"Power with": An alternative to medical colonialism

Medical colonialism and "power-over" approaches contribute to harms for Indigenous people, decrease their access to care, and lead to care avoidance.

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A First Nations senior presented to his hearing instrument practitioner with complaints of repeated episodes of vertigo. She advised him to go to the emergency room right away. He replied, "Listen, White girl, how do you think they will receive a stumbling Indian in their ER?" (oral communication from Ms Larissa Nelson, RHIP, 16 December 2024).

Modern scientific medicine can both participate in and be swept up by colonialism—at great cost.[1] This example demonstrates the importance of recognizing medical colonialism and of using a "power-with" approach instead of a "power-over" approach. By *power over*, I mean a relationship of control, with the unilateral ability to decide over another. By *power with*, I mean a relationship of dignity, with mutual decision making. By *medical colonialism*, I mean Western culture physician control, with the unilateral ability to make health care decisions without the inclusion of other voices. A power-over approach perpetuates medical colonialism, while a power-with approach helps to decolonize medicine. Power-over approaches and medical colonialism contribute to harms for Indigenous people, decrease their access to care, and lead to care avoidance.[2] This article compares these two approaches, drawing on medical and scientific publications, simplified examples from Western Canadian history, and my personal experience as the grandson of British immigrants who moved to Alberta in 1905.

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At the heart of colonialism is a belief in one's inherent superiority over others and the willingness to impose oneself accordingly, which leads to a dominant power-over approach of one culture over another. Historically, this has meant taking land from others, but the belief itself continues to justify impositions at individual, cultural, and societal levels.

Indigenous Elders (see the acknowledgments) teach that respect for a healthy environment enables a healthy community where individuals thrive. However, I cannot find reference to a thriving community in populations subjected to colonial violence—resisting the violence, yes, but not thriving. This is in line with the World Health Organization's social determinants of health. Even the best *individual* scientific health care will be either useful or successful only in proportion to the degree of *community* thriving.[3] Despite this, scientific health care literature focuses mainly on the care of individuals.

In this article, I use my specialty of psychiatry as an example of medical colonialism, but it applies to the health care system as a whole. The antipsychiatry movement was adopted by Frantz Fanon[4] and others[5] to articulate their resistance to the disrespect that psychiatric professionals can show to people experiencing situations of disabling thought, mood, or behavior. An antipsychiatry resistance is a logical response to power-over practices; resistance to any arrogant health care approach is similar. My experience with Indigenous patients is that they have asked me to stop my colonialist practices. From this, I recognized that they were asking me to stop my use of power-over (colonizing) ways of health care delivery.

Some historians describe the early British presence in Western North America as a transactional business partnership (power with), with the Hudson's Bay Company on one side and Indigenous intermediaries trading with other Indigenous communities on the other.[6] The Métis people emerged during this time. Then, rather suddenly, relations changed from a trading partnership to European settlement (power over). This new settler colonialism raised the question of what to do about the people already living here. The answer, after 140 years of mutual business partnership, was assimilation, which became genocide.[7]

The British government, followed by the Canadian government, attempted to assimilate the Indigenous trading partners, rather than adapting their own understanding to include Indigenous ways, as the business partners had. This soon meant Indian hospitals; pseudoscientific experiments;[8] Indian tuberculosis hospitals;[9] forced sterilization;[10] and residential school institutions, with language, dress, and cultural practices forbidden, leading to the recent discovery of hundreds of unmarked graves.[11] These components of forced assimilation exemplify what I mean by power-over practices. This colonialist violence was based in law, not war. It continued throughout the 20th century and, despite our increasing awareness and ambivalence, into present day.[12] Indigenous people are still often subjected to racist exclusion from health care. *In Plain*

Sight,[2] a 2020 commissioned report, details Indigenous-specific racism in the British Columbia health care system.

At both the federal and the provincial/territorial levels, Canada is changing its laws and behaviors through endorsement of the Truth and Reconciliation Commission of Canada's Calls to Action; the United Nations Declaration on the Rights of Indigenous Peoples; and justice, equity, diversity, and inclusion (JEDI) statements from various organizations, including Doctors of BC. The 2022 Physician Master Agreement contains an Indigenous-specific antiracism clause—BC has the first such clause in Canadian medical agreements with governments.[13] Many Indigenous health care workers are now providing health care services with Indigenous ways of knowing and being at their foundation. Most meetings I attend now include acknowledgment of the unceded land we are meeting upon. But we have not yet achieved a noncolonialist state.

Medical colonialism has been a part of our history for the last 200 years, and it occurs at different levels of perspective: individual, team or organizational, and societal. I understand this best by considering reports from Frantz Fanon and Henri Collomb,[14] partly because they were near-contemporary French psychiatrists, and partly because their reports show the polarity of power-over and power-with approaches.

Fanon wrote of his power-with experience in Saint-Alban's community psychiatric hospital. But he also wrote influential anticolonialist books about the destructive power-over approaches he experienced as a Black man, including in the 1954 Algerian War of Independence. Our descriptions of Canadian Indigenous people's suffering and resistance echo Fanon's reports of power-over suffering. Canadian Indigenous people have higher rates of suicide when separated from their purposefully suppressed cultures.[15,16] Their increased frequencies of diabetes,[17] poverty,[18] and criminality[19] can be seen as similar responses to Canada's genocidal power-over policies of assimilation.

But Collomb, sent to Senegal as head of psychiatry, found scientific medicine useful as a humble partner to traditional Senegalese health practices, and he learned from them by practising power-with inclusivity. For example, psychiatry is usually focused on illness and treatment of individuals, overlooking health and resilience as a function of belonging and connection. The latter orientation is common to Indigenous communities.[20] Fanon found imposed Western medicine toxic to Indigenous health; Collomb found it could be helpful when respectfully combined with traditional practices in a power-with way. When the potentially great asset of scientific medicine is imposed in a power-over way, it will likely be either avoided or of little to no benefit to the intended recipients because of the damage to their autonomy and dignity.

Looking back on my efforts in Cowichan general psychiatry, I have tried both options. I have legally enforced injections or seclusion on people in dangerous distress. This involuntary force can be harmful, even when necessary for safety. But how I spoke to them while I was doing this either preserved their dignity, when I spoke in a power-with way, or imposed a hurt they carried years after, if I spoke in a power-over way. And they all pushed back against me. The Collomb-like, humble partner, power-with way sustained me. When I tried the Fanon-described imposition, which Indigenous Elders proposed I stop, it corroded me and made me ill. I have many examples of happy, productive, and humble power-with integrations of psychiatry into community health organizations. For example, I helped develop a community of people experiencing mood disorders, who met weekly with the aim of supporting each other and educating each other as well as me. They learned leadership and ran the meetings; I attended as a special guest. Similarly, we hosted a community of people suffering psychotic disorders who took care of each other in the community. I hosted a successful exorcism on our psychiatry inpatient unit for a man with a devout Christian family. I had members of the Duncan Indian Shaker Church "sweep out" (spiritually cleanse) any room on the psychiatric inpatient unit for any First Nations person admitted there. Fortunately for me, there is more than one way of seeing things.[21]

Health care workers can adopt a position of power over their patients and teams, which Fanon described as colonialist psychiatric violence. That kind of health care is focused on rapid achievement of diagnosis and one-sided decisions about treatment and prognosis. Team members are treated as a subservient means of achieving the physician's will.

Don Berwick[22] described the omnipotent and supposedly omniscient "Era 1" medical practitioner of the 1950s to be later revealed as having caused unacknowledged morbidity and mortality, with the subsequent "Era 2" to be one of quality assurance measurements. Berwick proposes an "Era 3," keeping the best of Eras 1 and 2, but adopting humility and power sharing.

The Southcentral Foundation's Nuka System of Care[23] is a highly rated primary care system. It includes Alaskan Natives as "customer-owners" in operating their own health care system based on traditional Native values like respectful teamwork.

The Open Dialogue[24] approach is a Finnish family- and network-focused approach to mental health care, with transparent shared decisions. It values community treatment over hospitalization.

Like Collomb's community partnerships, these examples show the power-with approach to health care delivery to be superior. There are many similar reports.

Conclusions

There are well-described measures to be taken by scientific health care workers to achieve the objective of respectful shared power, including the Calls to Action of the Truth and Reconciliation Commission.[25] All Canadians should embrace the lifelong learning of cultural humility, in which we reflect on our biases and promote respectful relationships, and engage in cultural safety, where we recognize and strive to address power imbalance. These are the main tools we can use to avoid power-over practices and choose power-with practices instead.[26]

These tools from Indigenous Peoples, with awareness of the central value of dignity, apply to any health care system in the presence of less powerfully positioned people of any culture, but especially in Canada, a nation of many immigrants.

Adopting a power-with approach to health care delivery has implications for students, the selection of course content, and our continuing education path throughout our lifetimes.

It is a tragedy that people such as the First Nations senior with vertigo, mentioned previously, reject scientific health care because they do not feel safe with their practitioner. The hearing instrument practitioner replied to that man, "I had not thought of it that way. That is so unfair." ■

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