Beyond cultural safety: Exploring the intersection between medical colonization and healthcare social work

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What is medical colonization?

- In Canada, the government, religious organizations, and the professions of healthcare and social work merged to build systems that would speed Indigenous assimilation [1]
- Medical colonization is a term that captures the intersection and interplay between medicine, colonial domination, genocide and race. It refers to an ideology, which is systemic and structural and rooted in anti-Indigenous racism [2]
- Medical practices and policies establish, maintain, and/or advance a genocidal colonial project
- Encompasses the actions of colonial governments in providing segregated care and inequitable services, as well as perpetuating knowledge production that reifies racial hierarchies [3]

Indigenous experiences of healthcare

- Introduction of disease and starvation
- Birth alerts
- Forced sterilization
- Segregated Indian hospitals
- TB ships
- Medical experimentation
- Forced relocation to birth
- Starvation experiments
- Non caregiver accompaniment for pediatric patients
- Lack of funding to address social determinants of health
- Policies which create barriers to accessing healthcare
- Modern day racism in healthcare settings which lead to differential treatment, misdiagnosis and death
- Lack of culturally relevant healthcare options
- Dismissal of Indigenous practices to address illness, and achieve health [4]

The intersection of medicine and social work

- Both social work and medicine are complicit in creating and perpetuating racist ideologies and both are implicated in colonization [5]
- Medicine and social work grew out of a paradigm that seeks to define problems and solutions with universal, scientific truths [6]
- Both medicine and social work continue to determine who is 'legitimate' and who is not, as well as who is healthy, and who is not . This perspective maintain systems of social control and invalidates those that are identified as problematic [7]
- Both professions have focused on building superior, expert roles to regulate and legitimize their sphere of influence [8]
- Both disciplines have professional roles that maintain relations of power, and both retain surveillance and regulation of the public, as key constructs of practice [9]
- Like medicine, social work grew from the myth of the benevolent white settler state
- As the profession evolved, it developed within a framework of colonial policies, racial hierarchies and discriminatory practices against Indigenous peoples and racialized communities [10]

Health settings provided some of the first practice settings for social work professionals

1. There is a 'myth of meritocracy' that underlies both medicine and social work
2. There is a scaffolding of knowledge, which socializes social workers to believe that some groups have less inherent value
3. Social work has assisted in designing narratives of social problems as 'medicalized', as this provides power, credibility and influence to the profession [11]
4. Historically social work and medicine developed narratives of Indigenous populations as diseased, and *in need of protection,* thus justifying colonization [12]
5. In many ways the perspective of offering medicine and healthcare as a benevolent humanitarian action, to a diseased and ill group of people, continues to be perpetuated [13]

When healthcare providers do not understand the history and current contexts of medical care provision, for the people they serve, they are unable to recognize how foundational and embedded systemic biases impact the milieu in which they are educated, and eventually work in [14]

Moving forward

- Medically colonizing practices and policies continue to be prevalent in healthcare. Social work has a role in recognizing and addressing this [15]
- Recognizing the proximal, intermediate and distal determinants of health shifts the lens from an individual deficit-based perspective to one in which structurally oppressive agents are emphasized[16]
- When we interrogate the social structures of health, we recognize that if a biopsychosocial lens narrows the cause of poor health to conditions, a social determinants perspective prioritizes the causes that created the conditions, in the first place [17]
- By integrating a wholistic approach, disparities in healthcare can be addressed so that everyone is able to receive healthcare in a way that benefits them [18]

Medicine wheel beaded by my grandmother; Irene Woodward, 1997.

- Start with reflecting on your positionality
- Address unconscious bias and stereotypes. These directly affect delivery of healthcare. If we remain silent, the biases and perspectives of medical culture will reproduce [19]
- When we recognize that healthcare disparity is rooted in structural bias, communal inequity and experiences of racism, we recognize our responses can be similarly multifaceted [20]
- We can call on discourses and practices that deconstruct the supremacy of the medical model, and build different understandings of what it means to be healthy, *from an Indigenous perspective* [21]

References

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CIHR IRSC Canadian Institutes of Health Research / Instituts de recherche en santé du Canada

Indigenous Primary Health Care and Policy Research (IPHCPR) Network in Alberta