What it means to be an ally in Indigenous healthcare

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Abstract

Background: Strengths-based and culturally sensitive approaches to Indigenous healthcare are much needed within the Canadian healthcare system. This is where allyship comes in. Allyship is loosely defined as the actions of an individual who strives to advance the interests of marginalized groups in which they are not a member. This study investigated the concept of allyship with healthcare providers who were community-identified allies providing care for Indigenous patients.

Methods: Qualitative description methodology was utilized, and data was generated through semi-structured interviews with allies in and around the Edmonton area, in Canada. The interviews were conducted online, transcribed verbatim and then coded using thematic analysis.

Results: Interviews were conducted with 13 allies (eight physicians, four allied health professionals and one nurse). The results were captured into three main themes. The *meaning of allyship* demonstrated how allyship must be determined by the community, and encapsulates authentic action and advocacy, as well as working to create positive healthcare experiences. The *experience of being an ally* included commitment to the allyship journey, embracing emotions, and facing and disrupting systemic barriers. Finally, *cultivating allyship in healthcare* necessitated building and maintaining meaningful relationships with Indigenous people, and ongoing training and education.

Conclusion: The study results enabled a better understanding of how allies interact with their Indigenous patients within the confines of the healthcare system and could inform learning opportunities for those who seek to practice in a culturally humble way. In particular, transcending passive education and training modalities to include opportunities for real life interactions and the development of reciprocal relationships with Indigenous patients.

Résumé

Résumé français à venir.

Introduction

Historically, Indigenous societies in what is now called Canada flourished with sophisticated governance, trade, and cultural systems.[1] However, that changed since the early days of colonialism when Western authority was imposed over Indigenous knowledge, language and culture.[2] The colonization of Canada was built upon the belief system whereby Indigenous ways of knowing were deemed inferior and primitive.[3] This chapter of our history marked the beginning of the ongoing dispossession and attempted assimilation of Indigenous people and established a foundation of systemic inequalities still evident today.[4]

The Canadian healthcare system, not exempt from the colonial legacies, often mirrors the broader societal inequities that exist between Indigenous and non-Indigenous people. Indigenous health outcomes are generally poorer than the mainstream population.[5,6] For example, Indigenous Canadians have a life expectancy 12 years lower than the national average and experience higher rates of preventable noncommunicable diseases compared with non-Indigenous Canadians, while also facing barriers to accessing adequate healthcare in the face of individual and systemic racism.[5] This is both a consequence and mechanism of colonization.[6] Moreover, intergenerational trauma, resulting from policies such as the residential school system, continues to impact the health and social outcomes of Indigenous people.[7]

The systemic prioritization of non-Indigenous perspectives in healthcare underscores the need for a strengths-based and culturally sensitive approach to Indigenous health practice.[8] Wylie and McConkey (2019) went further and described that Indigenous people' healthcare have been compromised by "practice norms shaped by biases informed by discrimination"[(p.37)] and quality improvement strategies are necessary at multiple levels of the healthcare system.[3] *The Truth and Reconciliation Commission of Canada* (TRC)[9] final report put the spotlight on the inequities that Indigenous people in Canada experienced in the past and continue to face in the present. The TRC covers 94 Calls to Action and seven of them relate to improving Indigenous health. Call to Action 23, for instance, aims to increase the number of Indigenous people working in healthcare fields as only 3.13% of those in health occupations in Canada are Indigenous.[10] This generated significant amount of action in Canadian medical schools, including ongoing efforts to recruit and retain Indigenous students. Although this intentional process is expected to be fructiferous in indigenizing medical education, it will take time.[11] In the meantime, most healthcare professionals in Canada are non-Indigenous.

Many non-Indigenous people who have entered the Reconciliation space received little to no training in preparation.[11] They frequently find their role ambiguous and hard to navigate especially when trying to engage colleagues in meaningful discussions.[11] In some instances, the act of engaging non-Indigenous colleagues in Reconciliation work means confronting discrimination and addressing bias,[11] which has been characterized as allyship action.[12] Allyship is a concept that has seen increased popular and academic interest, and in 2021, "allyship" was the Dictionary.com's word of the year.[12] Although this was viewed as a notable opportunity to influence positive change, allyship and allies continued to be ambivalent concepts with multiple possible definitions, and implications for practice.[12]

Pietri et al. (2024) in a review article about understanding effective allyship defined allies "as people with privileged, high-status, or advantaged identities (that is, who belong to a social group that have historically had resources and power within a given society) who are working to end oppression and uplift members of marginalized groups (a group that has been oppressed, experienced mistreatment and faced discriminatory laws and policies that hamper social mobility."[13(p.2)] In the context of Indigenous healthcare in Canada, allyship involves a commitment to understanding the specific healthcare needs and addressing the unique challenges faced by Indigenous patients. It requires healthcare professionals to engage in ongoing self-reflection, education, and action to support Indigenous health and well-being.[14] Non-Indigenous allies are needed to respond to the Calls to Action outlined in the TRC while avoiding overburdening Indigenous health professionals and champions.[11] Non-Indigenous healthcare professionals have shown sincere efforts in educating themselves as a key step in reconciliatory work,[11,15] yet their roles as allies remains to be better understood.[16,17]

This study investigated the concept of allyship within the Canadian healthcare system towards Indigenous patients, focusing on the Amiskwacîwâskahikan/Edmonton (and surrounding area), Alberta context. The demographics of Indigenous people in Edmonton, Alberta, offered a unique context for this study. As the second-largest urban Indigenous population in Canada, Edmonton's healthcare system is a critical point of access for Indigenous patients

from diverse backgrounds.[18] We explored the meaning of allyship among community-identified, non-Indigenous allies in healthcare. By doing this, not only did we aim to contribute to the growing body of research on allyship in Indigenous healthcare, but also to offer a thorough account of what it means to practice as an ally to Indigenous people.

Methods

Methodology

We used qualitative description methodology to design our study. Qualitative description embraces the existence of multiple truths and the subjectivity of participant experience. Qualitative description was selected due to its exploratory nature and given that allyship to Indigenous people in healthcare, and as practiced by community-identified allies, must be better described and understood in the literature.[14] We worked and stayed close the data with the aims of answering our research questions and developing a thorough description and summary of the findings that could be relevant to practitioners and policy makers.[20]

Setting and ethics

We conducted this research virtually from April-July 2021. The University of Alberta Research Ethics Board (Pro00105578) approved the study. Most of the participants were in and around Edmonton, Alberta, Canada, as was the research team. Edmonton is in Treaty Six Territory and the Homeland of the Métis.

Recruitment and sampling

We purposefully selected participants based on characteristics and context and who could contribute to an in-depth understanding of the research topic.[21] To be included, research participants self-identified as non-Indigenous (some were Caucasian, and some identified as members of other minority groups), healthcare professionals who provided care to Indigenous patients. The participants were identified by Indigenous healthcare professionals and colleagues as being an "ally." The literature on allyship makes it explicit that allies ought to be identified by the community members with which they align themselves.[14]

MB contacted Indigenous healthcare professionals, via email, who had previous relationships with the research team. The initial email included an introduction to the research team, the criteria for inclusion in the study, a summary of the research project and what to expect in the interview. The email also asked if they would be willing to

identify specific individuals, who they considered to be allies, and share the research information with them. The Indigenous healthcare providers that helped recruit allies then shared the researcher's contact and information with those who showed interest in participating in the study. An informed consent form and the research proposal were provided to participants prior to the interviews, and a date and time to conduct interviews via Zoom (a secure online video teleconferencing platform) were mutually agreed upon.

Data collection

MB conducted one-on-one, semi-structured interviews virtually between April to June 2021. A casual conversation took place prior to the formal interview process. During this time, MB introduced herself and reviewed the research objectives of the project as well as the information letter previously sent via email. All participants had the opportunity to ask questions. Once they agreed to proceed, the consent form was reviewed, and verbal consent was received and recorded prior to starting the interview.

The interviews followed a prepared interview guide (supplementary material) and lasted between 20 minutes and 1.5 hours. Although we followed a predetermined set of questions, we remained flexible in the order and wording in which the questions were asked.[22] All interviews were audio recorded and transcribed verbatim. Participants were anonymized and given pseudonyms; their pseudonyms matched their gender because for some women-identifying allies their gender added another layer of complexity when advocating for Indigenous patients in their workplaces. Participants' real names and any potentially identifying information were not used in the transcripts or the analysis. Table 1 includes participants' pseudonyms and their profession in the healthcare system.

Table 1. Participants' demographics

Participant Pseudonym	Profession
Sarah	Specialist Physician
Linda	Specialist Physician
Stephen	Specialist Physician
Olivia	Specialist Physician
Philip	Occupational Therapist
Veronica	Specialist Physician
Samara	Specialist Physician
Stacey	Speech Language Pathologist
Melissa	Speech Language Pathologist
Elodie	Registered Nurse
Donald	Specialist Physician
Ashley	Occupational Therapist
Joanne	Specialist Physician

Data analysis and rigour

Data collection and analysis occurred concurrently, led by MB, using thematic analysis. Thematic analysis was a way of identifying and collating the similarities to the way allyship was discussed. It followed a six-step, iterative process that included familiarization, generating codes, constructing themes, revising themes, defining themes and subthemes, and producing a report.[23] After the first three interviews, MB transcribed the interviews and began the data analysis by reading them to ensure accuracy and become more familiar with the data. Next, MB began coding key words or ideas that emerged through the interviews.

These words and ideas were coded into themes and organized with other related topics that shared similarities. MB consulted RTO and MM during virtual meetings organized to discuss data collection and preliminary findings, and together we landed on three overall themes. These three themes were considered saturated when no new data related to them emerged, and themes continued being detailed in a clear and predictable way (i.e., participants were all saying similar things). MB used ATLAS.ti (Version 9.1.3) qualitative data analysis software for the analysis.

We used several verification strategies to ensure rigour so that our findings truly reflected participants' words and views of allyship to Indigenous patients. We approached the research through an inductive process to avoid being prescriptive and to allow themes to simply emerge from data. We collected and analyzed data concurrently, which formed a mutual interaction between what was being learned and what needed to be learned.[24] Another critical step was the use of reflexivity, as it ensured the researchers checked in with the biases they brought into the study. To this effect, we would like to briefly introduce the research team.

MB conducted this study as part of her master's degree in Community Engagement, and it was much more than a study. It was a way of connecting with her role as a non-Indigenous mother to Indigenous children. She hopes that this research helps to improve the way the healthcare professionals interact with Indigenous patients and their families. RTO comes from mixed European descent and since birth he has called Treaty Six Territory and Métis North Saskatchewan River Territory, in Alberta, Canada, home. His spirit name is Wapastim, which means White Horse in Cree. RTO positions himself as an equitable partner who supports strengths-based, solution-oriented, and community-driven approaches to research, building specifically on Indigenous ways of knowing. MM has been an engaged scholar her entire 30-year career, situating her work at the intersection of government, not-for-profit, structurally disadvantaged, and clinician communities. Her work focuses on the structural causes of disadvantage and how to mobilize against systems of inequity, using primarily qualitative and community-engaged research.

Results

A total of 13 participants were needed to reach data richness and saturation in the sense that new themes were not being introduced by participants. The results were captured in three main themes: i) the meaning of allyship, ii) the experience of being an ally, and iii) cultivating allyship in healthcare. These themes advanced the understanding of allyship in Indigenous healthcare, while also eliciting participants' assessment of both the successes and struggles of being an ally. We broke each theme into sub-themes and thoroughly describe them below.

The meaning of allyship

Participants spoke to the meaning of allyship, with three subthemes: allyship must be determined by the community and has distinct characteristics, allyship is authentic action and advocacy, and working to create positive healthcare experiences.

Allyship must be determined by the community and has distinct characteristics. Most of the participants recognized the importance of being community-identified, rather than self-identifying as an ally. One participant noted, *"it has to come from the community, it's something you earn" (Sarah).* Veronica explained what allyship meant to her and the importance of community within the discussion of allyship:

> I think allyship to me means, that I allow myself to be held accountable by the community I work with and for, and I allow myself to take direction from them. It is waiting for opportunities in which I can speak and provide my education and some of my expertise towards the questions that they're asking. But a lot of allyship to me means walking alongside and building relationships rather than coming in with solutions.

Most of the participants had clear convictions about what characteristics were central to allyship work in healthcare. Participants mentioned being: *"an advocate,"* a *"community member,"* an *"along-sider,"* or a *"co-resistor."* Other key characteristics that were highlighted as key in

allyship included: humility, trustworthiness, patience, good listening, willingness to learn, compassion, empathy, being a safe person, reciprocity, and self-reflection. Overall, participants generally agreed that the most critical aspect of allyship is *"the ability to be humble and listen"* (Elodie). Veronica added, *"I've really learned and appreciated the opportunities to just listen and just be quiet and just keep showing up. I think that it's been a hard lesson for me to learn, but allyship is listening."*

The concept of *"working alongside"* meant *"collaboration."* For example, working alongside for Sarah meant not imposing a "*white biomedical model of healthcare to patients"* and collaborating with patients, their families, their communities, and Indigenous healthcare professionals to ensure that Indigenous perspectives were being incorporated into their care. It also meant acknowledging that the biomedical model of healthcare was centred around settlers' experiences and worldviews, which generated inherent power imbalances within healthcare. For these reasons, participants acknowledged that collaboration was vital in the context of improving healthcare for Indigenous patients.

Allyship is authentic action and advocacy. A feature of allyship, according to the participants, was the important role of advocacy. They believed all allies had to be advocates for Indigenous people and motivate and inspire other healthcare providers to also stand up against discrimination. In participants' perspectives, all healthcare providers should take on the role of advocates, and work proactively against racism and prejudice, such as working to change policies and procedures and removing or reducing systemic barriers. Joanne explained that allyship meant, *"being willing to advocate for Indigenous people's rights, including the right to health equity."*

Participants noted that within healthcare, there are hierarchies embedded within the system. For example, their profession (e.g., physician or nurse), race, gender, sexual orientation, religion, and class, among others, played a role in their perceived ability to be advocates. Participants commonly experienced an internal tension between speaking up and not speaking up because they felt that they did not hold the power in a particular situation or had concerns regarding being the "great white saviour," as noted by Elodie, "*I have to be conscious about not being a white saviour. I'm not going in there being like, 'I want to save all these people, and I can't wait to just fix everybody!'"* These were key dilemmas that participants

mentioned in their allyship journeys and especially within the complex hierarchies within healthcare.

Beyond advocacy, allyship for participants also meant taking any immediate or necessary action to ensure their Indigenous patients had what they needed to have a better experience in the healthcare system. Olivia, a resident doctor, explained that for her allyship involves *"being willing to advocate for your patients when you see inequity or racism happening in front of you and being able to stand up for that."*

Allyship works to create positive healthcare experiences. Participants connected their understanding of allyship with thoughts around the meaning of a positive healthcare experience for Indigenous patients where they *"feel heard,"* *"feel safe,"* are *"not being judged or shamed."* Stephen, a physician who works on a First Nations reserve, provided insightful thoughts into what a positive healthcare experience means to him and his patients. He believes this requires patients to *"feel comfortable asking questions and returning for follow-up care,"* and that they *"believe their ailments were addressed and/or cured,"* and *"their culture, and that their experiences and needs were respected by the healthcare providers."* Elodie, a registered nurse, explained:

> *Allyship means understanding that me, as a white person, and my patients as Indigenous people, we are different, but that doesn't mean that I'm going to care for you differently. I'm not going to expect you to have the same views on life, the same medicines, and the same traditions as me. I think allyship is being a person that creates that environment for safe holistic healthcare.*

The Experience of being an ally

Participants detailed the experience of being an ally, with three major foci: commitment to the allyship journey, embracing emotions, and facing and disrupting systemic barriers.

Commitment to the allyship journey. One central finding of this research was the notion that allyship is a *"journey,"* *"a process"* or *"is on a spectrum."* Allyship was not something you could *"check-off a list."* It was perceived as ongoing and required a lifelong commitment to learning and improving. To increase allyship, participants believed it was important to meet people where they were at on their journey. What worked for one healthcare professional in one situation, might not work for another. Stacey stated:

You don't want to put other people down for their journey or where they're at in their journey. We want them on the journey, we all want everyone on the journey. I would love to have a world where everybody's on that journey accepting each other. I can't be self-righteous. I still make mistakes.

This aspect of allyship reaffirms what participants have said about the commitment to lifelong learning and unlearning, and that mistakes were normal and an integral part of the allyship journey. To minimize the harm of mistakes, Elodie suggested that an ally could *"ask a lot of questions," "admit your mistakes,"* and *"ask for forgiveness."* Some said self-reflection was key to good allyship because with reflection, mistakes could be major learning opportunities.

Embracing emotions. Most participants spoke of times when they had to be vulnerable in their emotions while being on the job. Working with and for Indigenous patients and their families can often be emotional. Indigenous people often enter healthcare having had previous negative experiences, combined with illness, vulnerability, trauma, racism, and prejudice. Participants shared about the overwhelming emotional burden they felt trying to improve Indigenous people's healthcare experiences, especially as participants spoke about the perceived uphill battles they faced within the hierarchies of the healthcare system. Some of the female participants, particularly, struggled with their own perceived lack of power and privilege being women-identifying healthcare providers.

Although some participants shared stories of negative emotions when recounting past experiences, most of the participants also shared positive and hopeful emotions and stories about their experiences. Those stories illustrated some of the positive emotions that came with being an ally in healthcare. Yet, participants were keen to highlight that their Indigenous patients were not victims, not broken or all tragically ill. Instead, they perceived them as examples of strength and resilience. Samara shared:

I didn't have any interaction with anyone who was Indigenous until I kind of sought that out… [there is] just so much richness and culture and beauty. If you are invited to be part of that, it's such an honour and privilege. I feel like healthcare just doesn't know that or get that. We don't realize how much we can learn from our Indigenous patients.

Samara and other participants mentioned that they felt it was an honour to help their Indigenous patients and were grateful for all the learning opportunities that their patients shared with them. Participants felt that being an ally in healthcare was emotional, with both positive and negative emotions, but that the good far outweighed the bad.

Facing and disrupting systemic barriers. Some participants were explicit about barriers that interfere with being an ally in Indigenous healthcare, such as *"time," "hierarchy in medicine," "leadership,"* and *"academic and medical markers of success that contradict what is needed for good allyship."* For example, Sarah stated, *"allyship is a necessary but an insufficient factor or component to dismantling all of those unequal structures."* While participants felt that allyship was useful and necessary, without structural systemic changes, they would continue to fight an uphill battle.

As an example, participants described that taking the time to build relationships with their patients was important to the participants, yet the current healthcare system did not encourage this type of service delivery. In this context, some participants criticized the *"fee for service model"* of healthcare, where some felt they were pressed for time and simply could be the best allies in providing care under these conditions. While these concerns were specific to physicians in the clinic, the same time constraints were common in most healthcare professions. This fundamentally contradicted the essential quality of relationships that participants identified as key to allyship: *"patience,"* *"good listening,"* and *"learning."* All participants mentioned that good allyship took time to establish, and that the current model of care did little to make space for this. As Stephen explained:

In medicine, time is always a challenge. Spending time with any patient is sometimes a challenge when you just have so many things to do. You don't have the time that you want to give someone, and sometimes these things just take time to do well.

Participants also highlighted additional systemic barriers, beyond healthcare, that negatively impacted their ability to provide appropriate care, as Olivia explained, *"improving the conditions that reinforce inequity and illness,"* such as access to *"clean drinking water," "safe affordable housing,"* and *"employment opportunities"* were imperative. All participants identified that a step forward must include *"dismantling barriers and the systems that reinforce inadequate and inequitable access and care for Indigenous people."* However, participants still felt that the small day-to-day interactions were important to Indigenous health and in cultivating allyship at an individual level.

Cultivating allyship

Participants carefully explored how allyship could be cultivated. This was described in two central sub-categories: building and maintaining meaningful relationships with Indigenous people; and ongoing training and education.

Building and maintaining relationships with Indigenous people. All participants spoke about being in relationship with Indigenous people as a key aspect of fostering their growth as allies. Simply stated, getting to know an Indigenous person was identified as a turning point in their lives in nearly all the interviews. Most of the participants identified early experiences involving positive experiences with Indigenous people, for example, through volunteering, through a faith organization, through a friendship or working relationship, or through a practicum or preceptorship in their formal education. As Joanne reflected, *"those positive experiences and getting to know people, as individuals, I think were quite important in my own journey."* Stacey also noted:

> I don't think education is the way. We all know what happened. I don't think that's going to increase allyship. Increasing allyship is going to happen through relational exchanges and creating ethical space to have those.

Stacey's statement about the importance of relationships was echoed by most participants. Relationships were perceived as key because they are a way to humanize one another. Nevertheless, participants were clear that these relationships cannot be transactional, they must be established, maintained, and reciprocal. Some participants mentioned the importance of the relationships they have cultivated within the communities they serve as key to their success as allies in Indigenous healthcare.

Beyond relationships with Indigenous individuals, participants also explained that relationships were key to teaching and learning about allyship. Joanne explained, *"allyship is best taught through role modelling or mentorship rather than teaching."* Some participants felt that the best way to learn about allyship was by watching someone else do it. For instance, Joanne mentored many medical students, and she felt that the best way to teach the students how to be allies was by modelling that behaviour herself.

Ongoing training and education. Participants noted specific ways they learned about Canadian history as it relates to Indigenous people and the ways they use to

continuously learn. Some key resources that participants found particularly helpful included the University of Alberta's Massive Online Open Course (MOOC) Indigenous Canada, book clubs and/or reading books by Indigenous authors, reading the TRC and *the Final Report of the Inquiry into Missing and Murdered Indigenous Women and Girls (MMIWG)*, watching Indigenous movies and listening to Indigenous podcasts, and attending virtual or in person learning opportunities or seminars that had been offered by universities, non-profits, provincial health services, various levels of governments, and the library.

Participants also mentioned the "benefits of experiential learning" where they learned from the communities they serve. Some examples included participating in a KAIROS blanket exercise, participating in ceremony when invited, attending a powwow or round dance, going out to the community, and taking the time to talk to an Elder or Indigenous person. Many of the participants mentioned the importance of involving Elders in their work, and this was especially true of the healthcare providers that work in Indigenous communities. As Donald explained, working with many Elders in various projects has "*really cemented my understanding of what it means to be an ally.*"

Participants raised many critiques about cultural awareness or cultural competency training as not the most effective way of educating healthcare professionals and that it had the potential to be harmful, as Sarah noted:

> There's no possible way you can know anything about the lives of the people that you meet. So, it's arrogant to assume that you can attain competency in some culture that's not your own. I mean, I'm not even competent in the culture of whiteness. I don't know if I have enough insight into my own privilege to be competent in it. So being competent in someone else's culture is a complete fallacy.

Sarah elaborated that it was important to avoid *"pan-Indigenous tokenistic kind of lessons that some available training opportunities rely on"* to simply *"check off a box"* for employees' cultural awareness training. Overall, participants felt that real life experiences represented a better way to learn and to advance allyship. Yet, learning opportunities offered by their organizations or through post-secondary institutions could still provide good opportunities to educate and encourage allyship.

Discussion

Key findings from this research reiterate the critical aspect of relationships between Indigenous and non-Indigenous people in allyship. Community-identified allies practiced with intentionality and looked for opportunities to better support their Indigenous patients through action and advocacy. Our study showcased the experiences and perspectives of healthcare providers who embraced reconciliatory work in their roles, and as a result were considered allies by their Indigenous colleagues. Our findings offer a rich addition to literature by describing what healthcare providers can do, despite the constraints to the healthcare system, to move beyond training and education.

The characteristics of our participants–who were considered allies by their Indigenous colleagues–and their ways of approaching allyship can be fostered through appropriate training and education. Brown[16] conducted a quantitative survey with 160 people of colour in the United States and found that some personal attributes and interpersonal skills of allies, as identified by the participants, included "respect, curiosity, partnership, information—and resource-sharing, risk-taking, resilience, understanding, courage, support, receptivity, loyalty, honesty, investment, and willingness to make mistakes."[16(p.714)] The findings from Brown's study were in alignment with the findings in the current research study that found that key characteristics of allies providing care to Indigenous patients included patience, humility, trustworthiness, active listening, and compassion.

The participants in this study explored their own allyship journeys and the concept of self-identifying as an ally. Most participants felt uncomfortable calling themselves "allies." Sumerau et al. [25] examined how people construct what it means to be an ally to marginalized groups. They conducted 70 in-depth interviews with college students who identified as allies to one or more marginalized groups and found that those who self-identified as allies were frequently in pursuit of being recognized as "good people"[25(p366)] who support better conditions for minorities. Furthermore, Smith et al.[14] found that "allyship is something that is designated by a person or community that one is aspiring to ally themselves with."[14(p6)] Therefore, Indigenous people should be the only ones who could deem a non-Indigenous person as an ally. Although this is a key aspect of allyship as it shifts the power in the direction of Indigenous people and communities, healthcare

providers need to be attentive to their fear of doing something wrong and, consequently, opting for inaction. Burm et al. (2024) described the feeling of uncertainty about respectfully contributing to reconciliatory work as a challenge to advancing reconciliation in medical education. This underscores the importance of understanding allyship as a journey.[11]

In Knudsgaard's[26] research (2019), Indigenous child welfare leaders identified non-Indigenous leaders who they considered allies. Non-Indigenous leaders were interviewed regarding their journeys to allyship, and they expressed that "allyship is not a destination that one fully arrives at. The journey to allyship is a process that allies continuously engage in."[26(p44)] Understanding allyship as a journey has practical implications. It encourages non-Indigenous people to continually seek learning opportunities and build safe, trusting relationships with colleagues, Elders, knowledge keepers, mentors, and the communities they serve. Findings from this research highlight the importance of education and training opportunities that emphasize real life interactions, meet people where they are at on their journey, and create opportunities for reciprocal relationships to be developed and maintained.

Relationship has been identified in the academic literature as one of the most crucial elements of allyship. While necessary for all types of allyship, relationship is a fundamental and central component to being an ally to Indigenous people.[27] Allies are supporters, not leaders, and to support the Indigenous community, relationships must be developed and maintained.[14] Relationships also create accountability and responsibility for sustained action.[14] Participants felt that these personal connections were key to the direction that their healthcare careers took in their work with Indigenous patients, moving them from advocates to community-identified allies. Therefore, participants felt that creating opportunities for other healthcare providers to develop relationships with Indigenous people could be a catalyst towards increasing allyship in healthcare.

In contrast to academic notions of education associated with the end goal of a degree, diploma, or certificate, allyship means continuous and ongoing education, both formally and informally. McLane et al.[28] held sharing circles with Elders, First Nations patients, healthcare providers and health administrators from across Alberta to better understand their experiences in accessing care in emergency departments in Alberta. Comparably, their

research found "health systems should create safe spaces and time for providers to engage in collective reflection and learning. This may allow providers to self-assess and correct biases impacting the care they provide."[28(p72)]

Not embedding Indigenous perspectives and methodology into this research study was one limitation of our study that could have provided greater insights into the allyship to Indigenous patients. However, the literature on allyship and reconciliatory work also emphasizes the overburden placed on Indigenous champions when spearheading reconciliation.[11,13] Therefore, by having only non-Indigenous healthcare providers identified as allies by Indigenous colleagues, we were able to contribute to the understanding of what it means to be an ally to Indigenous patients without adding more load to Indigenous people.

Overall, the results of this study found that healthcare providers who were identified by the Indigenous community as allies shared similar characteristics and beliefs when it comes to providing care for their Indigenous patients. They provided us with a better understanding of how allies interact with their patients within the restrictive confines of the healthcare system. Our results can help to inform the formal and informal learning opportunities and practices of healthcare providers who seek to provide Indigenous healthcare in an informed, culturally humble and safe, and respectful way.

Conclusion

We believe that this study has the potential to positively influence how healthcare providers interact with Indigenous patients. The actions of community-identified allies can offer invaluable insights to those striving to improve Indigenous people' experiences and health outcomes as a key step in the work of Reconciliation. By focusing on the key characteristics and opportunities outlined here, and especially by building genuine relationships, healthcare providers can enhance the quality of care for Indigenous patients. On an institutional level, applying an allyship lens and focusing on education at all levels could have a profound ripple effect across the entire healthcare system.

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