"Ignored to Death: Systemic Racism in the Canadian Healthcare System"
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Introduction

Widespread health disparities continue for Indigenous peoples in Canada. Indigenous peoples experience lower health outcomes than non-Indigenous peoples in Canada, which is exacerbated by the lack of access to quality health care and lower socio-economic situation (as confirmed by the social determinates of health). Indigenous peoples also lack access to adequate health services, especially in remote communities. In 2015, the Auditor General in Canada concluded that "Health Canada did not have reasonable assurance that eligible First Nations individuals living in remote communities in Manitoba and Ontario had access to clinical and client care services and medical transportation benefits as defined for the purpose of this performance audit." There is a failure to implement existing policies and strategies.

However, racism including systemic racism within the healthcare system is a significant contributor to Indigenous peoples' lower health outcomes. Racism is not limited to interpersonal issues during the provision of health services. Structural racism is evident throughout the Canadian health care system. Structural racism exists in the policies and practices in the Canadian public health system and other sectors, which has profound negative effects on access to health care and health disparities. Racial discrimination in the health care system as well as broader Canadian society has direct physiological effects on health. Racial discrimination negatively impacts health through:

- The direct effects of stress arising from interactions that are perceived to be discriminatory,
- The denial of access to resources such as healthcare that fits with peoples' needs,
- The internalization of stigma and discrimination, and
- The vigilance that is required in anticipation of negative treatment, which leads to stress and often tense social interactions.[1]

Ignored to Death: the Case of Brian Sinclair

Brian Sinclair, an Indigenous man from Manitoba in central Canada, died in the emergency department of Winnipeg's Health Sciences Centre (HSC) in September 2008. He was 45 years old. He had sought care from a family physician at a primary care clinic. The physician referred him to the emergency department of HSC located just a few blocks away for further care. Brian Sinclair was sent by taxi to HSC. In his wheelchair, he entered the emergency department of the

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[1] Stuber, J., Meyer, I. H., & Link, B. (2008). Stigma, prejudice, discrimination and health. *Social Science and Medicine, 67*(3), 351-357.

most comprehensive hospital in Manitoba. After being ignored, unattended, and uncared for during the next thirty-four hours, he died of complications of a treatable bladder infection.

The Manitoba government refused to call an inquiry into Brian Sinclair's death and instead ordered an inquest. Initially, the presiding judge said questions about racism, poverty, and disability would play a significant role when the inquest considered how similar deaths could be prevented in the future. Manitoba's Attorney General also stated that the inquest would address broader issues raised by Indigenous groups.

Almost five years after Brian Sinclair died, the inquest finally began. The inquest was to consist of two phases. Phase I was to examine the circumstances under which Brian Sinclair died. Phase II was to examine what could be done to prevent similar deaths in the future. In Phase I, numerous witnessed testified that staff at the Health Sciences Centre made assumptions about Brian Sinclair – that he was intoxicated; that he was homeless and had nowhere else to go. Nurses on shift while Brian waited in the waiting room testified they did not see Mr. Sinclair. However, the hospital's own video monitoring system showed many nurses walked right by him and looked directly into the patient waiting area where he was seated in his wheelchair. He was simultaneously "invisible" and "overly visible" as staff only saw stereotypes and assumptions, which were used to justify ignoring him to death. Many of the emergency department staff called as witnesses repeatedly said they were confident that racism was not a factor in Brian Sinclair's death because they "treat everyone the same."

In January 2014, the inquest presiding judge ruled that issues of race, racism, poverty, disability, and substance abuse were beyond the mandate of the inquest. The narrowed scope contradicted the original stated rationale for creating a second, distinctive Phase II charged with identifying how to prevent future similar preventable deaths. The ruling meant that there would be no analysis of systemic racism; no examination of the role that social exclusion or classism related to poverty played; or the evident racist stereotyping and neglect of Mr. Sinclair by staff. In response, a group of Indigenous leaders, health advocates, physicians, nurses, legal experts, academics, and health researchers came together to address the glaring insufficiency of the inquest. The "Sinclair Working Group" is developing an alternative report that discusses systemic racism in the healthcare system which led to a man with a treatable bladder infection dying without receiving care in the province's largest, most comprehensive healthcare facility.[2]

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[2] The Sinclair Working Group is comprised of Dr. Annette Browne, Professor in the School of Nursing at the University of British Columbia; Christa Big Canoe, Anishinabe kwe, mother, lawyer and Indigenous feminist, Legal Advocacy Director at Aboriginal Legal Services of Toronto's (ALST); Linda Diffey, Plains Cree and a member of the Peepeekisis First Nation, studied Medicine at the University of Manitoba and is currently undertaking a PhD in Applied Health Sciences that is focusing on anti-racist pedagogy in health professional education; Brenda L. Gunn, Métis, Associate Professor, Robson Hall Faculty of Law, University of Manitoba; Emily Hill joined, senior staff lawyer at ALST and was counsel for ALST in the Inquest into the death of Brian Sinclair; Dr. Emma LaRocque is a scholar, author, poet and professor in the Department of Native Studies, University of Manitoba; Dr. Barry Lavallee, Saulteaux and Métis, MD (Manitoba), Masters degree in Clinical Sciences at Western in 2004 with a focus on research and teaching in Indigenous health; Dr Josée G. Lavoie, Associate Professor in the Department of Community Health Sciences, Faculty of Health Sciences, University of Manitoba, Director of the MFN-Centre for Indigenous Health Research; Janice Linton, Librarian, University of Manitoba; Dr. Donna Martin, Assistant

Contrary to the testimony of nurses, wait times and sightlines were not the cause of Brian Sinclair's death. Brian Sinclair died of racism. Brian Sinclair required a simple procedure and some antibiotics to treat a bladder infection. Brian Sinclair's story exemplifies the way in which stereotypes and preconceived notions about Indigenous peoples are embedded in the healthcare system. These assumptions allowed hospital staff to ignore Brian to death. Clerical, security and medical staff all ignored the same patient throughout several shift changes. It was not physical sightlines of the waiting room that obscured the view of staff. It was the biased social lens through which Brian Sinclair was viewed. The vision of those charged with caring for this man was obfuscated by the stereotypes built within the system and throughout Canadian society.

Systemic Racism in Healthcare

Despite the growing body of research demonstrating the ways in which Indigenous people are often mistreated, healthcare administrators and frontline staff often deny that racism in healthcare is a determinant Indigenous peoples' health. Where it is discussed, racism tends to be conceptualized at the individual level. Racist discourses permeate Canadian society, including in the consciousness of nurses, doctors, social workers, unit clerks, and receptionists. Many settler Canadians continue to believe the myth that ill health, disease, injury and death are often one's own fault. There is little understanding of the social determinants of health and the role that the history of colonization, cultural oppression, socioeconomic disparities, discrimination, racism, and Western organizational culture have on Indigenous peoples' health.[3]

Health disparities between Indigenous and non-Indigenous people are rooted in Canada's colonial history. The colonial process in Canada introduced deadly contagious diseases, which negatively affected the vitality of whole communities. Colonial practices and policies such as starvation, incarceration, community confinement to reserves, and child removal to "schools" all had an enormous, unequal impact on Indigenous peoples' physical health and well-being. Disrupting Indigenous social, educational and knowledge systems and the outlawing of spiritual and medicinal practices undermined the health status of Indigenous people at the same time that non-Indigenous communities were beginning to benefit from those resources once used to sustain Indigenous peoples.

The organization of health and social services for Indigenous people was an important aspect of colonialism in Canada. The establishment of health care services was premised on the idea that Indigenous people deserved less care than other people in Canada and that the cost of such services should be lower. Social, educational and health services were mostly organized with the goal to spend the least amount of money while facilitating stated and unstated goals of segregating, assimilating, or eliminating Indigenous peoples. The delivery or withholding of

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limited, poorly funded and often ineffectual medical and nursing services ensured that Canada maintained control at the overwhelming expense of the Indigenous people.

In examining the history of the delivery of healthcare services to Indigenous people in Canada, most healthcare professionals and hospital staff do not realize that there have been, and continue to be, vast, systemic differences in the delivery of services to First Nations people compared to other people in Canada. The federal Department of Indian Affairs initially undertook healthcare for First Nations in the late 19th century. A distinctive imbalance between the way in which healthcare delivery systems were administered for Indigenous people compared to those designed for non-Indigenous people has prevailed since the very beginning. Jurisdictional issues surrounding what type of services are available to First Nations people both on and off reserve, and to other Indigenous people who are affected by the act, are a thorny, bureaucratic reminder of the messy legacy of the patriarchal system set up to 'manage' Indigenous people.

The system set up for First Nations people who were considered to be Status Indians, for example, required them to obtain special permission from federally employed Indian agents to access healthcare outside of the minimal set of services available on reserve, which were often provided by non-medical personnel. Today, poorer health status and lowered life expectancy for Indigenous peoples is often fueled repeatedly throughout the life course by jurisdictional, language and cultural barriers to accessing the healthcare services that non-Indigenous Canadians feel entitled to, and often receive without question.

This legacy of racial segregation in healthcare impacts the way Indigenous people encounter healthcare institutions as patients today. Indigenous peoples continue to be seen as those who don' t really belong; as drains on the system; whose care is never quite as urgent; and , in general, less deserving of the same level of treatment as non-Indigenous patients. Whether overtly or more subtly, Indigenous people are often blamed for their ailments and medical needs in individual encounters or as a homogenous population.

There is ample evidence showing that the healthcare system often serves Indigenous peoples poorly.[4] Indigenous people are often treated by the healthcare system as if they do not belong, or as if they are a problem and should be treated elsewhere. Given the documented pervasive nature of systemic racism in Canada (in the criminal justice system, in the education system, in the child welfare system), similar systemic issues must be recognized to exist in the health care system. The approach to "treating everyone the same" perpetuates Indigenous peoples' lower health outcomes.

The erosion of social welfare policies, the lack of affordable housing, and the devolution of community-based health and social services differentially impacts Indigenous peoples.[5] Consequently, Indigenous people face disproportionate structural disadvantages. Lower

[4] Browne, A. J., Smye, V. L., Rodney, P., Tang, S. Y., Mussell, W., & 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. See also, Fiske, J., & Browne, A. J. (2006). Aboriginal citizen, discredited medical subject: Paradoxical constructions of Aboriginal women's subjectivity in Canadian health care policies. *Policy Sciences, 39*(1), 91-111.
[5] Lavoie, J. G., Kaufert, J. M., Browne, A. J., Mah, S., & O'Neil, J. D. (2015). Negotiating barriers, navigating the maze: First Nation peoples' experience of medical relocation. *Canadian Public Administration, 58*(2).

educational attainment and lower income are inextricably tied to increased rates of homelessness and the over-representation of Indigenous peoples in the prison system. The unique experience of colonization of Indigenous peoples in Canada partially explains the disproportionate likelihood of violence against Indigenous women and girls. Racism, discrimination, social exclusion and lower socioeconomic status synergistically negative effect on the health of Indigenous people.

Health and wellbeing of Indigenous people continues to lag behind that of the overall Canadian population in virtually every measure. Infant mortality rates are a recognized barometer of the health of a population and should be cause for concern in any community. In Manitoba, the infant mortality rate for First Nations is almost double that of non-First Nations. At the other end of the spectrum of life, the mean life expectancy for Aboriginal men is projected to be 70.3 years compared to 79 years for other Canadian men. Life expectancy for Aboriginal women is predicted to be 77 years compared to 83 years for other Canadian women.

Despite efforts to increase cultural sensitivity and cultural safety in healthcare, research continues to demonstrate the extent to which a high proportion of the Indigenous population experience individual and systemic racism when seeking health services.[6] Unequal power and negative attitudes of healthcare providers impact on Indigenous peoples' ability to seek medical assistance. Experiences of racism is amplified when issues of poverty, substance use, or stigmatizing chronic conditions such as HIV or chronic pain syndromes intersect with peoples' sense of being treated differently based on race.[7] Experiences of racism in healthcare are merely a continuation of the experiences of racism felt by Indigenous people in Canada in their everyday lives.

In Canada, one of the most enduring stereotypical images about Indigenous peoples is as being prone to alcohol or substance use. The image of the 'drunken Indian' continues to be one of the most harmful stereotypes operating in healthcare settings. These broader societal views shape the assumptions of those charged with managing healthcare -- frontline workers and policymakers alike -- and impact on the attitudes of staff who make value judgments about which patients are credible or 'deserving' of care.[8] Despite this body of evidence, most healthcare systems and approaches in Canada fail to account for the historical and social roots of such issues for Indigenous people.

The Federal-Provincial Jurisdictional Debate

Under the Canadian Constitution divides jurisdiction between the federal and provincial government. The provincial governments have the responsibility to provide healthcare. But the

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[6] Varcoe, C. M., Browne, A. J., Wong, S. T., & Smye, V. L. (2009). Harms and benefits: Collecting ethnicity data in a clinical context. *Social Science & Medicine, 68*(9), 1659-1666. See also Browne, A. J., Varcoe, C., Wong, S., Littlejohn, D., Smye, V. L., Lavoie, J., . . . Rodney, P. (2012). Closing the health equity gap: Evidence-based strategies for primary healthcare organizations. *International Journal for Equity in Health, 11*(15).
[7] Browne, A. J., Varcoe, C. M., Wong, S. T., Smye, V. L., & Khan, K. B. (2013). Can ethnicity data collected at an organizational level be useful in addressing health and healthcare inequities? *Ethnicity and Health, 19*(2), 240-254.
[8] Browne, A. J., Smye, V. L., Rodney, P., Tang, S. Y., Mussell, W., & 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.

Constitution gave jurisdiction over Indian and Indian lands to the federal government. The federal and provincial governments have yet to clearly define areas of responsibility over First Nations' health. Jurisdiction is therefore defined based on interpretations by politicians, civil servants and healthcare providers. Interpretations vary from province to province, and changes in coverage occur periodically and arbitrarily. The jurisdictional debate often leads to both parties denying responsibility. These battles over responsibility occur over something as routine as whether or not to fund enriched baby formula for an infant born with a disability.

Healthcare providers and patients are often caught in a situation of systemic failure notable for uncertainty for Indigenous patients and families; breakdowns in communication; extraneous waiting periods not experienced by other patients in Canada; and a mass of paperwork for healthcare professionals and administrators. This often dysfunctional parallel system for Indigenous peoples often spills over into the attitudes healthcare providers hold for all Indigenous patients, compounding systemic issues in the delivery of healthcare services.

The federal government began to assume responsibility for the delivery of health services on-reserve in the 1920s. By the mid-1960s most First Nations reserves had access to some level of public health and primary healthcare services delivered by federally employed nurses and interpreters. While the federal government and many First Nations argue that the provinces retain an obligation to provide equitable access to all health services to all provincial residents, including First Nations, perceptions remain among some service providers and provincial governments that First Nations are a federal responsibility for all services, with possibly the exception of family physicians, specialist care and hospital-based care. This lack of clarity can result in delays, barriers, and denial of care, associated with statements that care should be sought on-reserve, where some might believe First Nations people 'belong', separated from the non-Indigenous community.

Adding further complication is the fact that most Canadians' (including healthcare professionals) understanding of federal and provincial obligations towards First Nations is poor, and garnered mainly through the media. The media's reporting on First Nations issues overwhelmingly focuses on decontextualized discussions of social ills, inflated federal investments and mismanagement of funds, fueling a perception that First Nations people have privileged access to funding and programs, which they then squander. There is little understanding that federal investments are related to constitutional obligations met by the provinces for other Canadians; that these investments are substandard in comparison to the payment for similar services by the provinces for other Canadians; and the result is substandard on-reserve health services, education, child welfare programs and infrastructure (school buildings, health facilities, drinking water, sanitation, fire and safety).

Most reserve communities have seen their healthcare budget capped for decades.[9] This is never discussed in the media. The disconnect represented in the media showing large federal investments and poorer health perpetuates assumptions that the lower health outcomes of Indigenous people is their fault, and validates erroneous, biased assumptions that it is acceptable to offer up a reduced level of care.

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[9] Lavoie, J. G., O'Neil, J., Sanderson, L., Elias, B., Mignone, J., Bartlett, J., . . . MacNeil, D. (2005). The Evaluation of the First Nations and Inuit Health Transfer Policy. Winnipeg.

<u>Recommendations</u>

To prevent deaths such as Brian Sinclair, healthcare leaders, policy makers and staff must acknowledge the existence of racism and develop strategies for counteracting the harmful effects of racism in healthcare. All existing policies and practices must be reviewed to ensure that racism is not being perpetuated. For example, recent reports indicated that Saskatchewan hospitals continue to engage in forced sterilization of Indigenous women. This work requires development of anti-racism policies and strategies, as well as anti-racism training for all who work in the health care system, as well as students in health care professions. These programs should include

1. Education on terminology; diversity; aspects of colonial history such as Indian residential schools and Indian Hospitals, time line of historical events; and contexts for understanding social disparities and inequities
2. Examination of culture, stereotyping, and the consequences and legacies of colonization
3. Introduction to tools for developing more effective communication and relationship building skills.

One example of such programming is the Indigenous Cultural Competency (ICC) Training Program, developed by the Provincial Health Services Authority in BC (http://www.culturalcompetency.ca/).

Addressing Indigenous peoples health disparities requires not only access to the Canadian health care system, but also better access to Indigenous health systems including traditional medicines and traditional foods. There are many barriers that exist, including Canadian law on harvesting of resources and development of Indigenous peoples' traditional territories that reduces access to traditional medicines and food.

Any attempts to improve Indigenous peoples' health outcomes must include Indigenous knowledge and worldviews such as measures that target all levels of the well-being – including spiritual, emotional, physical and social.

Finally, it should go without saying that improving Indigenous peoples' health will also require addressing other social determinants of health that contribute to Indigenous peoples' lower health outcomes.