

Away from deficit-based language

I am on a journey of self-reflection and education about Canada's treatment of Indigenous people. It has been humbling to discover the multitude of ways that I have been oblivious to the harmful traditions of colonialism and my role within them. My complicity could be passed off as unwitting, but that would be too generous. I have learned that it's my responsibility to actively look for ways to improve myself and our systems in order to do better.

Moving away from the use of deficit-based language in articles that discuss Indigenous people is one thing the Editorial Board has been working on. Deficit-based language like *vulnerable* or *at risk* tends to blame the victim for their predicament and “fails to acknowledge that they live within coercive systems that cause harm with no accountability.”¹ When certain language or problems are repeatedly associated with a specific population in the absence of context, stigmatization can occur.²

In a 2019 article for the *Canadian Journal of Bioethics*, Hyett and colleagues explain that health care research is inherently deficit-based because it is often designed to highlight poorer outcomes in one group compared with another.² This research may be well intentioned; however, historically, Indigenous people have been made into research subjects and described in ways that perpetuate harmful stereotypes.² For example, our implicit biases (and our overt medical education) might lead us to believe that Indigeneity is a “risk factor” for health outcomes like alcohol use disorder or diabetes. Stereotypes can become especially dangerous when they impact care. Hyett and colleagues recount the powerful examples of Brian Sinclair and Hugh Papik, whose fatal diagnoses were missed because they were falsely assumed to be drunk.

Strengths-based approaches consider the capacities and capabilities of Indigenous people—both within the person and in their environment—and how they might contribute to their well-being.^{3,4} Bryant and colleagues suggest that sociocultural approaches are better able to capture Indigenous ways of knowing because strengths

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go beyond those of an individual to consider social relations, collective practices, and identities.⁴

Considering both the people and the context, a population typically called *at risk* might be more appropriately referred to as *oppressed* or *underserved*. Indigeneity is a validated protective factor that has been demonstrated to improve health outcomes if appropriately recognized and supported.^{5,6}

I am learning about the various ways investigators can engage Indigenous stakeholders on health care research, such as through Elders' teachings.^{1,7,8} Colonialized institutions and research practices may impede our own progress, however. In an article recently published in *Nature*, University of British Columbia researcher Dr Jennifer Grenz writes about how “[u]niversity ethics boards are not ready for Indigenous scholars.”⁹ In her own academic experience, she found the “current standard requirements of ethics committees—such as providing the exact questions that [Indigenous researchers] will ask Elders and

knowledge keepers, and having fixed research objectives and methodologies—are not consistent with [Indigenous] ways of knowing. But this led to challenges with [the] ethics board. . . . [Her] research was seemingly held hostage until [she] complied to colonizing it.”⁹

As I write this editorial, an article in the *Globe and Mail* highlights the staggering rates of youth suicide in Canada's Indigenous communities.¹⁰ Tanya Talaga asks readers, “How have we grown numb to the suicide of Indigenous children?” I hope we have not. I believe there are many thousands of caring and thoughtful physicians in British Columbia who want to be part of the solution. Clearly, we need research to address the health care inequities we've created, but it is also apparent that a change in research methodology is critical if we want to achieve meaningful change. ■

—Caitlin Dunne, MD, FRCSC

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Stop, collaborate, and listen

I was going to write this editorial as a rant, Rick Mercer style, regarding the woes of family medicine, but I think we are all aware of the ongoing crisis facing us by now. Then I considered writing a Kumbaya piece instead, but that would have been disingenuous. I settled on looking at how 2023 was a year of positive change for family medicine.

The Longitudinal Family Physician Payment Model¹ was introduced in early 2023. It promotes good medicine while providing some improved compensation, and it values the time we spend outside the clinic completing forms, tasks, charting, and administrative work. In 2024, the model is expanding to facility-based care, including inpatient, maternity, palliative, and long-term care. The model does not, however, change the intense workload and 24/7 obligations we face, and there are still not enough family physicians to do the work at hand. An estimated 1 million people in BC do not have a family physician. An article in the *Vancouver Sun* from 20 May 2023² discusses this shortage and informs us there are many family medicine residency spots in Canada that go unfilled every year.

There are also unoccupied long-term care beds in the province because there are not enough family physicians providing this type of care. While some of my family physician colleagues feel pressure to maintain the care of their patients when they are transferred to long-term care beds and short-term subacute care beds, transitioning from hospital to home, they feel overworked and undercompensated and do not have the capacity to provide this care. Perhaps the new incentives will revive some interest in long-term care and subacute care.

On a positive note, some family physicians who were on the verge of retiring have stayed in practice thanks to the new payment model, and this shift has been beneficial for family medicine.

Speaking with newer family physicians has revealed that many of them want flexibility and diversity without the burden of fiscal and administrative obligations attached to having a family practice. They also fear not being able to find coverage when they are away from their practices for some well-deserved rest and relaxation. Currently, most locums have a 70/30 or 80/20 split, which means they are financially compensated equally with longitudinal fam-

Let's stop and reassess how we practise family medicine.

ily physicians, and the split barely covers the cost of keeping the doors open. Why would newer family physicians take on that extra burden?

Despite these barriers, there are new graduates who are considering joining practices or taking over retiring physicians' practices, and this newfound interest is largely due to the payment model. We are starting to see this trend in Kamloops.³

The terms *general practitioner* and *just a GP* are fading, and newer physicians want to be experts in family medicine and feel more valued. Many newer family physicians are pursuing this expertise in areas such as emergency medicine, rural medicine, maternity care, or hospitalist training.

I could go on regarding the issues facing family physicians, but we also need to discuss solutions. Many of the solutions need to come from the physicians entrenched in this predicament. To that end, what would make my life as a family physician easier is a common platform where family physicians, specialists, hospitalists, and long-term care physicians could communicate. It would be incredible if we all used the same EMR. The

amount of time currently spent retrieving and communicating information is wasteful and inefficient for physicians and patients. Occasionally it will take a patient multiple visits involving several physicians in different locations to resolve one issue. This redundancy of services could be eliminated if we had one common, easily accessible, secure platform. I realize this is a multifaceted undertaking, and hopefully it is already in the works.

Let's stop and reassess how we practise family medicine. Perhaps it's time to collaborate and communicate with each other, with our divisions, and with our health authorities, rather than trying to carry the burden individually. The *BCMJ* is here to listen to your concerns, your successes, and your solutions and to advocate on your behalf by sharing your stories. ■

—Jeevyn K. Chahal, MD

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Letters to the editor

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The inequities of climate change—Intersections between environmental health and health disparities

Climate change has been a global crisis of interest for decades; however, the physical and psychological impacts of climate change, particularly on Canada’s underserved populations, are underexplored. The impacts of climate change are readily visible in the country, with Canada’s average temperatures warming at twice the mean global rate.¹ However, recent extreme weather events, including wildfires raging through Western Canada and heat-induced storms in Ontario and Quebec, have brought the devastating health consequences of climate change to light. Canada has experienced unprecedented impacts from this wildfire season, with more than 5800 reported fires and over 15 million hectares burned to date.² Over 29000 Albertans were left displaced by wildfires in the period of a few months, and thousands in British Columbia and the Northwest Territories were required to evacuate their communities as flames strained emergency services.³ However, as we saw these events unfold, it became increasingly clear that the health hazards related to these environmental changes are not experienced uniformly across all populations in Canada,⁴ and the differential impacts on physical and mental health outcomes have the potential to exacerbate existing health inequities for oppressed and underserved populations.

Differences in regional distribution and adaptive capacities are key factors contributing to potentially disproportionate

exposure to climate-related events and resulting harms. For instance, lower socioeconomic regions, as well as northern and remote communities, face challenges in responding to and recovering from environmental hazards and disasters secondary to various factors, including lack of critical infrastructure and decreased capacity for emergency planning and response.⁴ In particular, Indigenous communities have been overrepresented in wildfire evacuations, experiencing 42% of evacuation events, despite representing only 5% of the country’s population.^{1,5} Limited resources, resulting from chronic underfunding and remote locations, make it all the more challenging to access emergency resources and support in times of crisis, thus prolonging and intensifying the detrimental impacts of climate events.¹

Physical impacts of climate change and environmental disasters are exacerbated by underlying health determinants such as poor housing, overcrowding, and geographic proximity to areas more prone to wildfires. A Health Canada report estimated that, annually, 54 to 240 premature deaths in Canada can be attributed to short-term exposure to wildfire, and 570 to 2500 premature deaths to long-term exposure.⁴ Furthermore, access to and availability of basic amenities such as clean water are already strained in Indigenous and northern communities, with disproportionately higher frequency and duration of boiled-water advisories.⁴ Extreme weather events can easily overwhelm fragile water treatment systems and exacerbate issues related to water sanitation and exposure to environmental contaminants.⁴

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