Nanaimo
Division of Family Practice
A GPSC initiative

GPSC
General Practice Services Committee

Case Study:

Culturally Safe Team-based Care at the Snuneymuxw Health Centre

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GPSC
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EXECUTIVE SUMMARY

The Snuneymuxw First Nation
The population of the First Nation is 1,812 with 1,225 living off reserve and 587 on First Nations land. The Snuneymuxw are a vital First Nation of the Coast Salish People, located in the centre of Coast Salish territory on the eastern coast of Vancouver Island.

The Patient Medical Home (PMH) Work – Introducing FPs to the Snuneymuxw Wellness Centre
Physicians work with the existing Snuneymuxw Wellness Centre staff (nursing, home care, adult & youth counsellors, and maternity services, etc.) to provide primary care, but clients are attached to the clinic rather than a specific provider. Currently FNHA funds 3 sessions per week, and Island Health funds 1 session, which translates to two full days of family physician coverage a week at the centre – Monday and Thursday.

Philosophy of the Health Centre: One Canoe model of care
The foundation of the model of care at the Centre is "One Canoe." Based on the rules of tribal journeys, the One Canoe model grounds all providers in the clear message of what leads to good work. At its core the One Canoe model specifies that every member of the team is essential to achieve the goal of health but the patients are the skippers. And, it is they who decide the direction of the canoe according to their personal health goals.

Key Impacts of the Snuneymuxw Health Centre Model of Care:

- Better Access to Care:
    - Approximately 60% of the community members were unattached to a physician. Some community members had never seen a doctor.
    - Previously patients were not able to obtain referrals to other necessary services-- specialists, detox services, pediatricians, x-rays, tests or any other services that require a referral from a physician.
- Increased Continuity of Care:
    - Patients are now receiving longitudinal care rather than accessing drop in physician services.
    - As trust develops patients are more likely to seek help from a physician in the future.
    - Physicians are able to follow up with medications.
- Culturally Safe Care:
    - The availability of physicians for home care provides the opportunity for the patient's family to perform sacred ceremonies for healing and for palliative care.
- Better Coordination of Care:
    - The Community Health Nurse is now informed of a patient's discharge and able to follow through with home care.
- More Comprehensive Care:
    - With the providers working as a team, patients have a full contingent of practitioners and wrap-around services.
    - The Community Health Nurses no longer have to "chase down a community physician" to get requisition forms signed to access necessary equipment.

Key Lessons on Implementing Culturally Safe Care

The Health Centre is unique in that culturally safe "One Canoe" model of person-centred care was well-established as a "way of being" before the physicians and other non-First Nations staff joined the team. While other centres established by health institutions struggle to introduce and incorporate cultural safety and create safe spaces for First Nations patients this was the reverse situation. The Centre created a safe space for the non-First Nations providers to learn cultural protocols. As one of the counsellors described it: "*Then the physicians assimilated with us inside of the other way around. But for me the most important thing was that they assimilated and they knew that in order for them to be here they had to take the minority seat –they had to take the place of deference and they did that very well."*

Preparation for working with First Nations providers and community members:

- Be prepared to make a long term commitment. Snuneymuxw Health Centre staff ask potential applicants: "*Why do you want to work here and how long do you plan to stay*?
- Attend cultural events and learn about the culture.
- Learn about trauma based care.
- Build team relationships organically and strategically by distributing information about providers to the community (posters, announcements), having new staff spend time in the Centre's programs.
- Develop collaborations among the Division of Family Practice and the Chief and Council members.
- Collaborate with Community Health Nurses to liaise with the hospital, family members, other services, and, to be mentored on cultural practices particularly for home visits.

To contribute to cultural safety-providers should:

- Attend cultural events.
- Be prepared that trust must be earned and is built slowly.
- Approach with an attitude of deference and humility.
- Learn and adopt the values of your local Indigenous communities as principles of care – such as the "One Canoe" model at Snuneymuxw Health Centre.
- Ask for guidance on protocols.
- Ask questions of patients gently to discover what can or cannot be talked about.
- Be seen at community events outside of office hours.

Team approach—how team work is facilitated:

- The dual Community Health Nurse model:
    - One nurse bridges health services and the Infant and Child Development Program enhancing prevention and health promotion;
    - One nurse liaises with physicians and accompanies them to home care visits, mentoring them on cultural practices.
- Everyone at the Centre is seen as part of the team, including office and maintenance staff.
- A poster with all of the physicians' pictures and a little bio was hung in the reception area.
- The team commits to the same values of care: the One Canoe model and person-centred care.
- Reciprocity: team members share knowledge and all knowledge is of the same currency.
- Staff spend time in each other's programs to get to know the work and to allow staff to get to know a new team member.
- Mentoring of new staff and debriefing particular patient issues.
- The approach is patient-centred rather than disease centric

Introduction

Good health for the population is the ultimate goal of health services. And, as the World Health Organization (WHO) describes it, health is: “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (WHO, 1948, 2020). This case study of the Snuneymuxw Health Centre is a small illustration of the imperative of that broad vision of health. In the case study, a brief history of the Snuneymuxw reserve and where the Health Centre is located is followed by relevant research for context and for situating the information within a historical viewpoint. A description of the investigative approach is then followed by the interviewees’ descriptions of the “One Canoe model of care created by the Health Centre.

Research evidence of the historical and generational effect of colonial practices on the health of Indigenous people provides a frame for understanding the significance of the achievements of the Snuneymuxw Health Centre. The team at the Centre have developed a compelling model of care referred to as the One Canoe model, which adapts the “10 Canoe Rules” to the health team environment (described in more detail below). The model is based on cultural practices, and is inherent in the work of the Centre. When physicians joined the team, it was essential for them to learn and

become part of this approach. Consequently, with compassion and respect for cultural practices, they are contributing to the long journey back towards full health, reparation and reconciliation.

Purpose

This case study was commissioned by the GPSC to explore the introduction of physician services to the Snuneymuxw Health Centre in Nanaimo. The Health Centre, established in the original building in 1998, is located on reserve, and serves the First Nation population of 1,812. Their website describes the objective of the Health Centre: to support adults, elders, children, and families who live on reserve by providing preventative services and advocacy. The work of the Health Centre focuses on Children and Youth, Mental Health and Addictions, Primary Health Care, Chronic Illness Prevention, Communicable Disease Control, and Environmental Health and Management (Snuneymuxw First Nation, 2020.)

Geographical history of the Snuneymuxw reserve

The Snuneymuxw originally had a total reserve land base of 266 hectares with 4 small reserves on the shores of Nanaimo Harbour and Nanaimo River and two tiny reserves at Gabriola Island. (Government of Canada, 2020) The community was divided into four separate, numbered reserves near Nanaimo Harbour and Nanaimo River. In March 2013, as part of a reconciliation agreement, the Snuneymuxw First Nation received 877 hectares of land, consisting of three parcels of land, in the Mount Benson area.

The reserves are small and odd shapes. Reserve 1, consisting of several city blocks, is between a railroad track and the main highway that goes through Nanaimo. Reserve 2 is on the east bank of the Nanaimo River and is cut off from reserves 3 and 4 by the river. The river and river banks are not reserve land. All three are on the estuary and appear to be in a flood zone. These small reserves are bounded by the main Island Highway, Duke Point Highway and Cedar Road. They are surrounded by the city of Nanaimo but have not been fully serviced with water and sewage infrastructure resulting in underdevelopment of the reserve. (Government of Canada, 2020)

In January 2013, Nanaimo River 2 and Nanaimo River 3 were dissolved and amalgamated into Nanaimo River Reserve 4. The Health Centre, located on Town Reserve 1, moved to a new building on MacMillan Road, Nanaimo River Reserve 4 in December, 2019. The River Reserve has 197.9 acres of land while the Town Reserve has 55.4 acres. The original intention of the Health Centre was to serve all community members within the geographical area including non-First Nations patients. Whether this will prove to be possible or practical is not yet known.

The Snuneymuxw First Nation

The population is 1,812 with 1,225 living off reserve and 587 on First Nations land. The Snuneymuxw are a vital First Nation of the Coast Salish People, located in the centre of Coast Salish territory on the eastern coast of Vancouver Island. Snuneymuxw territory encompasses a productive and resource rich area of the Salish Sea. The territory of the many First Nations who comprise the Coast Salish people is 84, 231 square kilometers (BC Assembly of First Nations, 2020). The population of the Snuneymuxw is growing and the Nation has several economic, education and health initiatives underway. Several Elders have held the position of “Elder in Residence” or are connected to the First Nations Studies program at the nearby university of Vancouver Island University.

Philosophy of the Health Centre: One Canoe model of care

The foundation of the model of care at the Centre is "One Canoe." Based on the rules of tribal journeys, the One Canoe model grounds all providers in the clear message of what leads to good work. Here is an excerpt from Rules of the Canoe (Tribal Journeys, 2020):

> *…4.* ***THE GIFT OF EACH ENRICHES ALL***
> *Every story is important. The bow, the stern, the skipper, the power puller in the middle – everyone is part of the movement.*
> *5.* ***WE ALL PULL AND SUPPORT EACH OTHER***
> *Nothing occurs in isolation. When we aren't in the family of a canoe, we are not ready for whatever comes.*

At the Health Centre these principles provide clear guidance that every member of the team is essential to achieve the goal of health but the patients are the skippers and it is they who decide the direction of the canoe according to their personal health goals.

Recently this model has been expanded to represent more canoes of the tribal journey. In the Health Centre there we will be 4 canoes: the spiritual canoe, the mental health canoe, the physical/medical canoe, and the landscape/administrative canoe. Other departments will also have more canoes. On the journey, the first canoe to pull out will be the Chief and Council and the others will follow in their canoes.

Introduction of Physician Services

The Nanaimo Division first became aware of the need for physician services in 2016. The First Nations Health Authority (FNHA) representative to the Collaborative Services Committee advised that Snuneymuxw First Nation community members who are in need of detox require a referral from a family physician. However, she estimated 60% of the population were unattached. This was new information for the Division as the First Nation declined participation in the A GP For Me survey. With some unused A GP For Me Impact Funding, the Division provided one session/week to trial FPs at the Snuneymuxw Wellness Centre from January 2017 to April 2017.

After this trial period, the Division collaborated with Island Health (IH), Aboriginal Health and FNHA to attain sustainable funding. As of April 1, 2017, IH (through the Ministry of Health) funded 1 FP session/week, 3.5 hours and FNHA funded 2 FP sessions/week. Currently FNHA funds 3 sessions per week, and IH funds one session per week. This translates to physician coverage for two full days a week – Monday and Thursday. This funding continues, but the Snuneymuxw Chief and Council, the Health Centre and the Division have been unsuccessful in their continued attempts to advocate for additional sessions.

Physicians work with the existing Snuneymuxw Wellness Centre staff (nursing, home care, adult & youth counsellors, and maternity services, etc.) to provide primary care but clients are attached to the clinic rather than a specific provider.

Purpose of Case Study:

The purpose of this case study was to:

- highlight the successes of the Snuneymuxw Health Centre
- describe the changes effected by the introduction of physicians to the Centre
- describe how assimilating the physicians into teams of care came into being.

Strengths-based approach

Although it is essential to recognize the negative health consequences of colonial practices, standard needs assessments and statistical reports focus on weaknesses. A strength-based approach on the other hand evaluates healthy development by focusing on community capacity, the strengths and assets that already exist within a community, including resources, wisdom, expertise and leadership (Barlow & Serkiz, 2001). Acknowledging the resiliency, strength and perseverance in First Nations communities facing hardships is a significant theme within a First Nations wellness model (Aday, 1997; Strickland & Strickland, 1996; van Uchelen et al., 1997). Value is attached to immediate and extended family involvement in care and health service delivery. The brief literature review of a First Nations wellness framework appears on page 5 and is important as a context for understanding the value of the Health Centre to the community.

Methods:

In preparation for beginning the case study, two cultural events were attended to strengthen understanding of historical events. The methods used to gather information included: touring the facility, observing the reception area, accompanying the Community Health Nurse to a client's home, written material, interviews and stories.

Literature Review:

First, a word about terminology. In the literature reviewed, the term Aboriginal people is used to refer to First Nations, Inuit and Metis in Canada. The term Indigenous, preferred by most First Nations recognizes the United Nations Declaration on the Rights of Indigenous Peoples and is more often used to refer to people across North America but in the literature is used interchangeably with the term Aboriginal. (Indigenous Corporate Training (2020). In this report, the term Aboriginal has been replaced with Indigenous as the preferred reference. First Nations is the more correct way to refer to Snuneymuxw community members.

Previous research describing the historical decline in health of First Nations people is necessary to establish a context for understanding the importance of the approach of the Health Centre. As will be seen in the research described below, the causes of ill health in First Nations communities are historical and generational trauma; healing, and the return to full psychological and physical health on a broad scale may take generations as well.

Research indicates that the health issues experienced by Indigenous peoples are due largely to the negative impact of colonialism on the traditional, cultural and social fabric of Indigenous communities, including: its' impact on language, governance, family structure, community relationships, diet, and means of subsistence; the poverty resulting from the reservation system and forced relocation; and, the introduction of alcohol and drugs to Indigenous communities by settlers (Kirmayer, Brass & Tait, 2000; Quantz, 1997; Chandler & Lalonde, 2001). The placement of Indigenous children in Christian residential schools not only exposed many of them to horrific physical and sexual abuse, but also greatly harmed

the inter-generational relationships vital to Indigenous life, including the disrupted transmission of traditional spiritual, cultural, and healing knowledge (Marsden, Clement & Schneider, 2000; McCormick, 1995; Shestowsky, 1995; Ship & Norton, 2000).

Policies that affected the health status of Indigenous people

The history of the 'colonization of the Indigenous body' described by Kelm (1998) suggests underlying assumptions were made with regards to First Nations bodies and health at the time of colonization. First, that the state of Indigenous bodies, as susceptible to disease, was 'natural', and second, the opinion of First Nations on the topic of health was unnecessary. Kelm explains it was not a genetic tendency for disease, in actuality, the infectious diseases that continued to affect First Nations into the 20th century were largely the result of policy decisions made by the governments of Canada and B.C. which instituted restrictions on fishing and hunting, apportioned inadequate reserves, forced children into injurious residential schools, and criminalized Indigenous healing. The health disparities experienced by Indigenous peoples in Canada have been well documented, with disproportionately high rates of infant mortality and hospitalization of children, respiratory ailments, hypertension, hypotension, diabetes, dysentery, dental disease, hepatitis, physical/sexual abuse, and HIV/AIDS. (BC Vital Statistics, 1999; Provincial Health Officer's Report, 2019; Claymore & Taylor, 1989; Heath K., Li, K, Muller, J., Hogg, R.S., O'Shaughnessy, M.V. & Schecter, M.T., 2001; Postl, 1997). The health of Indigenous peoples on virtually every health status measure and health condition is worse than for the overall Canadian population.

Community capacity and resilience

Although it is essential to recognize the negative health consequences of colonial practices, standard needs assessments and statistical reports focus on weaknesses. This obscures the socio-cultural resources within a community that should be supported to promote better health (Brough, Bond, & Hunt, 2004). A strength-based approach on the other hand evaluates healthy development by focusing on community capacity, the strengths and assets that already exist within a community, including resources, wisdom, expertise and leadership (Barlow & Serkiz, 2001). In addition, as the progression of Indigenous peoples taking over governance of health agencies has occurred, western medicine practitioners are learning about a different world view and how it relates to healing and wellness.

From a review of literature focused on community capacity, a conceptual model of health emerges that synthesizes a First Nations view of wellness. Emphasized in particular, is the importance of community values. A framework was proposed by Mullett and Fletcher (2008), that is rooted in, and organized around values that are intrinsic to life in a First Nations community, (see Appendix 1). The literature that informs this framework follows and is important as a context for understanding the value of the Health Centre to the community.

Indigenous Wellness Model

Indigenous peoples' beliefs about health are culturally anchored, influencing how illness is experienced, understood, and treated (Clarke, 1997; Goicoechea-Balbona, 1997; Holmes, Stewart, Garrow, Anderson, & Thorpe, 2002). While western health care systems tend to focus on pathology, emphasizing diagnosis and treatment of symptoms by specialized practitioners many First Nations conceptualize health or wellness as balance and harmony among interconnected aspects of the individual, family, and

community (van Uchelen, Davidson, Quressette, Brasfield, & Demerais, 1997). Acknowledging the resiliency, strength and perseverance in Indigenous communities facing hardships is a significant theme within an Indigenous wellness model (Aday, 1997; Strickland & Strickland, 1996; van Uchelen et al., 1997). Value is attached to immediate and extended family involvement in care and health service delivery. Whereas the focus of western medicine is individualistic, for many Indigenous people, practices relating to health and healing are communal (Browne & Fiske, 2001; van Uchelen et al., 1997; Vernon, 2001).

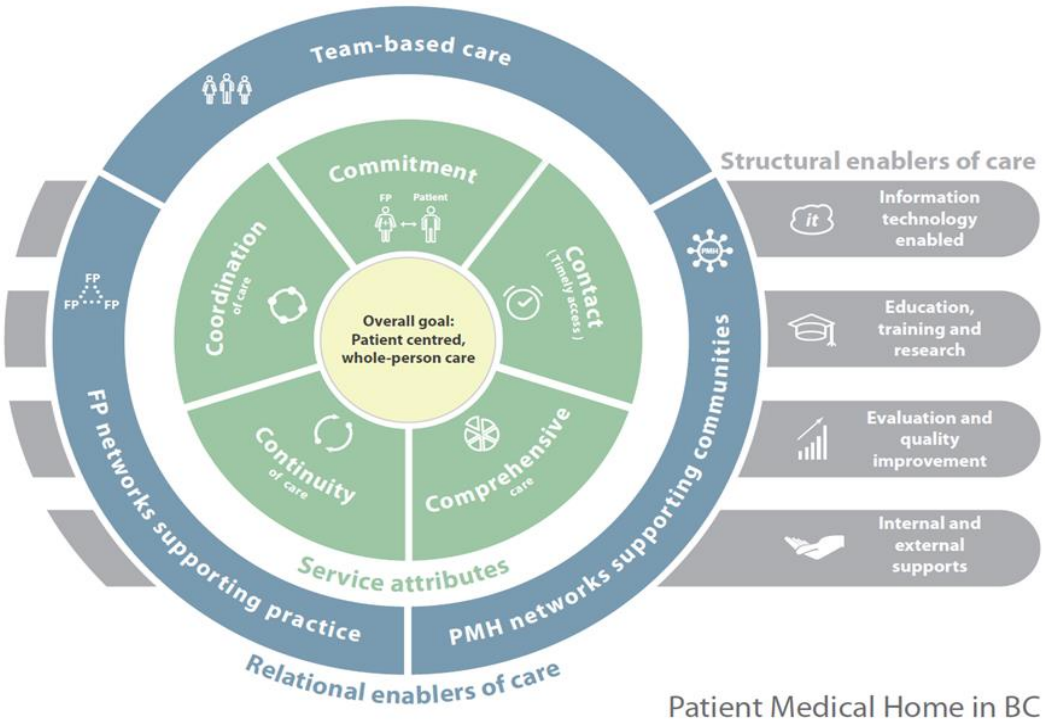
The primacy of the 'collective community' and the importance of tradition, highlights the necessity of creating culturally sensitive and accessible services. Also important is recognizing wellness as incorporating: a 'sense of community'; 'identity' as individuals and as First Nations people; 'traditions' as a source of strength; 'contribution' to the community; 'spirituality' as an essential aspect of life; 'living in a good way' -balance, self-respect and self-esteem; and, 'coming through hardship' including perseverance and resilience to both historical pressures and individual experiences (Van Uchelen et al.,1997).

Research clearly indicates that the policies of assimilation, designed to eliminate culture and community practices, severely affected the health of First Nations people, and, an individualistic, disease-oriented approach to that ill health overlooks the importance and healing properties of community. The statistics paint a grim picture of the health status of Indigenous peoples but they omit the strength and resilience communities have shown in surviving colonial policies and reasserting their right to engage in cultural practices. Consideration as to how a communal focus can be incorporated into health services is missing from the literature to date. This case study may offer some insight into how that might be achieved. For this reason, a strength- based lens was used to explore the unique model of care, the "One Canoe" model, that guides the Snuneymuxw Health Centre service delivery.

Patient Medical Home Model

The General Practice Services Committee (GPSC) set out a vision to enable access to quality primary health care that effectively meets the needs of patients and populations in BC. A key approach has been the implementation of the Patient Medical Home (PMH) model of family practice. The PMH positions family practice at the centre of an integrated system of primary and community care. The PMH emphasizes the use of a team-based care approach to deliver patient-centered care and enhance the quality of care. Patients have timely access to a primary care provider and coordinated, continuous and comprehensive care.

The GPSC has identified the following 12 attributes of the PMH model as key to achieve the overall goal of patient centered, whole-person care. The image below outlines these attributes:

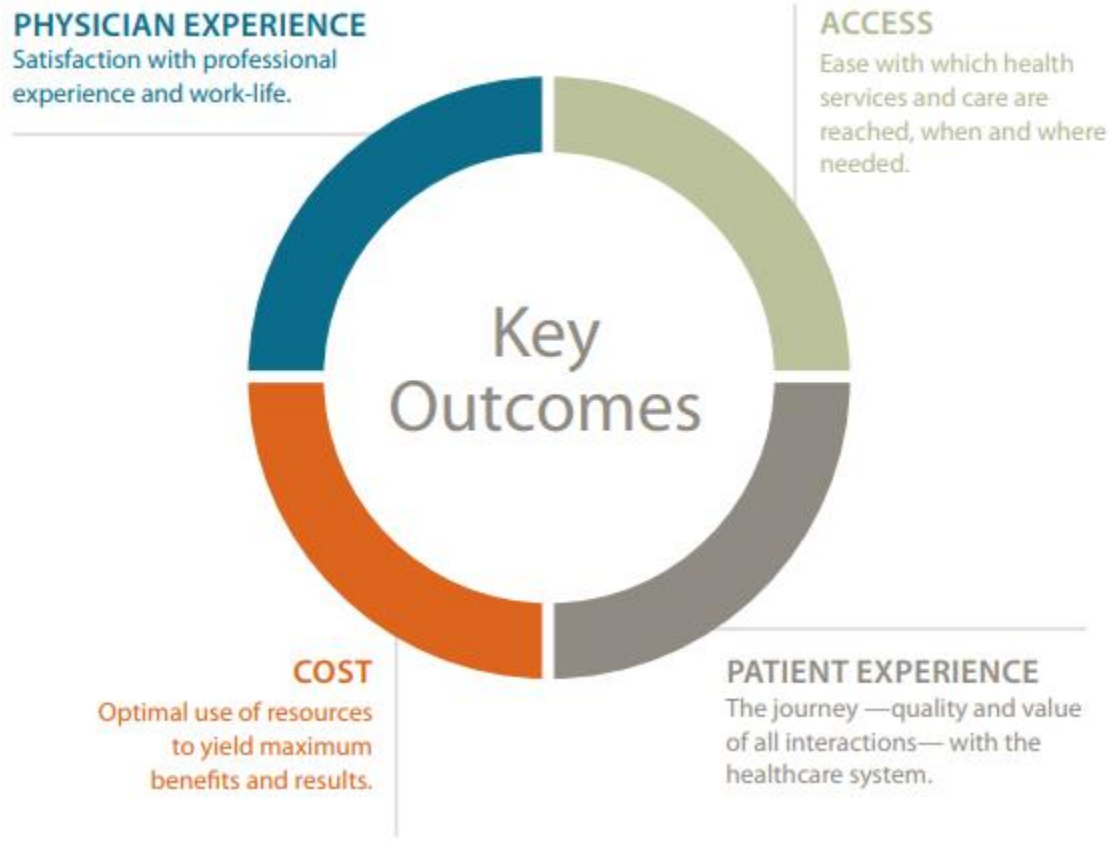


For more descriptions of the PMH attributes visit the GPSC webpage here. The work done in the Snuneymuxw Health Centre touches on multiple attributes of the PMH model, including:

- Team-based care:
  - FP services introduced into a culturally-safe, First Nations-led team based care environment
  - With the providers working as a team, patients have a full contingent of practitioners and wrap-around services.
- Contact (Timely Access):
  - Approximately 60% of the community members were unattached to a physician. Some community members had never seen a doctor.
- Continuity of Care & Commitment:
  - Patients are now receiving longitudinal care rather than accessing drop in physician services.
  - As trust develops patients are more likely to seek help from a physician in the future.
  - Physicians are able to follow up with medications.
- Coordination of Care:
  - The Community Health Nurse is now informed of a patient's discharge and able to follow through with home care.
- Comprehensive Care
  - Previously patients were not able to obtain referrals to other necessary services-- specialists, detox services, pediatricians, x-rays, tests or any other services that require a referral from a physician.
  - Patients have access to home care, chronic disease management, and Infant and Child Development programs, among others.
  - The Community Health Nurses no longer have to "chase down a community physician" to get requisition forms signed to access necessary equipment.
- Patient Centred, Whole-Person Care (Culturally Safe Care):
  - The availability of physicians for home care provides the opportunity for the patient's family to perform sacred ceremonies for healing and for palliative care.

GPSC model of evaluation:

The GPSC model of evaluation is predicated on the Patient Medical Home Evaluation Framework, which contains four outcome areas: physician experience, access, patient experience and cost. This model was used to synthesize the evaluation information into relevant categories.[1] Interviewees were also asked for the Centre's greatest strengths and advice to others planning a similar Centre and the themes from these questions follow. Note that the format of this report relies on quotes. This is deliberate. The purpose is to understand cultural safety or cultural responsiveness. The quotes illustrate how small gestures are interpreted and help to establish trust and build good will.



PATIENT EXPERIENCE:

During the time period that this case study was conducted three major incidents prevented a comprehensive firsthand account of the patient experience. However, the community health nurses are closely connected to community members and were able to provide observations of patient experiences. From accompanying one Community Health Nurse on a home visit to a patient, and, information from providers, the following advantages of the presence of the physicians to the patients were documented.

As described earlier, the FNHA representative to the CSC estimated that 60% of the community members were unattached to a physician. This meant that this same group of people were not able to

[1] The cost outcome was not explored in this evaluation.

get referrals to specialists, to detox services, to pediatricians, x-rays or any other services that require a referral from a physician. Some community members have never seen a doctor.

The physicians, in partnership with the team at the Centre see part of their purpose as building trust so that those in need will choose to seek out a doctor when necessary. Some clients were forthright with the physicians about that trust. As one physician described it: "*I had some awkward interactions with patients in the beginning and some were very honest saying: 'I don't really know you, I don't really trust you.' And then seeing our relationship evolve over home visits is not only rewarding but it is evidence that it makes a big difference."*

Prior to the physicians being at the Centre, patients were discharged from the hospital with no forwarding information. The Community Health Nurse did not receive any information from the hospital and may not even have been aware the patient was in hospital. With some of the physicians also working at the hospital that connection is now in place and follow up is direct from the physician to the community health nurses.

Perhaps one of the most significant aspects of the availability of physicians for home care is the opportunity for the patient's family to perform sacred ceremonies for healing and for palliative care. For some of these practices there are cultural restrictions around who can be a witness to traditional masks or ceremonies so they can only be performed in the patient's home or in the community. Colonial policies outlawed some ceremonies and healing rituals were dismissed according to one provider as: "*being regarded as voodoo*." This history and lack of respect has resulted in a reluctance to share the rituals and ceremonies with people outside the community. With the home care, community members have the freedom to fully embrace and utilize traditional practices to help the patient and the family.

The team at the Centre works cohesively and collaboratively, sharing information and concerns with the result that the patients feel well looked after. One Counsellor described it: "*They appreciate that they can have a relationship with 3 or 4 doctors and there is no waiting. Not just the medical team but Connie[2] talks to the doctors—clients talk to us and we talk to doctors and there is a kind of wrap around style care that they get and a lot of people have told me that they really appreciate that they can have that kind of service."*

Summary of the patient experience:

- Able to see a doctor (some for the first time)
- Building trust so that patients will be more likely to seek a doctor in future
- Patients are able to be seen in their home
- Patient's family is able to perform cultural practices at home with family and community - especially those practices not shared with non-community members
- Able to get follow up from hospital discharge
- Able to access specialist services and other necessary referrals
- Can experience wrap around care

[2] Connie Paul is the Home & Community Care Nursing Coordinator at the Centre.

ACCESS

The availability of physicians has not only enhanced access to care but also to needed supplies and resources for others to provide care. One physician described it: "*it is a bit of an archaic system still where you have to sign off on something even though we are not the ones doing the work or even know anything about it like I don't know anything about wound care –Connie does –yet I have to sign the care plan so that she can access the equipment needed."* Another provider said the availability of physicians saves valuable time. If a patient needs a referral or test, the providers get the physician on site to sign forms. Previously it was necessary to track down a community physician "*and get them to return calls."*

Without a physician, patients were not followed up to see if medications were being taken or if they were still sick. For example, one patient with COPD had been prescribed an inhaler. When one of the physicians from the Centre visited him at home he discovered that the patient was not able to use his inhaler because of the arthritis in his hands. The physician fashioned an extension to the inhaler out of cardboard and the patient went from visiting emergency 6 times a month to once in six weeks.

With home visits, physicians are caring for some patients who have never seen a doctor. Some, with life threatening diseases have been cared for and survived. Some others, if helped earlier would have had less serious complications as was the case with a patient who lost a limb to complications from diabetes. Patients without a family physician and with infectious diseases, diabetes complications and needing wound care were previously without help.

There is a unique aspect to access in the First Nations community that is significant on many levels—the availability of physicians symbolizes steps towards reconciliation. As noted in the literature review colonization, assimilation policies and residential schools left emotional and psychological wounds that are sometimes manifested in feelings of unworthiness. One provider described the psychological impact of the availability of physicians: *"Access is a really important part of them feeling important—like they counted. One patient said: "that you guys have made this happen—that the doctors are here for us is enormous."*

Some community members heard of the special treatment for pain relief received by one patient very late at night by a doctor and recounted to the counsellor: "*if we could have that when we need it –that care and compassion that would be wonderful"… any kind of personalized care is a way of saying you are valued in their mind and if we want to talk reconciliation really that is where the rubber hits the road. If you want to show us that you are sorry then show us that we matter. That is what it is about"*

The basic aspect of geography or proximity has improved access. Previous to having physicians close by at the Centre patients would have the effort of finding a physician in a place that is less welcoming or less familiar. With the result that patients may not have sought help when needed or waited until a condition became acute. One provider described it like this: "*one less barrier so they are much more likely to seek out help as opposed to trying to take a taxi or go across town to a physical environment that they may be less comfortable in."*

In addition to being on reserve, the placement of the new Centre is strategic within the reserve as "*having it close to houses and on reserve is really helpful –not having to make that geographical effort. On reserve land, it is where the sweat house is.. so close to cultural activities."* The sweat house or long house is the place of sacred ceremonies and community gatherings. This means that there is a smooth

transition from medical care at the Centre to cultural care in the home or long house and conversely for cultural influences to be imbued in care at the Centre.

As well as responding to patients' accessing the Health Centre, the physicians are also proactive in attending to needs identified by other team members. For example, Cheryl Mooney, another Community Health Nurse, also coordinates the Infant Development Program. A regular meeting with staff from that program provides the opportunity for the team to learn from each other about the needs of families for referrals to specialists such as a pediatrician, and, for the physicians to provide care for families identified by the staff.

With the availability of the physicians at the Centre, and their ability to do home visits, and, the collaborative team model, the patients are receiving culturally competent, longitudinal care.

Summary of increased access with addition of physicians to care team:

- Referrals to specialists, treatment facilities, tests
- Care in home
- Longitudinal care
- Development of trust has led to more willingness to access services
- Follow-up with medications
- Home visits facilitate blending of cultural healing practices into care
- Represents steps towards reconciliation

PHYSICIAN EXPERIENCE

The work at the Centre is very satisfying for the physicians for a number of reasons. The culturally safe team approach means that the physicians are getting a fuller understanding of a patient's history, their preferences and causes of disease. Once trust has been established, the community is generous in sharing cultural knowledge. One physician said he felt "*privileged to learn cultural teachings*." Another said after an awkward start with some patients, "*[I saw] our relationship evolve over home visits…[it] is not only rewarding, but it is evidence that it makes a big difference and that is not something you might be used to in the general population."* The work is described by providers as satisfying and fulfilling: "*[it is the] most satisfying medicine I have ever done."* Providers expressed these feelings primarily because they feel they are making a difference, and building relationships over time: *"I like the kind of continuity of seeing the progress with patients based on trust."*

For one physician, the person-centred One Canoe model of the Centre aligned well with the philosophy they were used to from working in the hospital: "*[it was] very similar between myself and that clinic and I really enjoyed that it reaffirmed what I was doing already. For me that was a positive experience and if I didn't have that philosophy, I would have learned that from them."* The team approach combined with the person-centred care of the Centre also fit well with this physician's own philosophy of person-centred, team-based care: *"the team based approach, the health nurses, the mental health workers will stop in the office and talk to you about a patient you are going to see—they have so much more knowledge that I can never gain and I really like that."*

There is more time to spend with patients and the time is necessary to build trust and discover some of the issues that have not been dealt with. "*The time you can spend with patients –I really like that and I don't like being rushed…and you really are rushed in a community practice."*

Summary of physician experience:

- Physicians enjoy having the time to establish trust
- Feel like they are making a difference
- Feel privileged to learn the cultural teachings
- Enjoy working as a member of a team
- "Most satisfying medicine I have ever done"

KEY LESSONS FROM THE CENTRE

Cultural Safety:

The Centre is a place of cultural safety. This is mainly due to the fact that the Centre was created by the community with First Nations staff. How then do non-First Nations medical personnel join this team and practice cultural safety? Interview questions were designed to determine how this is learned, how it is experienced and what recommendations the staff have for others who would like to emulate this experience, or, develop a similar Centre.

Advice from the physicians who have adapted to cultural practices and gained respect in the community is as follows. Preparation begins with an attitude of recognizing and appreciating that the community has a history of trauma, and, some in particular may have had more trauma than others. Time and effort are required to learn cultural practices and build trust. They advised that any online course can quickly become a way of standardizing and oversimplifying what is essentially a "way of being" and that those courses or manuals have the potential to be hurried through as quickly as a hand washing tutorial. One physician's approach was to attend cultural workshops and any cultural events to which he was invited.

When interacting with patients there are behaviours that signal respect and build trust. "*You need the time because a lot of the issues are very personal or emotional so you need time to ask softly the right questions—discover what you can ask and what you can't and what is offensive…[allowing more time per patient is] probably the system you have to run for a First Nations centre for now and probably over time and trust is developed [could be more efficient] but that will take decades."*

"I think you have to actually meet people. If you don't have any personal emotional ties you have to meet people like if you heard people talk about themselves, about being sexually abused or trauma that's hard to just bypass you and that would affect people much more than a poster or a module. You just have to meet people, makes it more real. You have to put the time in and you have to want to learn and when they offer you an opportunity to learn about their culture you have to take it –it is not something that is just going to come to you."

Connie, one of the community health nurses, has been a driving force in mentoring and coaching physicians in appropriate cultural practices when visiting clients in their homes. Small gestures that are significant to the culture have helped to develop relationships. Since Connie is the liaison with the

physicians she is instrumental in teaching and mentoring physicians on how to approach clients and their families.

The Health Centre is unique in that the cultural practices were well established as a "way of being" before the physicians and other non- First Nations staff joined the team. While other Centres established by health institutions struggle to introduce and incorporate cultural safety and create safe spaces for First Nations patients this was the reverse situation. The Centre created a safe space for the non -First Nations providers to learn cultural protocols. As one of the counsellors described it: "*Then the physicians assimilated with us inside of the other way around. But for me the most important thing was that they assimilated and they knew that in order for them to be here they had to take the minority seat –they had to take the place of deference and they did that very well."*

The First Nations staff introduce the non-First Nations staff to areas of the culture that are important to know when providing care "*the Big house, the shaker, what it means to be a dancer. We feel it is important to be inclusive and we are all working towards the same thing."* It was acknowledged that it can be intimidating for some when first encountering the culture but that "*it is important to show yourself, especially off hours because that is when the cultural events happen*." Meeting people and becoming known so that trust can be built is the first step as then people will feel comfortable in coming to see the care provider. In any First Nations, "*this is the priority for any new person."*

In a nutshell, the culture is mainly absorbed over time rather than learned in the usual sense of acquiring knowledge. Most importantly, a new person has to be seen in the community and through word of mouth, people will decide whether or not to come and see the provider. One physician said*: "in the general population you start with trust and it is yours to lose, this is the opposite, trust must be earned."*

Summary of learning/ensuring cultural safety:

- Attend cultural events
- Build trust slowly
- Approach with attitude of deference
- Learn and adopt the values of "One Canoe"
- Ask for guidance on protocols

Team-based approach

The medical and counselling staff work as a team. Team members provided information on how relationships developed and how relationships might be facilitated in other clinics. Although relationships were described as evolving organically there were some strategic actions at the start. For example: "*They did do a lot of things that were helpful. They did a poster to introduce all of the physicians' pictures and a little bio and they had it out front so that the community would know what they looked like. It was helpful because there was a very visual connection there but …they built the relationship strategically and in stages."*

Another member of the team who has been part of the Centre for longer described the small gestures everyone is encouraged to extend to the physicians and other providers to begin the process of relationship building: "*It is about being conscious, it is intentional—we don't leave it to—if it happens it happens. We are intentionally trying to form those relationships because we know how good they are in*

the long run for the community members. And that is at the bottom of everything we do—we say: "What is in our community's best interest?"

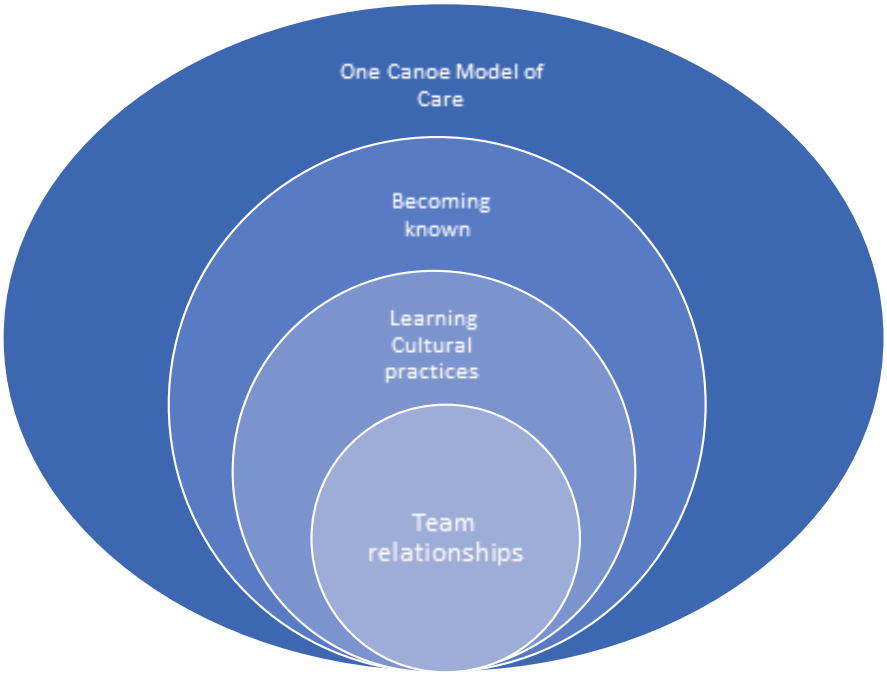
On the other hand, there is a period of good-natured observation, described as 'sussing out': "*We are fairly small and we make a conscious effort when someone comes in to sort of suss them out and find out what they are like. It is kind of an unwritten rule—who is this person and how well are they going to fit in because we are pretty solid in terms of our approach and we want to know that they are a good fit.* This is combined with staff being instructed to "*introduce yourself and find out* [who someone is]*—it is just a matter of being respectful and having a conversation."*

Relationships appear to be effortless due to a feeling that everyone is operating from the same values and are committed to person-centred care: "*All the helping professionals –the people—they put the clients first and are willing to do whatever is necessary to meet clients where they are and whether that means walking with them on their journey or driving out to see them. Eliminating as many barriers as possible. Compassion and empathy and ability to put themselves in another person's place. I haven't met anyone here whose heart is not in the right place."*

Another facilitator of the development of relationships on the team is reciprocity. The team appreciates the availability of the physicians and the physicians appreciate the knowledge the community team members have of the patient and their background. One physician said: *"We didn't have to seek out any relationships –they come to you and they are grateful to have us there –[but] the care workers get the right history and the right context for patients so without those people [the team] I would have no idea how to treat the patients so I think it is a mutually beneficial relationship and whenever something is mutually beneficial it makes for an easy relationship."*

Specific activities facilitate the development of relationships. Staff spend time in each other's program so that "*we get to know the new person and the new person gets to know how we work."* There is also specific mentoring of new staff and this results in a strengthening of the team overall. Debriefing over particular issues for clients helps share knowledge and promote relationships at the same time. The following diagram illustrates the organic full integration of the physicians to the Centre care team and philosophy.

Figure 1:



Summary: How have relationships developed between care providers on the team?

- Organically with some helpful processes
  - Posters introducing physicians / seeing their face before they start
  - Eating together
  - Community health nurses bridge cultures and mentors physician on protocol
  - Shared values
  - Commitment to patient first philosophy (One Canoe Model)
  - Not disease centric, but patient-centred
  - Reciprocity of knowledge sharing

Greatest Strengths of the Centre

When asked the question: "What are the greatest strengths of the Centre?" all respondents answered: "the people." All interviewees did not hesitate to say that the people who work at the Centre are the reason for its success. A typical response was the simple: "*Strengths are really within the people."* Members of the team were described as advocates, an essential role for patients who are not accustomed to asking for, or finding services for themselves. The value of having team members in this role was described as follows: *advocates who know everybody—they are all on a first name basis and they know the history of everyone so as a doctor –you show up there and you just need to start asking everyone around you, your colleagues for background and context.* For example, the attributes and contribution of Connie Paul, one of the Community Health Nurses, was described as: "*unbelievable. Not just her clinical skills, she used to do rural nursing but she is a huge advocate for patients and that population tend not to advocate strongly for themselves. If there is a poor interaction they are more likely to just shut it down and not to talk about it …so to have a really strong advocate and help people navigate through the system."*

The Centre has a cohesive staff who have worked together as a team for a long time and who cover most of the patients' requirements: mental health counsellors, nursing, physicians, Infant and Child

Development program, and at another site -physiotherapy and speech therapy. With one Community Health Nurse bridging health services and the Infant and Child Development Program, prevention and health promotion are achieved through the collaboration while the other Community Health Nurse is aligned with physician services and through home visits and hospital discharge follow up, relationships are developed in the community and the physicians are mentored in cultural competency

It is not only the clinical and counselling staff that are appreciated. The One Canoe model includes everyone at the Centre as part of the team helping patients and this was reflected in credit given to office staff: "*the people—the team, the staff. The Centre needs a really good office administrator for bookings and keys etc.—that stuff can be a real mess."* The MOA was also mentioned as essential to the success of the Centre. She is First Nations (but not from the community) and is the 'face' of the Centre to clients coming to seek physician services for the first time. She is also an advocate and helps patients navigate the system: "*our MOA is a very positive force."*

Also acknowledged as essential to the success of introducing physician services to the Centre was the Executive Director of the Nanaimo Division as the person who initiated the project to have physician services there. It was through her manner and respectful approach that smooth relationships developed between the Division and the Snuneymuxw. Her approach is described as follows: *Leslie is one of the reasons –if you ask how did this work –it takes certain individuals with the right approach and demeanor and she is so genuine and friendly and that is so important. In an initial meeting --with her being the face of the Division—in my opinion it is because of Leslie. She is that influential –she got along well with Charles [previous administrator] they had their AGM and she was recognized there and they had nothing but great things to say about her and everyone was clapping for her… her specifically is why it was a successful relationship. Very genuine.*

The importance of shared values is emphasized when doctors or others apply to work at the Centre. They have to satisfy the staff of their intentions by answering in the interview process: *"Why do you want to work here? How long are you going to stay?"* Staff or patients do not want to invest time in building relationships if the person does not intend to stay. They want to be assured that anyone coming to work at the Centre will be there for a while and is there for the right reason.

One provider cited their accreditation process as a major achievement and a source of pride for the Centre. Accreditation is a review of policies and practices that allows healthcare organizations to demonstrate their ability to meet regulatory requirements and standards established by a recognized organization: Accreditation Canada. This is a quality improvement process that requires extensive feedback from providers and community members as well as examining practices. Surveys were sent out to determine if the Centre was focusing on and achieving the health goals that were important to community members. It was arduous and thorough. Accreditation entailed articulation of clear standards that are now known to all staff and are a clear reference point. It was a four year process of developing policies and procedures around those standards. The staff member pointed out that standards are often seen by other First Nations groups as part of an institutionalized system. In this case, the process of examining their work led to a realization of the strengths of the Centre. It invigorated the team to articulate the procedures of the Centre that were officially recognized with accreditation.

Summary of the strengths of the Centre:

- Time spent developing relationships
- Team based approach to care
- Strong, respectful relationship with Executive Director of Division of Family Practice head

- One Canoe model
- Team is committed and has shared values
- Accreditation process
- Cultural practices are the foundation of the Centre; they are inherent throughout and all undertakings begin with this base.

Summary and Concluding Observations

The One Canoe model is well established and gives everyone a clear direction and shared values. This is, and will continue to be in the future, a compass point on which the team can focus and find accord. It is rooted in the rules of the tribal journeys, the teachings of the Elders and it is the way the community lives. As outlined in the review of the literature, colonization has acted to fracture the complex, intimate, and integral connection between the Indigenous self and the body. Whether or not this was a conscious purpose of colonial policies, it acted to separate the physical body of Indigenous people from the land, their family and their community. When these connections were shattered through settler colonialism the result was the production of ill-health in minds and bodies because for Indigenous people bodily health is connected to the multiple other contexts of physical, social, and material dimensions of communal and individual life.

This case study has attempted to show how the Health Centre brings together Western medicine and cultural practices in a collaborative attempt to restore the unity of spirit, identity, pride, connectedness and bodily health to the Snuneymuxw First Nations. Western medicine's contribution to the healing of the physical body is the entry point by which it can support the rebuilding of the practices of culture. By working as part of a team of cultural practitioners there are subtle effects that the commitment to this mandate represent to the Snuneymuxw. At a specific level, the allegiance of the team at the Snuneymuxw Health Centre to the One Canoe model of care affords a clear mandate and shared value on which to anchor the care; at the general level, the care of the physicians represents an act of reconciliation and reparation to the Snuneymuxw patients.

Finally, a word about the building itself. It represents a significant progression towards equity and recognition of the importance of cultural practices. As patients approach the Centre they will see a superb building with free parking, easy access, and, large glass windows and doors. Upon entering they will be surrounded by high ceilings, stunning art work, colourful seating and skillfully carved benches; a soft spoken, calm receptionist will greet them with a smile. To the left, there is a large kitchen for community feasts, a room for Elders, and outside, seen through the sliding glass doors-a firepit and a circle with seating. They will meet one of the care team who is dedicated to the One Canoe model of care, a model that puts them in charge of their care with everyone in the canoe, the other members of the care team, helping them get to their own health objective. It is the antidote to the long shadow of the old Nanaimo 'Indian' Hospital, with its history of ill treatment and racism, and that still influences some community members' decisions to seek care or not. The Snuneymuxw Health Centre, through its devoted, collaborative staff and commitment to creating a safe and welcoming environment in a beautiful building may help to build confidence and trust in a health system that has not served First Nations well in the past.

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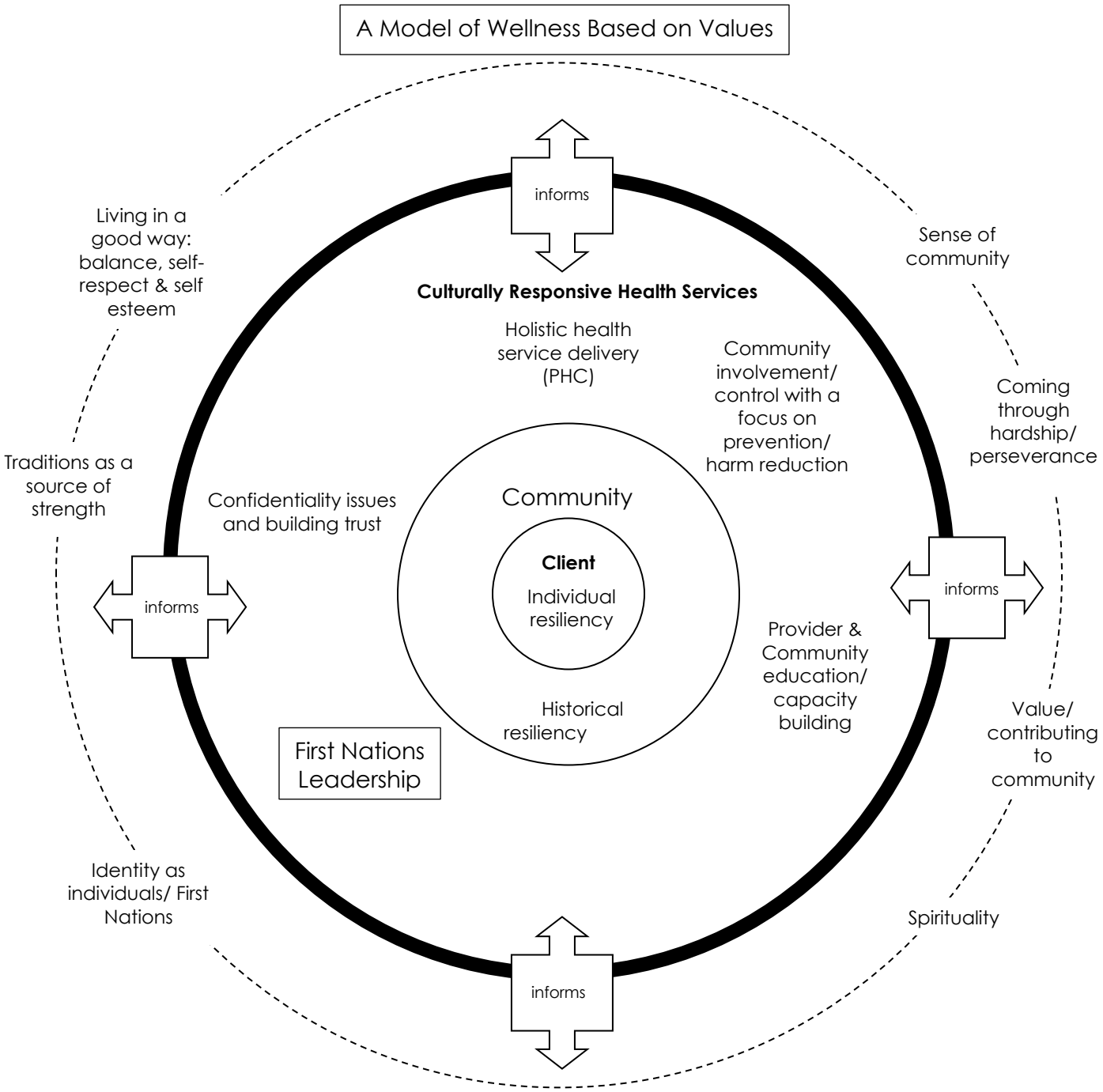
Appendix 1:



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