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Beyond shame, sorrow, and apologies—action to address indigenous health inequities

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On 1 April 2022, Pope Francis made a historic apology to indigenous peoples in Canada for what he described as "deplorable" abuses occurring in church run residential schools.[1] This statement is one of multiple apologies recently offered by world leaders for colonial injustices and abuses of indigenous people.[2-4] For many, these apologies represent landmark events. However, as indigenous health scientists who bear witness to the real life impacts of colonisation on indigenous health today, we cannot help but raise the question: "How do these apologies get translated into tangible changes that reduce indigenous/non-indigenous health inequities?" While we do not presume to hold all the answers, we are certain of two things. Firstly, while indigenous leadership and direction is essential, the hard work of change needs to be shared by all who have benefitted from colonisation. Secondly, current inaction appears to be rooted in so called know-do gaps—meaning there are gaps between what we know and what we do in policy and practice. In this instance, clear policy directions come from indigenous leadership globally and a growing evidence base that could inform action, yet indigenous/non-indigenous health inequities persist, and in many cases are getting worse. Building on these premises, we have three cross-cutting recommendations for non-indigenous decision makers, administrators, and practitioners of health and social system policy, on how to translate white and/or settler privilege into tangible change.

1. Understand the role of colonisation, settler systems, and how these systems perpetuate indigenous/non-indigenous health inequities

Coming to terms with colonisation is the first step towards transformation of indigenous health inequities, however this process is often stalled when the focus shifts from understanding the white supremacist foundations of colonialism to (re-)defining the term in an attempt to justify ongoing oppression. As Māori scholar, Moana Jackson states "colonisation was and is a very simple process of brutal dispossesion in which states from Europe assumed the right to take over the lands, lives, and power of indigenous peoples who had done them no harm."[5] Settler colonists regarded the lands as newly "discovered" despite the presence of indigenous populations on these lands.[5-7] Racism is central to colonisation. The rationale for denial of existing indigenous peoples' sovereignty was the prevailing thinking that indigenous peoples were materially, culturally, economically, and politically inferior. The historical settler colonial era deeply entrenched a racial hierarchy through a plethora of policies, systems, and structures based on racial hierarchies that have no evidentiary basis. Racist systems of classification or "hierarchies of race" were applied as scientific justification of oppression by differentially assigning value, opportunity, and resources to groups deemed "inferior."[8 9] While the research used to create a race classification system has been long disproven, the social, structural, and institutional legacies persist and are a cause of power imbalance that manifests in ways which perpetuate, reinforce, and justify a racial hierarchy to this day. This includes ongoing epistemic racism in which the knowledge and practices of indigenous people are considered inferior "lay knowledges" and relegated to a marginal role in academic health sciences.[10 11]

Settler colonialism remains an ongoing structure of domination that still aims to ensure continued coercive exploitation and control.[5 6] It is largely through societal systems of racism that settler colonial structures continue to maintain material and symbolic (eg, political) privilege, including in health.[8] For example, the disproportionate burden of mental health challenges experienced by many indigenous populations has been linked to historic and ongoing colonial policies, including disruption of traditional kinship, social, economic, and political systems.[12 13] Systems transformations that advance self-determination for indigenous populations, including self-determination of health and healthcare systems, have been recognised as essential to indigenous health.[13]

2. Become familiar with and learn to manage your discomfort, so that the focus can be on advancing indigenous health and wellbeing

Engagement with discomfort is embedded in the day-to-day practice of medicine. We bear direct witness to the pain and grief linked to individual and collective disease, and at our best bring compassion and tangible assistance. Self-awareness of our emotional responses is part of our ongoing professional training, and the expectation is that we will self-manage in a way that optimises our ability to focus on the wellbeing of the individuals and populations that we serve. Historically, there was an unrealistic expectation of near perfect practice and system performance accompanied by shaming and punitive measures when medical errors inevitably occurred, but more recently there has been a movement to create learning and practice

environments where individuals and teams are encouraged to acknowledge errors and seek out their root causes, as this approach has been shown to contribute to better patient outcomes.[14]

On matters of indigenous health inequities, we often perceive our settler colleagues to be struggling with feelings of shame and sorrow. At times, the expression and management of these feelings appear to interfere with the required focus on advancing indigenous health and wellbeing through tangible action. This white and/or settler fragility appears to be a barrier to action.[15]

As indigenous peoples, we too have strong feelings about colonial harms and the racism that drives these harms. In keeping with professional obligations and best practices, the labour of managing emotions arising from colonial harms and complicity should be taken on in a way that enhances, rather than detracts from a focus on tangible actions that will advance indigenous health. For example, through cultural safety approaches which include "a reflective self-assessment of power, privilege, and biases."[16 17]

3. Follow existing indigenous leadership recommendations and evidence

With enhanced baseline knowledge and understanding of the links between colonisation, racism, and health inequities, and the detachment of white and/or settler emotional responses from the task at hand, the path will be cleared for productive action. The next hurdle, in our experience, is ensuring action is aligned with recommendations from indigenous leadership and existing evidence in the context of racism and colonisation. It is a good time to engage in action for tangible change, as globally[18] and domestically[19 -21] indigenous leaders have worked to clearly articulate rights and recommendations for moving forward. For example, our first recommendation above is closely aligned with the first call to action in health of the Truth and Reconciliation Commission of Canada, which urges governments to make the links between colonial policies and current indigenous health inequities.[19] Further, a growing body of scientific evidence identifies actions that can reduce racial inequities in health and healthcare.[22]

Too often, we encounter settler colleagues who dismiss the wisdom of indigenous leadership or demonstrated evidence because they "know better." This commonly includes colleagues who are firm advocates for evidence based policies and patient centred care in other contexts. Part of the challenge appears to be a failure to acknowledge that within the context of addressing indigenous health inequities, there are policies, evidence, and expertise to be considered, just like in any other field of healthcare.

To achieve indigenous health equity, we need to disrupt persistent colonial frameworks and advance indigenous governance and management of indigenous affairs at all levels and across domains, including health and health services. Compelling evidence exists to support this argument. Global health systems and healthcare institutions are rooted in colonial social structures and continue to differentially provide social value, opportunities, and resources to settler populations over First Peoples. Clear recommendations from indigenous leadership and growing scholarship explain how to interrupt this injustice at policy, institutional, and practice levels. Yet there is resistance to acknowledging and acting on what is known. The uncomfortable truth is that, despite the commitment in healthcare to "do no harm or injustice," this is exactly what is happening every day across the globe to indigenous patients and populations.[23] The time to translate what we know into action is long overdue. If you are a non-indigenous health policy maker, administrator, or practitioner colleague, we hope that you now feel that you have a place from which you can start.

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