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Medical Colonialism and the Power to Care: Unsettling Participatory Inclusion in the Settler-State Care Paradigm

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Abstract

This article looks at the implications of medical colonialism in Canada for the feminist concept of care. Because medical colonialism is an ongoing material relation where “good” settler care cannot be separated from Indigenous dispossession, I defend the view that care and violence can be coextensive and suggest that a decolonial care ethic needs to disrupt the directionality of care as flowing from agential carers toward colonized care-receivers. I argue that contemporary medical colonialism should indeed be understood as a form of care if structural harm is to be addressed in practice, and trouble the notion of inclusion at work in some contemporary theories of care. By finding demands for assimilationist “participatory inclusion” in examples of government-run, Indigenous-serving care services, I caution against the implicit settler-colonial assumptions in notions of “caring democracies” and “caring societies” on the welfare-state model. If care is political and can participate in the normative pressures of civic assimilation, then to “decolonize” it through refraction, disruption, infiltration, disconnection, re-appropriation, and resistance also means to “decolonize” citizenship and civic life in the interests of Indigenous self-determination, rather than presumed inclusion in settler-state processes.

Settler colonialism and its decolonization implicates and unsettles everyone.

—Eve Tuck and K. Wayne Yang

One would be wrong to call what occurred at Canada’s Indian Residential Schools “care” in any sense of the word. The recent discoveries of hundreds of unmarked graves by the Cowessess and Tk’emlups te Secwépemc First Nations¹ are enough to dispel any remaining illusions about the nature of state custody for the 150,000 First Nations, Métis, and Inuit children who were forced to experience it (McGreavy 2021). The now well-documented abuse, mistreatment, and murder that took place not just

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at residential schools and day schools, but also at Native hospitals and other Indigenous-serving institutions, is a paradigm case of *un-care*—not just neglectful or inadequate care, but the active perpetuation of harm. Although the last residential school was closed in the late 1990s, Indigenous scholars and theorists of colonialism have emphasized how important it is to understand colonialism as an ongoing process and set of structures, and not as a regrettable bygone past for which Canadians can simply apologize.² As Patrick Wolfe has written, settler colonialism “is a structure, not an event. . . . Elimination is an organizing principle of settler-colonial society” with the purpose of establishing and maintaining a new society on an expropriated land base (Wolfe 2006, 388). Five years after the final report and closing ceremonies of Canada’s Truth and Reconciliation Commission, during which ninety-four calls to action were made as a way to chart a new future for Indigenous people in Canada, almost none of the Commission’s recommendations have been pursued; as scholars Eva Jewell and Ian Mosby write, Canada is failing Indigenous survivors, having addressed only eight out of the ninety-four calls to action (Jewell and Mosby 2020).

In light of this failure (and Canada’s reputation as a model welfare state) the fact that there are more Indigenous children in “state care” today than there were at the height of the residential school system deserves attention (Shaheen-Hussein 2020, 192).³ Although Canadian foster care and youth services, criminal justice, health, and other state social-service entities are not avowedly genocidal institutions, scholars and practitioners alike have documented their role in perpetuating racist violence and settler-assimilationist norms. As harmful as specifically Indigenous-serving government-run institutions have been, Indigenous treatment in settler-serving hospitals has not been much better: both are plagued by a structural racism that the First Nations, Inuit, and Métis Health Committee of the Canadian Pediatric Society have characterized as “built into our health system” (250). If settler racism is structural—embedded in norms, procedures, and the very democratic institutions that govern and administer social services—should we call what Indigenous, Métis, and Inuit people experience in settler health and social-service institutions “care”? If settler colonialism is ongoing, with its goals and ideologies integrated into institutional processes, clinical norms, and modes of production,⁴ what rationale can be given for using the language and conceptual framework of “care” to describe current forms of state custody, responsibility, attention, and response to the physical, mental, and social ills that are the direct product of settler dispossession?⁵

If we *do* call what contemporary settler social-service institutions do “care,” the consequences for feminist care theory could be serious. It would require us to ask whether it is enough to simply inject caring values where they are absent, and to face the possibility that the desire to protect the concept of care might sometimes be an aspirational deflection from the anti-Indigenous violence inherent in settler life. Is addressing the harm of settler “care” a matter of refining our normative ideals and principles of care in order to reform care policy, a matter of expanding or shrinking its scope and range of application, or something else altogether?

In a commitment to the context-specificity and applied nature of care theory, this article brings the care discussion back to the material realities of care in a settler context. I show that recognizing the colonial character of services—their violence, mistreatment, and neglect of Indigenous well-being and the correlative benefits afforded to settlers—has implications for our theories and practices of care, and particularly for political notions of care that take for granted settler notions of citizenship and civic concern.

There are certainly good reasons *not* to construe as care the assimilationist programs for Cree and Salteaux youth in Saskatchewan (see Dhillon 2017), including racist over- or under- medication in Winnipeg emergency rooms, broad relocation policies that remove people from their ancestral lands for the sake of “better access” to education and health institutions (see Daschuk 2013; Stevenson 2014), or foster-care programs that remove Indigenous children from their parents to place them with settler families. However, if we do *not* understand these examples through the lens of care, we miss an important dimension of their justification by the state, and an important opportunity to intervene in harmful norms. This is emphatically *not* to make the horrifying and cringe-worthy claim that we should retroactively describe residential schools as “caring.” It is, rather, to make the case for attending to the ways that their colonial violence is ongoing in affective and supportive services and relations, both within and outside of settler institutions. As Maria Puig de la Bellacasa has written, the “ambivalent terrains of care” are never neutral (Puig de la Bellacasa 2017, 5). Care is not, as Virginia Held has claimed, above power, but is a locus, motor, and outlet for exercising and potentially disrupting it (Held 2006, 151).

For this reason, this article makes the case for a normative concept of care that can recognize its own complicities while motivating and characterizing practices that move beyond and against the nation-state—an approach to care that does not take for granted the settler state and its accompanying assumptions of civic participation. I argue that if we want the notion of “care” to pertain to the shape and character of our societies—as it has been described by some contemporary care theorists—it must address settler colonialism and the modes of care that manifest it and uphold it. The implications of this for contemporary care theory are that both care and citizenship or civic participation should be unsettled, refracted, and rethought, with an awareness of the violent dynamics of settler colonialism in mind.

Recent political approaches to care like Joan Tronto’s and that of the Care Collective’s *Care Manifesto* have focused on normative inclusion, expanding the scope of care to address our current crises of care for the poor, older adults, migrants, care-workers, and non- and more-than-human nature (Tronto 2013; Chatzidakis, Hakim, and Rottenberg 2020). This is important and urgent work, urging us to put care at the center of all that we do, and to consider care and democracy as co-constituting. But the failures of settler-colonial societies like the US and Canada to care for the health and well-being of Indigenous people challenge the unqualified inclusiveness of caring democracy and the expansion of concern. The problem is that although settler states should certainly take responsibility for the harm caused by ongoing colonial genocide, the desire for civic inclusion in what Tronto has called a “virtuous circle of care” should not be assumed. As Indigenous and decolonial feminisms have long shown, the democracies of settler-colonial nation-states are premised on Indigenous dispossession and genocide, carried out through disappearance, assimilation and primary accumulation of land and natural resources. Given the violence carried out by governments and social-welfare programs, including health, medical, relational, and educational institutions, the politics of “inclusion” are deeply fraught, often associated with forced assimilation and cultural disappearance. As a white settler raised on unceded Kanien’keha:ka territory, I will not make claims about how, whether, and to what extent Indigenous people should be included in settler life and settler institutions. Rather, this article is meant to confront the tensions inherent in settler care and caring (my own included). In light of recent scholarship on settler affect in response to colonial harm,⁶ I argue here that a politics of care should respond to, and incorporate, the need

for those harmed *not* to be included in the broader communities of care determined by settler states and settler-capitalist institutions.⁷ A politics of care, in other words, should have the capacity to theorize Indigenous self-determination of the meaning and role of inclusion.

In drawing attention to the ways that care practiced in settler-colonial societies is always informed by the material circumstances of Indigenous dispossession and organized barriers to sovereignty and self-determination, I question whether care theory should seek to expand the concept of care, rather than to refract, multiply, or disrupt it. The basis for this questioning is the fact that when care is understood as universal or necessarily inclusive, it can sometimes assume the desirability of participation in dominant modes of giving and receiving.⁸ Rather than jettisoning the concept of care or care policy, this article thus aims to reckon with the failures and asymmetries of settler care by looking at medical colonialism as a structuring set of processes, and to the nonsettler, noncapitalist paradigms that operate alongside, outside, and within settler institutions. I suggest that paying attention to the forms of unincluded and disruptive caring alongside the violence of enforced civic participation could allow *not* for an expanded concept of care that includes “others” within its purview, but for a porous, unsettled, multiple, disruptable, and refusable idea and set of practices that enables those who have suffered harm in its name to disconnect, disrupt, or make demands for reparation on their own terms.

I begin with a brief description of medical colonialism in what is now called Canada. Although “medicine” and “care” are certainly not synonymous, I treat medical institutions as part of a bureaucratic and normative “entanglement” that includes criminal punishment, health, and other social-welfare institutions (Sabiston 2021). By describing these ongoing structures in broad strokes, I motivate the challenge I will pose to expanded forms of civic participation predicated on settler modes of inclusion. In the second and third sections, I then defend the view that care and violence can be coextensive and suggest that a decolonial care ethic needs to disrupt the notion that care’s directionality necessarily flows from agential carers with the “power to care” toward colonized care-receivers, whose dependence is constructed and rationalized by the settler paradigm. I draw on the work of decolonial feminists, arguing that contemporary medical colonialism should indeed be understood as a form of care if structural harm is to be addressed in practice. The fourth section troubles the idea that merely expanding services for more inclusion, increasing “participation,” “voice,” and “input,” or reforming existing policy will adequately address harms that are the result of ongoing dispossession and lack of Indigenous self-determination. By finding these demands for participation and inclusion at work in examples of government-run, Indigenous-serving care services, I caution against the implicit settler-state assumptions at work in notions of “caring democracies” and “caring societies.” I conclude by making the case for a refracted, disrupted, and unsettled care concept that can reveal the limitations of settler agency and concern while integrating this limitation into its ethic and practice. It is only by understanding care’s complicities with settler colonialism that we can push our analysis, policy, and practice beyond the violence of the settler nation-state. If care is political and can participate in the normative pressures of civic assimilation, then to “decolonize” it through refraction, disruption, infiltration, disconnection, reappropriation, and resistance also means to “decolonize” citizenship and civic life. A feminist care ethic may not capture or guide every dimension of this reworking, but I show here that it can certainly have an important, if ambiguous, role.

I. Medical Colonialism: A Material Relation

Medical colonialism refers both to the use of medicine as a tool for settler-colonial appropriation of land and accumulation of resources and to the differential effects of colonization on health and well-being for settlers and those who are colonized. Settler colonialism in Canada is a form of racial capitalism, and medical colonialism describes the health dimensions of Indigenous racialization through territorial dispossession and elimination (Toews 2018). Medical colonialism is the way that colonial governments appropriate power and land through knowledge-production that justifies racial hierarchies, then reifying those hierarchies by providing inequitable resources based on race. As Mary-Ellen Kelm has written, medical colonialism creates the category of the “Aboriginal body” through evaluative measures and methods that construe Indigenous people as “naturally” unhealthy and unadapted to the conditions of the settler state, thus requiring necessary health intervention that serves to manage and assimilate. As Kelm writes about the self-justificatory nature of medical colonialism,

medical science in western European and North American society became a “hallmark of racial pride” and a major component in the conceptualization of colonial “fittedness”: a “rational” basis, among others, for the right to rule. . . . In such a view, Aboriginal populations around the world consistently showed themselves, through their bodies themselves, to need and deserve colonization. And it was through colonization and the associated dual mechanisms of “civilization” and medicine that these indigenous populations could ultimately be saved. Both the diseases and their cures justified colonization in a perfectly circular logic. (Kelm 1998, 101)

Medical colonialism can thus be understood as a tool of material and political domination and cultural assimilation, motivated and legitimated by settler ideology and knowledge-production, that undertakes the racializing project of settlement on the terrain of Indigenous bodies through violent forms of cure, care, and disappearance.

Both interrelated dimensions of medical colonialism—its use as a tool of dispossession and conquest and its long-term impacts on health—have characterized the Canadian settler project since its very beginnings. As James Daschuk has documented in *Clearing the Plains*, the establishment and settlement of Canada was undertaken through deliberate policies of disease propagation through rotten food and infected clothing, addiction through the dissemination of alcohol as populations were being relocated and made dependent on settler modes of production and survival, and starvation campaigns, all of which meant to clear the land of Indigenous bodies in order to make way for colonial settlement (Daschuk 2013). Nineteenth- and twentieth-century provision of government health services to First Nations, Métis, and Inuit communities were generally part of programs with explicitly eugenicist goals, set up on the assumption that Indigenous life was inherently unhealthy, and that unhealthy Indigenous bodies should be managed to prevent disease transmission to the settler population—even when illnesses ravaging Indigenous communities, like tuberculosis, were most often brought by settlers themselves.

Medical colonialism is not a past-tense description, but a set of ongoing structural processes that shape and legitimate colonial relations in the present. Medical practitioners and researchers have increasingly stressed that looking to the social and structural determinants of health shows that higher mortality and suicide rates among

Indigenous youth; lower life expectancy; greater incidence of infectious disease, cancer, and chronic illness; and high rates of mental health struggles are directly associated with displacement, institutionalization and incarceration, racism, state violence, lack of clean drinking water and safe housing, and the poverty and deprivation resulting from the Canadian government's failure to satisfy its fiduciary responsibility to pay for healthy conditions for Indigenous peoples (Shaheen-Hussein 2020, 77). Although a model that takes social determinants of health like "socioeconomic status" into account can identify poverty and displacement as causes of illness, a structural model is better able to name the active relational processes of medical colonialism that continue to dispossess through care. Settler colonialism, as Sarah de Leeuw and Margo Greenwood write, is the structural determinant of the social determinants of health—the "cause of the causes" (de Leeuw and Greenwood 2011, 56). It is the framework that can help us see why decreased life chances for Indigenous people are not the passive result of the "legacy" of settlement or residential schools, but the direct result of the medical establishment's "significant and active role in shaping nation-states and colonial agendas" (Shaheen-Hussein 2020, 132).

Any doubts about the nature and cause of health disparities in Canada can be dispelled by looking at what they have in common with health trends in places in the world more readily recognized as having been colonized. "Tropical" infectious diseases associated with "underdevelopment" like trench fever, for example, are rare in Canada and the US, but cases are discovered with increasing frequency in Indigenous communities (Boodman, Wuerz, and Lagacé-Wiens 2020). The same is true for tuberculosis, HIV/AIDS, and leprosy, to name a few—conditions that disproportionately affect colonized populations around the world because of the impacts of land dispossession, displacement, and extractivism. As de Leeuw and Greenwood write, "indigenous peoples across Canada live what some call "Third World conditions of health" (de Leeuw and Greenwood 2011, 63).⁹

Looking at the extreme disparities in health and care conditions affirms that "settler colonialism" is not mere analogy or metaphor, but a material relation that continues to play out as a struggle over land and bodies (Tuck and Yang 2012). It is a set of racialized relations of production, extraction, exploitation, and benefit—and these relations have always been resisted by Indigenous peoples, even when settler agents and health providers may not have recognized the violence in their own health benevolence. As a white settler myself, I can understand the desire to separate the "good" (or at least "better") care many settlers have received from the "bad" care that Indigenous, Métis, and Inuit have endured. The two, however, cannot be understood apart.¹⁰ Even when Indigenous communities advocate for better access to government-provided care, it is in many cases for the treatment of ailments related to a colonization process that directly funded settler care institutions. As Mohawk activist Katsi'tsakwas Ellen Gabriel writes,

Any funding that Indigenous peoples receive is from Canada's assumed fiduciary responsibility. Canada is holding hostage the funds that could make a difference in the quality of our lives; to decolonize our minds and the daily processes that affect our realities. . . . The funds that each community receives come from a 19th century trust fund created from royalties on all the resources taken from our surrendered homelands. Indigenous peoples do not take from taxpayers; in fact, it is the other way around. (quoted in Shaheen-Hussein 2020, 277)

In other words, “poor care” for Indigenous people in settler states is directly related to the institutions that provide for and benefit settlers: settler health is predicated on the processes of extraction that create Indigenous un-health. This is as true at the state level, with extractivism and displacement filling the coffers of settler governments, as at the level of knowledge-production, with Indigenous bodies serving as material for nutritional and contraceptive experiments and drug testing, to name only a few instances of settler extraction of biocapital (Geddes 2017). “Care” is thus a dimension of a structuring set of relations. Whether it is acknowledged or not, care provision, good or bad, adequate or inadequate, cannot be understood outside the material circumstances of settler colonialism.¹¹ To dismiss “bad” care as outside the purview of care and caring ignores the political and economic relationality of care institutions, policies, and acts of care, and obscures the ways that anti-Indigenous racism occurs in and through care, with drastic differences in care occurring even at the hands of a single hospital unit or individual nurse. Some care theorists would claim that if care is not experienced by care-receivers as care, then it should not be called by that name. But if care is what is expected or hoped for, and is adequately received by others who are not Indigenous in the same context, some questions about this purist definition of care need to be asked—and can only be answered by looking at care as integrated into a set of political and material relations, and as more than a subjective assessment by individual care-receivers.¹²

II. Violent Care Is Still Care

The relations of medical colonialism described above pose an important challenge to understanding care and violence as separate, and thus create some difficulty for theories of care that seek to expunge violence from the normative concept of care. As Fiona Robinson has noted, feminist care ethics—a broad range of theories that address relations of dependence, interdependence, and vulnerability—has sometimes had an uneasy relationship with other feminisms, including decolonial and postcolonial feminisms, precisely because of its associations with benevolent political power exercised on those whose dependence is constructed by that very political relation (Robinson 2015, 293). Although there is a growing trend, of which this article is a part, to acknowledge the limits of the concept of care, much care theory tends to make the case that there should be more care where care has been left out, deprioritized, or inhibited, and better conditions for that care. As Marian Barnes writes,

if we understand care as something that we all need and receive at some stages of our lives, and we recognise that “individuals can only exist because they are members of various networks of care and responsibility, for good and bad” . . . then the challenge is not how we can replace care but how we can create the conditions in which good care can flourish. (Barnes 2011, 160)

This is a normative project that aligns with structural critiques of medical colonialism. On this view, settler colonialism and capitalism—and the exploitation, extractivism, commodification, and lack of self-determination associated with them—would be construed as “uncaring” conditions.

Many disagree on the limits and scope of care as a concept, but most theorists accept that putting the principles and values of a care ethic into practice involves difficulty and ambivalence. The experience of care is not always positive, for care-givers or care-

receivers, and the vulnerability of those who are dependent on care, or dependent on care work for their survival, makes the practice of care a terrain of risk when it comes to abuse and mistreatment (see Kittay 2019). Serene Khader has paid particular attention to the analogy between caring relationships and “participatory development” by missionaries and NGO staff, observing that foreign or privileged “helpers” intervening to mitigate poverty resulting from histories of colonialism are, just like care-givers, particularly prone to paternalism, and arguing that the care virtues can be a mitigating force (Khader 2011). Many thus seek to provide normative guidance for these morally “risky” practices of care, where power dynamics can easily taint caring relations. Often, however, the *concept* of care itself is not considered risky, but rather thought of as an antidote to risk and violence, as a set of values or norms that can make institutional care less violent, or a mode of receptive and vigilant relating and being that “must constantly evaluate whether we are being overly overprotective, too unresponsive, too reliant on our assumed ‘expertise’” (Tronto, quoted in Sevenhuijsen 1998, 67). As Tronto writes, care is the “premise by which we can expect that collective power will be used not to exclude or degrade any groups” (67).

Concepts can certainly do important work. But (as other care theorists have rightly pointed out) to treat care as a premise or meliorative goal can abstract from complex, on-the-ground, embodied practices of assistance and support, and can neglect the way those embodied practices and their complicated, contextual relations can tacitly inform the normative concept of care from below. For this reason, Christine Kelly writes that we should not limit ourselves to asking “how care is embedded within systems of oppression,” but should also consider “how oppressions and violence may be embedded within the very concept of care,” with caring relations, practices, and material demands influencing how care-workers and care-receivers conceptualize care (Kelly 2017, 98). This is why there is a growing feminist literature theorizing the limits of care, interrogating what it can describe, where it can intervene, and where it simply “recapitulates paternalistic logics that justify systems of oppression” (Velez 2020, 333)—whether or not such oppressive dynamics are intended. Theorists like Tronto and Selma Sevenhuijsen have been clear that care is not synonymous with the intention to care—caring “judgment” must have the receptivity to recognize when caring acts are not being received as care or are enacting relationships of power.

These enactments of power, however, are often seen as places for care acts to be adjusted using a trustworthy normative concept of care, or by simply applying caring values. Few have looked at the ways that the material circumstances of settler colonialism have influenced not just the distribution and quality of care, but its very normative, meliorative conception.¹³ Although care theory has only recently begun to reckon with settler colonialism and its implications for our concepts and practices of care, critiques of the colonial potential of care are not at all new. Among them is Uma Narayan’s oft-cited 1995 essay “Colonialism and its Others: Considerations on Rights and Care Discourses,” which gives a scathing critique of self-serving colonial care practices thought to be for colonized peoples’ “own good,” giving special attention to the “white woman’s burden” in maintaining colonial power relations (Narayan 1995, 136). Decolonial feminists have shown that institutions of colonial care, present and past, can be sites of simultaneous violence and nurturance, where normative concepts of care cannot be disentangled from ambiguous, power-laden relationships. On these accounts, it would be entirely possible for a nurse, social worker, or youth counselor to “really care” in earnest, providing support and assistance that may be received as adequate care in that moment, while simultaneously perpetuating colonial violence

through their participation in larger schemes of “management” of marginalized populations, relations, and practices that contribute to Indigenous subject-formation and self-conception, as well as other forms of harm. This certainly does not mean that concepts of care should be jettisoned, but it does mean that acts of care and the colonial policies that support and guide them cannot be separated. As Sevenhuijsen writes, these are cases where “it would not be justified *not* to speak of care . . . simply because they fail to satisfy the definition of ‘protection of vulnerability’” (Sevenhuijsen 1998, 21).

If the same act of care can be experienced as “murderous” to some while being adequate for others for reasons having to do less with personal preferences, needs, and virtues than with structural circumstances, the relationship between care and violence needs to be reconsidered beyond an untainted concept of care that cannot see its own colonial construction.¹⁴ This double nature of care as violent but nonetheless describable as care, even in its failure to “satisfy the definition of ‘protection of vulnerability,’” brings to mind the story of Joyce Echaquan, a thirty-seven-year-old Atikamekw woman who died as she sought care in Joliette, Quebec, in September 2020. Echaquan had gone to a regional hospital for abdominal pains because of a chronic heart condition. As she was being treated, she used her phone to livestream hospital staff using racial slurs and making disparaging comments. Her phone was still recording when staff restrained her, and when, shortly afterwards, she died. The circumstances of her death are still being investigated, but it is clear from Echaquan’s use of her phone that she was expecting the possibility of harm, even as she sought medical care. As her niece noted in an interview with the local news, her aunt had gotten into the habit of broadcasting her hospital visits on Facebook live because “she was always suspicious of public health” (Feith 2020; Bilefsky 2021). The fact that care for someone non-Indigenous would have been adequate, rather than murderous, raises questions for concepts of care that operate on a case-by-case clinical basis rather than looking more deeply at the structures that make the same care environment adequate for white settlers and deadly for Indigenous women.

Many would justifiably say that this horrific incident was not care at all, but a racist absence of care. As we saw above, however, even the presence of good or adequate care in settler societies is predicated on colonial dispossession, making “care” a site of violence and a relevant concept for understanding its material relations. This is why Métis health scholar Yvonne Boyer has argued that truly “effective” or “good” care for Indigenous peoples cannot be achieved without looking to “the implementation of Aboriginal and Treaty rights” (Boyer 2015, 168)—that is, the right to ancestral and treaty land, and traditional knowledge, culture, and heritage. Boyer notes that “health,” according to WHO, is not just the absence of disease, but “all the factors required for human well-being,” including self-determination (15). Good care, and good health, require care to be determined by colonized people on their own terms, with the material resources to carry it out. This is not achievable if the violent care received by Indigenous and colonized people is understood in isolation from the good, supportive care received by settlers.

III. Redirecting the Responsibility to Care

As we saw in section I, medical colonialism is a material relation that serves the dispossession of Indigenous people through ongoing racialization, extractivism, and land theft, all the while employing medical discourse and knowledge-production in order to legitimate those relations, which in turn inform concepts and policies. For this reason,

postcolonial care theorists Parvati Raghuram, Pat Noxolo, and Clare Madge have “unsettled” the notion that colonizing agents should be responsible for care, showing that a politics of care risks inscribing the colonizer as the responsible carer and the colonized as needing benevolent care (Raghuram, Madge, and Noxolo 2009). Although in the Canadian case, there is again no question that the government should fulfill its fiduciary responsibilities and honor treaties, caring agency for settlers can also reproduce the dynamics of violent erasure and participatory inclusion that give legitimacy to settler institutions while inhibiting Indigenous self-determination.

Raghuram observes that much of the literature on care is limited in its assumption that care-givers are the agential center. In a reflection on care and responsibility for proximate and distant others in colonial geographies, Raghuram asks, “When does acting responsibly mean refusing to be responsible? . . . Who benefits from delivering care? Is care necessarily good for the carer/cared[-for]? When does caring actually become an irresponsible act?” (Raghuram, Madge, and Noxolo 2009, 18). She emphasizes that care and “taking responsibility” may be experienced as an act of complicity with colonialism. When applied to the Canadian context, this critique would instead have those *harmed* by colonialism be the agential centers in redress, reparation, and reconciliation, and not the Canadian government. As Leanne Simpson writes in *Dancing on Our Turtle’s Back*, true reconciliation would involve “interrogation focused on the perpetrator of violence, not on the survivors. The responsibility and the authority for restoration are in the agency of the survivors, not the perpetrators themselves. The authority to hold the state accountable then rests with Indigenous nations, not the liberal state” (Simpson 2011, 23–24). In this way, a decolonial care ethic practiced in settler societies would have to ask “whether there is a way to re-circuit the transmission of influence from Indigenous to settler,” rather than assuming caring directionality to flow from settler to Indigenous. The answer, according to Navajo scholar Lou Cornum, “will come as we organize together against specific instances of resource extraction, enclosure, border policing and military aggression” (Cornum 2019).

The risk posed by an expansive concept of care that assumes carers should identify and manage a wide range of needs for a wide range of differently situated people is *not* that it takes Indigenous realities and demands into consideration and concern; settlers should have consideration and concern for the reality of colonialism. Rather, the problem is that it assumes that care, as consideration and concern, necessarily flows from responsible settler-carers, and that those dispossessed by settler colonialism will necessarily want to be the objects of a care and concern that isn’t accompanied by significant changes in material conditions and relationships (see Jewell and Maile 2021). As Wet’suwet’en land defenders have declared, “Reconciliation is Dead”: settlers and settler governments should not expect guilt to be assuaged through assumed caring relationality and participation in the same decision-making processes.

In this respect a caring politics (that involves settlers as its practitioners) needs not only to think beyond the nation-state paradigm, but to acknowledge forms of care that are unassimilable under settler-colonial capitalism, and therefore refuse to be incorporated into a settler-oriented ethic of care. This might include what Kumkum Sangari has described as a “refusal to call”—or a refusal to answer when one is asked to validate that settler care was well-received (Sangari 1987). This troubles the “receptivity” dimension of many contemporary theories that expect, and await, confirmation and validation from the care-receiver that care has been effective and well-received. For Olena Hankivsky, for example, caring policies should be formulated or ameliorated with the value of “responsiveness” that creates space for the “voice” and “expression” of those

who are marginalized, but does not question a policymaker's role as a receptive listener who adjudicates based on information received, or the care-giver or provider's role in making adjustments without necessarily changing the fundamental nature of the relationship (Hankivsky 2004, 35–37). The same could be said of Tronto's notion of "caring-with," which helpfully recognizes care as a relation that should not make a care-receiver more dependent and less of an agent. But an analysis of settler colonialism tests the "with-ness" of care, insofar as settler states demand that those who are Indigenous participate in the inclusive forms of community that perpetuate dispossession, while excluding them from the processes that would establish self-determination. A decolonial care ethic would thus disrupt assumptions about the nature, source, and directionality of care.¹⁵ As Emma Velez writes, decolonial care is "contextualist, and informed by the local practices of care of those who are historically marginalized and oppressed in colonial contexts" (Velez 2020, 344).

IV. Welfare States and Caring Democracies: Troubling the Assumption of Participatory Inclusion

Kanien'keha:ka author Patricia Monture-Angus has described Indigenous sovereignty as "the right to be responsible," referring to the fact that self-determination requires being considered primary agents in "care" and not mere recipients of benevolence (quoted in Shotwell 2016, 49). The previous section discussed the way care dynamics reinforce settler caring dominance by seeing care, and its adjudication, as flowing from non-Indigenous people assumed to be bearers of political agency that grant the power to care. The material deprivation, dispossession, and displacement caused by settler colonialism position Indigenous, Métis, and Inuit peoples as uncaring—unhygienic, disease- and addiction-ridden, criminal, unemployable, uneducable—constructing dependence and vulnerability and then legitimating that status through policy. Settler colonialism thus creates collective relationships of disempowerment through care. This section focuses on the problem of care as requiring inclusion and participation in a set of relationships and processes that serve settlers' power to care, rather than Indigenous self-determination. I argue that this problem has two sources: the assumption of civic inclusion and participation as a desirable goal in caring political relations, and the role of the welfare state as a colonial instrument. I show each at work in the assimilationist biopolitics of suicide-prevention in Inuit communities, and programming for "at risk" Indigenous youth in the prairies.

Since the political turn in care theory, marked by Tronto's *Moral Boundaries*, and later, *Caring Democracy* (Tronto 1993; 2013), care is well-established as a practice and normative set of concepts that extends beyond the domestic realm. On Tronto's and Berenice Fisher's oft-cited definition, care is a "species activity that includes everything that we do to maintain, continue, and repair our 'world' so that we can live in it as well as possible" (Tronto 1993, 103). This "public" notion of care, which understands care and justice together rather than apart, has moved the conversation about care in directions that enable the concept to address the global racialization of care work (Hankivsky 2014), the impacts of neoliberalism (Ward 2015; Casalini, in Urban and Ward 2020), capitalism and the commodification of care (Mahadevan 2021), care and biopolitics, the nature and structure of caring institutions and the political practices that enable them (Urban and Ward 2021), and caring citizenship (Tronto 1993; Sevenhuijsen 1998; Tronto 2013; Brugère 2021, among many). Few contemporary care theories, however, have developed this line of thinking beyond the existence of

settler citizenship and welfare-state institutions, even if many are critical of their increasing neoliberalization and orientation toward corporate profit. Without addressing the welfare state's imperatives to civic inclusion, productivity, and governmentally sanctioned "regimes of life," one cannot adequately address health disparities in Canada.

In caring democracy, Tronto proposes a society-wide distribution of care work organized through the mechanism of liberal democracy as an attempt to rectify inequalities, both care- and non-care-related. On her account, the function of democratic life is to distribute care responsibilities. Hers is a participatory model, where to be a citizen is to be responsible for care; care is a civic duty. She outlines phases of care that, rather than acting as the components of a normative ideal, are meant as tools to guide and evaluate our caring activities as we undertake them in real life (Tronto 2010). The notion of "caring-with," for example, captures the requirement that "caring needs and the ways in which they are met need to be consistent with democratic commitments to justice, equality, and freedom for all" (Tronto 2013, 23). "Caring-with"—a form of caring solidarity beyond merely "caring about," "caring for," "care-giving" or "care-receiving"—should be one of our political responsibilities. The flip side of this claim is that citizens will care about, and be actively involved in, democracy, since "a democratic state in which citizens do not care about justice . . . will not long remain a democracy" (xiv).

Tronto argues vociferously against neoliberal models of care that trap us in bootstrap discourses of autonomy, making the case for a societal shift away from the "vicious circle" of privatized care and toward a "virtuous circle" of caring democracy where everyone participates in care as the very definition of civic belonging. In caring democracy, the "state" does not have top-down power that requires particular forms of care to be undertaken according to abstract notions of citizenship and belonging, but rather has the role of facilitating the distribution of care tasks among the members of society, who themselves make decisions about what kind of care is needed. Making justice about caring, according to Tronto, would require a total reimagining of our modes of caring, our ways of doing democracy, and the institutions of democratic life. "How," she asks, "do we think about justice as an ongoing process of assigning and reassigning caring and other responsibilities in a framework of non-dominated inclusion?" (169).

This account can take us a good distance in rethinking care structures beyond colonial benevolence and beyond capitalism, insofar as "caring democracy" is portrayed as a bottom-up process where decisions can be made at the local level. However, it also makes a normative assumption about inclusion and civic participation in democratic life. Can inclusivity in settler-colonial paradigms be "nondominating"? The material relations of settler care make this difficult to imagine, though perhaps not totally impossible, if "inclusion" and "civic participation" are radically rethought beyond settler-state, welfare-capitalist assumptions. The vision outlined in *Caring Democracy*, however, retains many elements of the Canadian welfare-state model—as do many contemporary political conceptions of care (see Brugère 2021; Jesenková 2021; White 2021). In the reimagining of the political functions of "protection" and "production," for example, "the military, 'homeland security,' police and police powers, and the prison system" are envisioned as "caring tasks" (Tronto 2013 172). The vision of caring production, which does aim to fairly compensate workers, suggests that we "use market incentives to convince more people to enter care work" (174). Compensating care-workers in our current system is certainly a good thing, and there have been important and successful

Indigenous-led movements to recruit Indigenous nurses to work in their own communities (McCallum 2016).¹⁶ But it locates the work of care in the monetized economy that Tronto argues so vociferously against, without addressing the extractivism and primary accumulation that shape a care imaginary that still includes policing, prisons, the military, waged work, and homeland security—institutions that actively contribute to Indigenous dispossession and the entanglement of carceral institutions that carry it out.¹⁷ To be sure, no care is neutral, and there can be no pure practice of care. Tronto's suggestions do make a strong case for strengthening the commitment to caring and care work at the collective level. But as state-managed and supported programming for Indigenous youth and Inuit communities show us, organizing society around forms of inclusion that maintain the material relations of settler life cannot be left unchallenged once medical colonialism is taken into account.

In *Prairie Rising*, for example, Jaskiran Dhillon shows how nonprofits meant to benefit Indigenous youth engage in a seeming “paradox” of care in which Indigenous lives are managed, contained, and disciplined, even in its attempts to account for colonial harm (Dhillon 2017). By focusing on youth on Treaty Six territory (Saskatoon) where shrinking reservations caused an influx of Indigenous people into white, racist, settler spaces, Dhillon exposes the ways that nonprofits carry out federal mandates to integrate Indigenous youth through participation. These on-the-ground dynamics pose a challenge for the political concept of care, and for a participatory “caring democracy,” since they reveal how governmental institutions and nonprofits provide care in ways that preserve or ignore the underlying causes of colonial harm.

Governmental and social-service reports emphasize the urgency of the “Indigenous youth crisis”—mass incarceration, houselessness, poverty, physical and sexual violence, school discontinuation, drug use, and mental and physical health issues—and the necessary nature of state and nonprofit intervention. But, as Dhillon shows, these care responses to colonial ills are construed in this way as a pretext to “rescue” youth through care services that inculcate them into settler-colonial modes of life. Such care services tend to be a response to the construction of Indigenous children as “at risk,” or falling through the cracks in an otherwise well-functioning system. As Dhillon shows, however, responding to the “crisis” with linked carceral care services that aim to integrate Indigenous youth into settler-colonial culture, family, living, and work habits performs a kind of elimination through the very provision of care that not only erases Indigeneity and nonsettler ways of being, but *erases this very erasure* through both political deflection and the outright physical removal of Indigenous people through institutionalization (Dhillon 2017, 34, 199). Why, she asks rhetorically, aren't ongoing settler colonialism and land theft identified in government reports as the real causes of risk for “at risk” youth?

In a comprehensive survey and analysis of several Saskatchewan programs serving Indigenous youth, including grass-roots service-provision groups that participate in federal initiatives to “understand them” and “meet their needs,” Dhillon demonstrates that programming like job training, youth “rehabilitation” for drugs and criminalized behavior, sex-worker support, and culturally responsive education assumes the desirability of participation in the settler state by prioritizing labor and educational productivity, nuclear family stability, emotional regulation, and depoliticization. This shapes political subjectivity through a discourse of inclusion, partnership, and participation—concepts that many care theorists hold dear as essential to the provision of care. Dhillon's work shows how the use of Indigenous voices and values by government agencies, and as a way of securing funding opportunities, is framed as responsibility

for colonial harm, at the same time that it perpetuates that harm by deepening disconnection from land, and co-opting Indigenous culture for the purposes of integration into settler institutions in the form of school curricula, cultural sensitivity trainings, and nonprofit handbooks.¹⁸

Settler governments and settler complicity are to blame for the shocking lack of adequate services and material resources Indigenous people face, but Canada continues to take responsibility for those harms through rights frameworks tied to civic recognition and belonging. There is a clear extractivist rationale behind rights frameworks that require a politics of recognition, insofar as they assume a status quo beneficial to settlers and the settler state in terms of resources and decision-making power. Enjoying rights to health and social services thus involves inculcation into liberal norms of democratic “participation”—even if that “participation” is depoliticizing under neoliberal conditions (Varcoe, Pauly, and Laliberté 2011). As Matthew Chrisler writes, participation is often framed as a “cornerstone of democratic governance,” where the equal distribution of rights to all citizens frames justice as an apolitical, representational involvement in the Canadian political process. This kind of “pluralistic nationalism,” according to Chrisler, is a liberal fantasy that “promises the benefits of full citizenship based on an individual’s ability to take responsibility for and transform colonial racial pathologies into practices that reflect the normative objectives reproduced within the institutions of family, employment, education and health” (Chrisler 2017).

In this way, care work can serve as the affective medium of power relations between the state and Indigenous youth. A 2010 report of Aboriginal Affairs and Northern Development Canada recommends, for example, that “to the greatest extent possible, programs will be developed locally with a high degree of Aboriginal involvement and ownership” and that “urban aboriginal youth or their appropriate representative organizations” will be involved in the “identification of needs, priority setting, and program design” in partnership with mainstream organizations and government agencies (Dhillon 2017, 12). The report assumes and requires Indigenous cooperation—an approach that many Indigenous scholars have criticized as enforcing a “politics of recognition,” where in order to count as political actors, Indigenous people must join, or mirror, the structures and processes of the settler state.¹⁹ These programs and their mandates are biopolitical in character because they “normalize specific kinds of desire and sensibilities about the Canadian state” (21). As Dhillon writes, “for Indigenous people to be actively involved in decisions regarding the future of their children and youth, they must be inserted into a political game already being played with a set of rules not of their own making” (21).

Care theorists committed to caring democracy and its value of “caring-with” might understand this as a paradigm case of bureaucratic un-care, but Dhillon describes this articulation of care as something that could resemble “nondominating inclusion” insofar as programming tends to be decentralized and federal mandates and affects taken up and internalized by local Indigenous groups, with Indigenous leadership, according to settler behavioral rubrics and ideals of service provision: a classic colonial tactic. The goal of such of such service-provision is to rectify “past colonial blunders” through benevolent efforts to include “at risk youth” in settler society, making them active, responsible participants in its virtuous circles of care. As Leanne Betasamosake Simpson writes, participation, whether voluntary or coerced, risks “[benefiting] the state in an asymmetrical fashion, by attempting to neutralize the legitimacy of Indigenous resistance” (Simpson 2011, 22). She asks, “Are we participating in a process that allows the state to co-opt the individual and collective pain and suffering of our

people, while also criminalizing the inter-generational impacts of residential schools and ignoring the larger neo-assimilation project to which our children are now subjected?" (22).

Many Indigenous activists and intellectuals have long argued against the idea of inclusion, with some understanding it "as an erasure of the specificity of Indigenous political claims" and a "forced incorporation of Indigenous peoples into the 'domestic' space of the nation" (Rifkin 2017, 1). At the heart of the problem of inclusion in "caring" settler societies is the welfare-state framework, which, even if many of us currently depend on it to survive, cannot be dissociated from the global colonial project. Theories of "caring societies" in which Canadian-style social-welfare institutions are part of the imaginary are necessarily challenged by the fact that welfare states have always been extractivist, benefiting some at the expense of Indigenous and colonized people. When colonized people and lands are taken into account, the "socialization of wealth" in Europe and North America can be revealed as a development of colonial-racial capitalism. As W. E. B. Du Bois writes of the advent of industrial and colonial capitalism, "we called the process Revolution in the eighteenth century, advancing Democracy in the nineteenth, and Socialization of Wealth in the twentieth. But whatever we call it, the movement is the same: the dipping of more and grimmer hands into the wealth-bag of the nation," until it is clear that these kinds of social welfare democracies go hand-in-hand with expropriation in order to satisfy a labor-citizenship (Du Bois 1915)—albeit one that is rapidly giving way to the neoliberal model of globalized financialized capitalism (Fraser 2016).

Du Bois identifies the "darker nations" as the site of plunder—"Asia and Africa, South and Central America, the West Indies and the islands of the South Seas"—neglecting the fact that North America, too, should be added to the list of colonized lands whose inhabitants are thereby racialized. But his analysis of the development of the welfare state can help us understand, in a more systemic way and with a global outlook, why health conditions in Canada are simultaneously "first-world" and "third-world": the settler welfare state depends on the dispossession of the "darker nations" within its own midst. Under these circumstances, treating citizens as equal participants in an inclusive "caring society" without addressing the primary accumulation that makes national institutions possible can only result in poor care.²⁰

Just as Du Bois describes the relative wealth of workers in "first-world" or "developed" nations through their participation in colonial capitalist acquisition through financial investments in the colonized world, higher wages, and goods made cheap through extractivist trade agreements and corporate plunder, Indigenous people "at risk" can access care only as a form of participation in these relations of production. In this way, participatory care becomes a means of assimilation into the social relations that reproduce the settler nation-state. It is in this sense that anthropologist Lisa Stevenson has shown that care under settler circumstances is a settler "regime of life," where civic, material, and biopolitical production are inseparable. Stevenson's work, which documents the state responses to the Inuit tuberculosis epidemic in the 1950s and 60s and the current suicide epidemic among youth in the northern territory of Nunavut, frames care and social welfare as biopolitical from the outset. Care, as she conceives it, is "the way someone comes to matter and the corresponding ethics of attending to the other who matters" (Stevenson 2014, 3). It is a valuing of which lives matter, and *how*; it is concerned with the maintenance of Inuit "life itself," directed at the Inuit population as a whole where suicidal youth are "exhorted to live" at the same time that they are "expected to die" (7). Stevenson's work shows us that the settler

state's response to suicide construes it as a failure to cooperate in a regime of life—a failure to become the fully biopolitical subjects desired and required by the settler state—rather than an outgrowth of colonial displacement, resettlement, and health-based evacuations to southern Canada. If Inuit life isn't successfully preserved, it signals the breakdown of the civic, territorial project of the settler state.

The project of involving Inuit youth in suicide prevention as a mode of civic participation is consistent with what Dhillon describes in *Prairie Rising* insofar as “the bureaucratic project of creating health and extending life has been construed as a mutual one, requiring Inuit cooperation” to keep Inuit alive under colonial circumstances intent on erasing modes of life that run counter to reconciliation with, and absorption into, the settler state (Stevenson 2014, 61). Here, giving and receiving care are synonymous with civic cooperation. As Stevenson writes of the ethos of suicide-prevention programming, “to be a good citizen means to cooperate in this regime of life” (8). In spite of these efforts, the suicide rate has continued to rise.

Although Stevenson is not advocating for us to ignore the devastation of suicide in the North, her work also asks us to consider how care practices and institutions carry assumptions about agency, participation, and inclusion. The government, settlers, and southerners may have a responsibility to “care” for Inuit youth as a response to suffering and as a way to address colonial harm. But the responses to the tuberculosis epidemic of the 1950s and 1960s,²¹ and the current suicide epidemic, are each bound up with the cultivation of civic habits like “hygiene” and “productivity” that were necessarily part of time spent in the sanatorium and the suicide-prevention workshop. In the case of the latter, Stevenson shows *life* and citizenship to be synonymous in colonial care rhetoric—but life maintained by care experienced by Inuit communities as “murderous” in its forms of relating (73).

In each of these forms of care, we see at work Stevenson's definition of care as “how someone comes to matter”: Inuit health and life come to matter as indications that the settler state hasn't failed in accounting for Inuit lives in response to its own harms. Health and life, in and of themselves, are evidently not bad things, but their pursuit on the part of settler-colonial institutions and practitioners makes them biopolitical instruments of cooperation that have, for that reason, faced significant resistance. Stevenson documents the long history of Inuit refusal to board medical boats docked at settlements that took Inuit to southern Canada for treatment, and Inuit youth refusing to attend suicide-prevention workshops or to take them seriously when they do. As Stevenson writes, the settler response to this lack of cooperation was to double down on “a regime of stepped-up persuasion. Couldn't [they] see that the Canadian state agents—the northern service officers, the doctors, the nurses, and the social workers—*cared?*” (54)

The demand for participation in settler norms, politics, and modes of production that we see in Stevenson's and Dhillon's work establish “inclusion” as a difficult value for a decolonial politics of care, and this complexity is reflected in the mixed range of responses by Indigenous people to the transfer of health care from the federal government to individual bands and tribal councils. As Kelm writes, there is, on the one hand, “the desire to show how Aboriginal health problems have roots in the material conditions of wardship and therefore can be fixed once those conditions are removed, and on the other, the fear that taking control will eliminate non-Native responsibility” (Kelm 1998, xvii). A decolonial ethics and politics of care will therefore necessarily be complicit from a settler perspective. This demands the disruption of purist notions of care that see their expansion and inclusivity as necessarily a good thing, and a refraction

of care so as to recognize the labors of maintenance, support, attention, and stewardship on which settler societies have always depended. A decolonial care ethic divests from the settler “power to care,” while engaging in practices and agitating for policies that allow for Indigenous self-determination beyond the settler state.

V. Complicit, Open, Pluralistic, Refracted, Disrupted: An Unsettled Care Ethic

In this article, we have seen that the material relations of medical colonialism trouble the separation between care and violence, as well as the aspiration to participatory inclusion and civic membership in caring democracies on the welfare-state model. We saw that the imperative to inclusive care assumes that carers are necessarily those who are *already* empowered to care and are recognized as caring, and that that care requires participatory involvement in the systems of a caring society. In addition to risking the perpetuation of colonial dispossession, this kind of liberal imaginary also risks overshadowing and invisibilizing forms of unrecognized caring and social reproduction—including those on which settler life depends, like the stewardship of land and non- and more-than-human nature. Inclusive care practiced and theorized in settler-colonial societies may not recognize Indigenous forms of care and social reproduction that operate in direct opposition to capitalist production, or at least partially outside of it. As Rebecca Hall has shown, Indigenous women’s social reproduction is a site of decolonial struggle, insofar as it is a space that “holds within it both violent colonial oppression and exploitation, and the creative labors of resistance, growth, and possibility: production and reproduction of Indigenous, non-capitalist, non-patriarchal forms of caring, living, and working” (Hall 2016, 228). Rather than conceiving of care as folding these practices into its democratic concept, care—and, in particular, the care theorized and practiced by settlers and settler institutions—needs to refract, retract, and multiply in order to reconceptualize interdependence. If settlers and settler institutions are in a position to engage in benevolent care, it is because of a dependence on land and resources stewarded and cared for by Indigenous people, and a long-term process of using medicine to disrupt that caring relation. Recognizing the forms of labor, maintenance, and care that flow toward settlers and inform settler notions of institutionalized “good care” is crucial for a decolonial care ethic. Just as crucial is the recognition that these forms of care have continued, in resistance to the medical colonialism that sought to quash Indigenous political self-determination through family separation, infection, displacement for treatment, and cultural assimilation. This is to say that decolonial care has always operated within the systems it resists.

If the normative dimension of a decolonial care ethic, as we saw, centers the “local practices of care by those who are historically marginalized and oppressed in colonial contexts” (Velez 2020, 344), this would include the Cowessess and Tk’emlups te Secwépemc First Nations’ use of ground-penetrating radar to locate those whose lives were lost because of the residential school system—a technology frequently used by colonial archaeologists, and in this case, claimed and redirected toward Indigenous care and justice on Indigenous terms. It would include blockades and encampments that resist pipeline construction, Indigenous-led partnerships that give full decision-making and economic power to Indigenous communities as well as refusals to enter into partnerships at all, mutual support networks, peer addiction-counseling programs, and the reappropriation of settler techniques like land trusts to give land back.

The violence of settler-colonial care shows us that our theories and practices of care should be open to a retraction or rearticulation rather than an expansion of involved,

interpersonal, active, relations of nurturance. When some groups claim that “Reconciliation is Dead,” it is because “care” for settlers through the welfare state has been parasitic on Indigenous caretaking from the outset. For this reason, coming to terms with the violent care of medical colonialism has some important implications for settlers and settler institutions quite different from what some contemporary care theorists have suggested about “good care.” On the one hand, it means that care and caring cannot abstract from their role in domination, and that inclusive schemes to “reconcile” colonized people to participation and absorption into nation-state institutions will only perpetuate the extractivism of violent care. On the other hand, it implicates settlers and settler institutions, demanding accountability for the return of land and resources, fiduciary responsibility and reparations, respect for treaties and agreements—a process of significantly remaking collective and material life on Turtle Island. Beyond the “caring judgment” that Sevenhuijsen has suggested as a civic orientation, or “caring democracy,” a decolonial care ethic would involve the “open normativity” of supporting Indigenous resurgence, sovereignty, and self-determination (Shotwell 2016, 155).²² Support might be material and direct, but it might also place “no demand upon the state or its citizens other than to get out of the way and respect Indigenous self-determination and nationhood” (Simpson 2017, 237).

Given the ways that inclusion has been used for the purposes of Indigenous erasure, a transformative, decolonial concept of care should be able to support chosen forms of unbelonging and uninclusion. Rather than basing an ethic of care on inclusion and settler responsiveness, a decolonial care ethic would leave room for Indigenous disruption, adaptation, and delinking from settler care. This will require a radical transformation in and beyond our institutions: of seeing the land itself, and Indigenous claims to it, as crucial to caring relations under settler colonialism. This involves thinking beyond settler states as the political paradigm, and looking to the practices of care and survival that already exist at their internal limits. A decolonial care ethic requires a pluralistic, complicit, refracted, disrupted care that operates beyond settler policy-making in order to undo its damages, recognizing other registers of care practice and theory that cannot be captured or framed by the settler paradigm. It requires restitution, reparation, and fiduciary responsibility, since substantive sovereignty and self-determination are the most important conditions for counteracting medical colonialism in favor of Indigenous health.

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Notes

1 The graves were discovered at the sites of the Marieval Indian Residential School in Saskatchewan and at the site of the Kamloops Indian Residential School in British Columbia, respectively.

2 Former Prime Minister Stephen Harper finally apologized, while denying the existence of colonialism in Canada practically in the same breath, and now Prime Minister Justin Trudeau has also done so at the

closing ceremony of the Truth and Reconciliation Commission, wiping away tears as recommendations were announced, and subsequently doing almost nothing to address any of the Commission's recommendations.

3 This has been called the “Millennial Scoop,” after the “Sixties Scoop,” which refers to the mid-twentieth century mass removals of Indigenous children from their homes to be put into settler care.

4 Glenn Coulthard shows in *Red Skin, White Masks* that Marx's critique of capitalism ignores the fact that primary accumulation is ongoing, and not a phase in capitalism's past (Coulthard 2014).

5 The refusal to place settler-colonial domination squarely in the past has been given recent expression by #IdleNoMore, the long-awaited 2019 federal commission on Missing and Murdered Indigenous Women and Girls (MMIWG), the #LandBack movement, resistance to pipeline construction on unceded lands at Wet'suwe'ten, and the cancellation of Canada Day celebrations—to name only a few of many initiatives. Far from resisting an abstract “legacy” of colonialism, they confront the exploitation, violence, appropriation, and extractivism of settler domination in the present, continuing longstanding Indigenous resistance to settler dispossession.

6 As Audra Simpson writes, “In what world do we imagine the past to be settled in light of its refusal to perish and allow things to start over anew? What are the conditions that make for this imagining, this fantasy or rather, demand of a new start point? . . . [T]he Canadian practice of settler governance has adjusted itself in line with global trends and rights paradigms away from overt violence to what are seen as softer and kinder, caring modes of governing but governing, violently still and yet, with a language of care, upon on still stolen land” (see Simpson 2016).

7 A settler doctor who practices HIV/AIDS medicine in remote Indigenous communities recently related to me that settler norms of “good” care would have him conduct a virtual or phone check-in with patients on anti-retroviral drugs in order to obtain their “full consent” through the discussion of risks and side-effects, but he noticed, after having done this for some time, that patients felt this to be coercive. This particular group of patients did not want conversations about consent with a settler doctor; they wanted him to sign off on their anti-retrovirals, and did not want to have to endure an additional interaction with the medical establishment. Taking this psychological form of care into account, however, meant violating medical protocols that require fully informed consent in the form of a face-to-face conversation. In this particular case, the doctor in question understood the protocols to assuage doctors' feelings about doing the right thing more than they benefited patients.

8 To be sure, some important theories of care, like Eva Kittay's, call for universality without reciprocity, given that relationships of dependence include everyone, and are necessarily asymmetrical, as each one of us is or will be dependent on others (Kittay 1999; 2019). However, under our current paradigm, even interdependency that recognizes settler dependency on Indigenous stewardship of stolen land would require a massive reorganization of society, and a redefinition of civic belonging and ways of relating. The path to that reorganization will require the destabilization of universal notions of care and caring relations, insofar as those that currently prevail construct Indigenous dependency through political, cultural, and economic inclusion. This asymmetry of colonial care should be addressed, rather than naturalized, even if it is true (as Kittay has argued) that each one of us participates in relations of interdependency.

9 “Indeed,” as de Leeuw and Greenwood write, “although Canada is ranked among the best places to live in the world, if the United Nations Human Development Index were applied to indigenous people living on reserve, Canada would rank between sixty-eighth to eightieth in the world” (de Leeuw and Greenwood 2011, 63).

10 As Nancy Fraser has observed in “Contradictions of Capital and Care,” welfare states (or what is left of them) emerged as part of a phase of “state-managed capitalism” immediately prior to our own that depended directly on the looting of “the periphery” (accumulation from the realm of social reproduction considered outside of capital) in order to support a system in the colonial “center” based on the family wage and the collusion between the state and industry in the creation of social protections. The Canadian Medicare system, created in the mid-twentieth century, is easily describable using Fraser's periodization (see Fraser 2016).

11 This is certainly not to make a normative claim about what Indigenous people should or should not demand of the state, or to what extent inclusion should be sought or pursued; such claims are not mine to make. As a beneficiary of the Canadian welfare state, however, it is incumbent on me to understand the role that benefit has in perpetuating colonial harm.

12 Although Indigenous activists and scholars have been adamant about the need for the Canadian government to satisfy its fiduciary and treaty responsibilities toward Indigenous people, understanding medical colonialism as an extractive set of relations challenges the notion that increased government funding for existing programming, economic opportunities, and increased access to settler care institutions will be enough. As Taiaiake Alfred has written, these solutions are not effective because they take “integration into the market economy” and participation in the “colonial-capitalist” agenda for granted—both root causes of Indigenous un-health. “Social and health problems,” he writes, “seem to be so vexing to governments; large amounts of money have been allocated to implement government-run organizations and policies geared toward alleviating these problems but they have had only limited positive effect on the health status of our communities. These problems are not really mysterious nor are they unsolvable.” Rather, they reflect the colonial situation, and the complicity of care institutions in serving the interests of “the colonial regime and capitalism” (Alfred 2009, 53).

13 I am not arguing against meliorative normative conceptions of care in general, but rather calling attention to the ways that these conceptions are necessarily shaped by the circumstances in which they intervene.

14 As Puig de la Bellacasa writes, reclaiming care is “all but about purging and ‘cleaning’ a notion; rather, it involves considering purist ambitions . . . as the utmost poisonous” (Puig de la Bellacasa 2017, 11).

15 Sophie Bourgeault discusses the problem of power imbalances in care by making the case for a pluralistic notion of care characterized by attentive listening but does not address the specific material dynamics of settler colonialism (see Bourgeault 2021).

16 There is certainly something to be said for initiatives to train and compensate more Indigenous nurses to work in their own communities at Indigenous Health Board clinics (which have historically been staffed by underprepared white women with a high turnover rate), but these projects are (by contrast) driven by Indigenous self-determination, rather than justified by inclusion in settler-democratic processes that are necessarily tied to land and resource theft.

17 Indigenous peoples account for less than five percent of the Canadian population but represent more than thirty percent of the federal prison population. In a prairie province like Manitoba the numbers are even more extreme, with over three-quarters of the prison population being Indigenous (see Sabiston 2021).

18 Others have pointed out that the material beneficiaries of these programs tend to be settler workers paid to administer and manage them, rather than the Indigenous beneficiaries outlined in grant proposals and federal initiatives.

19 In *Red Skin, White Masks*, Glenn Coulthard describes the politics of recognition as “the establishment of political rights regimes that claim to recognize and accommodate the political autonomy, land rights, and cultural distinctiveness of Indigenous nations within the settler states that now encase them” (Coulthard 2014, 2). A “politics of recognition” refers to the models of liberal pluralism that “seek to ‘reconcile’ Indigenous assertions of nationhood with settler-state sovereignty via the accommodation of Indigenous identity claims in some form of renewed legal and political relationship with the Canadian state” (3). Coulthard argues that the politics of recognition promises to “reproduce the very configurations of colonialist, racist, patriarchal state power that Indigenous peoples’ demands for recognition have historically sought to transcend” (3).

20 As Maile Arvin, Eve Tuck, and Angie Morrill write, feminist discourses of multicultural inclusion work “to maintain settler colonialism because they make it easy to assume that all minorities and ethnic groups are different though working toward inclusion and equality, each in its own similar and parallel way. Justice is often put in terms that coincide with the expansion of the settler state” (Arvin, Tuck, and Morrill 2013, 10).

21 During the tuberculosis epidemic, the government orchestrated mass evacuations to southern sanatoria from which many never returned.

22 This is as an alternative to “grounded normativity,” theorized by Coulthard. Alexis Shotwell suggests that settlers can practice “open normativity” so as to avoid appropriating a term meant to describe an Indigenous ethic that derives from belonging to the land (Shotwell, 2016).

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