

Identifying Anti-Indigenous Racism at the Point of Care

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Abstract

Background: Substantial evidence suggests that anti-Indigenous racism is a concerning problem in health systems across Canada, and that racist health structures can result in poor quality of care and lead to poor health outcomes for Indigenous peoples. Moreover, inequitable care experiences and outcomes can have profound negative effects on Indigenous peoples' likelihood of accessing future care. This research aims to identify how anti-Indigenous racism 'shows up' in healthcare organizations for Indigenous peoples while seeking healthcare. While systemic racism in health services was also a focus of this study, those specific findings are not presented herein (due to space limitations).

Methods: A Narrative Review was undertaken of scholarly articles focused on Indigenous peoples' experiences with hospital-based services, wherein racism or discrimination were central to the study's aim. Scopus was searched for published articles from Canada, United States, New Zealand, and Australia due to their similar colonial histories and 17 articles were selected. Thematic content analysis was undertaken in NVIVO 12, and concepts on racism were used as a lens through which to view the data. Historically, literature on Indigenous peoples in the health field has been framed through a deficit discourse, pathologizing Indigenous peoples through narratives of deficiency and failure. Naming this pattern exposes the structural, systemic and internalized racism within the health system, and underscores the need to acknowledge the strength and resilience of Indigenous peoples in the face of violent colonization and cultural genocide.

Results: the findings of this study are framed through the behaviours of health providers, which is the main theme through which the data emerged. These behaviours primarily comprised of interpersonal racism, but also through vicarious racism, particularly for Indigenous health providers who witnessed anti-Indigenous racism. These key findings include: 1) Incomplete and inappropriate patient assessment; 2) Failure to obtain prior, full and informed patient consent for assessments/ treatments; 3) Denial of care or treatment requested by patients and their families; 4) Medical mistakes and/or harm to patients and their families; and 5) Vicarious racism.

Conclusion: Identifying anti-Indigenous racism at point of care is essential to acknowledge, understand and begin to address. Without doing so, racism will continue to be perpetuated at the peril of Indigenous patient health care experiences, quality of care, health outcomes, and ultimately, the population health of Indigenous peoples across settler colonized countries like Canada. Recommendations are provided to overcome the reproduction of anti-Indigenous racism within health systems in Canada.

Background

Canada has a harmful legacy of racist, inequitable healthcare for Indigenous peoples. Racism can be understood as "racist ideologies, prejudiced attitudes, discriminatory behaviour, structural arrangements and institutionalized practices resulting in racial inequality as well as the fallacious notion that discriminatory relations between groups are morally and scientifically justifiable" (1). Colonial policies that enabled the Residential School (2) and Indian Hospital (3) systems continue to impact the health of Indigenous peoples, as do ongoing experiences of systemic and interpersonal racism within healthcare. There is substantial evidence to suggest anti-Indigenous racism is a serious problem in health systems across Canada (4-11). Evidence also suggests that racist health structures can result in poor quality of care and lead to poor health outcomes for Indigenous patients. For example, recent studies have exposed the inequitable surgical care experienced by Indigenous patients, including their relatively low surgery utilization rates vis-a-vis relatively higher rates of post-surgical morbidity, death, and adverse events, when compared to non-Indigenous patients (12, 13). Research has also demonstrated that such racism has a profound negative effect on Indigenous peoples' likelihood of accessing future care (7-11, 14). Thus, it is unsurprising that First Nations, Inuit and Métis peoples experience a disproportionate burden of illness and premature death compared to non-Indigenous peoples in Canada (15, 16).

In 2015, Canada's Truth and Reconciliation Commission (TRC) recognized the legacy and impact of residential schools on Indigenous peoples across the country [17] and put forth 94 Calls to Action, including for the health, social work/child welfare, and education systems. These calls included providing cultural competency training for health professionals to address unconscious bias and systemic racism and developing culturally appropriate education curricula, while building student capacity for intercultural understanding, empathy, and mutual respect [18]. The calls also set out the need to ensure that social workers who conduct child-welfare investigations be properly educated and trained about the history and impacts of residential schools on children and their caregivers. Yet, much work remains to turn the TRC recommendations into action within the health, education and social service sectors within health and welfare systems across Canada. There is little evidence to suggest that substantive changes have been made to address anti-Indigenous racism in the health sector. For example, in late 2021, a report published by the Yellowhead Institute outlined that none of the TRC Calls to Action related to the health sector had been fulfilled (19). A 2022 follow up report similarly found that zero of the seven Calls to Action for the health sector have been completed. The report attributed the finding to "a gap in real commitment on Canada's part to honesty and transparency when it comes to (health system) reform" (20).

Methods

This aim of this study is to identify how anti-Indigenous racism 'shows up' in healthcare organizations for Indigenous peoples seeking healthcare. A narrative review was undertaken for its utility in both surveying the state of knowledge on a particular topic and summarizing previously published information with a relatively broad scope (21). A search of the literature was undertaken using Scopus in February 2022 and studies were selected if they met the following three criteria: 1) study involved original research; 2) the central research focus involved describing Indigenous peoples' experiences with racism while receiving health services; and 3) the study was undertaken in Canada, United States, Australia, and/or New Zealand due to their similar English-speaking Colonial history.

Seventeen studies were selected, and the references of these studies were searched for additional relevant sources, but no further studies were identified. The studies were uploaded into NVIVO 12 software and coded. Data was analyzed using thematic content analysis while remaining open to the 'essence' of the data as reported by participants of the selected studies. The first round of analysis involved coding data for the following themes: 1) patients' descriptions of experiencing racism as framed through health provider behaviours and/or organizational processes; 2) patients' descriptions of enacting protective behaviours while interacting with health professionals to avoid experiencing racism; 3) organizational processes within health service organizations that patients perceived as undermining the quality of their care. Following the initial coding, it became apparent that multiple types of racism were reflected in patients reported experiences. A second round of coding was then undertaken to categorize the dataset into different types of racism based on relevant concepts from the literature on racism and health (see Table 1: Typology of Racism). The findings from this study are organized by health provider behaviours, with consideration to the relevant type(s) of racism. Due to the limitations of this presentation format, only findings for interpersonal racism is covered herein.

Table 1: Conceptualizing Racism (22-24)

Racism (22)	Racism refers to practices at various levels of the society that create and reinforce oppressive social systems of race relations. Racism persists as a cause of exclusion, conflict, and disadvantage on a global scale. Racism can be expressed through stereotypes, prejudice or discrimination. This includes racist beliefs [cognition], emotions [affect] and behaviours.
Typology of Racism (23)	
Internalized Racism	The incorporation of racist attitudes, beliefs or ideologies within an individual's worldview. Internalized dominance (i.e. privilege) is the incorporation of attitudes, beliefs, or ideologies about the inferiority of another racial group and/or the superiority of own's own racial group. Internalized oppression is the incorporation of attitudes, beliefs or ideologies about the superiority of other racial groups and/or the inferiority of one's own racial group.
Interpersonal Racism	Racism at the interpersonal level can manifest through both direct racism (experiencing), and vicarious racism (witnessing) (24).

Results

1. Incomplete and Inappropriate Patient Assessment: Incomplete and inappropriate patient assessments were a common finding among Indigenous patients' reporting concerning medical symptoms. Patients' reported symptoms were either not taken seriously or else completely ignored. Among the most common findings involved complaints of acute pain and/or neurological symptoms (e.g., confusion, dizziness, slurred speech, loss of coordination etc.), that were dismissed by health professionals, who assumed patients were either intoxicated or else lying about their symptoms to receive narcotics. This findings was so common that, even when patients detailed their neurological history or a medical condition associated with acute pain, they were assumed to be lying. This internalized racism among health practitioners directly resulted in interpersonal racism when patients were then dismissed, ignored and/or discharged without undertaking a complete and appropriate patient assessment.

A 57-year-old Indigenous man fell [...] [and] called an ambulance to take him to the hospital, where he was x-rayed. Nurses subsequently informed the man that there was "nothing wrong" with him and [...] to go home. He protested, insisting he [...] couldn't walk [...]. He says two nurses [...] treated him poorly and made fun of him. "They just thought I was a drunk." Eventually [...] security was called, followed by the police. The man was ultimately arrested and taken to jail for the night. The next morning, he was released [...] and taken by ambulance back to the same hospital where, this time, he was diagnosed with two cracks in his pelvis. (Indigenous man)

[An Indigenous] client who went to an ER every day for almost two weeks feeling like they were having seizures or passing out. The client was turned away every [...]. Once they were finally admitted to the hospital, it was found that their ICD [implantable Cardioverter-defibrillator] was completely malfunctioning and was defibrillating them every day, sometimes multiple times in one day. [...] and I have heard people refer to them as a "frequent flyer." (Submission from RN to British Columbia's 2020-21 Anti-Racism investigation)

Results (cont.)

2. Failure to Obtain Prior, Full and Informed Patient Consent for Assessments/Treatments: Another common finding involved health providers completing assessments and/or procedures on patients without first establishing rapport and trust, nor seeking their consent for examinations and medical treatments. Patients described feeling anxious and afraid during these experiences, either stating or implying that they were not given information about the rationale for doing so, what they should expect, nor the potential risks and benefits to them from such treatments. It is essential to underscore that a patient's consent to treatment is only legal if this information has been provided to them in advance of any procedures being undertaken. Moreover, it is important to highlight that while having blood drawn for tests and receiving oxygen via a facemask are among the most common low-risk medical procedures provided at a hospital, they were nonetheless perceived as threatening by the individuals who reported these procedures.

"One nurse came over and [...] didn't say anything to me, just, 'Give me your arm, put your arm out like this, I need to take some blood.' [...] she was looking for a vein, couldn't find a vein. So, then she went over here, on the left arm [...] using the needle over, and over again, not explaining [...]. I started getting stressed [...] she was really in a hurry, and I was bruised. Finally, she said, 'Oh, for heaven's sake [...]. Finally, they got a vein [...] I was just poked and prodded being told, 'Give me this arm or that arm.' [...] It felt like I wasn't even a human being, because neither one of them said a word to me." (Indigenous woman)

"A patient became extremely anxious when an oxygen mask was put on his face. He thought they were trying to kill him. There was one Indian nurse with him, and he decided to convince himself that she was Aboriginal and then he could cope. (Physician, Indigenous Community Health Service Organization)"

3. Denial of Care or Treatment Requested by Patients and their Families: Even when Indigenous peoples were taken into hospital to receive care, they often did not receive appropriate treatment in response to their reported symptoms and requests for care. A common finding involved Indigenous peoples' reported requests for pain medication being frequently denied. In another case, an Indigenous mother described feeling unheard by the nurses in the Neonatal Intensive Care Unit and a perceived need to be hypervigilant around the care of her newborn child.

"I was in mind-bending pain [...] My sacrum had completely fallen out of joint, and I was [...] begging [the doctor] for something stronger because I was killing my liver by eating Tylenols and Advils [...] It felt very personal because she had mentioned my [Métis] status and my history on several occasions [...] She just sent me away in tears." (Indigenous woman)

"I could never breastfeed, like he could never latch. So, I pumped breastmilk. Even when I was pumping [...] bringing it for every feed, (the nurses) were feeding him formula. I said, "Why are you feeding him formula, there is breastmilk in the fridge?" She said 'Oh it is just quicker because the formula is room temperature' [...] so I would take the formula out of the warmer and put the breastmilk in. I would just do it myself." (Indigenous Mother)

4. Medical Mistakes and/or Harm to Patients and their Families: The incorrect assumptions of clinicians have also resulted in medical mistakes and/or direct harm to the patients or their family members. Indigenous women, for example have reported being fearful of and avoiding taking their children to receive care to avoid their children being mistreated or apprehended for no apparent reasons. This reality came to light for one woman, as outlined in the first quote below. The implication of this is that children do not receive the care they need when they become sick or injured. Other reports describe patients being mistreated by medical staff, even while experiencing a medical emergency.

"I went into the emergency [...] I had my daughter, screaming, fever. Her bum was really red and raw, and [...] they apprehended her from me right there. As far as they were concerned because of the way I looked, and because they didn't check on her previous (medical) history, they apprehended her. And they wouldn't let me see her [...] They didn't even contact [my doctor] to ask what the history was, and he was outraged. So, a few days after that, they contacted him, and he set them straight [...] Just because I'm a Native person [...] they just assumed the worse. It was just because of how I looked." (Indigenous mother)

An older Métis woman fell asleep after taking her medication [...]. She awoke [...] itchy all over her body and extremely weak. She called 9-1-1, went to her front doorstep and collapsed. After it arrived, she says the ambulance attendant sternly ordered her to "get up" from the step. And a fireman helped her into the ambulance. Once inside, the female paramedic was rough with her, preventing her from using a pillow to balance herself in the seat. After falling, the attendant yelled, "sit up in the seat!" After arriving in the ER, her urgent requests to use a bathroom were ignored. She eventually blacked out and awoke to the urgent sense of needing the bathroom. She recalls sliding off the bed, and making her way to the washroom where she passed out. When she was later found, she remembered medical personnel calling "Code Blue". She had become septic due to an aspirin allergy. (Indigenous woman)

5. Vicarious Racism: Indigenous clinicians also experienced racism, both by witnessing it first-hand against Indigenous patients, and by hearing stories of racism by health care providers toward Indigenous patients.

As a resident, I was often required to advocate for Indigenous patients who were scared and frightened due to mistreatment while they were in hospital. Within my first six months at one hospital, I had to report two nurses for unethical behaviours. One for continuously going through patients' personal items looking for drugs and/or equipment used for drugs. The other for lying to the patient about how much pain medication they were giving them. (Indigenous Medical Resident)

Conclusions & Recommendations

This study sought to identify and describe how anti-Indigenous racism presents at the point of care between health providers and patients in English speaking colonized countries. Drawing upon concepts of racism from the literature, five key findings emerged from the data specifically concerning health provider behaviours: **1) Failure to conduct complete, appropriate patient assessments; 2) Failure to obtain prior, full and informed patient consent for assessments and treatments; 3) Denial of care and/or treatment requested by patients and their families; 4) Medical mistakes and/or harm to patients and their families; and, 5) Vicarious racism, whereby Indigenous health providers are exposed to witnessing and hearing stories of racism against Indigenous patients.**

It's essential to highlight that the narratives from this study were primarily drawn from studies that centred the racist experiences of Indigenous peoples, rather than the racist behaviours of health providers. This particular focus inextricably reproduces harmful narratives about indigenous peoples. To avoid reinforcing anti-Indigenous racism, it is essential that future research studies acknowledge the resilience of Indigenous peoples who survived centuries of colonization and cultural genocide. Future research concerning Indigenous peoples should always adopt a strengths-based approach while keeping the advancement of Indigenous health as the central goal. This involves centring the racist behaviour of health providers and taking all necessary action to ensure the cessation of those behaviours.

The United Nations Declaration on the Rights of Indigenous Peoples established the inalienable right of Indigenous peoples to access health services without discrimination and to be actively involved in developing and determining health programs affecting them (24). While UNDRIP received Royal Assent by the Government of Canada in the form of Bill C-15 the same year (25), much work remains to translate UNDRIP's rights-based framework into new legislation across the country. Toward that end, there is an urgent need to develop a rights-based approach to health care for Indigenous peoples within health systems across Canada.

References

1. First Nations and Indigenous Studies Program. Indigenous Foundations. <https://indigenousfoundations.arts.ubc.ca/terminology/#indigenous> (accessed 13 August 2022).
2. Truth and Reconciliation Commission of Canada. Honouring the Truth Reconciling for the Future. Summary of the Final Report. Truth and Reconciliation Commission of Canada; 2015.
3. Lux MK. Separate Beds: A History of Indian Hospitals in Canada, 1920s-1980s. . Toronto: University of Toronto Press; 2016.
4. Geary A. Ignored to death: Brian Sinclair's death caused by racism, inquest inadequate, group says. CBC News. 2017 Sep 18, 2017.
5. Nerestant A. Racism, prejudice contributed to Joyce Echaquan's death in hospital, Quebec coroner's inquiry concludes. CBC News. 2021 October 1, 2021.
6. Turpel-Lafond. In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care. Full Report. . 2020.
7. Allan B, Smylie J. First Peoples, Second Class Treatment: The role of racism in health and well-being of Indigenous peoples in Canada. The Wellesley Institute, Toronto, Ontario 2015.
8. Browne AJ, Fiske J. First Nations Women's Encounters with mainstream health care services. Western Journal of Nursing Research. 2001;23(2):126-47.
9. Adelson N. The Embodiment of Inequity. Canadian Journal of Public Health 2005;Mar/Apr(96):545-561.
10. Quebec. Public Inquiry Commission on Relations between Indigenous Peoples and Certain Public Services in Quebec: listening, reconciliation and progress: Final Report Commission d'enquête sur les relations entre les Autochtones et certains services public; 2019.
11. National Inquiry into Missing and Murdered Indigenous Women and Girls. Executive Summary of the Final Report: Reclaiming Power and Place. 2019.
12. McVicar JA, Poon A, Caron NR, Bould MD, Nickerson JW, Ahmad N, et al. Postoperative outcomes for Indigenous Peoples in Canada: a systematic review. CMAJ. 2021;193(20):E713-E22.
13. McVicar JA, Hoang-Nguyen J, O'Shea J, Champion C, Sheffield C, Allen J, et al. Postoperative outcomes for Nunavut Inuit at a Canadian quaternary care centre: a retrospective cohort study. CMAJ Open. 2022;10(2):E304-E12.
14. Senese LC, Wilson K. Aboriginal urbanization and rights in Canada: examining implications for health. Soc Sci Med. 2013;91:219-28.
15. FNIGC. The First Nations Regional Health Survey (RHS) 2008/10: National report on adults, youth and children living in First Nations Communities. Ottawa: First Nations Information Governance Centre 2012.
16. Health Council of Canada. The Health Status of Canada's first Nations, Metis and Inuit Peoples. Toronto 2005. 22p.
17. Truth and Reconciliation Commission of Canada. Honouring the Truth Reconciling for the Future. Summary of the Final Report; Truth and Reconciliation Commission of Canada: Winnipeg, MB, Canada, 2015; pp. 1-535.
18. Truth and Reconciliation Commission of Canada. Truth and Reconciliation Commission of Canada: Calls to Action; Winnipeg, MB, Canada, 2015; pp. 1-20.
19. Jewell E, Mosby I. Calls to Action Accountability: A 2021 Status Update on Reconciliation. Yellowhead Institute 2021 December 2021.
20. Jewell E, Mosby I. Calls to Action Accountability: A 2022 Status Update on Reconciliation. Yellowhead Institute. December 2022
21. Baumeister RF and Leary, MR (1997). Writing Narrative Literature Reviews. Review of General Psychology. Vol.1, No 3: 311-320.
22. United Nations (2009). World Conference against Racism, Racial Discrimination, Xenophobia and Related Intolerance: Declaration and Programme of Action.
23. Paradies (2006). Defining, conceptualizing, and characterizing racism in health research. Critical Public Health. 16:2, 143-157.
24. Harrell (2000). A Multidimensional Conceptualization of Racism-Related Stress: Implications for the Well-Being of People of Color. American Journal of Orthopsychiatry. 70:1: 42-57.
25. United Nations Declaration on the Rights of Indigenous Peoples, Stat. 61/295 (2007).
26. Bill C-15: respecting the United Nations Declaration on the Rights of Indigenous Peoples, (2021).



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