Indigenous Health in British Columbia

The determinants of health disparities and what clinicians can do about them

Part III: Addressing health disparities in clinical settings

Practice Ready Assessment British Columbia (PRA-BC)
Centralized Orientation

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Disclosures & Acknowledgements

- We are gathered on the traditional and unceded territories of the Squamish, Musqueam, and Tsleil-Waututh peoples
- I do not have any conflict of interest to disclose.
- I do not possess lived experience from an Indigenous perspective as I am an Asian settler.
- This presentation is made from the perspective of a person without lived experience for other providers without lived experience
- The focus is on the deficits of the current health system to encourage appropriate response from health care providers. It does not claim to represent Indigenous perspectives and values on health and health care
- As part of reconciliation, the onus of learning how to mitigate the harms of the health care system and work towards health equity rests with settlers. The onus is not on Indigenous peoples to provide this education.

Disclosures & Acknowledgements

- This presentation does not seek to replace further training in cultural safety; rather, it seeks to provide some background to encourage further learning directly from Indigenous voices
- While immensely valuable, we do not have an Indigenous co-presenter today. The primary rationale is that many health care providers have yet to critically reflect upon and draw lessons from the tremendous input Indigenous voices have already contributed. We seek to draw from some of these lessons today.
- Personal preparation including education around context as well as active reflection is needed in order to optimize learning yield and decrease the risk of causing harm when learning directly from persons with lived experience. The aim of this presentation is to form part of this personal preparation and encourage each participant to learn directly from Indigenous voice when they feel ready.
- Speaking about Indigenous health from the lens of a non-Indigenous health care provider is not an attempt to add validity to Indigenous voices. These voices are intrinsically valid and do not require further validation by persons without lived experience. Our goal for discussing this topic today is an act of knowledge translation, in improving the accessibility of this topic to a medical audience.
- This presentation contain material that benefited from the expert input of Dr. Terri Aldred

Preface

- Most physicians will work with Indigenous patients in their practice regardless of their specialty and geographic location
- Most physicians work in settings that do not specialize in Indigenous health (such as dedicated Indigenous health clinics) and therefore do not have a menu of specialized Indigenous resources beyond what is available to all clinicians
- This presentation is aimed at the above described audience. It aims to help optimize your care of Indigenous patients in your regular practice settings

Preface

We will not be discussing Indigenous culture in our presentation today.

- It would be inappropriate to have a non-Indigenous person present Indigenous culture.
- There is incredible diversity among Indigenous cultures within BC, which may be difficult even for a panel of Indigenous presenters to review meaningfully within our presentation format.
- Participants are encouraged to explore existing Indigenous-led courses on Indigenous culture
- Cultural preferences are not the main drivers of health care disparities. Misattribution of health care disparity to cultural differences diverts attention from looking for concrete ways to improve equity.
- Each person may identify differently with their own culture. Rather than reviewing generalities about Indigenous culture, it would be more important to learn directly from individuals about what their relationship with their culture is, and how it affects them.
- Our presentation today will provide some approaches to working with Indigenous patients in a respectful and sensitive way, that will hopefully help foster trust and openness which may then facilitate individuals in showing you how best to meet their needs
- Each provider is encouraged to connect with the local communities that you'll be working with in order to cultivate respect and appreciation for local culture

You are working in a rural emergency department. The nearest regional hospital with specialty care and CT is 3 hours away.

63F

Presented with vomiting. Seen earlier in the day and diagnosed with urinary tract infection. Discharged on nitrofurantoin. Returning to the emergency department with vomiting.

What would be your differential diagnosis?

As you prepare to enter the room, the nurse says the following to you:

"I just wanted to let you know about some background information on this patient. I think she is from one of the First Nations reserves. She was just here earlier today. Her daughter brought her back because she's concerned about vomiting, but the vomit bag is still dry right now. She's moaning and groaning a lot. Not quite sure what that's all about. I sent a urine drug screen and it was positive for cannabis. They both look really anxious."

- What are some priorities and objectives in your clinical encounter?
- What are some challenges you may be concerned about?

You go to see the patient and find her in a recliner chair beside a few other patients. Her daughter is leaning against the wall beside her. You had to step over a bag to get beside her as they are carrying a few bags with them.

HPI:

Abdominal pain since yesterday afternoon. Malaise. Went to sleep last night and woke up worse. Seen early this morning and sent home on nitrofurantoin for UTI. Took one dose but vomited shortly after. 3 episodes of vomiting since then. Feeling quite weak.

PMHx:

- GERD
- HTN
- T2DM

Medications:

- Atorvastatin
- Ramipril
- Pantoprazole
- Insulin glargine

Allergies:

- NKA

Social:

- Smoke cannabis and nicotine
- Does not drink alcohol
- Doe not use other recreational substances
- Lives with daughter and 2 grand daughters

You go and ask the nurse to move the patient to an examination bed. There was a delay in order for this to occur.

PEx

- T37.6 HR 103 RR 18 BP 113/68 SpO2 98%RA
- Patient is alert and oriented. Looks uncomfortable.
- BMI 29
- Normal cardiac, respiratory
- BS present. Abdomen generally tender. Somewhat limited exam due to habitus.

What are your next steps in managing this patient?

You go and discuss your plan with the nurse. She asks

- Do you want to give any medications for symptom management?
  - ❑No analgesics at this time to facilitate observation
  - ❑Non-opioid analgesics
  - ❑Opioid analgesics
- Do you want me to add a blood alcohol level to the labs?
  - ❑Yes
  - ❑No

The nurse comes back and lets you know that the patient is refusing blood work. The patient's daughter seems to want to take the patient home.

How would you respond to this information?

- ❑Arrive at a treatment decision without bloodwork
- ❑Respect the patient's choice and discharge her home
- ❑Reassess the patient

You go and reassess the patient. The patient states that bloodwork was just done this morning. The daughter is concerned that if it’s not going to change much, then they should get going back home.

You explain the purpose of the bloodwork and they agree to stay for the rest of the assessment.

Labs:

- WBC: 16.8
- Hb 128
- GFR 78
- UA: trace leuk, trace blood

How would you manage this patient?

- ❑ Agree with previous diagnosis of cystitis. Continue nitrofurantoin
- ❑ Start the patient on outpatient antibiotic therapy
- ❑ Observe the patient in your ED and reassess in 24h
- ❑ Transfer the patient to higher level of care

The patient tells you that she does not want to go to the regional hospital. She has had bad experiences there personally and has heard other people in her community with similar experiences. She thinks she might be left to die if she is transferred to that hospital.

How would you address her concerns?

- ❑ If the patient does not wish to follow recommendations, she can leave against medical advice
- ❑ Start the patient on antibiotics and observe her in the local hospital
- ❑ Find out what specific steps we could take to improve her experience at the regional hospital
- ❑ Reassure her that she will receive excellent care at the regional hospital

You discuss your concerns about her abdomen, and that she could get sicker if she doesn’t go get further testing. You arrange a CT scan of the abdomen in the regional hospital, and you consulted the emergency physician to reassess the patient after the CT scan. You put in a referral to the Aboriginal Liaison worker. You wrote a letter so that the daughter can come with her to the regional hospital and get reimbursed for her accommodation. You put together transfer orders with symptom management medications including opioids and antiemetics. You draw blood cultures and start empiric antibiotics. She is NPO with maintenance fluids.

The patient receives a CT scan at the receiving center showing perforated viscous. She goes to the operating room the same evening and was found to have significant purulent fluids inside her peritoneal cavity. She was treated with antibiotics postoperatively as an inpatient.

Discussion

What was that experience like for you?

- Focus on how you feel only
- The medical aspects of the case is not the main emphasis. Please reserve specific observations of case details until the next part of the discussion

What stood out to you?

Discussion

- What were your thoughts when you read the triage note?
- How did you notice about your interaction with the nurse?
- How do you feel about your interaction with the patient and family?
- What were your considerations in managing pain?
- What were your considerations with regards to the nurse's question on blood alcohol level testing?
- What was your reaction when the patient refused bloodwork and requesting to go home?
- What do you think about the final diagnosis of the patient?

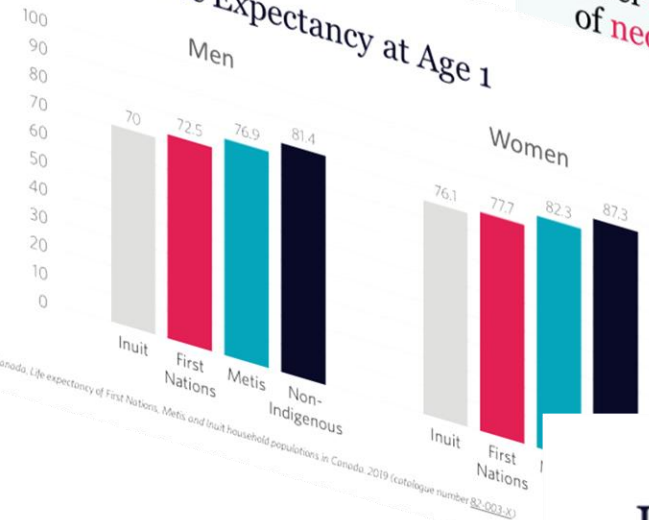
Discussion

- Did you make any observations that affected how you perceived the patient?
- What barriers made your assessment of the patient more difficult?
- What non-medical factors affect your decision-making
- What barriers affected your ability to manage the patient's condition?
- What role did bias play in this scenario
- What role did stigma play in this scenario
- What was the significance of the patient and her daughter's wanting to leave or not wanting to be transferred?
- What factors may have affected the patient's trust?

Discussion

- Is there anything you may be more aware of as a result of this exercise?
- How can you take this scenario and apply to your clinical approach

Indigenous Life Expectancy at Age 1



Statistics Canada. Life expectancy of First Nations, Metis and Inuit household populations in Canada, 2019 (catalogue number 82-003-X)

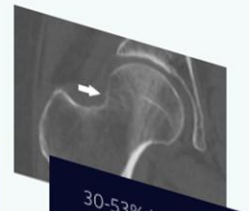
Over 40% higher rate
of neonatal death
...ous

First Nations adults have more than
2x the risk of dying from avoidable causes
Indigenous adults

...Health Reports, 2015; 26(8) 10-16.

"Compared with non-Aboriginals,

...st 2x rate of late
...ction after renal
...plant in Aboriginal
...hildren in BC



30-53% increased
mortality risk for hip
fractures in FN individuals

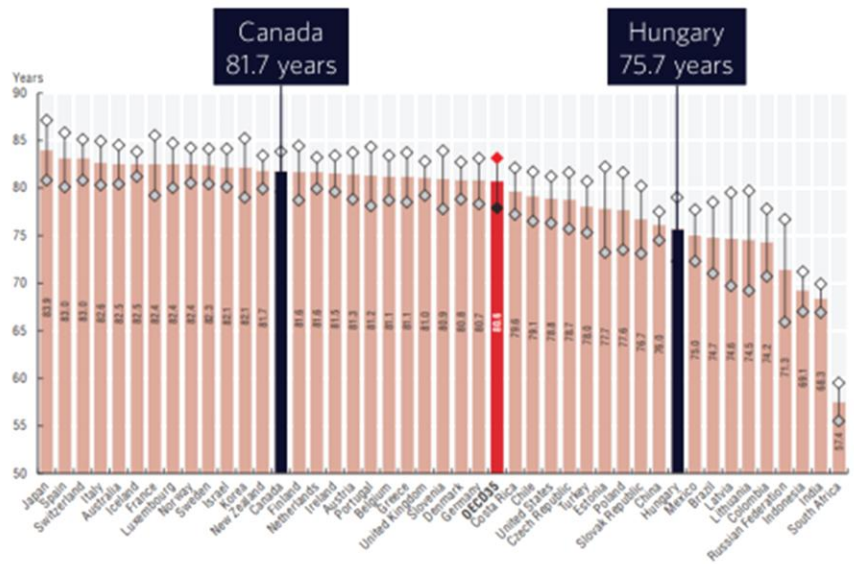
...diatric Transplantation. 2008;13, 856-860.
...ised analysis. Osteoporos Int. 2013; 24:1247-1256

...tween First Nation
Canada: Follow-up
...ohort

Cancer Epidemiology, Biomarkers & Prevention

...hort.

Life Expectancy at Birth by Country

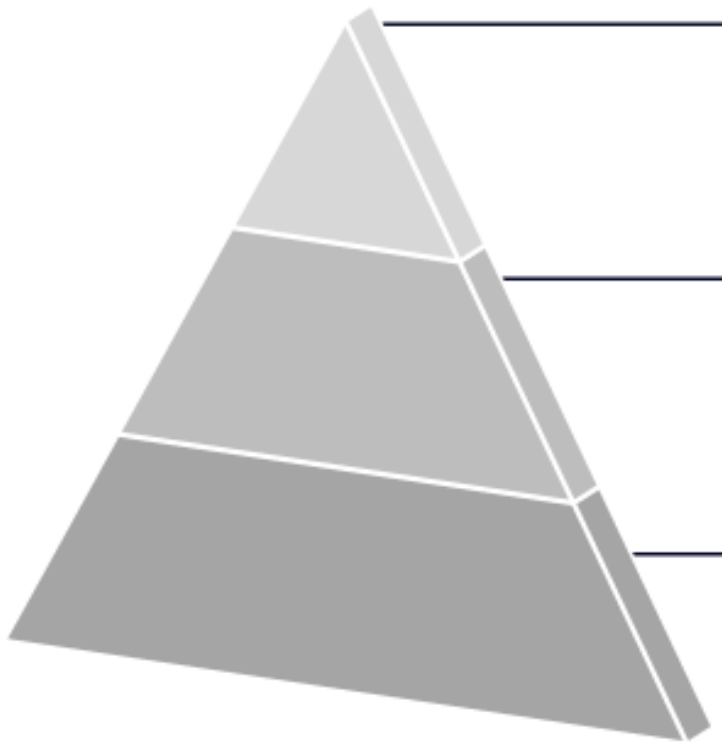


Provider Disconnect

- Provider perceive that the most important factors in improving outcomes for Indigenous patients are related to patients
  - Motivate patients to adopt healthy lifestyles
  - Help patients to seek preventative care
  - Improve adherence to medications
- Providers perceive that provider and systemic level factors as less likely to be important in affecting outcome

Bhattacharyya OK et al. Challenges to the provision of diabetes care in First Nations communities: results from a national survey of healthcare providers in Canada. BMH Health Services Research. 2011:11;283:http://www.biomedcentral.com/1472-6963/11/283

Determinants of Health

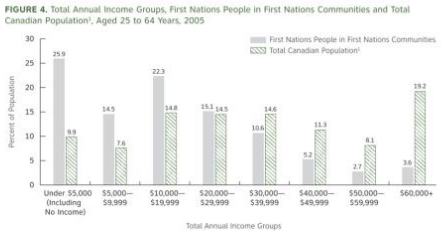


Proximal
- Health Behaviour
- Physical Environment
- Employment & Income
- Education
- Food security

Intermediate
- Health care system
- Educational system
- Community infrastructure
- Environmental stewardship
- Cultural continuity

Distal
- Colonialism
- Racial and social exclusion
- Self-determination

Income



ring outside First Nations communities.
66 up to 100% due to rounding.
006 Census custom tabulation.

Food Security

- 29% of Indigenous vs 9% of non-Indigenous households are food-insecure[1]
- Food insecure households have significantly higher rates of poor general health[2]
- Food insecurity is associated with obesity[2]
- Climate change is projected to reduce the intake of esser
  2050 in BC Coastal First Nations communities dependar

1. Willows N et al. Associations between household food insecurity and health outcomes in the Aborig
2. Rheaims J et al. The association of household food security, household characteristics and activities
   youth in Canada: results from the 2012 Aboriginal Peoples Survey. Health Promotion and Chronic Di
3. Mirzabeigi L et al. Potential impacts of climate-related decline of soybean harvest on nutritional stat

Social Services & Oppression

Sixties Scoop

- Mass removal of Indigenous children from their families
- Began as residential school were becoming phased out in the 1950's to 60's
- 1/3 of all children in government care were Indigenous
- Loss of culture, family, and identity

Medical System & Oppression

Nutrition deprivation experiment

- Indigenous children deliberately starved in 1940 - 1950's by government researchers
- Purpose is to identify the effects of malnutrition
- Involved at least 1,300 people
- Port Alberni, BC was one of the r

Source: https://www.thestar.com/news/canada/2013/07/16/hur unwittingly_in_nutrition_experiments_researcher_says.html
Report: http://hssh.journals.yorku.ca/index.php/hssh/article/view

Residential School

- 1870's: Canadian government partnered with Anglican, Catholic, United, and Presbyterians churches to establish and operate boarding and residential schools for Aboriginal (First Nations, Inuit, and Métis) children
- Intent to educate, assimilate, and integrate Aboriginal people into Canadian society
  - System designed "to kill the Indian in the child"

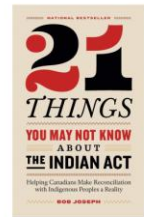
Aboriginal children across

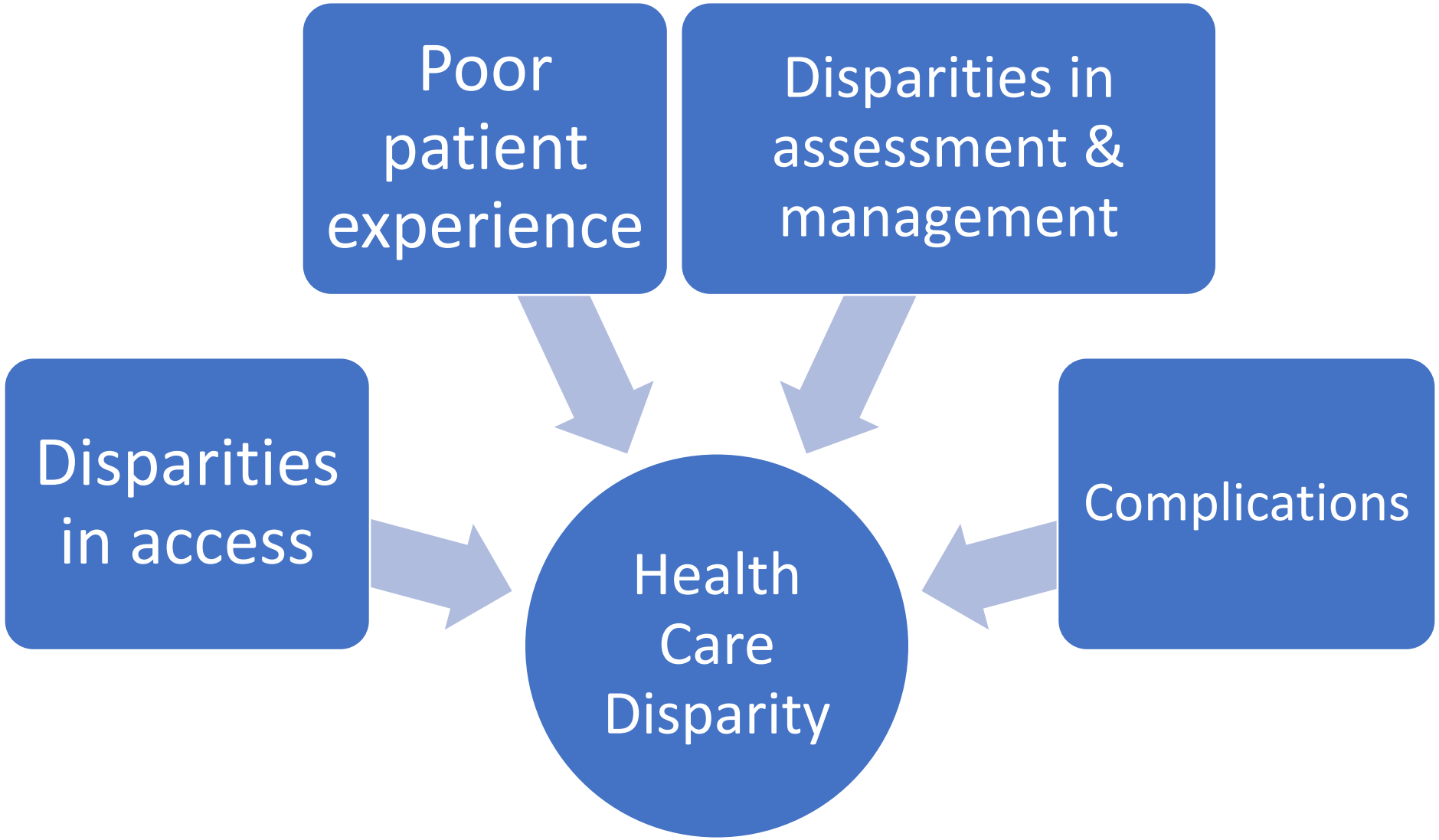
parents, including

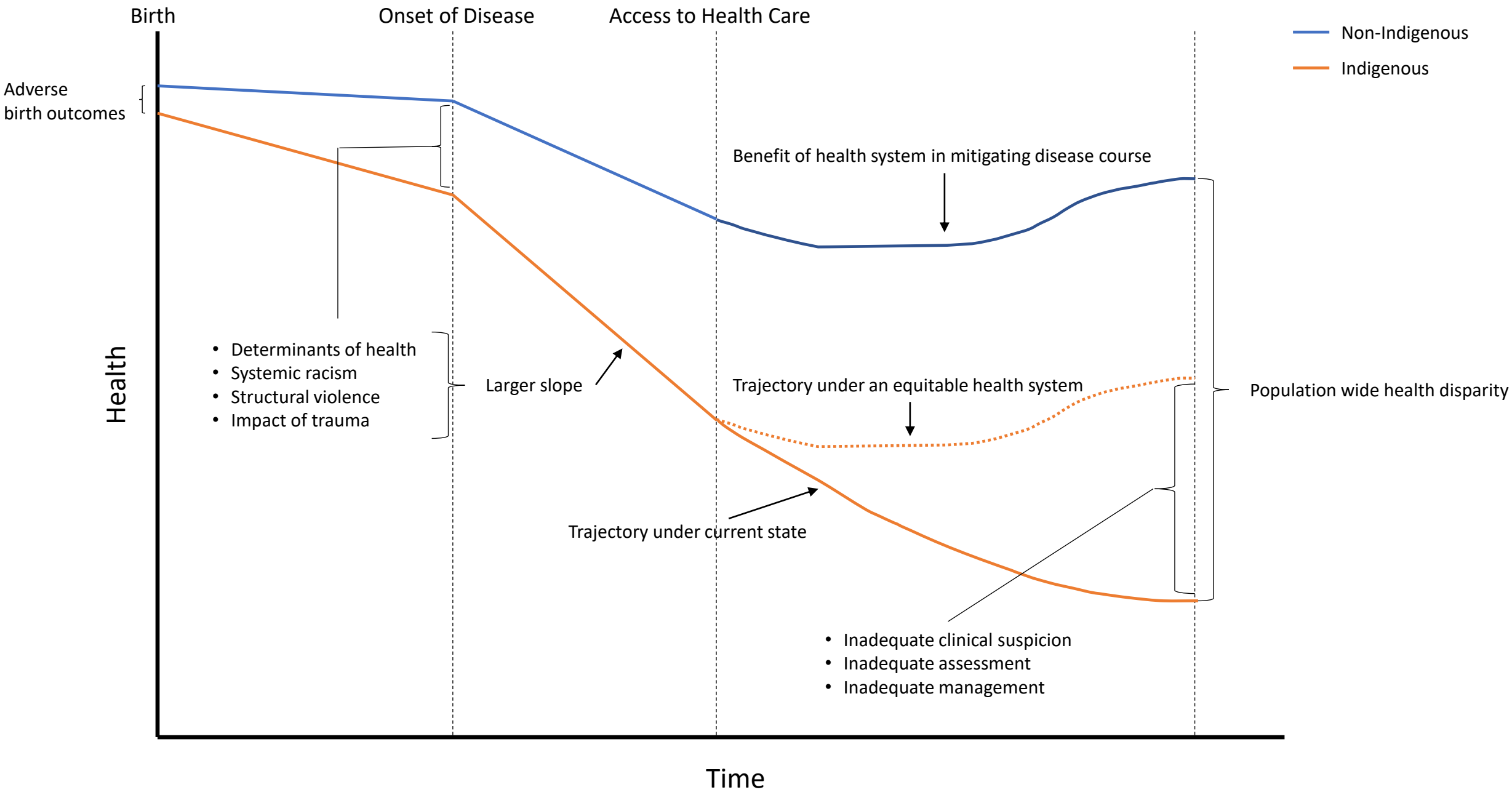
/missing-children-unmarked-burials-a-legacy-of-residential-schools/article27772367/

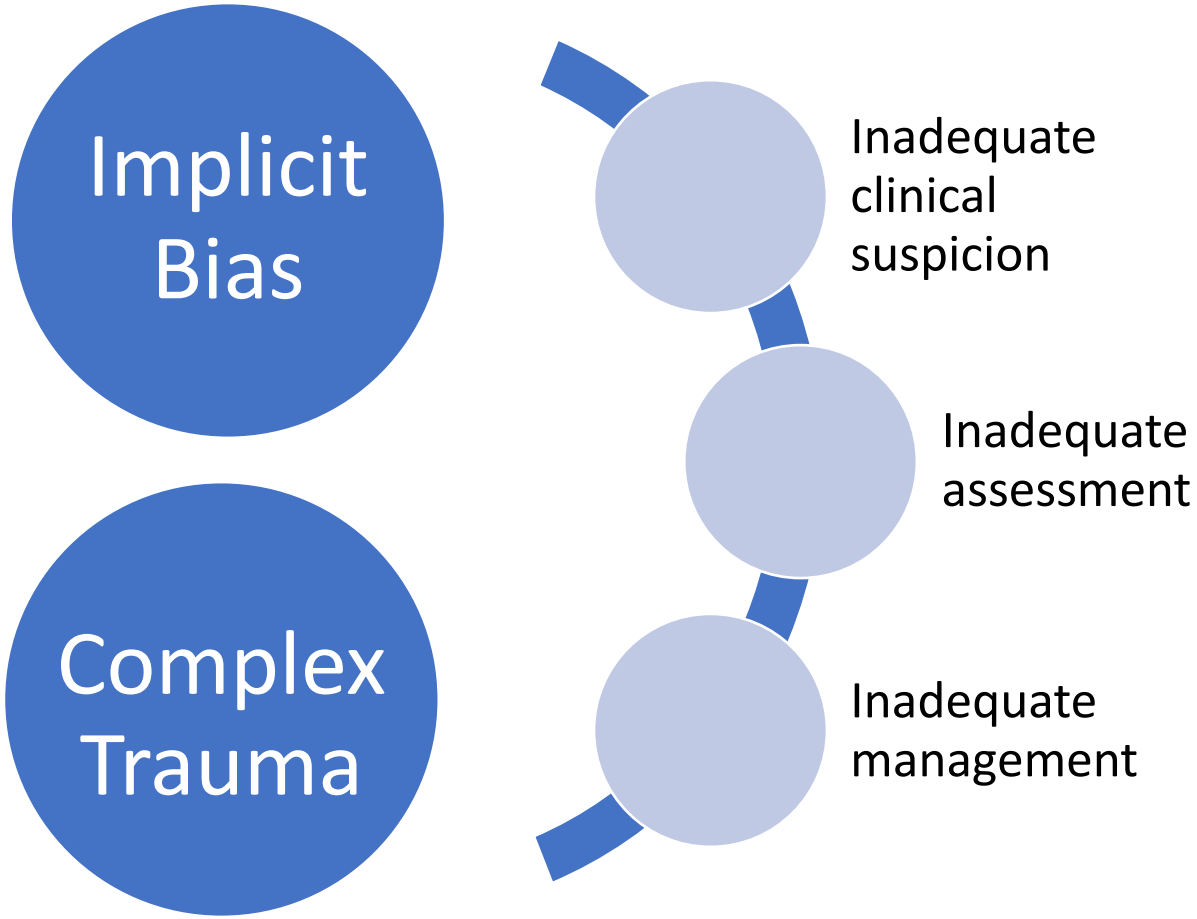
The Indian Act

- Disrupted traditional governance structures
- Prohibited political organization
- Denied right to vote
- Prohibited legal representation
- Imposed different rights between men and women
- Prohibited traditional practices
- Limited ability to sell farm products
- Restricted movement off reserves




Poor patient experience
Disparities in assessment & management
Disparities in access
Health Care Disparity
Complications


Birth
Onset of Disease
Access to Health Care
Non-Indigenous
Indigenous
Adverse
birth outcomes
Benefit of health system in mitigating disease course
Health
• Determinants of health
• Systemic racism
• Structural violence
• Impact of trauma
Larger slope
Trajectory under an equitable health system
Population wide health disparity
Trajectory under current state
• Inadequate clinical suspicion
• Inadequate assessment
• Inadequate management
Time


Implicit Bias
Complex Trauma
Inadequate clinical suspicion
Inadequate assessment
Inadequate management

Impairment of Clinical Process

- Inadequate clinical suspicion
  - Lack of recognition of external bias
  - Misattribution of presentation due to stereotypes
  - Lack of recognition of higher pre-test probability
- Inadequate assessment
  - Inadequate physical environment
  - Inadequate history and physical exam
  - Inadequate investigation
- Inadequate management
  - Lack of rapport may decrease adherence
  - Disproportionate focus on health behaviours causes loss of buy-in
  - Neglecting to connect patients with appropriate resources
  - Lack of proactive recognition and mitigation of barriers to help achieve treatment goals
  - Lack of understanding that patient may have poorer access to primary care

Implicit Bias

Implicit Bias

- Implicit bias involve associations outside conscious awareness and control
- Association between a group and a stereotype
- May lead to a negative evaluation of a person on the basis of irrelevant characteristics
- May not correspond with what the individual explicitly believes

FitzGerald C, Hurst S. Implicit bias in healthcare professionals: a systematic review. BMC Medical Ethics. 2017;18:19. doi:10.1186/s12910-017-0179-8.

Implicit Bias

- There is evidence of implicit bias in health care professionals
- Health professionals exhibit the same levels of implicit bias as the general population
- Significant relation between implicit bias and lower quality of care

FitzGerald and Hurst *BMC Medical Ethics* (2017) 18:19
DOI 10.1186/s12910-017-0179-8

BMC Medical Ethics

RESEARCH ARTICLE Open Access

Implicit bias in healthcare professionals: a systematic review

Chloë FitzGerald* and Samia Hurst

Abstract

Background: Implicit biases involve associations outside conscious awareness that lead to a negative evaluation of a person on the basis of irrelevant characteristics such as race or gender. This review examines the evidence that healthcare professionals display implicit biases towards patients.

Methods: PubMed, PsychINFO, PsychARTICLE and CINAHL were searched for peer-reviewed articles published between 1st March 2003 and 31st March 2013. Two reviewers assessed the eligibility of the identified papers based on precise content and quality criteria. The references of eligible papers were examined to identify further eligible studies.

Results: Forty two articles were identified as eligible. Seventeen used an implicit measure (Implicit Association Test in fifteen and subliminal priming in two), to test the biases of healthcare professionals. Twenty five articles employed a between-subjects design, using vignettes to examine the influence of patient characteristics on healthcare professionals' attitudes, diagnoses, and treatment decisions. The second method was included although it does not isolate implicit attitudes because it is recognised by psychologists who specialise in implicit cognition as a way of detecting the possible presence of implicit bias. Twenty seven studies examined racial/ethnic biases; ten other biases were investigated, including gender, age and weight. Thirty five articles found evidence of implicit bias in healthcare professionals; all the studies that investigated correlations found a significant positive relationship between level of implicit bias and lower quality of care.

Discussion: The evidence indicates that healthcare professionals exhibit the same levels of implicit bias as the wider population. The interactions between multiple patient characteristics and between healthcare professional and patient characteristics reveal the complexity of the phenomenon of implicit bias and its influence on clinician-patient interaction. The most convincing studies from our review are those that combine the IAT and a method measuring the quality of treatment in the actual world. Correlational evidence indicates that biases are likely to influence diagnosis and treatment decisions and levels of care in some circumstances and need to be further investigated. Our review also indicates that there may sometimes be a gap between the norm of impartiality and the extent to which it is embraced by healthcare professionals for some of the tested characteristics.

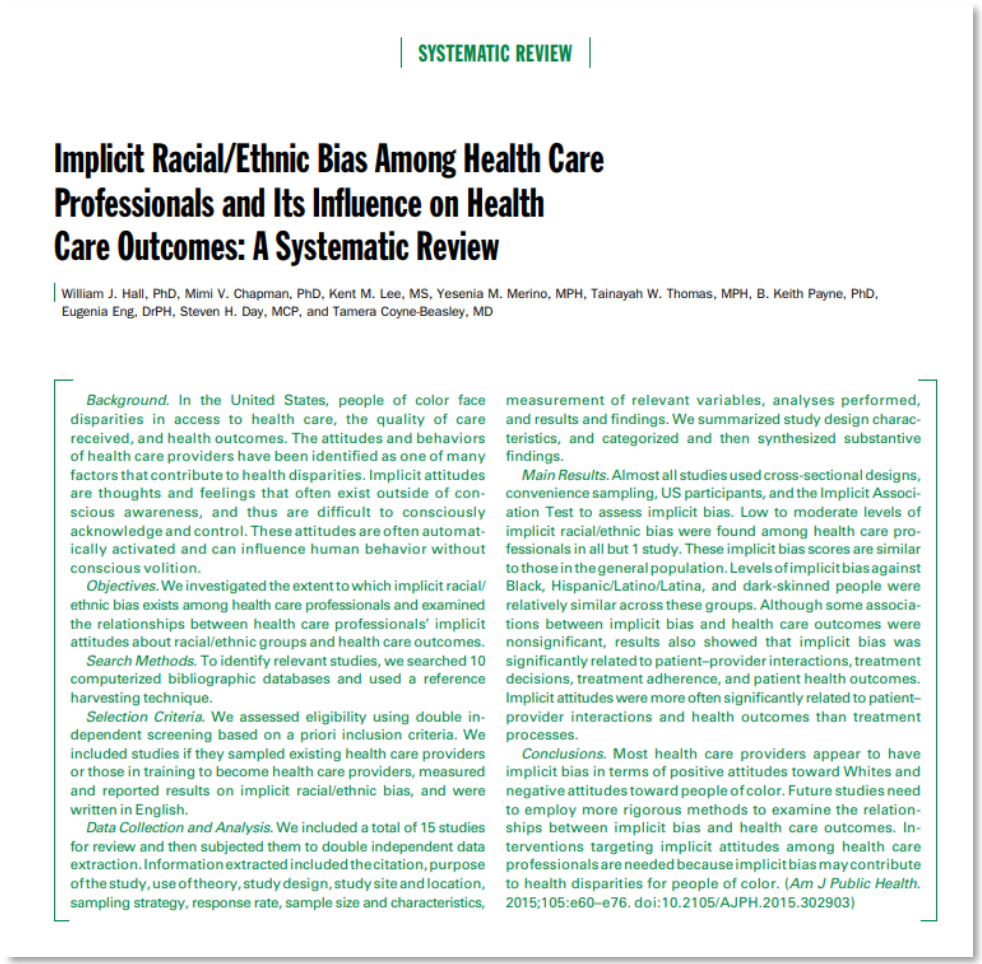
Conclusions: Our findings highlight the need for the healthcare profession to address the role of implicit biases in disparities in healthcare. More research in actual care settings and a greater homogeneity in methods employed to test implicit biases in healthcare is needed.

Keywords: Implicit bias, Prejudice, Stereotyping, Attitudes of health personnel, Healthcare disparities

FitzGerald C, Hurst S. Implicit bias in healthcare professionals: a systematic review. BMC Medical Ethics. 2017;18:19. doi:10.1186/s12910-017-0179-8.

Implicit Bias

- Implicit bias is significantly related to:
  - Patient-provider interactions
  - Treatment decisions
  - Treatment adherence
  - Patient health outcomes
- Most health care providers have a pro-White bias and negative attitudes towards people of colour



SYSTEMATIC REVIEW

Implicit Racial/Ethnic Bias Among Health Care Professionals and Its Influence on Health Care Outcomes: A Systematic Review

William J. Hall, PhD, Mimi V. Chapman, PhD, Kent M. Lee, MS, Yesenia M. Merino, MPH, Tainayah W. Thomas, MPH, B. Keith Payne, PhD, Eugenia Eng, DrPH, Steven H. Day, MCP, and Tamera Coyne-Beasley, MD

Background. In the United States, people of color face disparities in access to health care, the quality of care received, and health outcomes. The attitudes and behaviors of health care providers have been identified as one of many factors that contribute to health disparities. Implicit attitudes are thoughts and feelings that often exist outside of conscious awareness, and thus are difficult to consciously acknowledge and control. These attitudes are often automatically activated and can influence human behavior without conscious volition.

Objectives. We investigated the extent to which implicit racial/ethnic bias exists among health care professionals and examined the relationships between health care professionals' implicit attitudes about racial/ethnic groups and health care outcomes.

Search Methods. To identify relevant studies, we searched 10 computerized bibliographic databases and used a reference harvesting technique.

Selection Criteria. We assessed eligibility using double independent screening based on a priori inclusion criteria. We included studies if they sampled existing health care providers or those in training to become health care providers, measured and reported results on implicit racial/ethnic bias, and were written in English.

Data Collection and Analysis. We included a total of 15 studies for review and then subjected them to double independent data extraction. Information extracted included the citation, purpose of the study, use of theory, study design, study site and location, sampling strategy, response rate, sample size and characteristics, measurement of relevant variables, analyses performed, and results and findings. We summarized study design characteristics, and categorized and then synthesized substantive findings.

Main Results. Almost all studies used cross-sectional designs, convenience sampling, US participants, and the Implicit Association Test to assess implicit bias. Low to moderate levels of implicit racial/ethnic bias were found among health care professionals in all but 1 study. These implicit bias scores are similar to those in the general population. Levels of implicit bias against Black, Hispanic/Latino/Latina, and dark-skinned people were relatively similar across these groups. Although some associations between implicit bias and health care outcomes were nonsignificant, results also showed that implicit bias was significantly related to patient–provider interactions, treatment decisions, treatment adherence, and patient health outcomes. Implicit attitudes were more often significantly related to patient–provider interactions and health outcomes than treatment processes.

Conclusions. Most health care providers appear to have implicit bias in terms of positive attitudes toward Whites and negative attitudes toward people of color. Future studies need to employ more rigorous methods to examine the relationships between implicit bias and health care outcomes. Interventions targeting implicit attitudes among health care professionals are needed because implicit bias may contribute to health disparities for people of color. (*Am J Public Health.* 2015;105:e60–e76. doi:10.2105/AJPH.2015.302903)

Hall WJ, Chapman MV, Lee KM, et al. Implicit Racial/Ethnic Bias Among Health Care Professionals and Its Influence on Health Care Outcomes: A Systematic Review. American Journal of Public Health. 2015;105(12):e60-e76. doi:10.2105/AJPH.2015.302903.

Implicit Bias

Communication

- Explicit bias affects content of conversation
- Implicit bias affects non-verbal forms of communication
    - Eye contact
    - Mannerisms
    - Speech errors

Dovidio JF, Gaertner SL, Kawakami K. Implicit and Explicit prejudice and interracial interaction. Journal of Personality and Social Psychology. 2002; 82(1):62-68

Implicit Bias

Greater clinician implicit bias is linked to:

- Encounters with black patients:
    - Clinician verbal dominance
    - Lower liking of clinician by patient
    - Lower confidence in the clinician
    - Lower likelihood of recommending clinician to others
- Encounters with white patients:
    - Higher likelihood of perceiving respect
    - Believing they are liked by clinician
    - Lower likelihood of finding encounter to be participatory

Cooper LA, Roter DL, Carson KA et al. The associations of clinicians' implicit attitudes about race with medical visit communication and patient ratings of interpersonal care. American Journal of Public Health. 2012 May; 102(5): 979-987

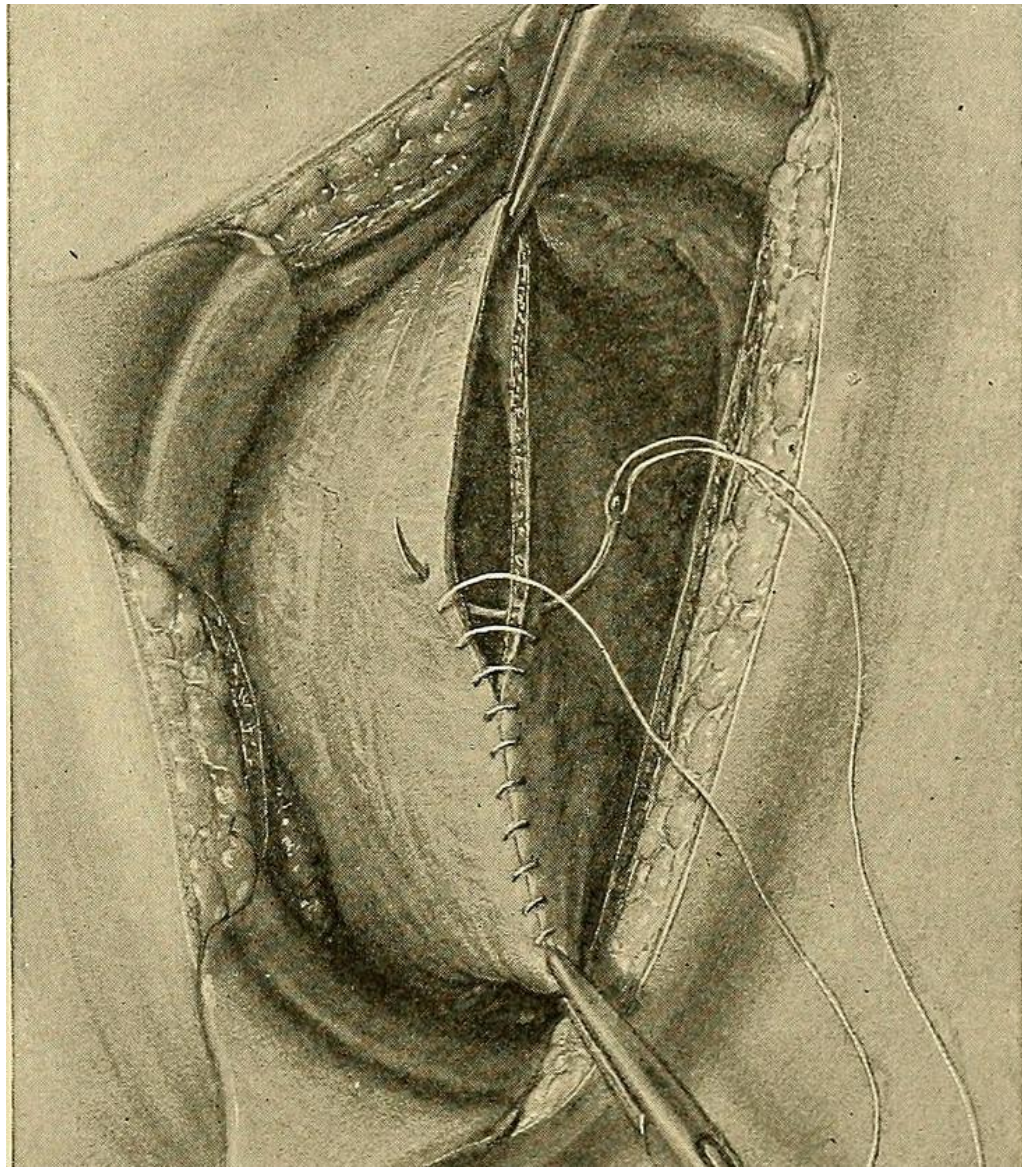
Impact of Implicit Bias

- **Discordance** in explicit and implicit bias is associated with **less positive interactions**
- Clinicians with low implicit and explicit bias is obviously perceived the best
- Clinicians with high explicit and implicit bias surprisingly is perceived better than those with discordant biases

Penner LA, Dovidio JF, West TV et al. Aversive racism and medical interactions with black patients: a field study. Journal of Experimental Social Psychology. 2010 Mar;46(2):doi:10.1016/j.jesp.2009.11.004

Cognitive Forcing Strategies

- Assume implicit bias is present
- Force yourself to ensure that the effects of implicit bias has been mitigated
- Imagine that your clinical encounter is being observed and assessed by an outside party, or by your own loved ones



Individualization

- Focus on seeing each patient as a unique individual rather than a representative of a population
  - Focus on social history
  - Involve family members

Devine PG, Forscher PS, Austin AJ et al. Long-term reduction in implicit race bias: a prejudice habit-breaking intervention. Journal of Experimental Social Psychology. 2012 Nov;48(6):1267-1278

Stereotype Replacement

- Stereotypic response:
  - Limited testing
  - Anticipate poor adherence
  - Non-patient-centered communication style
- Replace with favourable response
  - Opportunity to address the existing health disparity
  - Opportunity to mitigate risk factors and poor health determinants

Devine PG, Forscher PS, Austin AJ et al. Long-term reduction in implicit race bias: a prejudice habit-breaking intervention. Journal of Experimental Social Psychology. 2012 Nov;48(6):1267-1278

Increase meaningful interactions

- Make **meaningful friendship** with people outside of one's own demographic
- Develop healthy **respect and admiration**
- Opportunity to develop **counter-stereotypic imaging**

Aberson CL, Shoemaker C, Tomolillo C. Implicit bias and contact: the role of interethnic friendships. The Journal of Social Psychology. 2004; 14(3):335-347

Impact of Trauma

Types of Trauma

- Single incident trauma: related to an unexpected and overwhelming event
- Complex trauma: relating to ongoing abuse, intimate partner violence, war, ongoing betrayal, being trapped emotionally or physically
- Developmental trauma: exposure to early ongoing or repetitive trauma, often within the child's care giving system, interfering with heathy attachment and development
- Intergenerational trauma: psychological or emotional effects that can be experienced by people who live with trauma survivors
- Historical trauma: cumulative psychological wounding across generations emanating from massive group trauma

Centre of Excellence for Women's Health. Trauma Informed Practice Guide. 2013. Available: http://bccewh.bc.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf

Impact of Trauma

Physical	Emotional or Cognitive	Spiritual	Interpersonal	Behavioural
Unexplained chronic pain or numbness	Depression	Loss of meaning, or faith	Frequent conflict in relationships	Substance use
Stress-related conditions (e.g., chronic fatigue)	Anxiety	Loss of connection to: self, family, culture, community, nature, a higher power	Lack of trust	Difficulty enjoying time with family/ friends
Headaches	Anger management	Feelings of shame, guilt	Difficulty establishing and maintaining close relationships	Avoiding specific places, people, situations (e.g., driving, public places)
Sleep problems	Compulsive and obsessive behaviours	Self-blame	Experiences of revictimization	Shoplifting
Breathing problems	Dissociation	Self-hate	Difficulty setting boundaries	Disordered eating
Digestive problems	Being overwhelmed with memories of the trauma	Feel completely different from others		Self-harm
	Difficulty concentrating, feeling distracted	No sense of connection		High-risk sexual behaviours
	Fearfulness	Feeling like a 'bad' person		Suicidal impulses
	Emotionally numb/flat			Gambling
	Loss of time and memory problems			Isolation
	Suicidal thoughts			Justice system involvement

Centre of Excellence for Women's Health. Trauma Informed Practice Guide. 2013. Available: http://bccewh.bc.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf

“Trauma becomes decontextualized and over time can look like culture.

…and over time can look like family traits.

…and over time can look like personality.”

Resmaa Menakem

Principles of Trauma-Informed Practice

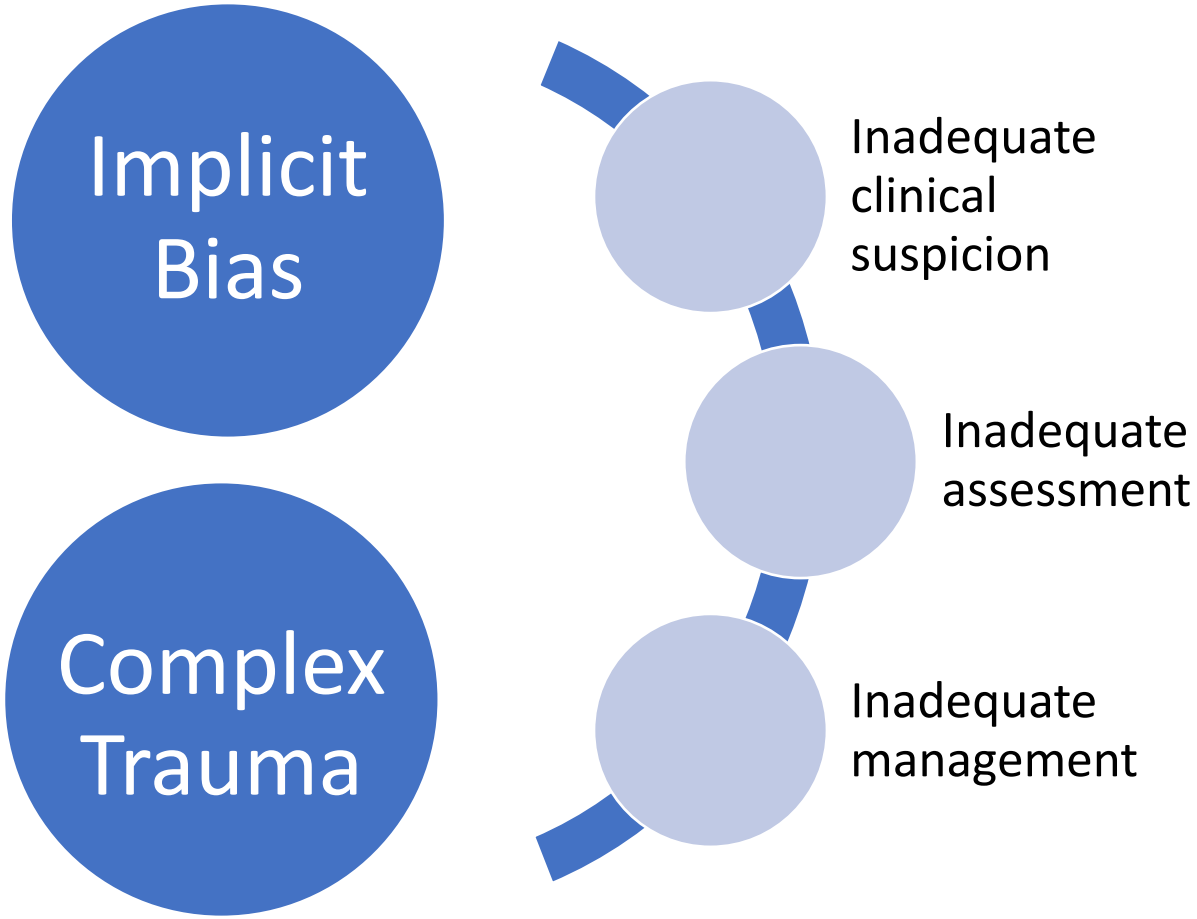
- Trauma awareness
- Emphasis on safety and trustworthiness
- Opportunity for choice, collaboration, and connection
- Strength-based and skill building

Centre of Excellence for Women's Health. Trauma Informed Practice Guide. 2013. Available: http://bccewh.bc.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf

Increase Trauma Awareness

FROM (Deficit Perspective)	TO (Trauma-Informed & Strengths-Based)
What is wrong?	What has happened?
Symptoms	Adaptations
Disorder	Response
Attention seeking	The individual is trying to connect in the best way they know how
Borderline	The individual is doing the best they can given their early experiences
Controlling	The individual seems to be trying to assert their power
Manipulative	The individual has difficulty asking directly for what they want
Malingering	Seeking help in a way that feels safer

Centre of Excellence for Women's Health. Trauma Informed Practice Guide. 2013. Available: http://bccewh.bc.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf


Implicit Bias
Complex Trauma
Inadequate clinical suspicion
Inadequate assessment
Inadequate management

Inadequate Clinical Suspicion

Recognize external bias

- You may receive information about the patient from other providers prior to your own assessment
  - Referring health care provider
  - Allied health workers
  - Clerical staff
- Their impression of the patient may be affected by their own bias
- Consider how this may affect your level of clinical suspicion

Recognize external bias

- First Nations patients were less likely than other Canadians to have an urgent CTAS score (30.1% vs 44.1%)
- Paradoxically, First Nations patients also have admission rates 50 to 70% higher in the CTAS 4 to 5 group
- Raises the potential that initial triaging may underestimate acuity

Turpel-Lafond ME. In Plain Sight: Addressing Indigenous-specific racism and discrimination in BC Health Care. 2020. Available: https://engage.gov.bc.ca/app/uploads/sites/613/2021/02/In-Plain-Sight-Data-Report_Dec2020.pdf1_.pdf

Recognize external bias

- Among patients saturating >92% on pulse oximetry, occult hypoxemia (<88% by ABG) was found in 12% of Black patients vs 4% of White patients[1]
- Most pulse oximeters have likely been calibrated using light-skinned individuals with the assumption that skin pigmentation does not matter[2]

1. *Sjoding MW et al. Racial bias in pulse oximetry measurement. New England Journal of Medicine. 2020:383(25);211-214*
2. *Bickler PE, Feiner JR, and Severinghaus JW. Effects of skin pigmentation on pulse oximeter accuracy at low saturation. Anesthesiology. 2005;102(4):715-719*

Recognize the impact of stereotypes

Evidence of widespread Indigenous-specific stereotyping in the BC health care system

- Less “worthy” of care
- Alcohol use
- Drug-seeking
- Bad parents
- “Frequent flyers”
- Irresponsible
- Non-adherent
- Less capable
- Unfairly advantaged

Turpel-Lafond ME. In Plain Sight: Addressing Indigenous-specific racism and discrimination in BC Health Care. 2020. Available: https://engage.gov.bc.ca/app/uploads/sites/613/2020/11/In-Plain-Sight-Full-Report.pdf

Recognize the impact of stereotypes

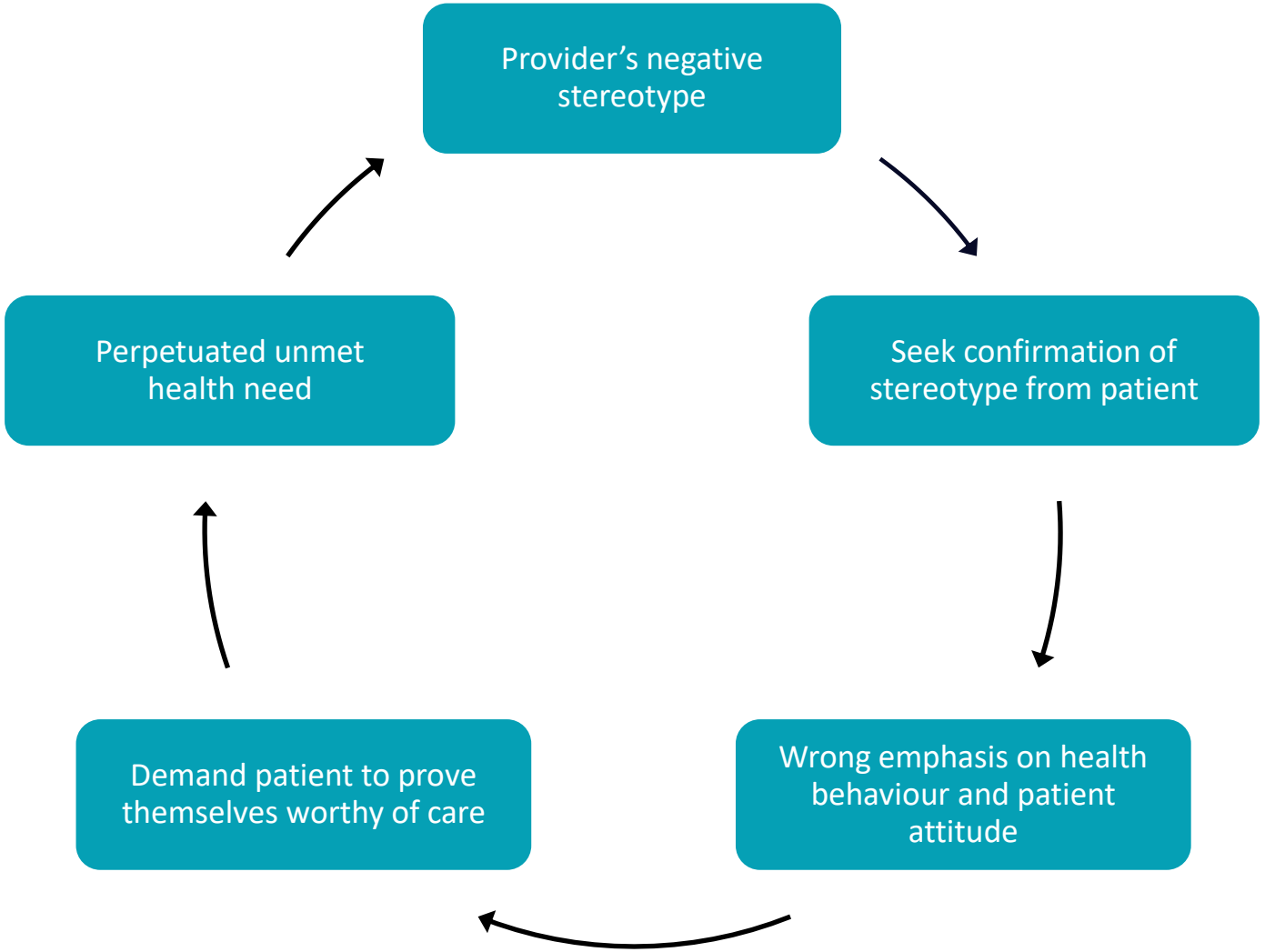
- When primed with images of black faces, physicians reacted more quickly for stereotypical diseases
- Not limited to genetically predisposed diseases, but also conditions such as obesity and substance use

Moskowitz GB, Stone J, Childs A. Implicit stereotyping and medical decisions: unconscious stereotype activation in practitioner's thoughts about African Americans. American Journal of Public Health. 2012 May;102(5):996-1001

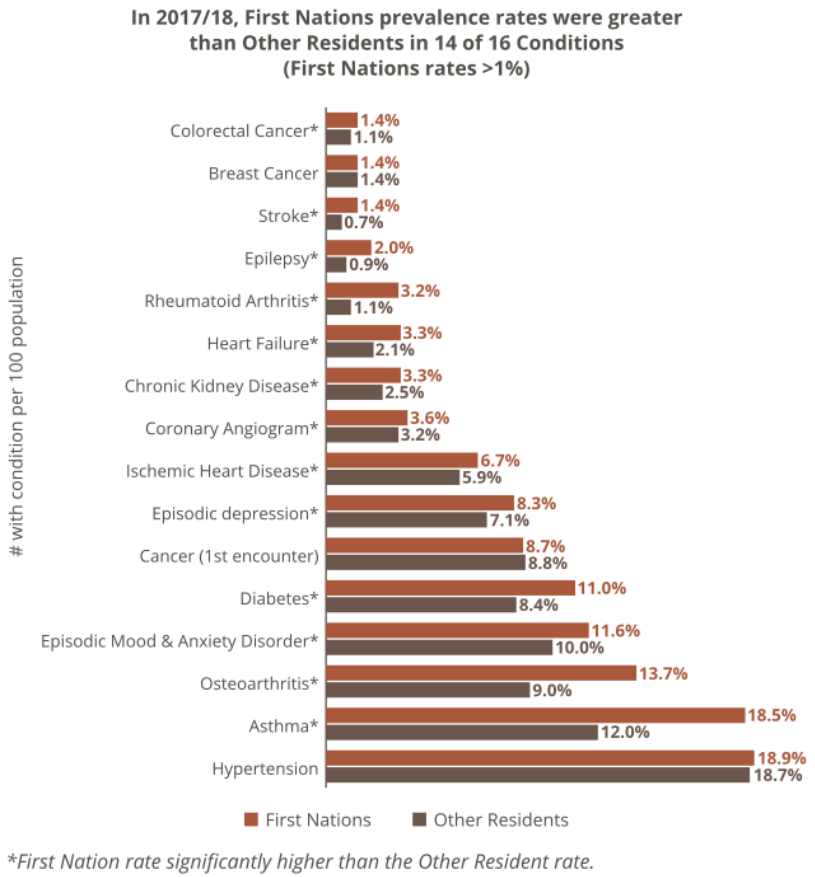
“Power is the ability not just to tell the story of another person, but to make it the definitive story of that person.”

Chimamanda Ngozi Adichie

Recognize the impact of stereotypes

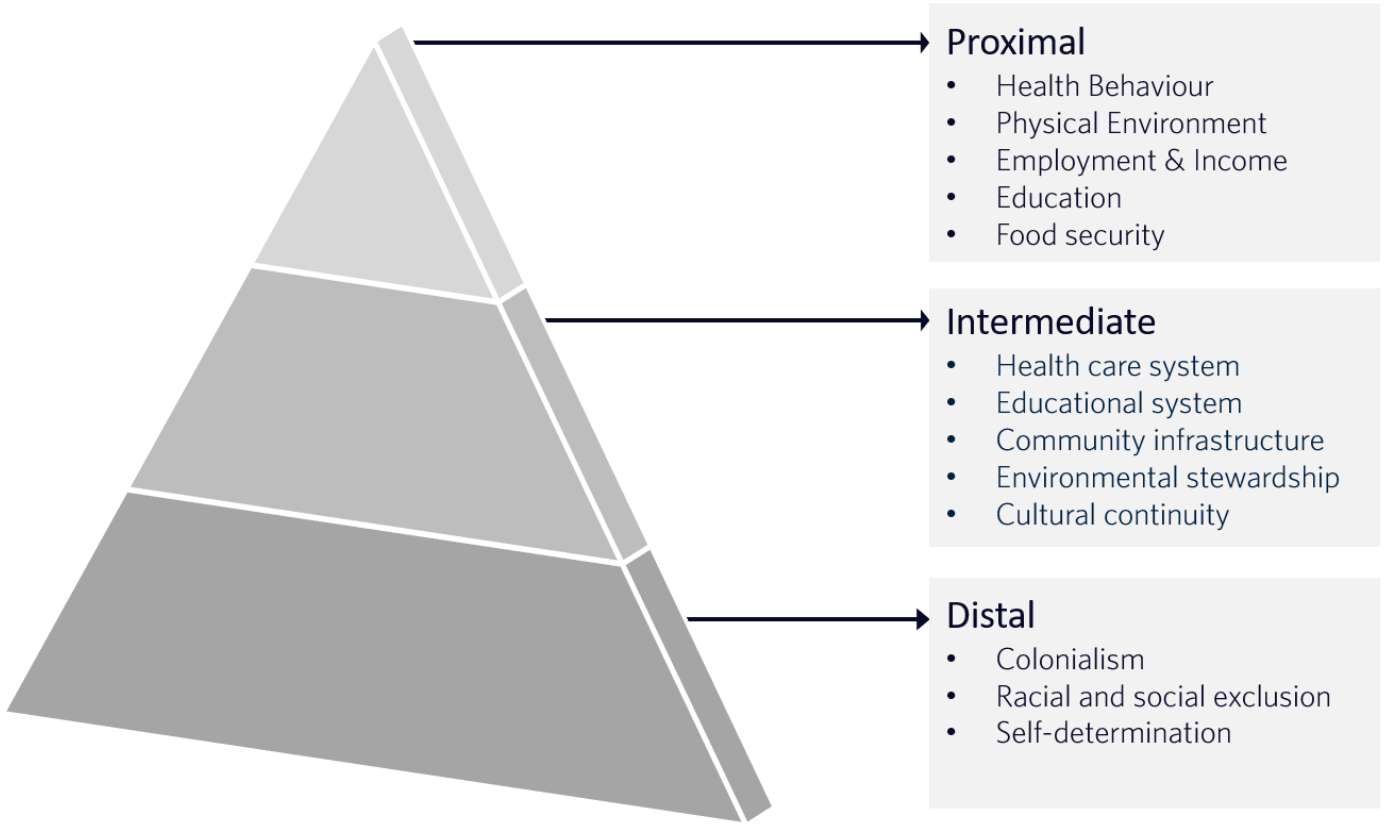


Recognize higher pre-test probability



Turpel-Lafond ME. In Plain Sight: Addressing Indigenous-specific racism and discrimination in BC Health Care. 2020. Available: https://engage.gov.bc.ca/app/uploads/sites/613/2020/11/In-Plain-Sight-Full-Report.pdf

Recognize higher pre-test probability



Using Determinants of Health as a risk prediction model was accurate for all cause hospitalization and death

Hammond G et al. Social determinants of health improve predictive accuracy of clinical risk models for cardiovascular hospitalization, annual cost, and death. Circ Cardiovasc Qual Outcomes. 2020;13:e006752

Inadequate Assessment

Prioritize earning trust

- Recognize that individuals may feel unsafe due to prior experiences
  - Respond to expressions of anger or frustration with empathetic and respectful responses
- Do not expect or assume trust from the beginning
- Make earning trust a distinct clinical objective in the clinical encounter
- Be responsive to immediate needs
  - Physical comfort, pain, food, clothing, housing, or transportation

1. Centre of Excellence for Women's Health. Trauma Informed Practice Guide. 2013. Available: http://bccewh.bc.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf
2. Browne AJ et al. Enhancing health care equity with Indigenous populations: evidence-based strategies from an ethnographic study. BMC Health Services Research. 2016:16(544). Doi 10.1186/s12913-016-1707-9

Prioritize earning trust

Trust can be related to the physician getting to know the patient as an individual and as a member of their community.

“Talk with them, get to know them… That’s what really makes a difference with this doctor that I’ve got. He really knows a lot about me and my family situation, my upbringing and it really…made me feel comfortable.”

Towle A, Godolphin W, Alexander T. Doctor-patient communications in the Aboriginal community: towards the development of educational programs. Patient education and Counseling. 2006:62;340-346

Prioritize earning trust

Trust could be earned over time by developing relationships

“They just have to gain their trust and lots have, you know. I’ve seen lots gain trust real fast and some never, never get the trust…The ones that seem to get it…tried extra hard to communicate…The ones that went on home visits were always solidly in quicker…The ones that came to things was a sign that they respected our ways.”

Towle A, Godolphin W, Alexander T. Doctor-patient communications in the Aboriginal community: towards the development of educational programs. Patient education and Counseling. 2006:62;340-346

Prioritize earning trust

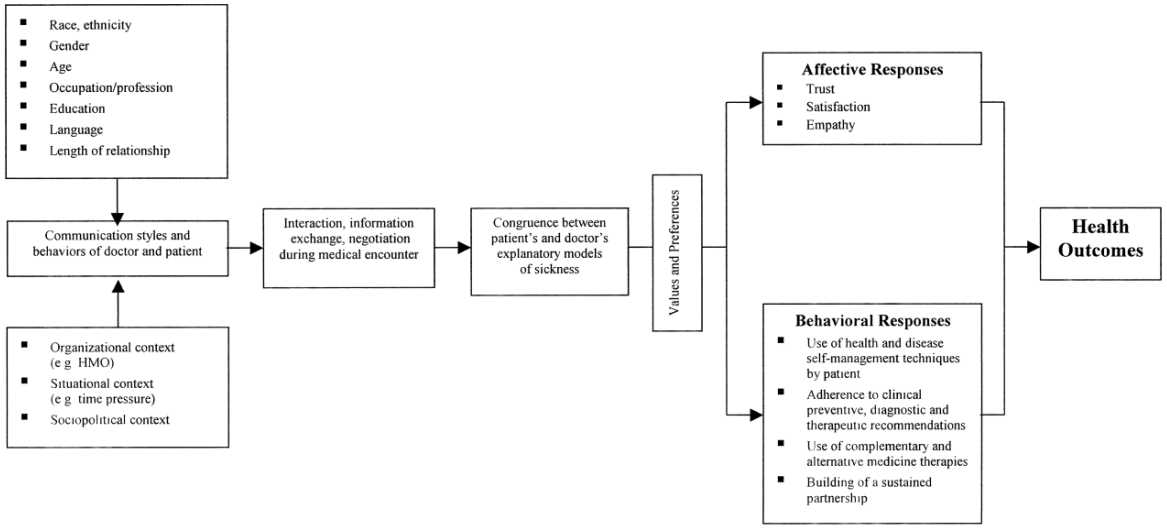
- Avoid creating unnecessary doubt towards the health care system or other health care providers
- Avoid contributing to an impression of an impersonal system that is unlikely to meet their needs or does not care about the patient
- The aim is to reduce the likelihood of future care avoidance
- Does not apply to cases where there is significant deficiencies in care, which should follow the standard harm disclosure and response framework

Convey a caring attitude

"Professional. To be not so…professional. I've known her for years and years but I don't know her. I know it's professional, it's her job but she could at least take the time."

Towle A, Godolphin W, Alexander T. Doctor-patient communications in the Aboriginal community: towards the development of educational programs. Patient education and Counseling. 2006:62;340-346

Convey a caring attitude



- Physicians have poorer interpersonal skills, provide less information, and use less-participatory decision-making styles with minority patients
- Primary care physicians are more likely to adopt a narrowly biomedical communication pattern with African Americans
- Physicians perceive patients who state their concerns and ask questions as better communicators
- Patients from minority groups may be less inclined to share their health narrative, use different terms to describe the same phenomenon, and may self-censor content that they feel may be unacceptable

Ashton CM et al. Racial and ethnic disparities in the use of health services: bias, preferences, or poor communication? Journal of General Internal Medicine. 2003:18;146-152

Convey a caring attitude

Examples of valued elements in clinical encounters

- Being visible: being seen as Indigenous, heard, and respected
- Being treated as a “human being” in the patient-caregiver relationship
- Attentive and responsive to needs
- Provide timely care with demonstrated effort
- Being “straight” with people
- Apologize for delays

Hole RD et al. Visibility and Voice: Aboriginal people experience culturally safe and unsafe health care. Qualitative Health Research. 2015:25(12);1662-1674

Convey a caring attitude

Opening statement

- Sets the tone for the conversation
- Convey that you will support the individual
- Explicitly let the individual know that you will figure out together the most helpful way forward

“Thank you for taking the time to speak with me. I appreciate it’s not easy coming in to speak with someone you don’t know, and that accessing health care can be a frustrating experience. My goal today is to find out how we could best support your needs today.”

Centre of Excellence for Women’s Health. Trauma Informed Practice Guide. 2013. Available: http://bccewh.bc.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf

Convey a caring attitude

Reflective listening

- Help individuals feel heard and valued

Patient: “You’re the third person I’ve had to talk to since I got here…I’m so sick of answering everyone’s questions.”

Practitioner: “It is really frustrating to have to keep retelling your story. You might be wondering if I can be helpful, or if I will just pass you on to the next person.”

Centre of Excellence for Women’s Health. Trauma Informed Practice Guide. 2013. Available: http://bccewh.bc.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf

Be as transparent, consistent, and predictable as possible

- Offer explanation for
  - Questions on sensitive topics or common stereotypes
  - Physical exam, especially ones involving sensitive parts or discomfort
  - Investigations, treatments, and referrals
- Keep promises
- Take responsibility for errors and miscommunication
- Use guidelines to maintain consistency
- Clearly outline boundaries and expectations in advance

Centre of Excellence for Women's Health. Trauma Informed Practice Guide. 2013. Available: http://bccewh.bc.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf

Be mindful of the use of language

Consider how the order of questions may leave the patient with an impression or associations

Physician: “Where do you live?”

Patient: “I live in Yekooche” (First Nation community)

Physician: “How much alcohol do you drink in one week?”

While both substance use and living circumstances are typical parts of the social history, discussing them together may lead the patient to believe that you are making an association

Be mindful of the use of language

Asking about substance use

- Consider new order of history taking
  - History of presenting complaint
  - Past medical history
  - Medications
  - Substance use
  - Allergies
  - Social history

- “People may use medications that are not prescribed by physicians, over the counter medications, chemicals, other substances, cigarettes, cannabis, or alcohol. It is helpful for me to be aware if this applies to you.”

- “May I ask you more about this?”

Be mindful of the use of language

- Be cautious of “benign assumptions”
- Examples
  - “How much alcohol do you drink?” (Assumes alcohol use)
  - “Do you drink 10 or 20 drinks per week” (Assumes amount)
- Some use ‘benign assumptions’ with the hopes that it normalizes and destigmatizes substance use
- Some feel that offering an exaggerated estimation will make patients feel more comfortable disclosing their actual use because it is lower
- This may be problematic while working with Indigenous patients given the prevalence of damaging stereotypes

Be mindful of the use of language

- Consider mirroring the patient's language around identity
- Be cautious of derogatory terms even if it is used by the patient (e.g. 'Indian,' or 'Native')
- While 'reserve' is a legal term, consider using the term "community"

Be mindful of the use of language

- Compared with White patients, Black patients were 2.54x more likely to have at least 1 negative descriptor in their history and physical notes
- E.g. non-adherent, aggressive, agitated, combative, exaggerate, unpleasant, defensive…etc.
- May contribute to lowering other provider's clinical suspicion and inducing bias

Sun M. Negative patient descriptors: documenting racial bias in the electronic health record. Health Affairs. 2022;41(2):203-211

Apply Patient-Centered Communication

Table 1. Recommended Sequence for Patient-Centered Medical Interviewing

Item	*Suggested phrases/comments*
Introduce and build rapport	All persons present at the visit should be introduced. In nonurgent situations, positive remarks about nonmedical issues, such as the weather, generalities about the day, or nonspecific encouraging observations, can help build rapport.
Elicit the patient's agenda	Avoid starting with "How are you feeling?" or "How are you today?" because these questions may lead the patient to somatize his or her concerns into physical symptoms. Instead, use phrases such as "How may I help you today?" or "What can I do for you today?" to bring the focus to the purpose of the visit.
List all of the patient's agenda items	Ask the patient, "Is there something else?" until he or she replies in the negative.
Negotiate the agenda	Suggested phrases: "Which of these is the most concerning to you?" "I would also like to discuss your… today." "Because we have limited time, which of these problems would you like to discuss today?" "I know… is important to you, and I am very concerned about your… Could we start with… first?"
Start discussing the patient's concerns with open-ended questions	Suggested phrases: "Tell me more about…" "Would you like to talk more about…?" "I want to know how it started…" "Tell me what the… was like?" "What else did you notice?"
Ask direct questions to elicit details about the chief concern, and perform a review of systems	Questions should address the duration, severity, and location of the problem; radiation and character of pain; relieving and aggravating factors; and any associated symptoms.
Elicit the patient's perspective	See Table 3.
Empathize	See Table 4.
Summarize	Suggested phrases: "So, from what you have told me so far, you…" "Let me summarize what we have discussed so far." "You have told me a lot of things. Let me just say it out loud, so you know that I have heard you correctly."
Transition	Suggested phrases: "Now I would like to ask you some routine questions. These may seem personal or unrelated but are important for us to help you." "Now I would like to ask you some questions about your previous health."
Additional data	Elicit information about medicines and allergies, medical history, and social and family histories (including social support network, interests, and spirituality).

Table 3. Phrases to Help Elicit the Patient's Perspective

Areas of focus	*Suggested phrases*
Feelings	"How did that make you feel [emotionally]?"
	"Tell me more about what was worrying you."
	"What were your emotions at that time?"
	"What would you say is worrying you the most?"
	"How do you feel about that?"
	"What was that like [emotionally]?"
Ideas	"What do you think is the cause of…?"
	"Do you have any thoughts on what might be causing this?"
Concerns	"What do you worry about regarding your health?"
	"Is there something you worry might happen?"
	"What are your fears about…?"
Impact	"How has your illness affected your daily life?"
	"What difficulties are you facing because of your illness?"
Expectations	"What would you like to get out of today's visit?"
	"What more can I do for you today?"
	"Is there anything else you need from us today?"

Hashim MJ. Patient-centered communication: basic skills. American Family Physician. 2017;95(1):29-34.

Perform a Physical Exam

- Patient presents with right ear pain for 3 days with yellow discharge. Went swimming 5 days ago. While speaking with the patient, you notice there is visible swelling and dried discharge.
- Reasons to perform a physical exam
  - Rule out alternative diagnosis (e.g. foreign body)
  - Rule out more severe complications (e.g. malignant otitis externa)
  - Validate patient concern
  - Build trust
  - Increase likelihood that the recommended treatment will be accepted

Commit to communication

- Avoid attributing difficulties with communication to ‘cultural issues’
  - Be aware of the ‘burden of history’ shaping everyday interactions and experiences
- Be aware that silence may not mean agreement, consent, or lack of concern
  - “That says a lot when you are silent as First Nations because you’re thinking about what’s being said and you need to give the right answers back.”
- Rapid focus on diagnosis and management may be perceived poorly and impair trust

1. *Towle A, Godolphin W, Alexander T. Doctor-patient communications in the Aboriginal community: towards the development of educational programs. Patient education and Counseling. 2006:62;340-346*
2. *Browne AJ. Clinical encounters between nurses and First Nations women in a Western Canadian hospital. Social Science & Medicine. 2007:64;2165-217*
3. *Jacklin KM et al. Health care experiences of Indigenous people living with type 2 diabetes in Canada. CMAJ. 2017 January 23;189E106-12. doi:10.1503/cmaj.161098*

Be attentive to power differential

History of colonialism requires an awareness on the power dynamics in physician-patient relationships

“I’m scared to talk to a doctor because…their voice, the way they talk is like an authority kind of thing with me…I find that with a lot of my friends too that are Aboriginal that they go to the doctors, they feel inferior.”

Towle A, Godolphin W, Alexander T. Doctor-patient communications in the Aboriginal community: towards the development of educational programs. Patient education and Counseling. 2006:62;340-346

Be attentive to power differential

Patients may avoid health providers and lose trust when

- Feel that the physician was too prescriptive or authoritarian
- Sense of coercion
- Lack adequate explanation and participation

Jacklin KM et al. Health care experiences of Indigenous people living with type 2 diabetes in Canada. CMAJ. 2017 January 23;189E106-12. doi:10.1503/cmaj.161098

Budget more time

Complex stories that combine the personal, social, and historical elements may mean that some Indigenous patients suffer disproportionate disadvantage from having insufficient time in the patient encounter.

“Because you know…they don’t even know your real background. They don’t take the tie to ask you…why you need that certain thing…There’s a pen, okay write it out and you’re on your way. In and out in five minutes.”

Towle A, Godolphin W, Alexander T. Doctor-patient communications in the Aboriginal community: towards the development of educational programs. Patient education and Counseling. 2006:62;340-346

Budget more time

Spending time in getting to know patients and avoiding a rushed atmosphere may help convey sense of caring

“My family doctor is more like in a rush, in a hurry and just basically diagnoses me… Whereas the other one takes the time to find out more questions, she asks me questions and I feel she’s got more [care] towards me than the other doctor.”

Towle A, Godolphin W, Alexander T. Doctor-patient communications in the Aboriginal community: towards the development of educational programs. Patient education and Counseling. 2006:62;340-346

Investigations

- There is evidence of disparities in the rates of investigations between different racial groups[1]
- Use clinical guidelines to standardize patient assessment where appropriate
- Ensure that decision on investigations is based on patient assessment rather than assumptions or stereotypes

1. *Owens A, Holroyd BR, McLane P. Patient race, ethnicity, and care in the emergency department: a scoping review. CJEM. 2020;22(2):245-253*

Inadequate Management

Manage pain and symptoms

- Racial minorities are less likely to receive opioid medications
- Racial minorities are less likely to receive a prescription for analgesics
- Racial minorities may wait longer before receiving analgesics

Owens A, Holroyd BR, McLane P. Patient race, ethnicity, and care in the emergency department: a scoping review. CJEM. 2020;22(2):245-253

Opportunity for collaboration and choice

- Discuss preferences for care
- Explore and problem-solve around barriers
- Elicit individual's priorities and hopes for treatment
- Obtain informed consent for all treatments and procedures
- Demonstrate to the patient that you've been attentive and that you've taken the care to optimize results
- Request feedback and input

1. Centre of Excellence for Women's Health. Trauma Informed Practice Guide. 2013. Available: http://bccewh.bc.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf
2. Browne AJ et al. Enhancing health care equity with Indigenous populations: evidence-based strategies from an ethnographic study. BMC Health Services Research. 2016:16(544). Doi 10.1186/s12913-016-1707-9

Opportunity for collaboration and choice

Making collaboration and choice explicit:

- “I’d like to understand your perspective.”
- “Let’s figure out the plan that will work best for you.”
- “What is the most important for you that we should start with?”
- “This may or may not work for you. It’s important to have your feedback.”

Centre of Excellence for Women’s Health. Trauma Informed Practice Guide. 2013. Available: http://bccewh.bc.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf

Affirm strength and resilience

Affirmations

- Genuine, specific, and relevant affirmations build self-sufficiency
- Acknowledge effort and strength

Examples

- “You have been through so much in your life and are doing everything you can to make sure that things are different for the next generation.”
- You made it here today, in spite of all the chaos at home this morning.”
- You are doing really well at school even though there is a lot you are dealing with right now.”

Centre of Excellence for Women’s Health. Trauma Informed Practice Guide. 2013. Available: http://bccewh.bc.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf

Support cultural needs

- Invite and support cultural practices in care
- Inquire about additional supports to involve in care
  - Extended family members
  - Elders
  - Community Health Representatives
  - Community nurses
  - Aboriginal Liaison workers

Jacklin KM et al. Health care experiences of Indigenous people living with type 2 diabetes in Canada. CMAJ. 2017 January 23;189E106-12. doi:10.1503/cmaj.161098

Provide Low Barrier Care

Consider the real or perceived impact of

- Provider attitudes
  - Emphasis on patient choice, behaviour, and responsibility without acknowledging and mitigating the impact of barriers
- Policies
  - Limits on number of people involved in care
- Fees
  - Cancellation and late fees
  - Form completion fees
- Physical environment
  - Explicit display of religious symbols

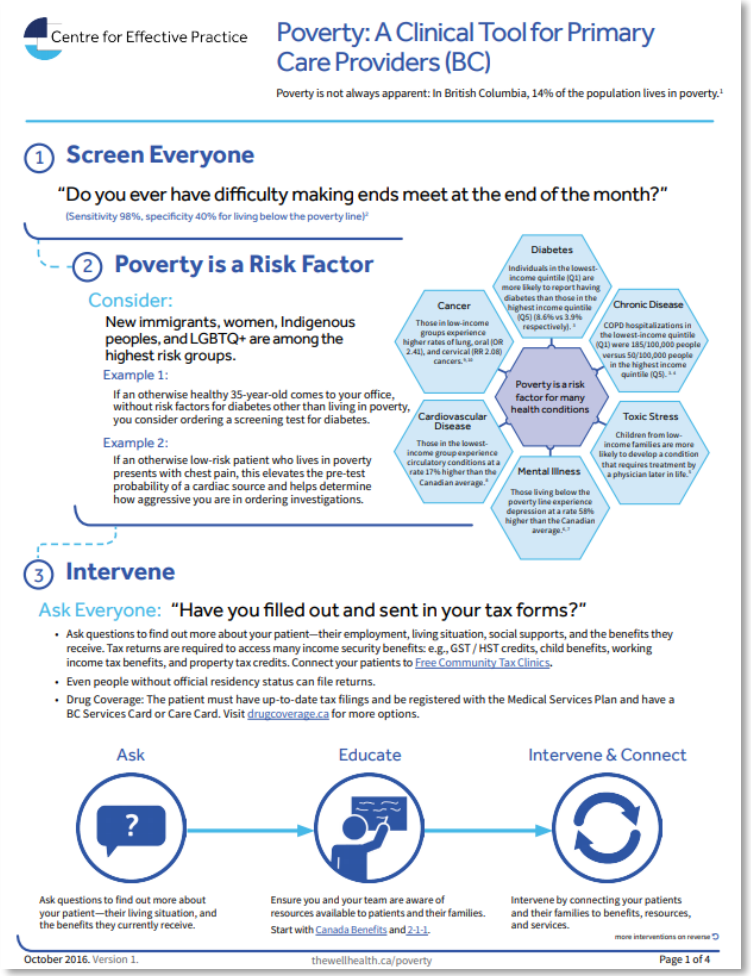
Provide Low Barrier Care

- Flexibility is required to foster trust
- Increase use of drop-in appointments to be as responsive as possible to what patients perceive as their highest priorities

Browne AJ et al. Enhancing health care equity with Indigenous populations: evidence-based strategies from an ethnographic study. BMC Health Services Research. 2016:16(544). Doi 10.1186/s12913-016-1707-9

Use Appropriate Resources

- Support determinants of health
  https://bccfp.bc.ca/why-join/poverty-tool/



Centre for Effective Practice

Poverty: A Clinical Tool for Primary Care Providers (BC)

Poverty is not always apparent: In British Columbia, 14% of the population lives in poverty.[1]

1 Screen Everyone

"Do you ever have difficulty making ends meet at the end of the month?"

(Sensitivity 98%, specificity 40% for living below the poverty line)[2]

2 Poverty is a Risk Factor

Consider:

New immigrants, women, Indigenous peoples, and LGBTQ+ are among the highest risk groups.

Example 1:

If an otherwise healthy 35-year-old comes to your office, without risk factors for diabetes other than living in poverty, you consider ordering a screening test for diabetes.

Example 2:

If an otherwise low-risk patient who lives in poverty presents with chest pain, this elevates the pre-test probability of a cardiac source and helps determine how aggressive you are in ordering investigations.

3 Intervene

Ask Everyone: "Have you filled out and sent in your tax forms?"

- Ask questions to find out more about your patient—their employment, living situation, social supports, and the benefits they receive. Tax returns are required to access many income security benefits: e.g., GST / HST credits, child benefits, working income tax benefits, and property tax credits. Connect your patients to Free Community Tax Clinics.
- Even people without official residency status can file returns.
- Drug Coverage: The patient must have up-to-date tax filings and be registered with the Medical Services Plan and have a BC Services Card or Care Card. Visit drugcoverage.ca for more options.

Ask questions to find out more about your patient—their living situation, and the benefits they currently receive.

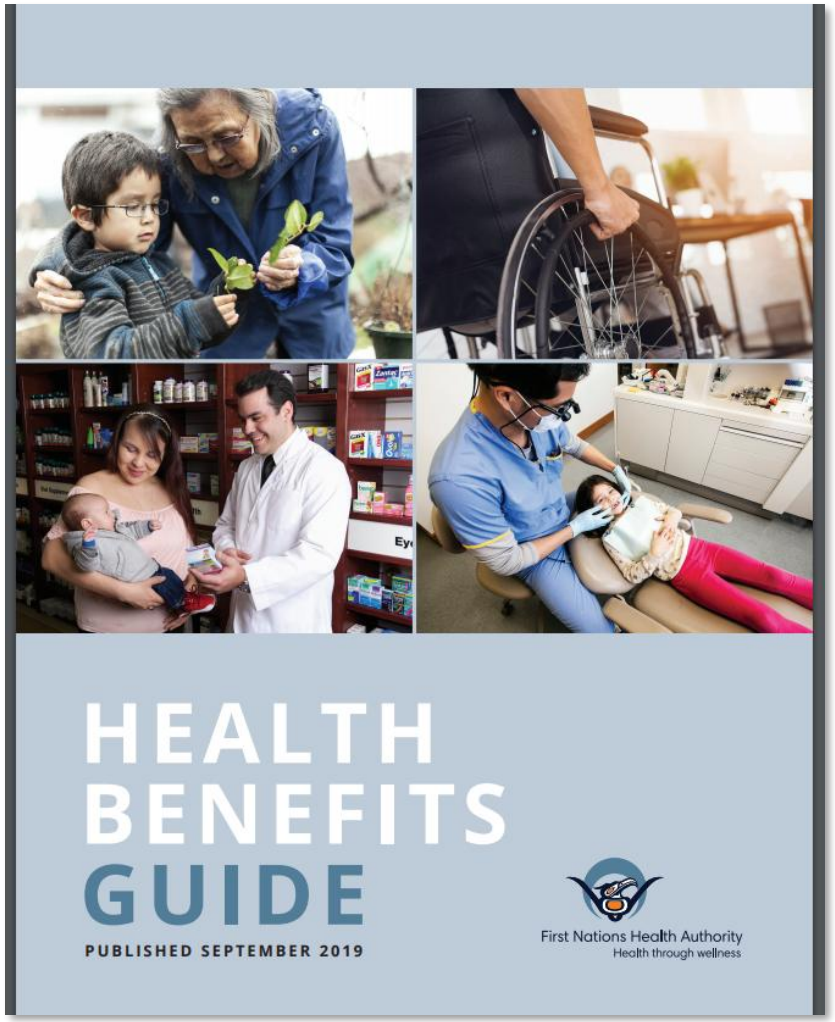
Ensure you and your team are aware of resources available to patients and their families. Start with Canada Benefits and 2-1-1.

Intervene by connecting your patients and their families to benefits, resources, and services.

more interventions on reverse

Use Appropriate Resources

- Utilize First Nations Health Benefits *https://www.fnha.ca/Documents/FNHA-Health-Benefits-Guide.pdf*



Use Appropriate Resources

Health

- mobility aids
- wheelchair ramps
- addiction services
- services from Elders
- mental health services
- specialized hearing aids
- traditional healing services
- services for children in care
- assessments and screenings
- transportation to appointments
- medical supplies and equipment
- long-term care for children with specialized needs
- therapeutic services for individuals or groups (speech therapy, physiotherapy, occupational therapy)

Social

- social worker
- land-based activities
- personal support worker
- specialized summer camps
- respite care (individual or group)
- specialized programs based on cultural beliefs and practices

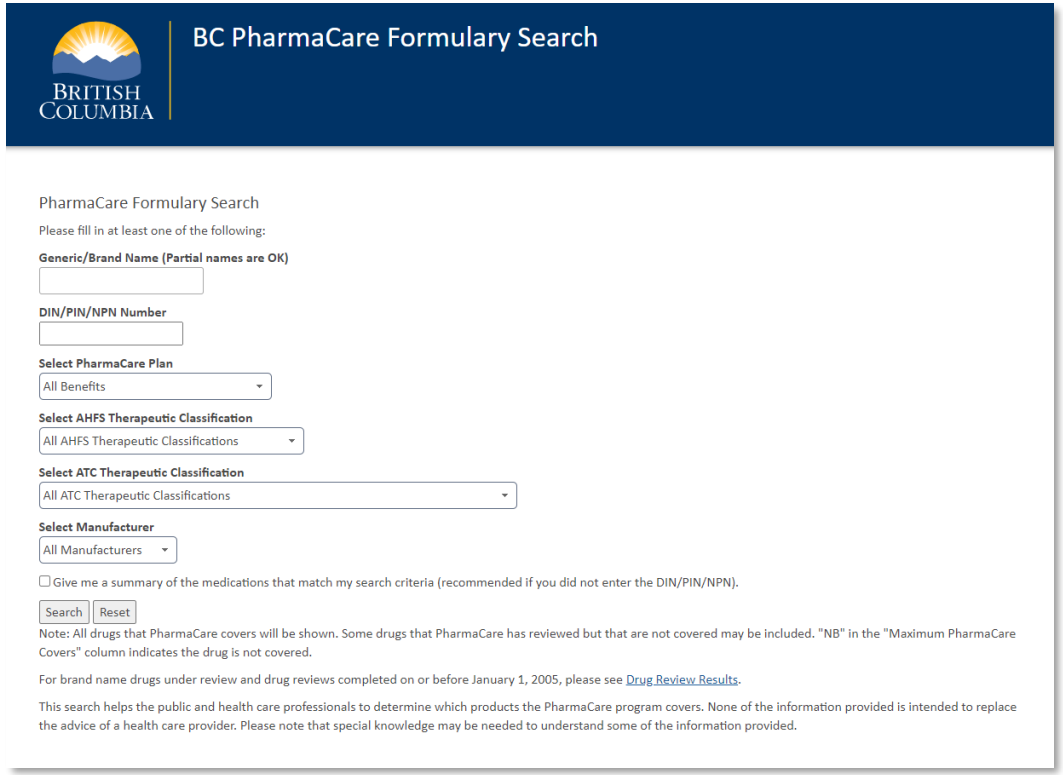
Education

- school supplies
- tutoring services
- teaching assistants
- specialized school transportation
- psycho-educational assessments
- assistive technologies and electronics

- Jordan's Principle
- Covers certain Indigenous persons under the age of majority in their province
- For more information:
  - 1-855-572-4453
  - 24/7 information

Use Appropriate Resources

- Use Pharmacare Plan W
  - *https://pharmacareformularysearch.gov.bc.ca*
  - *https://www.fnha.ca/Documents/FNHA-PharmaCare-Formulary-Search-Instructions.pdf*



Use Appropriate Resources

- Use over-the-counter medication coverage
  - *https://www2.gov.bc.ca/assets/gov/health/health-drug-coverage/pharmacare/planw-otc-meds.pdf*
  - *https://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/pharmacare/pharmacies/product-identification-numbers/plan-w-non-drug-otc-benefits*

First Nations Health Benefits (Plan W) Over-the-Counter Drug Benefits

DIN	Chemical Name	Brand Name	Manufacturer	Strength
00013668	acetaminophen	ACETAMINOPHEN	Church & Dwight	500mg
00389218	acetaminophen	ACETAMINOPHEN	Teva	325mg
00559393	acetaminophen	ACETAMINOPHEN	Johnson & Johnson	325mg
00559407	acetaminophen	ACETAMINOPHEN	Johnson & Johnson	500mg
00723894	acetaminophen	ACETAMINOPHEN	Johnson & Johnson	325mg
00723908	acetaminophen	ACETAMINOPHEN	Johnson & Johnson	500mg
00792691	acetaminophen	ACETAMINOPHEN	Pendopharm	32mg/mL
00875988	acetaminophen	ACETAMINOPHEN	Paladin	80mg/mL
00875996	acetaminophen	ACETAMINOPHEN	Paladin	32mg/mL
00884553	acetaminophen	ACETAMINOPHEN	Paladin	16mg/mL
00887587	acetaminophen	ACETAMINOPHEN	Pendopharm	80mg/mL
01901389	acetaminophen	ACETAMINOPHEN	JAMP	32mg/mL
01905864	acetaminophen	ACETAMINOPHEN	Laboratoires Trianon	80mg/mL
01938088	acetaminophen	ACETAMINOPHEN	JAMP	325mg
01939122	acetaminophen	ACETAMINOPHEN	JAMP	500mg
01958836	acetaminophen	ACETAMINOPHEN	Laboratoires Trianon	32mg/mL
02015676	acetaminophen	ACETAMINOPHEN	Tanta	80mg
02017431	acetaminophen	ACETAMINOPHEN	Laboratoires Riva	160mg
02017458	acetaminophen	ACETAMINOPHEN	Laboratoire Riva	80mg
02027798	acetaminophen	ACETAMINOPHEN	Teva	32mg/mL
02027801	acetaminophen	ACETAMINOPHEN	Teva	80mg/mL
02046040	acetaminophen	ACETAMINOPHEN	Johnson & Johnson	32mg/mL
02046059	acetaminophen	ACETAMINOPHEN	Johnson & Johnson	80mg/mL
02046660	acetaminophen	ACETAMINOPHEN	Pendopharm	120mg suppository
02046695	acetaminophen	ACETAMINOPHEN	Pharmascience	650mg suppository
02129957	acetaminophen	ACETAMINOPHEN	Vita Health	80mg

Engage mental health support

- Engage mental health support
  - Kuu-us Crisis Line
    - 24/7 crisis line providing risk assessment, monitoring, and outreach
    - Youth: 250-723-2040
    - Adult: 250-723-4050
  - Métis Crisis Line
    - 24/7 crisis line providing risk assessment, monitoring, and outreach. Can also refer to Métis community resources
    - 1-833-638-4722
  - Hope for Wellness Helpline
    - Immediate mental health counselling and crisis intervention
    - 1-855-242-3310 (24/7)

Engage mental health support

- Engage mental health support
  - Virtual Substance Use & Psychiatry Service
    - Addictions: M-F 13:30 to 17:30
    - Psychiatry: M-F 10:00 to 15:00
    - Referral Form: https://www.dropbox.com/s/x2he29dkac2403y/FNVSUPS%20REFERRAL%20FORM.docx?dl=0
  - Residential Schools Resolution Health Support Program
    - 24/7 emotional support for residential school survivors
    - 1-866-925-4419

Avoid termination of care

- Lack of adherence to recommended treatment may require further work to identify where unmet needs are[1]
- Structural violence and discrimination can induce patient responses that results in patients being banned from certain care settings[1]
- Offer explanation on why patients may need to wait, and explain the care process if patients are becoming impatient[2]
- Carefully consider the circumstances where patients are being ejected from care[2]
- Prioritize the use of de-escalation strategies and meeting the patient's needs over the involvement of security and police

1. *Browne AJ et al. Enhancing health care equity with Indigenous populations: evidence-based strategies from an ethnographic study. BMC Health Services Research. 2016:16(544). Doi 10.1186/s12913-016-1707-9*
2. *Tang SY. "Race" matters: racialization and egalitarian discourses involving Aboriginal people in the Canadian health care context. Ethnicity and Health. 2008:13(2);109-127*

Improve Continuity of Care

- Recognize that Indigenous patients have lower FP attachment rates
- Accept Indigenous patients into your practice
- Actively adopt a low-barrier and harm-reduction approach to reduce the number of patients who exit the practice
- Consider a low-barrier approach where every door is the right door
- Coordinate care with community-based services

Improve Continuity of Care

- Follow up
  - Create active follow-up actions for those with limited social support systems
  - If patients miss appointments, or has not completed follow up actions, have an active mechanism for following up

Browne AJ et al. Enhancing health care equity with Indigenous populations: evidence-based strategies from an ethnographic study. BMC Health Services Research. 2016:16(544). Doi 10.1186/s12913-016-1707-9

Referrals

- Respect patient's concern about providers who are providing culturally unsafe care and make an effort to make alternate referrals

Jacklin KM et al. Health care experiences of Indigenous people living with type 2 diabetes in Canada. CMAJ. 2017 January 23;189E106-12. doi:10.1503/cmaj.161098

Provide written information

Benefits

- Allows patients to review information covered in the visit
- Increases success of management plan
- Supports health literacy[1]
- Allows participation of family and supports

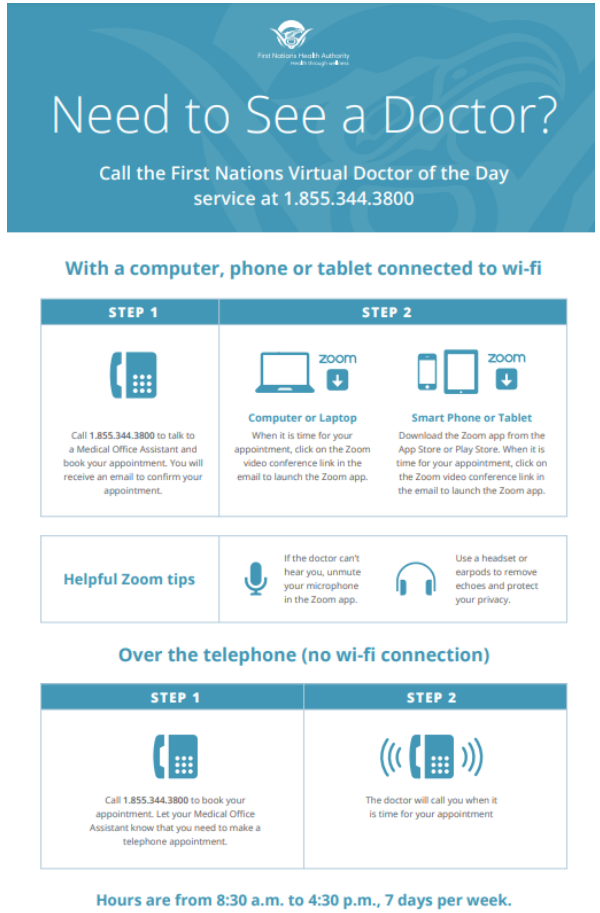
Consider including

- Diagnosis
- Follow up actions
- Patient information and resources
- How to manage symptoms
- Referral information

1. *Smylie J et al. Primary care intervention to address cardiovascular disease medication health literacy among Indigenous peoples: Canadian results of a pre-post-design study. Canadian Journal of Public Health. 2018:109(1);117-127*

First Nations Virtual Doctor of the Day

- First Nations Doctor of the Day service
  - 1-855-344-3800
  - 8:30 to 16:30 7 days a week



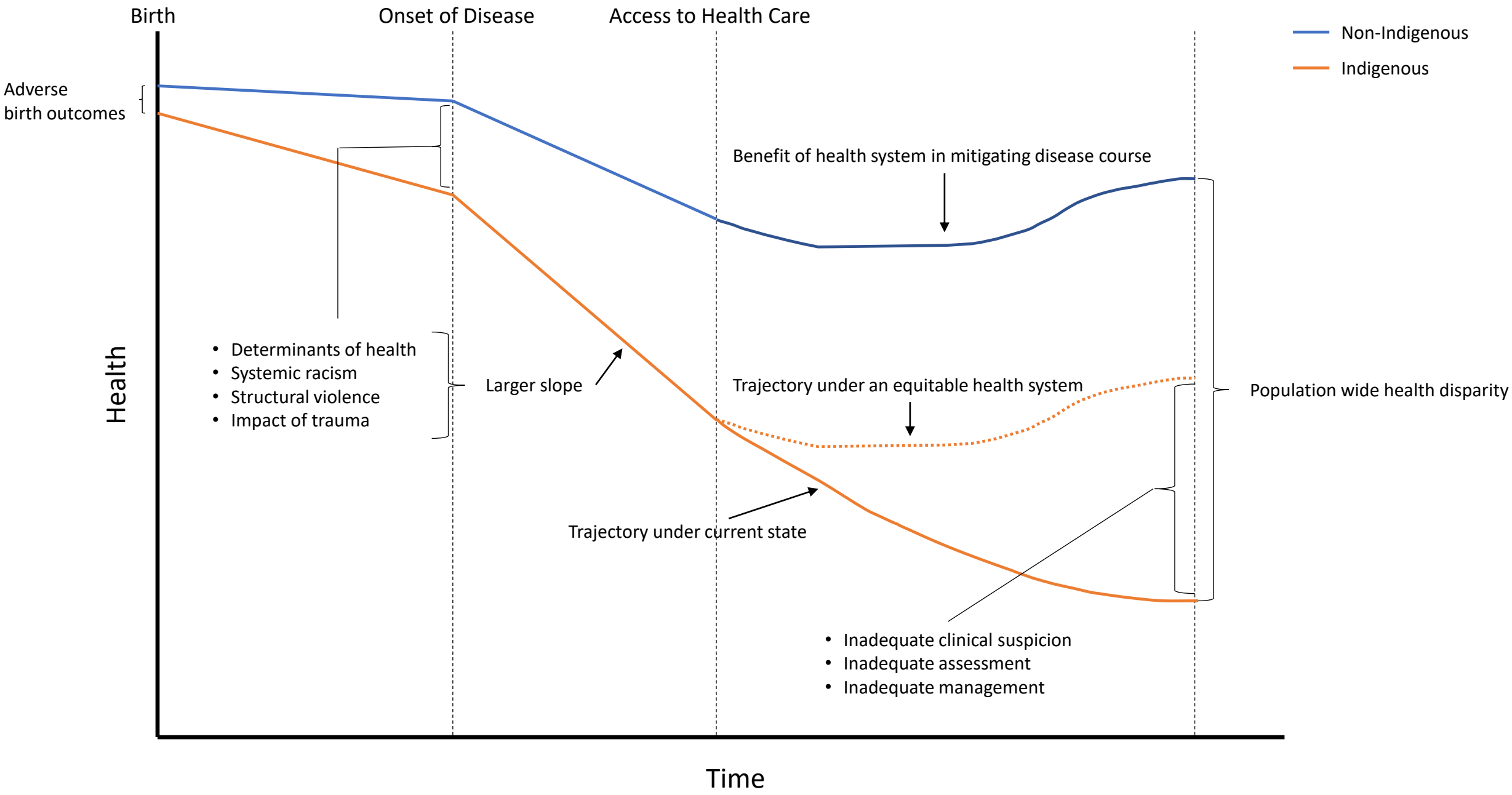
Compliments or Complaints

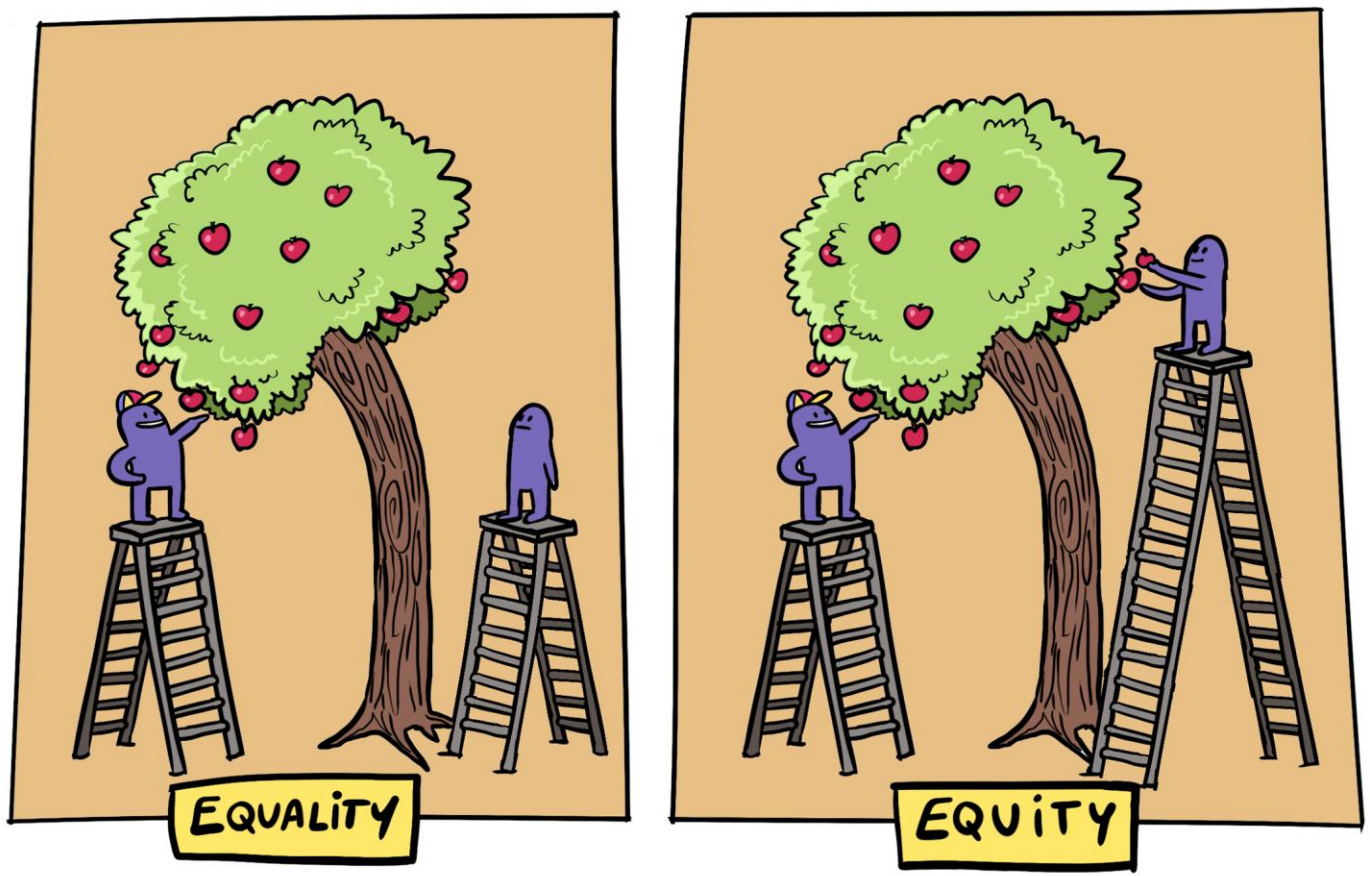
- FNHA Quality Care and Safety
  - Phone: 1-844-935-1044
  - Email: quality@fnha.ca
- Requested information
  - Name and 2 methods for contact
  - Brief description of compliment or complaint
  - Location where it happened
- Service offered
  - Assist in gathering information and outline options available
  - Assist with issues arising from any health care encounter in BC
  - May facilitate connection with appropriate Patient Care Quality Offices

Physical Environment

- Consider signs in local Indigenous languages
- Consider featuring local Indigenous art
- Arrange equity walk through https://equiphealthcare.ca/resources/toolkit/equity-walk-through/

Concluding thoughts


Birth
Onset of Disease
Access to Health Care
Non-Indigenous
Indigenous
Adverse
birth outcomes
Benefit of health system in mitigating disease course
Health
• Determinants of health
• Systemic racism
• Structural violence
• Impact of trauma
Larger slope
Trajectory under an equitable health system
Population wide health disparity
Trajectory under current state
• Inadequate clinical suspicion
• Inadequate assessment
• Inadequate management
Time



Illustrated by Armin Mortazavi

Illustrated by Armin Mortazavi

CAMH Bill of Client Rights

1. Right to be treated with respect
2. Right to freedom from harm
3. Right to dignity and independence
4. Right to quality services that comply with standards
5. Right to effective communication
6. Right to be fully informed
7. Right to make an informed choice, and give informed consent to treatment
8. Right to support
9. Rights in respect of research or teaching
10. Right to complain

Centre for Addiction and Mental Health. Available: https://www.camh.ca/en/your-care/your-rights/bill-of-client-rights

Systemic Racism

- When a system meant to serve the public, while functioning as intended, produces different outcome for different races of people

- Contributing to racialized health care disparity does not necessarily require explicit ill-will

The role of culture

- Benefits of learning about Indigenous culture
  - Demonstration of respect and humility
  - Part of the pathway towards reconciliation
  - Increase our own comfort
  - Dispel our own misunderstandings
  - May help move towards a holistic understanding of the patient's context
  - May offer some tools and opportunities to improve connection with the patient

The role of culture

- Considerations around culture
  - Culture is deeply personal
  - Every individual experiences and expresses their culture differently
  - Avoid turning information about culture into stereotypes and assumptions
  - Indigenous communities have experienced damage to cultural identity through colonization and genocide
  - Need permission to enter someone's cultural space
  - Adopting tokens of culture without a foundation of anti-racist and health equity approach is ineffective
  - Suspend interpretation or judgement
  - Approach with humility and respect rather than entitlement
  - Cultural differences alone are unlikely to be the primary driver of health care disparities at present

Treat every patient as an individual

Ongoing Personal Development

- Other topics to explore
  - Local Indigenous culture
  - Indigenous history in Canada
  - Traditional healing and medicine
  - Indigenous perspectives on health and wellness
  - Racism and colonialism in Canada
  - Allyship and anti-racism strategies
  - Implicit bias
  - Trauma-informed practice

Ongoing Personal Development

- Next steps
  - Review additional resources listed in this presentation
  - Connect with local Indigenous organizations for additional learning opportunities
  - Attend local events held by Indigenous organizations
  - Connect with local Division of Family Practice for professional development opportunities

Additional Resources

CPSBC | College of Physicians and Surgeons of British Columbia

Practice Standard

Indigenous Cultural Safety, Cultural Humility and Anti-racism

Effective:	February 25, 2022
Last revised:	May 6, 2022
Version:	1.1
Next review:	February 2025
Related topic(s):	Access to Medical Care Without Discrimination; Indigenous Cultural Safety, Cultural Humility and Anti-racism Learning Resources; Indigenous Cultural Safety, Cultural Humility and Anti-racism FAQs

A **practice standard** reflects the minimum standard of professional behaviour and ethical conduct on a specific topic or issue expected by the College of its registrants (all physicians and surgeons who practise medicine in British Columbia). Standards also reflect relevant legal requirements and are enforceable under the *Health Professions Act*, RSBC 1996, c.183 (*HPA*) and College Bylaws under the *HPA*.

Registrants may seek guidance on these issues by contacting the College or by seeking medical legal advice from the CMPA or other entity.

Working with Indigenous Patients

- Advice to health care providers from patients

Educating for Equity Care Framework

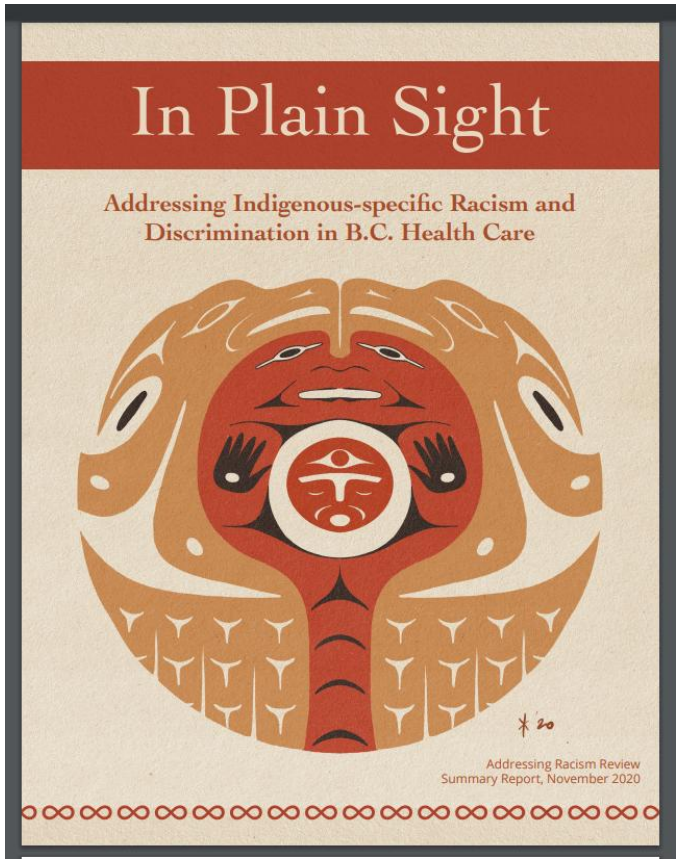
Table 2. The E4E Care Framework for engaging the social reality

KEY CONCEPTS OF ENGAGING THE SOCIAL REALITY	RECOMMENDATIONS
Social and economic resource disparities*	Considering Indigenous patients' social and economic realities: • Screen for and explore resource limitations that influence diabetes onset and management • Acknowledge with the patient the effect of resource limitations on diabetes onset and management • Support access to key proximal health determinants • Assess diabetes knowledge and health literacy
Socioeconomic disadvantages • Socioeconomic disadvantage is a normalized state for many patients, limiting choices while increasing stress and diminishing capacity for self-care and healthy behaviour patterns	
Family and limited resources • These are contexts in which self-care might occur. Food and financial sharing within large families results in diversion of resources, becoming another stressor	
Knowledge barriers • Health knowledge is affected through structural access barriers to learning, ongoing adverse life experiences, and discord within the health care relationship	
Accumulation of adverse life experiences†	Considering patients' adverse life experiences: • Acknowledge with the patient the connections between adverse life experiences and capacity for diabetes management • Explore patients' perspectives on personal adverse experiences in the context of diabetes in order to address their priorities
Family adversity and support • Family and community are viewed as supportive but also potentially stressful in the context of pervasive social dysfunction arising from the outcomes of historical trauma, poverty, and underlying inequities from colonization	
Personal and collective loss • The nature and extent of multiple forms of loss (eg, personal, cultural, historical) are key features of adversity affecting individuals, families, and communities	
Effect of residential schools • The residential school experience traumatized individuals, disrupted communities, and continues to adversely influence health and health behaviour	
Culture frames knowledge‡	Helping build Indigenous patients' knowledge about diabetes care: • Build a shared understanding of diabetes that integrates and contextualizes biomedical, social, political, and cultural explanatory frameworks • Use language appropriate for the patient's educational and cultural background; consider metaphors within a narrative approach
Knowledge contextualization and exchange • Knowledge contextualization and exchange rather than just information delivery was identified as an effective means to facilitate patient education	
Culture as therapeutic§	Recognizing culture as therapeutic: • Strive for cultural congruency of management recommendations • Explore patients' preferences and support choices for accessing cultural resources • Engage with the community to learn about local beliefs and practices, as well as healing resources
Culture is protective • Health is positively correlated with a sense of security in cultural identity and access to cultural knowledge and traditions	
Traditional medicine and ceremony • Traditional medicine and ceremony are desired modalities to access and reconnect with, in conjunction with Western medicine	

Crowshoe L et al. Educating for Equity Care Framework: Addressing social barriers of Indigenous patients with type 2 diabetes. Canadian Family Physician. 2019:65(1);25-33

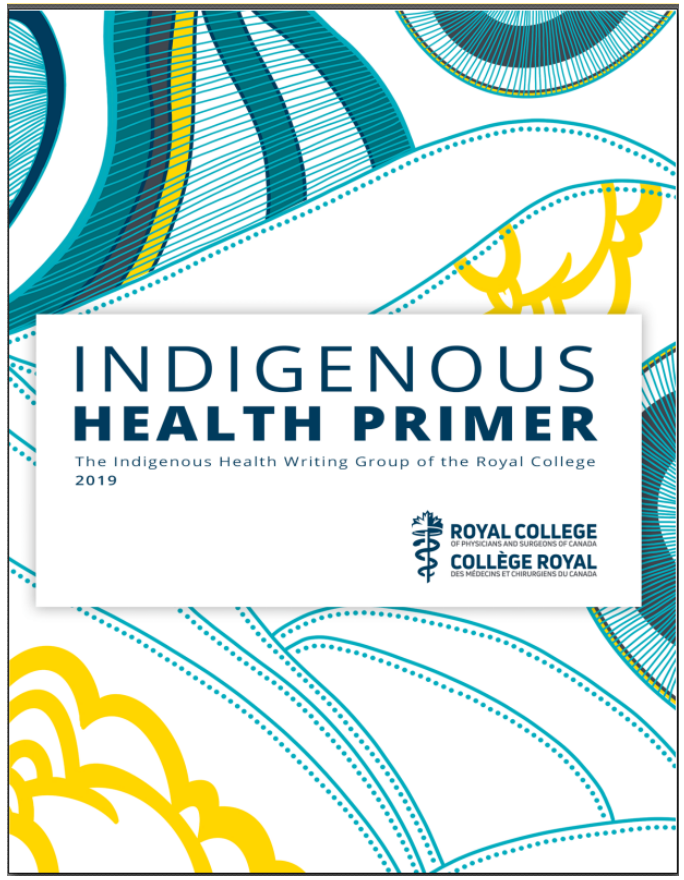
In Plain Sight Report

- Investigation into the poor health care experiences and health care disparities facing Indigenous peoples in BC
- Reveals widespread racism within the BC health care system



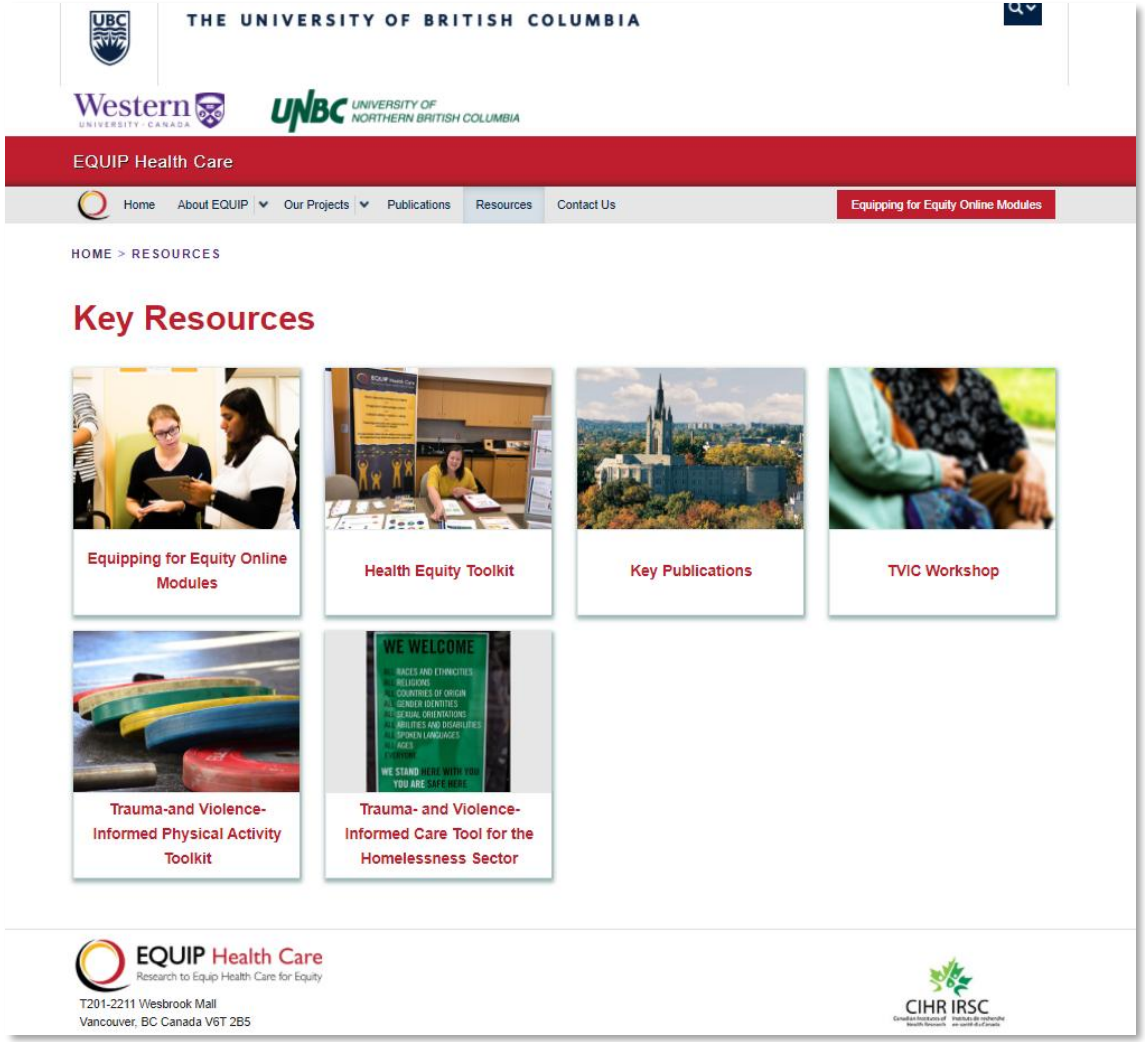
Indigenous Health Primer

- Overview on topics such as
  - Indigenous knowledge and rights
  - Racism
  - Cultural safety
  - Legislation and policies



Equity-Oriented Practice Resources

- Resources by the EQUIP research group
- Online modules on health equity
- Toolkit to improve health equity in your practice
- Research publications



Cultural Safety Resources

- ICS Collaborative Learning Series
  Webinar series with national experts on cultural safety
  http://www.icscollaborative.com/
- FNHA Cultural Humility Webinar Series
  https://www.fnha.ca/wellness/cultural-humility
- U of A Indigenous Canada Online Course
  Online course on Indigenous history and culture
  https://www.coursera.org/learn/indigenous-canada#about
- Cancer Care Ontario – Indigenous Cultural Safety Course
  Comprehensive course on a variety of topics
  https://www.cancercareontario.ca/en/resources-first-nations-inuit-metis/first-nations-inuit-metis-courses

Additional Resources

- National Centre for Truth and Reconciliation
  https://nctr.ca/
- National Collaborating Centre for Indigenous Health
  http://www.nccah-ccnsa.ca/
- Statistics Canada: Aboriginal Peoples
  http://www.statcan.gc.ca/aboriginalpeoples
- First Nations Health Authority
  https://www.fnha.ca/

Additional Resources

Local Indigenous resources

- https://www.indigenoushealthnh.ca/resources/local-cultural-resources
- https://www.islandhealth.ca/learn-about-health/aboriginal-health
- https://www.fraserhealth.ca/health-topics-a-to-z/aboriginal-health
- https://www.interiorhealth.ca/YourHealth/AboriginalHealth/Pages/default.aspx
- http://www.vch.ca/your-care/aboriginal-health

Thank you

✉ james.liu99@gmail.com