

Interactions Between Indigenous Women Awaiting Childbirth Away From Home and Their Southern, Non-Indigenous Health Care Providers

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Abstract

We examine patient–provider interactions for Indigenous childbirth evacuees. Our analysis draws on in-depth interviews with 25 Inuit and First Nations women with medically high-risk pregnancies who were transferred or medevacked from northern Quebec to receive maternity care at a tertiary hospital in a southern city in the province. We supplemented the patient data with interviews from eight health care providers. Three themes related to patient–provider interactions are discussed: evacuation-related stress, hospital bureaucracy, and stereotypes. Findings show that the quality of the patient–provider interaction is contingent on individual health care providers' ability to connect with Indigenous patients and overcome cultural and institutional barriers to communication and trust-building. The findings point to the need for further training of medical professionals in the delivery of culturally safe care and addressing bureaucratic constraints in the health care system to improve patient–provider communication and overall relationship quality.

Keywords

doctor–patient; nurse–patient; communication; women's health; gender; childbirth; reproduction; pregnancy; stress; distress; marginalized or vulnerable populations; qualitative; participatory research; North America

Introduction

There are grave disparities in perinatal health between Indigenous and non-Indigenous populations in Canada. For instance, infants born to Inuit women in northern Quebec are 4 times more likely to die before reaching their first birthday compared with infants born to non-Indigenous women in southern Quebec (Luo, Wilkins, Platt, Kramer, & Fetal and Infant Health Study Group of the Canadian Perinatal Surveillance System, 2004). Adverse birth outcomes such as preterm birth (<37 weeks completed gestation) are also much more prevalent among Indigenous than the non-Indigenous populations (Auger et al., 2012; Luo et al., 2010). These perinatal health disparities reflect both historical and contemporary sociopolitical processes that have systematically disadvantaged Indigenous peoples and women in particular (Allan & Smylie, 2015; Bourassa, McKay-McNabb, & Hampton, 2004; Browne & Fiske, 2001).

The poorer perinatal health profile of Indigenous women, in conjunction with government policies of maternal birthing evacuation (Cidro & Neufeld, 2017), means that a sizable proportion of women must leave

their remote and northern communities to access specialized maternity health care services in southern urban centers. Although primary care services are now accessible in some rural and remote regions of Canada, the specialists, technology, and facilities necessary to handle medically high-risk pregnancies are only available in southern cities. As such, women with medically high-risk pregnancies have little choice but to be transferred or medically evacuated to the south for childbirth (hereafter, childbirth evacuation). In some communities, Indigenous women are sent away for childbirth regardless of whether they have a high-risk pregnancy because access to midwives

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or other maternity care services is not available locally (Brown, Varcoe, & Calam, 2011; Cidro & Neufeld, 2017; Lawford, Giles, & Bourgeault, 2018).

Prior studies have documented how childbirth evacuation affects Indigenous women, their families, and communities (Brown et al., 2011; Chamberlain & Barclay, 2000; Kornelsen, Stoll, & Grzybowski, 2011; Olson, 2017). Yet, to our knowledge, none have explored how the process of childbirth evacuation is implicated in the quality of the medical encounter between Indigenous women and their southern, typically non-Indigenous health care providers. In this article, we document and analyze patient–provider interactions from the perspectives of medically high-risk Indigenous childbirth evacuees and their southern, non-native doctors and nurses (hereafter, health care providers). The findings presented in this article are part of a larger study on the maternity health care experiences of Indigenous women with medically high-risk pregnancies, a vulnerable obstetric patient population whose perspectives are currently lacking in the literature.

Background

Indigenous Peoples' Experiences With the Mainstream Health Care System in Canada

Prior studies have documented the experiences of Indigenous peoples' encounters with mainstream health care in Canada (Browne, 2007; Browne & Fiske, 2001; Neufeld, 2014; O'Neil, 1989; Towle, Godolphin, & Alexander, 2006). Misunderstandings between patients and their health care providers are a recurrent theme in these studies. The misunderstandings are rooted partly in cultural differences in communication styles, medical beliefs, and values and partly in systemic racism and negative stereotypes of Indigenous peoples. The studies highlight the complex interplay of history (colonialism, residential schools), racism, and contemporary inequalities (e.g., socioeconomic and political marginalization) in shaping the unequal relations between Indigenous patients and their non-Indigenous health care providers (Allan & Smylie, 2015; Bourassa et al., 2004).

The studies also identified factors that contribute to positive experiences for Indigenous patients. For example, a study of hospitalization among Mi'kmaq First Nations patients by Baker and Daigle (2000) revealed that nurses who showed compassion and nondiscriminatory attitudes contributed to patients' perceptions of being understood. Browne and Fiske (2001) found that affirming encounters in the mainstream health care system tended to occur in situations where First Nations women had long-standing positive relationships with their health care providers. Continuity of care by the same doctors or

nurses helped to instill trust among the First Nations patients in their study. Notably, continuity of care is not always feasible for many Indigenous people living in rural and remote regions of Canada because of the transient nature of primary health care services in the north (O'Neil, 1989) and the disruption that occurs when tertiary care is required in the south (Brown et al., 2011).

Factors Affecting Patient–Provider Interactions

Research has mostly focused on the characteristics of patients and the behaviors of individual providers when investigating barriers to good patient–provider interactions (Ha, Anat, & Longnecker, 2010). Less attention has been given to institutional practices and policies. An institutional factor that affects interactions between health professionals and patients is hospital bureaucracy. Although hospitals are not perfect bureaucracies in the strict Weberian sense due to the autonomy of clinicians (Weber, 1968), hospital bureaucracy can contribute to the dehumanization of the medical encounter for patients (Cockerham, 2015). For instance, in efforts to limit costs, reduce use of resources and maximize efficiency, hospitals may impose rigid regulations governing visit times. Both doctors and patients bemoan the trend of diminishing time that is allotted for medical visits (Davidoff, 1997). But far from a mere preference for more face time, visit length is correlated with quality of care (Dugdale, Epstein, & Pantilat, 1999). Shorter visits limit the amount of information that can be shared and preclude queries about other pertinent factors such as psychosocial issues (Davidoff, 1997; Dugdale et al., 1999). Time constraints on medical visits can also be costly for patients' health in other ways such as inappropriate drug prescriptions (Tamblyn et al., 1997) and high prescription rates (Davidson, Molloy, Somers, & Bedard, 1994). In contrast, longer visits may allow for more attention to patient participation and education (Towle et al., 2006).

Research shows that trust and positive health care experiences are related to the amount of time that providers spend with Indigenous patients (Canales et al., 2011). Towle and colleagues (2006) noted that physicians who rushed through their sessions with Indigenous patients without taking the time to get to know them on a personal level were perceived as less caring. Sokoloski (1995) similarly found that interactions in which doctors were perceived to be in a hurry and impersonal caused Indigenous women to be dissatisfied with their prenatal care. Time constraints may affect the patient–provider relationship for all Indigenous women commuting to urban centers for maternity care, regardless of whether they reside in northern and remote regions or in the south. For instance, in Winnipeg, Manitoba, lack of time was mentioned by health care providers as a barrier to provision of adequate

prenatal care for First Nations and Métis women with gestational diabetes mellitus (Neufeld, 2014). Nonetheless, development of trusting patient–provider relationships may be especially impaired by short medical visits for Indigenous childbirth evacuees from northern and remote communities because continuity of care by the same health care providers throughout pregnancy is not feasible (Kornelsen, Stoll, & Grzybowski, 2011).

Time constraints may also negatively affect patient–provider communication. Research shows that poor communication can derail the patient–provider relationship (Ha, Anat, & Longnecker, 2010; Martin, Roter, Beach, Carson, & Cooper, 2013). Moreover, poor communication is partly responsible for some of the health disadvantages in Indigenous communities (Towle et al., 2006). In contrast, good communication can facilitate better patient–provider partnerships, increase patient satisfaction, and improve patients’ emotional well-being, pain management, and symptom resolution (Bartlett et al., 1984; Ha et al., 2010; Stewart, 1995). Longer visits can facilitate better communication by allowing for more patient engagement and exchange of information pertinent to aspects of care (Ridsdale, Carruthers, Morris, & Ridsdale, 1989; Wilson & Childs, 2002).

Patient–provider communication can be characterized as either instrumental or affective. Behaviors such as “giving information, asking questions, giving direction, identifying treatments, and discussing test results with patients” are considered instrumental (Ong, De Haes, Hoos, & Lammes, 1995, p. 906). Affective communication includes behaviors such as being “encouraging, extremely friendly, showing concern, and providing verbal support” (Ong et al., 1995, p. 906). The literature suggests that affective communication may be important in medical encounters involving Indigenous patients (Towle et al., 2006).

A History of Childbirth Away From Home

Indigenous women living in northern Canada have been routinely evacuated to southern hospitals for childbirth since the 1970s. For example, in Arctic Canada, a uniform evacuation policy was the default choice for medical staff serving pregnant Inuit (Douglas, 2006; O’Neil & Gilbert, 1990). Childbirth evacuation was viewed as a practical means of reducing high rates of maternal and infant mortality among First Nations and Inuit women living in rural and remote regions (Chamberlain & Barclay, 2000; Lawford et al., 2018). Evacuation to southern maternity wards was considered key to improving perinatal outcomes and providing Indigenous women adequate access to technologically advanced obstetric care. Thus, began the legacy of “outside management of [Indigenous] women’s reproductive lives” (Jasen, 1997, p. 396).

The policy of birthing evacuation contributed to the medicalization of childbirth that was already underway in Canada since the early 20th century (Jasen, 1997) and spread to the Canadian Arctic region since the 1950s (Kaufert & O’Neil, 1990). Childbirth evacuation was met with resistance. Some Indigenous women even went as far as hiding their pregnancies from medical authority because they feared having to leave their communities for childbirth (Douglas, 2006). Unreported births were just one of the many consequences of a colonial policy that incurred great emotional, cultural, social, and economic costs to women, their families, and communities (Brown et al., 2011; Chamberlain & Barclay, 2000).

Routine childbirth evacuation has been criticized by Indigenous community members, activists, and some health care practitioners as a colonialist strategy that disregards and disrupts Indigenous knowledge, cultural practices, and health care approaches (Cidro & Neufeld, 2017; Douglas, 2006; Jasen, 1997; Van Wagner, Epoo, Nastapoka, & Harney, 2007). Birthing outside the community has been linked to social and cultural isolation, which diminishes women’s psychosocial well-being (Kornelsen, Kotaska, Waterfall, Willie, & Wilson, 2011; Lawford et al., 2018; Olson, 2017). Among Inuit, childbirth evacuation has been associated with substance use and poor diet for evacuated women (Van Wagner et al., 2007). Van Wagner and colleagues observed that families also suffer as children and adults left behind must cope with the mother’s absence and the additional social and financial strain this causes. Child neglect may also be an unintended consequence of childbirth evacuation as it is not always feasible to arrange for reliable child care for older children who are left behind (Van Wagner et al., 2007). Despite the documented challenges associated with birthing outside of the community, many Indigenous women in Canada continue to be subjected to contemporary childbirth evacuation policies due to the lack of maternity care services on reserves or in northern and remote communities (Cidro, Dolin, & Queskekapow, 2017).

Method

Study Design and Ethical Considerations

This is a qualitative study involving semistructured in-depth interviews with First Nations and Inuit patients as well as non-Indigenous health care providers. Consistent with a participatory research approach (Hovey, Delormier, McComber, Levesque, & Martin, 2017; Macaulay et al., 1999; Zubrzycki, Shipp, & Jones, 2017), an advisory committee was established to guide all stages of the study. The committee included Indigenous and non-Indigenous representatives of government and nonprofit organizations providing health

and social services to First Nations and Inuit peoples, midwives working in northern Quebec, and physicians with clinical experience in the north. The interview guides for both patients and health care providers were reviewed and approved by the committee. Committee members also participated in the interpretation of findings and dissemination of study results.

This study was reviewed and approved by the Cells, Tissues, Genetics and Qualitative Research (CTGQ) panel of the McGill University Health Centre Research Ethics Board (REB no. 15-454-MUHC). In addition, the study was reviewed and approved by the Indigenous governmental organizations participating on the research advisory committee. Pseudonyms are used to protect participants' identity. Some of the characteristics of study participants—e.g., age and occupation (for health care providers only)—have also been altered to further disguise participants' real identities.

Research Setting

Inuit and First Nations peoples differ from one another historically and culturally (Satzewich & Liodakis, 2017). Although it is beyond the scope of this article to delve into all the nuances of these group differences, one important distinction is the access to maternity care in northern Quebec. The establishment of maternity wards in Puvirnituq, Inukjuak, and Salluit has enabled 86% of Inuit women on the Hudson Coast to remain in Nunavik for childbirth (Van Wagner, Osepchok, Harney, Crosbie, & Tulugak, 2012). In addition, Hudson Coast Inuit families have access to Inuit midwives who can provide care in their language. On the Ungava coast, Inuit women also have access to a birthing center. However, the midwifery program is less established. Hence, a larger portion of Ungava Coast Inuit continue to be sent to the south for childbirth, particularly, when involving medically high-risk pregnancies. Examples of pregnancy-related complications requiring tertiary care in southern Quebec include severe hypertension, multiple births, gestational diabetes, early preterm labor (<35 weeks gestation), and births requiring cesarean section (Houd, Qinuajuak, & Epoo, 2004). The typical time that women are sent to the south is around 36 weeks of gestation or earlier (Van Wagner et al., 2007).

For First Nations women in northern Quebec, there is little option to remain in their communities for childbirth because of the absence of birthing centers and established midwifery programs. Thus, the norm is to travel south or to a regional hospital for childbirth. For example, Eeyou Istchee Cree women in northern Quebec are sent away for childbirth regardless of whether they have a medically high-risk pregnancy (Duff & Little, 2016). Women who want to remain in their community for childbirth must

sign a medical waiver. First Nations women in the blended communities (mixture of Inuit and First Nations residents) of Nunavik also give birth in the south because there is presently not an arrangement for them to access services through the Inuit health care system.

Study Population

The patient sample consists of 25 pregnant and postpartum First Nations and Inuit women who were medically evacuated or transferred from northern Quebec to Valley Hospital for pregnancy-related complications or childbirth. Valley Hospital is a tertiary care institution located in Metropolis, a city in southern Quebec.

Purposeful sampling was used to recruit participants between April and August, 2016, from the antepartum/postpartum unit and OB/GYN clinic. Nurses helped to identify eligible patients to the research team. Women were included in the study if they were 18 years or above, currently pregnant or new mothers who recently gave birth to a live-born infant, and did not have a medical condition preventing informed consent (e.g., major hearing impairments, mental illness, or cognitive impairment precluding fully informed consent). Verbal consent was obtained from patients (and where applicable, their family member/friend who also participated in the interview).

Table 1 shows the sociodemographic characteristics of the Indigenous women. Eighty percent of the participants were currently pregnant at the time of the interviews. The women ranged in age from 18 to 42 years, with a mean age of 30 years ($SD = 7$). Twenty-two (88%) women were multiparous whereas three (12%) were nulliparous. But information about parity is insufficient to capture the complex childrearing and family living arrangements of Indigenous women in the study. For instance, 17 women (65%) had two or more older biological children living at home. But it was not uncommon for women to also have biological children who were adopted by relatives. A couple of the women were also caring for children whom they adopted from other family members. Among the expecting women, there was a wide range in the gestational ages of the pregnancies, with a minimum of 18 weeks to a maximum of 39 weeks. The mean was 32 weeks ($SD = 5$). For six women, it was their first experience with childbirth evacuation. At the time of the interviews, the women had been in Metropolis between 1 and 114 days (nearly 4 months). The average duration in Metropolis for pregnant women was 15 days ($SD = 22$) whereas for postpartum women it was 37 days ($SD = 44$). The majority of Inuit and First Nations women had some high school education or less.

We also included a total sample of eight physicians and nurses who delivered care to Indigenous women in either the OB/GYN clinic or the antepartum/postpartum

Table 1. Sociodemographic Characteristics of the Indigenous Patients.

	Total (n = 25)	Inuit (n = 18)	First Nations (n = 7)
Mean age (SD)	29.72 (7.29)	29.17 (6.59)	31.14 (9.28)
Nulliparous, %	12.00	11.11	14.29
Mean gestational age, pregnant women only (SD)	31.94 (5.05)	34.00 (3.26)	26.60 (5.18)
First childbirth evacuation, %	24.00	22.22	28.57
Marital status, %			
Married	24.00	11.11	57.14
In a relationship	64.00	77.78	28.57
Single	4.00	5.56	0
Missing/unknown	8.00	5.56	14.29
Education, %			
Some middle school or less	28.00	27.78	28.57
Some high school, no degree	40.00	44.44	28.57
High school degree	4.00	0	14.29
Collège d'enseignement général et professionnel (CEGEP) or technical training	12.00	11.11	14.29
Some university, no degree	8.00	5.56	14.29
Missing/unknown	8.00	11.11	0

Note. For all variables, differences between Inuit and First Nations women were not statistically significant at $p < .05$ level.

unit. Some of the health care providers were the primary obstetrician or nurse of some of the patients included in the study. However, it was not our intention to actively match patient–provider pairs for the study. We interviewed nurses and physicians because they are the main health care providers responsible for delivery of obstetric care to Indigenous patients at Valley Hospital. Other health care providers such as dietitians or sonographers have more limited contact with patients. Research staff presented information about the study to prospective health care providers at staff meetings. Names and contact information from providers who expressed an interest in the study were collected. Research staff then followed up with interested providers to schedule interviews. Research staff also coordinated with nurse managers to identify and recruit providers who would be willing to participate in the study. Verbal consent was obtained from health care providers as well.

The health care providers consisted of four nurses and four physicians. They had worked between 1 and 13 years at the hospital, with a mean of 7 years. However, some providers had been practicing clinicians at other hospitals and clinics for a decade or more prior to working at Valley Hospital. None of the providers had formal training in medical or nursing school that was specific to the delivery of care for Indigenous patients. However, a few of the nurses had some on-the-job training in the form of an in-service workshop at the hospital. Both doctors and nurses had at least weekly contact with Indigenous patients at Valley Hospital.

In-Depth Interviews

Patient interviews ranged in length from 17 minutes to 56 minutes, with an average duration of 34 minutes. The first and third authors conducted all the patient interviews. The first author is a woman of Indigenous ancestry from Southeast Asia whereas the second author is a Caucasian Canadian woman. Their outsider statuses may have affected patients' willingness to disclose information relating to patient–provider interactions that they deemed too sensitive to share with out-group members (e.g., experiences with racism or poor treatment). However, as neither of the interviewers were health care providers at the hospital (and this fact was stressed to patients), this may have allowed patients to be more candid in discussions about patient–provider interactions. In addition, rapport between the interviewers and patients were facilitated by multiple points of contact (e.g., initial contacts for study recruitment followed by interview at a later date). Nonetheless, we cannot rule out the possibility that patients might have revealed different information had the interviewers been of North American Indigenous ancestry.

Most the interviews (85%) were audio-recorded with a digital recorder and transcribed verbatim by a professional transcriber. For the patients who did not wish to have their interviews recorded, handwritten and/or typed notes were taken by the research staff who conducted the interview. Notes were then later transferred to a Word document. During the transference

process, thick description techniques were used to inscribe as much detail as possible about the content of the interview. Verbatim quotes and phrases were retained where available. Most interviews with outpatients took place on site at the hospital, in a private conference room or another location at the hospital (e.g., cafe), on the same day that the patient was approached about the study or at her next medical appointment. All interviews with in-patients were conducted in the patient's private hospital room. The majority of the interviews were conducted in English. An Indigenous professional interpreter facilitated one of the interviews with a First Nations patient. A family member or friend—who happened to be present with the patient at the time of the interview—assisted in translation in four of the interviews with Inuit patients. During the interviews, patients were asked about their background (e.g., education, occupation), pregnancy experience, the childbirth evacuation process (e.g., medical escorts, arrangement of child care for older children in the north, etc.), and their interactions and communication with doctors and nurses at Valley Hospital.

The provider interviews ranged in length from 28 to 47 minutes, with a mean duration of 39 minutes. Interviews with health care providers took place on site at Valley Hospital during their regular work hours. The interviews were conducted by the first author in a private conference room or office. All health care providers agreed to have their interviews audio-recorded. During the interviews, providers were asked about their professional background (e.g., training specific to working with Indigenous patients), how language and culture affects interactions with patients, and examples of good and poor communication with Indigenous patients.

Analysis

Data analysis entailed open coding, axial coding, and thematic analysis of interview transcripts using MAXQDA 12 software (VERBI Software, 2017). We followed a grounded theory approach in which data collection and analysis occurred simultaneously to facilitate discovery of emergent concepts and exploration of possible factors affecting patient-provider interactions (Corbin & Strauss, 2015). Inductive open codes were used to organize the interview data during the first stage of coding. The third author completed the open coding of the transcripts. The first author reviewed the open codes and performed random coding checks for consistency between codes and coded text. During the second stage, the first author used focused codes to synthesize the data into themes and axial codes to draw analytical linkages across the themes. The constant comparative strategy was employed to uncover both common patterns as well as variations in the data.

Results

The medical encounter between Indigenous childbirth evacuees and their southern, non-Indigenous health care providers were affected by three factors: evacuation-related stress, hospital bureaucracy, and stereotypes. The combination of these factors created situations where misunderstandings and mistrust could occur. The communication and interpersonal skills of individual providers was key to the quality of the patient-provider interaction in this context.

Evacuation-Related Stress

Childbirth evacuation was a stressful experience for Indigenous women, owing in part to their medically high-risk pregnancies. But the separation from their families, especially older children, was also a source of stress. Significant household management and childrearing challenges arise for women because they must coordinate with adult family members and friends to care for their older children while they are away. A 25-year-old First Nations expecting mother shared the following:

I know it [being sent to the south for childbirth] is for our safety. [But] it's hard to have to leave. . . my mom's working at a camp [away from home]. . . and there's no one to take care of my kids. So the kids are up north with my spouse's family and I feel so distressed over it even though I'm only here 2 weeks. I can't imagine some of them [other pregnant women] that have to wait longer.

This participant usually relies on her mother to care for her older children when she must leave home for childbirth. But this time around, her mother had to work and was not available to help. Instead, the participant must rely on her in-laws to watch her older children while she and her husband are in Metropolis. She is grateful for the help but notes that it is not an ideal situation because her in-laws already have other children to care for as well.

The separation from older children can be especially challenging if women need to remain in the south for an extended period. A 42-year-old postpartum First Nations woman was separated from her older children for several weeks while she awaited childbirth in Metropolis. The separation was made even more difficult when subsequent health complications following the birth of the baby required the mother and her partner to stay in Metropolis for an additional 4 months to await surgery for their newborn. During the 4 months, the older children were cared for by relatives up north. The prolonged separation from her older children was a daily stressor, causing the patient to vacillate between worry over her newborn's fragile health and anxiety about the absence of continuous parental supervision of her other children.

Access to economic resources can help mitigate some of the challenges of arranging care for older children. A 43-year-old postpartum Inuit woman had a comparatively easier time partly because she had the financial means to bring her older children with her to Metropolis. Notably, the older children were only able to accompany their mother because the patient's confinement coincided with a 2-week school vacation, otherwise as she pointed out, it would have been difficult to pull the children out of school. This patient's situation is the exception rather than the rule. Most Inuit and First Nations women in our study did not have the option of bringing their older children with them to Metropolis because of limited financial resources and poverty.

The psychosocial effects of childbirth evacuation on women spill over into their interactions with health care providers at Valley Hospital. Women often arrived at their medical appointments feeling overwhelmed and stressed. Both nurses and doctors mentioned different strategies that they use to support patients. One strategy was to minimize the stay in Metropolis if it was medically safe to do so. If it was not possible for patients to temporarily return to the north, then providers would advocate for patients to have an escort so that patients could have some support while awaiting childbirth in Metropolis.

Escorts are family members or other nonfamily individuals who accompany patients while they are receiving medical care in the south. Escorts provide many social support functions for patients including language interpretation, cultural knowledge broker, and emotional support during childbirth and the immediate postpartum period. Travel, lodging, and a per diem are provided for escorts by the government, but escorts are not paid a stipend for their service (Government of Canada, 2018). There is variation in the timing that escorts can accompany pregnant women to Metropolis for childbirth, with local regional hospitals in northern Quebec setting the guidelines. For example, Inuit childbirth evacuees from the Hudson coast are allowed an escort from the time they leave for labor in Metropolis. On the Ungava coast, childbirth evacuees are typically allowed an escort at 39 weeks gestation onward, but escorts may be permitted to travel earlier depending on the medical situation of the pregnant woman. Furthermore, not all women will have an escort because of employment, child care, and other obligations preventing family and friends from accompanying the expectant mother.

Another strategy was to acknowledge Indigenous women's emotional state. The following excerpts from two health care providers, a physician and nurse, respectively, illustrate how the act of acknowledging what patients are going through can help break down barriers to create more effective patient-provider relationships:

I just try to let them know that I understand that it's not easy for them to leave their community and their family and that it's great that they've done it. . . They don't like to be taken out of their community and so I think that it's important for them to know that the providers know where they're coming from and they're not just another number that we're seeing without any real identity.

Sometimes, the way they're feeling [stressed], I just listen and acknowledge like "yes this must be very hard for you, you're away from your family, you're away from your children, it's scary, you don't like the food here, the beds aren't comfortable" and just to acknowledge what they're going through.

The kind of acknowledgements used by these health care providers above are a form of affective communication behavior. The physician quoted above noted that she adopted this communication style with her patients after learning about the history of settler relations with Indigenous peoples in Canada.

I read about the history of their relationship to the European population over the course of the past several hundred years, [it] has really shaped their communication with us. . . the non-Inuits [sic] and the non-Aboriginals. . . and explains a lot of their [Indigenous peoples'] behaviour and their attitudes. . . So basically once I learned a little bit about the history, I would spend a lot more time reassuring them that I was going to try to get them back to their family. . . as soon as I could.

Knowledge of Indigenous peoples' historical encounters with European colonizers in Canada and their experiences of forced separation (e.g., residential schools; see Truth and Reconciliation Commission of Canada, 2012) helped this physician to better understand her Indigenous patients' wariness toward non-Indigenous health care providers. This awareness enabled her to be more empathetic and take on an advocacy role for her patients.

Hospital Bureaucracy

We found that hospital bureaucracy adversely affected the medical encounter in two ways. First, bureaucratic procedures such as long waiting times and multiple points of contact with different health professionals can be emotionally and physically draining for patients. For new patients, their first visit to Valley Hospital can be overwhelming and exhausting, owing to the lack of familiarity with the routines of a large tertiary hospital. Women unfamiliar with the bureaucracies of large southern hospitals lamented that they did not anticipate the long waiting times and day-long appointments with multiple health professionals. Other patients expressed frustration at having to repeat the same medical information to multiple

providers over the course of their visit. The following quote from a 24-year-old postpartum Inuit woman, succinctly captures patients' overwhelmed state:

I find they have a lot of patients, like one after the other. They're in a rush, rush, rush. You're being asked by this nurse your medical history and then you're transferred to another nurse or a student resident, they ask you the same questions and then finally the doctors saw you and the same questions. So it's repeating one after the other. And then you get frustrated with the same questions.

The frustration expressed above is not unique to Indigenous patients at the hospital. Indeed, in the process of our fieldwork, which involved waiting around in the obstetrics clinic waiting room, we overheard non-Indigenous patients also complaining about the long waiting times. What is unique to Indigenous patients, however, is that the lack of familiarity with hospital bureaucracy, coupled with the evacuation-related stress they are already experiencing, can cause patients to withdraw. Some patients withdrew physically by leaving the hospital altogether, without having seen their health care provider. Others withdrew emotionally by being less forthcoming with medical information when asked by their nurses and doctors. Emotional and/or physical withdrawal has consequences for effective health care delivery. Emotional withdrawal limits the amount of information that providers can ascertain from patients, thus potentially compromising providers' ability to accurately diagnose and treat health conditions. Physical withdrawal precludes the regular monitoring of women's overall prenatal health, therefore, increasing the likelihood that health complications may go untreated. In the north, patients may also get frustrated with long waiting times and leave without seeing their health care providers. Yet, they may be less likely to fall through the cracks because the patient volume is substantially lower in northern health clinics than in southern tertiary hospitals (Haggerty et al., 2004). Consequently, providers working in northern clinics may have more flexibility to reschedule missed appointments.

Second, through limited interaction time with doctors and nurses, hospital bureaucracy compounded patients' frustration and contributed to a perception that providers were "rushed" and "impersonal." When asked why Indigenous patients might have this perception of health care providers at Valley Hospital, a physician articulated:

I think it's resources. The difference between that population of patients [from the north] and the population of patients that we see here [in Metropolis] is different. . . first of all the patients from up north, we don't see them as often. My patients [who live in Metropolis] I'll see more often and so I have many more chances to get across to them that I'm really a human being and that I'm there for their interest

despite the fact that I'm rushing. But when you see a patient only once or twice because they're followed up north and they're just coming here for a consult, I don't have as many chances or interactions to show them that I really want to [care for them as an individual]. And I need to get stuff done. So I'm going to get technical stuff done because I know that that's in their best interest. . . And so it's a question of resources because I don't have an hour to spend with them. Now, it would be very different, I can guarantee you, if the Aboriginal patients that I'm seeing, instead of having to see 40 patients that day, I only had to see four because then I can be the human being in that one interaction. I can't be a human being in a 2-minute interaction.

Health care providers at Valley Hospital are confronted with the dilemma of trying to establish a relationship with Indigenous childbirth evacuees within the constraints of a 15-minute encounter once a week for a short period of 2 to 3 weeks. Given the realities of their limited contact with patients, health care providers may opt for more instrumental communication strategies and behaviors during the medical encounter rather than affective ones. Yet, it is precisely the instrumental behaviors that may leave Indigenous patients feeling dehumanized.

To mitigate the sense of alienation that hospital bureaucracies can impose on patients, some of the health care providers used a variety of communication approaches. Being friendly, using their first names instead of titles, and taking time to make small talk with patients was most often mentioned. These efforts by health care providers may explain why, despite being frustrated with hospital bureaucracy, many Indigenous patients with whom we spoke were generally satisfied with the care they received at Valley Hospital.

Stereotypes

Perceived cultural differences between Indigenous and non-Indigenous peoples and subsequent stereotyping affected the ways in which Indigenous patients and health care providers interacted with one another. Indigenous patients' nonverbal communication style emerged as an important perceived cultural difference that frustrated both doctors and nurses alike.

A lot of patients are not very verbal. They shrug their shoulders. You'll ask their health history [and they respond by saying] "I don't know. I can't remember." So they don't volunteer necessarily information to us. It makes our assessment very limited.

Initially when I have one of these patients, I treat them like any other patients. So I ask them about their past obstetrical history and I wouldn't get a lot of answers. Some of it is cultural but I'm sure some of it is also because they're in Metropolis, they're away from home. But they're not exactly

chatty people. . . Some of them are, but most of them like to keep very short and simple answers. So I became frustrated initially as a health care provider to try to get as much information as I could to make the best diagnosis but not getting a lot of answers.

The first excerpt above is from a nurse who had been working at Valley Hospital for over a decade. She elaborated that this nonverbal communication style can be misinterpreted by health care providers as Indigenous patients “being non-compliant or uneducated or rude.” She attributes Indigenous patients’ communication style to culture: “but you know their culture, where they’re coming from, it’s considered the norm.” She further believes that offering a kind word to patients can go a long way toward breaking down these cultural communication barriers:

I think if we could connect with them and sometimes like just speaking to them in a kind way and saying “Oh you know you’re funny,” or “you’re such a sweet woman and you can trust me, you can tell me whatever, it’s confidential.” They feel they can open up a little bit more. . . and saying, “Look I’m not going to document if it’s something that you don’t want it have documented.” It’s trying to build that trust with those patients because depending where they’re coming from, depending on their childhood, their upbringing you know experiences in life might make them be closed off to certain people. It could be doctors; it could be the health care system or what have you. They’re just suspicious. They’re on guard and you know they’ll give you limited information.

It is worth noting that while this provider believes that Indigenous patients’ nonverbal communication style is rooted in their culture, her own statement above suggest that noncultural factors are at play as well. Indigenous women’s past experiences with the mainstream health care system and other institutions (e.g., child protection services) might also be contributing to their reticence. The comment about not “documenting” certain things reveals an awareness that formal documentation of certain conditions or behaviors might place an Indigenous woman and/or her unborn child in a difficult situation. Given the current overrepresentation of Indigenous children in child protection services in Canada and the history of seizure of Indigenous children by the Canadian state (Blackstock, Trocme, & Bennett, 2004), it is not surprising that Indigenous women do not want to disclose information for fear of being labeled an unfit mother and thus risk their children being taken away. Hence, while culture is often invoked as a primary explanation for Indigenous women’s nonresponsiveness during medical encounters, noncultural factors—notably, institutional discrimination and negative past experiences with non-Indigenous health care providers and/or other authority

figures—also contribute to women’s reluctance to share information with health care providers.

Not all health care providers were able to make sense of their Indigenous patients’ reticent communication styles though. This is especially true for health care providers who do not have a lot of experience working with Indigenous patients, as shared below by a nurse.

[Some health care providers] are also very hesitant to talk to them. . . like anyone who starts new or comes from a different floor where they don’t see as much Inuit patients, it’s more difficult [for them to adapt to the patients’ non-verbal communication]. So they’ll think “I’ll do my thing and then leave.” There’s no questioning [the patient] or talking [to the patient]. I don’t think it necessarily means they’re being treated differently. But it’s just a bit uncomfortable being on the health care provider side too you know.

When asked about the sources of novice providers’ hesitancy to interact with Indigenous patients, the provider elaborated:

I think it’s mostly what you hear around the unit. . . from the other [health care providers]. When you [first] start [your job]. . . it’s like mostly your support system is your colleagues. If you have any questions you’re going to go to them. If . . . you have an admission or like weird things going on with your admission, you’re going to go to them and be like, “This is what’s happening, I don’t know what to do, is this okay if I do this?” So when you get that admission and she’s an Inuit patient and you’re like, “Oh hi, how are you?” and the patient doesn’t respond or even look at you, you just do your thing. But when you’re finished with the patient, you feel differently, so you go ask your colleagues “Is this normal?” And then they’re like, “Oh yeah this is okay, that’s how they are.” They [your colleagues] can either normalize it or they can be like, “Oh no, look out for this, look out for that.” So they’re kind of either scaring you or they’re like, “Oh no this is okay, it’s normal.”

These comments reveal that this stereotype of Indigenous patients as unresponsive is believed to be *inherent* to their culture (“that’s how they are”). Thus, what results is a form of cultural essentialism (Narayan, 1998). Some health care providers may not necessarily have a nuanced understanding of the multiple structural factors that contribute to Indigenous women’s reluctance to share information or otherwise engage with their non-Indigenous health care providers. The comment further illustrates that the circulation of stereotypes occurs at an interpersonal level between health care providers and whether a provider “normalizes” his or her encounters with Indigenous patients has a lot to do with the information shared by colleagues.

An unintentional by-product of health care providers adopting a strategy of “just do your thing” and then leave

when anticipating an unresponsive Indigenous patient, is that this kind of avoidance behavior can create a perception among Indigenous patients that health care providers are not consulting them. The following conversation with a 22-year-old First Nations expecting woman and her mother, who had escorted her to Metropolis, conveys this perception of being left out of the medical consultation:

Mother: When we came here. . . the doctor wanted to do some tests and she just like—she didn't explain herself, what she's going to do.

Researcher: Does it bother you that they come in and just do their test like that without explaining first what they're going to do?

Participant: Yeah a little bit, yeah.

Researcher: Yeah?

Participant: Yeah.

Mother: That's how they do it.

As prior scholars have noted, the process of childbirth evacuation can be disempowering for Indigenous women as control over their bodies and birthing decisions are vested in the hands of others (Brown et al., 2011). The discussion with this young expecting woman and her mother reveals how Indigenous patients are reminded of the unequal patient-provider power dynamics through the behaviors of providers. Furthermore, given the poor treatment of Indigenous peoples in Indian hospitals, residential schools, and child protection services, it is not surprising that Indigenous patients would interpret health care providers' avoidance behaviors as another form of collective oppression. When health care providers do not take the time to explain medical procedures to Indigenous patients, it can create medical mistrust and further alienate patients.

Discussion

Numerous studies have documented the cultural disconnect, social isolation, and stress that occurs for Indigenous women in Canada who must leave their communities for childbirth (Chamberlain & Barclay, 2000; Cidro et al., 2017; Kornelsen, Kotaska, et al., 2011; Olson, 2017). First Nations and Inuit women in our study were similarly stressed and overwhelmed by their temporary relocation to southern Quebec for childbirth. They were especially anxious about how their absence affected older children who remained in the north. Our study adds further nuance by highlighting the mechanisms whereby hospital bureaucracy

compounds women's distress by leaving them feeling dehumanized by the medical encounter. Specifically, short medical visits emerged as an important bureaucratic impediment to building effective communication and trusting patient-provider relationships.

Despite the empirical evidence that the length of medical visits plays an important role in patient-provider relationship building (Dugdale et al., 1999; Ha et al., 2010), mainstream health care institutions have not heeded patients' and health care providers' desires for longer visits. Consequently, time constraints incentivize health care providers to use communication strategies that are instrumental rather than affective, which can lead to patient dissatisfaction and perceptions of health care providers as impersonal. A handful of studies on the medical experiences of Indigenous peoples in Canada indicate that time is an essential ingredient in the delivery of culturally safe care (Sokoloski, 1995; Towle et al., 2006). For example, Oster et al. (2016) noted that effective delivery of prenatal care to pregnant First Nations patients in Alberta required time for relationship building and authentic interactions that are nonjudgmental. Likewise, Neufeld (2014) found that "taking time to engage in reciprocal exchange" helped to establish trust between prenatal health care providers and pregnant Indigenous women in Manitoba (p. 8). These studies, along with our findings in this article, underscore the importance of lengthening the medical visit to transform hierarchical patient-provider relations into respectful partnerships that are more aligned with cultural safety principles (Anderson et al., 2003; Greenwood, de Leeuw, & Lindsay, 2018).

We also found that stereotypes of Indigenous patients and the ensuing misunderstandings and avoidance behaviors that occur further strains patient-provider interactions. Stereotypes of Indigenous patients as unresponsive due to their more reticent communication style can hinder the development of trusting relationships. The potential for harm lies in individual health care providers' behavioral responses to the stereotypes. Indeed, research has documented the myriad ways through which stereotypes can mediate the health care experiences of Indigenous peoples through overt behavior and unconscious bias (Ly & Crowshoe, 2015). For example, a recent study found that nurses' assumptions about First Nations women's different social needs led to unnecessary and excessive medical discharge procedures (Browne, 2007). In the present case, stereotypes of Indigenous patients also had perceptual and behavioral consequences. The stereotypes set up expectations among health care providers for how the patient-provider interaction will unfold. Nurses and doctors who anticipate that a patient is going to be difficult or less forthcoming with information may interact with her in ways that might cause the patient to further shut down.

Institutional efforts can be targeted toward dispelling stereotypes. Informational workshops that educate health care providers about Indigenous peoples' culture, history, and contemporary situations is a step in this direction. However, we caution against cultural sensitivity training that does not appropriately contextualize Indigenous peoples' experiences within larger historical, social, and political processes because such ahistorical cultural workshops run the risk of further engendering cultural essentialism. Workshops could also be supplemented with real-world cultural learning opportunities that incorporate Indigenous knowledge from Elders and other community members (Doyle, Cleary, Blanchard, & Hungerford, 2017). Research suggests that ongoing cultural learning opportunities are better at facilitating patient-provider trust than formal cultural sensitivity training (Oster et al., 2016).

Conclusion

In sum, the medical encounter between Indigenous child-birth evacuees and non-Indigenous health care providers can be viewed as a site of intergroup contact that can both promote as well as stymie the patient-provider relationship. On one hand, the medical encounter is an opportunity to break down cultural barriers, challenge stereotypes, and improve health care service delivery. On the other hand, the medical encounter can also reinforce stereotypes, instill medical mistrust, and further marginalize and disempower Indigenous patients. Currently, the determination of whether the medical encounter leads to an opportunity for relationship building or misunderstanding rests in part on the communication styles and interpersonal skills of individual health care providers. However, health care providers' individual efforts to decolonize the medical encounter must also be supported by parallel institutional commitment to equalize patient-provider power dynamics and improve maternity care services for Indigenous women in Canada.

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