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Biases, Racism, and Discrimination in Healthcare

INDIGENOUS HEALTHCARE EDUCATION AND PRACTICE:
A Community-Led and Community-Informed Collaborative Initiative

Please note:

This Companion Guide is a resource created to complement the online modules.

This online module was developed by the Office of Professional Development and Educational Scholarship (Queen's Health Sciences) and the Northern Ontario School of Medicine (NOSM) to address the Calls to Action set forth by the Truth and Reconciliation Commission. This project is made possible with funding by the Government of Ontario and through eCampusOntario's support of the Virtual Learning Strategy. To learn more about the Virtual Learning Strategy visit the eCampus Ontario website (*click to view*).

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MODULE INTRODUCTION

Welcome to the learning module titled “Biases, Racism, and Discrimination in Healthcare”. This module is part of the seven-module series titled “Indigenous Healthcare Education and Practice: A Community-Led and Community-Informed Collaborative Initiative”. Throughout the modules in this series you will be connecting the 2015 Truth and Reconciliation Commission (T R C) of Canada Calls to Action (C T A) report, a report designed to advance the process of Canadian reconciliation and redress the legacy of residential schools, to healthcare and education practice.[1]

For your interest, explore the Truth and Reconciliation Commission of Canada Calls to Action report.

Truth and Reconciliation Commission of Canada: Calls to Action

Calls to Action (C T As) addressed in this module include: C T A 10, C T A 18, C T A 19, C T A 20, C T A 21, C T A 22, C T A 23, C T A 24, and C T A 62.

The modules in this series can be used to increase your awareness and knowledge of Indigenous healthcare education and practice. You will learn about historical perspectives of Indigenous Peoples in Canada and their implications for health outcomes, biases, racism, and discrimination in healthcare, Indigenous ways of knowing, healthcare rights and services, culturally safe healthcare, and intersections between education and healthcare. This module will specifically address the historical and current biases, racism, and discrimination experienced by Indigenous Peoples in Canadian healthcare.

Note that these modules should be viewed as an introduction to Indigenous healthcare education and practice. It is important to continue to reflect and engage with this material over time, as our understanding and perspectives of this material are influenced by broader social and contextual factors. Please also recognize that decisions in regard to policy and legislation are constantly changing so it is important to keep up to date on current events. Gaining and understanding Indigenous healthcare education and practice is a lifelong journey that involves a willingness to learn, practice, and self-reflect. As you work through the modules of this series, please also acknowledge that the term health encompasses physical, spiritual, emotional, and mental wellness.

Content Warning: The content covered by this module may be difficult to process due to the challenging nature of the material. This may particularly occur if you have lived-experiences in relation to this material or are learning about these realities for the first time. We ask all learners to access supports if necessary.

Page Link:

https://www2.gov.bc.ca/assets/gov/british-columbians-our-governments/indigenous-people/aboriginal-peoples-documents/calls_to_action_english2.pdf

End of Module Introduction

MODULE 02 COMPANION GUIDE

BIASES, RACISM, AND DISCRIMINATION IN HEALTHCARE

In this module you will learn about the many ways that different manifestations of racism, biases, and discrimination impact the lives, well-being, and overall health of Indigenous Peoples navigating the healthcare system. Furthermore, you will be equipped with some effective tools, understandings, and practical strategies to help Indigenize and decolonize your own practices, ultimately making the healthcare system safer for Indigenous Peoples.

After completing this resource, you will be able to:

- Identify implications of unconscious bias and stereotyping in cross-cultural interactions.
- Assess and address the role of racism (interpersonal, systemic, and epistemic) in differential access to healthcare.

Introduction to Racism, Bias, and Stereotyping

Before beginning the module, it is worth making sure you understand some key terms or themes discussed within the module. These include interpersonal, systemic, and epistemic racism as well as unconscious bias and stereotyping. Racism, bias, and stereotyping can be manifested at different levels and it is important for any healthcare professional to understand how it can impact people's lives.

Click the tabs to review these key terms and themes.

Interpersonal Racism

Interpersonal racism refers to the type of racism that happens at the relationship level. This means racist acts that occur between people through, but not limited to, hurtful behaviour, microaggressions, or prejudice acts.

Systemic Racism

Systemic racism refers to the common societal procedures and structures that disadvantage people across different ethnic or racial groups, resulting in many outcomes of racial disparity.

Epistemic Racism

Epistemic racism refers to the placement of certain racialized knowledge above or below that of another group. Marginalized knowledge is either devalued or disregarded entirely.

Unconscious Bias

Unconscious bias refers to the implicit ideas that people unconsciously hold about another group or individual that come from certain associations acquired through former experiences. Unconscious bias, without work being done to undo it, is often uncontrollable, unintentional, and unconscious.

Stereotyping

Stereotyping refers to a set idea or generalization about one person or group that is askew and exaggerated. Stereotyping is often controllable, intentional, and conscious.

"Old values; Indians were not humans! Indians were not allowed services like hospitals and healthcare. There were Indian Hospitals, Tuberculosis Hospitals, and Missionary Hospitals where Indians had to go to from the 1900's to 1960's. Our mom got tuberculosis when she was young; the Elders said the TB hospitals were a death sentence! She was sent there, then sent home to die and our medicine people cured her. The historical impacts of a 'Two Tier system' give the discrimination, racism, and biases we face today."

[author] Wendy Phillips

Implications of Unconscious Bias and Stereotyping in Cross-Cultural Interactions

Many studies have revealed that unconscious bias and stereotyping based on race and ethnicity play a major discriminatory role in the way that the healthcare system currently operates as demonstrated throughout this resource. It is therefore essential that healthcare education addresses this problem and prepares its industry workers accordingly.

"The ultimate aim of a curriculum on disparities is that learners develop a professional commitment to eliminating inequities in health care quality and understand and accept their role in eliminating racial and ethnic healthcare disparities".[2]

Ethnicity and race can influence the quality of care and treatments that patients receive within the healthcare system.[3] For example, in examining Indigenous patients' adverse experiences in healthcare settings, patients reported having their medical problems being trivialized or dismissed, being treated poorly (particularly in relation to pain-based discussions), and lower quality care.[4]

Watch the video of Jack Moher, a registered nurse who works in urgent care, discuss one of their experiences as a nursing student (5:15).

T R C C T A: Advice on Addressing Biases

Start of Video Transcript:

[text] Please introduce yourself and your role in the health professions.

[Jack Moher] Yeah. So my name is Jack Moher. I'm a registered nurse who works in urgent care, which is kind of like an emergency setting. So I see a lot of patients in my day to day, just a wide variety of people ranging from different ages and through to different cultural backgrounds. So this project is quite relevant to my setting where I practice healthcare and to kind of my day-to-day experience at work.

[text] What advice would you give healthcare learners about applying the T R C Calls to Action in healthcare settings?

[Jack Moher] I think the most important advice I would give to a learner, speaking as someone who was a learner very recently, you may feel that you don't have the experience or confidence to challenge existing norms or to challenge co-workers who have more seniority, however, I feel that, as a learner, your lack of

experience gives you a fresh perspective on the healthcare environment. If you feel that something is wrong or that someone is being treated unfairly, don't be afraid to speak up. And I'll just briefly mention a story I had from my first clinical placement where I had started on a floor at K G H. I think it was my first or second shift as a nursing student, so I was completely overwhelmed by everything. I was kind of terrified. I was having to wake up very early in the morning to come to the hospital. And I had an Indigenous patient who was flown in from a community up north, who had a lot going on with them, in a health sense, a lot of like different conditions that were being managed.

And they were in a lot of pain due to these kind of conditions. And they would frequently ask for better pain control or pain medications, which at that point, I couldn't, I wasn't allowed to give medications being, you know, first, my first placement. And so when I would talk to the other nurses that I was kind of assigned with, they were really dismissive of this patient and their concerns for their pain control, saying things like, "Oh, they're just kind of -- they're a faker," "They're just kind of like drug-seeking," or whatever. "Oh, they use IV drugs." And that was really tough to kind of face because I felt that I couldn't really say anything, even though I, at the time, disagreed with their approach to managing that patient.

In my opinion and what we've sort of been taught is that pain is a subjective thing and that pain management is really important for recovery from, you know, health, like disease and from surgical procedures. I felt that this patient wasn't being given the quality of care that they deserved to have. And I felt that, partially, that was because of them being Indigenous and there being a very strong language barrier between the healthcare professionals and the patient themselves, so I feel like the patient wasn't able to express their desire for pain control as well as they could have or could have if the healthcare professionals were able to understand the language that this patient spoke. And at the same time, I think there was also a lot of stigma that was present in that situation, partially because I think the patient was Indigenous and, you know, very marginalized, and also had struggles with addiction as well. So it was just kind of a really bad combination of things that I believe led to them not getting the quality of care that they should have had.

But the lesson from that story is that I didn't really speak up and I'm kind of very regretful that I didn't say something to one of the other nurses or to one of the physicians kind of overseeing that patient. But I was just so overwhelmed it being my second shift there that I felt like I couldn't say anything when I was still just trying to figure out how to take blood pressure properly and all of that. So my advice to other learners, if you find yourself in a similar situation, please speak up because your, you know, your voice is important. Regardless of how much time you've spent working in the hospital, you still have a valuable perspective that is worth being heard.

End of Video Transcript.

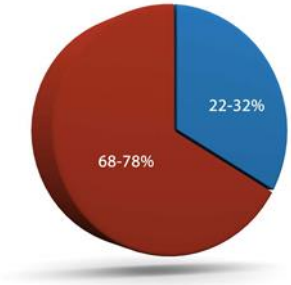
In addition to patients' health outcomes, previous research illustrates the negative influence of biases on healthcare services, including unnecessary tests and visits and longer hospital stays.[5]

Longer and/or unnecessary hospital stays are just one result from biases in healthcare services.

The Reality of Negative Stereotypes

Indeed, after controlling for access-based factors, stereotyping, discrimination, and implicit biases these have been associated with disparities in health services, health outcomes, and patient safety.[4,5,6] In a

survey of 154 healthcare providers, one third agreed with negative stereotypes about Indigenous Peoples. For example, participants perceived Indigenous children to be more challenging and their caregivers less compliant than non-Hispanic white patients. Participants also reported preferences for non-Hispanic white patients to Indigenous patients.[7]



One third of surveyed healthcare providers agreed with negative stereotypes of Indigenous Peoples.[7]

The work of Haider and colleagues demonstrates the significant implications of such conscious and unconscious race and social biases of healthcare providers on patients' outcomes, including nurses[8], medical students[9], residents[8], and surgeons.[10] The research data yielded from these studies, and others alike, demonstrates the insidious prevalence and ubiquity of prejudice towards both ethnicity and race and how it can severely impact the quality of care and treatments that patients receive within the healthcare system.

Assessing the Role of Racism in Access to Healthcare

Due to colonization, racism within the healthcare system impacts Indigenous Peoples in very specific ways. It is essential as healthcare professionals to be able to assess and address the roles that racism plays for Indigenous Peoples as they seek to gain access to healthcare. Evidence indicates that access is neither equal nor equitable among all Canadians, and Indigenous Peoples in Canada tend to have more difficulty accessing healthcare services than non-Indigenous Canadians.[11,12,13]

Health Canada and others have recognized barriers to accessing healthcare for Indigenous Peoples in Canada including:

- Limited availability of services and healthcare providers to on-reserve First Nations [14]
- Limited availability and retention of healthcare providers[15]
- Long wait lists[14,16]
- Limited access to screening and preventative services[12,14]

Other factors, including lower levels of education, are associated with poorer health, particularly among Indigenous peoples in Canada.[11] As the National Collaborating Centre for Aboriginal Health (N C C A H) notes, one underlying pathway is that **lower education attainment** may result in a **lack of**

awareness regarding **early detection and preventative care**, which is a barrier to accessing healthcare.[12]

The Influence of Unequal Power Dynamics and Imbalances

Horrill and colleagues point out that previous negative experiences with healthcare services and/or healthcare providers is another clearly identified barrier to the access of healthcare by Indigenous Peoples in Canada.[17] Access to healthcare is delayed and trust between healthcare providers and patients is lacking, because of:

- Racism (overt and tacit),
- Discrimination,
- Intimidation,
- Harassment, and
- The fear of being judged based on race or social class.[18,19, 20,21]

Other difficulties in accessing healthcare come from the direct and intergenerational historical trauma of colonization and residential schools on Indigenous Peoples in Canada; the resultant power differentials cause more distrust in the healthcare provided by the provincial and federal governments.[17, 22, 23]

Power differentials cause more distrust in the healthcare provided by the provincial and federal governments.[24]

How Systemic Racism Affects Population and Patient Health

The effects of systemic racism are pervasive within Indigenous communities in Canada. Working to undo them is essential for the well-being of Indigenous Peoples. In order to address these effects, it is important to examine and understand examples of how racism operates at both the interpersonal and systemic levels and creates health inequities.[25] The pathways driving racism and its negative effects are complex, intertwined, and deeply embedded in diverse systems. This includes economic, political, and psychosocial pathways.[26]

Explore some examples of interpersonal or systemic racism and its impacts on Indigenous Peoples.

Colonial Policies

Indigenous culture and language, familial relations, and mental wellbeing have been intergenerationally affected by compulsory residential schools, the involuntary disorganization of communities, prejudiced legislation regarding child welfare, and the banning of Indigenous ceremonies and gatherings.[27] Furthermore, the details concerning the ongoing and historical effects of colonial policies as well as the C T As can be accessed through the summary report of the T R C documents.[28]

Limited Healthy Food Choices

Connection and access to Indigenous food and economies has been interrupted by the colonial efforts to disconnect Indigenous Peoples from their lands. Indigenous Peoples living remotely, urbanly, and rurally frequently do not have necessary access to healthy and cost-effective foods.[29, 30]

Inadequate Living Conditions

Housing and living conditions are often substandard for Indigenous Peoples who live in both rural and urban communities as well as remote communities. For example, the city of Hamilton has a rate of overcrowded housing that is 24 times larger for First Nations people than that of the general Canadian population.[30] Furthermore, the peoples of Inuit Nunangat have higher rates of tuberculosis infection than the general Canadian population because low-quality housing stock results in overcrowding and bad respiratory health.[31]

Substandard Healthcare

Prevalent rates of racism within healthcare environments have been reported from 39 percent to as high as 78 percent for Indigneous Peoples in multiple survey studies. These reports of racism have even meant unequal and inadequate treatment for Indigenous patients.[30, 32, 33, 34, 35] Many studies have revealed that Indigenous patients have high levels of perceived interpersonal racism towards them, from healthcare providers in a multiplicity of healthcare environments. This is so common that one Canadian study has shown that Indigenous patients strategized and pre-planned to deal with racism before pursuing health support at the emergency room.[36]

Case Studies Highlighting the Impact of Racism, Bias, and Stereotyping in Healthcare

Systemic and interpersonal racism clearly have real life material effects on Indigenous Peoples trying to seek support within the healthcare system. The tragic stories of Joyce Echaquan and Brian Sinclair are representative of the terrible multifaceted racism that many Indigenous patients continue to experience.

Joyce Echaquan was an Indigenous woman who died in the hospital after being taunted by nurses.

Joyce Echaquan is an example of the terrible multifaceted racism that many Indigenous patients continue to experience.[36]

Watch the news report on the case of Joyce Echaquan (2:17). As you watch, reflect on how Indigenous patients routinely pre-plan to deal with racism before pursuing health support at hospitals.

Dying Indigenous woman records slurs uttered by Quebec hospital staff

Start of Video Transcript:

The calls for answers are growing louder and the anger is building over how an Indigenous woman was treated in a Quebec hospital. Joyce Echaquan recorded video of her last moments alive as staff made racist and callous comments about her. She lay strapped to a bed and was pleading with them to help her. They appeared indifferent and she died a short time later. Echaquan, a 37-year-old Indigenous, woman was the mother of seven children ranging in age from seven months to 21 years. Indigenous leaders say her video

exposes the realities of systemic racism as Felicia Parillo reports, three investigations are underway into her death, and a warning some viewers may find the video disturbing.

37-year-old Joyce Echaquan leaves behind her children, a husband, family, friends, and an entire community on Monday. During the last moments of her life Echaquan recorded herself pleading for help as nurses mocked her and called her names. Family members say Echaquan was speaking in Atikumit her mother tongue saying she was being given too much medication and that's exactly what family members believe led to her death.

We don't need much investigation said a cousin. We know the fact, we saw the recordings, we saw her condition. Family and friends say this wasn't an isolated incident according to them Echaquan had been treated at the Jaliette hospital before and had experienced racism during past visits, it was like a couple of times that she had experienced and she say herself you know weeks before one day they're going to kill me. On tuesday Quebec's premier Francoise announced that a nurse involved in the incident had been fired and that investigations were underway but the family doesn't think that's good enough the firing of one nurse doesn't fix anything there wasn't just one nurse in the video there were three he says Cindy Blackstock executive director of the First Nations child and family caring society believes the blame goes beyond just the hospital staff involved. So often we look at individual actions and that's where we focus our attention on racial discrimination and that's an important place but often it's reinforced at the systemic level and even by governments themselves. The premier denies systemic racism played a role in Echaquan's death but Quebec's first aboriginal surgeon says that is simply untrue. Systemic racism is present here as it is across the country that's happening throughout Canada in Toronto, Winnipeg, Vancouver, Montreal, Halifax so we have to act as a country as a province to go against systemic racism. The regional health authority denied our request for an interview but in a statement said there are three levels of investigations underway they added that internal meetings are taking place to determine if there will be more disciplinary actions against any other staff who were involved, Felicia Perillo Global News Jaliette Quebec.

End of Video Transcript.

Brian Sinclair was an Indigenous man who died in a Winnipeg hospital due to neglect.

Watch the news report on the case of Brian Sinclair (2:26).

Sinclair inquest testimony

Start of Video Transcript:

[Dawna Friesen] He died after waiting thirty four hours for treatment in a Winnipeg emergency room and today disturbing testimony was heard at the inquest into the death of Brian Sinclair. He was an Aboriginal man, he was also a double amputee, and as Crystal Goomansingh reports, many are questioning whether racism played a role in his death.

[Crystal Goomansingh] Security video shows Brian Sinclair at the triage desk with hospital staff. He goes to the waiting area. There, he stays. An entire day passes, and the double leg amputee stops moving. It's now Saturday, and Alain Remillard is working security. A stranger tells him a man in a wheelchair has been sick. Remillard's memory of that shift back in 2008 is fuzzy. He called housekeeping, and video shows that. He also

didn't have any interaction with the man in the wheelchair. While testifying at the inquest into Sinclair's death, Remillard said he assumed Sinclair was intoxicated and sleeping it off. The inquest started earlier this month, and many say this is an example of widespread racism.

[Leslie Spillett, Ka Ni Kanichihk Executive Director] We assume that that kind of acts of name-calling and those sorts of things constitute racism, but really it's the those underlying assumptions.

[Crystal Goomansingh] The inquest has heard from a number of security guards working in the emergency department at the Health Sciences Centre, including the one security official who discovered Sinclair wasn't sleeping, but was in fact dead. He told the inquest when he alerted medical staff, they thought he was joking.

Gary Francis testified Wednesday he tried to shake Sinclair awake. The security supervisor pinched him, finally tilted his head up, and saw his eyes were black and face very white. That was 34 hours after Sinclair entered the E R needing treatment for a bladder infection. It's believed he may have sat there dead for up to 7 hours.

[Vilko Zbogar, Sinclair Family Lawyer] It seems that oftentimes a culture of dismissiveness has prevailed over a culture of empathy and compassion.

[Crystal Goomansingh] Changes have been made at the emergency department and more could be recommended. The Sinclair's family lawyer anticipates more disturbing testimony to come when the inquest resumes in October. Crystal Goomansingh, Global News, Winnipeg.

End of Video Transcript.

What Can We Do About It?

Inequalities between Indigenous and non-Indigenous peoples in Canada clearly persist. Despite the growth of Indigenous populations in urban settings, information on their health is scarce. The objective of a 2020 study in the Canadian Journal of Public Health was to assess the association between the experience of discrimination by healthcare providers and having unmet health needs within the Indigenous population of Toronto. Studies like these are an essential step in the process of making the healthcare system a safer place for Indigenous Peoples.

For your interest, access the study.

Unmet health needs and discrimination by healthcare providers among an Indigenous population in Toronto, Canada

As the case studies you have learned so far have concretely established, the lives and well-being of many Indigenous Peoples are gravely impacted by modern manifestations of systemic and interpersonal racism within the healthcare system. It is therefore imperative that all healthcare workers operating within the healthcare system take it upon themselves to constantly engage with anti-Indigenous racism and ways to decolonize their own practices.

As the case studies you have learned so far have concretely established, the lives and well-being of many Indigenous Peoples are gravely impacted by modern manifestations of systemic and interpersonal racism within the healthcare system. It is therefore imperative that all healthcare workers

operating within the healthcare system take it upon themselves to constantly engage with anti-Indigenous racism and ways to decolonize their own practices.

Whether it is through clinical practice, community work, education and professional development, or collaboration and advocacy, you can help make the healthcare system a safer place for Indigenous Peoples.

You can work to make the healthcare system a more inclusive and safe place in many different ways and at various levels, including:

- In clinical practice
- In your local community
- In education and faculty/professional development
- In advocacy and collaboration with Indigenous organizations

Next, you will review some practical strategies at each of these levels.

- **Clinical Practice**

Within the realm of clinical practice you can work to decolonize your work and the healthcare system as a whole in multiple ways.

A. Culturally Safe Care

One way in which healthcare professionals can build trust and form lasting relationships with Indigenous patients is to commit to providing **culturally safe care**. This emphasizes explicit attention and action to address power relations between the service user and service provider. Implementing culturally safe care requires that the:

- Patient's way of knowing and being is respected as valid.
- Patient is a partner in the healthcare decision-making process.
- Patient determines whether or not the care received is culturally safe.[41]

B. Self-Reflexivity

Evidence has demonstrated that self-reflexivity regarding one's own biases and stereotypes is a core skill that can be learned and facilitates the development of culturally secure relationships.[38] One approach is to begin to critically recognize and challenge stereotyping in day-to-day life (e.g., the media).

Apply your Knowledge: Self-Reflexivity Exercise

View the questions and take a few moments to reflect and practice your own self-reflexivity.

Question 1: What is your perception of Indigenous Peoples where you currently live/work?

Question 2: Where did you get the information that has influenced this perception?

Question 3: Can you identify any potential biases or stereotypes in the source of the information that has prompted your perception of Indigenous Peoples where you live/work?

Question 4: How can you, as a healthcare provider and a leader in your professional environment, change the outlook on Indigenous Peoples?

Question 5: How have your own actions played a role in perpetuating negative stereotypes about Indigenous Peoples and their health?

Developing the capacity to engage in culturally safe care is a lifelong learning endeavour that requires critical self-reflexivity and positive behavioural changes. It can take years to fully develop the ability to engage in culturally secure interactions with Indigenous patients.[39]

Watch the video of Dr. Jason Pennington, member of the H W Nation and community general surgeon at the Scarborough Health Network, discuss culturally safe care and self-reflexivity (4:03).

T R C C T A: Culturally Safe Care and Self-Reflection

Start of Video Transcript:

[text] Please introduce yourself and your role in the health professions.

[Dr. Jason Pennington] Hello. I am Dr. Jason Pennington, and I am a member of the Huron-Wendat Nation. I practice General Surgery at a community hospital in Scarborough and I am the regional Indigenous Cancer Lead for the Central East Regional Cancer Program. I have helped the University of Toronto and Queen's University in developing cultural safety and curriculum around Indigenous health issues and concepts.

[text] Please describe an experience you've had applying the T R C Calls to Action in a healthcare setting. How have they informed your practice?

[Dr. Jason Pennington] I think that the Calls to Action, and especially one around becoming a culturally safe practitioner, has been the most important in my day-to-day practice. Having -- implemented more self-reflection into my practice and time to look at things from the perspectives of the people I am treating has really helped. I know that for caring for some of my Indigenous patients with P T S D and intergenerational trauma, it has definitely helped me to become a better practitioner and to help those around me to provide more culturally appropriate care to these patients. But also practising in Scarborough with such a multicultural population, it has helped me to provide care to people from various cultures. But, of course, all of this is always a journey. And we're always self-reflecting and gaining more insight, and learning on this journey of becoming, of practising in a culturally safe way for all of our patients. But definitely, it has allowed me to provide better care for my patients, their families, and their communities.

[text] As a healthcare learner who is new to the process of self-reflection, what advice would you give them as a starting point?

[Dr. Jason Pennington] When one wants to start on the path towards becoming a culturally safe practitioner, it's all not about learning about all of the cultures and religions in the world, it's learning about ourselves and these unintended and sometimes -- learnt, learnt biases that we have gained over time because growing in our society, about different genders, about different cultures, about different religions. And also the fact that all of these different genders and religions all have different views among themselves in and in themselves are very diverse. And just to recognize what those different things bring about and your own opinions that have been formed by yourself and pre-formed by the media and society that we have grown up in. So really, the whole beginning of providing better care to others is to better understand oneself and to gain insight into one's own biases. And we all have them. Whether or not, we come from a marginalized background or not. We have all grown up in a society with systemic stereotypes and biases, and have been impacted by them, whether we recognize it or not. So it's very important for all of us to recognize what different clinical situations and patient characteristics bring out in our own subconscious and sometimes conscious way we act in caring for them and their families.

End of Video Transcript.

Cultural training courses, such as the one offered online by the Provincial Health Services Authority of British Columbia, can provide a good starting point for the ongoing enhancement of your clinical skills in this area.

For your interest, access the Provincial Health Services Authority of British Columbia.

Provincial Health Services Authority of British Columbia

- **Your Local Community**

Healthcare professionals can reach out to and build lasting partnerships with local Indigenous organizations which are found not only in rural and remote predominantly Indigenous communities but also in almost every major city in the country. Healthcare professionals can reflect on the role of their professional and institutional power in contributing to culturally safe care or rectifying unsafe care within their communities. Identifying the needs of your community may also affect the composition of your primary care team.

Depending on the characteristics of the population your practice serves, the inclusion of social workers, dietitians, and other health professionals may result in an improved ability to meet the needs of the community.

The South East Health Line page is a great resource that offers a list of community-led health programs and services for First Nations, Inuit, or Métis communities in Ontario.

For your interest, access the South East Health Line page.

South East Health Line

- **Education and Faculty/Professional Development**

Healthcare professionals and educators can work to introduce **trauma-informed care** that acknowledges and teaches about the Indigenous-specific effects of colonial policies and how they are linked to historic and current medical services for Indigenous Peoples. Healthcare curricula and faculty development programs that cover anti-racism and anti-oppression, health inequities and the determinants of health, and the impacts of residential schools in a clinical setting are a necessity.

- **Advocacy and Collaboration with Indigenous Organizations**

If you are interested in advocating for improved health equity for Indigenous Peoples, you can lend your voice to one of the many Indigenous-led organizations that advocate both with and on behalf of affected communities. Groups such as the Indigenous Physicians Association of Canada, the Assembly of First Nations, the Métis National Council, and the Inuit Tapiriit Kanatami could greatly benefit from applying your expertise and voice to their continued work. As healthcare professionals, you can also advocate for increased attention and funding for Indigenous health research. Healthcare professionals can also work with regional tribal councils and treaty areas to ensure that the interests of Indigenous communities and patients are respected and ensured.

For your interest, access the links for the Indigenous Physicians Association of Canada, Assembly of First Nations, Métis National Council, and Inuit Tapiriit Kanatami.

Indigenous Physicians Association of Canada

Assembly of First Nations

Métis National Council

Inuit Tapiriit Kanatami

As demonstrated, there are many different ways and areas that you as a healthcare professional can engage with in efforts to make the healthcare system safer for Indigenous Peoples. Be sure to engage with decolonial and anti-racist practices at these different levels and ensure to stay up to date on the actions that our government and Indigenous leaders are making to help address these major issues.

"The Government of Canada is acting to address racism. Together with Indigenous partners and health professionals, governing bodies and provinces and territories, the government will act to: address racism and systemic discrimination, help enhance access to culturally safe services across Canada, [and] ensure Indigenous peoples have access to equitable and compassionate care."

Government of Canada[40]

Page Links:

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https://doi.org/10.17269/s41997-019-00242-z

https://cdn.embedly.com/widgets/media.html?src=https%3A%2F%2Fplayer.vimeo.com%2Fvideo%2F666826389%3Fh%3Ddc39797ea2%26app_id%3D122963&dntp=1&display_name=Vimeo&url=https%3A%2F%2Fplayer.vimeo.com%2Fvideo%2F666826389%3Fh%3Ddc39797ea2&image=https%3A%2F%2Fi.vimeocdn.com%2Fvideo%2F1350264065-1b6be1b7fca1cbc180a03eca0a3535b142c167cd6128b178e7682602a25d0aed-d_1280&key=40cb30655a7f4a46adaaf18efb05db21&type=text%2Fhtml&schema=vimeo

https://www2.gov.bc.ca/gov/content/health/about-bc-s-health-care-system/partners/health-authorities/provincial-health-services-authority

https://www.southeasthealthline.ca/listservices.aspx?id=10071

https://www.ipac-amac.ca/

https://www.afn.ca/Home/

https://www2.metisnation.ca/

http://www.itk.ca/

End of Biases, Racism, and Discrimination in Healthcare

MODULE CONCLUSION

Throughout this section on bias, racism, and discrimination you have explored the many ways that different manifestations of these harmful deterrents impact the lives, well-being, and overall health of Indigenous Peoples navigating the healthcare system. Furthermore, you have been presented with some effective tools, understandings, and practical strategies to help Indigenize and decolonize your own practices, ultimately making the healthcare system safer for Indigenous Peoples.

You have completed one of the seven learning modules within the series "Indigenous Healthcare Education and Practice: A Community-Led and Community-Informed Collaborative Initiative." The modules within this series aim to increase your awareness and knowledge of Indigenous healthcare education and practice. These modules explore how Indigenous Peoples' health outcomes have been negatively impacted by colonial policies and practices, and how the health and wellness of Indigenous Peoples can be improved through the inclusion of traditional healing practices and by addressing biases, racism, and discrimination within the healthcare system.

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References:

- Truth and Reconciliation Commission of Canada. (2015). *Truth and Reconciliation Commission of Canada: Calls to Action.* Retrieved from, https://www2.gov.bc.ca/assets/gov/british-columbians-our-governments/indigenous-people/aboriginal-peoples-documents/calls_to_action_english2.pdf
- Smith, W., Betancourt, J.R., Wynia, M.K., Bussey-Jones, J., Stone, V.E., Phillips, C.O., Fernandez, A., Jacobs, E., & Bowles, J. (2007). Recommendations for teaching about racial and ethnic disparities in health and health care. *Ann Intern Med, 147*(9), 654-665.
- Lewis, N. M., Friedrichs, M., Wagstaff, S., Sage, K., LaCross, N., Bui, D., McCaffrey, K., Barbeau, B., George, A., Rose, C., Willardson, S., Carter, A., Smoot, C., Nakashima, A., & Dunn, A. (2020). Disparities in COVID-19 Incidence, Hospitalizations, and Testing, by Area-Level Deprivation - Utah, March 3-July 9, 2020. *MMWR. Morbidity and mortality weekly report, 69*(38), 1369–1373. https://doi.org/10.15585/mmwr.mm6938a4
- Goodman, A., Fleming, K., Markwick, N., Morrison, T., Lagimodiere, L., & Kerr, T. (2017). "They treated me like crap and I know it was because I was Native": The healthcare experiences of Aboriginal peoples living in Vancouver's inner city. *Social Science & Medicine, 178,* 87–94. https://doi.org/10.1016/j.socscimed.2017.01.053
- Smedley, B. D., Stith, A. Y., & Nelson, A. R. (2003). *Unequal treatment: Confronting racial and ethnic disparities in health care.* National Academy Press.
- Walker R, St. Pierre-Hansen N, Cromarty H, Kelly L, Minty B. (2010). Measuring cross-cultural patient safety: identifying barriers and developing performance indicators. *Healthc Q, 13*(1), 64-71. DOI:10.12927/hcq.2013.21617
- Puumala SE, Burgess KM, Kharbanda AB, Zook HG, Castille DM, Pickner WJ, et al. (2016). The role of bias by emergency department providers in care for American Indian children. *Med Care, 54*(6), 562–9. https://doi.org/10.1097/MLR.0000000000000533
- Haider, A. H., Schneider, E. B., Sriram, N., Scott, V. K., Swoboda, S. M., Zogg, C. K., Dhiman, N., Haut, E. R., Efron, D. T., Pronovost, P. J., Freischlag, J. A., Lipsett, P. A., Cornwell, E. E., MacKenzie, E. J., & Cooper, L. A. (2015). Unconscious Race and Class Biases among Registered Nurses: Vignette-Based Study Using Implicit Association Testing. *Journal of the American College of Surgeons, 220*(6), 1077-1086.e3. https://doi.org/10.1016/j.jamcollsurg.2015.01.065
- Haider, A. H., Sexton, J., Sriram, N., Cooper, L. A., Efron, D. T., Swoboda, S., Villegas, C. V., Haut, E. R., Bonds, M., Pronovost, P. J., Lipsett, P. A., Freischlag, J. A., & Cornwell, E. E. (2011). Association of Unconscious Race and Social Class Bias With Vignette-Based Clinical Assessments by Medical Students. *JAMA, 306*(9), 942–951. https://doi.org/10.1001/jama.2011.1248
- Haider, A. H., Schneider, E. B., Sriram, N., Dossick, D. S., Scott, V. K., Swoboda, S. M., Losonczy, L., Haut, E. R., Efron, D. T., Pronovost, P. J., Freischlag, J. A., Lipsett, P. A., Cornwell, E. E., 3rd, MacKenzie, E. J., & Cooper, L. A. (2014). Unconscious race and class bias: its association with

decision making by trauma and acute care surgeons. *The journal of trauma and acute care surgery, 77*(3), 409–416. https://doi.org/10.1097/TA.0000000000000392

- Canadian Institute for Health Information (CIHI). (2004). *Improving the health of Canadians.* Retrieved from http://www.cihi.ca
- National Collaborating Centre for Aboriginal Health (NCCAH). (2011). Access to health services as a social determinant of First Nations, Inuit and Metis health. Retrieved from http://www.nccah-ccnsa.ca
- Peiris, D., Brown, A., & Cass, A. (2008). Addressing inequities in access to quality healthcare for indigenous people. *Canadian Medical Association Journal, 179*(10), 985–986. https://doi.org/10.1503/cmaj.081445
- Public Health Agency of Canada. (2008). *The Chief Public Health Officer's report on the state of public health in Canada*. Ottawa: Chief Public Health Officer.Retrieved from http://www.phac-aspc.gc.ca
- Lavoie, J. G., Kaufert, J., Browne, A. J., & O'Neil, J. D. (2016). Managing Matajoosh: Determinants of first Nations' cancer care decisions. *BMC Health Services Research, 16*(1), 402. https://doi.org/10.1186/s12913-016-1665-2
- Health Council of Canada. (2013). *Progress Report 2013: Health care renewal in Canada.* Toronto, ON: Health Council of Canada. Retrieved from https://publications.gc.ca/site/eng/9.507029/publication.html
- Horrill, T., McMillan, D. E., Schultz, A., & Thompson, G. (2018). Understanding access to healthcare among Indigenous peoples: A comparative analysis of biomedical and postcolonial perspectives. *Nursing inquiry, 25*(3), e12237. https://doi.org/10.1111/nin.12237
- Browne, A. J., Smye, V. L., Rodney, P., Tang, S. Y., Mussell, B., & O'Neil, J. (2011). Access to Primary Care From the Perspective of Aboriginal Patients at an Urban Emergency Department. *Qualitative Health Research, 21*(3), 333–348. https://doi.org/10.1177/1049732310385824
- Cameron, B. L., Carmargo Plazas, M., Salas, A. S., Bourque Bearskin, R. L., & Hungler, K. (2014). Understanding inequalities in access to health care services for aboriginal people: a call for nursing action. *ANS. Advances in nursing science, 37*(3), E1–E16. https://doi.org/10.1097/ANS.0000000000000039
- Denison, J., Varcoe, C., & Browne, A. J. (2014). Aboriginal women's experiences of accessing health care when state apprehension of children is being threatened. *Journal of advanced nursing, 70*(5), 1105–1116. https://doi.org/10.1111/jan.12271
- McGibbon, E., Etowa, J., & McPherson, C. (2008). Health-care access as a social determinant of health. *The Canadian nurse, 104*(7), 22–27
- MacDonald, C. D. (2013). Exploring Mi'kmaq women's experiences of pap smear screening in Nova Scotia. Unpublished doctoral dissertation, Dalhousie University, Halifax, NS.

- Wakewich, P., Wood, B., Davey, C., Laframboise, A., & Zehbe, I. (2016). Colonial legacy and the experience of First Nations women in cervical cancer screening: a Canadian multi-community study. *Critical public health, 26*(4), 368–380. https://doi.org/10.1080/09581596.2015.1067671
- Rammohan, I. (2019). Why do Indigenous people in Canada face worse health outcomes than non-Indigenous people? *The Varsity.* Retrieved December, 2021 from: https://thevarsity.ca/2019/09/15/why-do-canadas-indigenous-people-face-worse-health-outcomes-than-non-indigenous-people/
- Leyland et al. (2016). *Health and Health Care implications on Indigenous people of Canada.* Retrieved from https://www.cfpc.ca/CFPC/media/Resources/Rural-Practice/SystemicRacism_ENG.pdf
- Smedley BD, Stith AY, Nelson AR. Racial and ethnic disparities in diagnosis and treatment: a review of the evidence and a consideration of causes. *Unequal treatment: Confronting racial and ethnic disparities in health care*. 2003. Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK220337/
- Bombay A, Matheson K, Anisman H. (2014). The intergenerational effects of Indian Residential Schools: Implications for the concept of historical trauma. *Transcult Psychiatry, 51*(3), 320-338.
- Truth and Reconciliation Commission of Canada. Honouring the Truth, Reconciling for the Future: Summary of the Final Report of the Truth and Reconciliation Commission of Canada. 2015. Retrieved from www.trc.ca/websites/trcinstitution/File/2015/Exec_Summary_2015_06_25_web_o.pdf
- Reading, C., & Wien, F. (2013). Health inequalities and social determinants of Aboriginal Peoples' Health. *National Collaborative Centre for Aboriginal Health.* Retrieved from, https://www.nccih.ca/495/Health_inequalities_and_the_social_determinants_of_Aboriginal_peoples__health_.nccah?id=46
- Smylie J, Firestone F, Cochran L, et al. (2011). *Our Health Counts: Urban Aboriginal Health Database Research Project. Community Report: First Nations Adults and Children.*
- Kulmann, K., & Richmond, C. (2011). Addressing the persistence of Tuberculosis Among the Canadian Inuit Population: The need for a social determinants of health framework. I*nternational Indigenous Policy Journal, 2.* https://doi.org/10.18584/iipj.2011.2.1.1
- McCaskill D, Fitzmaurice K. (2007). Urban Aboriginal Task Force, Final Report. *Ontario Federation of Indian Friendship Centres, Ontario Metis and Aboriginal Association, and Ontario Native Women's Association.* Retrieved from https://ofifc.org/wp-content/uploads/2020/03/2007-Urban-Aboriginal-Task-Force-UATF-Final-Report.pdf
- Assembly of First Nations. (2007). *First Nations Regional Longitudinal Health Survey (RHS) 2002/03: Results for adults, youth and children living in First Nations communities.*
- McCaskill D, FitzMaurice K, Cidro J. (2011). *Toronto Aboriginal Research Project, Final Report*. Toronto Aboriginal Support Services Council.

- EKOS Research Associates, Inc. (2006). *Survey of First Nations People Living Off-Reserve, Métis and Inuit –Final Report.* Ottawa, ON; submitted to Indian and Northern Affairs Canada.
- Page, Julia. (2021). *Hospital orderly, caught on video mocking Joyce Echaquan before she died, tells inquest she meant no harm. CBC News.* Retrieved from https://www.cbc.ca/news/canada/montreal/joyce-echaquan-coroner-inquest-may-19-1.6032387
- *"Never give up": Cousin of Brian Sinclair urges Echaquan family to fight for justice—APTN News.* (n.d.). Retrieved January 7, 2022, from https://www.aptnnews.ca/national-news/never-give-up-cousin-of-brian-sinclair-urges-echaquan-family-to-fight-for-justice/
- Devine, P. G., Forscher, P. S., Austin, A. J., & Cox, W. T. (2012). Long-term reduction in implicit race bias: A prejudice habit-breaking intervention. *Journal of experimental social psychology*, 48(6), 1267–1278. https://doi.org/10.1016/j.jesp.2012.06.003
- Walker, R., St Pierre-Hansen, N., Cromarty, H., Kelly, L., & Minty, B. (2010). Measuring cross-cultural patient safety: identifying barriers and developing performance indicators. *Healthcare quarterly (Toronto, Ont.), 13*(1), 64–71. https://doi.org/10.12927/hcq.2013.21617
- Canada, G. of C. I. S. (2021, January 28). G*overnment of Canada actions to address anti-Indigenous racism in health systems.* Retrieved from https://www.sac-isc.gc.ca/eng/1611863352025/1611863375715
- DeSouza, R. (2008). Wellness for all: the possibilities of cultural safety and cultural competence in New Zealand. *Journal of Research in Nursing, 13*(2):125-135. doi:10.1177/1744987108088637

End of Module Conclusion