

In Plain Sight: Elaboration on the review

Authors discuss the review on Indigenous-specific racism and discrimination in BC health care.

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This article has been peer reviewed.

In June 2020, the BC Minister of Health commissioned an independent review to examine systemic Indigenous-specific racism in the provincial health care system after allegations were made of a guessing game in BC emergency departments in relation to the blood alcohol levels of Indigenous patients. The review examined this allegation and the health system more comprehensively in relation to the experience of Indigenous patients at the point of care, and Indigenous health workers within care delivery settings in BC. The resulting reports are available online:

- Summary report (<https://engage.gov.bc.ca/app/uploads/sites/613/2020/11/In-Plain-Sight-Summary-Report.pdf>)
- Full report (<https://engage.gov.bc.ca/app/uploads/sites/613/2020/11/In-Plain-Sight-Full-Report.pdf>)
- Data report (https://engage.gov.bc.ca/app/uploads/sites/121/2020/11/In-Plain-Sight-Data-Report_Dec2020.pdf1_.pdf)

The review was met with full cooperation by all organizations and entities in the health system, including delegated authority from the Minister of Health, enabling access to all required data, comprehensive submissions from Indigenous peoples and health care organizations and practitioners, and timely and frank key informant interviews. This cooperation, in part, reflects a unique environment in BC resulting from decades of work by Indigenous peoples

to compel recognition of their human rights. While serious reconciliation work remains to be done, there has been some promising progress in recent years. This includes the adoption in November 2019 of the Declaration on the Rights of Indigenous Peoples Act (Declaration Act), legislation that requires the implementation of the United Nations Declaration on the Rights of Indigenous Peoples in BC. As well, specific to the health care sector, there has been adoption of declarations of commitment to advance cultural safety and humility by the leaders of all major health organizations, and the establishment of a First Nation health governance structure to advance inclusion of First Nations people in health care design and decision making.*

Despite this unique context in which some efforts toward transformative change in relations with Indigenous peoples have been welcomed, the review clearly confirmed that the problem of Indigenous-specific racism persists, and is in fact pervasive across all regions and health care settings. But the review sought to do more than demonstrate that the problem exists. It sought to undertake a comprehensive approach that would allow for full critical analysis of what needs to be done. Over a 6-month period, a small team administered surveys among Indigenous peoples and BC health care professionals (Indigenous Peoples' Survey [IPS] and Health Workers'

* See the following tripartite evaluation report for a comprehensive overview of the unique efforts in BC. These efforts have included previous major studies on the health and wellness of Indigenous peoples issued by the BC Provincial Health Officer since 2001. Former Provincial Health Officer Dr Perry Kendall was instrumental in these efforts and also provided advice and leadership to this review. First Nations Health Authority, Province of British Columbia, Indigenous Services Canada. Evaluation of the British Columbia tripartite framework agreement on First Nation health governance. 2019. Accessed 27 December 2020. www.fnha.ca/Documents/Evaluation-of-the-BC-Tripartite-Framework-Agreement-on-First-Nations-Health-Governance.pdf

Survey [HWS]), received submissions from Indigenous peoples and the general public about incidents of Indigenous-specific racism, conducted key informant interviews, and undertook extensive qualitative and quantitative analysis of data regarding health system performance for Indigenous peoples and their health outcomes. Taken together, almost 9000 individuals directly shared their perspectives with the review, and approximately 185 000 Indigenous individuals were reflected in the analysis of health sector data.

As the data and information were compiled, a systematic effort was made to assess and analyze the long-standing, pervasive reality of Indigenous-specific racism, including exploring origins and causes, assessing how racism continues to be transmitted and/or held in place, and understanding the impact of racism on Indigenous peoples' access to care and health and well-being. Approaching the problem in a systematic way, using a methodology of engagement, case review, and assessment of data, permitted the reviewers to craft recommendations arising from the sources with a more definitive goal to disrupt the cycle of racism that continues to limit health care access and services for Indigenous peoples in BC.

Core concepts

A key observation of the review was that, despite strong leadership acknowledgment of Indigenous-specific racism and cultural safety and humility, a shared understanding of critical terms and concepts across the health system is lacking. This lack of shared understanding is a major impediment to change at individual and systemic levels; without it, efforts to address racism commonly elicit reactions marked by discomfort, resistance, and fear. Terms such as *diversity*, *inclusion*, and *cultural safety and humility* are repeated as mantras with very limited understanding—and therefore application—of what they mean in a practice setting. Essentially, the review found that the growing focus on professionalism and/or grouping together of human resource concerns such as bullying, harassment, and workplace culture and discrimination into broad-based strategies cast a net too wide and, therefore, insufficiently address racism against Indigenous peoples.

The clear and standardized articulation of core concepts and standardized language describing the problem, desired outcomes, and the conditions and interventions required to achieve the necessary change are among the first critical steps in facilitating effective dialogue and action on the pressing and difficult problem of

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Indigenous-specific racism. The review developed and implemented the following understandings in its work, as part of an effort to build shared understanding throughout the health care sector (see the In Plain Sight full report for a more comprehensive set of key terms, p. 8).

The problem

- Racism is the belief that a group of people are inferior based on the color of their skin or their culture. It leads to both a) prejudice—a negative way of thinking and attitude toward a socially defined group and toward any person perceived to be a member of the group, and b) profiling—a preset negative idea of a group in society applied to individuals who are members of that group.
- Racism, prejudice, and profiling lead to discriminatory behaviors and policies that oppress, ignore, or treat racialized groups as less than nonracialized groups.
- Indigenous-specific racism refers to the unique nature of stereotyping, bias, and prejudice about Indigenous peoples in Canada that is rooted in the history of settler colonialism. Stereotyping and profiling of Indigenous peoples springs from the historic beliefs cultivated about Indigenous peoples' genetic, cultural, and intellectual inferiority that enabled settlers and their governments to expropriate Indigenous lands and resources.

- Systemic racism is enacted through routine and societal systems, structures, and institutions such as requirements, policies, legislation, and practices that perpetuate and maintain avoidable and unfair inequalities across racial groups.

Solutions: mindsets and tools

- Antiracism is the practice of actively identifying, challenging, preventing, eliminating, and changing the values, structures, policies, programs, practices, and behaviors that perpetuate racism. It is more than just being “not racist” but involves taking action to create conditions of greater inclusion, equality, and justice. As related to anti-Indigenous racism, the tools must be grounded in clearer understanding of the main areas of prejudice impairing health services and communication at the clinical level and active measures to address these.
- Cultural humility is a lifelong process of self-reflection and self-critique. Cultural humility begins with an in-depth examination of the provider's assumptions, beliefs, and privilege embedded in their own understanding and practice. It requires curiosity and a commitment to lifelong learning about oneself, as well as the equally legitimate worldviews and practices of those of other cultures.

Desired outcomes

- A culturally safe environment is a physically, socially, emotionally, and spiritually safe environment, as defined by the patient, without challenge, ignorance, or denial of their identity. A culturally safe environment upholds the unique human rights of Indigenous peoples—including the right to access care free of racism and discrimination, the right to one's language and identity, and the right to traditional medicine and cultural practice.
- Substantive equality refers to the requirement to achieve equality in opportunities and outcomes, and is advanced through equitable access, equal opportunity, and the provision of services and benefits in a manner and according to standards that meet any unique needs and circumstances,

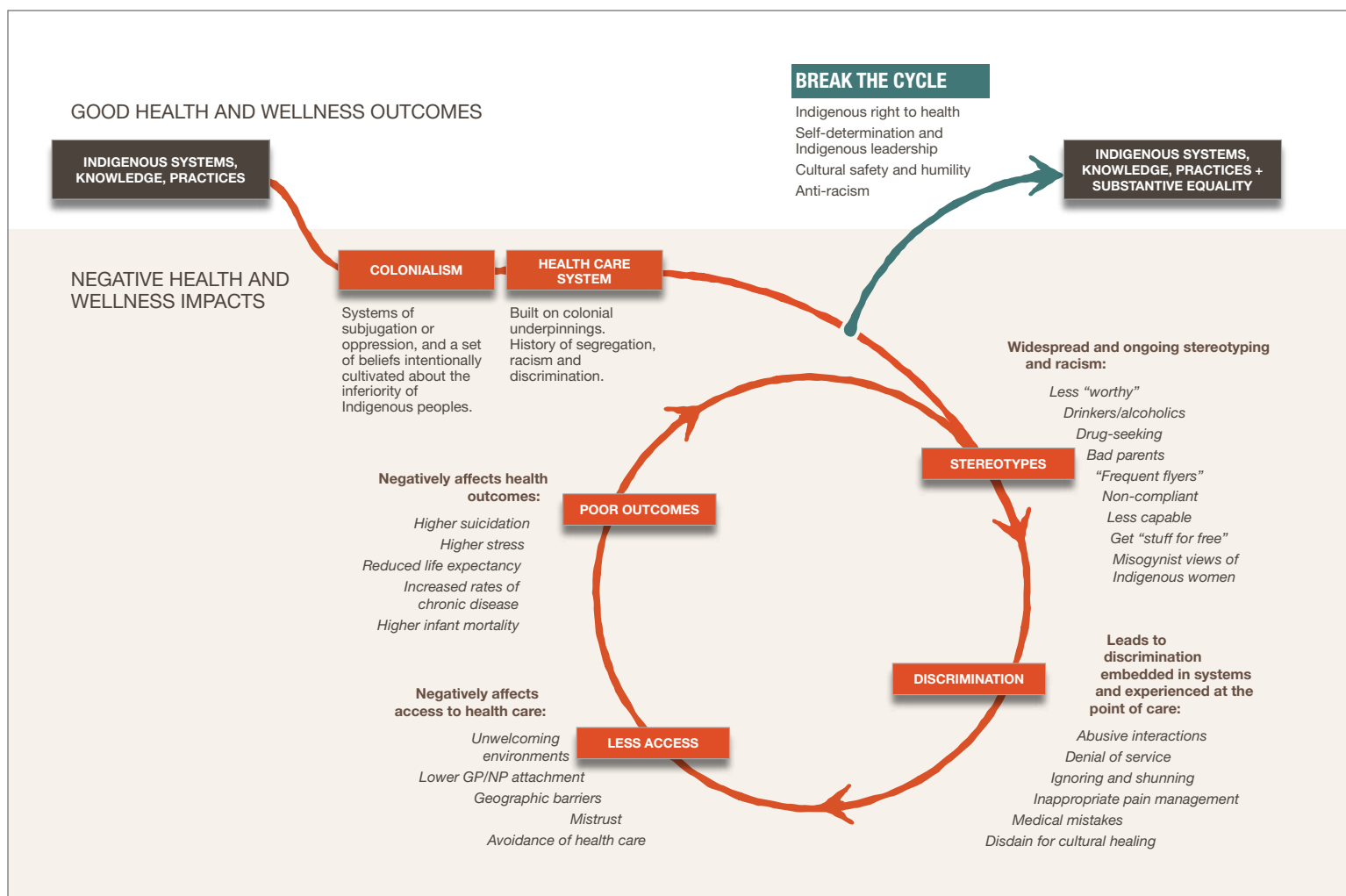


Figure. Infographic depicting what Indigenous-specific racism looks like, how it operates, and the impacts it has on Indigenous peoples’ health and wellness.

Source: *In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in BC Health Care*, full report, November 2020.

such as cultural, social, economic, and historical disadvantage.

- Indigenous human rights refer to the specific requirement to ensure that Indigenous peoples enjoy protection of human rights in BC in keeping with the minimal standards for the protection and survival of Indigenous peoples as provided in the United Nations Declaration on the Rights of Indigenous Peoples. UN Declaration Article 24 is of particular relevance as it provides that Indigenous peoples must access health and social services without discrimination.[†]

As the province of BC has adopted the UN Declaration by provincial legislation in November 2019, the health care system must shift to align with the standards in the Declaration.

Review findings

The review found widespread anti-Indigenous racism in health care in BC. In the IPS, only 16% of all Indigenous respondents reported never having been discriminated against while receiving health care. In another survey targeted to all health care workers in BC, 35% of

respondents indicated that they had witnessed interpersonal racism or discrimination directed to Indigenous patients or their family and friends, and 84% of White respondents reported this racism in health care to be “somewhat,” “very,” or “extremely” prevalent, or were unsure. The existence of Indigenous-specific racism is clear and incontrovertible.

Beyond simply “proving” the existence of the problem, the review articulated what this racism looks like, how it operates, and the impacts it has on Indigenous peoples’ health and wellness (see Figure for a visual summary). Indigenous

[†] Article 24 of the UN Declaration on the Rights of Indigenous Peoples states: “1. Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals and minerals. Indigenous individuals also have the right to access, without any discrimination, to all social and health services. 2. Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view to achieving progressively the full realization of this right.” United Nations General Assembly. *United Nations declaration on the rights of Indigenous Peoples*. 2007. Accessed 27 December 2020. www.un.org/development/desa/indigenouspeoples/wp-content/uploads/sites/19/2018/11/UNDRIP_E_web.pdf.

peoples have a long and rich history of health and wellness, guided by a wholistic understanding of well-being supported by physical, emotional, spiritual, and mental health, healing, and medicinal practices. These practices were intentionally undermined through colonialism, including measures such as segregated residential schools, Indian hospitals, and the Indian Act, designed to eliminate Indigenous peoples and cultures and make way for European settlement. To enable these measures, colonial beliefs were promoted about Indigenous peoples as morally and culturally inferior, dying off, and incapable of managing their societies, lands, and resources. Without much public education in Canada on the history of colonialism and the concept of racism and bias, those beliefs have continued, evolved, and exist in a widespread way across Canadian society, including in health care. The assumptions take the form of stereotypes about Indigenous peoples that are at the core of Indigenous-specific racism existing today, in health care and other sectors. Analysis of submissions and multiple data sources gathered by the review revealed that the most prevalent stereotypes about Indigenous peoples in BC's health care system relate to the concepts of inferiority and incapability—that Indigenous peoples are therefore “less worthy” of care, are alcoholics or drug seeking, and are “bad parents,” to name a few (see Finding 1 of the full report, p. 36).

These widespread stereotypes result, often unconsciously, in health care workers profiling Indigenous patients. Subconsciously predetermining that Indigenous peoples are less worthy, less capable, and substance-dependent results in discriminatory treatment of Indigenous patients. Again across multiple data sources, the review found that discriminatory treatment of Indigenous patients most commonly takes the form of improper personal interactions, misdiagnoses, inappropriate pain management, and denial of service. It is unsurprising that Indigenous peoples consistently report poorer experience of care in all data examined by the review. In fact, the experience of racism leads many Indigenous peoples to avoid health care.

For example, when compared to other patients, First Nations were more than twice as likely to leave BC hospitals against medical advice in the years 2015 to 2018.¹

It must be noted that interpersonal racism is only one aspect of the problem. Canada's institutions, systems, and laws are founded upon

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and reflect its settler colonial origins, and create systemic barriers to access to health care for Indigenous peoples. These include the results of relocation of many First Nations communities far away from urban centres, the fact that health care does not consider, reflect, or respect Indigenous health practices and medicine, and continuing jurisdictional barriers related to on- and off-reserve funding of health care services, and provision of health services on-reserve. Key policies and practices of colonialism, including residential schools and Indian hospitals, have lineage today, triggering intergenerational trauma response in health care interactions and settings.

The intersection of interpersonal and systemic racism shapes inequitable and inadequate health system performance for Indigenous peoples across a range of measures (see Finding 2 of the full report, p. 55).[‡] In examining attachment to general practitioners/nurse practitioners, First Nations of all age groups had significantly lower rates compared to other residents (the residual BC population that remains after a data linkage using the First Nations Client File has identified and extracted all First Nations who

have Indian status and are registered in the BC Medical Services Plan). For example, for First Nations in the 65-and-older age group, the First Nations rate for nonattachment was 88.5% higher than that of non-Indigenous people.¹ The review also examined avoidable hospitalizations for ambulatory care sensitive conditions among First Nations residents as a barometer of inadequate access to primary health services. The hospitalization rate for these conditions among First Nations was over 2 times higher than among other residents in 2017/18.¹ Lack of attachment to primary care could potentially impact equitable access to preventive screening. For example, when examining Pap testing, in all age groups First Nations women's rates were approximately 70% of those of non-First Nations women, despite First Nations having a 1.6-times higher prevalence rate of cervical cancer.¹ This lesser access to preventive and primary care appears to contribute to a disproportionately high reliance on emergency services—First Nations were 1.8 times more likely to visit the emergency department in 2017/18 than non-First Nations people, and the First Nations rates were significantly higher among those who were not attached to a general practitioner/nurse practitioner.¹

Cumulatively, this poor health system performance results in inequitable health outcomes for Indigenous people including a life expectancy for First Nations persons 9 years less than non-First Nations people,² a twofold higher rate of infant mortality,² and increased rates and earlier progression and complexity of chronic disease.¹ Additionally, first-of-its-kind examination of data gathered through the most recent round of the First Nations Regional Health Survey found that the very experience of racism is associated with self-reported negative health outcomes—those who report having experienced racism also report much higher rates of distress and stress, suicidal ideation, and use of mood-altering substances.¹ This affirms other research demonstrating that racism tends to precede ill health rather than vice versa, and does so in both mental ill health and physical disease.³

[‡] Health system performance was examined in the review generally through analysis of First Nations quantitative data. The comparatively low numbers of Métis in BC resulted in an inability to report on many health service utilization and health outcome measures, or in other cases, to show statistically significant differences between Métis measures and those of the non-Indigenous population.

The impacts of the two current public health emergencies in BC serve to magnify the issues, particularly when compounded by the determinants of ill health (e.g., poverty, inadequate housing) that too are disproportionately experienced by Indigenous people (see Finding 4 of the full report, p. 80). To 31 October 2020, First Nations died from overdoses at a 5.5 times higher rate than other residents, with the gap between the rate of First Nations dying from opioid overdose and that of other residents increasing annually from 2016 to the present. In the first 7½ months of the COVID-19 pandemic, First Nations in BC experienced a 56% higher rate of infections than non-Indigenous population.¹

It was also important for the review to examine the experiences and outcomes of various subpopulations of Indigenous peoples, including those based on gender, age, and region. Two groups were starkly evident. Indigenous women shoulder a particularly disproportionate burden of these harms, a situation brought into sharp focus during the course of the review with the broad media coverage of the treatment of Joyce Echaquan. Indigenous women in BC experience the intersection of gender and race discrimination, involving misogynist stereotypes, deep feelings of unsafety in accessing health services, and the most acute gaps in health outcomes of any population segment examined in the review (see Finding 3 of the full report, p. 72). Additionally, Indigenous health care workers experience racism and discrimination that is tolerated in their professional and learning environments (see Finding 5 of the full report, p. 91). In the HWS, 42% of White respondents reported witnessing racial discrimination toward racialized health workers, and 52% of Indigenous respondents reported personally experiencing racial prejudice at work, most commonly in the form of discriminatory comments by colleagues or superiors. Indigenous respondents indicated that the racial prejudice or discrimination they experienced negatively impacted their emotional health (95%), mental health (92%), self-esteem (81%), job satisfaction (80%), and spiritual health (80%), demonstrating both the personal and professional toll that racism exacts from Indigenous health workers.

Understanding the findings

The review sought to understand why this problem persists in an environment very publicly committed to reconciliation and cultural safety. HWS respondents most commonly reported the following reasons why systemic or organizational racism exists:

1. Staff not willing to stand up and call out racially prejudiced behavior.
2. Staff not regularly reminded of the many ways discriminatory behavior can occur.
3. Underrepresentation of Indigenous personnel at all levels of the organization.

In both the IPS and HWS, respondents called most strongly for interventions focused on leadership, policies and practices, and training or education for staff.

Interestingly, there are interventions in place ostensibly to address these concerns, and these existing policies and processes were examined by the review. Complaints processes were shown to be largely unused by Indigenous peoples, and when they were used, did not have capability to examine allegations of racism, in part because quality in health services has not been adequately defined as requiring an antiracism standard or dimension (see Finding 7 of the full report, p. 110). The review was overwhelmingly advised of the many barriers for health professionals in accessing cultural safety and antiracism training, and that these programs lack practical strategies and tools (see Finding 6 of the full report, p. 102). Established commitments and targets to Indigenous (particularly BC First Nations) health professional education, recruitment, and retention are lagging. There are many promising and, in fact, positive initiatives underway across the entire health system, yet these are not supported by the necessary legislative, policy, or regulatory underpinning that would truly hardwire cultural safety as a desired outcome of BC's health care system (see Finding 9 of the full report, p. 125). There is also no routine measurement of health system performance on this issue, serving to mask a problem that this review has demonstrated is “in plain sight” (see Finding 11 of the full report, p. 143).

Ultimately, the review's critical examination of the “solutions” in place to address Indigenous-specific racism reveals that, perhaps unsurprisingly, the lack of a shared

understanding of core concepts as earlier described is intimately connected with a lack of integrated strategy to address Indigenous-specific racism, the proliferation of well-meaning but disconnected initiatives, and an inability to assess results at a systemic level. In other words, there is work that has been done, but its effectiveness is not measurable or meaningful, and of greatest concern, it does not adequately operate to inform or improve practice at the clinical setting or point of care.

Moving forward

The review identified 24 recommendations designed to disrupt the cycle of racism, improve health system performance, and enable substantive equality, consistent with the obligation to uphold Indigenous human rights in accordance with the new Declaration Act. A systemic problem requires a systemic solution. The recommendations are structured in three interlocking categories—systems, behaviors, and beliefs—reflecting the complex nature of the change, and the need for changes both by individuals and the structures they operate within. In considering implementation of these recommendations, Indigenous peoples shared a clear and consistent message with the review: while those who experience the problem of racism must be involved in developing and evaluating solutions, the primary responsibility and burden of this work lies with non-Indigenous individuals, organizations, and governments.

Recognition that the problems in health care today are deeply rooted in an enduring legacy of colonialism means that confronting that legacy requires substantive, transformative change. It is not adequate to suggest that these problems in health care are merely a reflection of broader societal issues. Health care can and must lead the way in confronting the ongoing legacy and responding to anti-Indigenous racism, in part by removing the responsibility to address it from Indigenous advocates and patients, and taking full ownership of and accountability for the problem.

Physician leadership will be critical in confronting this historic legacy and in creating positive change. As leaders, this means championing required legislative and policy change, including an antiracism act, a cultural safety

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accreditation standard, and fostering organizational culture that encourages employees to speak up against racism. As practitioners, this means a commitment to further education and training, and the application of antiracism tools. As colleagues, it means creating a welcoming environment for Indigenous health care professionals. And as human beings, it means adopting a cultural humility mindset, approaching relationships with curiosity, and meaningfully self-interrogating one's own biases and privilege. Collectively, these efforts will move us beyond awareness-raising and oft-repeated mantras to genuine cultural safety and reconciliation, and to building a stronger health care system for all British Columbians. Having a set of antiracism tools in BC health care to better support the

access, services, and outcomes for Indigenous peoples is long overdue, but certainly within reach. ■

References

1. Turpel-Lafond ME. In plain sight: Addressing Indigenous-specific racism and discrimination in BC health care, full report, November 2020. Accessed 27 December 2020. <https://engage.gov.bc.ca/app/uploads/sites/613/2020/11/In-Plain-Sight-Full-Report.pdf>
2. First Nations Health Authority, Office of the Provincial Health Officer. First Nations population health & wellness agenda, summary of findings. 2020. Accessed 27 December 2020. www.fnha.ca/Documents/FNHA-PHO-First-Nations-Population-Health-and-Wellness-Agenda-Summary-of-Findings.pdf.
3. Paradies Y, Ben J, Denson N, et al. Racism as a determinant of health: A systematic review and meta-analysis. *PLoS ONE* 2015;10:e0138511.

Suggested reading

- DiAngelo R. *White fragility: Why it's so hard for white people to talk about racism*. Boston: Beacon Press; 2018.
- Geddes G. *Medicine unbundled: A journey through the minefields of Indigenous health care*. Vancouver: Heritage House Publishing Company; 2017.
- Kendi IX. *How to be an antiracist*. New York: One World; 2019.
- Lux MK. *Separate beds: A history of Indian hospitals in Canada, 1920s-1980s*. Toronto: University of Toronto Press; 2016.
- McGibbon EA, Etowa JB. *Anti-racist health care practice*. Toronto: Canadian Scholars Press, Inc.; 2009.

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