"IT HAS BEEN THE BEST THING AND THE WORST THING": EXPERIENCES OF INDIGENOUS HEALTHCARE PROVIDERS IN BRITISH COLUMBIA, CANADA

Madeline Elder,[1] Doris Fox, Pamela Barnes,[2] Alicia Ditty,[3] Vinci Lai,[4] Hali McLennan,[5] Ashley Lessard,[6] Justin Turner,[7] Narges Bouzari,[8] Zahara Czar,[9] Yael Mayer,[10] Ashley Quinn,[11], Katie Lee Bunting,[12], and Tal Jarus[13]

[1] Faculty of Medicine, University of British Columbia. Maddield@student.ubc.ca
[2] Ajunct Professor, UBCO School of Nursing. Pbarnes@shaw.ca
[3] The Occupational Sciences and Occupational Therapy Department, Faculty of Medicine, University of British Columbia. Alicia.maroney@phc.ca
[4] The Occupational Sciences and Occupational Therapy Department, Faculty of Medicine, University of British Columbia. Vinci.lai@gmail.com
[5] School of Soial Work, University of British Columbia. Hali.mclennan@gmail.com
[6] University of British Columbia. AshyL17@gmail.com
[7] The Occupational Sciences and Occupational Therapy Department, Faculty of Medicine, University of British Columbia. Justin.turner@ubc.ca
[8]University of British Columbia. Nargesbouzari3@gmail.com
[9] The Occupational Sciences and Occupational Therapy Department, Faculty of Medicine, University of British Columbia. Zaharaczar22@gmail.com
[10] School of Therapy, Counseling and Human Development, Faculty of Education, Haifa, Israel The Occupational Sciences and Occupational Therapy Department, University of British Columbia Faculty of Medicine, Vancouver. Yaelmayer10@gmail.com
[11] Assistant Professor, Factor-Inwentash of Social Work, University of Toronto. Ashley.quinn@utoronto.ca
[12] Associate Professor of Teaching, Department of Occupational Therapy, Faculty of Medecine, University of British Columbia. Katie.leebunting@ubc.ca
[13] Professor, Faculty of Medecine, University of Bristish Columbia. Tal.jarus@ubc.ca

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Abstract

Introduction: Indigenous Peoples comprise approximately 5% of the Canadian population, but only 1.2% of health professionals. Research has demonstrated that rectifying these disparities has the potential to improve health outcomes for Indigenous people.
Objective: The purpose of this project is to identify and understand the barriers and facilitators Indigenous health and human services (HHS) professionals face in achieving and maintaining positions in their professions.
Approach: A qualitative research design with a narrative approach was adopted to provide a relational understanding of Indigenous professionals' experiences. Sharing circles facilitated by Indigenous researchers were used to gather the stories of participants.
Findings: Thirteen HHS workers attended a sharing circle. Facilitators of participant success included connection to culture and community, while obstacles included geographic, structural, and financial barriers, as well as racism. These discussions led to participants developing recommendations for future change.
Conclusions: This study represents a step towards addressing the Truth and Reconciliation Commission of Canada's Call to Action to improve recruitment and retention of Indigenous HHS professionals, by identifying facilitators and barriers to their success.

Keywords: Indigenous Peoples, health equity, cultural competency, health workforce, racism

Résumé

Introduction : Les peuples autochtones représentent environ 5 % de la population canadienne, mais seulement 1,2 % des professionnel·le·s de la santé. Les recherches ont

démontré que la réduction de ces disparités pourrait améliorer les résultats de santé des personnes autochtones.

Objectif : Ce projet vise à identifier et à comprendre les obstacles et les facteurs facilitants auxquels les professionnel·le·s autochtones des secteurs de la santé et des services humains (SSH) sont confronté·e·s pour accéder à leur profession et s'y maintenir.

Approche : Une méthodologie qualitative fondée sur une approche narrative a été adoptée afin de développer une compréhension relationnelle des expériences vécues par les professionnel·le·s autochtones. Des cercles de partage animés par des chercheur·euse·s autochtones ont été utilisés pour recueillir les récits des participant·e·s.

Résultats : Treize travailleur·euse·s des secteurs de la santé et des services humains ont participé à un cercle de partage. Parmi les facteurs ayant favorisé leur réussite figuraient le lien avec la culture et la communauté, tandis que les obstacles relevés comprenaient des barrières géographiques, structurelles et financières, ainsi que le racisme. Ces échanges ont conduit les participant·e·s à formuler des recommandations en vue de futurs changements.

Conclusions : Cette étude constitue une étape vers la mise en œuvre de l'Appel à l'action de la Commission de vérité et réconciliation du Canada visant à améliorer le recrutement et la rétention des professionnel·le·s autochtones des secteurs de la santé et des services humains, en identifiant les facteurs facilitants et les obstacles à leur réussite.

Mots-clés : peuples autochtones, équité en santé, compétence culturelle, main-d'œuvre en santé, racisme

Positionality of the Research Team

Indigenous research methodologies require self-reflection, both in an attempt to mitigate power differentials in research and in hopes of identifying the purpose of the research, which often arises from our personal narratives (Absolon, 2010; Hampton, 1995; Kovach, 2021). I (Madeline Elder) am of mixed settler and Indigenous ancestry, as my paternal grandfather was a member of the Lax Kw'alaams Ts'msyen band. I am still learning what it means to be of mixed settler and Indigenous ancestry. As such, doing this work is as much a personal journey for me as it is a professional or academic exercise, and writing this manuscript is my commitment to continuous learning.

Our research team was composed of First Nations, Métis, and settler researchers. We were fortunate beyond measure to be guided and supported in this project by Elder Doris Fox of the xʷməθkʷəy̓əm (Musqueam) Nation, Elder Pamela Barnes of the Syilx Westbank First Nation, and an advisory committee of Elders, Knowledge Keepers and health officers from the xʷməθkʷəy̓əm (Musqueam), Syilx Okanagan, Songhees, and Lheidli T'enneh First Nations, as well as Métis Nation British Columbia, without whom this project would not have been possible. Within our research team, we strove to foster an environment of respect, power-sharing, trust, and equity, which is foundational to intercultural research (Tachine et al., 2016).

Background

Since time immemorial, Indigenous Peoples have lived on the land now called Canada, embodying a rich diversity of cultures and languages. Colonization established policies and practices that enforced systemic racial discrimination, segregation, forced assimilation, cultural and physical genocide, and the economic oppression of Indigenous Peoples (Allan & Smylie, 2015). Unsurprisingly, this has led to disproportionately poor physical and mental health outcomes for Indigenous Peoples (Allan & Smylie, 2015; King et al., 2009; Kirmayer et al., 2007).

Access to the Western Canadian Healthcare System

Compounding these disparities are the social, physical, historical, and political barriers that hinder Indigenous Peoples' access to healthcare (Horrill et al., 2018). In addition to the physical barriers of geography and availability of services, the relationship between many Indigenous Peoples and the Canadian healthcare system is fraught with mistrust (Horrill et al., 2018; Vogel, 2015). Historically, the Canadian medical system has been used as a tool of oppression against Indigenous Peoples, who continue to experience racism, discrimination, and harassment while accessing healthcare services in Canada (Addressing Racism Review Team, 2020; Allan & Smylie, 2015; Browne et al., 2013; Horrill et al., 2018). This poses an urgent threat to the lives and well-being of Indigenous Peoples in Canada. As such, multiple approaches must be taken to dismantle the barriers that Indigenous people face in accessing care, and guidance from Indigenous Peoples on how to do this is becoming inceasingly available (Addressing Racism Review Team, 2020; Horrill et al., 2018).

The Importance of Representation of Indigenous Workers in the Health and Human Services (HHS) Professions

One such approach is to increase the number of Indigenous professionals working in the healthcare field, which is outlined by the Truth and Reconciliation Commission of Canada in the 23rd Call to Action (Addressing Racism Review Team, 2020). Although it is important to note

that many Indigenous communities have traditional health practitioners who make important contributions to individual and community wellness that may be unrecognized by the Western health system, Indigenous people are vastly underrepresented in the HHS professions (Statistics Canada, 2017). According to the 2016 Canadian Census (Statistics Canada, 2017), over 1.6 million people identified as Indigenous, accounting for 4.9% of the total Canadian population. Yet, only 1.2% of all health professionals in Canada identified as Indigenous (College of Nursing, 2016).

Rectifying these disparities will be crucial to improving health outcomes for Indigenous Peoples in Canada. Representation is thought to improve health outcomes through the hastening of policy change, improvements in health literacy, incorporation of Indigenous ways of knowing into healthcare, improvement of patient–practitioner relationships, bridging of cultural gaps between patients and providers, and increases in the number of practitioners working with underserved Indigenous communities, among other mechanisms (Conway et al., 2017; Deroy & Schutze, 2019; de Witt et al., 2018; Huria et al., 2014; Power et al., 2024; Saha & Shipman, 2007). In order to develop effective strategies to support Indigenous HHS professionals and address the 23rd Call to Action, the perspectives of these professionals must be understood and centred.

Aim

The aim of this study was to identify barriers and facilitators to the self-defined success of Indigenous professionals working in HHS professions in Canada. The ultimate goal of this work is to inform future directions for research, community action, and policy change to best support Indigenous professionals, and consequently to improve the health and well-being of Indigenous people in Canada. The motivations behind this research are inherently political and aligned with the fundamental principles of Indigenist research. As described by Lester-Irabinna Rigney (1999), the goal of Indigenist research is to "serve and inform the Indigenous struggle for self-determination" (p. 118). Aligning research with the struggle for genuine self-determination in this way "makes the researcher responsible to the Indigenous communities and their struggle" (p. 118). This responsibility motivated us in every step of the project.

Methods

As many Indigenous researchers have done before us, we employed Indigenous methodologies in this project in hopes of avoiding the known pitfalls and harms of applying Western research methodologies in working with Indigenous people (Kovach, 2021; Tachine et al., 2016). Rigney (1999) described Indigenist research as being informed by liberation epistemology, in that it is conducted by Indigenous researchers and centres Indigenous participants. In order to centre participant voices, we chose to collect data through sharing circles led by Indigenous researchers, analyzed the data using narrative analysis, and relied on member-

checking to ensure personal and relational reflexivity. Throughout, we aspired to uphold Indigenous values and protocols such as power-sharing, partnership, trust, and reciprocity, which are requirements for decolonizing research (Caxaj, 2015).

Participants

To be included, participants needed to (1) self-identify as Indigenous, and (2) have at least one year of experience working in the HHS sector in Canada. A mix of purposive and convenience sampling was used. Despite our efforts to reach diverse Indigenous practitioners, the rich complexity of Indigenous experiences in Canada cannot be fully encompassed in our single study. Instead, we aim to convey the common and personal experiences of a small but meaningful number of Indigenous HHS professionals in British Columbia.

Sharing Circles

Storytelling has always been the primary means for knowledge transmission within Indigenous communities (Kovach, 2021; Lavallée, 2009; Rothe et al., 2009). Research sharing circles are a vehicle for narrative, which in turn allows us to convey meaning, teachings, and practices that serve to benefit members of the collective (Kovach, 2021). They allow for a nuanced understanding of complex topics; as Russell Bishop (1999) writes, using storytelling as a research tool allows for the representation of the diversities of truth. Moreover, storytelling disrupts the power hierarchy inherent to research (Kovach, 2021; Bishop, 1999), allowing participants to "use their own voices and tell their own stories on their own terms" (Thomas, 2015). This method is analogous to research topic yarning, as described by Bessarab and Ng'andu (2010), in that it uses a semi-structured interview to gather stories from research participants, and is both purposeful and relational.

The sharing circles were run by myself (M.E.) and Hali McLennan (H.M.), who is Métis, and was completing her Master of Social Work degree at the time. In the circles, we followed cultural protocols familiar to us as researchers, such as offering gifts and self-locating, and encouraged participants to bring their teachings to the circle, as well.

Research sharing circles allow for the co-construction of knowledge, wherein each story shared contributes to a whole (Absolon, 2022). This requires an element of vulnerability from not only the participants but from the researchers, as well, as they are equal participants in the circle (Kovach, 2021). As both I and H.M. are Indigenous students and were engaged in healthcare education at the time, we brought our personal and academic narratives into the circle. This reciprocal process allowed us to build relationships that could hold the stories we collected. Our research team met after each circle to discuss our experiences and observations in order to promote reflexivity and relationship building within the team.

The circles were conducted using Zoom video conferencing to allow participants from remote areas to take part in the study. The virtual nature of the circles posed limitations,

including that we were not able to sit in a physical circle and that we were not able to share in a meal, as would have been appropriate in employing this methodology (Kovach, 2021; Tachine et al., 2016).

Analysis

Narrative inquiry was used for the analysis of sharing circle data as it enables reflexivity, contextualization, and co-construction of narratives (Hunter & Cook, 2020). This maintenance of context was important because, within Indigenous epistemologies, stories are understood to be inextricably connected to their teller, place, and time (Kovach, 2021). The data was transcribed using AI software, then reviewed for accuracy. Next, two transcripts were analyzed by five authors (A.D., V.L., A.Q., K.L.B., and T.J.), using memoing, then compared for consistency (Birks et al., 2008). Once memoing was found to be consistent between researchers, A.D. and V.L. memoed the remaining transcripts. Frequent topics and significant experiences were identified inductively and deductively. Multiple authors discussed and reflected on the main topics, which helped create new insights and contributed to reflexivity.

Honouring Participant Stories

As Margaret Kovach (2021) explains in her foundational work *Indigenous Methodologies: Characteristics, Conversations, and Contexts* (first published in 2009), the word *data* is derived from the Latin verb *dare*, meaning "to give." The stories that participants shared in this project are understood to be gifts, given in the context of the relationships between researchers and participants. It is in this relational nest that knowledge is co-created (Kovach, 2021). As such, honouring the stories we were gifted was of utmost importance in the analysis and presentation of our findings. To this end, we involved participants in the development of themes by going through multiple rounds of member-checking, providing participants the opportunity to confirm, clarify, or correct them (Caxaj, 2015; Rothe et al., 2009). Ethical approval for this study was granted through the University of British Columbia's Behavioral Research Ethics Board. Written consent was obtained from all participants prior to data collection.

Findings

A total of 13 participants from 8 different health professions ultimately participated in the study. All participants self-identified as either Métis or First Nations, with 1.5 to 30 years of experience in their respective fields. Below, we report on the themes identified by participants regarding the barriers and facilitators to their success, along with relevant participant quotations.

Table 1

Summary of Barriers and Facilitators to Success for Indigenous People Working in HHS

Theme	Subthemes
1: "I just try to stay true to who I am": The value of culture and community	1.1 Giving back to the community as a sense of purpose
	1.2 Community and family support
	1.3 Relationships with patients and holistic care
2: "When I go to a school, I want the students to think 'I could do that too.'": The importance of representation in HHS	2.1 Tokenism
	2.2 Indigenous mentorship
	2.3 Indigenous communities of practice
3: "As Indigenous people, we don't have super rich families to pay for schooling, so I took it upon myself to get the funding that I needed.": Material and structural factors	3.1 Financial
	3.2 Geographic
	3.3 Structural
4: "There's always the racism, to me that's a given.": Anti-Indigenous racism from self to systems	4.1 The moral conflict of choosing healthcare as a profession within the context of colonization
	4.2 Racism in education
	4.3 Racism in the workplace
	4.4 Internalized racism
	4.5 Experiences participating in anti-racism training

"I just try to stay true to who I am.": The value of culture and community

It was clear across sharing circles that participants identified their connections to their own cultural values as empowering. Many spoke of values of relationality and wholism being essential to their work in all dimensions, from motivating them to embark on a career in HHS in order to give back to their communities, to guiding their approach to working with patients.

> I went to the Band manager, and I said, I need to go back to school. She just looked at me, and she just said, "Good for you." So I said, "I want to become a social worker so I can help my people, help all Aboriginal people."

Once in training, participants spoke of relationships with family and community as a primary facilitator in their success.

> My immediate family is probably my biggest support, and my partner. They supported me through school. Whether that was making me food, or giving me food, buying me food, feeding me was the big one. My mom would can for me if I didn't make it home to pick berries. She made sure I had, you know, the traditional foods and stuff while I was down in Vancouver. Deer meat and moose meat and all that stuff – my partner's a big hunter, too, so he always made sure we had that.

Once in the workforce, multiple participants noted that the way in which they practice in their field of healthcare is guided by their cultural values, such as wholism and relationality.

> In our teachings anyways, in being [Indigenous] we tell people who we are, we tell people who our parents are, and our grandparents. And so I do that with the Indigenous folks I work with, I just try to stay true to who I am, what I was raised with. And yeah I keep the ethics and principles of my profession in place, but also just remembering, you know, I am Indigenous, I have my own cultural identity to acknowledge and respect too in the work that I do.
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> …
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> I really liked the idea of midwifery because you treat the whole person. It's a very wholistic profession compared to some other of the medical professions that I could have chosen. And I just like the idea of getting to build a relationship with my clients and getting to have longer appointment times. Midwifery appointments are about 45 minutes, as opposed to if you had just a traditional physicians' clients, they would be about maybe 5–10 minutes for each appointment. So I really like that idea of relationship building.

"When I go to a school, I want the students to think 'I could do that too'.": The importance of representation in HHS

The importance of Indigenous representation and the deleterious effects of the lack thereof were manifest in a multitude of ways for participants. Many felt that from a young age, seeing themselves represented in HHS was essential to being able to make a decision to choose that path. Once pursuing an HHS career, many participants felt the weight of being the only Indigenous person in the room, and often not having Indigenous mentors or communities in their fields.

> If you really want to create more Indigenous health care providers, you have to be able

> to give young people the opportunity to see that they can do it too. And so I really wish there was more mentorship right from the time they were young so that they would see that. So when I go to a school, I want the students to think I could do that too.

One participant shared that they had been hoping to use Indigenous research methodologies in their master's course, but were advised against it by the instructor, for fears of the research not being publishable.

> I took his advice, and I started designing my study, not using what I wanted to, but then I wasn't as interested in it. So that felt strange. But then I thought, oh well, he knows what he's talking about, he's someone in the field. So that was a barrier, because I'm not really interested in using all your Western methods, they felt less personable. I ended up switching that design over with the support of my supervisor who connected me to an Indigenous co-supervisor, but that took time. Having a faculty member not know anything about [Indigenous methodologies], and then advising students not to use it. That was problematic.

Looking into the future, many participants viewed it as part of their role to become a mentor within their field to future generations of Indigenous clinicians.

> Being able to see people who look like you and have similar backgrounds in these different professions ... that has a really tangible impact on making you feel what's possible. I just hope that I can be a mentor for future Indigenous clinicians, and make a welcoming space ... so that they don't feel the way that I felt before.

Tokenization was identified by many participants as a downstream effect of the lack of Indigenous representation in the HHS professions. Participants noted that they are often asked to do additional advocacy work in Indigenous health or related fields, which is typically unpaid. Even when not asked, the majority of participants reported that by nature of being Indigenous they felt compelled to engage in work beyond the scope of their paid roles.

> In my current work it's a little strange, because half the time I feel very tokenized. Right now, I'm the only Indigenous person that works in the unit. ... But the other half of it is kind of amazing, just because I know that they value my opinion so much. And really, they don't mean to make me feel tokenized, they really want to be better researchers.

To combat this, participants spoke often about intentionally building communities of Indigenous clinicians in the environments that they worked in, both formally and informally. The intention behind building these communities was identified as being both personal and professional for participants.

> Going to my first [Indigenous Physicians' Association of Canada] meeting was just revolutionary for me. And it was like my annual church, is what I would call it. Because it was the first time I talked to people who grew up on the reserve, who grew up in poverty, who grew up with a lot of struggles. And they were in third year, so I was like, well, if they can make it to third year, then at least I can maybe make it to third year.
> …

> I feel like the residents that go through the program, create like a little micro-army that's growing in B.C. and across the country. And I'm hoping to do that with practicing physicians. And that hopefully, there's enough of us that get to enough tables, that eventually our little waves become tsunamis.

"As Indigenous people, we don't have super rich families to pay for schooling, so I took it upon myself to get the funding that I needed.": Material and structural factors

Underlying the relational and social factors that mediated success in the HHS for participants, there were multiple material and structural factors identified.

> We didn't have computers still at the time, and so I actually almost missed the acceptance letter that came through email, and then they needed some amount of money down. And you know, with me and my family at the time, there's not very many people I could borrow money from. And so it was an intense scramble to try to make that when I decided. And for me, it was terrifying.

To combat this, many participants credited financial support in the form of scholarships, awards, and bursaries with their ability to pursue their education. Participants frequently reported that the geographical constraints of training dovetailed with financial pressures, creating a sense of otherness, disconnection, and overwhelm.

> Traveling so far, to an expensive city, outside your home community, everything you've known your entire life, that was a challenge for sure.
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> …
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> I'll just also note the northern and rural barriers that are present. When people have to go a long way from home, and go into big cities, like when I landed in Edmonton to write my MCAT and to start Pharmacy. It was so impossibly huge to me and I got to the quad and got lost, and it was very emotional. It just creates another element of not belonging or of being othered, and you also don't have your support network with you.

In response, multiple participants spoke of the significance of being able to choose where they went for their placements. They also noted that this was often not a well-established process, and there was frequently uncertainty in their ability to work or learn on their traditional territory.

> We're allowed to choose one of our placements, we can propose to them where we want to be placed. So I think that's really helpful for people that, for example, for me, I really want to push going back to Winnipeg and practicing there for one of my placements. I'm not sure if that is something that they can approve, but I definitely am going to put in a proposal for that. I think that would be really beneficial for me. I think that that's really good for students, if they want to go back to their home communities that they get to choose at least one of those places.

Once geographically and financially situated in training and in their careers, many participants found that their institutions were still not built to accommodate the specific and unique needs of Indigenous learners and staff. Specific needs that participants identified included flexibility in their schedules to meet familial responsibilities, as well as academic accommodations where needed.

When speaking about access in relation to admissions, one participant identified how discriminatory and exclusionary admissions criteria are.

> We can't just use GPA. That's racist, like You know, first generation newcomers to Canada are at a disadvantage. Indigenous people are disadvantaged. There's so many poor people, there's so many things that make having a 3.8 GPA impossible. You know, I wouldn't have gotten in, honestly, I couldn't get into my program now and I'm a professor in it.
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> …
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> Some Indigenous people in the healthcare profession may not be able to fit into the structure of rigid roles. And that shouldn't mean that we can't be in the profession, we can fit, it may just need to look a bit different.

"There's always the racism, to me that's a given.": Anti-Indigenous racism from self to systems

The negative effects of anti-Indigenous racism and colonization manifested themselves explicitly over many timescales in participants' journeys. Even prior to embarking on a profession in healthcare, the decision to do so was complicated for many participants by the relationships they had as Indigenous people with the healthcare system in Canada.

> I think it's hard to choose social work as an Indigenous person just because of the sordid history of social work. ... Sometimes it almost feels like being Indigenous and a social worker is something that cannot go together.

Many participants highlighted experiences of racism that they had faced in their training, from the classroom to the clinic. Many of these experiences revolved around having instructors who were not equipped to teach in a culturally safe manner.

> Going through the Masters itself, I had to confront some of my instructors on racist ideologies and perceptions. Some instructors, they weren't always very culturally safe .... Most are great, don't get me wrong. But there was a time an instructor made a comment about a drunken Indian in class and it completely blew me away. I started sobbing in class in front of all my classmates in my Masters, because I wasn't expecting that. I was completely taken off guard. And I left the room because I was like, I can't be here right now, like this wasn't safe. ... Then I met with the instructor after that, and was like, 'Hey, this is why that was not okay, that was not safe, that wasn't good,' and just confronted it. I felt like, here I am supposed to be a student, educating the educator.

These experiences often continued once in the workforce.

> When I was very first hired, my manager, who was only there for a couple months before me, she told me that she wasn't sure if I was the right person for the job, but because I was First Nations, I got the position. And I was like, 'Oof, okay, so am I not qualified to be here?' It didn't sit right with me and really messed with me for the first year that I was there.

Participants noted that it was often experiences like these that led them not to disclose their Indigenous identity to other classmates or faculty, or to try to differentiate themselves from other Indigenous people who they saw being negatively represented.

> That pressure to be doing better than everyone else so that nobody can criticize you, which is kind of internalized racism in a lot of ways, at least in my family. That's how it was expressed, right? It was like, okay, well, we're Indigenous, but we're not that kind of Indigenous. Separating ourselves and trying to use that to better ourselves in some way, which is really unfortunate. I think I went through periods of really being angry at my family for being so negative towards Indigenous people, and so racist. ... But then I also have to hold forgiveness for them, especially my grandmother, as she grew up in a very abusive and difficult situation with residential schools.

Another topic that arose frequently in discussion with participants was their experiences with cultural safety and anti-racism training. Some participants found these training sessions at their home institutions to be empowering, allowing them to build confidence in denouncing discrimination when it arose. However, some participants felt that there is a lack of data surrounding the efficacy of cultural safety training, and whether it has made a tangible impact on the experiences of Indigenous people accessing care.

> One of the things I feel really passionate about is about the data piece. We've kind of been doing cultural safety and humility for a long time, and I'm not sure that it's made a big impact on people's experience, the experience of people when they access care.

Some noted the difficulties with participating in these sessions as an Indigenous person themselves.

> We have mandatory Indigenous sensitivity training, that assumes no one taking it is Indigenous, I'm like do you have to assume that we're all white? Because I'm Indigenous, and this isn't how I would tell my story.

The logistics of training posed barriers as well, as participants noted that online modules can be easy for their peers to skip over. Of note, interactive or live sessions were largely preferable for participants, even when conducted online.

Discussion

In this study, we sought to understand the experiences of Indigenous people working in healthcare as a necessary precursor to increasing the number of HHS workers in Canada, and ultimately improving health outcomes for Indigenous people.

"I just try to stay true to who I am": The value of culture and community

The notion that Indigenous people are driven to pursue HHS careers by a desire to give back to their respective communities is widespread in the literature (Bailey et al., 2020). As described in participants' stories herein, this motivation can range from addressing community health needs to advocating for individual patients. Community service motivations have also been found in previous research to serve as a factor in job retention (Lai et al., 2018).

Participants in this study spoke little of the challenges inherent to returning to community after graduation, but these have been previously identified in research and include lack of band funding or capacity to manage a healthcare system, the difficulties of caring for sick friends and family, and conflicts between professional and community responsibilities (Johansen, 2010; Lai et al., 2018; Schulling, 2003). As described by participants in this study, family support has been identified in the literature as a valuable facilitator of student success, namely thought to provide students with encouragement and confidence to enable their recruitment and retention in tertiary education programs (Garvey et al., 2009; Johansen, 2010).

Participants spoke often of the importance of integrating Indigenous ways of knowing and being into their work. Research from both Australia and Canada supports the notion that Indigenous HHS workers often integrate Indigenous epistemologies and values into their practice, with the values of relationality and wholism being most consistently cited (Bearskin et al., 2016; Van Bewer et al., 2020). Relationality is the concept that we are all related to one another, bringing with it a set of responsibilities to kin and to land (Van Bewer et al., 2020). Indigenous wholistic theory can be thought of as an extension of this in that it relates the spiritual, emotional, mental, and physical wellness of Indigenous people to relationships between the individual identity, culture, land, and community (Absolon, 2010; Antoine et al., 2018; Miles et al., 2023). The practice of integrating Indigenous cultural values into one's work in healthcare has previously been described as living in two worlds (Bailey et al., 2020). This is akin to the concept of Two-Eyed Seeing, or Etuaptmumk in the Mi'kmaw language, which was developed by Elders Murdena and Albert Marshall (Bartlett et al., 2012).

The literature supports our findings in this study that being able to work in a way that aligns with personal values of relationality and wholism actually enables recruitment and retention of Indigenous HHS workers (Bailey et al., 2020; Lai et al, 2018; Van Bewer et al., 2020). According to a 2018 review by Lai et al., Indigenous health professionals value culturally safe workplaces that allow for the integration of holistic approaches rooted in Indigenous knowledge and practices. A recent article from Van Bewer et al. (2020) notes that the incorporation of Indigenous perspectives into the otherwise colonial practice of nursing can actually strengthen the profession's adherence to its core values of relationality and wholism. In an educational context, the recognition of one's "Aboriginal self" and maintenance of one's Indigenous culture have emerged as tools contributing to success in HHS training programs (Johansen, 2010).

"When I go to a school, I want the students to think 'I could do that too'.": The importance of representation in HHS

Advocacy on behalf of Indigenous patients is understood to be a strength that Indigenous HHS providers bring to their field (Bailey et al., 2020). However, participants noted that this can cause workers to feel like the token Indigenous provider, leading to increased workload. Research in keeping with this has shown that Indigenous providers are disproportionately chosen to look after Indigenous patients, and often made to feel tokenized (Addressing Racism Review Team, 2020; Lai et al., 2018). A contributing factor to this is role ambiguity, which has led

Indigenous health professionals to be treated as cultural experts or token representatives rather than being recognized for their clinical or professional expertise (Lai et al., 2018). To combat this, the definition of clear role responsibilities, inclusion in decision-making processes, supported learning, and access to suitable resources have all been identified as facilitators for the success of Indigenous HHS workers (Lai et al., 2018).

As suggested by multiple participants in this study, another key strategy to combat tokenism is Indigenous mentorship. Previous research has shown that simply knowing someone else who works in health and receiving encouragement in the personal pursuit of a career in healthcare are important facilitators of success (Bailey et al., 2020; Schulling, 2003). Lai et al.'s 2018 systematic review identified Indigenous mentorship and peer support as the most frequently cited enablers for job retention among Indigenous healthcare providers, leading to increased job satisfaction, alleviation of emotional fatigue, and reduced rates of stress and burnout (2018). They note that the inverse was also true, where the lack of formal mentorship and support led to negative perceptions of the work environment and increased turnover. Where culturally appropriate clinical mentorship is not available, they suggest that workplaces hire an external cultural mentor to support Indigenous staff.

Indigenous communities of practice are described as an extension of mentorship and peer support, and have been shown to be meaningful factors in the retention of both students and professionals (Adams et al., 2005; McCubbin et al., 2023; Taylor et al., 2019). Analogously to the Indigenous Physicians' Association of Canada being identified by one participant in this study as a facilitator of their success, research from Australia has identified the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives and the Australian Indigenous Doctors' Association as providing invaluable support to members at varying stages in training and work (Taylor et al., 2019).

At the level of education, development of both formal and informal opportunities for Indigenous mentorship has been shown to improve recruitment and retention in both healthcare training programs and in tertiary education more broadly (Taylor et al., 2019). Indigenous mentors are seen to play a vital role in acting as both positive role models in healthcare professions, and helping to define and communicate program expectations for more junior trainees (Garvey et al., 2009; Schulz et al., 2018). It follows from this that many students have identified the need to increase the number of Indigenous faculty, lecturers, and staff they engage with (Adams et al., 2005; Taylor et al., 2019).

"As Indigenous people, we don't have super rich families to pay for schooling, so I took it upon myself to get the funding that I needed.": Material and structural factors

It is noted across the literature that HHS professional training is resource-intensive (Garvey et al., 2009). In keeping with the experiences participants described herein, a 2019 systematic review conducted by Taylor et al. (2019) found that a quarter of articles examining barriers to recruitment and retention of Indigenous students in tertiary education programs identified financial hardship as a key barrier. Conversely, financial assistance has been identified as a facilitator of retention for Indigenous students (Schulling, 2003; Taylor et al., 2019). Once in

the workplace, inadequate remuneration and lack of job security are frequently mentioned barriers to the retention of Indigenous health workers in Australia (Lai et al., 2018).

The structural barriers that Indigenous HHS providers face have their origins early in life. According to a 2012 literature review by Curtis et al. in New Zealand, inequities in academic achievement rates between Māori and non-Māori students exist by the time they reach secondary school, and Māori students are often guided away from pursuing careers in health by careers advisors and teachers (Curtis et al., 2012). This has led many to call for the recruitment and preparation of Indigenous students for careers in healthcare at the high-school level or earlier (Curtis et al., 2012; Orchard et al., 2010; Schulling, 2003). Once in tertiary education, there is significant research to suggest that the presence of an office dedicated to the support of Indigenous students can support recruitment and retention through the modulation of structural barriers and facilitators (Garvey et al., 2009). The specific benefits identified as contributing to this include the provision of information regarding financial assistance, practical resources, advocacy, and personal and cultural support (Garvey et al., 2009). The need for flexibility in training and work that participants spoke of is also reflected in the literature, as it's been suggested to increase retention of Indigenous workers by allowing them to meet their professional, community, and cultural obligations (Lai et al., 2018).

"There's always the racism, to me that's a given.": Anti-Indigenous racism from self to systems

Nearly all participants spoke of experiences of racism in training or in the workplace. There is widespread evidence in the literature that Indigenous HHS providers experience racism in the workplace both directly and indirectly through witnessing discrimination against Indigenous patients (Addressing Racism Review Team, 2020; Lai et al., 2018). As described in Bond et al.'s 2019 review, experiences of racism, bullying, and harassment are common amongst Indigenous Australian healthcare professionals. Unfortunately, this experience extends to healthcare professionals in Canada, as Bearskin et al.'s 2024 work attests to the frequent encounters Indigenous providers have with racism in the workplace. They also highlight the lack of established policy and protocol at the institutional level when Indigenous providers experience or witness racism at work (2024). According to the 2020 report *In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care* (Addressing Racism Review Team, 2020), over 90% of Indigenous respondents reported that their mental and emotional health was impacted by racial prejudice experienced in the workplace. In contrast, culturally safe practices in the work environment have been found to improve job satisfaction and enable worker retention (Lai et al., 2018).

Experiences of racism and discrimination in educational environments have been described in the literature as a key barrier to the retention of Indigenous students in healthcare training programs (Garvey et al., 2009; Johansen, 2024; Lai et al., 2018; Power et al., 2024; Taylor et al., 2019). For instance, research suggests that many students face discrimination based on others' misconceptions regarding a lack of competency in Indigenous students placed into seats reserved for Indigenous applicants (Garvey et al., 2009). This is analogous to the

participant's experience in this study who was accused of only being hired for their position they had because they were Indigenous.

Cultural safety training for students in HHS training programs has been identified as the principal strategy to address the issue of racism in health education (Addressing Racism Review Team, 2020; Power et al., 2024). The importance of all health profession students learning about Indigenous people and culture, as well as cultural safety, is generally agreed upon among Indigenous HHS workers (Power et al., 2024). However, there is evidence to suggest that Indigenous students enrolled in subjects that explore Indigenous content may be exposed to culturally unsafe curricula, as well as potential harm from non-Indigenous instructors and classmates (Francis-Cracknell et al., 2023).

The second challenge of cultural safety training that participants identified was the difficulty in assessing the degree of efficacy of these trainings. Numerous studies have shown subjective benefits to Indigenous cultural safety training in students' self-assessed knowledge and ability to care for Indigenous patients (MacLean et al., 2023; Rand et al., 2019). However, as participants noted in this study, it is difficult to demonstrate a correlation between Indigenous cultural safety training and improved healthcare delivery to Indigenous patients (MacLean et al., 2023).

Conclusion

This study brings forward the perspectives of Indigenous HHS providers in British Columbia, offering insight into the barriers and facilitators to their employment satisfaction and career success. We draw heavily on previous research done internationally, notably by and with Australian Indigenous and Torres Strait Islander students and professionals, to contextualize and understand the experiences of Indigenous people in British Columbia. Of note, written publication is not a traditional form of knowledge dissemination, but has been undertaken intentionally with the understanding that it is the best means by which to reach our intended audience, namely non-Indigenous healthcare providers and the general public more broadly. With this in mind, we invite correspondence and further dialogue, and raise our hands to you for engaging in this important work.

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