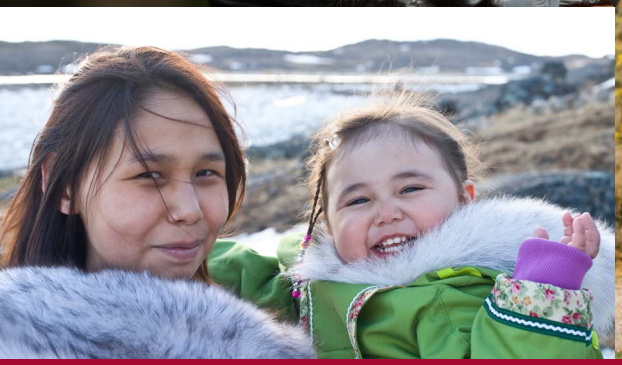
THE COLLEGE OF FAMILY PHYSICIANS OF CANADA

LE COLLÈGE DES MÉDECINS DE FAMILLE DU CANADA



Health and Health Care Implications of Systemic Racism on Indigenous Peoples in Canada

Indigenous Health Working Group

FACT SHEET

Health and Health Care Implications of Systemic Racism on Indigenous Peoples in Canada

Prepared by the Indigenous Health Working Group of the College of Family Physicians of Canada and Indigenous Physicians Association of Canada.

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Family physicians know that supporting a patient's health requires trust, compassion, and mutual respect. For Indigenous patients and their families, this is not always achieved. Systemic racism has been identified as a major barrier to positive relationships between physicians and Indigenous patients and the best care of Indigenous peoples.[1] This brief guide for physicians helps you understand better the role that systemic racism can play in shaping an Indigenous patient's clinical experience, and what you can do about it. As Indigenous patients, Indigenous physicians, and allies, we are appealing to you to help us address this pervasive and harmful problem.

The Case of Brian Sinclair

From Grandmother Madeleine Keteskwew Dion Stout of the Well Living House Grandparents Counsel; in Allan B, Smylie J. First Peoples, Second Class Treatment: The Role of Racism in the Health and Well-Being of Indigenous Peoples in Canada. Toronto, ON: Wellesley Institute; 2015.

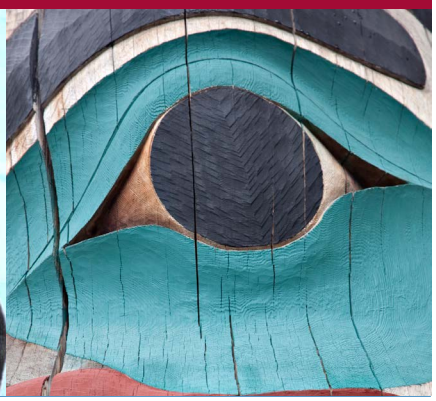
Racism in the Canadian health care system can be fatal. This reality is clear in the case of Brian Sinclair, a 45-year-old Indigenous man who visited the emergency room of the Winnipeg Health Sciences Centre in 2008. Mr Sinclair was referred to the ER by a community physician for a bladder infection. While he waited, Mr Sinclair vomited on himself several times, and other ER visitors pleaded with nurses and security guards to attend to him.[2,3] Following a 34-hour wait, Mr Sinclair died of the bladder infection in the waiting room without ever receiving treatment. The Sinclair family, their legal counsel, and local Indigenous leaders asked a provincial inquest into the matter to strongly consider the ways in which Mr Sinclair's race, disability (Mr Sinclair was a double amputee and had suffered some cognitive impairment), and class resulted in his lack of treatment and subsequent death.[4] In February 2014, the Sinclair family withdrew from the provincial inquest due to frustration with its failure to examine and address the role of systemic racism in his death, and in the treatment of Indigenous peoples in health care settings more broadly.[5]

Clarifying Terms

Aboriginal is a constitutional term created by the Canadian government that collectively refers to three groups: Indians (now commonly referred to as First Nations), Inuit, and Métis.[6]

In this document we use **Indigenous** as an inclusive term to describe First Peoples, or the people whose ancestors lived for millennia on lands now known as Canada before European colonization. Our use of this term allows for individuals and collectives to exercise self-determination in their identity based on their experiences, kin relations, and land ties. This self-determined approach to identity has greater utility in a clinical setting, as it is more likely to accurately include and reflect patients whose lives have been affected by colonization and systemic racism.





What Is Systemic Racism?

When we think of racism, we often are referring to interpersonal or relational racism—when individuals experience some form of discrimination on a personal level in their daily lives. This could range in severity from being treated poorly or differentially from others to overt forms of violence. It can be intentional or unintentional. Our expectation is that physicians and other health care providers maintain an attitude of professionalism and challenge any overt discrimination that they see or experience in the workplace. Despite these expectations, unintentional interpersonal racism is a pervasive problem in health care settings. It can be hard to address and manage, because we are often not even aware that it is happening. Studies have shown that the large majority of physicians in the United States, for example, have significantly higher implicit positive associations toward patients that they racialize as white compared with those they racialize as black.[7] This type of race preference bias has been linked to differential treatment by physicians, even when the physician is explicitly morally opposed to racism. For Indigenous peoples in Canada, unintentional racism commonly manifests in the form of erroneous assumptions (based on negative stereotypes) regarding patient health behaviours or diagnoses. In the case of Mr Brian Sinclair, the erroneous assumptions that he was intoxicated and/or homeless proved fatal.

To understand **systemic racism**, one must examine the emergence of race as a defining set of categories at the same time that European nations began to colonize other continents.[8] The establishment of colonial governments both relied on and lent further legitimacy to the idea that Indigenous peoples were both a separate and inferior race.[9]

But why does this still matter? The history of our country is the sum of the total actions that brought us to the present moment, and has implications for the entire framework around which our society is built. In the recently released Truth and Reconciliation Commission final report, the authors wrote:

> *For over a century, the central goals of Canada's Aboriginal policy were to eliminate Aboriginal governments; ignore Aboriginal rights; terminate the Treaties; and, through a process of assimilation, cause Aboriginal peoples to cease to exist as distinct legal, social, cultural, religious, and racial entities in Canada.*[10]

The legacy of these policies is a society where one social group has disproportionate access to power and resources in society, leading to avoidable and unfair inequalities between these groups—or systemic racism against Indigenous peoples.[1] This imbalance of power and resources is maintained through inequitable treatment under the law and unfair policies, rules, and regulations. It is commonly manifested in social exclusion and isolation that limits or prevents political, social, and economic participation, or access to and participation in other social systems such as education and health.[11]

Interpersonal or relational racism fuels the perpetuation of systemic racism. For example, it has been shown that Indigenous peoples in Australia, Canada, and New Zealand are less likely than non-Indigenous comparison groups to get timely access to coronary angiography and/or revascularization following acute myocardial infarction despite a high prevalence of cardiovascular disease. This example of systemic racism has been

examined in a New Zealand study of underlying gaps in health care professional understandings of Maori patient experiences. Issues of access to care and health care professional–patient miscommunication interfered with optimal treatment.[12] Health care professionals were unintentionally making blaming assumptions about their Maori patients, an example of interpersonal or relational racism. When the health care providers were informed of the study results, they were motivated to further develop their cultural competencies.

How Systemic Racism Affects Population and Patient Health

The effects of systemic racism are pervasive in Indigenous communities. We have provided examples of how racism operates at both the interpersonal and systemic levels. The causal pathways driving racism and its negative effects are complex, intertwined, and deeply embedded in diverse systems, including economic, political, and psychosocial.[13] Below are some examples of how systemic racism leads to health inequities that are reflective of the broad disadvantage that Indigenous communities and individuals living in Canada face:

- **Colonial policies:** Mandatory residential schools, the outlawing of Indigenous gatherings and ceremonies, forced community dislocations, and discriminatory child welfare legislation have had lasting and intergenerational effects on mental health, family relationships, and Indigenous language and culture.[14] The summary report of the Truth and Reconciliation Commission provides important narratives, a detailing of historical and ongoing effects of colonial policies, and recommendations for action.[10]
- **Limited healthy food choices:** Dispossession of traditional lands has interfered with traditional economies and access to traditional foods; urban, rural, and remote Indigenous peoples often have inadequate access to affordable healthy and nutritious foods.[11,15]
- **Inadequate living conditions:** Indigenous peoples living in cities and rural and remote communities are faced with inadequate housing and living conditions. For example, the peoples of Inuit Nunangat experience overcrowding and poor respiratory health from low-quality housing stock, leading to elevated rates of TB infection compared with the general Canadian population.[16] First Nations persons living in the city of Hamilton have a rate of overcrowded housing that is 24 times that of the general Canadian population.[15]
- **Substandard health care:** In addition to the differential access to acute cardiac imaging and intervention discussed above, studies describe high levels of perceived interpersonal racism toward Indigenous patients from health care providers across health care settings. Experiences of racism, including unfair treatment as a result of racism, have been reported in multiple Indigenous survey studies, across geographic settings, with prevalence rates ranging from 39 per cent to 78 per cent.[15, 17, 18, 19, 20] In one Canadian study, this was so severe that Indigenous patients strategized on how to manage racism before seeking care in the emergency room.[21]

What You Can Do About It

There are many levels at which you can become involved:

In Your Clinical Practice

One way in which family physicians 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
- that the patient is a partner in the health care decision-making process
- that the patient determines whether or not the care received is culturally safe[22]

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.[23] One approach is to begin to critically recognize and challenge stereotyping in day-to-day life (eg, the media). As a starting point, clinicians might want to ponder the following questions:

- What is your perception of Indigenous peoples where you currently live/work?
- Where did you get this information?
- Can you identify any potential biases or stereotypes in the source of this information?

Developing the capacity to engage in culturally safe care is a lifelong learning endeavour that requires critical self-reflexivity and positive behavioural change. It can take years to fully develop the ability to engage in culturally secure interactions with Indigenous patients.[24] Cultural safety 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.

In Your Local Community

Family physicians 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. Physicians 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 affects the composition of your primary care team. Depending on the characteristics of the population your practice serves, inclusion of social workers, dietitians, and other health professionals may result in an improved ability to meet the needs of the community.

Examples of local, regional, and national Indigenous organizations

Anishnawbe Health Toronto
www.aht.ca

First Nations Health Authority (Vancouver)
www.fnha.ca

Aboriginal Health Access Centres (Ontario)
Examples: Southwest Ontario Aboriginal Health Access Centre, Anishnawbe Mushkiki, Gizhewaadizwin Health Access Centre
www.aohc.org/aboriginal-health-access-centres

Vancouver Native Health Society
www.vnhs.net/home

Wabano Centre for Aboriginal Health (Ottawa)
www.wabano.com

Pauktuutit Inuit Women of Canada
pauktuutit.ca

Inuit Tapiriit Kanatami
www.itk.ca

Akausivik Inuit Family Health Team (Ottawa)
www.aifht.ca

Manitoba Métis Federation
www.mmf.mb.ca

In Education and Continuing Professional Development (CPD)

Academic family physicians 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. There is also a need for medical curriculum and CPD that cover anti-racism and anti-oppression, health inequities, and the social determinants of health and residential schools in a clinical setting.

In 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 physicians, you can also advocate for increased attention and funding for Indigenous health research. Family physicians can also work with regional tribal councils and treaty areas to ensure that the interests of Indigenous communities and patients are respected and ensured.

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