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ADDRESSING ANTI-INDIGENOUS RACISM IN THE B.C. HEALTH CARE SYSTEM WEBINAR RECORDING

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Disclaimer: This summary was prepared by Dr. Birinder Narang and not by the speakers.

Webinar Summary

Introduction – Dr. Evelyn Voyageur

- **Dr. Voyageur's Story**
  - We all have a responsibility in addressing anti-Indigenous racism. One does not need to be a counsellor to be a good listener of others' experiences.
  - In the Indigenous way of health, there are no restrictions for time; for example, a care provider can stay 24 hours with a client if needed
  - Our healthcare system focuses on the physical health, but neglects emotional, mental & spiritual aspects
  - Though Dr. Voyageur was not sexually or physically abused in residential schools and does not suffer from substance use, she realized that she still has a lot of pain once she understood she was abused spiritually, emotionally, and culturally
  - This understanding informed her work going forward to further understand what others are going through
  - "The lifestyle they have chosen is a defense mechanism to the trauma they experienced." – Dr. Evelyn Voyageur

Mitigating Systemic Racism in Health Care – Dr. James Liu

- **Life Expectancy Comparisons**
    - The average Canadian life expectancy is 81.7 years, but for Indigenous people it is 75.7 years, which is 6 years shorter and comparable with Hungary
    - First Nations adults have greater than 2x the risk of dying from avoidable causes compared to non-Indigenous adults
- **Adverse Health Outcomes and Systemic Racism**
    - Structural violence and trauma have accelerated an onset of various medical conditions and increased the severity of these conditions in Indigenous peoples
    - When Indigenous peoples access health care, health care disparities exacerbate or perpetuate these upstream inequities, leading to population-level disparities
    - These inequities are best described as Systemic Racism: when a system that is meant to serve the public, while functioning as intended, produces different outcomes based on the system user's race
- **In the Context of BC**
    - Indigenous people have less of an attachment to Family Physicians and reduced access to specialist care
    - Non-Indigenous patients saw cardiologists 3.32x more often than Indigenous patients
        - This is not driven by either socioeconomic status or rurality
    - Indigenous patients are less likely to have positive experiences such as being treated with respect or being included in care decisions
    - Under-triaging in Indigenous patients:
        - First Nations patients were less likely than other Canadians to have an urgent CTAS scare (30.1% vs 44.1%)
        - Paradoxically, First Nations patients also have admission rates 50-70% higher in the CTAS 4 to 5 group
    - Complications:
        - A recent systematic review found that Indigenous patients have a 30% higher mortality rate after surgery as compared to non-Indigenous peoples
            - Additionally, Indigenous patients have a higher rate of surgical site infections and pneumonias
- **Impairment of Clinical Processes:**
    - Inadequate clinical suspicion (failure to recognize bias)
    - Inadequate assessment (with history and physical exam)
    - Inadequate management
        - Lack of rapport
        - A disproportionate focus on health behaviors

        - Neglecting to connect the patient with appropriate resources
        - Lack of understanding that a patient may have reduced access to primary care
        - Lack of proactive recognition and mitigation of barriers to help achieve treatment goals
- **The Way Forward**
    - We must ensure appropriate clinical suspicion, which can be done through:
        - Recognizing external biases
        - Recognizing the impact of stereotypes
        - Recognizing higher pre-test probability
            - e.g. higher prevalence of chronic disease, adverse determinants of health
- **How we can optimize assessment:**
    - Prioritize earning trust
    - Convey a caring attitude
    - Be transparent, consistent, and predictable
    - Be mindful in the use of language
    - Apply patient-centered communication strategies
    - Perform a physical exam
    - Commit to communication
    - Be attentive to power differentials (e.g. avoid an authoritarian tones)
    - Budget more time
    - Be aware of disparities in rates of investigations
- **How we can optimize management:**
    - Manage pain and symptoms
    - Offer opportunities for collaboration and choice
    - Affirm strength and resilience
    - Support cultural needs
    - Provide low-barrier care
    - Use resources to mitigate barriers in the determinants of health
    - Engage mental health support
    - Avoid termination of care
    - Improve continuity of care
    - Provide written information and reference materials
    - Optimize physical environments

5 Misconceptions about Anti-Racism Work & Indigenous Cultural Safety & Humility – Len Pierre

- **1) Proximity to Indigenous Patients**
    - Myth: Clinics or sites don't need training because "we don't have Indigenous patients/families"
    - In reality, anti-Indigenous work is not at an inter-personal level
    - The whole rationale for reconciliation today in anti-racism work is because it is embedded in the system
- **2) Only focusing on the good things and the culture**
    - E.g. drumming and singing, listening to Elders or knowledge keepers or focusing on inter-generational strengths of Indigenous communities
    - Though it may be well-intentioned, focusing only on the positive aspects of the culture is avoiding the "Truth" aspect in "Truth and Reconciliation"
    - We want to be in a state of broadening our social perceptions to uncover a lot of our blind spots in addressing anti-racism
- **3) Cultural Safety is for all cultures**
    - Indigenous cultural safety should be Indigenous-specific
    - We often observe colleagues or peers default to defer to "all cultures", because people will say multicultural safety training is for all cultures
    - However, Indigenous-specific is something we must become familiar with in anti-racism work
    - By default, we tend to gravitate towards generalizing to all cultures
        - This serves as a pitfall and a step backwards because it occurs by the erasure of Indigenous peoples and has perpetuated harm
    - What if someone asks why it should be Indigenous-specific?
        - We have Indigenous-specific programs, services, and initiatives in health care because Indigenous peoples have specific rights reflected in provincial, federal, and international legislation through the United Nations declaration on the rights of Indigenous people
- **4) Using an approach that is oriented through historical awareness**
    - An example of this approach is saying "we don't need to be culturally safe, because we know exactly what the residential schools are"
    - It is simply not enough to be aware of atrocities; there are "ghosts in the room" when the deeper meaning is not uncovered
    - 3 areas to consider in our approach to anti-racism work:
        - Absolute awareness of history
        - Examination of power imbalances that inherent in healthcare systems and practices

        - Developing and formulating anti-racism strategies to create culturally safer practices for Indigenous patients
- **5) Anti-racism work can exist with equity, diversity, and inclusion (EDI) models**
    - Indigenous Cultural Safety and Humility and anti-Indigenous racism work cannot exist in the same container as EDI models
    - As Indigenous peoples have been erased without representation, anti-Indigenous racism work often becomes diluted and falls through the cracks
    - The context of anti-Indigenous racism work is very different than EDI models even if they are aligned
    - We cannot "include" Indigenous peoples in a space or state where they have been victims of state sponsored violence; we must reconcile with them in that
    - The context of the word is important
    - EDI work is important within its own time and space but anti-Indigenous racism work also needs its own time and space

Recommendations – Dr. Terri Aldred

- **Re: Pathologizing Indigenous Peoples**
    - In medical training, a lot of pathologizing has occurred
        - i.e. being First Nations, Metis, or Inuit would be a risk factor for some chronic diseases (such as Diabetes) or poverty, along with low socioeconomic status, obesity, or substance use.
    - This paints a narrative that being Indigenous makes you at higher risk for these conditions
    - Indigenous peoples do have higher rates and lower life expectancy, and have poorer health on lots of metrics
    - However, having higher rates is not the same as saying that being Indigenous is a risk factor
    - A lot of these numbers are collected without considering colonialism, racism, and other social determinants of health
        - Colonialism is a risk factor
        - Facing racism is a risk factor
        - Inter-generational and personal trauma are risk factors
    - In lots of ways, being Indigenous is a strength
        - E.g. being connected to culture, language, and community Elders has been shown to offer protection
    - There is a study on youth and suicide that showed that the more cultural traditions the youth was tied to, the lower the amount of suicides within that group

        - If a youth is connected to more than 5 cultural traditions, there are no suicides within that group
- **Talking about Racism**
    - We often view racism as a moral issue; most of us don't see ourselves in it
    - We see our colleagues, hospital, work etc. as mainly good, and we cannot be both good and racist
        - This can cause us to feel shame and become avoidant of the shame
    - How do we validate Indigenous voices?
    - Often people request "more proof"
        - When we do that, it distracts from having the crucial conversations
    - We were all born into a racist and sexist culture, to no fault of our own, but the legacy of colonization lives on
    - As we recognize ongoing harms, we must learn how to address this and have conversations about it. We must all be willing to receive feedback as well.
        - This requires shame resilience and psychological safety
    - A core skill in developing cultural awareness and cultural humility that we have control over is self-reflective practice
        - It is important to do this yourself and with colleagues

Questions & Answers

Q: What relationship building programs are currently in place and available?

A: The Touchpoints course is a relational and developmental course. Training is available and free for Comox, BC families.

Additionally, at Fraser Health Authority, "re-envisioning cultural safety education and training" is influencing educational program design in partnership with local land-based Indigenous communities. For example, there is an experiential learning course bringing physicians into these communities to share history food, culture, etc.

There are also "racism scales" – these tools can help find where you fall on the "scale". People in the medical profession tend to fall around the middle. Increasing relational components and building awareness around anti-Indigenous racism can be helpful, along with learning non-race ways, adverse childhood experiences (ACEs), the effect of poverty, etc. We want to get people to a place where they can ingest and digest the Indigenous cultural safety content in order to apply it. People who are overtly racist tend to live in permanent states of fear; to address this, there are courses based on love and compassion that are available. There is a wider approach needed to overcome this issue.

Cultural advocacy is important as well. If you lead a team, and there is no training available, take

that initiative and responsibility upon yourself.

Q: As a mental health professional, how can I discuss epigenetics and systemic trauma without making assumptions of one's experience?

A: This is an important part of the toolbox, and it can be very sensitive. It depends on where the patient/client is and how receptive they are.

Best practices revolve around targeted interviewing and bringing people into this work. Parenting programs can be a good way to introduce this.

In essence, we want to find a way to introduce hope and develop resilience. Though epigenetics can serve as an explanatory model, we must ask patients for permission to share our insights.

Q: How do I acknowledge realities for a client that are also stereotypes without making them feel like I am stereotyping them?

A: Follow the leadership of the person you are working with in a trauma-informed and resiliency-informed manner. Give the power and autonomy to the patient and let them invite us in to have a culturally safer conversation.

Intent is important; treat your patients as individuals and learn their story as well as what has contributed to their own determinants of health.

Thanks to the speakers on the video:

- **Dr. Terri-Leigh Aldred**, Medical Director, Primary Care; Office of the Chief Operating Officer, First Nations Health Authority
- **Dr. James Liu**, Emergency Physician; Primary Care Physician, Carrier Sekani Family Services; Clinical Instructor, UBC
- **Len Pierre**, Indigenous Cultural Safety Consultant
- **Dr. Shirley Sze**, Family Physician; Co-Chair Child and Youth Mental Health and Substance Use Community of Practice
- **Dr. Evelyn Voyageur**, Registered Nurse; PhD in Psychology