundation, a circle that encompasses everything. Indigenous Foundation correlates to community affiliation. It signifies the respondents' reported identification and epitomizes a symbolic context that arises when Indigenous individuals work within a non-Indigenous, or mainstream, professional environment. Next, I created Thematic Phases to show high level data reported by respondents and Discrete Areas that consisted of more detailed information taken from the respondents' interviews. Data gathered during the interview process was voluminous. The Thematic Phases and Discrete Areas make the data manageable and accessible; they also provide an organized format for presentation purposes. Multidirectional arrows show the relationship between the rectangle-shaped Thematic Phases and oval-shaped Discrete Areas. These arrows illustrate the respondents' actions and reactions during their education and employment phases.

The three Thematic Phases (Beginning, Working, Experiencing) convey a relationship between reported experiences and broad intervals during the respondents' careers. Intervals denote their experiences which occurred in different places (e.g., in classrooms and clinics) and during different periods of time (e.g., while in school or at work). These intervals and locations represent a Continuum of Time where respondents gain knowledge about the field and how this relates to their own Indigenous identity. Some respondents worked for many years while others were starting their careers. The respondents' choice to participate in this study show their commitment to the field and their calling to help their own Indigenous communities.

Inclusion of Respondent Data

In the next section, I explain in more depth how the Vision Quest framework consists of Thematic Phases and Discrete Areas (Figure 5). Next, I include respondents' data as quotes for two reasons. First, the selected quotes illustrate individual voices as well as professional learning. Respondents provided intimate descriptions of working environments dominated by the experience of working between mainstream and Indigenous cultures. The additional analytic diagram entitled Naming Ceremony which is located at the end of this chapter shows how non-Indigenous environments impact respondents' Indigenous experiences (Figure 6). Second, respondents' quotes demonstrate some of the convergence and crossover that can be overlooked when organizing data into categories with seemingly rigid boundaries. I believe that bringing attention to blurred boundaries reminds us of the human experience respondents described in their interviews. I created pseudonyms to share respondent data in a relatable manner. These careful descriptions devoid of identifying information help protect respondents' identity and the Indigenous communities they serve.

Vision Quest Framework Components

In this section, first I quickly define the three Thematic Phases (Beginning, Working and Experiencing) and four Discrete Areas (Educational Training, Experience Working, Challenging Environment and Making Recommendations). Illustrations of the Vision Quest Framework (Figure 5) are used for reference when describing the component parts.

Three Thematic Phases: Beginning, Working, Experiencing

These three Thematic Phases are labeled as 1) Beginning; 2) Working; and 3) Experiencing. These Thematic Phases illustrate respondents' high-level experiences over time in different settings.

Reported experiences occurred in separate Indigenous communities across Canada. School and work settings were also very different. Furthermore, these experiences occurred over a continuum of time which differed for each respondent. Nevertheless, all respondents followed a broad common pathway by going to school and working as an Indigenous healthcare provider. Beginning, the first Thematic Phase, encompasses the time a person entered the field as an individual with an Indigenous background enrolled in a healthcare education or training program. The second Thematic Phase titled Working includes experiences acquired as a healthcare provider in the field. Experiencing, the third phase, lists respondent insights and wisdom which stem from experiences gained in the Beginning and Working phases. These three Thematic Phases arose from four Discrete Areas described below. The phases were created by coding and categorizing respondent interviews and analytic memos. Now that the framework model's basic building blocks have been described to show how the research data were organized into broad categories, the section below examines the data more closely.

Throughout this section, first I briefly introduce the Thematic Phases in the same order they were discussed above (Beginning, Working, Experiencing). Thematic Phases are followed by any of the four relevant Discrete Areas. Put differently, a Thematic Phase can have two or more Discrete Areas with several areas appearing more than once in each phase. Although each phase contains a brief description, much of the material comes from respondents' comments. This content allows their voices to appear as naturally as possible and it makes more visible the process that lead to filtering data into various aspects of the framework model.

Four Discrete Areas: Educational Training, Experience Working, Challenging Environment and Making Recommendations

These Discrete Areas shown in Figure 5 form a key method for organizing data during the interpretation process. The four Discrete Areas, Educational Training, Experience Working, Challenging Environment and Making Recommendations, rose up from respondent contributions. Please note how Experience Working and Third Thematic Phase titled Experiencing are related, but the Third Thematic Phase represents experiences gained over careers of both school and work. Graphic representation of reviewed and decontextualized respondent interviews provides a place for the researcher to gather codes and include them in matching Discrete Areas. Process Analysis enabled coded data to undergo an interpretive process consisting of sorting, coupling and associating content into segments which were then separated into one of four Discrete Areas. These four areas along with the three thematic phases represent analyzed data in the larger Vision Quest Framework (Figure 5).

The first Discrete Area comprised of Educational Training constitutes the Beginning Thematic Phase (Figure 5 above). The next two Discrete Areas, Experience Working and Challenging Environment comprise the second Thematic Phase titled Working. The final Discrete Area Making Recommendations comprises data located in the third Experiencing Thematic Area. Collectively this last Discrete Area entitled Making Recommendations represents information gained from respondents from all phases but are integrated at the end in order to represent experiences gained collectively.

Indigenous Identity, as noted previously, is included as an 'Indigenous Foundation' component (recall the Indigenous Foundation encircles all of the Discrete Areas and Thematic Phases). Indigenous Identity forms an essential part of each Framework component because respondents reported it being thematically prevalent. Additionally, respondents uniformly identify as Indigenous community members affiliated with either a First Nation, Métis or Inuit community. Lastly, Indigenous Identity was central to the overall theme of the study.

Thematic Phase One: Beginning

Data related to the Beginning Thematic Phase appeared consistently in every interview, sometimes non-sequentially. Although Indigenous experiences during healthcare educational training were excluded from the initial study questions, respondents themselves referred to these experiences during their interviews. Consequently, during analysis, these contributions were prioritized because Constructivist Grounded Theory directs researchers to prioritize respondent data for a more comprehensive inquiry (Charmaz, 2014). Indigenous researchers such as Smith (2012) and Wilson (2008) call for recognizing Indigenous experiences and I upheld respondent discussions as both a valid and an important resource. Readers will note how Indigenous respondents validate their own identities consistently as a thematically defining aspect of their reported experiences.

Discrete Area One: Educational Training

Medical professionals require specific educational attainment in order to enter and work in healthcare. Educational Training as a Discrete Area is included in the Beginning Thematic Phase even though the process of becoming educated as a healthcare professional was described by respondents differently. For example, some respondents worked many years before earning a degree, while others entered healthcare education programs directly after high school. All respondents described educational and training experiences as a mandatory requirement to work with their own community on reserves or in urban settings.

As noted above, I used pseudonyms to refer to respondent contributions and to link them to the unfolding storyline which consists of multiple participants. When Joan, Pat and Eloise and the other respondents introduced below share about specific things they experience, their quotes illustrate and emphasize commonalities among the respondents. Overall, these examples represent what I term a penury of Indigenous identity in the educational training and certification process. Moreover, the examples provide readers with accurate Indigenous voices and offer them a glimpse into an Indigenous identity upheld by lone Indigenous participants working in healthcare delivery schemes. These individual examples highlight the challenges that Indigenous students and professionals face on a daily basis. Though there are solutions readers might envision for each of their specific examples, I hope to illustrate the wide gap, both felt and reported on individual and systematic levels, between Indigenous communities and mainstream institutions.

Indigenous Isolation

Data extrapolated from individual experiences describe what one might expect in a conventional education and training program. However, for Indigenous students there is a marked difference which must be noted. In the Educational Training Discrete Area, all Indigenous health professionals involved in this doctoral study experienced isolation during one or all of their post-secondary educational components. Pamela shared “I have had tokenizing experiences all the time because at [the university] there are not very many Indigenous students, so it's often just me.” After working in the Canadian prairies, Pamela was in the process of starting her academic career as an Indigenous registered nurse. Eloise, an Indigenous respondent from the Maritimes, identified being the only Indigenous student during her entire educational program: “I was the only Indigenous person, …I was in the final stages of my program.”

Stressful Learning

Isolation at school was not the only challenge facing respondents. Joan, an Indigenous nurse with many years of clinical and administrative experience, relayed troubling issues she encountered during a continuing educational training held online and via video conferencing.

> I remember also, during one learning webinar, and it was specific to Residential School survivors, I am assuming that [another person taking the training] was not First Nations and he said “You know, every time I work with First Nations, they act like they are owed something…we did something wrong and we owe them something. Why don't we just get over it…why don't they just get over it? The Jews did.” And something in me…a switch went off and I was very angry.

Joan works in a First Nation health centre school program. She shared this example to show how a non-Indigenous professional’s negative attitudes encountered in a continuing education training had angered her. Ironically, the training was about increasing knowledge and sensitivity when working with Indigenous community members.

Geri, an Indigenous medical student also encountered negative stereotypes as an Indigenous student and shared:

> Like in medical school I definitely think that a little bit of, I would say criticism of racism, might be that they say "oh, I really don't deserve to be there because I am Native, and [I'm only there because] there is a reserved seat for Native applicants".

Incomplete Curriculum

Eloise shared about her awareness of the conspicuous lack of Indigenous content in her educational program and her disappointment about the response to her advocacy to have Indigenous community training opportunities. Eloise wanted both Indigenous training in school and the ability to have a practicum in her own community and relayed:

> So it was kind of frustrating for me, knowing that I was in a, in a very discriminatory educational system, in a discriminatory curriculum. And, um, I even asked my professor "How come we don't have any practicums? Or any experiences with our so-called community?" And they were like "Well, it's difficult to do, we tried, but it always flopped." And it was my home community and I know these people. I know the nurses and without the cultural training I can't even help my own people.

This concern about the lack of cultural training was echoed by Pat, another Indigenous nurse who presented about Residential schools to students in her program with little or no knowledge of Indigenous history or oppression. Pat works in a First Nation health centre providing services to Indigenous elders. She shared her experience providing Indigenous content in class.

> And, uh one of the girls, I felt bad because it wasn't that I was trying to give a guilt trip to

> anybody, but just more as an education session [university class session about residential schools] and she said, “I am so sorry that, like, my People did this to you.” And she cried also. I said it was like at least if we made the difference in one particular person’s way of thinking.

Pat’s example shows us how deeply impacted her classmate was when learning about the State’s abuse of Indigenous Peoples. Pat’s insight about affecting one classmate’s thinking illustrates the fact that, in this case, exposure to Indigenous content was provided almost by happenstance. In other words, a student’s presentation delivered vital information absent from the standardized curriculum.

Other respondents described how Indigenous content was unavailable and not incorporated into the educational process. Eloise noted, “So, all of my clinical experience was in my undergrad because it’s so, I am sorry if I can’t pronounce it right, it was so ‘hospital centric’.” Eloise shared how this prompted her to changed academic program in response to curriculum lacking Indigenous content.

> So, I decided to join an [advanced] program and I had made the tough decision to let go of [a specific program] and go into my [current program] because I realized I had this big gap in knowledge, about Indigenous People, that I didn't understand why we had all of those health disparities. Like I realized colonialism is still happening.

Rhonda, a First Nation nurse working on her reserve with many Indigenous community members from different Nations residing in the same First Nation community, speculated that education programs and funding agencies “…are not addressing the, you know, wholistic approach and understanding that this individual is connected to a family, which is connected to a community.” Rhonda described her own community as having a very specific context because there were different First Nations with distinct traditions and languages using the same service centre. Eloise went on to discuss how her school offered Indigenous content but missed an opportunity to engage a local Indigenous community right next door to the school.

> Hahah yeah, well I can say that through my nursing degree, we were reviewing Indigenous content, Indigenous health, and even though we had a community two minutes away from our University, there was no linkages, no relationship established within the School of Nursing, and the health director or the community health nurse.

Eloise advocated for educational exposure to different Indigenous communities in order to make her educational experience more complete. She shared that she “got my final practicum [after advocating specifically for an Indigenous placement] in an [Indigenous] community outside of my province, a different setting, because I really wanted to see, to see the reality in Canada”.

Students as Teachers

Respondents also talked about being expected to serve as a resource about the global Indigenous experience for the educational institution, staff and other students. Pat, who talked earlier about another student’s reaction to Indigenous content described how her presentation came about in the first place.

> And umm, going back to nursing school too, we had to do a presentation, me and a group of Indigenous nurses and they [students] had no idea about residential schooling. Or anything about cultural genocide, or things like that so it was a very difficult presentation to give.

Pat identified a serious issue where Indigenous Peoples are expected to know about and explain long histories of oppression, though they themselves may have not been taught these topics in school. Geri, an Indigenous physician, shared a similar concern regarding the lack of Indigenous history in educational curricula: "…it's surprising how little you do learn in elementary programs and high school in this country." Eloise also relayed her experience being sought out as a resource about Indigenous identity for the educational institution, staff and other students, as described in the following quote:

> And for me, being the only Indigenous nursing student, it was a challenge for me because every time we would talk about Indigenous health or Indigenous issues, the class would look at me, and, and it was like they would rely on me to give this picture about their barriers. The way that they were teaching the content, they really didn't have a full understanding about the complexity of the issues.

Both Pat and Eloise identified how during their university programs they served as unofficial experts on Indigenous community subject matter, even if they did not feel qualified. Pamela, who shared about going back to school earlier, also helped the Nursing department provide Indigenous content even after she completed the program: "In Nursing school, I had already done workshops with my fellow students and once I graduated I was a guest lecturer [for] transcultural safety cases, things like that."

Unsupportive Training

Pat described difficulties she had during internship training at a mainstream hospital outside her community. Pat shared how "…unfortunately [I] had to go do some stages [internships in] French, so um, having to work with Francophone nurses and me being an Anglophone for one, and me being a Native person, um, I experienced a lot of racism."

The stage or internship phase of medical education is an important opportunity for students to gain valuable clinical skills. Pat's discussion about language barriers and negative attitudes toward people who do not speak French and Indigenous Peoples illustrates a stark reality about her experience as an English-speaking Indigenous student. Later in the chapter, the ways in which the provincial language requirements affected her ability to work professionally will be presented.

Another example of lacking support was described by Eloise and Geri who intentionally advocated for training in Indigenous communities. In fact, they went to great lengths to secure internships and receive the support they needed. Eloise secured a practicum in an Indigenous community in a different province, while Geri arranged a placement with an Indigenous community in the North. However, she felt the experience was incomplete:

> Umm, I had, in medical school, I went up to [Indigenous communities] and I worked in a couple of health centres and home communities. But, again, as a med student it was such limited care that I was providing because I was a medical student, ha ha…I didn't really have any medical office or anything so it’s hard to speak to that and it’s so hard to remember now. Umm, so I think it is fairly limited, really.

Problematic Experiences

Respondents also relayed problematic interactions during the educational process with patients. Pat spoke about a difficult encounter in her stage with a non-Indigenous patient who related to her Indigenous identity using negative stereotypical references:

> I’ll never forget this old man. I had to give him an injection, so he said, “You must have a very good aim because you shoot bows and arrows,” so ha ha, so I said, “Yes, yes sir that’s correct.” And it was like oh my God, it was just like a, like an outrageous experience for me so I got to see both aspects where there are People that are very receptive to your culture, and may already know about your culture and they have that cultural sensitivity and you know. And then you see the opposite, you see the People that

> just are ignorant and too the type of People that live in [the city], hmm so working at the hospital too, I had quite the pleasure of working with quite a few students who have followed me.

Pat also described her positive experience supervising non-Indigenous students. This example shared by Pat shows the dichotomy of negative and positive experiences which she encountered as an Indigenous healthcare student.

Supportive Learning

Respondents discussed experiencing a positive impact made by supportive Indigenous staff and Indigenous programs and student services at their respective universities. Geri explained, "In terms of what you get, teachings, about Indigenous populations in health and medical school. I mean where I went to school we were very fortunate, we had [an Indigenous doctor], who was the director of the Indigenous health program." Another respondent highlighted that recruitment and retention services were helpful. Twila, an Indigenous nurse who currently serves as an executive in an Indigenous health consortium, talked about the importance of student-support services. Twila related how an offer to keep her current job factored into her decision-making process when the university assured her job was secure: "You won't have to resign your job you can just take leave. And we will provide support for you to go to your program." Twila also emphasized the importance of intentional recruitment strategies that focused on attracting Indigenous People in her area: "And in the early 90s, the college here came out ...the Nursing program…really trying to attract…Indigenous students." Mary, another respondent who also serves as an Indigenous healthcare executive, described how she and others went further than relying on recruitment strategies to attract Indigenous applicants to university health programs. Mary worked with Indigenous community institutions and community members to support creating local community-based nursing education.

> …then a few of us nurses in the community wanted to get our education and get a bachelor's degree in nursing. So we rallied together because we knew that a [university] was doing satellite programs, so you didn't have to go to off reserve. They would bring classes to you by internet.

Mary emphasized that this locally provided program and educational training helped her and others prepare to practice in the field: "You know we outreached and we have gotten what we have asked for like the [nursing] program. But unfortunately, it does not exist anymore through [the university] at all." Although the program was discontinued, Mary shared the positive impact made as most of the nurses who participated were still working in the community many years later. Joan, who described above encountering racism during online training, highlighted the lack of Indigenous community resources, noting the need for "more, empowerment, more pushing of First Nation students…communities would do a lot of better." Maureen, an Indigenous nurse working on a surgical ward of a city hospital talked about how she continued to promote Indigenous enrollment after graduation, noting: "…I have been trying to more active in [Indigenous recruitment programs] in [university]".

Joan highlighted a need to go beyond recruiting Indigenous community members into health education. She expressed the importance of Indigenous identity in clinical care and how Indigenous Peoples are bringing their cultures with them to the field, sharing that "a lot of Aboriginal First Nations staff...do...traditional teaching…I find that there is a movement...to follow more of our old teaching." Joan went on to describe other kinds of educational experiences, beyond healthcare and post-secondary training, that are important culturally as well. She shared about an example of engaging youth in cultural training while in high school on a

First Nation Reserve:

> I know they started the rites of passage and the traditional teaching and when they first started 5-6 years ago and they got 5 kids to do it, and these 5 kids they found it so good they told their friends and then then doubled, and then it doubled again and they are to a point that they have a waiting list.

Cultural Strengths

Indigenous cultural connections were different for each respondent. Some respondents related to rich descriptions of how they connected to their Indigenous identity. Twila talked about her Indigenous background being a prominent part of her identity:

> And you know I identify as an Indigenous woman and this is a strong part of my identity. So, yeah, it was really a missing piece right. So, when I finished high school I went home to my mom's home community and I worked there for several years with her family. And, I also married from there, a man, and we lived really traditionally for a long period and had children together.

Pat, who gave the training about Residential Schools to her class, related how she was in the process of connecting to both her Indigenous identity and the larger history of repression of Indigenous Peoples at the start of her educational career. Pat related, "I was just digging more deeply into that [historical persecution of Indigenous Peoples] myself." Yet, in spite of this, she was asked to provide a class training on residential schools and cultural genocide for other students. Pat also shared how she recognized the restorative nature of educational programs like Indigenous language immersion schools. She talked about how these community-based programs were creating stronger cultural foundations for her children.

Professional education pathways in healthcare generally resonate with the ‘Beginning’ Thematic Phase and naturally provide a mode for grouping data along a similar timeline. The respondents completed the same formal training required to earn educational certification and licensing and to be recognized as a healthcare professional in mainstream settings. Learning about these experiences through individual report and collective analysis provided insightful information about barriers Indigenous students face.

Overview

In summary, Educational Training was uniformly experienced by all respondents regardless of community of origin or geographic location. Participants reported starting their educational and professional careers by applying to and attending non-Indigenous institutions. One respondent participated in an Indigenous program that was a part of a larger university program. Discourse about medical internships provided additional information related to respondent experiences with education and training for professionals. In particular, respondents put emphasis on the Discrete Area of Educational Training. This section’s title seeks to describe the uniform nature of medical training, which respondents revealled as oppressive through problematic scenarios during interviews. Some themes were more prominent in some categories. Social isolation developed particularly as a key theme, which resonates with Indigenous students in general regardless of academic program affiliation. Respondents shared interrelated themes of being the only Indigenous person in a non-Indigenous setting or field placement for most of their time in school. Aside from the one respondent who received training in her own community, which was organized by students and paid for by local organizations, respondent experience is based on mainstream environments disconnected from Indigenous social practices or community affiliation.

Thematic Phase Two: Working

Respondent data in the Working Thematic Phase represents diverse experiences accumulated in community clinics, hospitals and mental health and substance use treatment institutions. I feel this component upholds what Wilson describes as the need for "relationally accountable" (p.3) approaches with Indigenous Peoples to uphold equitable engagements (2008). I sought to do this by prioritizing Indigenous respondent experiences which emerged throughout discussions and analysis as paramount and used their reported experiences to drive analysis and synthesis. Respondent priorities were incorporated to support Indigenous engagement and uphold their reported experiences, which is also in alignment with constructivist grounded theory prioritizing respondent knowledge and experience (Charmaz, 2014). Half of the respondents worked on reserve and the other half in regional or urban centres. Most respondents worked providing direct clinical services and health education. Three respondents served as executives fulfilling supervisory or leadership roles and one respondent specialized as an Indigenous health policy advocate. Respondents had differing amounts of work experience. Some respondents recently graduated while others had been working for more than 30 years professionally. Information relating to this Thematic Phase comprises relevant and important respondent contributions, which squarely relate to professional experiences in the field. Data in the Working Thematic Phase includes Discrete Areas of Experience Working and Challenging Environments.

Discrete Area: Experience Working

Indigenous respondents related to the healthcare field as an established mainstream process to help them achieve their goals of working with other Indigenous community members.

Indigenous Motivation

Twila, who shared earlier about the importance of her Indigenous identity, described this connection by sharing “So I wanted to be able to be one of the first Indigenous persons working, and I thought ‘you know we can really make this thing better, the experience of being in a hospital better, for Indigenous People.’” Mainstream healthcare services, however, are not specifically organized to match Indigenous patients with an Indigenous provider. Some providers like Geri and Maureen did not even know if they were treating Indigenous patients, or if they would ever be able to specifically, knowingly be able to help Indigenous patients in urban settings.

Respondents revealed specific issues they encountered working with Indigenous community members on reserve and in urban or metropolitan settings. Some examples provided below speak to how respondents were able to discern issues about systematic healthcare delivery schemes, which might not be seen or highlighted in the same way by other non-Indigenous health professionals. These examples may not occur in a linear fashion, but because Indigenous healthcare professionals have identified them, they are connected, and they are relevant.

Indigenous Diversity

Respondents discussed working with Indigenous People from very different communities, with individuals coming from various remote areas. Indigenous diversity and differences between Indigenous communities arose as an important insight for Indigenous providers themselves. Maureen shared that working with different Indigenous Peoples also presented challenges.

> And the cultural differences can be a bit challenging for me because though I've tried to get to know more of the local communities and immerse myself a bit here [specific Indigenous community], I find that sometimes I am a bit insecure about that, in the sense that I don't know as much as I would like about many of the people that are coming in

> and their cultural background and what their lifestyle is like. And I can't relate to them if they are from a northern community necessarily because I grew up in a small farming community.

Maureen went further in her discussion about Indigenous Peoples belonging to different groups and coming from very different geographic settings. Her insight and experience revealed this aspect of care that might only be known by Indigenous Peoples.

> …I find being in an acute care centre, where you are providing care for People from communities, that are not, you know, that are coming from quite far away. And, umm, trying to integrate People from these different communities that are quite far from each other and it's not like we are always getting People from the same place necessarily as well. So, I think that can provide challenges even if you are trying to be more specific and trying to help somebody or be more aware. I mean we serve so many different smaller communities that it is hard to get to know any one population.

Pamela, who also worked in an urban medical setting also identified how she would try to bridge ethnic differences between Indigenous patients and Indigenous staff by using Indigenous words from the patients' communities of origin. She described patients lightening up when they heard a specific word or term in their language and how this helped her feel more connected to the patients under her care.

Other respondents remarked on the inability of healthcare organizations to fully engage diverse Indigenous cultural and ethnic groups. Rhonda noticed a government office's inability to recognize diversity between Indigenous groups. Based on her experience working with many different First Nation communities situated in the same reserve, she asserted that "neighboring cities or public health units they think of us all the same ... we're so diverse." Rhonda spoke at length about the implications stemming from governments' and institutions' inability to discern different Indigenous groups and communities. She explained that many Indigenous communities might have difficulties relating to each other. She provided an example that health services offered using an Indigenous word from one group might exclude Indigenous Peoples who use a different language.

Knowing Community

Indigenous staff, and students, also reported having difficulty because of confidentiality challenges unique to small Indigenous communities where People are related or socially connected to entire communities. Twila shared a compelling example about her experience as a new nurse working in a small interrelated Indigenous community.

> Like the patient said something like, to the other nurse, "Oh yeah, she is my cousin." You know and I probably was, you know it was like a little town of 600 people. And sure that was that familial connection by marriage or by whatever. But, that doesn't, well, you know the thing that happened was I got reprimanded because I should have disclosed the fact that we probably were related. There was no understanding, even when I tried to explain like, "Maybe he is a cousin, but this is not how I would define the relationship, and the fact that I have never met him before." There was no understanding of how that works in a small community, or when you know them. I guess they just wanted to make a point.

Scenarios like this shared by Twila illustrate a reality known by many Indigenous community members coming from small communities. Twila also highlights the impact and liability of confidentiality policies that do not account for her situation. Eloise, who made many insightful contributions about her experiences in the educational process, also referred to the confidentiality issue raised by Twila. Eloise shared an example that occurred during the end of her educational program but was included in the Experience Working discrete area because it relates to confidentiality challenges in the workplace. She shared:

> Umm so I didn't have a chance to serve my People [during her internship]. So on the last day they had someone coming from my reserve to my hospital. But then when that happened I was related to them, so I was not allowed to have them as a patient.

Analytic memos taken during respondent interviews included concerns from Indigenous healthcare professionals about how confidentiality standards in many Indigenous communities are very difficult to maintain. Merna, who works as an Indigenous nurse in a First Nation mental health and addiction treatment facility, noted that community members routinely sought clinical advice about medical issues by posting pictures of a cut or bruise to her Facebook profile. Requests came from many quarters because everyone in the community knew she was clinically trained as a nurse. She redirected people to the local clinic but had to be very careful in doing so. Merna was concerned how failing to respond in a timely manner might hurt her reputation as a provider. There is an interesting contrast between the contexts of Maureen and Geri, who discussed how they might not even be aware of treating an Indigenous patient because of the acute care setting and also being in an urban or metropolitan environment, to the context that Merna shared, about how she might be treating people who were related to people she went to high school with or she knew about through extended family.

Seeing Problems

Indigenous providers also were aware of other kinds of challenges facing Indigenous communities. Joan discussed an example of how she saw how different Indigenous community contexts were revealed through inconsistent healthcare delivery environments.

> However, ummm, the remote communities. They have 600 people, 1,200 people, so they weren't getting quite of big chunk of funding. And, umm, because they're so remote they have one person, who has like, let's say a diabetic ulcer who needs a leg amputated, or one motor vehicle accident with Traumatic Brain Injury and they can't provide services in the community. So, they are sending them to [the city], and that, that transportation cost comes from their budget. So they are eating up a lot of their budget…Now look at the location of the reserve, and that they do …I am hoping that they do, make allowances that they're given more funding for being in a remote community.

Joan's discussion about the impact of medical transportation costs on remote Indigenous communities shows how barriers to effective care might arise from different funding or structural service delivery gaps that are not controlled by the community. Twila echoed similar insights and described how she realized community services were not structured to meet complex cases or community needs.

> And there were a lot of patients who were Indigenous. And mostly the types of things that I was doing in medicine would have been alcohol related. So, we don't have a detox centre here so people are in need of it. Let's say they had an injury but related to alcohol but they will most likely end up on the medicine ward, and diabetics who were having trouble managing themselves, COPD, and um…That's when I experienced things, you know like I had high hopes.

Another issue Joan raised related to how capabilities of local Indigenous communities impacted abilities to get funding. Joan discussed how this might provide a unique perspective on why some Indigenous communities have more health services than others. Joan said:

> I know also that, ummm, you know a lot of the things and the services they have in our

> community is based on writing proposals. And I know that we have excellent people who are excellent at writing proposals. And that's not true for every community. You know that there is a lot of difference.

Describing how community resources can be highly dependent on the capabilities of community members might also illustrate the powerful insights gained by an Indigenous person working many years in the field. Joan had many years in the field and her contributions during the interview highlighted her understanding of administration issues faced by Indigenous professionals. She spoke in depth about larger operational environments, and, in this way, was similar to the other executives Mary and Twila who related to larger healthcare system issues.

Indigenous Familiarity

Respondents highlighted concerns about non-Indigenous providers caring for Indigenous patients who might not provide in-depth assessments. Rhonda shared, "Because, so often I find, perhaps if they are seeing individuals who are not First Nations or don't have that Indigenous background, they are just very 'treat, treat, treat'." Rhonda described how working on Reserve as an Indigenous provider might create quality healthcare delivery by ensuring services are appropriate because of the providers' own Indigenous affiliation. She stated "[Indigenous providers place a] priority on the community and individuals that live within that community. How? Indigenous providers themselves ensure that."

Having Allies

Respondents also remarked on positive contributions of non-Indigenous professionals. The reality of a small Indigenous workforce requires First Nations to enlist many non-Indigenous professionals in order to provide care. Merna shared "… there are a lot of great nurses, who are not Native, who provide amazing care. Like the community of nurses in [Native community], a lot of them aren't Native and they provide amazing care." Merna also shared how being an Indigenous health are professional did not mean one was better than a non-Indigenous professional. Pat talked about how she came across non-Indigenous healthcare providers who were both open and receptive to Indigenous cultures. She shared:

> Umm, but know I can't put a label on people. There is…a lot of healthcare professionals that I have worked with, that I have come across that are very open and they want to learn both, the culture and the cultural ways.

Joan also noted how non-Indigenous nurses provided quality care and were open to cultural practices saying:

> And umm, in my community we do have Native and non-Native nurses and umm, I can't speak badly about the non-Native nurses we have here. Because they are in the community and they are culturally aware of the beliefs of the People, the ways of the People and they do have good rapport with them.

However, Joan also talked about how community members would sometimes also want to receive care from another Indigenous person.

> But I do know that some of my co-workers have had the patients say, "Oh you know that White girl." And I say, "Well she is a good nurse," but you know I think that people want to be served by their own community.

Overview

In conclusion, the data revealed how information from respondents in this Discrete Area provided succinct information about challenges when facing diversity within Indigenous communities at work. Respondents also reviewed concerns about the reality of upholding narrow definitions of confidentiality more synonymous with anonymity. Professionals working in urban settings may not come across patients again outside of health facility setting. Challenges while working in small, interrelated communities include knowing many People that present for services. Respondents also had unique perspectives about how services are operationally affected by geographic location, funding, community size, service limitations and local ability to write grants. One respondent elaborated how being in smaller community settings allowed for more prescriptive treatment opportunities as opposed to large systems focused on processing treatments en masse. Another point arose about how Indigenous community affiliation might motivate Indigenous workers to be more accountable and provide a higher level of care. Lastly, positive contributions of non-Indigenous coworkers were recognized, however one respondent discussed Indigenous community preferences for working with Indigenous healthcare providers. This data does not provide a uniform picture of Indigenous community experience but highlights how Indigenous professionals also grapple with different Indigenous cultures and contexts. The next Discrete Area, Challenging Environment is also included in the Working Thematic Phase and provides stark examples of respondent experiences experiencing and witnessing discriminatory care.

Discrete Area: Challenging Environment

Respondents recalled polarizing negative work experiences. Interviews seemed to provide a needed platform for respondents to be afforded an opportunity to disclose specific details about racial oppression.

Provider as Patient

Rhonda recalled how she was treated as an Indigenous patient seeking care.

> And, umm, you know I can share with you even a personal comment when I went to the hospital, staff they asked me if I was diabetic. And I said no, and they said, “Well, you

> will be." And I took that definitely as an interpretation based on my race and umm, you know kind of of what the expectation is, as that all First Nation individuals are going to have diabetes.

Joan reviewed similar concerns about racism while seeking medical care as a patient. She noted, "I mean I too can speak to that in terms of my own health and being a patient, say I have gone to emergency treatment or something and experiencing a lot of what I notice here as racism."

Language Issues

Oppression was also referenced in dealings with provincial government laws. Mary, who brought an online nursing program to her community talked about language barriers in her role as a healthcare executive. She remarked how official policies and laws about language represented a major obstacle for her community.

> Well, I can tell you one big barrier for our community is the French language. Everything is in French and none of us are fluent to use French so we are always having to translate documents. We are always having to scramble to see, oh there is a law being put into place, so we have to scramble to make sure we have it translated and also comply.

Mary continued to share about difficulties hiring Indigenous professionals because of language barriers and licensing restrictions.

> So, if you want to hire an Indigenous professional it can be very limiting because most Indigenous communities speak English. So, for nursing licensing you can get one if you are Indigenous and speak English you can get licensed to work in the community only.

She discussed one instance where an appropriate Indigenous candidate was identified for a long vacant social work position, but funding agencies would not approve the hire due to lack of proficiency in French, even though the community was English-speaking. Pat, who described her own challenges facing racism and discrimination as an Indigenous English-speaking student in a stage placement earlier also discussed language restrictions limiting work. She went on to describe how she was only able to find work after graduation in her own First Nation community due to the barriers of restrictive language licensing regulations.

Stressful Work

Merna described a caustic work situation that blindsided her as a new professional. She related to this particular incident as one of her reasons to work primarily in First Nation organizations.

> OK I'm not sure if I have an experience, like with a patient, but I had an experience as a brand-new nurse. Ahh, umm, I was opening, you know when you do wound care? It has to be completely 100% sterile? So, I was opening it, and I had a, like a, what do they call it, like a senior nurse with me. And she yelled at me, like, "What are you doing with the tweezer?" … like, "It's not sterile now!" So I had to open another one. And I was doing my wound care and she called me a waste of tax dollars.

Merna was very animated when relating this incident and repeated it loudly during the interview process saying, "a waste of tax dollars!" Merna talked about how difficult working in mainstream setting with non-Indigenous staff was. She described how she felt very visible in mainstream settings, while conversely working in a primarily Indigenous setting with other Indigenous community members has been very rewarding and positive.

> Well, yeah, not only that but say [when] I am working in a non Native setting then, though like you said I am representing all Natives, I feel like I am being watched. Whereas here, we are all Native, our clients are all Native. I can relate to them, I just feel I can shine.

Joan discussed how she heard of negative incidents from other Indigenous professionals who often worked in the field. She stated, “I find I hear it, over and over, the white population...western mainstream...doesn’t have a good view of First Nations Peoples…[We are] considered as less than, another drunk Indian, or a dumb Indian and there are a lot of stereotypes.” Joan had many decades of experience in the field. Her ability to talk to many Indigenous professionals occurred when she was engaged as a healthcare consultant evaluating Indigenous programs, an ongoing career. This role made her a very valuable informant and her comments were revealing. She was able to discuss working both in her own First Nation as well has having interviewed and audited programs in other First Nations across Canada.

Merna related to how stigma affected how she felt in a non-Indigenous workplace. She related to instances when other Indigenous People came for care but were not clean or were living on the streets.

> The part, where you are a Native nurse with other non-Native nurses. I feel like, and someone comes in and is either dirty, homeless, they’re Native and they come with this stigma. For one second, a part of you feels ashamed of yourself.

Merna’s discussion about how being isolated in the workplace combined with her identification with other community members living in privation and substance use was revealing. Her own identity, being in the minority and feeling shame about indigent community members revealed a very stressful work experience.

Operational Barriers

Joan talked about how adverse work environments may have been created by operational problems in healthcare delivery in remote communities. Joan provides an example below of how poorly structured health delivery compensation schemes specifically impact Indigenous professionals.

> In the remote areas, they have a lot of agency nurses who are non-Native. The agency nurses get paid probably double what I do. So, they are making good money. [An Indigenous nurse described] other nurses were trying to push her out. They would be mean to her and it was kind of like she was a threat to them because she was from the community.

Competition for higher paying shifts indicate competitive work environments and examples such as these show how one Indigenous healthcare professional encountered resistance while working in her own community. This level of detail about how Indigenous professionals perceive or experience the ramifications of compensation schemes is very important to know about, especially in a field where Indigenous healthcare providers are identified as the solution for low health status found in Indigenous communities across Canada. Merna discussed how weak healthcare services was problematic on many different levels for Indigenous communities.

> Because, one of the things I notice is that a lot of my clients tell me, from all communities, tell me, that in their community they might have one clinic. And there might be one nurse there, there might be a doctor who comes and goes, and they said they're so used to getting "nobody cares about them."

Merna's description of how service scarcity in Indigenous communities creates scenarios where Indigenous People are inadequately connected to care, and perhaps, consequently, they feel their health is unimportant to health professionals working in these understaffed and underfunded centres. This issue, how Indigenous People might be unmotivated to receive care because they have only experienced a low quality of care delivery, speaks volumes about the complexity facing the field of Indigenous healthcare.

Joan provided another example describing why funding amounts might vary between Indigenous communities based on size and how community members might perceive these differences. Her discussion also included how funding discrepancies create jealousy and competition between Indigenous communities.

> There were just First Nations People and I know that People from other communities would look at us and say “Oh, you gobble up all the funding, you take everything.” But what they didn't understand was at that time, the funding was population based. So, we have a population of [many]... People, so we do get a big chunk of the funding.

Respondent comments on these scenarios highlight the need to know more about how Indigenous communities perceive funding allocation.

Ethical Concerns

Pamela provided a poignant description of her work placement and raised several ethical issues in the treatment of Indigenous children from remote areas. Pamela reported these experiences as being damaging to her own mental health status and greatly affected her professional performance.

> Some [Indigenous pediatric inpatients] would have family members that would have family members that were criminally in jail or had encountered a childhood in the system. And then they come there, and it's locked, they are locked in. So, they felt like they were in jail, that they had hadn't done any criminal act. So, they would try to figure out “Why am I in jail?” And especially for the kids that were flown in from up north I felt very … kind of bad, kind of like a moral dilemma, because a lot of the kids from “the city” would come and if they were held against their will they would get, like the legal documentation that says they are being held against their own will for their own safety.

> But, the kids from up north. It was kind of like something that nobody had ever thought of I guess. But, basically, they were being held there and it's like they were being held against their will, because they kind of were. Like another kid from "this town", they could just go out and go home. Because they lived "here". Whereas these kids, if they wanted to leave they have to go on a flight back home so, even if, I don't know, I guess it was like a moral thought experiment for me. But, I just think it's unfair because they were being held there against their will. And without the legal documentation. Just because of the fact of the matter they cannot be put into a home. And, so I just was struggling a lot with, like … every day the ethical dilemmas change, like it's so heavy.

Pamela's thick and robust description involves more than one case. She is describing how every case is affected by an oppressive treatment protocol in a locked environment. Clinical care and case dispositions managed through systematic protocols described above call into question the impact of these operations on Indigenous children, who are there to receive healing care. Her insight into how Indigenous children with previous experiences of family members incarcerated or institutionalized in preventive services is also impactful.

Pamela emphasized a contradiction of means in care delivery and illustrated how trauma can be replicated through mandated services. Pamela additionally talked about how difficult treatment delivery schemes also impacted non-Indigenous professionals.

> They [staff] would be like, "We don't know what we are going to do with these kids because they are so vulnerable and so isolated." Like, it's just hard on staff morale. I wish we had a way, I mean at one point it was like there was just all of the beds, in this one unit, they were all filled up with these "northern kids", as they called them. And everybody was saying, even one of the psychiatrists was saying, "Well, I really hate it

when there are so many northern kids, it’s really bad for staff morale,” basically. Pamela recalled painful statements staff candidly made about patient care. Her discussion seems to stand out as a call for more appropriate engagement and relief for patients. Other respondents reported facing difficult situations and attitudes at work as well. Merna voiced how professional frustrations about negative attitudes toward low functioning Indigenous patients caused her to become professionally motivated. Merna shared, “But I found that the more confident I got that the more I was able to educate other professionals. You know? Speak for the clients.” These discrete areas reviewed above are dichotomous and reflect respondent examples of injustice and negative experiences in the workplace as well as unsupportive social attitudes.

Structural Deficits

Rhonda identified the need for communities to focus on “building that capacity...capacity is really lacking...no research out there… nothing...looking for evidenced-based info...for us to fall back.” She went further to describe barriers to research across Indigenous communities, “because a lot of the damage that has been done to individuals…hesitation to share...fear that it’s going to be used against us.” Rhonda identified a lack of resources available to Indigenous communities as well as the community prohibitions created by unethical research practices experienced by community members.

Overview

This Discrete Area provided a soul-searching roster of ethical complaints about service systems and professional environments. Respondents started by reviewing negative incidents they had as Indigenous patients. Another serious concern was provincial language requirements, which limited both Indigenous professionals and communities in work capacities. One example of a biting workplace reprimand was followed by another statement of how negative stereotypes of low-functioning Indigenous People remain common. One respondent’s analysis of how Indigenous children experience brutalized treatment settings during inpatient stays was particularly shaking. Respondent concerns about the scarcity of relevant research and Indigenous distrust highlighted barriers towards improvement. Lastly, one respondent voiced how opposition motivated her to be an advocate for all Indigenous People in treatment. The following section offers an overview of wisdom gained by respondents through professional engagement.

Thematic Phase Three: Experiencing

Data from the Experiencing Thematic Phase is described in the last Discrete Area titled Making Recommendations. The Experiencing Thematic Phase reveals perspectives of Indigenous People who went to school to become medical professionals and used their degree to work in the field with their own community. Though five of the respondents worked in First Nations communities, the remaining five worked in urban or metropolitan centres but identified as desiring to work with Indigenous People. Respondents shared about themselves and their work regimens from this intentional perspective. It is important to see their commitment and dedication in the workplace. This Discrete Area also reveals individuals speaking from an Indigenous perspective in a mainstream setting.

The Experiencing Discrete Area is different than the previously explored Discrete Areas which consisted of describing respondents self-reported experiences at school and work. This Discrete Area relates to instances in the working life of Indigenous healthcare providers when they see Indigenous identity as a pronounced opportunity. Moreover, respondents talked about meaningful connections created through their Indigenous identity. Respondents shared how their own cultural background arose in the context of remembering and self-validating their effectiveness as both a medical professional and a fellow community member. This dual membership is a defining aspect of the Indigenous healthcare professional role.

Discrete Area: Making Recommendations

Respondents related profound experiences emanating from working in the field from their roles as Indigenous healthcare providers. Respondents reported how familiarity with Indigenous context provided advantages for building relationships with Indigenous patients. Knowledge provided by Indigenous professionals seems to be primarily rooted in familiarity. This aspect of connection through Indigenous identity came up in many discussions.

Patient Connectedness

Rhonda alluded to a special, shared connection with Indigenous patients saying, “So when I work with individuals, um, and perhaps…they are coming to me because they are not getting the support that they need.” She speculated further about special relationship qualities between Indigenous professionals and Indigenous patients by stating, “So that in terms of that, I feel that there is quite an ability, having an individual who is Indigenous working with an Indigenous People. There is an understanding, there’s a trust.”

Respondents shared how important familiarity with negative aspects of mainstream health delivery systems was also important. Rhonda shared about how instrumental it could be for Indigenous health professionals to know from experience the negative aspects of care Indigenous communities encounter in mainstream settings or from non-Indigenous providers. Rhonda shared:

> So that’s stereotyping and racism and what I find is very, um, prevalent. And I hear that a lot in…with the community members I work with. So that I take it from an approach that I know what they are up against [being treated as a stereotype].

Rhonda continued to talk about how taking extra time with Indigenous patients was key and talked about “understanding, ...not easily shared...affording them (Indigenous patients) the time and the ability for them to voice...[what] they want.” Twila shared a vignette about how working with Indigenous patients as an Indigenous provider created bonds that lasted well beyond the scope of treatment. Her example also highlights the importance of providing time for patients to experience care. She shared about working the nightshift in a remote Indigenous community area.

> Like I remember I had an older Indigenous man, he had come in because he had hurt himself when he was out hunting. The infection wasn’t healing or it had gotten worse and so I was working nights, which sometimes was better because there is not this sense of People being there to provide oversight. You have a little bit more autonomy and so I could do things like chit chat with him about things. And you know I think that was in that particular situation with that particular patient there was need for just sitting and talking, not just only about sick. But it was about having a connection and feeling ok and just having somebody there that you can relate too. And I see those guys and they still remember me and they would say, “You were the best nurse” and things like that. You know there were other things like that too but being and Indigenous nurse, there were things that I could provide, you know like comfort and connection.

Merna commented on how Indigenous providers might relate better to Indigenous patients because of sharing the experience of being discriminated against as an Indigenous person and having more familiarity with an Indigenous cultural background.

> I just, I guess it depends…I do feel like Native healthcare providers provide better care for Native patients. It's just because you can relate on a personal level. You can

> understand, you can put yourself in their shoes. Because you most likely have had been in their shoes at some point.

Familiarity Advantage

Knowledge about specific Indigenous community languages and behaviors also highlight advantages Indigenous providers might have when working with Indigenous patients. Pat shared how important knowledge of Indigenous language can be when working with elders.

> Umm, you know, just, we have some things on the medication cart that I will say some certain things in in our language because People with dementia, they go back to their first language. Yeah, even if it's just one word it can be comforting to them.

Merna noted how working in smaller communities can enhance community communication about treatment. The example she shared to illustrate this aspect highlights a positive outcome found in a small community setting, which may also struggle with confidentiality as she and others mentioned earlier. Merna shared:

> There is a lot of um, feedback, like I feel like because we come from such small communities that other mainstream may not have that. Like we can often see when we have an effect. Through our programs and our stuff. Where People actually do do better or maybe it's one less hospitalization or 911 call. Whereas, other communities, they are so big, it's like the masses.

Patient Vulnerabilities

Familiarity also relates to gender roles and norms specific to Indigenous community members, which might not be understood by professionals outside of the community. Merna talked in depth about importance of this kind of specialized familiarity and knowledge. The vignettes Merna shared below have many layers and insights related to her identity as an

Indigenous provider. She related:

> Well, one thing I found is that culturally, is a lot of men, especially, men, they laugh when they are in pain. They won't look you in the eye. They won't admit it, maybe another healthcare professional would see that as "Oh, you are not in pain then", or "They won't look me in the eye" so they will chart that, you know, as part of the mental status, that they won't make appropriate eye contact. And stuff like that, but I find like I am Native and I understand, so I know, I know that they don't normally make eye contact. They don't normally tell you they are in pain. They laugh through their pain.
>
> And, also, with this population, with substance users. A lot of them went through, umm, sexual, like sexual abuse. So, when I am examining them I always ask permission.

Merna went on further to explain how a female patient became emotional during a routine physical exam because of having been sexually violated by an Indigenous nurse in another program. This scenario of an Indigenous professional violating an Indigenous patient shows another layer of complexity and traumatic experiences faced by an Indigenous patient. Merna's examples illustrate how familiarity allows the provider to better understand patient perspectives and reactions.

Merna went on to discuss how Indigenous communication styles also might make patients vulnerable when dealing with non-Indigenous providers who may not know how to interpret patient reports of pain. She talked about two scenarios that represent patient disconnects with providers and health services.

> They [patients] will go in and they will get "Ahh, just go home it's just nothing. It's nothing", and they go home and it might turn out to be something devastating like cancer.
>
> So they say they are so used to, like, taking on a personality where they don't want to

> bother anyone. So they could come and tell you, “I’m in tremendous amount of pain” but they don't want to bother you so they don’t act like they are.

Supporting Heritage

Joan, relying on her many years of experience, spoke positively about Indigenous identity and the need for more Indigenous-centered approaches to healthcare delivery. She was very motivated to talk about traditional practices and knowledge. She spoke eloquently about the value of using Indigenous community-based resources to deliver complimentary care.

> But I find there is more acceptance, more talking about it and even here in our community, we are looking at starting a traditional section of the “medical centre”. If a person walks in the door they have a choice: if they want to go traditional or western, they have a choice. If they’re traditional they are looking at the emotional, the spiritual and the social. And that a lot of People are holding on to things, and People don’t know how to forgive. And if you go to our teaching, it’s a good mind, love and peace and compassion. And People hold grudges and give more to the negative and pricked more in the negative.

Joan went on to share personal examples of how traditional ways supported meaningful living for herself personally.

> And I know myself, I have been doing more of the traditional, I do more of the traditional teachings, it’s not complicated, it’s simple. But I find that I am a happier person and I am in a better place and I have control of my thought, my mind. And because my thoughts and mind are in a good place, my body follows it.

Respondents had unique and diverse viewpoints about how to improve Indigenous healthcare delivery and also how to look at service provision in a more profound way. Joan highlighted the importance of Indigenous input while creating effective funding plans saying, “We know best what the community needs. We can... credit where that funding is needed most.” Joan used her experience visiting health services in many Indigenous communities to emphasize the power of Indigenous cultural heritage. She noted, “I think going out to the different communities, that there is more of that (Traditional teachings), and People are realizing that it is a precious resource.” She went on to discuss how different Indigenous communities use more cultural approaches, recalling, “And they (First Nations health centre) have a lot of Aboriginal First Nations staff, and they are also doing a lot of traditional teaching.” Pat described how cultural exchanges between Indigenous groups are important for sharing unique information gained as an Indigenous provider working in the home community. She described visiting other Indigenous groups as “a way to get back what you know when you do these things.”

Joan shared insights about effective care relating to Indigenous identity, which echo mainstream discussions about alternative approaches to health and wellbeing.

> It’s not just the First Nations People, but also the outside People who are wanting to do sweats and fasts because they know there is healing in it and it’s precious resource and it’s limited. You [can] go anywhere and see a doctor but you can’t get these teachings, they are a special gift that we have.

Joan went on to share about how traditional ways were becoming more common and Indigenous communities are incorporating more of their Indigenous knowledges in treatment modalities, both informally and in formal clinical settings.

> I find that there is a movement to follow more of our old teachings…sweats, fasts, ceremonies. People were doing things underground and not talking about traditional things and traditional medicines they take. I find there is more acceptance, talking,

starting a traditional section of the medical centre.

Rhonda also shared how communities are “reflecting back on that knowledge and power that exists within the community and allowing them to continue. So that we’re not taking away [Indigenous knowledge] from them.” These suggestions to improve healthcare delivery by emphasizing the preservation and incorporation of Indigenous knowledge is a key finding reported by respondents. Twila described programs that had Indigenous-based services such as a room for burning sage, tobacco and other traditional medicines. However, Twila also noted that using traditional medicines in the medical centre required People to use a dedicated room, which is still part of a formal medical system. Contradictions arising from providing a traditional practice in a non-traditional setting may be invisible to non-Indigenous professionals but are obvious to Indigenous community members.

Overview

This Discrete Area provided powerful descriptions of how respondents indicated trust and familiarity as key assets they had as Indigenous providers helping Indigenous patients. One respondent shared how she was able to identify how some Indigenous patients minimize their own needs due to previous experiences of experiencing neglect during medical visits. A respondent described the opportunities some First Nations are taking to incorporate traditional knowledge and shared personal benefits of Indigenous community-based healing. Another respondent recommended more Indigenous control over funding decisions. Many respondents shared their trust in the power of traditional approaches and how Indigenous individuals can learn from each other. One respondent held the view that small community size also created a safer place because People are more tightly connected. Another articulated how traditional treatments need more than one singular approach or dedicated room. These viewpoints offer an opportunity for the study to share what Indigenous providers experience and identify as essential for the field.

The last section provides a theoretical discussion about Indigenous experiences and led the way to the descriptive Framework in Figure 6, mentioned at the beginning of the chapter, which illustrates the overall experience of conflict Indigenous healthcare providers experience entering and working in the field.

Conclusion: Naming Ceremony - Indigenous Identity Framework, Context and Conditions

This last section provides the reader with a descriptive overview of the Naming Ceremony: Indigenous Identity Framework which arose from a high-level composite picture of respondent data. The Naming Ceremony diagram represents respondent vulnerability in a context of educational and professional experiences that impact respondent Indigenous identities. Study context and conditions are also reviewed along with a descriptive summary that illustrates how this theory of impacted identity was created.

Naming Ceremony: Indigenous Identity Framework

Respondents talked about how deeply their Indigenous identity was impacted at school and through work experiences. Indigenous identity formed the primary discussions around education and work as shown in the Vision Quest Framework (Figure 5). Indigenous Foundation was shown as a large circle that encircled all Thematic Phases and Discrete Areas. This circle illustrates how respondent discussions about Indigenous identity occurred from Indigenous perspectives related to their roles as students and healthcare professionals. A major theme emerged around talking about how the roles of institutional education and the provision of healthcare services largely continue to require Indigenous providers to operate in a medical environment that is both non-Indigenous and inflexible. Medical education and the professional field did not change to support Indigenous professionals. Instead these professionals changed. Their educational experiences and jobs were not only focused on upholding medical mainstream professional mandates anymore but also their roles grew to include becoming an Indigenous witness and advocate.

The Indigenous Identity Framework shown below provides a graphic illustration of how Indigenous healthcare providers encountered conflict and oppression at school and work and how this impacted their Indigenous identity (Figure 6). The first circle illustrates individual identity as an Indigenous person before entering the field. This circle is connected by a very thin arrow to a middle circle representing conflict and oppression experienced at school and work. The arrow then connects these two interconnected circles showing how school, work and Indigenous identity are intertwined in the cumulative professional experiences of Indigenous respondents.

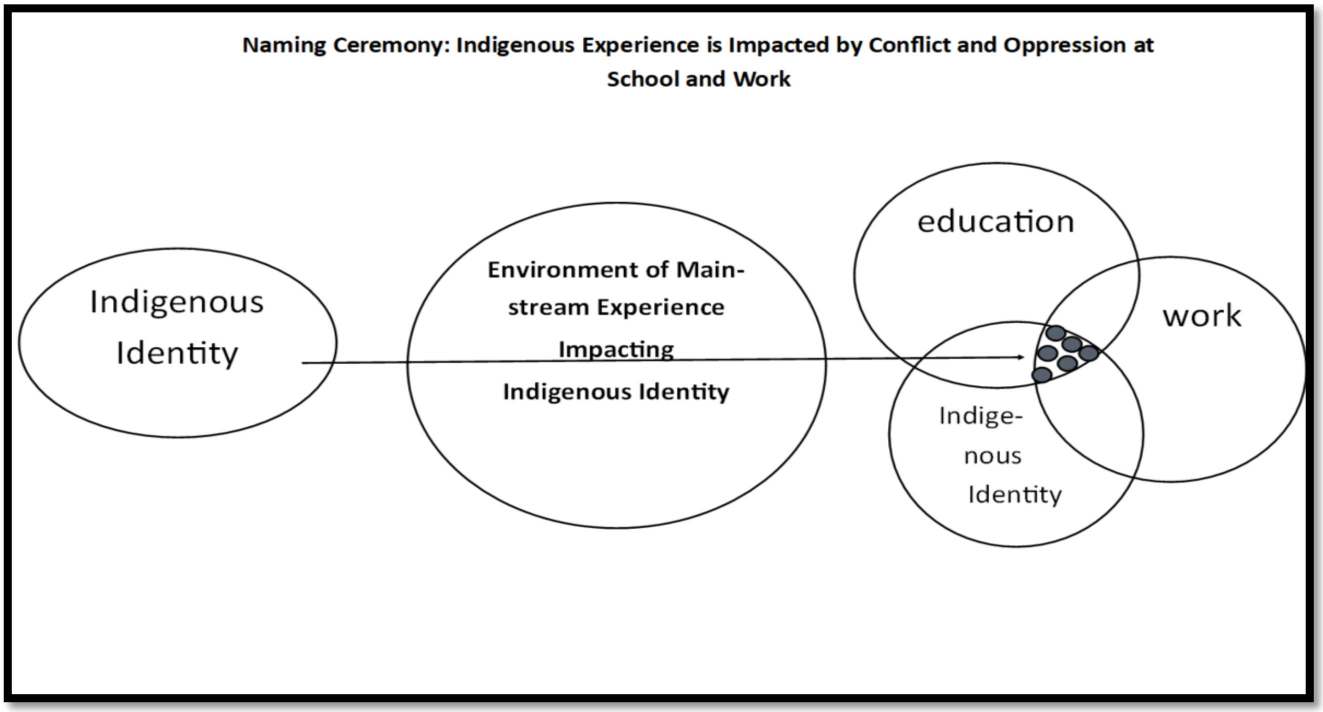


Figure 6: Naming Ceremony: Indigenous Experience is Impacted by Conflict and Oppression at School and Work.

Context of Identity

The Naming Ceremony Framework graphically illustrates a larger context of experiences of conflict reported by Indigenous respondents. This model also represents Indigenous respondent themes and reactions about conflict and oppression. Conflict and oppression are charged words, and when used broadly, might lose the kind of impact one can gain through talking to people who can recall defining examples. I feel this framework illustrates the ability of Indigenous Peoples to be informed reporters and highlights Indigenous individual and community resilience. Indigenous scholar Margaret D. Jacobs describes how many Indigenous education researchers also uphold Indigenous resilience; in this case, I believe healthcare respondents also provided a positive example of Indigenous resilience (2017). This second Framework makes apparent how often instances of conflict and oppression form a substantial component of respondent professional experiences. I drew from social work scholars using the Indigenous concept of the Medicine Wheel to reframe roles Social Workers take to provide a balanced approach when working with Indigenous community members (Verniest, 2006). I took a similar approach using Indigenous traditional knowledges to support the reframing of the Naming Ceremony. I used the Naming Ceremony to reframe how healthcare education and work impacted Indigenous community members. Respondents described how these difficult experiences have impacted their lives as healthcare workers when they changed jobs in response to hardship or went back to school to become better informed about what they were experiencing. Indigenous identity changes during the respondents' educational process. Indigenous students described how they could not just walk into school and come out with clinical skills that would help them work effectively with Indigenous People. Instead they had to translate what they learned in order for it to relate to their own experience as Indigenous Peoples who were also professionals.

Work environments further impacted Indigenous identity and created almost what I might term a “double calling”. That is, one is first motivated to become a healthcare professional in order to help one’s own community. Then, after going to school and entering the field, one is motivated to continue as an advocate for Indigenous Peoples who can describe barriers to care rooted in discrimination and racism. Out of these experiences I came up with the Indigenous name “Double Calling Warriors” for respondents and the heroic roles they occupy.

Contexts encompassing Indigenous identities emanated directly from the personal and professional lives shared by Indigenous healthcare providers. Important aspects of analysis arose around these identities. Consistent references by respondents about the importance of their Indigenous identities occurred regardless of individual connection to communities of origin. Some respondents grew up immersed in Indigenous cultures and communities while other respondents had intermittent exposure to their heritage and community of origin. Indigenous social and community networks were referenced strongly by respondents. Indigenous ethnic and cultural practices were similarly commented on. Respondents demonstrated intentional connections to First Nation, Métis and Inuit Peoples regardless of their work environment or geographic location. Respondents articulated specifically how the formalized healthcare contexts impacted them on a personal level as students and as they grew professionally. Respondent stories of transformation arose from conceptualized interviews detailing dynamic changes experienced as Indigenous students, professionals and advocates.

Conditions of Environment

There is a long history and contemporary experience of conflict and oppression known by Indigenous Peoples in Canada aside from what respondents reported during interviews. Moreover, one might see conflict and oppression illustrated in Figure 6 as being consistent with a reality of larger Indigenous struggles for survival. This study focused on how many respondents specifically related to Indigenous identity and health professions, which are inexorably related to the overall plight of Indigenous communities throughout Canada.

Summary

Indigenous respondents shared how they thrived in education and work environments despite problems. Healthcare consists of a highly specialized technical field requiring exacting standards of practice. The environment of medical service provision overwhelms students and professionals alike. Respondents also, however, brought resilient Indigenous individual perspectives forged through personal mandates to promote cultural survival while experiencing rude awakenings. Respondent accounts of racial oppression and colonial domination reflect a complex environment made more overwhelming through systematic health delivery schemes. Discussions about these results in the next chapter will seek to provide a review based on what the respondents or “Double Calling Warriors” emphasized in their practice. Important questions about the structure and delivery of healthcare services were raised by respondents and will be considered in the Discussion chapter. Compelling examples of Indigenous community resilience and difficult treatment scenarios will also be included. Indigenous community connections, trust and familiarity will frame deliberations about effective relationships between Indigenous providers and Indigenous patients. Overall, respondent contributions provided fresh insight and a uniquely Indigenous dialogue for the fields of health education and health services.

Chapter Five Discussion

I was compelled to learn more about the experiences of Indigenous healthcare professionals because of my own background as an Indigenous professional working in hospitals and at Indigenous community-based organizations in the United States. I wondered what Canadian Indigenous healthcare professionals experienced when working with Indigenous community members. The doctoral study first occurred to me after reading calls to action published by both the RCAP (1996) and the TRC (2015) that strongly emphasized the need for more Indigenous healthcare professionals. I hoped the study might elucidate experiences known specifically by Indigenous healthcare professionals about their effectiveness with Indigenous patients. Eventually, I started talking to respondents and analyzing data in hopes of learning more about their experiences of working with Indigenous community members. I was interested in learning more about what they described as working well with Indigenous patients. These initial discussions quickly developed into larger insights about their school and work experiences. Gradually, I realized respondents’ shared experiences went far beyond my initial questions: they provided descriptions of unjust school and work experiences.

As I reflected on these realizations, I began to define them as the opposite of reconciliation. This definition led me to wonder if increasing the number of Indigenous healthcare professionals would also mean increasing the number of Indigenous students and professionals subjected to brutalizing experiences. I asked: If more healthcare providers are identified as essential to reconciliation, whose reconciliation are we talking about? Are brutal experiences occurring consistently across Canada? Now, I believe the respondents have a distinct voice that deserves to be heard, especially because they are experts on their own experiences at work and school. I believe the current rush towards reconciliation activities must include voices of Indigenous healthcare workers. In particular, whenever programs and policies are reviewed and revised, crafted and consulted, articulated, implemented, and enforced their voices must be taken into consideration, especially those activities and documents directly related to training and educating Indigenous healthcare workers and when planning or reviewing healthcare service delivery programs.

This “Discussion” chapter provides a vital opportunity to review literature, respondent contributions and to review analysis critically. Overall, it unites the experiences reported by respondents with information assembled throughout this dissertation. I begin by evaluating two frameworks created during data analysis and described in the “Results” chapter. I review how data from this previous chapter provide conceptual support for the first framework. Then, I talk about how data guided analysis to better understand the second framework. Both frameworks are described and critically examined in order to review the central role these graphic tools play in data presentation. Next, I review practical implications arising from the study. Discussions start by comparing respondent contributions to Indigenous health literature. I then focus on recommendations and identify study limitations by highlighting six issues. Lastly, I conclude with a chapter summary.

Two Frameworks

Data analyzed in the previous chapter were summarized by the creation of two graphically illustrated frameworks (Figure 5; Figure 6). They furnish a concise format to illustrate what Indigenous respondents expressed about their professional journeys; they also include data analysis. In general, respondents’ information was integrated into each framework to show very broad perspectives. They offered insights into how participating in educational and work environments provided unique vantage points as Indigenous students and professionals and how this in turn affected their identities.

First Framework: Indigenous Identity, Education and Professional Environment

The first framework entitled "Indigenous Identity, Education and Professional Environment" (hereafter, "Identity and Environment") summarizes respondent descriptions of going to school and to work; it can be found on page four of the "Results" chapter (Figure 5, page 114). Basically, the respondents described processes which are woven into all medical and health professions. However, the Identity and Environment framework provides a vehicle to show the psychological impact of medical professional trajectories reported by the Indigenous respondents. The data coalesced to reveal specific experiences related to perspectives from an Indigenous viewpoint. Indigenous healthcare professionals have been clearly identified as a way to help Indigenous communities that continue to experience prolonged health and social issues. Ohler (2018) has discussed how they are likely to promote a sense of familiarity with Indigenous patients due to a shared social, cultural and historical experiences. Allen et al. (2020) also highlight the need for healthcare services that are inclusive of Indigenous cultures and traditional knowledges, as well as responsive to the many identified barriers (created through colonial oppression) that prevent Indigenous community members from accessing health and social wellbeing.

Indigenous identity, which is shown as an all-encompassing circle in this first framework, serves as a focal point for the doctoral study. During interviews, respondents consistently raised it as a priority topic. The Identity and Environment framework illustrates different processes that they experienced while at school and work. Their discussions about the roles they occupy as Indigenous students and healthcare professionals revolve around the key component of

Indigenous identity. This is true whether respondents talked about going to school or working in health facilities on First Nation Reserves or in urban settings.

The Identity and Environment framework consists of three Thematic Phases and five Discrete Areas; each one of these components was derived from respondent contributions. Throughout the study, the ten Indigenous healthcare professionals identified a prevalence of Indigenous subjugation which, in many ways, is consistent with privations, sovereignty struggles and hostile environments scholars described Indigenous community experiencing. This first framework helped organize data along a professional trajectory based on descriptions by Indigenous respondents discussing experiences in formal medical education or clinical work. They recounted experiences squarely tied to their Indigenous identities.

Respondents all spoke about how they answered the call to become health professionals to help other Indigenous community members and how this role would empower them to accomplish this goal. Respondents reported that formal medical education and clinical careers were filled with disconnected experiences for Indigenous Peoples. Furthermore, they revealed how experiencing oppression in education and work as an Indigenous person enabled them to highlight scenarios where these disconnects were profound. The RCAP (1996) explicitly calls for an increased number of Indigenous health professionals to address Indigenous health and social crises for Indigenous Peoples. The TRC (2015) also calls for more Indigenous healthcare professionals and the incorporation of Indigenous content in health and training programs. However, these calls do not consider respondent data which show the challenges Indigenous healthcare professionals experienced on their professional educational journey. As noted above, understanding and mitigating these experiences may be where reconciliation work begins. In this case, the work would involve listening to Indigenous healthcare professionals describe and interpret their experiences at school and work.

The respondent data operate on two levels: 1) they provide a glimpse into the complex world Indigenous professionals occupy and 2) they contribute to the larger goal of supporting reconciliation by engaging with Indigenous professionals. Currently, in Canada the term "reconciliation" frequently appears to coincide with that of "Indigenous communities." For this reason, next, I briefly summarize Canada's mobilization of the reconciliation process. In 2008, Canada was the first G8 nation to establish an independent commission commonly referred to as the TRC (Winders, 2016). The TRC provided a platform for Indigenous community members to share experiences being forced into residential schools where they were separated from family and prohibited to speak Indigenous languages (Winders, 2016). Residential Schools were in operation for more than a century and Indigenous children were abused physically and sexually and experienced malnourishment (Winders, 2016). The TRC provided a forum for Indigenous community members to talk about their experiences of attending Residential Schools and its continued impact in their personal lives and communities (Winders, 2016). The Commission enacted public forums with Indigenous Peoples across the country (Henderson & Wakeham, 2013). Apologies both preceded and followed the TRC. First, in 1998, Prime Minister Stephen Harper apologized for the Indian Residential School abuses; second, in 2017, Prime Minister Justin Trudeau apologized to former students of Residential Schools in Newfoundland and Labrador (Government of Canada, 2008; 2017). Canada's TRC process was instrumental because it provided a forum for Indigenous communities to share their experiences and it created a platform for upholding truths as well as acknowledging harms. The TRC (2015) highlighted education, not just for increasing the amount of educated and trained Indigenous healthcare professionals but also for directing educational institutions to engage with Indigenous communities to improve educational content.

Canadian legal scholar Julie Jai (2014) noted that fair and balanced agreements are essential when creating meaningful reconciliation; moreover, she states these agreements signify social change. Also, reconciliation scholar Julie Renner (2013) notes that in post-conflict societies reconciliation fails to produce lasting and meaningful change unless all parties support it. Further, Burkart and Nicholl (2013) point out that governments need to create forums capable of simultaneously supporting dissension and cooperation, a process which could lead to new kinds of government operations. In turn, these alternative operations would support co-existence and differences. In this light, Burkart and Nicholl join Renner (2013) in positioning Truth and Reconciliation Commissions as an essential way to evaluate reconciliation programs. One might envision that without far reaching alternative government operations, or systems of improvement, Indigenous professionals will continue to encounter numerous challenges such as the ones respondents described regarding education and work.

Their reported experiences raise questions about the ability of medical schools and healthcare institutions to become more supportive and inclusive of an Indigenous student body and workforce. The TRC (2015) directs schools to include more Indigenous content and to engage Indigenous communities; however, this approach is relatively new and will take time to integrate into these contexts. As stated previously, the ten respondents discussed experiencing and witnessing oppression along all phases of school and work. We can learn from their contributions about the adverse environment that pervades classrooms and clinical settings. I believe this doctoral study, especially the respondent data, validates earlier academic work that explores and documents the deleterious effects of racism. I also hope it provides a background to better understand Indigenous communities' distrust of healthcare which is rooted in an uninterrupted history of colonialization (Wakewich et al., 2016).

Primarily, I derive from the Identity and Environment framework a long-standing sense of divergence between the goals of reconciliation and the affirmation of Indigenous respondents' strength. The study data reveal the ways in which these Indigenous healthcare professionals entered the field to assume the role of a skilled actor to help Indigenous Peoples, but then continually encountered difficult experiences whose interrelated causes and effects were linked to their own Indigenous identity. Respondents also validated many of the emergent care issues described by healthcare researchers and healthcare professionals. I felt speaking to respondents was similar to conducting a TRC forum that engages truth telling and makes visible reported experiences of oppression. For this reason, there is a great opportunity for education and healthcare policy makers to evaluate how they might foster change by first becoming informed about the challenges Indigenous students and healthcare professionals face. Although leadership from medical and nursing schools across Canada have embraced many of the TRC Calls to Action, I wonder where they get the information required to enact meaningful improvement. By this I mean, when I reviewed the scope of work needed to integrate the Calls into local healthcare education programs as well as into hospitals and clinics across Canada, I found the challenges to be daunting. I argue that only qualitative studies can provide information about Indigenous students' and healthcare professionals' experiences to medical and nursing schools as well as to and healthcare institutions.

I agree with Renner's (2013) assertion that reconciliation does not have one definition; rather, the notion represents complex activities which are heavily impacted by the place in which reconciliation is enacted. For healthcare education and service provision, these complex activities include ongoing consultation at the local level that comprises Indigenous communities, individuals and professionals. Barkan and Karn (2006) describe the reconciliation process as an opportunity to both express confrontation and address historical injustices through connective and ongoing dialog, which creates an atmosphere where apology is genuine. Because the doctoral study focuses on Indigenous Peoples' education pathways or employment in healthcare centres, I assert study findings can inform the reconciliation process about opportunities for change. This assertion builds on Mitchell and Enns (2014) who identify Indigenous participation and support as key ingredients required for long term reconciliation. Furthermore, reconciliation requires upholding Indigenous partnerships and government accountability to foster mutual development (Sheppard, 2013). The Identity and Environment framework sets the stage for the second framework below which formulates how respondent experiences impacted their Indigenous identities.

Second Framework: Naming Ceremony: Indigenous Experience Impacted by School and Work

For the second framework, entitled "Naming Ceremony: Indigenous Experience Impacted by School and Work" (hereafter, "Naming Ceremony"), I turned inwards toward my own Indigenous background and relied on many Indigenous scholars to help access my own Indigenous viewpoint. Also, some Indigenous methodologies helped me access respondent data as valid knowledge and valuable resources that uphold Indigenous experiences. Overall, Indigenous identity permeated the respondents' descriptions. These descriptions helped produce the second framework which demonstrates how Indigenous Identity was amalgamated with respondents' reported experiences at school and work. Specifically, the Naming Ceremony framework (see "Results" chapter, page 153) shows how experiences related to Indigenous identity created unique situations during educational training and at work in the "Results" Chapter (Figure 6).

Elements from the second framework link respondents' trajectory to the corresponding environments.

All ten respondents attended nursing or medical school; additionally, they all worked in professional healthcare settings. The second framework (Figure 6) takes the school-to-work trajectory further by reviewing how these environments impacted the respondents. Recall, the framework elements depict this trajectory as follows: the circle labeled as "Indigenous Identity" is connected by a thin arrow to a larger circle that represents school and work environments. These environments are connected to a Venn diagram which illustrates Indigenous identity intersecting with education and work. Overall, the Naming Ceremony framework encapsulates and confirms two distinctly divergent experiences reported by respondents. First, all respondents shared negative school and work experiences. But despite oppressive experiences and environments, the framework illustrates respondent reports of relying on the strength of their Indigenous identity to continue at school and work in spite of negative experiences and oppressive environments. Second, the respondents discussed positive connections to their Indigenous identities; the framework highlights these connections. Overall, I believe the framework helps the readers see how strong connections to Indigenous identity connects to resiliency in school and at work; it also identifies areas for improvement in both these contexts. The preceding "Results" chapter includes vignettes that validate the respondents' positions as both Indigenous community members and Indigenous healthcare professionals who commonly experienced oppressive environments at school and work. Consequently, I wonder how the TRC will transform Indigenous educational training or impact health and social services provision.

Respondents shared their experiences which illustrate an important opportunity to learn more about Indigenous healthcare workers from their unique perspectives as providers of services. I believe respondent discussions might evolve and can become part of a larger dialogue of how to engage Indigenous community members to improve healthcare services. As frequently mentioned, many scholars (Allen et al., 2020) recommended increased engagement of Indigenous community members in service planning to reduce barriers in service creation. Respondents as a professional Indigenous cohort of former students and healthcare workers represent a vital resource for schools, health planning boards and Indigenous community engagement forums. It is my hope that Indigenous healthcare providers be further interviewed about the roles they occupy. This information, which would be derived from a cohort of Indigenous professional voices, would complement other Indigenous community voices about barriers they experience at school and through the provision of healthcare services. Descriptions of issues experienced during school and work could then be used to evaluate how to improve these systems for Indigenous community members. I hope the goals of seeking Indigenous collaboration become apparent in Naming Ceremony framework because it illustrates the value of those respondent contributions that describe their experiences and viewpoints. Reconciliation opportunities might be compared with this data in order to formulate a greater depth of change in both Indigenous healthcare education and service provision.

Typically, literature that describes health and social crises in Indigenous communities does not adequately address how Indigenous healthcare providers might address continued racism and oppression in educational and employment settings. Respondents point to this inconsistency when they clearly state that Indigenous student and professional needs are not consistently met. This doctoral study provides educators with an essential viewpoint; however, the researcher recognizes the need for more current assessments. On one hand, Indigenous healthcare students and professionals are a professional minority in Canada; on the other hand, their individual and collective needs and experiences are not well understood. Potential solutions to address such gaps might only be identified after a pan-Canadian in-depth assessment of educational processes and professional environments in healthcare fields are conducted.

The Naming Ceremony framework indicates that Indigenous healthcare professionals experience tension between their Indigenous identities and interactions with non-Indigenous professionals. In fact, the respondents were more informed about their own school and work experiences than might be discerned by relying solely on information gathered from my Literature Review (see Chapter Three). In summary, the second framework shows that Indigenous health professionals need more support in both educational and professional environments; further, it shows that Indigenous identity is integral to their work.

Discussion of the First and Second Framework

Canada's colonial domination spans hundreds of years. I believe reconciliation may require an equally long time period to reverse the negative effects caused by such deep-rooted oppression. The United Nations (2012) focuses on reconciliation activities as a path toward conflict resolution and describes the need for each society to take individual approaches. I think it is important that the steps required to improve Indigenous healthcare education and healthcare services be based on input formulated from Indigenous community experiences. I sought to show how the Identity and Environment and the Naming Ceremony frameworks demonstrate what Indigenous respondents reported as being negative throughout their careers at school and work. Yet, I also hoped to show how respondents demonstrated resiliency through their descriptions of being affected by adverse employment and educational environments.

Both frameworks illustrated how the experiences of Indigenous People continue to be distinctive, even when they participate alongside non-Indigenous professionals in formal education and work programs. During their interviews, respondents shared insights about their experiences and I felt this revealed how their roles were transformed from that of interviewees into that of being advocates. Respondent participation provided a depth of perspective about their experiences as Indigenous students and professionals. As both frameworks helped me show how respondent data grew into a powerful Indigenous narrative, I began to access my own Indigenous knowledge as a result of their stories. This synthesis helped me formulate Indigenous concepts and illustrations. I saw a vision quest ceremony evolve from their experiences, and used this framework during analysis to show how knowledge compiled from cumulative academic and work experiences of Indigenous respondents could be seen through an Indigenous lens. Respondents data, for example, coalesced into discrete areas such as grouping of "Cultural Strengths", "Indigenous Familiarity", and "Supporting Heritage" (see Figure 5). These areas consisted of respondent data and shaped how I drew upon my own Indigenous identity as respondents shared about their Indigenous identities. Their experiences occurred over time as they left a community environment to pursue healthcare education, and respondents clearly described how the education they received was based on the western model and not geared towards helping them as Indigenous students. Respondents also lamented how they felt that the education they received would not help them learn more about providing care to other Indigenous People. Though two of the respondents were able to go to school in an Indigenous community, they still made that journey to the west through a learning model based on western medical approaches. They worked in western accredited medical settings as well even when provided in Indigenous communities. Respondents discussed being deeply connected to their own Indigenous identities. I also felt connected to respondents as an Indigenous researcher and a student. Respondent Indigenous identity became prominent in all areas of the study. I feel this is where I relied on Indigenous research methodologies upholding the validity of our own Indigenous identities in academia and research (Smith, 2012; Wilson, 2008). I connected to respondent discussions and this helped me formulate a relationship to respondent Indigenous identity and my own Indigenous identity. This grounded my analysis and approach as I constructed a way to use Indigenous concepts to honor their paths as healers in both Indigenous and western contexts. I feel this is the apex of what Wilson (2008) terms as relationality, and hope that this work validates Indigenous resiliency as something that can be found even in the most sterile of medical settings. As discussed earlier (see Chapter 2), I strengthened the correlations between data analysis and study synthesis by relying on Indigenous cultural and community perspectives as resources for the methodological presentation.

Then I created a naming ceremony framework to encapsulate what I saw emerge from respondent experiences in the vision quest. The vision quest informs the naming ceremony in this case, and I relied upon discrete areas grouping of data such as “Supportive Learning”, “Indigenous Motivation”, Knowing Community”, “Ethical Concerns” and “Patient Connectedness” for example, to guide me (Figure 5). As noted earlier, Kovach (2009), Smith (1999) and Wilson (2008) call for more Indigenous scholarship with increased incorporation of Indigenous methodology. Thus, the naming ceremony incorporates Indigenous methodology in this sense by acknowledging how Indigenous viewpoints about western educational and professional realms are refashioned through respondent reported Indigenous experience and identity.

The two frameworks offer indispensable tools to show how professional healthcare training and medical workplaces manifest into markedly different environments for Indigenous Peoples. I believe discussions and research about Indigenous identity can be made stronger through accessing Indigenous knowledges. By comparison, relying on western deficit-based analysis describing Indigenous problems will not help transform discussions about healthcare education and services to include Indigenous resiliency. The next section highlights Practical Implications related to information derived from these two Frameworks and data arising from the Results Chapter.

Practical Implications

Indigenous social work researcher Nicole Penak (2019) states that Indigenous content in social work programs does not result in structural programmatic changes leading to decolonization. Instead, schools offer a handful of Indigenous-themed courses or hire a few Indigenous staff. She reviews examples of reconciliation efforts that leave oppressive structures in place by promoting non-Indigenous workers' "moral development" (p. 149) via "cultural competency" trainings as sufficient and not focusing on the need for instituting profession-oriented reforms. Indigenous child welfare scholars have also called for increased Indigenous content in social work education programs, and relate incorporation of Indigenous content as a way to reform Indigenous child services and increase effectiveness of service provision (Tamburro, 2013). Scholars call for increased use of post-colonial perspectives when evaluating programs to balance colonial practices found in Social Work education, which continue (Tamburro, 2013). Social work scholars further discuss the need to increase anti-colonial research in social work fields and note the absence of inquiry (Hart, 2009). As Canadian health professions programs seek to enact some of the TRC's (2015) Calls to Action, without structural changes that support Indigenous leadership and ongoing engagement with Indigenous communities, it is possible these reconciliation efforts will ultimately fail. I argue that most changes lacking Indigenous community consultation, in this case a community of Indigenous healthcare professionals, will be less likely to address Indigenous points of view and more likely to fail to improve educational training or healthcare work settings.

Indigenous researchers have described how historical changes in professional practice and social work education have been problematic. Returning to Penak (2019) for example, she discusses how systematic changes in government policy and programming have not fostered improvement. Hugh Shewell's (2004) provides important scholarship about the long history oppressive Indigenous government programs and offers an historical example describing the emergence of Canadian social work influence in government, and how social work advocacy impacted Indigenous health and social policy. The Canadian government convened a committee between the years 1946-1948 to examine the 1876 Indian Act and oppressive government relationships with Indigenous Peoples (Shewell, 2004). Shewell highlighted the collaboration between the Canadian Welfare Council and Canadian Association of Social Workers to professional briefs to examine ways to change and improve Indigenous communities. These briefs were instrumental in establishing social work on reserves and opening the door for provincial non Indigenous-grounded social work programs. Building on Shewell, Penak (2019) insists that Indigenous sovereignty was greatly impacted by provincial policies and services (which vary by province), especially policy recommendations that increased the scope of social work by working directly in Indigenous communities. She adds another example of how the social work profession adopted anti-oppressive practice (AOP) in curriculum and professional development programming in schools of social work. Her concern about the professions' adoption of AOP practices omits discourse of race and does not foster systematic change (Penak, 2019). Similarly, land acknowledgements also highlighted by both Penak (2019) and the originator of the contemporary practice Hayden King (Deerchild, 2019) as missed opportunities for creating meaningful Indigenous engagement (Deerchild, 2019). Overall, Penak highlights an essential critical review of missed opportunities to improve the social work profession. How do the critiques raised by Penak apply to healthcare education and services?

It is important to review the examples outlined above in order to better understand challenges facing healthcare educational programs and healthcare organizations which are on a road to promote reconciliation. The TRC (2015) Calls to Action provide a wide-ranging activity aimed at improving reconciliation with Indigenous communities, and specifically call for more Indigenous healthcare providers. In this doctoral study, I raise the question whether proscriptive changes in healthcare education and healthcare services will be informed by Indigenous community members most affected by these changes. I raise this question because data analysis relied upon respondents reported experiences of harsh and oppressive educational and work experiences. I think that changes to healthcare education and healthcare services through proclamations endorsing Indigenous reconciliation should be informed through an examination of Indigenous Peoples' experiences in these systems. Respondents offered many ideas about how to improve Indigenous education by describing what helped them. Respondents also raised many barriers they experienced in healthcare education and work environments. This study reveals the need for greater examination of negative experiences consistently reported by respondents. I have experienced how both healthcare educational processes and healthcare service delivery programs are fairly standardized and repetitive. Because of the highly formalized professional requirements in healthcare education and service provision, changes are difficult to make. For this reason, it is essential to seek information from Indigenous healthcare students and providers about their experiences to inform schools, institutions and organizations which comprise a complex environment.

I draw from nursing scholars next to further develop how I see engaging Indigenous healthcare students and professionals as a resource for information. Horrill et al. (2018) compared differences between biomedical approaches to healthcare services and post-colonial approaches. Horrill and colleagues compared how biomedical healthcare models focus on providing services; a biomedical approach also defines the responsibility to access these services as resting with individuals wanting the service (2018). Conversely, these scholars identified how a post-colonial approach toward service delivery would entail healthcare systems that value increasing access to services as a social responsibility and seek to engage users in a dynamic relationship in order to align services with user needs (Horrill et al., 2018). Emphasizing a post-colonial view of healthcare services frames delivery models as social spaces and not only places for medical service provision (Horrill et al., 2018).

This juxtaposition between biomedical models and post-colonial models strongly aligns with the tensions respondents shared about their experiences in school and at work. Respondents uniformly described how formal healthcare education and training is not geared towards supporting Indigenous participants. In spite of this, respondents did not reject western medical education. Respondents brought attention to oppressive educational experiences: isolation; hostile stage placements; negative attitudes about Indigenous community members; lack of opportunity to work in nearby Indigenous communities; having to create desired Indigenous community placements. Respondents discussed how they embraced their Indigenous identity while participating in educational training programs: by advocating for field placements in

Indigenous communities; looking for Indigenous curriculum; wanting more traditional knowledges and healing; noting the importance of Indigenous mentorship; describing how they served as resources for Indigenous representation for school programs; and sharing how Indigenous support programs strengthened them.

Likewise, respondents provided many examples of how formal medical services were not geared toward supportively engaging Indigenous community members as patients by discussing: restrictive confidentiality policies; traumatic inpatient treatment modalities for youth from rural Indigenous communities; language barriers at work; restrictive licensing requiring French language; negative stereotypes at work; isolation; lack of awareness of Indigenous community diversity; inconsistent resource allocation across communities; unequal pay and professional opportunities; respondents own descriptions of their poor experiences as patients. Respondents equally identified important positive aspects they experienced working as Indigenous healthcare professionals: seeking to work professionally to help other Indigenous Peoples in spite of the barriers they faced; referencing powerful Indigenous traditional medicines and knowledges; incorporating Indigenous languages to positively engage with elderly patients with dementias; using experience from auditing Indigenous health programs to better understand Indigenous community challenges.

I feel that this summary review of partial respondent data shows a depth to Indigenous respondent experiences which should inform how healthcare education and service programs might improve. In other words, this is the kind of material that is needed in order for education and service organizations to respond to Indigenous education priorities and experiences. Fostering meaningful Indigenous engagement requires assessments such as data gathered from respondents in order to document and make visible their reported experiences as a resource. In this manner, I believe that respondents, by sharing their experiences, provided a pathway towards better understanding how healthcare education and services fail to recognize Indigenous resiliency. Inversely, healthcare education and service programs might benefit from reviewing these reported deficits and successes for incorporation.

Indigenous community engagement and consultations should be repeated often. Single- or one-off consultation engagements with Indigenous healthcare students and healthcare professionals does not allow for the continual adjustments needed to effectively create supportive practices for Indigenous users. I am hoping this approach of directly engaging with healthcare professionals would help educational institutions and healthcare organizations become more apt to bend to Indigenous community needs. I believe Indigenous participation in this light is akin to leadership and closer to using a post-colonial approach; solely relying on increasing the number of Indigenous healthcare providers as a way to advance reconciliation avoids the critical need for relationality and will not improve educational and healthcare services and thus long-term health outcomes for Indigenous Peoples.

Assessment Discussion

Indigenous-led assessments of educational and healthcare services are urgently needed; they could provide a key opportunity for health planners, educators and government agencies to improve culturally-responsive approaches to their work. This study seeks to uphold the value of Indigenous community engagement by illustrating issues that affect Indigenous healthcare professionals. All ten respondents described the myriad institutional barriers faced by Indigenous patients; as Indigenous healthcare workers, these barriers also affected them. Highlighting respondent experiences would inform Indigenous healthcare education and service delivery systems; they would also provide healthcare educators and professionals with a tool to assess perceptions about the barriers faced by Indigenous Peoples. In all likelihood, issues affecting Indigenous healthcare professionals will increase as the call for more Indigenous healthcare professionals is realized across Canada. It is critical for education and healthcare institutions to increase envision patient outcomes that encompass all aspects and issues associated with Indigenous healthcare.

It bears repeating that Indigenous professionals provide unequivocal access to complex issues. They offer sophisticated perspectives about their experiences along with relevant descriptions of the barriers they encounter while delivering care in Western systems. For example, the respondents spoke proudly about their own Indigenous experiences and their desire to continuously help Indigenous Peoples attain better health. They used resilient approaches that came from upholding personal connections to their own Indigenous identities and communities. Additionally, they articulated the benefits of sharing their experiences as a way to improve visibility of problems facing Indigenous healthcare students and professionals.

I am hoping that further inquiry into the experiences of respondents will strengthen understanding of how Indigenous healthcare students and professionals might serve as invaluable resources of information. The opportunity to create structural change in healthcare education programs and healthcare organizations will not automatically occur without meaningful Indigenous-led community engagement. Community engagement, grounded in authentic relationships, makes all the difference when it comes to knowing what should be done to rectify particular situations raised by respondents.

Relation to Literature

At the outset of the doctoral study, I was unaware of larger opportunities for seeing how Indigenous healthcare professionals encountered resistance and barriers in educational settings and in the workplace. Data collection and analysis helped me derive perspectives that might only be gained by talking to people studying and working in healthcare settings. Regarding the Indigenous health literature, I was able to assess the holistic ways in which it focuses on health and social issues facing Indigenous communities. This body of literature associates Indigenous healthcare problems with colonial oppression, poor administration schemes and daunting social determinants of health. For example, the respondent Joan discussed how her work as an auditor inspecting Indigenous health programs across Canada discussed how Indigenous community funding is affected by geographic isolation. Scholars also have identified how geographic isolation, provincial boundaries and jurisdictional mandates impact Indigenous communities (Lavoie et al., 2016). Joan also discussed how she saw that some northern Indigenous health systems were not evaluated like other health programs that face audits and compliance certifications. Articles about the death of Indigenous community member Ina Matawanit from Northern Ontario also describes a poorly organized healthcare system that failed to track outcomes which makes improvement difficult (Martell, 2019). Rhonda discussed how she was unsure if Indigenous community diversity was considered in health assessments and service planners who might be unaware that her First Nation community comprised of three different Indigenous communities with different languages, traditions and histories. Indigenous leaders raised this issue as well by describing how Indigenous community priorities and participation in healthcare planning and oversight is not focused on Indigenous priorities or equitable (AFN, 2018). Scholars also discuss how health policy engaging Indigenous community members brings to light inequity and imbalances of power in decision making (Fridkin, 2012). Merna discussed how she felt that Indigenous patients had experiences of being ignored by healthcare providers in the past, and how she thought that Indigenous patients then would not reveal pain or problems as a result of their experiences. Racism against Indigenous Peoples has been discussed in the literature as a serious barrier preventing Indigenous People from seeking care or getting services (Allan & Smylie, 2015; Britten & Blackstock, 2015; Hojjati et al., 2018). The respondents, in comparison, articulated their perspectives as providers. In some cases, their perspectives matched information described in the literature while contributing new perspectives about their roles. At the same time, literature I was able to review in the fields of Indigenous health education, training, and professional healthcare work environments did not encapsulate all of the ten respondents' data. This chapter concentrates on reviewing instances where respondents either reported challenges cited in the literature or were not described well. For this reason, rather than include all of the ten respondents' data, portions of it are included in this dissertation. Mainly, I sought to prioritize issues related to educational and vocational pathways. To be clear, this selection does not discount the importance of all information raised by respondents nor the value in assessing their stories as a whole but seeks to highlight opportunities to assess their experiences specifically in schools and healthcare institutions.

Notably, respondents did not have access to the literature review as it was driven by their own contributions and compiled after the interviews were completed. Even though they may have been exposed to Indigenous healthcare literature at school or work, the respondents never raised the topic of Indigenous health literature. However, they advocated for more Indigenous content in training curriculum, a recommendation frequently found in the literature I reviewed. Surprisingly, many of their contributions validated relevant issues highlighted in this literature. For example, respondent data validated literature that describes ineffective health service delivery systems. The ten respondents also gave several examples of ineffective care. Indigenous health research has grown in scope and importance in health and social science fields across

Canada (Adelson, 2005; Mian et al., 2019; Reading & Nowgesic, 2002). Scholars note for many years there has not been enough improvement in service models based on western approaches to address Indigenous health problems (Commission on Social Determinants of Health, 2007; Dyck, n.d.; de Leeuw, Greenwood & Cameron, 2010). This lack of improvement remains despite knowing many of these problems have arisen from delivery systems that historically use oppressive colonial operational frameworks. Several scholars describe the need for healthcare planners to better understand that colonialism is elemental to Indigenous experiences. They argue it is vital to know this because colonialism plays a large role in diminishing the provision and quality of healthcare services (Browne et al., 2005; Browne, 2009; Browne, & Varcoe, 2007; Browne & Varcoe, 2006; de Leeuw et al., 2010; Kelm, 1998).

Linking discussions about the study originating with respondent data in the Results Chapter and related findings in the Literature Review Chapter was a key activity. Increasing the understanding of Indigenous health disparity is an essential task as governments, health advocates and Indigenous communities themselves are looking for ways to ameliorate poor health and social outcomes in Indigenous communities (Kue Young, 2003; Wilson & Kue Young, 2008). Several scholars have called for action to correct circumstances many Canadians find deplorable and out of context with their national identity (Tompkins et al., 2018; Richmond & Cook, 2016; Widdowson, 2015) and the inability of Indigenous People to access healthcare a national disgrace (Gone, 2014; Kirby, 2001). Advocates look for ways to show how negative health and social outcomes are evidence of continual intentional systematic government aggression against Indigenous communities (Britten & Blackstock, 2015).

Respondent voices provided a glimpse into the experiences of Indigenous healthcare professionals and highlighted issues they viewed as important. Both Twila and Merna for example discussed some of the challenges involved in enacting confidentiality practices in small interrelated Indigenous communities, particularly when they had community relationships outside of the provider-patient relationships. Halverson and Brownlee (2010) noted this tension particularly with regard to ethnical guidelines that prohibit dual relationships in rural and remote Canadian communities. Both respondents bring attention to hardships experienced by professional staff when they encounter inflexible confidentiality practices that ignore the relationships that exist outside the healthcare setting. In this regard, the respondent' contributions revealed to me the reality of Indigenous healthcare professionals working in tight knit community settings. Ideally, their contributions would motivate researchers to broaden their focus from assessing aspects of non-compliance to, for instance, learning more about effective confidentiality practices for Indigenous communities. Possibly, better confidentiality practices validating respondent challenges and might help Indigenous healthcare professionals everywhere and prevent alienating polices that put them in no-win situations. How can healthcare educators and policy makers, often so far removed from Indigenous communities both geographically and socially, be attuned to Indigenous community needs?

I believe action is needed to help Indigenous communities on multiple fronts, including more responsive planning and coordination of appropriate healthcare services, more research into gaps affecting Indigenous populations as well as an increase of Indigenous healthcare professionals. Indigenous professional participants shared narratives rarely heard in the evaluation of Indigenous healthcare education and medical services. Findings include a call by Indigenous healthcare professionals for more prescriptive engagement in educational programs as well as improved work settings.

Increased incorporation of Indigenous content provided by Indigenous Peoples would provide an essential first step to health training programs to address some of the educational gaps raised by respondents. Respondents talked about how they answered this deficit of knowledge by serving as a resource for classroom training and through participation on advisory boards at schools. Yet this was not enough to provide all health students with consistent exposure to Indigenous issues. An example of successful incorporation of Indigenous content provided by Indigenous community members is found in the McGill School of Social Work course, *Interdisciplinary Field Studies* (IDFC 500). This field course provides equal opportunity for students to learn from Indigenous subject matter experts about their own community perspectives; Indigenous contributions are considered as important as academic literature in the course curriculum. Respondents also discussed how they had to advocate for Indigenous specific internships that would help them have a more complete educational training experience. Greater inclusion of Indigenous content such as in the IDFC 500 course, provided in part by Indigenous Peoples, might address some of these frustrations and provide a more informed introduction to Indigenous communities.

Additionally, health training programs require more resources to create Indigenous student support services. Many of the respondents identified the positive impact Indigenous student support had on their careers. The efforts to increase Indigenous student enrolment in health programs across Canada should also include increased supportive services targeting retention and access to Indigenous community support. Isolation, described as a hardship by most respondents, might be better countered through consistently organized Indigenous programs in University and College departments.

Finally, a broader assessment of the Indigenous healthcare workforce is recommended in order to identify the kinds of training needed to increase knowledge about Indigenous issues and promote effective engagement practices. Indigenous healthcare fields represented a daunting operational area of practice. Respondents provided the opportunity to show how knowledgeable Indigenous professionals can be about their own work environment. They were informed about Indigenous community issues as well as problems in formal medical services. Indigenous professional concerns about workplace bias, racism and stressful work environments are important to explore further. Respondents bravely provided a glimpse into their professional lives, and in doing so also issued an appeal for more in-depth recommendations followed by their implementation.

This chapter's key activity was to link the "Results" chapter to the "Literature Review" chapter. Put differently, this chapter linked results originating from some respondent data to related findings highlighted in the latter chapter. Ideally, by linking discussions about the doctoral study to recently published academic literature, it became clear that the doctoral study added to contemporary conversations regarding the persistent health disparities that Indigenous Peoples face. For example, I join Kue Young (2003) and Wilson and Kue Young (2008) to emphasize that governments, health advocates and Indigenous communities have an essential task which is to look for ways to ameliorate poor health and social outcomes in Indigenous communities. In agreement with this strand of literature, I seek ways to show that negative health and social outcomes are evidence of continual intentional systematic government acts of aggression against Indigenous communities.

Increase Indigenous Presence

As outlined throughout this dissertation, action is needed to empower Indigenous communities on multiple fronts, including an increase of Indigenous healthcare professionals; more responsive planning and coordination of appropriate healthcare services; and more research into gaps affecting Indigenous populations. For the doctoral study, respondents shared narratives rarely heard in the evaluation of Indigenous healthcare education and medical services. Therefore, my findings broadcast calls for more Indigenous engagement and leadership in educational programs as well as improved work settings.

They also advocated for Indigenous-specific internships to complete their educational training experience. Analysis of Indigenous social work education discusses institutional failures to support Indigenous students adequately as well as uphold social justice (Harris, 2006). Scholars recommend incorporation of Indigenous worldviews by employing a post-colonial approach upholding decolonization and Indigenous self-determination (Harris, 2006). I also issue a call for increased Indigenous content in both healthcare education programs as well as in healthcare service programs. Yet, for all health students, these roles and internships inadequately impart consistent exposure to Indigenous issues. Increased inclusion of Indigenous content similar to *Indigenous Field Studies* described above provides opportunities for change only if all academic departments seek to offer students a similar course.

Indigenous Workforce Assessment

Finally, I recommend a more thorough assessment of the Indigenous healthcare workforce; this assessment would identify types of training needed to increase knowledge about Indigenous issues and to promote effective engagement practices. Although I acknowledge transforming Indigenous healthcare represents a formidable task, encouragement is embedded in the respondents' profound knowledge about their own work environment. They were well-informed about Indigenous community issues as well as about problems in formal medical services.

Informed Funding and Services Planning

Recall how Joan related insights regarding Indigenous health funding. Joan described how many Indigenous community members did not know how funding levels are determined based on a First Nation communities' population size. She explained that this practice leads to unequal funding among different Indigenous communities and that some Indigenous community members perceive this funding difference as unfair. She added that many Indigenous community members may be unaware that funding based on population size which creates different service possibilities for various communities. Joan reviewed another reality that impacts funding allocation which is transportation. She described how transportation costs affect remote communities differently based on their geographic location in relation to urban or southern hospitals and health specialists. Some of the literature reviewed for the doctoral study focused on geographic isolation as a serious barrier for service delivery (Health Canada, 2016; Ohler, 2018). Joan's contribution helped me perceive links to a possible explanation for discord between Indigenous nations and communities because community leaders may not understand how government processes for determining program funding works. When an Indigenous community is underinformed or ill-informed about federal and provincial funding schemes, this ignorance could create negative speculation about the reasons for funding-level variances between communities and nations. In turn, negative speculation can sow discord when what is needed is solidarity across Indigenous communities to overturn oppressive government funding practices.

Continual Assessment

Study findings underscored healthcare professionals’ calls for change. Respondents identified viable concerns and articulated reasons for improvement based on their experiences and insights as Indigenous Peoples. I recommend adding processes to engage Indigenous healthcare professionals for feedback frequently about their experiences, as well as relying on Indigenous advisors on academic or healthcare institutional review boards. I advocate for a more timely and direct approach for getting information and Indigenous collaboration to help create proactive change. I feel this is in alignment with discussions about the need for more relational accountability raised by Indigenous researcher Shawn Wilson (2008). I recommend more canvassing of Indigenous healthcare professionals about all aspects of health and social issues affecting Indigenous communities to draw from their expertise.

Overall, I assert that Indigenous healthcare providers themselves can be important resources for schools and healthcare institutions seeking strategic, informed and prescriptive ideas. I believe engaging Indigenous professionals as informants in this sense fosters both much needed partnership and leadership. The TRC Calls to Action (2015) identify the need for all schools and healthcare institutions to improve Indigenous community engagement. Indigenous Saami Scholar Rauna Kuokkanen describes how educational programs are unable support Indigenous faculty and students because programs do not incorporate Indigenous worldviews and expect students to conform to Western values instead (Kuokkanen, 2007). I think of respondents Geri, Pamela, Eloise and Mary who had to advocate and create the kinds of Indigenous educational training they identified as essential. I feel that respondent data presents a viable opportunity to help make the struggles of Indigenous students visible. This in turn could be used to counter resistance to change as educational institutions engage more Indigenous students. Indigenous scholars have discussed how questions about knowledge and truth from an Indigenous viewpoint provoke defensive reactions in established Western educational systems (Kovach, 2015). I feel it is important for respondent voices to heard in order to provide many critical examples about difficult Indigenous experiences in Western educational systems and in healthcare services.

I recommend this thesis be used as an example to illustrate how other Indigenous students and researchers might engage Indigenous healthcare providers. I embraced my own Indigenous background and viewpoint throughout this study. I felt using traditional ceremonies like the vision quest and naming ceremony provided a pathway for me to honor respondents for their service as healthcare professionals. I also choose to use these two ceremonies to uphold the validity of respondent experiences using an Indigenous lens.

I would go so far as to recommend local, regional and national level forums, like the TRC (2015). I would recommend forums to be held annually to review how healthcare education programs in post-secondary education institutions engage Indigenous Peoples as recipients. I also recommend the same level of review for healthcare service programs and providers. Academic healthcare training programs and healthcare services programs are both reviewed for accreditation purposes. I recommend engaging Indigenous students and Indigenous healthcare professionals in these kinds of compliance audits. I believe this approach would make reconciliation a meaningful process for Indigenous communities, healthcare training programs and healthcare services programs. The TRC reconciliation process may not be revisited on a national level, and if it is enacted again it may take many years for this to occur. I believe regional and local forums are needed to engage Indigenous healthcare students and Indigenous healthcare professionals to assess how Calls to Action 23 and 24 (TRC 2015) are being addressed. TRC Calls to Action 23 identifies the need to increase both the number and retention of Indigenous healthcare professionals as well as training for all healthcare professionals focused on cultural competency (TRC, 2015). Calls to Action 24 directs schools of nursing and medicine to provide skills based educational training focusing on “intercultural competency, conflict resolution, human rights and anti-racism” (p.3), and on many aspects of Indigenous community experience including: Indigenous health; residential schools; United Nations Declaration on the Rights of Indigenous Peoples; Treaty and Aboriginal rights; Indigenous teachings (TRC, 2015). I believe this thesis exemplifies how the TRC Calls to Action can be revisited with Indigenous students in professional training programs as well as Indigenous professionals working in health and social service programs.

Additionally, respondents identified a need to learn more about the impact of diversity within Indigenous communities and how Indigenous healthcare professionals might engage community members from other Indigenous groups. For example, when Pamela recounted specific scenarios regarding adverse inpatient treatment, she also questioned the operational administration of protocols that negatively affect Indigenous children from Northern communities. Pamela related how she learned words in other Indigenous languages in order to build a connection with Indigenous children remanded to long and isolating inpatient hospitalizations. Gaps in knowledge point to the need for more qualitative research engaging Indigenous healthcare professionals about these specific details. I believe this especially true for professionals who work in these settings with Indigenous Peoples who have multiple social locations and come from large geographic areas.

Recommendations

Respondents shared a sense of deep commitment to their professional calling despite the many difficult situations they encountered. Respondents highlighted their intention to serve other Indigenous community members, to help others from their own communities as well as other communities. I believe their message of resilience and commitment toward Indigenous healthcare services is important for Indigenous healthcare students and professionals everywhere as well as their allies. I find respondent data motivating because of overwhelming health and social issues that continue to weaken Indigenous communities. Respondents carry a message of hope and strength because they committed to sharing information during interviews. The following sub-sections focus on recommendations and insights garnered throughout the doctoral study.

Engage Indigenous Identity

A central aspect of Indigenous health research is that it is, for the most part, conceived and conducted by non-Indigenous institutions and health researchers. For Smith (1999), Indigenous researchers and advocates have repeatedly raised questions about who is researching our communities and to what end; what methods are being used; and to what degree, if any, information might be used against Indigenous Peoples. I thought of this often in regards to the TRC’s (2015) Calls to Action, especially those calling for increasing the presence of Indigenous healthcare students and professionals in academic and work settings. This is why respondent voices are essential to help inform schools and healthcare programs about respondent experiences. I recommend a larger number of Indigenous healthcare providers across all provinces and territories for a more in-depth study of Indigenous healthcare professionals. I believe information needed to contrast experiences of Indigenous professionals with this call for more Indigenous professionals in order to support arguments for stronger commitments to improve Indigenous healthcare training and work environments. For example, some respondents highlighted their ability to be both effective workers and informed Indigenous community members. Put differently, they emphasized how important it is for students and professionals to be dedicated to serve Indigenous individuals and communities. Respondents described how they felt more connected to providing care to Indigenous patients, and even described how they were "safeguard care" from bias and discrimination they witnessed in their roles as providers. As frequently mentioned, the respondents spoke about a wide range of barriers they experienced in educational and workplace settings. Moreover, they encountered issues that were directly related to their own Indigenous identities. Prioritization of Indigenous identity and culture is also found in the literature. For example, the Wabano Centre for Aboriginal Health (2014) situated in Ottawa conducted an impact assessment which involved a heavily engaged collaboration with Indigenous community members. Among other things, many members voiced respect of Indigenous identity as key element of care. As a result, the Centre positioned their services to include Indigenous cultures and traditional knowledge keepers to respect community concerns and desires.

Several of the respondents identified important implications for the fields of Indigenous education and healthcare to be proactive in creating curriculum to inform all students about Indigenous communities and histories of colonial oppression. Many respondents talked about the lack of Indigenous-specific curriculum, Indigenous cultural resources or access to traditional Indigenous knowledges available in education settings and a few discussed how they served as this resource. Respondents also called for more integration of Indigenous healing practices and traditional knowledges. Once again, increased awareness of Indigenous viewpoints is essential for professional fields to successfully integrate supportive Indigenous services in clinical practice, policy development and health promotion activities.

Assess Educational Programs

Both the RCAP (1996) and the TRC (2015) calls for increased Indigenous enrolment in health education programs; however, these calls overlook the requirement to assess current educational programs. I found respondent reports of experiences in school compelling and relevant. A large portion of Canadian universities are increasing enrolment by utilizing targeted programs to attract and retain Indigenous students. Some respondents also suggested increasing Indigenous student resources. To illustrate, McGill University School of Medicine offers the Indigenous Health Professions Program (2019) while the School of Social Work offers Indigenous Access McGill (2019). Both programs offer Indigenous community support in a university setting to their Indigenous students. The integration of visible Indigenous activities and community events seeks to address the isolation mentioned by many of the respondents. However, respondents also identified several other issues such as limited or nonexistent Indigenous-based curriculum or training opportunities which have yet to be addressed. In fact, the absence of relevant curriculum continues to be a reality for Indigenous and non-Indigenous students. Therefore, improving Indigenous recruitment and retention in healthcare educational programs requires institutions to reexamine ways in which they engage with Indigenous community members and incorporate supportive Indigenous services. While consulting with Indigenous community members presents an opportunity for educational institutions to include more Indigenous input, institutions should also look to enrolled Indigenous students for their advice and guidance to assess and improve the academic programs. Several respondents clearly illustrated gaps in their own experiences applying for school and reported how Indigenous retention programs were key, thereby identifying important opportunities to increase effective educational and training programs for Indigenous students. When contemplating recommendations based on this doctoral study, I strove to go beyond topical modifications to educational programs such as narrowly focusing on incorporating more Indigenous content into the curriculum. The call for increased Indigenous healthcare professionals requires new approaches to support Indigenous student enrolment and retention.

Study Indigenous Workers

Many respondents were concerned about Canada's formal nature of Indigenous healthcare funding and service provision. They viewed funding and service as complex and determined by government offices far away from the Indigenous communities they serve. The literature I was able to review upheld similar perspectives. For example, O'Sullivan (2012) claims that Canada's bureaucratic systematic approaches to Indigenous health services is unchanged and unengaging. Respondents also discussed how they felt Indigenous health programs needed to be improved and services increased. Research focused on Indigenous front-line community workers has revealed the need for increased interventions based on Indigenous realities including both historical and cultural realities (Williams, 2005). I feel my incorporation of Indigenous data is in alignment with calls for increasing Indigenous approaches to Indigenous healthcare education and work. When I performed my own activity of writing reflective field notes and when I analyzed respondent data, I included descriptions about the problems they raised about funding; lack of assessments available for Indigenous patients; Indigenous patients and respondents themselves encountering racist and discriminatory treatment experiences; lack of Indigenous specific services incorporating Indigenous traditional medicines and knowledges;

and few Indigenous providers as colleagues. These issues highlight a multitude of problems respondents were able to discuss in depth about the provision of care.

I find it insightful also that respondents raised many issues specific to Indigenous providers in an Indigenous community that may not be widely understood. These issues include an increased sense of patient engagement related to the patients' familiarity with and trust in an Indigenous healthcare provider. Quite possibly, non-Indigenous healthcare providers and advocates may not consider creating trusting relationships a prerequisite to effective care, even when they create programs located in Indigenous communities that mainly serve Indigenous community members. The knowledge to establish trust could differentiate Indigenous healthcare professionals from other professionals in the same field working in similar systematic institutional structures. However, respondents also discussed how Indigenous patients also had negative experiences with Indigenous providers and this points to complex issues for Indigenous providers to be aware of.

The need for Indigenous community representation in healthcare planning is pressing. This study illustrates that research should not only focus on Indigenous communities as consumers of health services, but should also pay attention to the experiences of Indigenous health professionals. There is a strong desire for health programs to improve Indigenous engagement in light of the TRC Calls to Action (2015), which also includes understanding positive viewpoints of Indigenous healthcare professionals about their own communities. Respondents provided thoughtful and deeply informed contributions which encapsulated a wide array of challenging experiences at school and work. The sheer scope of their reported experiences was overwhelming. Nevertheless, they helped me better understand the healthcare field, particularly nursing, through a rarely heard vantage point. Overall, they identified serious issues in healthcare delivery settings, which underscore the need for further research into their experiences.

Critical Analysis of Study Limitations

Below, I discuss five issues associated with the doctoral study. First, respondents were concerned about affiliation with specific Indigenous communities or healthcare institutions. Second, I discuss limited sample size encountered during data collection. Third, limitations also relate to the emic and etic position of an Indigenous researcher doing research in a broad Indigenous community. Fourth, all study respondents were women, though men were canvased and sought out. Lastly, I review how the sample size consisted mostly of Indigenous nurses and only one Indigenous physician.

Affiliation

During the study, respondents and other researchers wanted to know which specific Indigenous communities were participating in the project. As detailed in chapter two, I explained, rather than focus on one single community, the doctoral study concentrated on Indigenous nurses and doctors, a professional cohort, that worked with Indigenous patients in any capacity. In addition, some people asked which hospital or clinic supported the doctoral study. I clarified that the respondents worked in various settings. Therefore, it was unnecessary to investigate a specific medical organization or medical service. Basically, a study that involved a specific community or medical institution would have altered the doctoral study's objective: to explore Indigenous health professionals' educational and work experiences regardless where they studied and worked.

Limited Sample Size

The ten Indigenous health professionals provided rich, in-depth descriptions of their educational and professional experiences. Respondents provided thick descriptions that were used to analyze their experiences and aspects of their professional lives. I reviewed qualitative research about sampling to ensure I could create an appropriate sampling**.** Both Charmaz (2014) and Loftland and Loftland (1984) criticize data collection methods used in grounded theory that lead to a small sample size and the ensuing analysis. Aware of this criticism, I relied on theoretical saturation (as defined in grounded theory) to reach a sufficient number of participants. According to Strauss and Corbin (1998), grounded theory validates the practice of gathering enough data for theme or category saturation, which I reviewed in order to determine adequate data collection after interviewing ten respondents. I feel I was able to use qualitative research approaches to help me maximize my ability to determine theoretical saturation by combining valid data collection, and researcher reflections memos with a thorough analysis of participant data. As stated above, rather than generalize across all Indigenous healthcare professionals, the goal of the doctoral study was to engage with Indigenous healthcare professionals and explore their experiences in the field. Thus, the small sample size is appropriate.

My Position as an Indigenous Researcher: Emic and Etic Challenges

My Indigenous self is inseparable from my doctoral candidate self; separating them was neither possible nor desirable. These multiple identities shaped how I approached this study, including collecting and analyzing data. I read how Indigenous researchers identified incorporating Indigenous (Wilson, 2008) and how Smith (1999) emphasizes the importance of knowing more about the position of Indigenous researchers working in their own communities.

For Wilson (2008) and Archibald (2019), Indigenous researcher identity and story is a hallmark of Indigenous practice. Strega and Brown (2015) describe how Indigenous identity is a key resource in Indigenous research. Describing Indigenous connections to community and individual Indigenous identity presents an important opportunity for Indigenous researchers (Archibald, 2019; Cardinal, 2006; Kovach, 2009; Smith, 1999; Wilson 2008).

For the doctoral study, I observed constructivist grounded theory protocols and established Indigenous methodology engagement practices. For example, the literature review was conducted after the data collection and was responsive to and reflective of respondent data (Charmaz, 2014). Additionally, the "Results" chapter included a naming ceremony as part of practicing the integration of Indigenous methodology. Inclusion of Indigenous cultural and spiritual practices in academic research aligns with Indigenous authors' call for integration of Indigenous community experiences and perspectives (Archibald, 2019; Kovach, 2009; Smith, 2012; Wilson, 2008).

Ethical considerations are highlighted as a distinguishing practice for Indigenous individuals doing research in Indigenous communities (Absolon, 2004; Kovach, 2009). The McGill Research Ethics Board approval process also incorporated Indigenous-specific protections for participants that safeguard autonomy and confidentiality. Issues did not arise during data collection, analysis or thesis writing related to these potential limitations. Discussions around emic and etic considerations are relevant to this work. Emic is used to describe the perspective in research of how local participants think and perceive their world and explain it to others including social rules, important personal interpretations, and how they think about and describe their experiences (Kottak, 2006). The description of emic knowledge and meanings are culturally developed through local customs and community beliefs that are explained by a community member (Ager & Loughry, 2004). Acknowledging the emic and etic tension and perspectives are relevant to discussions about Indigenous knowledge and the changing role of researchers in these communities. The etic perspective generally takes the focus of the science investigator and describes information from the viewpoint of discipline-specific inquiry, such as anthropology, which shifts the focus away from local interpretations and instead utilizes researchers' interpretations (Kottak, 2006). Additionally, etic perspectives incorporate generalizations about human interactions that are thought to be true as well as link the interest of the investigator to cultural practices regardless of whether these practices are identified by community members as relevant (Morris, Leung, Ames & Lickel, 1999). The seemingly conflictual nature of emic and etic perspectives has been described as being complementary to anthropological study (Jingfeng, 2013). Emic and etic perspectives are especially significant to Indigenous researchers because individual wellness in Indigenous communities is deeply connected to concepts of shared kinship and an enlarged sense of community compared to mainstream Canadians (Pulla, 2013; Richmond & Ross, 2008).

Indigenous research methodologies can be described as being both old and new as they are being established through academic studies. Indigenous research incorporates existing relationships and traditions of sharing of knowledges which is an age-old practice highlighted by Indigenous researchers (Wilson, 2008) However, the practice of formalizing Indigenous research methodologies is new and helps bridge practices that are part of older traditions with newer practices of academic inquiry (Archibald, 2019; Kovach, 2009; Wilson 2008). Challenges associated with the development of new methodologies counter existing western-based practices. Charmaz (2014) describes how Glaser and Strauss founded grounded theory as viable alternatives to the then current methodologies and "offered systematic strategies for qualitative research practice" as a both a statement and confrontation of accepted research practices (p. 7). Since then, researchers have used these tools and theory to exponentially develop qualitative research (Charmaz, 2014).

Indigenous authors underscore how approaches to Indigenous methodologies are both emergent and primarily defined through application (Archibald, 2019; Strega & Brown, 2015; Wilson, 2008). Indigenous researchers advocate for an approach defined through Indigenous experiences that includes both ancient knowledge as well as colonial experiences (Kovach, 2009). Indigenous researchers identify traditional Indigenous community mandates that uphold the importance of sharing experiences with the community. Indigenous-led research, in this light, augments knowledge to assist all community members in their development, which legitimizes Indigenous researchers (Archibald, 2019; Kovach, 2009).

Indigenous researchers might rely on the description of the historical development of grounded theory in order to inform others what steps are required to further develop Indigenous methodologies. Grounded theory came about and was established through a discursive development process.

Indigenous Women Respondents

All respondents were women. Although men and women nurses and physicians were equally canvassed, only women consented to participate in the study. While this was not the intent, the sample is reflective of the gendered realities of women in healthcare systems: Indigenous nurses are the most represented in the field of Indigenous healthcare providers. Therefore, while all findings are based on women's experiences, implications discussed have broad application and speak to the general lack of knowledge regarding Indigenous healthcare professionals who reflect multiple social locations.

Nine Indigenous Nurses and One Physician

I made several attempts to engage Indigenous physicians during recruitment. I had several Indigenous physicians express interest in participating verbally and in email correspondence. I also received assistance from many professional associations and healthcare institutions to advertise the study. However, I was not able to secure more than one Indigenous physician. I do not think this is problematic given the very small representation of Indigenous physicians in healthcare settings currently. Most of the physicians I contacted who initially expressed interest reported being unable to find time to participate. One Indigenous physician was adequate because Indigenous nurses vastly outnumber physicians and the small number of Indigenous physician representation is what one would find in the field of healthcare currently.

Chapter Summary

Linking discussions about the study originating with respondent data in the Results Chapter and related findings in the Literature Review Chapter was a key activity. Increasing the understanding of Indigenous health disparity is an essential task as governments, health advocates and Indigenous communities themselves are looking for ways to ameliorate poor health and social outcomes in Indigenous communities (Kue Young, 2003; Wilson & Kue Young, 2008).

Action is needed to help Indigenous communities on multiple fronts, including an increase of Indigenous healthcare professionals, more responsive planning and coordination of appropriate healthcare services, and more research into gaps affecting Indigenous populations. Indigenous professional participants shared narratives rarely heard in the evaluation of Indigenous healthcare education and medical services. Findings include a call by Indigenous healthcare professionals for more proactive engagement in educational programs as well as improved work settings.

Additionally, health training programs require more resources to create Indigenous student support services, which is described in the 24th Calls to Action fully (TRC, 2015). Many of the respondents identified the positive impact Indigenous student support had on their careers. The efforts to increase Indigenous student enrolment in health programs across Canada should also include increased supportive services targeting retention and access to Indigenous activities. Isolation, described as a hardship by most respondents, might be better countered through consistently organized Indigenous programs in University and College departments.

Finally, a larger assessment of the Indigenous healthcare workforce is recommended in order to identify the kinds of training needed to increase knowledge about Indigenous issues and promote effective engagement practices. Indigenous healthcare fields represented a daunting operational area of practice. Respondents provided the opportunity to show how knowledgeable Indigenous professionals can be about their own work environment. They were informed about Indigenous community issues as well as problems in formal medical services. Indigenous professional concerns about workplace bias, racism and stressful work environments are important to explore further. Respondents bravely provided a glimpse into their professional lives, and in doing so also issued an appeal for more in-depth recommendations.

Chapter Six Conclusion

I believe these Indigenous healthcare professionals, though trained to provide medical evaluation and treatment services based on western scientific traditions, are consistent with the traditional Indigenous intention to practice healing arts. I am hoping this study helped build upon both professional perspectives and distinct Indigenous human experiences by listening to the experiences of respondents, the frontline workers. I was deeply moved when listening to these Indigenous healthcare providers as they shared vivid scenarios about educational training programs and their professional environments. I feel a strong Indigenous connection to healing was forged as respondents described both challenges and recommendations.

I rely on Archibald's' writing about the importance of Indigenous story pathways as a way to both include and highlight Indigenous experience (Archibald, 2008). To me personally as an Indigenous community member I found respondent reported experiences of continually connecting with their own Indigenous experiences, even in the most adverse formal school and medical settings, to be extremely important. I believe these new stories of survival are akin to some of our own Indigenous creation stories.

There is a story, for instance, from my community about how the robin got it's red breast feathers. The story unfolds about how the first man on earth's surface fell asleep by a fire. He had come up from a cave in the Black Hills of South Dakota and did not need fire to keep warm where he came from. While sleeping the fire almost went out save a robin who flew down to fan the smoldering embers and in the process of rekindling the fire the robin burned its feathers and they turned red.

I interpret respondents reported experiences of using words from Indigenous languages or relying on Indigenous medicines or referencing Indigenous community connections with patients as being the same as the mighty lifesaving wings of the little robin. I thank the Indigenous respondents continually as they referred to their own Indigenous identities as the most important aspect of their educational and work experiences. I will provide each of them with a copy of the final thesis and recognize it's not the advancements of modern medicine respondents reported wanting. I believe respondent data provided an essential contribution to the fields of healthcare education and service provision by showing how individual experiences reveal opportunities for change. I am hoping this study contributes to the knowledge base of Indigenous healthcare literature in this way. I hope respondent descriptions, which motivated me to draw upon my own Indigenous experiences and identity, might be used again to motivate other Indigenous students. I believe the expansion Indigenous research methodologies and theories requires future application and inquiry by Indigenous researchers themselves.

I personally have found colonial domination of Indigenous People to be a heavy burden touching every aspect of my own community of origin, and not only historically but in our lives now. Inclusion of respondent experiences and reflections throughout analysis was done in hopes of finding a way to lessen the burdens they shared. I feel this journey with respondents has helped me look for ways to promote healing in my community. Exploration and discovery in this sense has been very fulfilling.

Findings are not solely intended for schools of medical training or clinical service providers. This information might also be applicable to assist Indigenous community health departments and Indigenous leaders as they seek to foster an environment of effective medical services in their own communities. Indigenous community advocates in urban settings may also find this information helpful as reference. I also hope that information gained in this study can also be used in studies of other minority or oppressed groups.

I thought of the words witness and testimonial during respondent interviews. I am hoping this thesis provides an example of Indigenous engagement that is required over time, and should be repeated to assess and adjust healthcare education, policy and practices. Alignment with Indigenous goals, cultures, traditional knowledges, and experiences of colonial oppression are thought by many scholars to be key toward reducing barriers to care (Allen et al., 2020).

Study findings might also be helpful to define future intervention strategies in academic training programs focused on increasing the understanding Indigenous health issues. Additionally, the idea of investigating the professional and ethical concerns highlighted by respondents and incorporated into the discussion chapter can be used to expand parameters of Indigenous health research. I believe respondents imparted something of tremendous value by showing how they placed faith in their own Indigenous identities. I felt as if I found voluminous examples of their strength. This is what motivates me to help contribute to the endurance and continuation of Indigenous Peoples in learning institutions and at work. Pidamiya, Thank you, Merci.

Lastly, I recommend learning more from the Indigenous work force in every field. Indigenous educators, law enforcement officers, business leaders, youth and family workers and community development administrators to name a few. Together these professional cohorts may provide proscriptive and community aligned solutions to health and social problems found in Indigenous communities across Canada.

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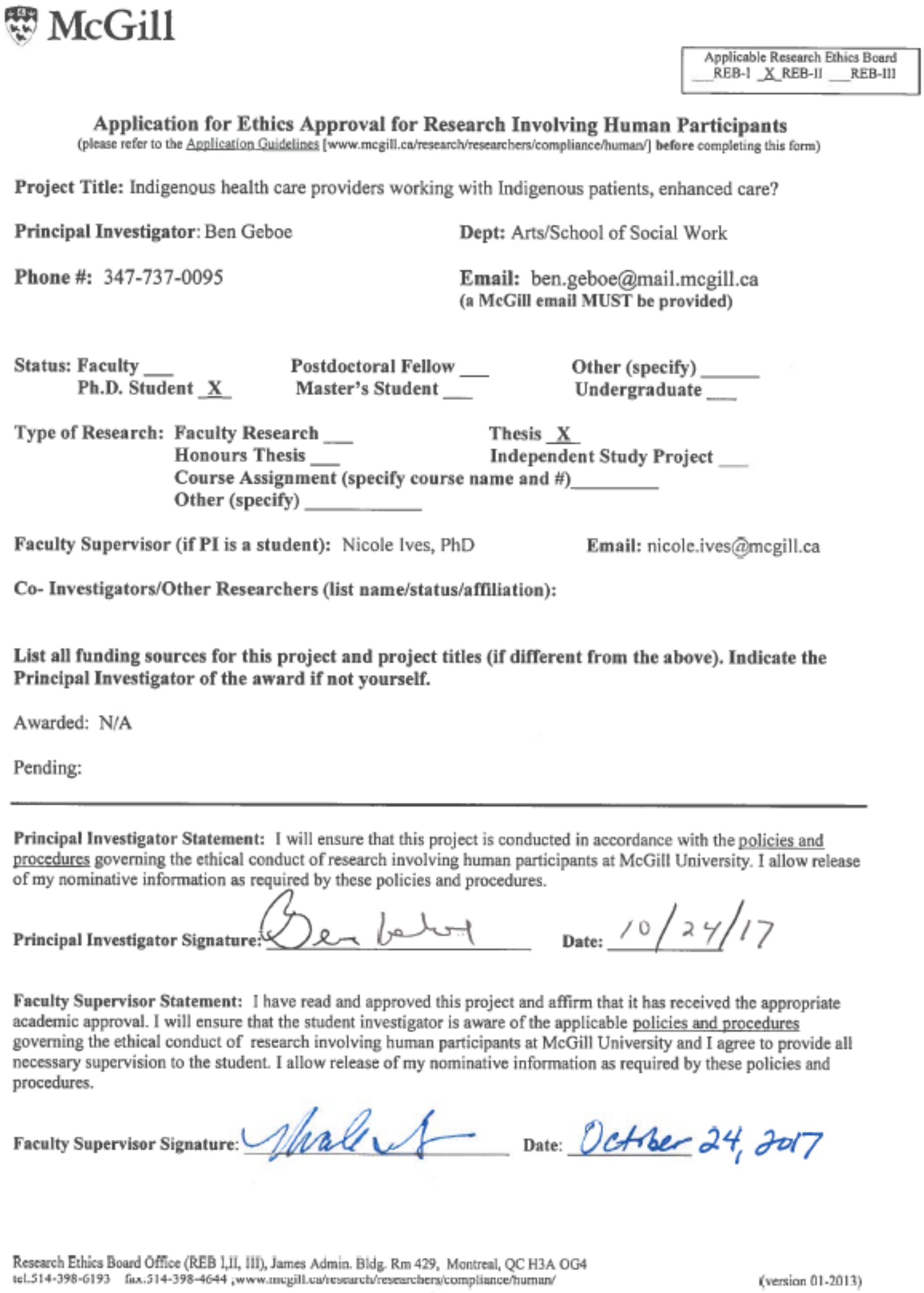
Appendix A: Application for Ethics Approval for Research Involving Human Participants.



McGill

Applicable Research Ethics Board
___REB-I _X_REB-II ___REB-III

Application for Ethics Approval for Research Involving Human Participants
(please refer to the Application Guidelines [www.mcgill.ca/research/researchers/compliance/human/] **before** completing this form)

Project Title: Indigenous health care providers working with Indigenous patients, enhanced care?

Principal Investigator: Ben Geboe **Dept:** Arts/School of Social Work

Phone #: 347-737-0095 **Email:** ben.geboe@mail.mcgill.ca
(a McGill email MUST be provided)

Status: Faculty ___ Postdoctoral Fellow ___ Other (specify) ______
Ph.D. Student _X_ Master's Student ___ Undergraduate ___

Type of Research: Faculty Research ___ Thesis _X_
Honours Thesis ___ Independent Study Project ___
Course Assignment (specify course name and #)_________
Other (specify) ____________

Faculty Supervisor (if PI is a student): Nicole Ives, PhD **Email:** nicole.ives@mcgill.ca

Co- Investigators/Other Researchers (list name/status/affiliation):

List all funding sources for this project and project titles (if different from the above). Indicate the Principal Investigator of the award if not yourself.

Awarded: N/A

Pending:

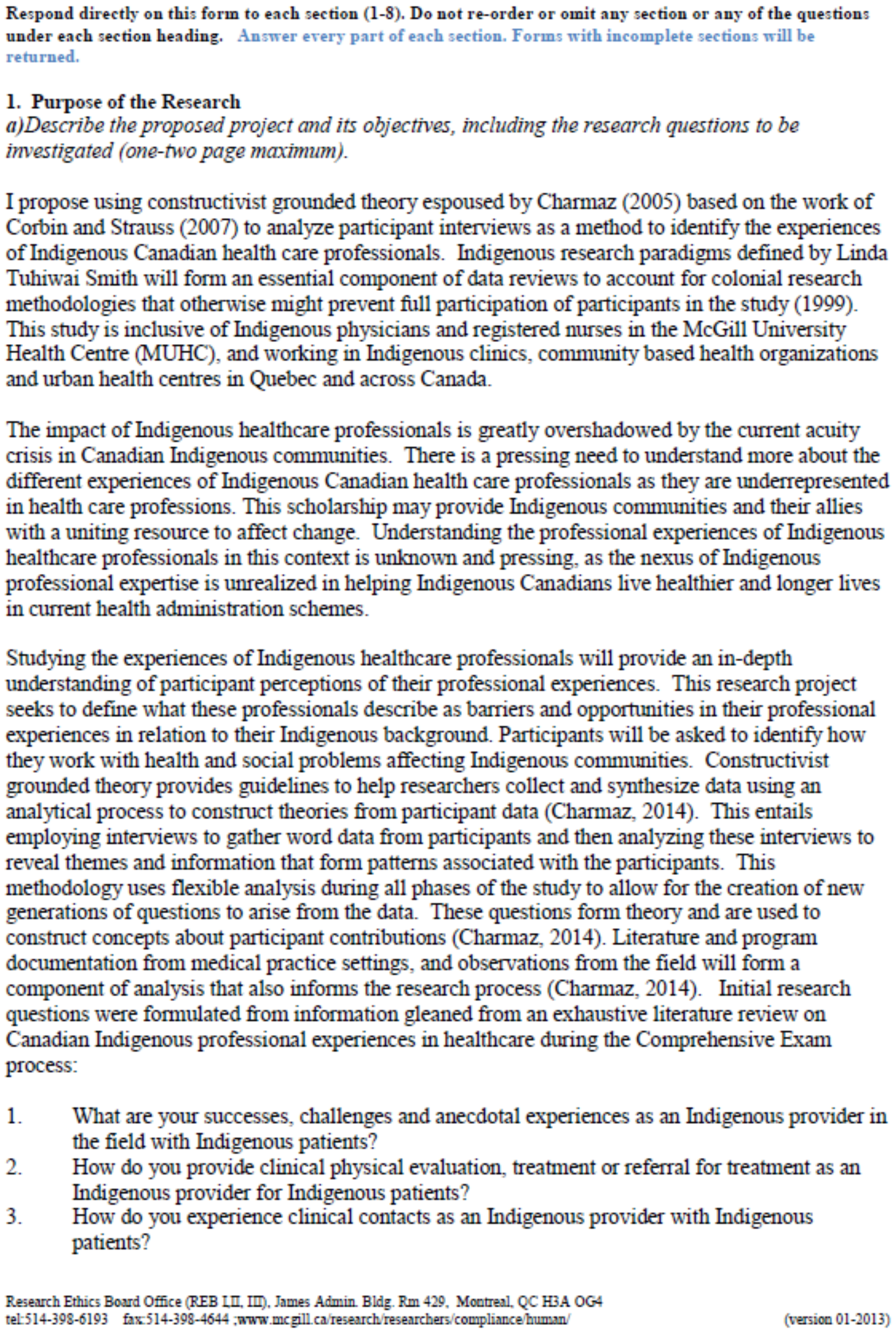
Principal Investigator Statement: I will ensure that this project is conducted in accordance with the policies and procedures governing the ethical conduct of research involving human participants at McGill University. I allow release of my nominative information as required by these policies and procedures.

Principal Investigator Signature: Ben Geboe **Date:** 10/24/17

Faculty Supervisor Statement: I have read and approved this project and affirm that it has received the appropriate academic approval. I will ensure that the student investigator is aware of the applicable policies and procedures governing the ethical conduct of research involving human participants at McGill University and I agree to provide all necessary supervision to the student. I allow release of my nominative information as required by these policies and procedures.

Faculty Supervisor Signature: **Date:** October 24, 2017

Research Ethics Board Office (REB I,II, III), James Admin. Bldg. Rm 429, Montreal, QC H3A 0G4
tel.514-398-6193 fax.514-398-4644 ,www.mcgill.ca/research/researchers/compliance/human/ (version 01-2013)



Respond directly on this form to each section (1-8). Do not re-order or omit any section or any of the questions under each section heading. **Answer every part of each section. Forms with incomplete sections will be returned.**

1. Purpose of the Research

a)Describe the proposed project and its objectives, including the research questions to be investigated (one-two page maximum).

I propose using constructivist grounded theory espoused by Charmaz (2005) based on the work of Corbin and Strauss (2007) to analyze participant interviews as a method to identify the experiences of Indigenous Canadian health care professionals. Indigenous research paradigms defined by Linda Tuhiwai Smith will form an essential component of data reviews to account for colonial research methodologies that otherwise might prevent full participation of participants in the study (1999). This study is inclusive of Indigenous physicians and registered nurses in the McGill University Health Centre (MUHC), and working in Indigenous clinics, community based health organizations and urban health centres in Quebec and across Canada.

The impact of Indigenous healthcare professionals is greatly overshadowed by the current acuity crisis in Canadian Indigenous communities. There is a pressing need to understand more about the different experiences of Indigenous Canadian health care professionals as they are underrepresented in health care professions. This scholarship may provide Indigenous communities and their allies with a uniting resource to affect change. Understanding the professional experiences of Indigenous healthcare professionals in this context is unknown and pressing, as the nexus of Indigenous professional expertise is unrealized in helping Indigenous Canadians live healthier and longer lives in current health administration schemes.

Studying the experiences of Indigenous healthcare professionals will provide an in-depth understanding of participant perceptions of their professional experiences. This research project seeks to define what these professionals describe as barriers and opportunities in their professional experiences in relation to their Indigenous background. Participants will be asked to identify how they work with health and social problems affecting Indigenous communities. Constructivist grounded theory provides guidelines to help researchers collect and synthesize data using an analytical process to construct theories from participant data (Charmaz, 2014). This entails employing interviews to gather word data from participants and then analyzing these interviews to reveal themes and information that form patterns associated with the participants. This methodology uses flexible analysis during all phases of the study to allow for the creation of new generations of questions to arise from the data. These questions form theory and are used to construct concepts about participant contributions (Charmaz, 2014). Literature and program documentation from medical practice settings, and observations from the field will form a component of analysis that also informs the research process (Charmaz, 2014). Initial research questions were formulated from information gleaned from an exhaustive literature review on Canadian Indigenous professional experiences in healthcare during the Comprehensive Exam process:

1. What are your successes, challenges and anecdotal experiences as an Indigenous provider in the field with Indigenous patients?
2. How do you provide clinical physical evaluation, treatment or referral for treatment as an Indigenous provider for Indigenous patients?
3. How do you experience clinical contacts as an Indigenous provider with Indigenous patients?

These questions will evolve as interviews are reviewed, sorted and used to synthesize new questions (Charmaz, 2014, pg. 4). The research method uses comparative coding of data segments during data collection, which may require the researcher to return to participants as subsequent questions are generated to further inform data collection (Charmaz, 2014, pg 4). The researcher will also write memos about the research process and these notes will be compared during the study as the researcher identifies ideas about the data and begins to interpret categories of data (Charmaz, 2014, pg. 4).

Participants will be asked to participate in an audio recorded interview. Voluntary written consent for audio recordings will be asked prior to the interview, and participants who decline the audio recording consent will not be treated any differently than participants who provide consent. Participants who decline the audio recording will have participant data recorded by interviewer note taking using a note pad and a pen. All interviews will be analyzed and formulated in a final report. Participants will be not be associated with specific details in the report.

b) What is the expected value or benefits of the research?

The purpose of this research is to collect and review professional experiences of Canadian Indigenous physicians and nurses working with Indigenous patients to learn more about their experiences. Interviews with healthcare professionals from Indigenous Canadian communities may identify common experiences and highlight issues unique to individuals faced by health care providers from Indigenous communities. This work will contribute to social work scholarship and increase the understanding of professional experiences of Canadian Indigenous healthcare. This study may also help professional schools and organizations understand how to attract and retain Indigenous participants. The resulting work may also increase visibility of Indigenous health care professionals working in the field and may serve as a recruiting tool to attract and retain Indigenous health care students.

c)How do you anticipate disseminating the results (e.g. thesis, presentations, internet, film, publications)?

The finished work will be made available to the public as an academic dissertation. I may also use the information from this study to write scholarly articles about Indigenous professional experiences for academic journals, books or articles for publication.

2. Recruitment of Participants/Location of Research
a)Describe the participant population and the approximate number of participants needed.

Approximately 20-30 Indigenous healthcare professionals will be solicited to participate in the study and a goal of 10-15 participants will be sought. Participants will consist of Indigenous physicians and nurses working in the McGill University Health Centre as well as Indigenous professionals working in Indigenous clinics, community based health organizations and urban health centres across Quebec and other parts of Canada.

b)Describe how and from where they will be recruited. Attach a copy of any advertisement, letter, flier, brochure or oral script to be used to solicit potential participants (including information to be sent to third parties).

Participants will be provided with a letter of invitation (attachment #1) via email (attachment #2) explaining the scope and purpose of the study and the interviews. An informed consent form will also be provided for review (attachment #3). The McGill First Peoples' House will help identify potential participants connected to the McGill University Health Centre (MUHC) and will assist the researcher to contact prospective Indigenous participants (attachment #4). Indigenous clinics, community based health organizations and urban health centres across Quebec and the rest of Canada will be solicited to help identify participants that may be in Montreal for health care conferences, training or educational engagements, or be available for a telephone, skype or teleconference interview.

c)Describe the setting in which the research will take place.

Interviews will take place in person, or on the telephone or by web based conference calling. In person interviews will be conducted in neutral settings (e.g. offices, coffee shop, library, etc.). Settings will be chosen according to participant's preference. Interviews will be in person when possible in the participants private office, the School of Social Work in a private closed office, or in a private library room, or other setting of the participants choice. Telephone interviews and internet conference call interviews may be used to accommodate participants unable to participate in a face to face interview.

d)Describe any compensation subjects may receive for participating.

Participants will not receive monetary compensation for their involvement.

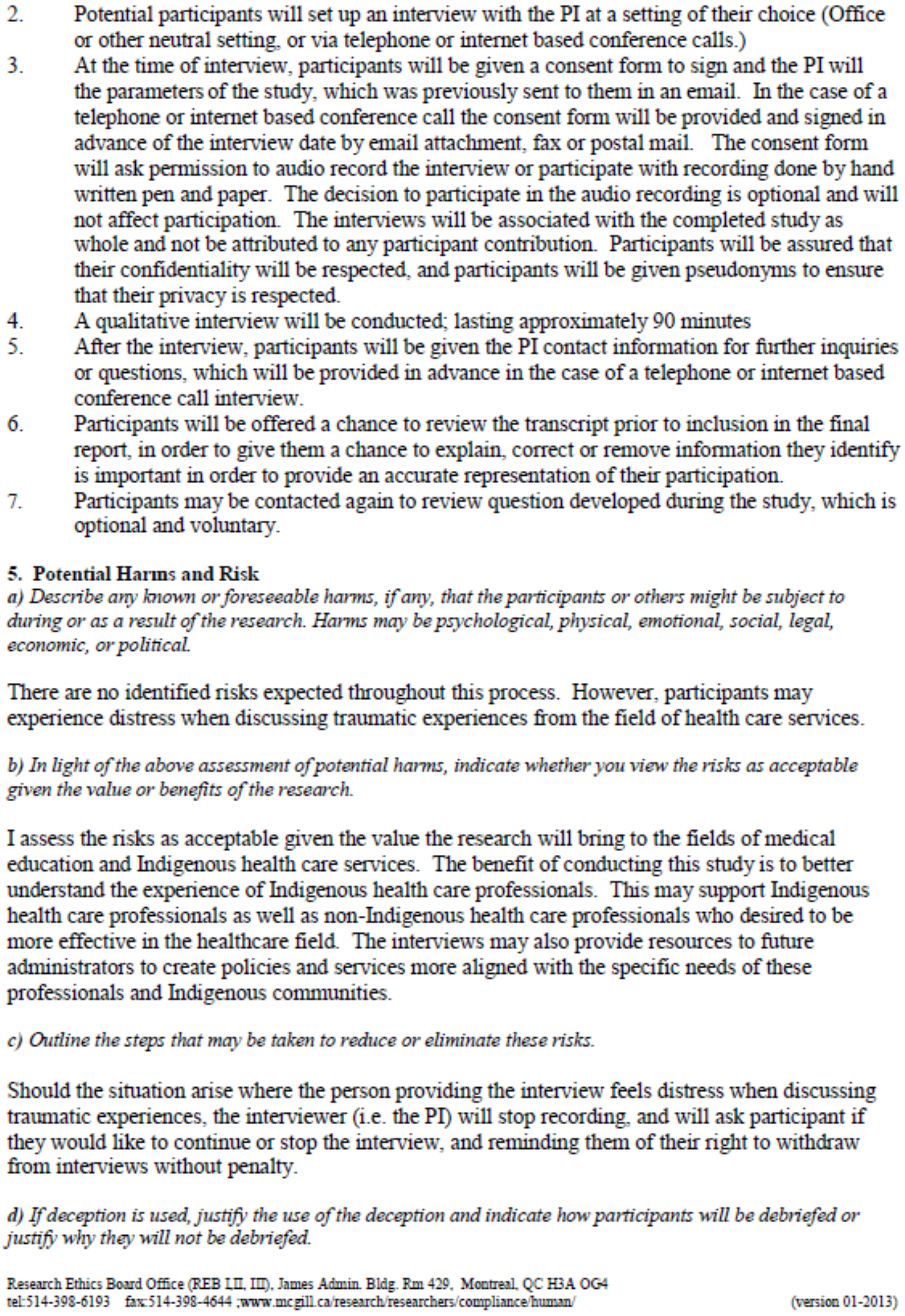
3. Other Approvals
When doing research with various distinct groups of participants (e.g. school children, cultural groups, institutionalized people, other countries), organizational/community/governmental permission is sometimes needed. If applicable, how will this be obtained? Include copies of any documentation to be sent.

No other approval is necessary for this research project. The Canadian Government Ethics Policy for Research Involving the First Nations, Inuit and Metis People of Canada (TCPS 2-Chapter 9) was consulted by the investigator. This project does not require community engagement as described in Article 9.2 of the policy, because the participant's involvement is unlikely to directly affect their own identified communities. Also participants are at liberty to participate in research projects they see as beneficial to themselves or society, and participation is part of the freedom to express individual viewpoints as citizens.

4. Methodology/Procedures
Provide a sequential description of the methods and procedures to be followed to obtain data. Describe all methods that will be used (e.g. fieldwork, surveys, interviews, focus groups, standardized testing, video/audio taping). Attach copies of questionnaires or draft interview guides, as appropriate.

The following is a sequential description of the proceedings for this study:

1. Recruitment letters with attached consent forms will be sent via a formatted email to identified Canadian Indigenous healthcare professionals working at the McGill University Health Centre requesting potential participants to contact the PI indicating their interest. Indigenous clinics, community based health organizations and urban health centres across Canada will be solicited to help identify participants that may be in Montreal for health care conferences, training or educational engagements, or be available for a telephone, skype or teleconference interview. The First Peoples' House will also identify, refer and introduce potential participants, who will receive an email of invitation.



2. Potential participants will set up an interview with the PI at a setting of their choice (Office or other neutral setting, or via telephone or internet based conference calls.)
3. At the time of interview, participants will be given a consent form to sign and the PI will the parameters of the study, which was previously sent to them in an email. In the case of a telephone or internet based conference call the consent form will be provided and signed in advance of the interview date by email attachment, fax or postal mail. The consent form will ask permission to audio record the interview or participate with recording done by hand written pen and paper. The decision to participate in the audio recording is optional and will not affect participation. The interviews will be associated with the completed study as whole and not be attributed to any participant contribution. Participants will be assured that their confidentiality will be respected, and participants will be given pseudonyms to ensure that their privacy is respected.
4. A qualitative interview will be conducted; lasting approximately 90 minutes
5. After the interview, participants will be given the PI contact information for further inquiries or questions, which will be provided in advance in the case of a telephone or internet based conference call interview.
6. Participants will be offered a chance to review the transcript prior to inclusion in the final report, in order to give them a chance to explain, correct or remove information they identify is important in order to provide an accurate representation of their participation.
7. Participants may be contacted again to review question developed during the study, which is optional and voluntary.

5. Potential Harms and Risk

a) Describe any known or foreseeable harms, if any, that the participants or others might be subject to during or as a result of the research. Harms may be psychological, physical, emotional, social, legal, economic, or political.

There are no identified risks expected throughout this process. However, participants may experience distress when discussing traumatic experiences from the field of health care services.

b) In light of the above assessment of potential harms, indicate whether you view the risks as acceptable given the value or benefits of the research.

I assess the risks as acceptable given the value the research will bring to the fields of medical education and Indigenous health care services. The benefit of conducting this study is to better understand the experience of Indigenous health care professionals. This may support Indigenous health care professionals as well as non-Indigenous health care professionals who desired to be more effective in the healthcare field. The interviews may also provide resources to future administrators to create policies and services more aligned with the specific needs of these professionals and Indigenous communities.

c) Outline the steps that may be taken to reduce or eliminate these risks.

Should the situation arise where the person providing the interview feels distress when discussing traumatic experiences, the interviewer (i.e. the PI) will stop recording, and will ask participant if they would like to continue or stop the interview, and reminding them of their right to withdraw from interviews without penalty.

d) If deception is used, justify the use of the deception and indicate how participants will be debriefed or justify why they will not be debriefed.

6. Privacy and Confidentiality

a)Describe the degree to which the anonymity of participants and the confidentiality of data will be assured and the specific methods to be used for this, both during the research and in the release of findings.

Participant names will never be revealed in written or oral presentations and no record will be kept beyond the parameters described below. The findings of this study will be published in thesis format at McGill, and will be made available for future publication in articles, textbooks and research projects. Participants will be assigned an random code that allows for confidentiality, and interview data will be referenced only by random assigned codes.

b)Describe the use of data coding systems and how and where data will be stored. Describe any potential use of the data by others.

Digital audio recordings and all paper and electronic research documentation will only be accessible to Ben Geboe and will be kept by Ben Geboe in the Indigenous Access McGill office in the Social Work office, Wilson Hall room 319, McGill University campus in a locked office and in a locked file cabinet. Electronic information will be kept on a password protected jump drive and a password protected computer in a secure office. There is no unforeseen reason why others need to have access to the data.

c)Who will have access to identifiable data?

Ben Geboe, PhD c. graduate student.

d)What will happen to the identifiable data after the study is finished?

The digital audiotape of the initial and subsequent interviews will be destroyed four months after the transcription of the interviews has been completed, and after participants are given the opportunity to review and revise the transcript. All electronic files of original paper documents will be destroyed after seven years, after they are scanned and stored on a password protected jump drive and stored in a locked file cabinet in a secure office.

e)Indicate if there are any conditions under which privacy or confidentiality cannot be guaranteed (e.g. focus groups), or, if confidentiality is not an issue in this research, explain why.

There is no unforeseen reason why privacy or confidentiality cannot be guaranteed.

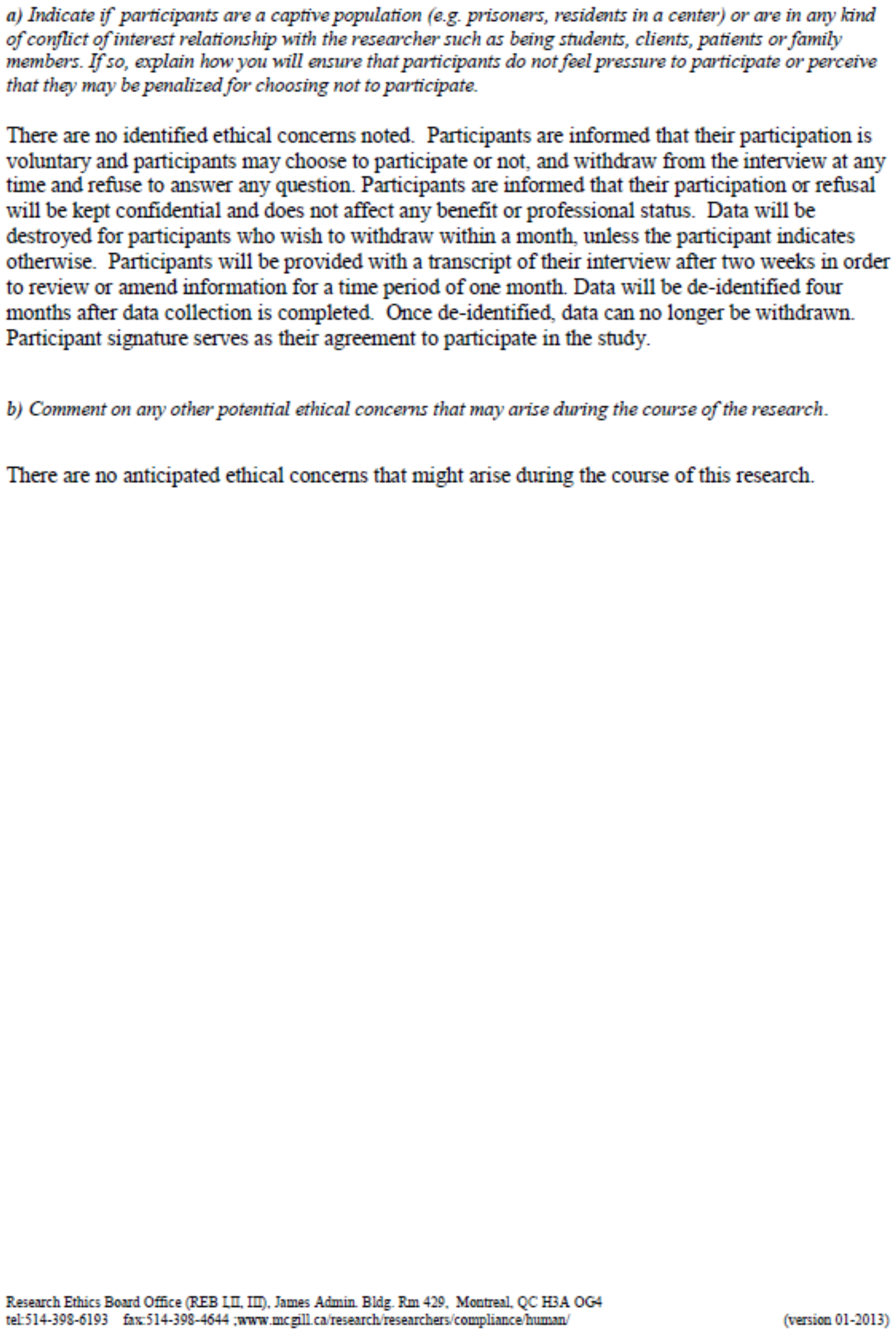
7. Informed Consent Process

a)Describe the oral and/or written procedures that will be followed to obtain informed consent from the participants. Attach all consent documents, including information sheets and scripts for oral consents.

All participants will be provided with an informed consent form (Attachment #3), outlining all parameters of the study and the purpose of the interviews. This information will be reviewed and read at the beginning of the interview in English to ensure that participants understand the objective of the study.

b)If written consent will not be obtained, justification must be provided.

8. Other Concerns



a) Indicate if participants are a captive population (e.g. prisoners, residents in a center) or are in any kind of conflict of interest relationship with the researcher such as being students, clients, patients or family members. If so, explain how you will ensure that participants do not feel pressure to participate or perceive that they may be penalized for choosing not to participate.

There are no identified ethical concerns noted. Participants are informed that their participation is voluntary and participants may choose to participate or not, and withdraw from the interview at any time and refuse to answer any question. Participants are informed that their participation or refusal will be kept confidential and does not affect any benefit or professional status. Data will be destroyed for participants who wish to withdraw within a month, unless the participant indicates otherwise. Participants will be provided with a transcript of their interview after two weeks in order to review or amend information for a time period of one month. Data will be de-identified four months after data collection is completed. Once de-identified, data can no longer be withdrawn. Participant signature serves as their agreement to participate in the study.

b) Comment on any other potential ethical concerns that may arise during the course of the research.

There are no anticipated ethical concerns that might arise during the course of this research.