Queen's University | DEPARTMENT OF FAMILY MEDICINE Global Health Program

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HORIZONS

THIS ISSUE
INDIGENOUS HEALTH

The Invisible Minority

By Thomas Dymond, Queen's Medicine Class of 2020

January 29, 2016, is a day I will never forget. I received an invitation to interview at Queen's School of Medicine as an Indigenous applicant.

I remember first being overwhelmed with joy, after having been rejected from Memorial University. But it didn't take long for thoughts of self-doubt and angst to set in. I thought, "Am I qualified?" I spent the next several months questioning my ability to succeed in the interview and in medicine. Thankfully, I was admitted, but I continued to question my qualifications.

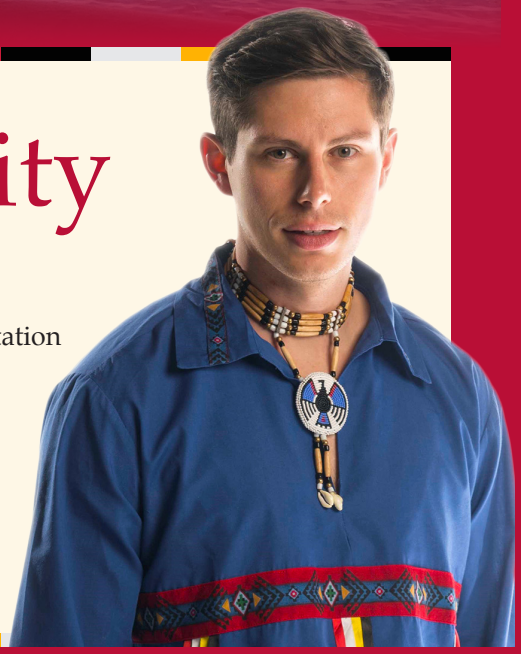

Photo Courtesy Indspire

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Queen's recognizes the critical shortage of Indigenous physicians in Canada and the need to educate more Indigenous physicians to serve as role models and address the health-care needs of Canada's Indigenous people. Using an alternate process for assessment of Indigenous candidates, a maximum of four qualified Indigenous students per year may be admitted to Queen's Undergraduate Medical Program. Candidates may also choose to apply through the regular admission process.

"Qualified Indigenous applicant" is a phrase for which I have sought a definition since first applying to medical school. Apart from having status (either as a First Nations person recognized as an Indian under the Indian Act, a Métis person recognized by a provincial association, or an Inuit person having a beneficiary card) and having met arbitrary admissions standards, the path to landing a medical school interview as an Indigenous applicant is still murky.

Most medical schools in Canada have adapted some form of affirmative action plan to increase the number of Indigenous students in their program. These plans generally include designated seats within the program, recruitment strategies and application assistance. I believe programs like this are imperative to ensuring that Canada's Indigenous population is proportionately represented in medicine.

As a First Nations man who grew up off-reserve, I had minimal exposure to Indigenous culture until my late teens. Back then I felt ashamed for not knowing my culture, not speaking my language and not "looking" Indigenous. But throughout university, I grew to accept myself as an Indigenous person, and people around me knew me as such. I learned to challenge myself and those around me on what it means to be Indigenous – what it looks and sounds like. (Surely people can't expect that our people look the same as we did after hundreds of years of colonization.)

While I learned to embrace my Indigenous identity, I still am not someone who would be regarded as visibly Indigenous.

During one of our first lectures in medicine, I remember being astounded by the diversity in my class. Yet, as I looked around the room, no one could see that I was Mi'kmaq. No one knew I was different – a drummer, a leader, an advocate. One might say I was an invisible minority, someone who could pass as white.

Sadly, I let my own fear of being judged hide my identity as an Indigenous person. I feared persecution from my colleagues. Given the competition for medical education, I did not want to be ostracized for having been admitted under an alternative method. I would be lying if I said I haven't heard the remark "so that's how you got in," from someone who just found out I am Indigenous. That was a teachable moment, though. Being Indigenous is part of my identity; it should not diminish my accomplishments. But I digress.

It is not uncommon for people in medicine to experience impostor syndrome. I experienced this, but to add to the mix, I also felt that I was less qualified than those around me because I was an Indigenous applicant. Again, what did it mean to be qualified, and was I as qualified to be at Queen's as my classmates?

I actually can recall a time early in first semester when I tried to convince one faculty member that I was merely a check in a box on an accreditation form so that Queen's could say it was producing Indigenous physicians. Over the course of first year, my continued success has

enhanced my confidence to know that I am more than a check in a box. I have also come to realize that Queen's is committed to increasing Indigenous enrolment in medicine through initiatives such as peer mentoring and hiring an Indigenous recruiter.

We have covered diversity and culture in our Population and Global Health course, with increasing attention being given to Indigenous health. No doubt, my class could recite the definition of cultural competency and cultural safety, but this learning lacks practical application and minimizes the provision of empathetic care when working with Indigenous patients.

As future medical professionals, we will be in a privileged role. As an Indigenous person in medicine, I feel tremendously fortunate to bring an Indigenous perspective to medicine that I can share with my colleagues. Since being open about my Indigenous identity in medicine, I have shared invaluable knowledge about my drum and the sacred medicines I use to smudge – knowledge my colleagues likely would not have acquired anywhere else. This leads me to two points:

- Lecture-based knowledge does not necessarily translate into practical knowledge about Indigenous people. If we want to truly educate students about Indigenous people, their traditions, customs and health, students need to be immersed. I believe the foundation to understanding more about Indigenous people is through interactive learning, such as spending time in or with a community.
- Having a diverse class, including Indigenous students, can stimulate conversations and further people's knowledge and understanding of Indigenous people. Continued support should be given to recruiting and mentoring Indigenous students in medicine, with the goal of building an Indigenous community as part of the faculty.

Despite my openness in stimulating conversations around Indigenous people, I do not want to discount the value of Indigenous students in medicine who choose not to self-identify in class. The presence of Indigenous people, visible or not, is still working toward increasing the number of Indigenous physicians in Canada, and the larger the presence, the more likely people will be open about their own Indigeneity. Being Indigenous does not envelop our entire identity. However, it will ideally enhance our colleagues' ability to relate to future patients, their families and their lives.

In closing, I would like to say M'sit Nogama, which means all my relations in Mi'kmaq. This means that we are all related or interconnected with each other.

Thomas Dymond won the award in the Youth – First Nation category in this year's Indspire Awards, which celebrate the significant contributions of Indigenous peoples in Canada. Read more about Thomas and this prestigious award here.

In July, Thomas travelled to Iqaluit as one of 30 youth ambassadors of Canada C3, a signature project of Canada's 150th anniversary of Confederation. The centrepiece is a 15-leg, 150-day sailing journey from June 1 to October 28 from Toronto to Victoria via the Northwest Passage. Thomas's journey began in Nain, Nunatsiavut, on July 21 and ended in Iqaluit, Nunavut, on July 29. A cross-section of close to 350 Canadians was selected to participate in the voyage from among more than 5,000 applicants. Canada C3 is exploring the four key themes of Canada 150: Diversity and Inclusion, Reconciliation, Youth Engagement and the Environment. (Photo on previous page: Thomas's journey included a trip to Saglek Fjord in Nunatsiavut (Torngat Mountains National Park, at the northern tip of Newfoundland and Labrador).

KCHC Indigenous Health Program, Council, a Community Endeavour

Kingston Community Health Centres (KCHC) – a multi-service, multi-site community health centre – is a non-Indigenous health organization that has been providing services to Indigenous clients for more than six years in its Deseronto, Napanee and Kingston sites.

A series of Indigenous community-driven visioning circles in 2011 resulted in the formation of the Indigenous Health Council (IHC), along with an understanding that access to Indigenous Traditional approaches to health and well-being should be a cornerstone to serving the Indigenous community. The KCHC leadership team has supported this vision and directions in numerous and substantive ways, including creating Indigenous spaces in the design of two new builds, the Street Health Centre in Kingston and the Napanee Area Community Health Centre.

The IHC comprises community members who volunteer to provide leadership and cultural governance so that the Indigenous Health Program (IHP) is grounded in the community; conduct business and decision-making using Indigenous protocols; and engage with KCHC as a governance body, rather than an advisory committee.

Indigenous Health Council members understand the need to address the harm resulting from the ongoing impacts of colonization, including loss of identity, cultural affiliation and family. The IHP is designed to address these harms, with a key understanding that when people are treated like family, they respond in a more positive way, feel included, and start to trust and embrace their own wellness in a more holistic way.

To this end, an Indigenous community-development worker carries out intensive work to promote cultural

awareness and safety, and to be that "safe and welcoming person" to Indigenous and non-Indigenous people. A Traditional Medicine Person provides teaching, counselling, ceremony and medicines to individuals and families, as well as outreach to grassroots and street-involved people. An Indigenous nurse practitioner provides culturally safe primary care.

Program activities include traditional doctoring the Indigenous Medicine Person provides, drum circles, community kitchens, teaching circles related to plant medicines, and on-the-land traditional activities such as medicine walks, deer hide tanning and drum making. A culturally safe blood pressure screening clinic presented at many conferences, such as the Canadian Stroke Congress in Montreal in 2016, is an example of a harmonized approach to health from an Indigenous and Western perspective.

The IHP also integrates a trauma-informed and harm-reduction approach, and enables access to Indigenous healing practices the Indigenous Medicine Person facilitates at the Street Health Centre weekly for community members who live with substance use issues.

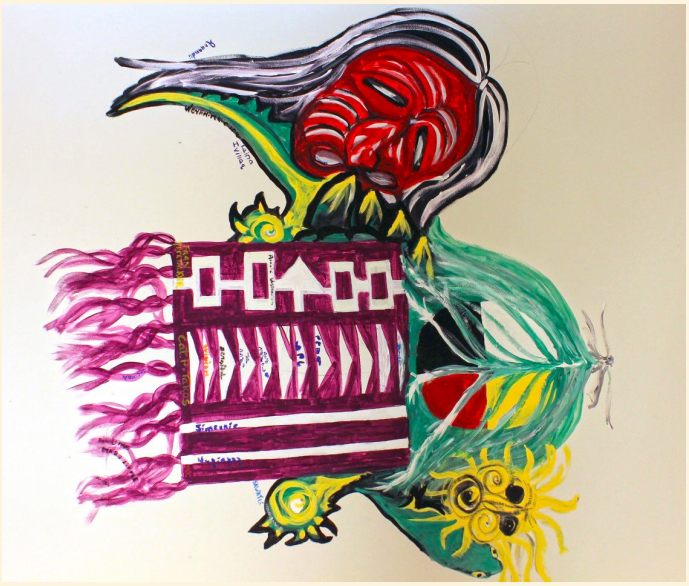
The KCHC financially supports the IHP, which arose from the ashes without stable funding. Of the program's three positions – Indigenous Nurse Practitioner, Indigenous Medicine Person/Knowledge Keeper and Indigenous Community-Development Worker – only one has stable funding. A major goal is to create sustainability, and the Indigenous Health Council and Indigenous Health Program strive to braid the Indigenous model of health with the Western medicine model through this understanding.

One of the program's main teachings is the four quadrants of the Medicine Wheel: emotional, mental, physical and spiritual. As Indigenous people come to this understanding, their well-being will come into balance with the knowing that this is always a lifetime endeavour.

The Cedar Lodge at the new Napanee Area Community Health Centre has become an important gathering place for both the Indigenous and non-Indigenous community. To highlight an activity such as a drum circle, held monthly, participants join the circle with their own drum and share their drum story with others. The circle now includes a Haudenosaunee water drum, an Anishnaabe hand drum, a Celtic hand drum and a Netherlands hand drum. The circle's primary purpose is to provide an opportunity for Elder/Knowledge Keeper David Jock to offer teachings to reconnect Indigenous people, and to share these teachings with non-Indigenous people.

Even in these reconciliation times, the Indigenous Health Council and Kingston Community Health Centres advocate for sustainable funding for Indigenous health. Short-term funding for short-lived programs perpetuates distrust in the community. If reconciliation is to be achieved, a long-term commitment is essential.

For more information, contact the Indigenous Health Program at 613-354-8937, Ext. 7163, to leave a message.



Previous page and top photo, above: Murals on display at Kingston's Street Health Centre

Middle photo: Medicine Wheel painting at the Napanee Area CHC

Bottom photo: A display inside Cedar Lodge, Napanee Area CHC

Photos Courtesy Kingston Community Health Centres

PROFILE

Photo: Lesley Bovie, Lakeridge Health

Kathy MacLeod-Beaver

Aboriginal Navigator
Central East Regional Cancer Program

By Dr. Michelle Fraser

The Queen's Department of Family Medicine's Peterborough-Kawartha site is in the city of Peterborough, also known as Nogojiwanong, The Place at the End of the Rapids. Our residents, preceptors and patients live on the land of the Michi Saagiig Anishinaabe (Ojibway) and Haudenosaunee (Mohawk) peoples. According to Michi Saagiig Nishnaabeg scholar, writer and artist Leanne Simpson, the area surrounding Nogojiwanong was teeming with life prior to colonization. Atlantic salmon migrated up the lakes and rivers each spring to spawn, the waters were covered with life-giving Manoomin (wild rice), hectares of maple trees provided sap and sugar, and a great forest stretched north from Lake Ontario.

In order to grant land to European settlers arriving in the 1800s, the colonial government forcibly removed the Indigenous people who had been thriving on the land for generations. They were relocated to small reserves now known as Curve Lake First Nation, Hiawatha First Nation, Alderville First Nation and Scugog Island First Nation. Even now, nearly 200 years after the theft of their land and their forced segregation from colonial society, Nishnaabeg communities continue to work for the good of their members and to create innovative ways to heal and to move forward.

In honour of the resilience of the original people of this land, I met with Kathy MacLeod-Beaver to learn about her work as Aboriginal Navigator, Central East Regional Cancer Program. Kathy's work accompanying Indigenous people on their cancer journeys is founded in a deep love for her people and her culture, which shone throughout our conversation.

I will let Kathy tell her own story.

Boozhoo! Semaakwe ndishnikaas. Mkwa dodem, Alderville First Nation ndoonjibaa. My spirit name is "Tobacco" Woman and I am from the Bear Clan. I am from Alderville First Nation. My husband's name is Ken, my daughters' names are Sarah and Mary, my son-in-law is Jeremy, and my granddaughters are Holly and Faye.

I grew up and live in my community at Alderville First Nation. Many people think that if they had grown up in their own First Nation they would have had access to their language and to the teachings of their culture. However, the disruption in our history caused by assimilation policies meant that even those of us living in our First Nation didn't grow up with cultural practices like ceremonies and knowledge of traditional medicine and language.

Despite this, I knew my First Nation had a beautiful history and one that had originally been tied to our culture. I knew the key to getting back to nminobimaadiziiwin – "the good life" – was connecting to my culture. My culture comes from the Creator.

Prior to the trauma of the residential school legacy, we had our own language and we were a healthy, thriving Nation. In residential school, children were only permitted to speak English and were punished if they spoke in the language. My grandmother would tell me that when she was younger, her parents spoke in the language but would stop once she walked into the room. She started learning the language in her mid 70s when Melody Crowe started teaching it in our community. Merritt Taylor, Elder from Curve Lake, told me that our language is the sacred sound given to us by the Creator. I took language lessons and learned our language through songs I learned at ceremonies (Sharing Circle, Full Moon and Sweatlodge).

In my journey, the connection to the land was the biggest thing. We have ceremonies and teachings about the importance of the land to us. The water is one of the sacred gifts bestowed upon us. Women in our culture are the life-givers; they carry the sacred water. We know that the water is the lifeblood of our mother, the Earth. It's our responsibility as women to look after and pray for the water. Learning that teaching made me feel special; it made me feel good about myself. This experience taught me that part of my work in my community was to create opportunities for other people to learn our culture.

In my role, I have had the pleasure of working with Dr. Jason Pennington, Regional Aboriginal Cancer Lead for the Central East Regional Cancer Program. Together, we have been providing information sessions to the Peterborough and Oshawa Queen's residency program these last two years. Our presentation is centred on providing information on Indigenous Ways of Knowing and approaches to health in cancer care. We speak of the history of Indigenous peoples in Canada, social determinants of health, and the impact assimilation policies have had on our health. Understanding past history and current status is vital for setting the stage for a mutual relationship.

In her work as Aboriginal navigator, Kathy goes about the daily, concrete tasks of reconciliation. She says that "relationships between settlers and Indigenous people in the past have not been positive. We're at a time now where we're trying to work together."

The theme of relationships emerged over and over again in our conversation as a key component in the effective and culturally safe provision of health care to Indigenous patients. Without the trust that is built through relationships, Indigenous patients continue to feel outside of the medical system and distrustful that it is working on their behalf.

Relationships are so important that they were the first thing Kathy started cultivating when she assumed her role as Aboriginal navigator. She believes in connecting with her clients in person, one-to-one in their home communities and at their medical appointments. She builds face-to-face relationships with other service providers so she can provide personal introductions when her clients need their services.

Kathy is encouraged to see this same ethic at work in her colleagues.

"When Dr. Jason Pennington took on the role as Aboriginal lead, the first thing he did was go out to communities and meet with their members. He and I meet with community leadership regularly. We sit with First Nation, Inuit and Métis Advisory Circles to make sure that we're moving forward in a good way – we want the direction to come from the communities."

Dr. Michelle Fraser is a family medicine preceptor in Peterborough and the Queen's Department of Family Medicine's global health lead for the Peterborough-Kawartha site.

Kathy's Recommended Resources

Cancer Care Ontario: Tools for the Journey: Palliative Care in First Nations, Inuit and Métis Communities – A Resource Toolkit

Cancer Care Ontario: Aboriginal Relationship and Cultural Competency Courses

Canadian Virtual Hospice: Living My Culture

Queen's TRC Report Brings Communities Together

At an event to unveil the Queen's TRC Commission Task Force Final Report, community members gathered for a ceremonial dance

By Wanda Praamsma
Senior Communications Officer
Queen's University

At a special reception in March this year to mark the unveiling of the Queen's Truth and Reconciliation (TRC) Commission Task Force Final Report and recommendations, Principal Daniel Woolf told the crowd of students, staff, faculty, alumni and local Indigenous community members that, "Today, our communities come together to change course.

"By taking steps to ensure that Indigenous histories are shared, by recognizing that we can all benefit from Indigenous knowledge, and by creating culturally validating learning environments, we can begin to reduce barriers to education and create a more welcoming, inclusive and diverse university," Principal Woolf said.

The reception, held at the Agnes Etherington Art Centre, and the TRC report represent a significant milestone for Queen's and the local Indigenous communities, signalling a broad and sustained effort to build and improve relations, and to affect meaningful institutional change. The report's recommendations span everything from hiring practices and programming to research, community outreach and the creation of Indigenous cultural spaces on campus.

In reiterating his commitment to fulfilling the task force's recommendations, Principal Woolf announced that the university would be creating an Office of Indigenous Initiatives.

"This is just one of the task force's many recommendations that I am committed to implementing across campus, and because I believe that we are stronger together, I welcome the rest of the Queen's community to join me in that commitment," he said.

Principal Woolf also stated his commitment to the TRC recommendations in a special Senate meeting in March, where he recognized Queen's 175th anniversary as well as the university's history "as an institution that participated in a colonial tradition that caused great harm to Indigenous People."

We are Making History

Queen's Truth and Reconciliation Task Force co-chairs Drs. Mark Green and Jill Scott hosted the final report's unveiling reception, which brought together Indigenous and non-Indigenous community members. The event

showcased the importance of ceremony – with a traditional Mohawk opening presented by lecturer Nathan Thanyehténhas Brinklow, presentations by Elder Marlene Brant Castellano and student Lauren Winkler, and an Anishinaabe Honour Song performed by the Four Directions Women Singers. To close out the ceremony, a Haudenosaunee Round Dance, led by performers from Tyendinaga Mohawk Territory, brought guests together, hands linked, in a huge circle.

"Ceremony reminds us that what we do today is important, impacting the relationships and responsibilities that we carry forward, and woven into our memory as a community," said Dr. Brant Castellano, a task force member, Queen's alumna, and pioneer and champion of Indigenous rights and education.

"We are making history," Dr. Castellano continued. "In creating the task force, Queen's has stepped up to ask of itself: What can we do to advance reconciliation? … The task force has brought together voices from the Queen's community, saying: We can do this. We have a responsibility to do this. The report is presented to the principal, who speaks on behalf of the university. In this ceremony, all who are present become witnesses to Queen's acknowledgement of past errors and commitment to walk together with Indigenous Peoples and others of good mind to restore and maintain a relationship of peace, friendship and respect."

"Our education system has failed and is failing to educate our students at the cost of Indigenous students. The university recognizes this – it's one of the truths in our truth and reconciliation process."

Lauren Winkler, student and president of the Queen's Native Student Association, as well as deputy commissioner of Indigenous affairs for the Alma Mater Society and member of the TRC Task Force, spoke about the experiences of Indigenous students and the challenges and racist encounters they face on Queen's campus.

"Our education system has failed and is failing to educate our students at the cost of Indigenous students. The university recognizes this – it's one of the truths in our truth and reconciliation process," said Winkler, who then thanked Principal Woolf for his acknowledgements of the history of mistreatment of the Indigenous community and Queen's role in perpetuating the mistreatment.

Queen's Native Student Association President Lauren Winkler, left, and Marlene Brant Castellano, Co-Chair of the Aboriginal Council at Queen's

"I would like to thank you all here today because by being here, you are showing me that you acknowledge the truths of our past, that you stand in support of these recommendations, and that you will make a commitment to seeing the recommendations through," said Winkler.

The TRC Task Force's final report, which includes reproductions of artwork in the Indigenous art collection at the Agnes, outlines recommendations and timelines for implementation – in particular, the formation of an implementation team that will work with faculties, schools and shared service units to expedite recommendations. The task force asks for five-year plans from the faculties, schools and other units to be completed by fall 2017.

Queen's formed the task force in April 2016 to begin the work of responding to Truth and Reconciliation Commission of Canada's final report on the history and legacy of Canada's residential school system for Aboriginal children. Composed of Indigenous and non-Indigenous faculty, staff, students, senior administrators and community members, the task force considered how to meaningfully respond to the TRC's calls to action.

In addition, the task force explored how the university can play an active role in addressing the report's broader themes, including relationship-building, changing perspectives and policy, and promoting an awareness of the rights, histories and contemporary issues of Indigenous Peoples.

The final report is titled in three languages: Yakwanastahentéha (Mohawk), Aankenjigemi (Ojibway) and Extending the Rafters (English).

Read more about the report here.

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Photos of reception to unveil the Queen's TRC Commission Task Force Final Report: Garrett Elliott

Janice Hill, Director of Four Directions Aboriginal Student Centre, chats with lecturer Nathan Brinklow during the Queen's reception

Queen's TRC Recommendations

In the final report, and in addition to the creation of the Office of Indigenous Initiatives, the task force calls for, among other things:

- continued efforts to develop and strengthen relationships with Indigenous communities in the Kingston region;
- proactive efforts to ensure that selection and nomination processes of candidates for senior administration positions and governance bodies do not unintentionally limit Indigenous candidates from consideration;
- the expansion of advancement strategies to increase philanthropic funding for Indigenous initiatives, as well as the development of partnerships to proactively advocate and engage with government for system-wide programs and policies that support Indigenous students;
- the creation of culturally validating spaces by incorporating Indigenous art and languages into public spaces and signage, planting traditional Indigenous plants to honour the traditional territory of the Haudenosaunee and Anishinaabe Peoples, and the creation of Indigenous spaces for ceremonies and events;
- the creation of new bridging and pathway programs to increase access to post-secondary education for Indigenous youth, as well as expanded recruitment and outreach initiatives into Indigenous communities. Faculties are to ensure an Aboriginal admission policy is developed to improve access in all undergraduate, graduate and postgraduate programs;
- an increased number of Indigenous staff and faculty, as well as exploration of ways in which to recognize traditional knowledge as a valid means of scholarly achievement in hiring practices;
- an increased awareness of Indigenous-focused research occurring on campus and assurance that necessary supports are in place to allow research in these fields to flourish;
- inclusion of significant and meaningful Indigenous content in every program offered at Queen's, ensuring graduating students gain a basic understanding of Indigenous knowledge systems relevant to their discipline;
- the assurance that all students receive appropriate cultural awareness training to understand the complex histories and modern realities Indigenous Peoples face. (Additional training and resources for faculty members are required to ensure instructors are comfortable promoting dialogue between Indigenous and non-Indigenous students on Indigenous issues.)

The incorporation of Indigenous ceremonies and practices into university events will also serve to foster a sense of inclusion for Indigenous students and increase awareness of Indigenous practices among non-Indigenous students, staff and faculty.

OPINION

Improving Indigenous Health: From Truth to Reconciliation

By Dr. Jason J. Pennington

When it comes to the health status of Indigenous Peoples in Canada, the statistics are undeniably abysmal. News reports on topics including decreased life expectancy, increased diabetes, depression and suicide evoke a wealth of emotions including sadness, horror and outrage.

Substance abuse, poverty, food insecurity, lack of potable water and deplorable, overcrowded living conditions are but a few of the social determinants impacting your Indigenous patients. You likely muse, "I want to help, but it seems so overwhelming. What can one physician do?" Let us start from the beginning.

By all accounts, the health status of the millions of people inhabiting Turtle Island (North America) at the time of "Discovery" was excellent. The Indigenous Peoples were inviting and generous, providing food, shelter and medicine to help the newcomers through their first winters. Initial treaties, like the Two Row & Dish with One Spoon Wampum Belts, talked of sharing resources peaceably and sustainably in friendship. If, and when, disagreements arose, the parties could come together to negotiate a mutually acceptable resolution. This sounds like a very firm foundation on which to start an equitable, mutually beneficial relationship.

Over time, without a war and, often, without the ceding of territory, the equality of these agreements slowly eroded. Paternalism, as much a part of medicine as any other aspect of Western society, became the prime way of dealing with the "Indian problem" in fledgling Canada. The Indian Act, residential schools and the Sixties Scoop all attest to that mission. These, among other acts and programs, were assimilatory in nature, aimed at "removing the Indian from the child" by disallowing and demonizing Indigenous language, culture, medicine and ceremony. These processes, which can be given many different names, have led to the personal and intergenerational trauma that underlies all of the other social determinants of Aboriginal health and the current health inequities that exist. That is the Truth.

The first step in Reconciliation is to face the Truth. That goes for all of us – non-Indigenous, Indigenous and mixed individuals alike. Every person, family and community in Canada has been, and continues to be, impacted by this history. That is why one of the "calls to action" of the Truth and Reconciliation Commission (TRC) was to recommend that this history be included in the curriculum of every medical school. Physicians with this knowledge may better recognize how it may affect the health of Indigenous patients and complicate therapeutic encounters. This history impacts both the patient and the provider.

Only upon acknowledging the Truth, and becoming conscious of its impact, can we begin Reconciliation. For health-care professionals, the TRC calls upon us to get cultural safety training. Cultural safety is an Indigenous concept, first published by a Maori nurse who demonstrated culture to be an independent risk factor in health outcomes. I like to acknowledge the origin because it demonstrates that Indigenous Peoples, including traditional healers and knowledge holders, can contribute to the health care of all.

Culturally safe practices are not only applicable to Indigenous patients; they can be used with any number of factors that may be different from your own. These include, but are not limited to: race, religion, orientation, ability and socio-economic status. Becoming culturally safe is an ongoing process by which the health-care practitioner uses self-reflection to mediate the impact of their biases on a clinical encounter.

There are a number of cultural safety workshops and online courses available, including Cancer Care Ontario's free, Mainpro-accredited Aboriginal Relationship and Cultural Competency Course.

Another valuable resource is San'yas Indigenous Cultural Safety Training.

I have participated in several workshops and courses, and continue to learn something new with each experience. Taking a course or workshop does not make one culturally safe. Having Indigenous leads, navigators or an assigned office does not make an institution culturally safe. However, if implemented with self-reflection and without paternalism, they are a good start.

If these things are done in a "good" way, then we are actually recognizing and honouring the spirit of the original Wampum Treaties. This will help heal and build relationships, both therapeutically and more broadly. For good relationships are essential to help us along the difficult path to Reconciliation and wellness.

Please join me. You may arrive at the Truth alone, but Reconciliation requires us to walk together.

All My Relations,

Jason J. Pennington, MD, MSc, FRCSC
Regional Aboriginal Cancer Lead
Central East Regional Cancer Program
Member of the Huron-Wendat First Nation

Eight Weeks in Moose Factory

A Little Island with a Lot of History

Dr. Shruti Sebastian, left, and Dr. Christina Klassen felt privileged to be part of the community of Moose Factory during their residency rotation

By Dr. Shruti Sebastian and Dr. Christina Klassen

The opportunity to rotate through Moose Factory is one of many attractions of the Queen's Family Medicine postgraduate education program. It is a unique privilege to live and learn full-scope rural medicine, and explore the challenges and rewards of serving our remote First Nations communities.

Working as residents in Moose Factory allowed us to fully delve into the breadth of family medicine and apply our knowledge and skills as we learned to care for patients in every aspect of health and illness. This remote setting provides the unique challenge of balancing finite resources, navigating systemic barriers such as transportation from remote communities, and learning to provide culturally sensitive care to people with a different understanding of health and the human body.

As an outsider looking in, Moose Factory can seem like a desolate place, with harshly cold winters and scattered abandoned buildings. But as you get to know the people, and understand the history of this land, you begin to see the stories behind every place.

Moose Factory is a place of resilience with a rich history of culture; a deeply rooted feeling of community; and a sense of wonder with an ever-changing landscape of wildlife, forest and rivers.

As visiting residents, we were quickly welcomed into the community. We had the opportunity to join in many community celebrations and attend several unique cultural experiences. Among them was a Segabon – a celebration of the hunting season in which we enjoyed roasted duck cooked over the fire; delicious moose meat stew; and bannock, a traditional bread and historical staple of the Cree diet.

Among the many memorable highlights of our rotation in Moose Factory were coastal visits to Peawanuck and Fort Albany. These communities are isolated, remote regions scattered along the Western James Bay coast. They are largely inaccessible without an airplane or the ice road, and uniquely different from the community in Moose Factory. Located almost at the tip of Northern Ontario, Peawanuck is the smallest of the coastal communities.

In many ways, the remote location has worked in this community's favour, as it has allowed its residents to preserve many of their cultural practices and largely live off the land, as their community has done for generations. The lovely Thelma Bird was kind enough to share with us her shop – full of fox, beaver and even polar bear pelts – and teach us a little bit about trapping foxes and the leather-making process.

In Fort Albany, we learned first-hand of the longstanding shadow of the notorious St. Anne's Residential School and the horrors of its electric chair. Despite this tragic history, the community has proved its resilience as its members continue to heal together slowly.

The Cree people are rich in culture and tradition, and always willing to share their story if you take the time to listen.

We were lucky to learn some of the history directly from Dr. Judy Gillies and her family. Judy is a former nurse in the community whose husband grew up in the Fort Albany First Nation. She later retrained as a family doctor, and now returns to run the coastal clinic when able.

Whether in Moose Factory, Fort Albany, Attawapiskat or Peawanuck, the wounds of history run deep. Still, the Cree people remain hopeful for a brighter future. Rich in culture and tradition, they are always willing to share their story if you take the time to listen.

In eight weeks that flew by far too fast, we learned that medicine – whether in Kingston or Moose Factory – is much the same (albeit with later presentations, and the added challenge of navigating weather and transport). But to be patient-centred, to form an alliance, requires only your time and an open mind.

We encourage residents with rotations in Moose Factory to take the time to learn the history before you go and, without stereotype or judgment, understand the limited resources and the systemic inequality that underpin the patients' wariness of you, your privilege and your transience.

It is only with time and consistency that relationships can be formed and maintained, but with a dedicated, supportive group of colleagues who become friends and, occasionally, patients who drop in on you like family, even in eight weeks, we felt privileged to be part of this remote community.

PROFILE

Dr. Colleen Davison

Assistant Professor
Department of Public Health Sciences
Queen's University

Photo: Catherine Davison

Dr. Colleen Davison during field work in Arviat, Nunavut, 2016.

International Initiative to Promote Deliberative Dialogue on Wellness

With the occasion of Canada's 150th anniversary of Confederation, and the Truth and Reconciliation Commission summary events of the past two years, all Canadians are being called to reflect on our shared history.

Dr. Colleen Davison, Assistant Professor in the Department of Public Health Sciences, has been doing health and educational research with northern Indigenous communities for the past two decades. She emphasizes the need to recognize the implications of our colonial history, and the obligation and opportunity that remain.

Since her time as a school teacher on South Hampton Island, Nunavut, and PhD researcher in Behchoko, NWT, she has looked for ways to build on local strengths to tackle the structural inequities that are realities in many communities. She uses her research to highlight injustices that remain in Canada and globally, particularly those affecting First Peoples and those who live in remote areas.

In our wealthy and vibrant nation, we continue to have families without potable running water, adequate housing and affordable food. Rates of violence, injury and suicide in some northern communities are the highest in the world. Finding ways to act to catalyze improvements to these kinds of complex injustices has been the focus of Dr. Davison's work.

Over the next two years, Dr. Davison will be working with partners at the Hamlet of Arviat (in Arviat, Nunavut), and colleagues at Queen's University and B.C.'s Interior Health to undertake a research and capacity-development initiative focused on the conduct of community dialogues about wellness. The team has been successful in receiving a catalyst grant from the Canadian Institutes for Health Research (CIHR) to undertake the project. The group will work with local trainees in Arviat to learn deliberative dialogue and arts-based discussion facilitation.

"These dialogue techniques have real promise for helping us respectfully engage in difficult health and wellness discussions," Davison says. "They are a part of a whole suite of decolonizing methods that can be powerful community-based research and development tools."

Deliberative dialogue is a method for bringing people together to explore topics with an eye to the future. Dialogues are guided by existing knowledge and what we know about something that is important to a community. Artistic creation and expression is one way to elicit and deepen communication in deliberative dialogue.

As part of this new CIHR project, local trainees will learn these discussion techniques and be able to practise them in three community discussions over the next 18 months. In this process, community members will have an opportunity to reflect on their own wellness journeys, and the Hamlet of Arviat will be able to explore its role in supporting wellness in its community programming.

Dr. Davison is happy to be working with the team to undertake this important project. The aim is for the work to help inform future programming, and provide opportunities for reflection and sharing about wellness. Dialogue facilitation skills will be built as part of the project, and it is hoped this work will catalyze further wellness research and effective interventions in Arviat and beyond.