Author's response to reviews

Title: What all students in healthcare training programs should learn to increase health equity: Perspectives on postcolonialism and health

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Response to Reviews

Title: What all students in healthcare training programs should learn to increase health equity: Perspectives on postcolonialism and the health of Aboriginal Peoples in Canada

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Date: ## May 2015

Dear Dr. Ming-Jung Ho,

Thank you for these exceptionally helpful reviews, which have served to strengthen our manuscript considerably. Below, please find our point-by-point response to the reviewers’ suggestions. We have also noted changes to the original manuscript using track changes.

We have modified the methods to adhere to RATS guidelines.

Sincerely,
Allana Beavis
Corresponding Author
**RATS Guidelines**

- We have ensured that our manuscript reporting adheres to RATS guideline.

**Abstract**

- In an effort to reflect the major revisions in our abstract, this section of the paper has been modified. Lines 26 – 57 reflect the adjusted Abstract.

**REVIEWER 1**

**Major Compulsory Revisions**

The research questions are well defined but the problem from which these research questions arise must be clearer and presented at the beginning of the paper, rather than starting on page 4.

- Thank you for this helpful advice. We have revised the introductory section extensively, including shifting the rationale for the research questions to earlier in the paper.

Health inequities arise from contexts or conditions of social injustice related to the legacy of colonialism and this era of neocolonization. What are the problems underlying colonialism and neocolonialism? It would be important to discuss about the notion of ‘democratic racism’ and how it affects public and private discourses in Canada (See Tator & Henry) on democratic racism. One cannot discuss postcolonialism without discussing ‘race’ and the exclusionary process of racialization. How does racialization work in the health care system and how does racialization work within nursing and health care professions? (e.g., Puzan (2003) The Unbearable Whiteness of Being in Nursing).

Aboriginal peoples in Canada live the aftermath of colonization (e.g. residential schools, the Indian Act), and the current politics of neocolonialism, (also derived from racialization) but translated into ideologies that affect lack of accessibility to health services, discrimination based on stereotypes, and gendering. In other words, I suggest presenting or describing health problems related to colonization/neocolonization or problems related to health encounters with mainstream Canadian professionals and attitudes that may be unsafe when caring for Aboriginal peoples.

- We are grateful for this constructive guidance. We have extensively revised the Introduction, taking into account these comments and also the audience we are trying to reach in BMC Medical Education, which may or may not already be familiar with these concepts. We would be happy to engage even further with ideas of race, racialization, whiteness and their links with colonization if requested.

p. 3 I see postcolonialism not as a tool but as a theoretical approach; postcolonialism is an abstract theoretical approach and cultural safety may be the concept (or proxy) by which the ontological and epistemological assumptions of postcolonialism can be operationalized at the clinical, practice or education levels.

- Changes have been made to reflect this point.
- Page 5, Lines 105-106 changed to: Postcolonialism is a powerful theoretical approach that enables healthcare professionals (HCPs) to understand how unequal power relations create health inequities.
- Page 21, Line 464 now reads: “Postcolonialism is essential in healthcare education and practice.”
p. 3 I do not understand why it would be necessary to define postcolonialism from an overarching definition. It is not the postcolonialism lacks a single definition; it is that postcolonialism cannot be reduced to a single entity. It is like feminism, there are many strands of feminist theories.
   - This point is well-taken. We have deleted the phrase: “The term ‘postcolonialism’ lacks a single, common definition [2-4]”

p. 3 Please provide some examples of health inequities in Canada arising from colonialism and neocolonialism. What is the health status of the ‘colonized’? What are the outcomes of unequal relations of power on the health of the populations? Say more about this so that international readers may understand the broader historical, social, cultural, economic, and class contexts of health inequities.
   - We have added detail into this paragraph on page 4-5, line 87-97 regarding health inequities arising from colonization.

p. 4 Postcolonialism has been integrated into healthcare training programs” How and can you describe the strategies used to implement postcolonialism into healthcare training programs? Or is this a conflation between postcolonialism and cultural safety?
   - We have revised this paragraph to reflect that there is very little research exploring how postcolonialism has been integrated into healthcare training, and we have presented details of two studies that have used this approach (page 6, lines 116-121).

p. 4 The authors need to expand on cultural safety and provide a definition from the original author Ramsden. It would be important to bring some original definitions especially the one from Ramsden. I suggest saying the descendants of British settlers. Settlers were colonizers but New Zealand and Australia like Canada were privileged colonies of settlers whereas other countries were pillaged of their human capital and natural resources by European colonialist countries.
   - We have adjusted this paragraph to respond to these suggestions (page 6, lines 121-131).

p. 4 Risk of becoming agents of colonization (yes but only if ideologies that underpin view of Western medicine and nursing practice are not critically examined). I would argue that nurses can be agents of colonization/neocolonization if they do not reflect on their own racial and ethnical biases and if they do not critically engage with cultural differences. Neither is it a question of total rejection of one’s own culture, it is a question of reflexivity to deconstruct racism and ethnocentrism.
   - Thank you for this helpful nuance, which we have added to this paragraph (page 5, lines 102-104).

p. 5 Papers on postcolonialism cannot escape a discussion on ‘race’ and the process of racialization because colonialism is based on the ideology of racial discrimination. The ideology of Whiteness (Frankenberg, 1988) is the underpinning of any colonial enterprise.
   - We appreciate the encouragement for us to more directly address race, racism and racialization in this paper. We have endeavoured to address these important concepts within the revised Introduction section.

p. 5 Avoid conflating colonialism and racialization.
   - Thanks you for flagging this point. We have audited the manuscript with this conflation in mind.
Please clarify the use of an interpretivist paradigm. As I read the results and the discussion, it seems that this study is rooted in a post-positivist paradigm which does not preclude the interpretation of data. It is like the ‘etic’ knowledge in a conventional ethnography.

- While the motivation for the study may be viewed as post-positivist (specifically, that we are interested in challenging the status quo and dismantling taken-for-granted assumptions in healthcare training in Canada), we view inquiry itself is interpretivist. i.e., we viewed data collection as a form of meaning making together with participants; we stayed at the level of making sense of participants’ claims and not looking for “the story behind their story”; we did not seek to reflect on discourses that may have been present in the narratives of our participants, etc. To that end, while the framing of the inquiry has a critical orientation and emancipatory aims, the analysis itself was a fairly straightforward. We have attempted to clarify these points at the start of the Methods section on page 7, lines 150-156.

p. 7 How the use of this DEPICT method may stifle creativity in qualitative inquiry? See Sandelowski on “rigour and rigour mortatis” in qualitative research.

- On the contrary, the DEPICT method is designed to open up and promote analytic creativity, especially for junior researchers who may be relatively new to qualitative analysis. We have added detail into the Data Analysis and the Rigour sections to clarify this point (pages 9 and 10, lines 188-218).

p. 7 It seems as if the data were analysed according to the research questions. Why did you decided to approach data analysis from the research questions? Does it affect induction and the process of emergence?

- It would appear that the results may be a mirror image of the research questions; however, the analytic journey to arrive at these results was multi-phased and iterative – and should give the reader much confidence in the results. We have elaborated on this process in the Data Analysis and Rigour sections. We have also modified the Figure 2 illustrating the results to better reflect the weight given to each of our findings, and to differentiate that the quality of the results about content are different than the results about how to deliver this content (i.e., the who, when and how). Additionally, lines 144-148 on page 7 were deleted.

p. 7 Did you achieve data saturation? and when did you achieve it?

- We tend to be cautious about the concept of data saturation in our qualitative work (following, e.g., O’Reilly and Parker, “Unsatisfactory saturation”: A critical exploration of the notion of saturated sample sizes in qualitative research. Qual Res 2013;13:190-7), instead preferring to explicate our analytic steps as a strategy for demonstrating the trustworthiness of our results. To this end, we have added a new section on Rigour (page 10, lines 206-218).

p. 7 How qualitative validity was attended? Were participants informed about your collective interpretation of the data? Did they receive their transcripts? How data trustworthiness was ensured?

- We did not engage in member checking, or inviting additional reflection from participant beyond the initial interview. One exception is an interviewee who requested her transcript to use as a teaching tool in her work, which we were happy to provide. However, we attempted to ensure rigour in other ways, as outlined in our Data Analysis and Rigour sections (page 10, lines 206-218). We will note, however, that the experience of this study has energized us to pursue additional research and advocacy in this area, and we are planning a dialogue on this topic at our upcoming national professional Congress (for physiotherapy), to which many of the
participants have been invited. However, this dialogue is beyond the scope of the inquiry being presented here and is not discussed in this manuscript.

p. 10 What do you mean by intersectionality? What are the differences between intersectionality theory and postcolonialism? In other words, is intersectionality a better theoretical approach than postcolonial feminism? And if yes, why?
   - We have chosen to remove the reference to intersectionality in the results section (page 13, line 282), because it was not a major finding. However, we have preserved and bolstered the comment about intersectionality in the Discussion (see page 22, lines 500-507) as an idea advanced by Van Herk et al (2011).

p. 11 I suggest not referring to non-Western immigrants and refugees in the text because the emphasis is on Aboriginal peoples. Colonialism/neocolonialism can affect these groups differently; however the common denominator of colonial practices is racialization. There is no one size fits all. Racialization can be effected through the presence of an accent (language), sexual orientation, and faith/religion. I suggest reading Tang and Browne (2008).
   - The reviewer flags an important point here. We entered the study expecting to hear more about the impacts of colonization for immigrant and refugee populations. However, the nature of the results (likely shaped by our sampling) was a predominant focus on Aboriginal health. We have therefore responded to the reviewer’s recommendation by removing the one-time reference to refugee health in the results (page 14, lines 301-304) since it was indeed not a major finding. However, given the significance of the health and experiences of non-Aboriginal people of colour in Canada related to colonization, we have preserved the reference to this group in setting up the inquiry in the Introduction, and we have added a point in the Limitations section about how this is a gap in the current inquiry and an important area for future research.

p. 12 Please appraise the following piece of data: “This notion of competency in someone else’s culture is ridiculous.” Can this excerpt also translate the fact that perhaps cultural competency is misunderstood? It is evidence that one cannot speak all languages in Canada and knows about all ethnocultural groups but is there a certain ethical duty to know about cultural differences? Can we be culturally safe without being a priori culturally competent?
   - Thank you for bringing this important consideration to our attention. In the discussion section we take up this in the Discussion, at least in part. We have revised the content in the Discussion (pages 21-23, lines 477-512) that allows more reflection on how cultural safety and competency can complement each other, and what each approach offers and its limitations.

I suggest pushing further the analysis in the discussion and move at a higher level of theorization. On page 14, what could be the advantages and disadvantages of having only Aboriginal instructors to teach postcolonialism? While acknowledging the negative and stigmatizing experiences lived by First Nations, Inuit and Metis peoples of Canada though colonization, I would avoid making sweeping generalizations that create opposing dichotomies and may reinforce a priori stereotypes. The experiences of colonization and suffering and the colonized subjects’ lived experiences of subjugation or oppression or marginalization are important to reveal. Yet, it does not mean that some mainstream instructors or health professionals cannot understand race and racialization. I suggest reading the cogent discussion of Dr. Joan Anderson about the Conundrums of Binary Categories and how she argues that “racialization can cut both ways” (2004, p. 12).
   - Our findings articulate that Aboriginal educators ought to be involved in design, review and teaching of curriculum. I think our participants are advocating for being inclusionary toward and
building capacity within Aboriginal communities, rather saying that Aboriginal educators would be better than non-Aboriginal educators. In an effort to avoid constructing binaries, on page 17 line 386 the phrase “a preference for” has been replaced with “that.”

**p. 17** I suggest avoiding using postcolonialism as a tool. It is a complex theoretical perspective that can be operationalized at the clinical and practice level through reflexivity and cultural safety without disregarding some important elements of cultural competency like attitudes and skills.
- Changes have been made to address this point.
- Page 5, Lines 105-106 changed to: Postcolonialism is a powerful theoretical approach that enables healthcare professionals (HCPs) to understand how unequal power relations create health inequities.
- Page 21, Line 464 now reads: “Postcolonialism is essential in healthcare education and practice.”

**p. 18** A critical appraisal of cultural competency may reveal some advantages of the concept. Culturalist theorists focus on ethnicity an “exotic” cultural differences but it was never asked to know every ethnocultural differences. But the goal of cultural competency is not to challenge relations of power, it is about cultural openness (attitudes and skill), cultural knowledge, cultural awareness (attitude), and cultural desire (Campinha-Bacote, 2005). So cultural competency and cultural safety address different concepts yet cultural competency and safety may be more correlated than expected.
- We have added nuance to this paragraph to emphasize not only the limitations of cultural competency, but also the strengths offered by this approach (page 21-22, lines 480-490)

**p. 18** Explain in more details how your findings align with the cited authors under the section Beyond Cultural Competency. Culture is a social determinant of health.
- In our endnotes, we include culture and race in our definition of “social determinants of health.”

The major limitation that has not been stated is that a qualitative sample of 19 participants does not allow for generalizability. It can inform the teaching of cultural safety through using postcolonial or intersectionality theories.
- We have added text to the Limitations section (page 24, lines 538-542) to address this point.

I suggest to move content from page 4 to page 1 and describe the problem. What is the problem and why healthcare educators are invited to rely upon postcolonial theories to approach health inequities and issues of social injustice that create negative health outcomes of some racialized populations. It will bring a logical presentation of the arguments.
- We have re-organized and revised the Introduction entirely, inspired in part by this comment.

**Minor Essential Revisions**

**p. 3** The authors seem to refer to political colonization through imperialism. But there are other forms of colonization and imperialism such as science, knowledge, the politics of evidence in health research, the politics of race, and neoliberal economic policies. So it is important not to reduce colonialism to a political and ethnic domination but to other forms of subjugation.
- We have revised the Introduction section to address this helpful comment.

**p. 4** I would suggest not completely rejecting the notion of cultural competency. Campinha-Bacote’s model can be useful to develop attitudes, skills, and knowledge that will be used to understand cultural safety.
We have edited the section on cultural competency in the Discussion (page 21-22, lines 480-490) to highlight both the limitations and strengths of this approach.

p. 4 The Indian Act must be a bit more discussed to locate international readers. What are the elements of the Indian Act that preclude empowerment or decolonization?
- Further detail has been provided on page 4, Lines 72-85.

p. 9 Do you mean statistical data or epidemiological data. Please clarify.
- We reviewed the original data and found that only one participant brought up statistics as reinforcing stereotypes, whereas other participants just described stereotypes. As such, we have decided to delete the phrase “...that can exist based on statistical data” on page 12, Line 266.

p. 10 I suggest changing Eurocentric worldview to Western worldview because it includes both European and North American worldviews. The notion of causality of diseases and treatments can be interesting to explore here (mechanistic vs. holistic views of health). Yes but the data analysis should go deeper. For instance, in p. 11 an important element emerge from the data analysis. It would be interesting to add more depth on reflexivity.
- We have preserved the term Eurocentric in this section of the results (page 11) to stay true to the participant’s narrative; however, we have changed the term in other places, including page 23, Line 516-518 changed to: “An emergent theme in our results was that HCPs need to challenge the ideas they hold as knowledge and truth. Our participants explained that HCPs require an awareness of how the Western worldview dominates in healthcare and devalues Aboriginal ways of knowing.”

I suggest revising the title. The focus is on Aboriginal peoples and it must be reflected in the title.
- We have changed the title to reflect this helpful comment.
  o Lines 1-2 now read: What all students in healthcare training programs should learn to increase health equity: Perspectives on postcolonialism and the health of Aboriginal Peoples in Canada

Discretionary Revisions

p. 6 Were participants sent a letter to explain the goals of the study?
- We have made this change on page 8, Line 176-177, adding: “Participants were sent a Letter of Information detailing the goals of the study and...”

p. 9 Insert ““around “Sixties Scoop”
- We have made this change on page 12 on line 254 and lines 259-260.

REVIEWER 2

1) My biggest concern is the use of the term post colonialism as if it is a kind of fixed and identifiable thing in and of itself. For example, the authors suggest that postcolonialism is a “tool” that can used. (page 3, line 54). Post colonialism is a social and political context. It is fluid, ever changing and different in every country and even territory. I think it is an important analytical perspective but I don’t think it can be called a tool.
- Changes have been made to reflect this helpful point.
Postcolonialism is a powerful theoretical approach that enables healthcare professionals (HCPs) to understand how unequal power relations create health inequities.

Page 21, Line 464 now reads: "Postcolonialism is essential in healthcare education and practice."

2) The authors acknowledge that their participants spoke to a particular post colonial context as Aboriginal community members, teachers and professionals. The references to the euro-centricity of health care professionals and the system and the impact of “whiteness” tends to leave out other non-European practitioners and members of the community as having a different experience in post-colonial context. After all, many HCPs are from Asia, Africa and the Caribbean. They will have alternative but equally valid perspectives to share with learners. There are broader conversations to be had about power and privilege related to social class and gender that are products of a post-colonial reality.

- We greatly appreciate this reflection, which dovetails with a comment made by Reviewer 1. We entered the study expecting to hear more about the impacts of colonization for immigrant and refugee populations. However, the nature of the results was a predominant focus on Aboriginal health. We have therefore responded to the reviewer’s recommendation by removing the one-time reference to refugee health in the results (page 14, lines 301 - 304) since it was indeed not a major finding. However, given the significance of the health and experiences of non-Aboriginal people of colour in Canada related to colonization, we have preserved the reference to this group in setting up the inquiry in the Introduction, and we have added a point in the Limitations section (page 24, lines 551-555) about how this is a gap in the current inquiry and an important area for future research.

3) The discussion around the notion of cultural competency is very important and I think the linking to critical consciousness is great. This is linked to reflexivity and is one way to overcome the issue of who teaches material and whether they have lived experience upon which to draw and their ability to critically position themselves in regard to the challenges they are provoking. The research methodology is clear. I think the paper should be published with perhaps some thought to how postcolonialism is referenced. It is a theoretical tool certainly but I think the use of the word lens is a better description of how this important in both teaching and in practice for HCPs.

- We thank this reviewer for these helpful reflections.