Tools to address anti-Indigenous racism in health care

It is said that the best time to plant a tree was 20 years ago, and the second-best time is today. September is our reminder to reflect and recommit to learning about the ongoing impacts of colonialism on Indigenous Peoples in Canada—and how we, as health care professionals, can contribute to change.

The National Collaborating Centre for Indigenous Health (NCCIH) is a valuable resource for physicians and health care providers. Established in 2005 by the Government of Canada and funded by the Public Health Agency of Canada, it "support[s] First Nations, Inuit and Métis public health renewal and health equity through knowledge translation and exchange." The NCCIH listens to community voices and shares knowledge to guide meaningful improvements in public health. Its work includes supporting research, producing reports, and co-creating resources rooted in Indigenous perspectives and priorities.

The NCCIH is hosted in Prince George, BC, on the unceded traditional territory of the Lheidli T'enneh First Nation. At the *BCMJ*, we're excited to share that one of our Editorial Board members, Dr Terri Aldred, was appointed as the academic lead at NCCIH on 7 May 2025. Dr Aldred's priorities include serving edge populations and communities first and translating more of the NCCIH's work on cultural safety and humility and Indigenous-specific antiracism standards into best practices for everyday clinical applications.

As we work toward decolonizing health care in Canada, it's important to amplify Indigenous-led governance in public health. I asked Dr Aldred a few questions about her new role with the NCCIH and how physicians and researchers from across BC can get involved.

Q: If a medical learner or community physician in BC wanted to get involved but didn't know how, where could they start?

A: The NCCIH has close ties with universities across the country and with the Canadian Institutes of Health Research. We focus on knowledge translation of research for Indigenous populations and support research by request from independent researchers, academics, funders, and community groups.

September is a reminder of the opportunity we have for humility, listening, and growth—both as individual practitioners and as a profession striving to do better.

Q: Tuesday, 30 September 2025, is the National Day for Truth and Reconciliation. The Truth and Reconciliation Commission's Calls to Action 18–24 focus on Indigenous health, including recognizing Indigenous healing practices. Can you share an example where this is done well?

A: Lu'ma Native Housing Society has its own primary care clinic with sweat lodges, traditional medicines, Elders, and other traditional healing offerings. It is also guided by the urban Indigenous community it serves. It's an excellent example.

Q: At the *BCMJ*, we are aiming to evolve how we learn and share research, including Indigenous ways of knowing and storytelling as valid and essential forms of health knowledge. What community-led projects or NCCIH publications would you like to highlight that help promote Indigenous worldviews?

A: Cultural safety and humility initiatives are a highlight of the NCCIH's work. The Health Arts Research Centre recently released an open-access anticolonial learning resource called HEAL Healthcare (Hearts-based Education and Anti-colonial Learning in Healthcare). It is arts-based training about how to address bias in medicine through poetry, storytelling, visual arts, and other creative tools.

I learned about the NCCIH through its emails, which you can sign up for at the bottom of its website (www.nccih.ca). You can also search publications by health topic on the site. The cultural safety and respectful relationships collection, for example, contains a Diversity Awareness Self-Reflection Tool with 25 questions to help guide future reading and learning to improve patient-centred care.[1]

In this issue of the *BCMJ*, we'll hear from Dr Lui in the President's Comment about honoring truth and pursuing reconciliation outside the clinic, as well as from the BCCDC on truth telling in public health. The breadth of these commentaries speaks to the wide-reaching concern about anti-Indigenous racism in health care. Reforming our systems in pursuit of reconciliation will continue to be complex, difficult, and multifaceted, but we have solved complex problems together in the past. In fact, solving problems is what physicians do every day. September is a reminder of the opportunity we have for humility, listening, and growth—both as individual practitioners and as a profession striving to do better.

—Caitlin Dunne, MD

Reference

1. Alberta Health Services. Diversity awareness self-reflection tool. March 2015. Accessed 6 August 2025. www.albertahealthservices.ca/assets/info/hp/phc/if-hp-phc-rc-gen-diverse-awareness-reflection-tool.pdf.

Beyond Kelowna: A wake-up call for child health in British Columbia

For many of us, the closure of the pediatric inpatient unit at Kelowna General Hospital in May 2025 did not come as a surprise. Pediatricians in the region had been raising concerns about safety and sustainability for years. When no action followed, they began to leave. The result was a total shutdown of hospital pediatric care in one of the fastest-growing urban centres in the province. The subsequent scramble to stabilize care—urgent negotiation, expansion of locum coverage, and solicitation of ad hoc support from maternity and emergency services—laid bare the fragility of the system we depend on to care for children in BC.

Over the last decade, pediatricians have seen surging demand for care and increased patient complexity across the board. The system is struggling to keep up. Children with routine, but serious, concerns—such as developmental delays, mental health challenges, and chronic conditions—now wait up to 3 years for subspecialty assessment, often while their conditions worsen and their families struggle to cope in the absence of a diagnosis and coordinated support.

There are growing geographical disparities in the provision of care as well. In the face of unrelenting caseloads, limited support, and few incentives, many pediatricians are choosing urban practice instead of work in rural and remote communities. In many parts of the province, there are no pediatricians at all. Fort St. John, for example, the epicentre of BC's current measles outbreak, has no local pediatrician coverage. Individual initiatives, such as the CHARLiE program for pediatric real-time virtual support (https://rccbc.ca/initiatives/rtvs/charlie), offer some resources for clinicians, but these models of care are unable to provide the continuity and relational care that are so fundamental to pediatric practice. Moreover, they face constant human resource and financial challenges of their own.

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At the same time, we are losing new medical graduates to other areas of medicine. Many young physicians, aware of the demands placed on pediatricians and a remuneration schedule that is not competitive with other medical and surgical disciplines, choose otherwise. While medical student classes have ballooned and competition for residency positions is higher than ever, pediatrics residency programs are seeing an unprecedented number of unmatched spots.

The situation is not due to lack of effort. Pediatricians are consistently answering the call to provide emergency locum coverage throughout the province, often above and beyond their own local practice; developing innovative programs to provide pediatric support in underserved communities; and working at well over 100% capacity in pediatric subspecialty areas at BC Children's Hospital to reduce wait lists. The strain is not borne only by pediatricians. Family physicians, already stretched thin, are increasingly asked to take on complex pediatric care without ready access to consultation. Maternity providers find themselves managing both mothers and newborns, with an increasingly complex set of concerns. Emergency physicians carry the burden of stabilizing children who should have been admitted to a pediatric unit and then spend hours coordinating transfers to distant hospitals.

What is happening in Kelowna is not an isolated operational anomaly; it is a high-profile symptom of a deep and long-standing provincial failure to develop a robust and cohesive strategy for child health care, one that prioritizes the unique needs of children and places equitable access to high-quality services at its core. The system needs to be resourced appropriately, and we need to respect the clinicians providing the care. We are at an inflection point. There can be no more excuses preventing us from establishing this strategy now. The future of the next generation in the province depends on it. ■

—Kristopher Kang, MD, FRCPC