



# The tools at their fingertips: How settler colonial geographies shape medical educators' strategies for grappling with Anti-Indigenous racism

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## ABSTRACT

Settler colonialism implicates settler and Indigenous populations differently within ongoing projects of settlement and nation building. The uneven distribution of benefits and harms is a primary consequence of settler colonialism. Indeed, it is a central organizing feature of the settler state's governance of Indigenous societies and is animated, in part, through pervasive settler ignorance and anti-Indigenous racism, which has manifested in persistent health disparities amongst Indigenous peoples. This broader socio-political context surrounding medical schools, which are seeking to develop teaching and learning about Indigenous health presents a significant challenge. Understanding the cognitive and affective tools that settler educators use when grappling with questions of race, racialization, and Indigenous difference is an important step in addressing anti-Indigenous racism in health care provision. This paper reports on findings from in-depth semi-structured interviews with educators at one Canadian medical school. Our intent was to elicit respondents' understandings, experiences, and attitudes regarding Indigenous-settler relations, Indigenous health and healthcare, and the inclusion of Indigenous health in the curriculum as a means of identifying facilitators and barriers to improving Indigenous health and health care experiences. Respondents were generally sympathetic and evinced an earnest desire to include more Indigenous-related content in the curriculum. What became clear over the course of the data collection and analysis, however, was that most respondents lacked the tools to engage critically with questions of race and racialization and how these are manifested in the context of asymmetrical settler colonial power. We argue that this inability, at best, limits the effectiveness of much needed efforts to incorporate more content relating to Indigenous health, but worse yet, risks re-entrenching anti-Indigenous racism and settler dominance.

## 1. Introduction

In Canada, as well as other settler states, it is imperative to understand settler colonialism as a determinant of both Indigenous and settler health and wellbeing, and to have this understanding reflected in teaching and learning in medical schools. The uneven distribution of a settlement's benefits (e.g., good health), privileges (e.g., access to health care), violences (e.g., non-consensual medical experimentation), and harms (e.g., systemic intergenerational trauma) is evidenced in the health disparities that persist between Indigenous and settler

(especially white) peoples in all settler colonies (Adelson, 2005; Czyzewski, 2011; Paradis et al., 2015). The uneven distribution of benefits and harms is a primary consequence of settler colonialism and a central organizing feature of the settler state's governance of Indigenous societies (Coulthard, 2014; Povinelli, 2011). Indigenous and non-Indigenous scholars who work with, and through, Settler Colonial Theory have consistently shown how logics of elimination and erasure continue to structure the relationship between Indigenous and settler societies (Coulthard, 2014; Povinelli, 2011; Simpson, 2016; Tuck and Yang, 2012; Wolfe, 2006). The structuring imperative to eliminate and

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erase shapes the social worlds in which medical practitioners and educators work, learn, and live. Failure to attend to the structuring effects of settler colonialism on settler health practitioners complicates calls to “decolonize” or “Indigenize” teaching and learning for health care (Nazar et al., 2015). It is for these reasons that Canada’s Truth and Reconciliation Commission (2015) called for: medical and nursing schools in Canada 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. This will require skills-based training in intercultural competency, conflict resolution, human rights, and anti-racism.

Few studies explicitly center settler colonial structures and logics when exploring how medical school educators work through questions of Indigenous health and anti-Indigenous racism in the health care system (for notable exceptions, please see Ly and Crowshoe, 2015 as well as Allan and Smylie, 2015). Given the volume of scholarly work that investigates how the double burden of colonialism and racism affects Indigenous people, this is a considerable oversight. The aim of our paper is to contribute to this emerging literature by reporting on findings from 13 in-depth, semi-structured interviews with medical school educators. Our intent was to elicit respondents’ understandings, experiences, and attitudes regarding Indigenous-settler relations, Indigenous health and healthcare, and the inclusion of Indigenous health in the curriculum. Our analysis illustrates how taken-for-granted embeddedness in settler colonial social formations conditions how many of this study’s respondents grapple with these questions. It is our hope that the findings of this study will demonstrate the importance of engaging with Settler Colonial Theory to constructively critique dominant approaches to educating about Indigenous health and to inform decolonial and anti-racist health pedagogies in settler colonies.

To be clear, this is not an exercise in highlighting the individual failings of particular respondents. This would elide the subtle (and not-so-subtle) pervasive structuring effects of racial-colonial hierarchies as they manifest in respondents’ attempts to grapple with questions of Indigenous difference, race, and racism. Our research aims to show how when working through a ‘problem’, people tend to pick up the tools close at hand. In a settler colonial society, racial-colonial hierarchies shape and condition these tools. We situate medical education in the context of settler colonialism before detailing our methods and presenting our findings. After outlining the logics and strategies employed by respondents, we suggest ways to address some of the challenges and make the delivery of education around Indigenous health more effective.

### 1.1. Situating medical education within the context of settler colonialism

Settler colonialism must be differentiated from other forms of colonialism. Dominant imaginaries tend to frame colonization as an historic, external, extractive relationship between a colonizing metropole and a colonized periphery. These divisions, however, do not address the relationship between Indigenous Peoples and settler states. In settler colonies there is no spatial separation between colony and metropole (Tuck and Yang, 2012). In the words of anti-colonial scholar Patrick Wolfe: “Settler colonizers come to stay: invasion is a structure not an event” (2006 p. 388). The will to stay and construct a society upon the territories of already existing societies creates the ‘problem’ of the Indigenous societies on whose lands settler societies are forcibly emplaced. One must not view this exclusively as an historical occurrence. It is an ongoing process that continues in the present (Coulthard, 2014; Simpson, 2007; Tuck and Yang, 2012; Wolfe, 2006).

In attempting to address the ‘problem’ of the prior (and ongoing) occupancy of Indigenous societies, settler states have deployed an extensive political, social, economic, religious, and militaristic apparatus oriented toward the elimination and replacement of Indigenous societies, as such (Simpson, 2016; Veracini, 2013; Wolfe, 2006). In Canada,

at its most overt, this has occurred, for instance, through the Indian Residential Schools (TRC, 2015), the forced starvation of Indigenous people (Daschuk, 2013), the Sixties Scoop of out-of-culture adoptions (McKenzie et al., 2016) as well as the ongoing imposition of the 1876 Indian Act (Vowel, 2016).

While state-sanctioned policies and practices targeting Indigenous societies for elimination are no longer overtly genocidal, the perpetuation of harms wrought by the imposition racial-colonial hierarchies persists by other means (Alfred and Corntassel, 2005; Coulthard, 2014). Examples include the continued overrepresentation of Indigenous children in Canada’s child welfare system (Blackstock, 2009; Leeuw and Greenwood, 2017), Indigenous peoples in the Canadian carceral system (Razack, 2015), and murdered and missing Indigenous women and girls in Canada (Anderson et al., 2018). Anti-Indigenous racism endures as an important animating force within contemporary processes of nation-building and acquiring land. This fact must remain central when seeking to locate commonplace anti-Indigenous racism and its impacts on Indigenous health within the settler health care system (Bombay et al., 2013; Bombay et al., 2011; Paradies et al., 2015).

Medical schools, for their part, in seeking to be more socially accountable and to educate toward patient-centered care, have developed curricula and interventions designed to address racism. For decades, variants of multiculturalism have figured prominently as frames through which to organize educational interventions targeting the attitudes and behaviours of learners (Browne and Varcoe, 2006; Ly and Crowshoe, 2015). As settler nation-states increasingly came to adopt multiculturalism as a policy direction to deal with the ‘problem of diversity’ in the late 1970s and onward (Day, 2001), there has been a concomitant proliferation of culture-based approaches in health care as evidenced through ever evolving phraseology from cultural sensitivity (Lum and Korenman, 1994) and cultural humility (Tervalon and Murray-Garcia, 1998) to cultural competency (Anderson et al., 2003), and from insurgent multiculturalism (Wear, 2003) to multicultural education (Murray-García and García, 2008; Nairn et al., 2004), and now more recently cultural safety (Browne et al., 2009).

Tracing a critical genealogy of the concept of multiculturalism and the different understandings of culture embedded within specific culture-based interventions is beyond the scope of this article. However, liberal multicultural state policy has rarely, if ever, led to structural changes in the relationship between settler and Indigenous peoples. In fact, Cornellier and Griffiths (2016 p. 306) argue that rather than shifting socio-political and economic relations across settler states, “liberal multiculturalism policies act comparably across multiple sites and spaces as avenues for the reinstitution of dispossession”. In noting the transnational work of multicultural policies, Kahnawake Mohawk anthropologist Audra Simpson (2016 p. 440) argues that “where there is a language and a commitment to ‘multiculturalism’ as the protection, preservation and perhaps even celebration of one’s ‘cultural’ difference, there is a simultaneous commitment to the taking of [Indigenous] territory.” These observations raise important questions about the political work carried out by, not only state multiculturalism policies, but also the taken-for-granted ways that such sweeping policies inform the manners in which settler citizens (including medical practitioners) think about and work through cultural differences.

Attending to the analytics and insights of Settler Colonial Theory can enable *critical* interventions into how we educate health professionals that move beyond the language and limitations of multiculturalism. In using the modifier ‘critical’, we situate our understanding of Settler Colonial Theory as both a corollary of, and necessary extension to, critical social theory more generally. Considerable diversity exists under the rubric; at its most general, ‘doing’ Critical Social Theory concerns knowledge production that identifies, interrogates, and ultimately works to dismantle oppressive structures and social relations. Here, the act of research can best be understood as a praxis, iteratively linking reflection and action toward social and economic justice.

While an intellectual debt to Marxist critiques of oppressive social relations under capitalism conditions our own understanding of Critical Social Theory, we find greater theoretical and political affinity with feminist, Black, and Indigenous critical theorists that do not subordinate uneven social relations to crude developmentalist and economic categories. Indeed, Dene political theorist Glen Coulthard (2014) makes precisely this point when arguing that working in settler colonial contexts requires a “contextual shift in analysis from the capital-relation to the colonial relation,” and that we attend to the “inherent injustice of colonial rule... *on its own terms and in its own right*.” (p. 11 emphasis in original). Engaging Settler Colonial Theory allows us to centre colonial relations in our analysis of how settler social formations affect Indigenous health by sensitizing us to the complex intersecting axes and forces of racism, whiteness, patriarchy, neoliberal capitalism, etc. in a way that multiculturalism simply cannot.

In no way should this be construed as an argument for abandoning efforts to provide culturally appropriate care in favour of explicitly anti-racist orientation to teaching. Canada's Truth and Reconciliation Commission's (2015) 94 Calls to Action concerning the intergenerational traumatic impacts of state-sanctioned Indian Residential Schools, is unequivocal about the importance of both. Given these recommendations, which echo calls from many Indigenous communities, governments, and organizations and their allies, we are seeing a proliferation of effective, Indigenous-led, culturally informed health initiatives (Leeuw and Greenwood, 2017; King, 2011). However, the degree to which such recommendations, as well as the success of Indigenous-led health initiatives, have intervened or shaped how we educate future health practitioners in settler colonial states has been limited, illustrating the significant challenges of addressing socially entrenched racial-colonial hierarchies (Allan and Smylie, 2015).

While engaging with culture is necessary to develop anti-racist practices and attitudes, it is far from sufficient (Allen, 2010). Uncritical uptake of ‘multiculturalism’ to deal with ‘the problem’ of cultural diversity risks merely replacing older, and now theoretically bankrupt modes of racialological thought with an equally problematic culturalist language that leaves un-interrogated the asymmetrical power relations for which an engagement with culture was intended to intervene. More recent interventions for addressing health inequities have developed explicitly anti-racist frameworks that extend beyond the racial animus of individuals in order to attend to the effects of structural racism on the health of communities and populations (cf. Philbin et al., 2018). Such studies have demonstrated the need to develop empirical research that links histories of structural racism (e.g. intentional disinvestment in racialized communities, mass incarceration) to the health inequities experienced by oppressed communities (Hicken et al., 2018). While much needed, such interventions nonetheless fall short, as their exclusive focus on the process of racialization elides the fact that in the governance of Indigenous societies, racialization is deployed in the service of claiming and maintaining settler territory, as such (Byrd, 2011; Simpson, 2007).

To be clear, addressing anti-Indigenous racism in health care provision and developing culturally safe care are essential to ameliorating health inequities between settlers and Indigenous peoples (Allan and Smylie, 2015; Bombay et al., 2013; Bombay et al., 2011; Paradies et al., 2015). Moreover, calls to locate histories of structural racism in research that explores health inequities are longstanding. Nevertheless, we contend that neither a critical analysis of racism nor liberal discourses of multiculturalism are the most effective conceptual tools for understanding the persistence of Indigenous-settler health disparities. Instead, we center Settler Colonial Theory in the following analysis of interviews with educators at a Canadian medical school to explore how settler colonial realities configure and distort respondents' attempt at grappling with Indigenous difference in settler Canada.

## 2. Methods

The social location of this study's authors, in conjunction with the academic and political projects that shape our research and personal lives, have considerable bearing on this study-from design to dissemination. There is no pretense to neutrality here. As Feminist philosopher Sandra Harding (1992 p.570-71), stated over two decades ago: “it is absurd to assume that in giving up the goal of neutrality one must give up the ideal of objectivity.” Thus, our varied commitments and relationships to Indigenous and decolonial projects should be understood as informing the tenor, tone, and direction of this paper.

The study population consisted of two types of medical school educators, those who deliver professional competency training ( $n = 8$ ) (PCT) and those who direct clerkships ( $n = 5$ ) (CD) in an undergraduate Medical School program within a postsecondary institution in Canada. PCTs are responsible for facilitating professional competency training in the first two years of training in the medical school program and are the educators responsible for the front-line delivery of all case-based sessions containing Indigenous-related content in this program. At the time of this study there were two sessions relating to Indigenous health; one in the first year of the program, and another in the second year. Indigenous health cases are comprised of a 1-h lecture and 2-h tutorial facilitated by the PCT where medical students discuss the Indigenous health cases they've been presented. Clerkship Directors are the medical school faculty members responsible for directing all aspects of clinical education, within their realm of expertise, for third and fourth year medical students (e.g. clinical rotations in surgery, obstetrics, etc.). While Clerkship Directors are not involved in the front-line delivery of education, they nonetheless have considerable influence in developing third- and fourth-year clerkships, as well as undergraduate curriculum, more generally.

We had permission from the Dean of Undergraduate Medical Education to send our recruitment materials to the Faculty's administrative office, and then prospective respondents were sent a notice about the study via the Faculty's listserv with a letter of support from the Dean encouraging participation in the Winter of 2016. Because we were not permitted to contact prospective respondents directly, we cannot say for certain how many individuals were on the listserv but our review of the institution's informational materials suggests approximately 40 PCTs and 10 CDs.

Respondents were invited to take part in a 60-min, in-depth, semi-structured interview; these are an excellent means of investigating complex behaviours and motivations, to explore a diversity of opinions, meanings and experiences, and allow the researcher enough flexibility to improvise and pursue unexpected lines of inquiry (Dunn, 2016; George and Stratford, 2016). All interviews were conducted by the first author to ensure continuity in the interview process (Holstein and Gubrium, 2003). Interviews were audio recorded and transcribed verbatim to ensure accuracy (Baxter and Eyles, 1997). Interview questions were developed by the research team in collaboration with five Indigenous and two settler experts in Indigenous health, program evaluation, and medical school curricula.

Questions were designed to assess: 1) educational, personal, or professional knowledge regarding Indigenous-settler histories and realities, and experience working with Indigenous communities or in Indigenous health; and 2) views regarding the current state of the Medical School's Indigenous health curriculum, how it may be improved, perceived barriers and opportunities for doing so, and perspectives on addressing anti-Indigenous racism through medical school curricula. Interviews were thematically analysed using a two-stage approach to coding that combined a round of initial coding using a data-driven constant-comparative method and a second round of a priori theory-informed coding (Fereday and Muir-Cochrane, 2006). Analysis was conducted using QSR (2011) NVivo 10 software.

The first stage of the analysis consisted of developing a structural codebook using the interview guide as an initial analytic scaffold. This

process consisted of grouping responses in terms of similarities and differences to specific questions under descriptive codes derived from the interview data to categorize and group respondents' answers (Charmaz, 2006; Ryan and Bernard, 2003). Once the authors had collaboratively reviewed the initial round of descriptive coding, we held a meeting with the advisory group to share the results from the first round of coding. A second round of analysis involved developing thematic codes. This involved using settler colonial theory as an a priori conceptual frame to perform a deeper level of analysis that sought to reveal the latent meanings, discourses, and structuring assumptions that undergirded respondents' attempts to grapple with issues of Indigenous difference, race, and racism. Quotes used in the findings section of this paper were returned to respondents for member checking to enhance the credibility of our findings (Baxter and Eyles, 1997).

While we draw insight from Charmaz's work in Grounded Theory (GT) in structuring our approach to the initial round of coding, we do not claim to be adhering to the tenets of GT. As much as the decision to apply an a priori theoretical framework in the second round of analysis was a direct result of the kinds of response categories we were seeing, the thematic categories that organize our findings are not primarily data-driven. The purpose of our analysis was not to develop a more comprehensive or in-depth theory of settler colonialism, but instead, to show the structuring effects of settler colonialism on thinking through Indigenous-settler relations and to demonstrate how an already extensive body of theoretical work by Indigenous and non-Indigenous scholars can be marshalled for the purpose of critiquing and transforming health education.

### 2.1. Findings

There was a good deal of variability among respondents with respect to their understandings of historical and contemporary Indigenous-settler relations and how these may influence Indigenous health. This is owing in large part to the considerable range in their experiences with Indigenous people; several respondents had spent significant time doing clinical rotations and placement in Indigenous communities, while others obtained most of their knowledge from mainstream media, or the exposure they had in facilitating sessions on the topic. None of the respondents had received any formal training regarding Indigenous health. Despite this, all those who responded with informed consent to our recruitment strategy said they felt comfortable treating Indigenous patients or working with Indigenous communities.

Internalized settler narratives of Indigenous realities: Situating colonialism in the past, perpetuating colonial stereotypes in the present

As expected, respondents who had spent considerable time working in (or with) First Nation, Métis, or Inuit communities tended to advance more nuanced understandings of Indigenous-settler realities in general and Indigenous health in particular; they did not reproduce common settler stereotypes regarding Indigenous people when discussing these issues. While we often see essentializing in the media and mainstream discourse, these respondents did not submit to such a tendency:

I think that perhaps the average Canadian thinks that it's a very homogeneous landscape, but my experience has been that it's an exceptionally heterogeneous landscape, with certain communities being exceptionally well-organized and well-serviced and other ones having huge needs. R10

This recognition of the complexity of the Indigenous health landscape in Canada was further echoed by comments about the need to have Indigenous health programming and education be Indigenous-led and evoking theoretical frameworks such as the concept of Two-Eyed Seeing (Marshall et al., 2015) as a means of engaging in integrative health work.

In contrast, respondents whose education regarding these issues had occurred primarily through the media and informal interactions with other settlers tended to echo the views and discourses espoused by those outlets. For instance, in speaking of their understanding of recent

Indigenous-settler histories, one respondent spoke of the fear evoked by the 1990 Oka uprising as a way of delineating the boundaries of acceptable Mohawk land defense:

The Oka Crisis was... a very frightening thing. I didn't necessarily feel badly towards First Nations other than that I think they had a few rabble-rousers in their group calling themselves warriors and being very aggressive, and they were causing trouble for everybody else. I don't necessarily think the rest of the people felt that way... and they were trying to protect their religious grounds from a golf course encroaching on it. R3

It should be noted that at Oka, the warrior societies present did not show force until the Sûreté du Québec invaded sovereign Kanien'kéha:ka Mohawk territory and that many inside and outside the community of Kanien'kéha:ka celebrated the defense of the Sacred Pines as a victory over the Canadian State (see for instance Simpson and Ladner's edited volume (2010)). In this statement Respondent 3 sympathizes with the plight of the Kanien'kéha:ka Mohawk but only to the point that resistance to the settler state is carried out in ways that the settler state deems appropriate. In a similar vein, another respondent questions the reality of intergenerational trauma associated with the Canadian residential school system:

I still am not sure I buy the residential schools being the reason everything's wrong today thing. I'm not hard to convince on things. I used to be a debater. I can debate almost anything. But I have a hard time understanding why several generations later, one generation can say, "Well, all my problems are based on what happened here," when I don't see that in other situations, be it poverty, alcoholism, torture, refugees, home violence... R4

Respondent 4 uses their self-perceived open-mindedness and a claim of self-directed analysis on the issue to legitimize a disavowal of intergenerational trauma. Beyond the fact that health researchers have empirically demonstrated links between residential school attendance and second and third generation mental health outcomes (e.g., Bombay et al., 2013; Wilk et al., 2017), or that many of the "other situations" listed by the respondent also have robust literatures supporting the fact of intergenerational trauma (e.g., afterlives of transatlantic slavery), there is, to our knowledge, no claim that the residential school system is the "reason everything's wrong today." Rather, the residential school system must be understood as one among many aspects of systemic brutality that settler-Canada has wrought upon Indigenous communities, and that while the last residential school only closed in 1996, these deeply troubling effects and relationships persist. Embedded within Respondent 4's discussion of residential schools is the often-mistaken assumption that Canada's colonial relation to Indigenous peoples is a thing of the past.

Understanding the present as a break from our collective colonial past obscures the social, political, and economic continuities that enable a critical contextualization of Indigenous and settler realities under settler colonialism. This point is made clear by Respondent 2's recounting of a student's racist assertion during an Indigenous health ProComp Tutoring session, something they characterized as "mild intolerance":

She [first year medical student] said: "You know, I'm trying to be unbiased but it's very hard when you're living surrounded by things that you see [...] the First Nations people would be given some money and they would build new houses for them, and then you go back a year later and they're like slums. They don't look after them. And if you ask them, 'Why don't you just look after your houses?' They say, 'Well, the government will give us a new one in another year or two.'" She related that story and people felt kind of uncomfortable because you didn't want to be perpetuating maybe a myth of some sort and we don't know how true that was because I've never seen it... I don't know. R2

Indigenous housing is economically and politically complex (for a primer see Vowel, 2016 p. 141-150). Suffice it to say, "free housing" is a common and pernicious myth, often deployed to blame Indigenous people for poor housing conditions in some Indigenous communities.

The student's racist assertion about Indigenous housing and the silent affirmation of the classroom who "don't know" because they've "never seen it," are the moments (multiplied innumerable times across settler colonies) that animate anti-Indigenous racism. Failing to critically intervene is a missed opportunity that retrenches racist stereotypes.

What these seemingly disparate statements share is an unreflexive commitment to centering the normative viewpoints of mainstream white settler society as the objective position from which to assess complex Indigenous realities. Moreover, they each in their own ways situate Canadian colonialism in the past and in doing so effectively (even if unconsciously) work to temporally shift the responsibility for redress from the present. Tuck and Yang (2012) refer to such linguistic tactics as "settler moves to innocence", noting that shifting responsibility from the present is a common strategy employed by settlers to absolve themselves from complicity in ongoing processes of settler colonialism.

Reifying race and individualizing racism: situating anti-Indigenous racism and the limits of liberal multiculturalism discourse

All of the respondents for this study categorically condemned the idea of racism. Nevertheless, as discussions involving race and racism progressed over the course of the interviews it became apparent that in grappling with these questions, respondents held highly divergent, frequently narrow, and sometimes internally inconsistent understandings of these concepts. With the exception of two respondents, when asked specifically about how they conceptualized racism the majority spoke explicitly about both interpersonal and structural racism, offering conceptions similar to Respondent 12's description of racism as "discrimination of one person or population over another on the basis of their race." While most respondents demonstrated some awareness of the existence of structural forms of racism, when asked if they had experienced issues of racism in the classroom the overwhelming majority of respondents framed their responses in terms of overt, interpersonal forms of racism and neglected to consider the myriad ways in which institutional racism may structure medical school in general or this program in particular:

I wouldn't say racism... some of the sessions that I'm involved in that have those sensitive kind of discussions might be around the LGBT community, where we had [...] some kind of awkward moments that students have when they're delivering that [...] how they kind of get around some of their awkward wording. R11

One respondent went so far as to claim that:

I think racism is kind of innate. Well, maybe in the Maritimes ... I never even met a black person until I was almost 20. So just the otherness, xenophobia sort of thing. R4

While xenophobia and prejudice can arguably be said to be ubiquitous across a range of social locations and temporalities, racism—as a mode of hierarchically categorizing and organizing societies using arbitrary physical features in a manner that privileges one social group to the exclusion of racialized others—is a process, intimately tied to colonial capitalism with histories we can track. Failing to apprehend this leads to the tendency to think of 'race' as a form of biologically determining essence with inherent explanatory power. For instance, when asked about the importance of incorporating teaching around race and racism, Respondent 13, who has spent considerable time working with Indigenous communities, responds:

It's not just as simple as race and racism. I think that for many Aboriginal people, it's not just their race. It's the fact that they are impoverished, that they are living under poor social conditions, that there are issues of substance abuse. It's not just the fact that they are First Nations. R13

This is a challenging statement to assess. On the surface the assertion that Indigenous health disparities cannot and should not be reduced to anti-Indigenous racism suggests a critical understanding of race and racialization. However, the next sentence conflates race with Indigeneity. By thinking of race as having an inherent determining

quality and then conflating race with Indigeneity, it is possible for the respondent to divorce this list of social ills from the "fact that they are First Nation." While settler colonial oppression does not define Indigenous peoples, as such, and while the experience of settler-colonialism cannot be reduced to one over-arching narrative, if we accept Patrick Wolfe, 2006 observation that a determining feature of settler societies is the "elimination of the Native", then the "fact that they are First Nation" has direct bearing on the prevalence of the social ills the respondent lists. Indeed, failing to recognize that being Indigenous speaks to a shared experience of settler colonialism enables the respondent to locate manufactured vulnerabilities such as "impoverishment", "poor social conditions", and "substance abuse" outside of historic and contemporary settler colonial relations.

This contrasts with Respondent 8, a PCT with training in Critical Social Theory rather than medicine, as they attempt to grapple with the same question of incorporating teaching around race and racism:

It's of prime importance if we are going to conceive of health as beyond our aches and pains. [...] As Canadians I don't think we actually have a true appreciation of how deep these wounds run and how those will affect health. Even just the fact that the differential between First Nations people and other "mainstream Canadians" or whatever in terms of poverty, access to healthcare services, clean water, housing – these are such basic things that can affect your health outcomes. I just think that if students don't... if they can't make these connections, if they can't see that, then what are we doing?

For Respondent 8, anti-racist pedagogy must explicitly make "connections" between the deep "wounds" of the historical process of settler colonization with its contemporary manifestations in the form of structural poverty and inequitable access to basic needs.

Equally important, and with few exceptions, respondents generally did not consider the ways in which they themselves may be 'raced' and how being socialized in a society where racism is a fundamental organizing condition may shape how they teach and practice medicine. This is most pointedly demonstrated in the consistent tendency of respondents to articulate liberal multicultural discourses of equality when asked, given their training with respect to Indigenous health, if they would feel comfortable working with Indigenous communities:

[E]veryone's the same. If you have a disability of some sort, it doesn't matter for the most part whether you're Aboriginal or non-Aboriginal, Chinese, whatever. It's helpful to be able to understand, perhaps, some of the reasons for the things that they're doing. It might be cultural or religious even. [...] But I would still treat them like I treat anyone else. You need help, you need help. R14

"I treat everyone the same" was a common refrain among respondents. The act of "sameing" is understood as a universalizing strategy that is often deployed as a way of avoiding being perceived as racist but can actually function as a mode of erasure (Tuck and Yang, 2012). While the impulse toward "sameing" may seem noble, it works to dilute very real and important differences, so that the self that "sames" over-represents itself and its experiences as that of the human in general. While treating people the same is sometimes appropriate, other times it entrenches racial-colonial hierarchies (Denis, 2015). Moreover, such statements signal a lack of awareness of the implicit biases that develop when embedded in a society where the means of representation (e.g. news media, film, fiction, education, etc.) are overwhelmingly controlled and operated by a privileged racialized group. Again, such statements effectively individualize racism as personal failing ('that person does not treat people equally, but I do') rather than demonstrating an awareness of how being socialized in societies that are structured through racial-colonial hierarchies mediates moments of encounter with racialized others. Respondent 6 demonstrates this in a pointed fashion:

[H]ere they're not as much of a visible minority and many do not look native at all, in my opinion. So it's not always easy to know

what you're dealing with. [...] You could be dealing with a problem and I suppose if they looked a certain way you'd say, 'well, that was sort of part the mix'. R6

Here, "look[ing] native," enables the practitioner to ascribe a narrative to the racialized body—homogenizing the individual not just based on racialization but also socioeconomic status, gender and sexual identity, and so on—prior to any actual exchange with the patient. When pressed about the importance of including learning about race and racism in the medical school curriculum they elaborated:

I mean ideally we would treat every patient the same when they walked in the door. We would be colour-blind, and we can't be colour-blind. I make prejudgments of you because you've got a beard and carry a backpack. We make judgments on people, and physicians are trained to assess people. And you can say well, they're prejudging them, but in fact, part of it is the mix R6

While the recognition of the impossibility of being "colour-blind" is important, failing to consider how being embedded in a racially hierarchical, settler-colonial society may mediate and structure prejudgements suggests a disavowal of the encultured and raced, privileged social position of the participant. It is interesting to note that while the interviewer had a beard, they did not carry a backpack; it was a computer satchel. The interviewer also wore a collared shirt and tie. The intent is not to make too much of this encounter, only to suggest it as an example of how ascribing a narrative to the body of an 'other' can work to (mis)shape our perceptions in ways that in other contexts could have far more significant consequences.

## 2.2. Conceptualizing diversity: difference as distance from a normative white subject

Condemnation of racism by respondents was often paired with discussions of the importance of learning to accommodate the "cultural differences" of not only Indigenous patients, but of, as Respondent 3 puts it, other "specialized cultural groups." Indeed, it was common for respondents, when pressed about the role of expanding Indigenous health curriculum as a means of addressing anti-Indigenous racism in health care, to respond in the affirmative and then to list examples of what they saw as other cultural practices to argue for a more broadly inclusive form of cultural awareness:

[Y]ou could look at the class getting sensitivity training for lots of different minority groups. That doesn't mean only Aboriginal health. But if we had a female Muslim patient, then the male student may not be allowed to engage in hands-on care with that patient [...] And if there's certain sensitivity training issues, like I said, you know, male students can't touch female Muslim patients, Jehovah witness patients will not accept blood transfusions. R5

There's certainly a number of cultural differences in dealing with Arabic populations, Aboriginal health, and others... that there's certainly some nuances there that I think deserve to be addressed in the curriculum. [...] it depends on the group that you're dealing with, but there are a number of cultural beliefs and practices where you can actually offend someone, simply in the way you introduce yourself – physical contact with women, handshakes, gestures, things like that – that if you're not aware of and not attuned to, can have a negative impact on your interaction with a patient. R9

Perhaps the most widespread liberal multiculturalist tendency evident in respondents' discussions of race, racism, and Indigenous health was the tendency to ascribe culture, as if it were a thing, to an Indigenous or racialized other. Here 'culture' stands as a marker and measure of difference from a normalizing heterosexual, white, Western bourgeois social location, whose occupants do not see themselves as bearers of culture or 'race' and therefore experience themselves as neutral observers. In a sense, culture names what is idiosyncratic and anachronistic in relation to the supposedly 'a-cultural' practices of the white professional physician. What is more, deploying such an analogy

(a common strategy for grappling with the question of difference among respondents) demonstrates a fundamental lack of understanding the power laden colonial-racist processes that have systematically sought to marginalize or destroy Indigenous social, political, economic, spiritual, and health practices. This is more pointedly evinced when Respondent 5 was pressed to consider whether it would be appropriate to include teaching around Indigenous healing traditions; they responded:

I mean it's like any herbal remedy, any non-traditional, naturopathic type of remedy, I see no problem if people also want to try those... It'd be almost similar to Catholics getting last rites or something else. Like if they want to do it, I see no problem in accommodating them as much as is reasonable, feasible. R5

Once more the way in which difference is grappled with is to reduce it, through analogy, to a category of practices that are considered deviations from a norm. Moreover, the degree to which a 'remedy' is recognized as legitimate, and therefore tolerable, relies on it being "reasonable" and "feasible." Setting the criteria for determining what is "reasonable" and "feasible" necessarily occurs within a field of power relations that are highly asymmetric. The object here is not to debate the relative merits of naturopathic versus allopathic medicines, nor is it to argue for a more 'politically correct' nomenclature. Rather, the purpose is to illustrate the subtle pervasiveness of a mode of thinking about the 'other' that always constructs difference as 'difference from'. In a settler colonial society that is structured through racial-colonial hierarchies this has the effect of centering white, Euro-American ways of knowing as an objective, superior norm, rendering deviant and inferior 'other' ways of knowing and being, which do not conform to the cultural practices of a particular ethno-class of human. In this way, seemingly socially progressive discourses, such as tolerance and equality elicited above, remain problematically rooted in assumptions that work to maintain, repair, and reproduce the racial-colonial hierarchies they are ostensibly meant to deconstruct.

## 3. Discussion

Many of our respondents have been involved in facilitating Indigenous health modules (some for years) and though they demonstrate a general understanding (and considerable empathy) for what gets broadly glossed as 'Indigenous issues' (which should be more aptly described as 'Settler issues'), as well as an unequivocal condemnation of racism and racist practices (as they understand it), the way that racism, culture, and difference gets talked about and reasoned through suggests a considerable gap between respondents' understanding of these issues and the sort of critical understanding required to work through their privileged position within settler colonial structures of power. What became clear over the course of our analysis was that most respondents lacked the tools to engage critically with questions of race and racialization and how these are manifested in the context of asymmetrical settler colonial power. Our findings suggest that this inability, at best, limits the effectiveness of much needed efforts to incorporate more content relating to Indigenous health, and worse yet, risks re-entrenching anti-Indigenous racism and settler dominance.

Placing these interviews into conversation with critiques of settler colonialism clarifies how the relative position of this study's respondents within racial-colonial hierarchies, conditions the tools and strategies available to them for working through questions of anti-Indigenous racism, culture, and Indigenous difference. It illustrates how being socialized within settler colonial socio-political formations, with their dominant historical narratives, policies, and techniques of erasure and replacement, mediates moments of encounter, whether in-person in the clinic or emergency room, or through a case study in the classroom. Furthering our understanding of the specific strategies employed by white settler medical educators in grappling with the politics of racism, culture, and difference is essential for developing targeted interventions to address these challenges.

In highlighting this, we reiterate that we are not interested in cataloguing the failures of individual respondents. We refuse to reduce these tools and strategies to the racial-colonial animus of individuals; instead we situate them within the broader structure of Canadian settler-colonialism. For instance, the acts of disavowal that inhere in “*Internalized settler narratives of Indigenous realities*” are more productively understood (at least in part) as artifacts of mass epistemic ignorance; a purposeful ignorance that has been actively cultivated by the settler education system from kindergarten through to post-secondary (Godlewski et al., 2010; Schaefli et al., 2018). Indeed, that settler students graduate from secondary or post-secondary institutions without being able to link centuries of colonial rule to the contemporary structural inequities from which their relative privilege is derived evidences an enduring capacity deficit that implicates educational institutions in projects of settler colonial rule. This deficit is re-entrenched if educators themselves are unable to draw these same critical linkages for their students. As Regan (2010) argues, settler Canadians must engage in an ongoing process of unlearning the colonial myths perpetuated by schools, media, and other settler institutions (such as the notion of Canada as a ‘benevolent peacemaker’), listening to and reflecting on Indigenous peoples’ stories and experiences, and reframing their own (settler) identities and interests in ways that support Indigenous resurgence and decolonization.

Falling back onto the political pabulum of liberal multiculturalism is an anemic response to grappling with settler colonial oppression and anti-Indigenous racism. Its limits are apparent in “*Conceptualizing diversity*” where many respondents supported inclusion of increased Indigenous health content into medical school curriculum and then immediately pivoted to talk about incorporating content on a variety of idiosyncratic encultured others. On the surface, this genre of cultural tolerance is readily legible as adopting an equitable and socially progressive position. Yet, as Verna St. Denis (2011, p. 311) argues, the act of equating the unique social and political location of Indigenous people in settler colonies “with racialized minorities and particularly with racialized ethnic immigrants,” elides the fundamentally different character of the political relationship between Indigenous Nations and the Settler state. It conflates racialization with colonization, deflecting and deferring the struggles of Indigenous nations through a cacophony of competing struggles (Byrd, 2011). It is microcosm for how settler states deploy such policies to defer and bracket Indigenous claims to sovereignty and inherent rights at the national level (St. Denis, 2011).

A similar observation can be made in this study where respondents’ strategies mirror Canadian settler-state strategies for governing Indigenous Peoples through the progressive impulse to *recognize* and accommodate difference, but only insofar as is ‘reasonable’ and ‘feasible.’ This form of reckoning with difference bears a striking resemblance to how state forms of liberal multiculturalism get articulated and enacted in Canada through the liberal ‘politics of recognition’. In this register, the ‘politics of recognition’ as Glen Coulthard (2014) explains, refers to “an expansive set of recognition-based models of legal pluralism that seek to reconcile Indigenous claims to nationhood with Crown sovereignty via the accommodation of Indigenous identities through some form of renewed relationship with the Canadian state” (p. 3). Although seemingly progressive when contrasted to a legacy of unapologetically assimilationist state policies, scholars critical of the recognition paradigm have demonstrated how the politics of recognition erode, rather than enhance, the self-determination efforts of Indigenous people by facilitating the theft of land through ‘gentler’ means. (Coulthard, 2014; Day, 2001 Povinelli 2011).

While a full accounting of the political work of recognition is outside the scope of this paper, there are key features worth noting that bear striking similarities to strategies employed by respondents. For one, recognition in a settler colonial context is inherently asymmetrical and, as such, has the tendency to reproduce racial-colonial hierarchies rather than dismantle them. It is granted, as a gift, from a position of power (Day, 2001). Consequently, if an expression of Indigenous

cultural difference does not conform to particular a priori categories (if it is not “reasonable” or “feasible”) it remains illegible to state authorities. Recognition is then denied or bracketed (Povinelli, 2011). Moreover, if we situate recognition within a broader bureaucratic project of state multiculturalism that turns on the production of official identity categories (Day, 2001), we see that it reifies and reinforces uncritical constructions of race and culture rather than dismantling them.

#### 4. Implications

The purpose of highlighting the parallels between respondents’ strategies for working through questions of racism, culture, and Indigenous difference, and those of the settler state is not to suggest that respondents are agents of the Crown directly involved in projects of elimination and replacement. Rather, we do this to articulate a structural argument about how the social location of respondents *as settlers* within a settler colonial social project matters when facilitating teaching and learning around Indigenous health and health issues. The argument that practitioners need to reflect on how their identity influences their practices is not novel (Allan and Smylie, 2015; Browne et al., 2009; Gonzalez et al., 2014). However, a critical engagement with settler colonial theory enables us to sketch a relationship between conversations with respondents and ongoing processes of settler colonialism. As an exploratory study, our analysis suggests the potential fruitfulness of a more fulsome engagement with critiques of settler colonialism by Indigenous and non-Indigenous scholars for shaping health education.

The medical school educators who responded to our invitation to participate in this study were generally sympathetic and evinced an earnest desire to include more Indigenous related content in the curriculum. This corresponds with recently published findings of a survey the authors conducted with first- and second-year medical school students for the same medical school (blinded for review). Our findings, though, make visible some of the common-place logics and strategies that respondents used when trying to work through questions of race, racism, and Indigenous-settler relations. The institutional and individual barriers to accomplishing such a task have received considerable attention and will not be revisited here (see instead: Ly and Crowshoe, 2015; Nairn et al., 2004; and Nazar et al., 2015). Suffice it to say, lectures and workshops alone are not the answer. Crowshoe et al. (2010) note the use of interactive drama such as Forum Theater, a participatory approach to theater where student/audience members are able to intervene in racist encounters, as a fruitful approach to generating thoughtful and creative self-reflection. Castleden et al. (2013), and others, have written about the effectiveness of immersive, multi-day field schools that get learners out of the classroom and into Indigenous spaces to promote cross-cultural learning in facilitating behavioural and attitudinal transformations in settlers.

Yet, as much as settler colonial theory may offer considerable insights into the myriad processes through which settler colonization continues to structure Indigenous and settler health, it has its limits. We must be cognizant of not reproducing totalizing accounts of settler violence that reduce the complex and dynamic terrains of Indigenous health to figurations of absolute colonial deprivation. This too is an act of violence, which elides the successes and lessons of a growing number of exciting Indigenous-led and strengths-based initiatives for health education and health promotion as well as the growing momentum of Indigenous resurgence globally.

There are also a growing number of exciting and innovative Indigenous-led and decolonial education initiatives available to medical schools with an earnest desire to address TRC Call to Action concerning the education of Health professionals. For instance, San’yas Indigenous Cultural Safety Training Program has been lauded as a leading approach because of its theoretical grounding in anti-racist and transformative learning pedagogy, innovative online approach, and the

supports it offers for Indigenous staff and participants. The program was originally developed by Indigenous women leaders through the Provincial Health Services Authority in the Canadian province of British Columbia and has since developed training in partnership with Indigenous stakeholders in the provinces of Manitoba and Ontario (Ward et al., 2017). Training programs such as San'yas represent practical opportunities for medical schools to be able to respond to some of the critiques developed in this paper without having to redesign their curriculum. While not an end in itself, collaborating with organizations who are already doing this work in a manner that is sensitive to local contexts is an example of necessary first steps that institutions can take immediately.

## 5. Concluding comments

The unwitting and commonplace reproduction of similar discourses amongst respondents for this study elucidates both the challenge and the urgency of working to equip educators and students for engaging with difference. Given the abundant theoretical and practical terrain from which to draw, we find it troubling that the respondents in our study generally lacked the discursive tools to engage critically with questions of 'race,' culture, and anti-Indigenous racism. Many of the institutions responsible for educating future practitioners, by marginalizing the themes we have been discussing within their curriculum, participate in the active erasure, disavowal, or anachronization of not only Indigenous health practices but also the myriad social, political, economic, and cultural realities of Indigenous nations whose territories are occupied by settlers who understand themselves primarily, and unproblematically, as 'Canadian'. How are educators, whose own understandings of these questions mirror the multiculturalist discourses of the settler colonial state, meant to guide students through this challenging terrain? At the risk of seeming glib, would any School of Medicine tolerate a podiatrist facilitating a workshop on thoracic surgery? Failing to equip practitioners with the tools to shape their practice through a critical understanding of race and culture makes these programs complicit in the reproduction of anti-Indigenous racism.

While hopeful examples of innovative approaches are becoming increasingly common, they nonetheless remain highly marginalized within allopathic medical education (Ly and Crowshoe, 2015), and do not create the types of sustained supportive environments that are required to reinforce and foster continued transformation (Nazar et al., 2015). Too often, students return to spaces where the insights they have gained are met with scepticism and even hostility. Given the impacts of racism and settler colonialism on the health of Indigenous peoples (Allan and Smylie, 2015; Paradies et al., 2015), it is imperative that we create learning spaces where these insights are nurtured rather than suppressed.

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