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

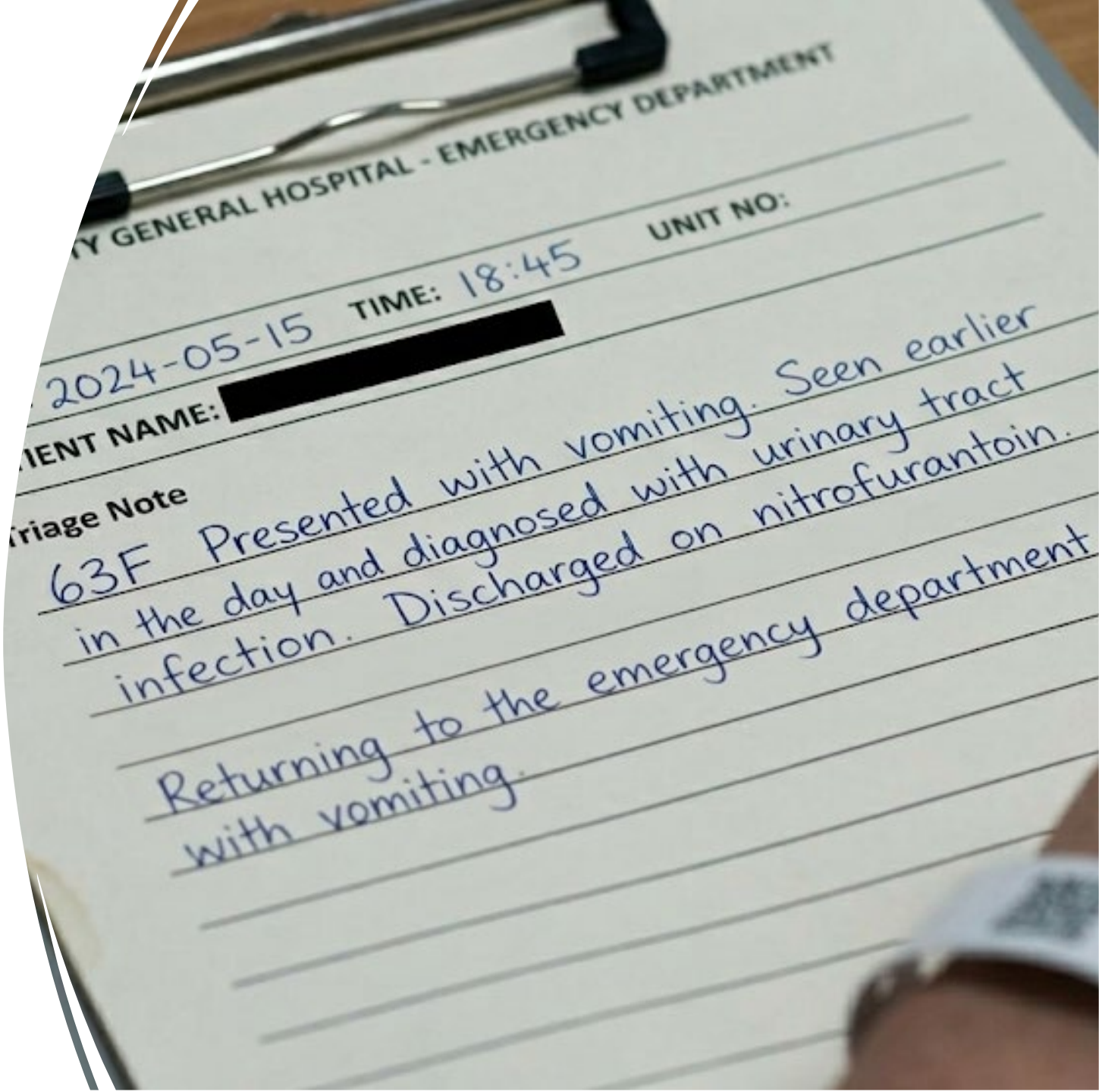
- Most physicians will work with Indigenous patients in their practice regardless of their specialty and geographic location
- Most physicians work in specialized Indigenous health clinics and therefore do not have a menu of specialized Indigenous resources beyond what is available to all clinicians
- This presentation is aimed at the above-described audience. It aims to help optimize your care of Indigenous patients in your regular practice settings
- Some slides refer to “racial minorities.” These refer to race-based health disparity research in countries such as Canada, US, and Australia. This language is preserved for accuracy in reference to the cited studies but is not generally an appropriate term for referring to Indigenous peoples in Canada.

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.

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:

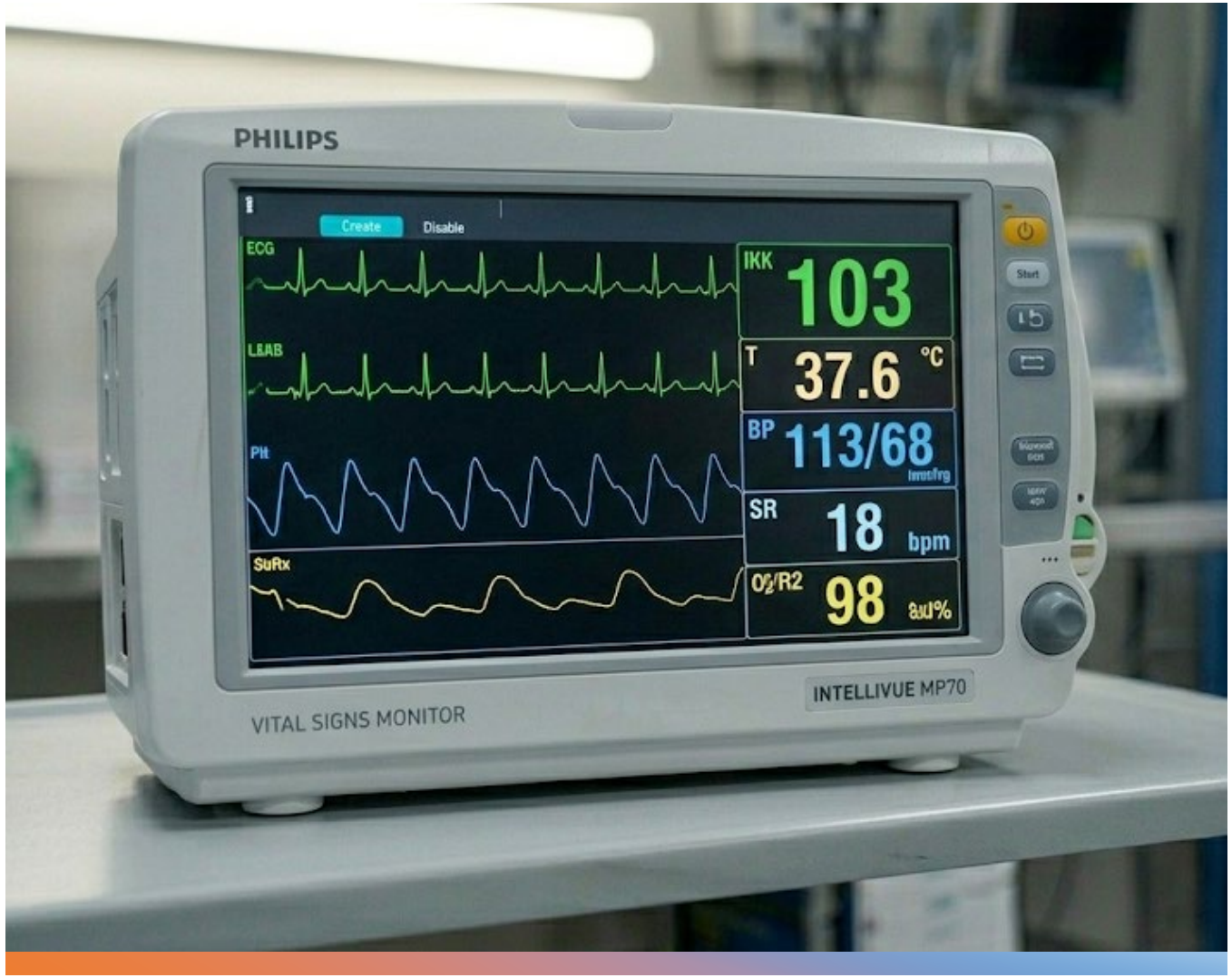
- Atorvastatin
- Ramipril
- Pantoprazole
- Insulin glargine

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?

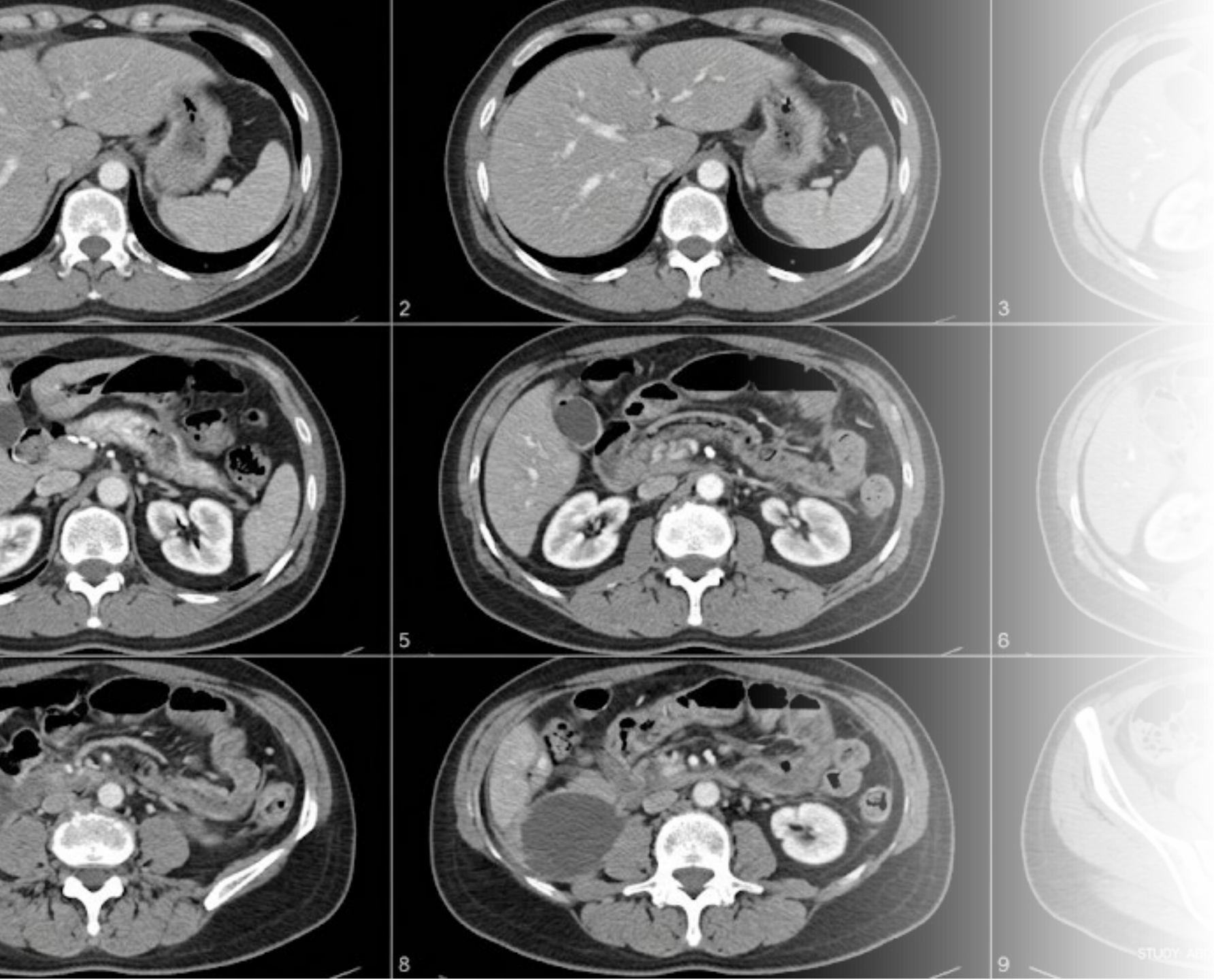
- ❑ Agree with previous diagnosis of cystitis. Continue nitrofurantoin
- ❑ Start the patient on outpatient antibiotic therapy
- ❑ Observe the patient in your ED and reassess in 24h
- ❑ Transfer the patient to higher level of care

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?

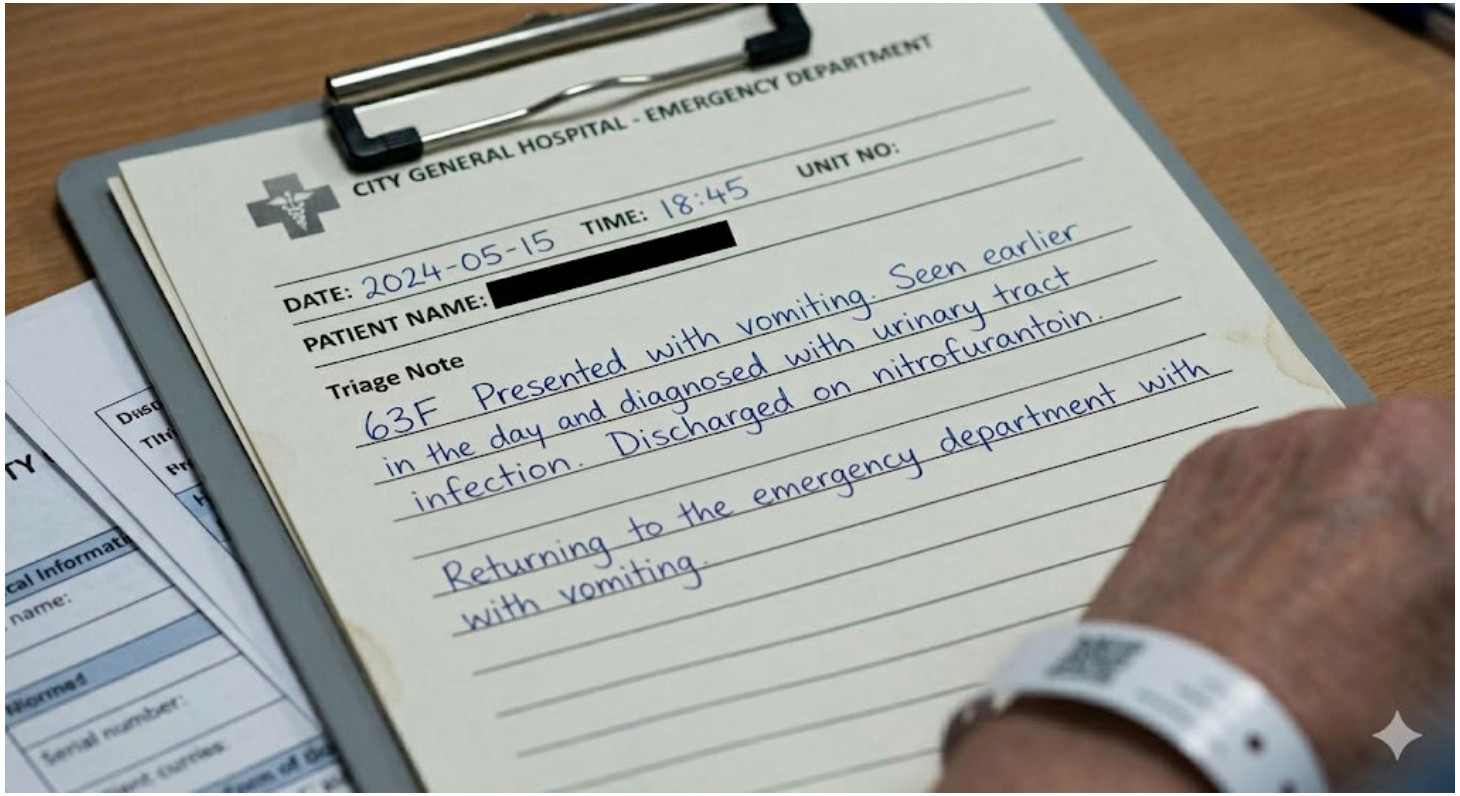
- ❑ If the patient does not wish to follow recommendations, she can leave against medical advice
- ❑ Start the patient on antibiotics and observe her in the local hospital
- ❑ Find out what specific steps we could take to improve her experience at the regional hospital
- ❑ Reassure her that she will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

Did anything stand out to you about the triage note?



What stood out to you in your interaction with the nurse?

What stood out to you in the interaction with the patient and her daughter?

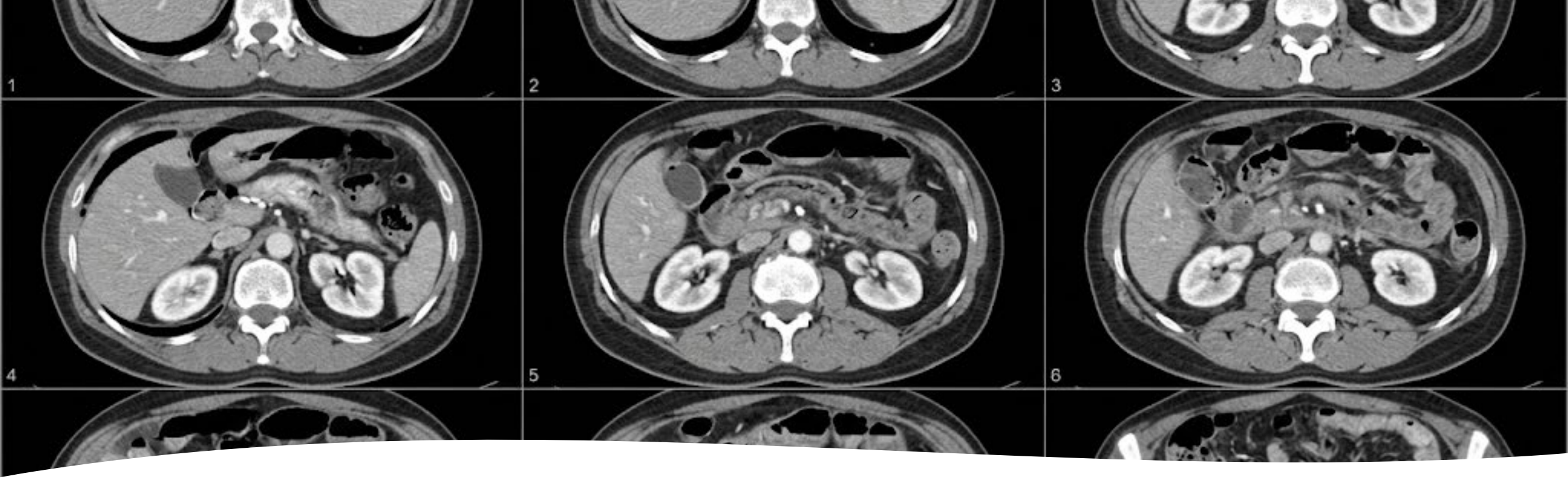
Did anything stand out to you about the process of assessing your patient?

What were your considerations in managing pain

What were your considerations around blood alcohol level testing?

What was your reaction when the patient considered declining bloodwork and going home?

What did you think about the patient’s hesitation around transferring to a regional hospital?



What do you think about the patient’s final diagnosis?

What observations affected your perceptions of the patient?

What barriers made your patient assessment more difficult?

What non-medical factors affected your decision-making

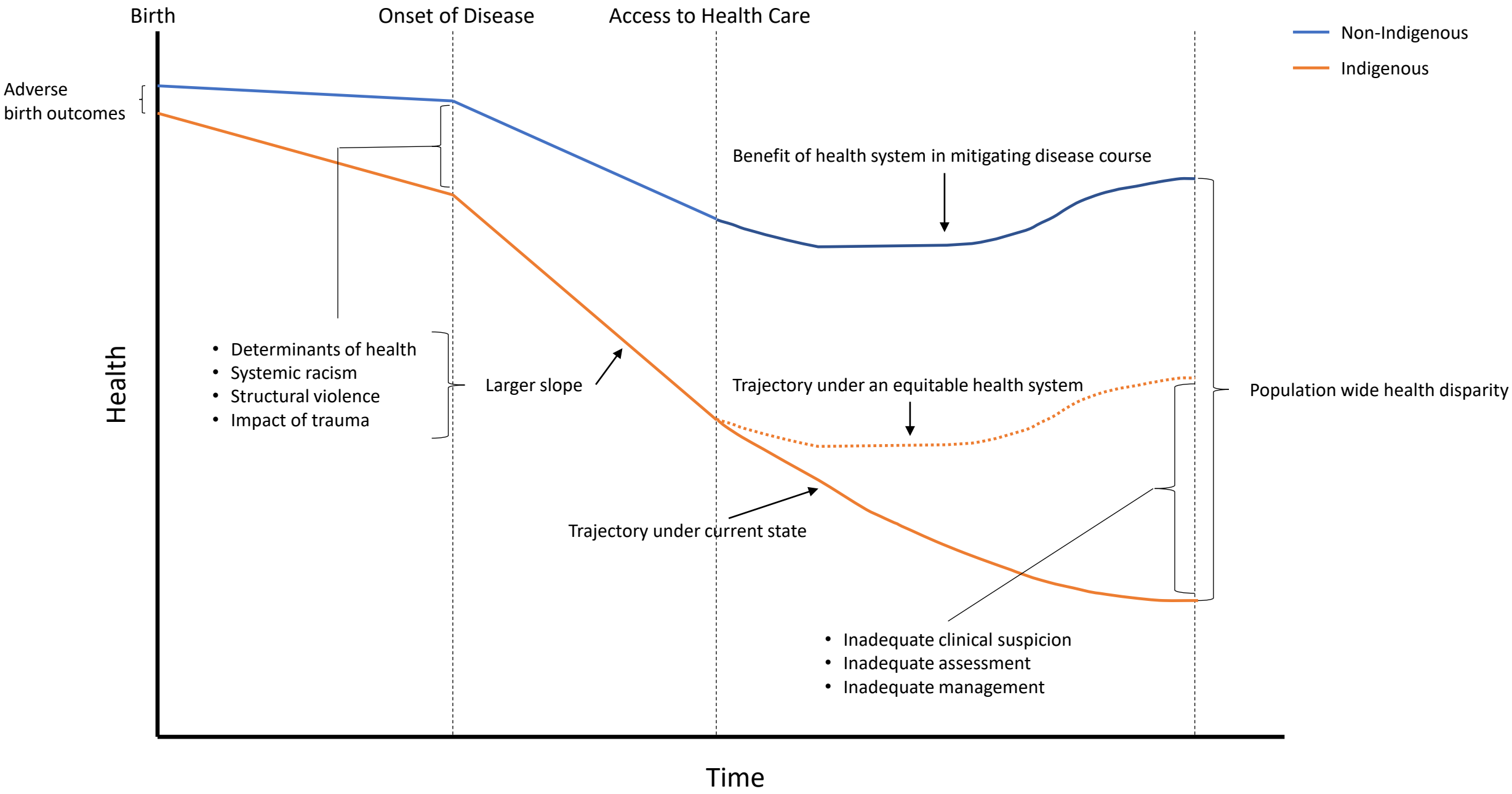
Were there any barriers that affected your patient management

What role did stigma and bias play in this scenario?

What factors could have affected the patient’s trust?

What has this exercise made you more aware of?

What will you take away from this scenario to apply to your clinical approach?


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

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

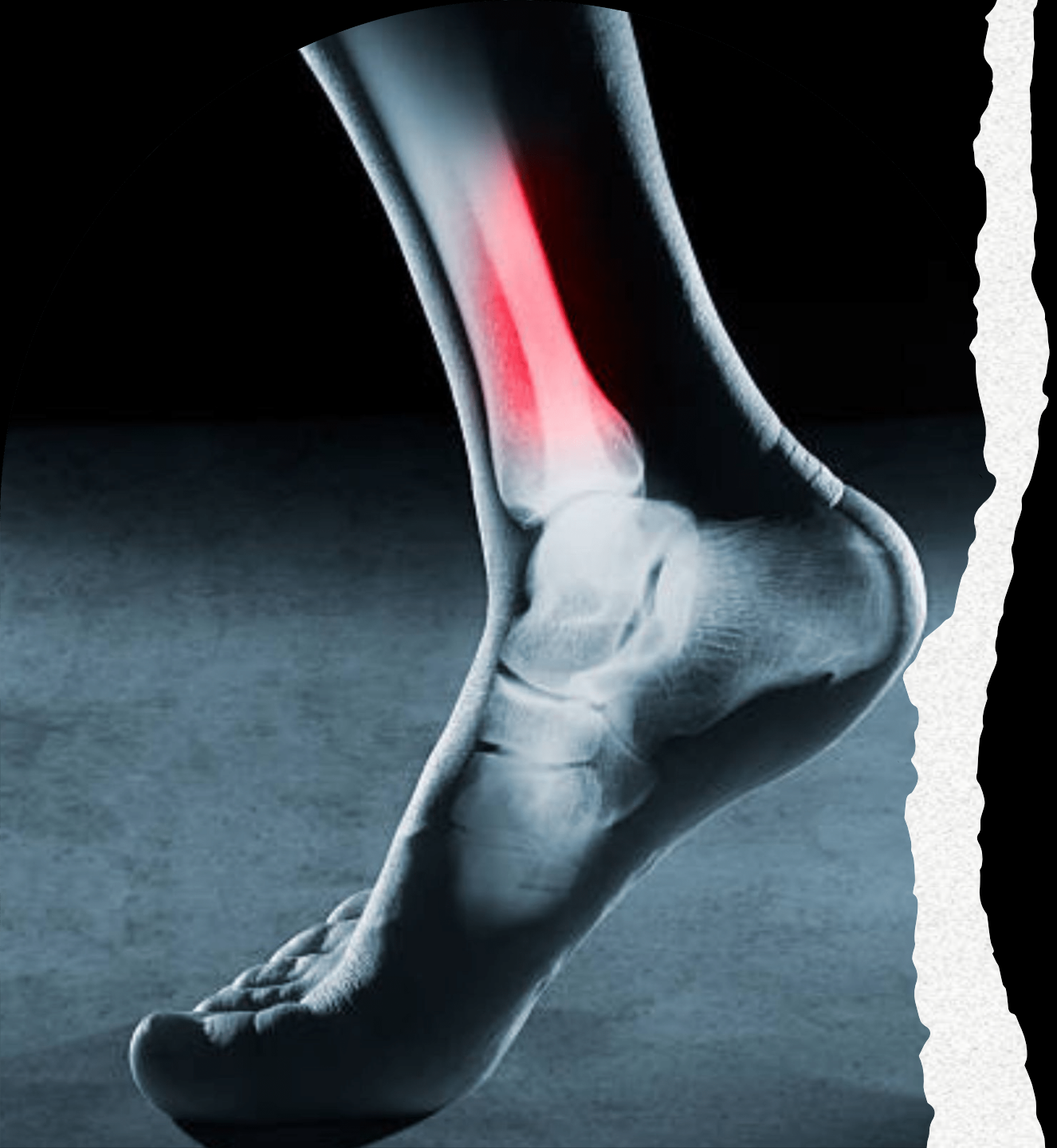
Disproportionate focus on health behaviours causes loss of buy-in

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

Case 1



A 37-year-old Indigenous patient suffered a fall 7 days ago at work. He registered in the ED 3 days ago and was sent for an ankle x-ray by the triage nurse. Upon chart review, the encounter was closed as “left without being seen.” He returns today as he could no longer walk, and his workplace asks that he hold off on further shifts until he is assessed by a physician. Radiology report of the x-ray from 3 days ago shows no fractures.

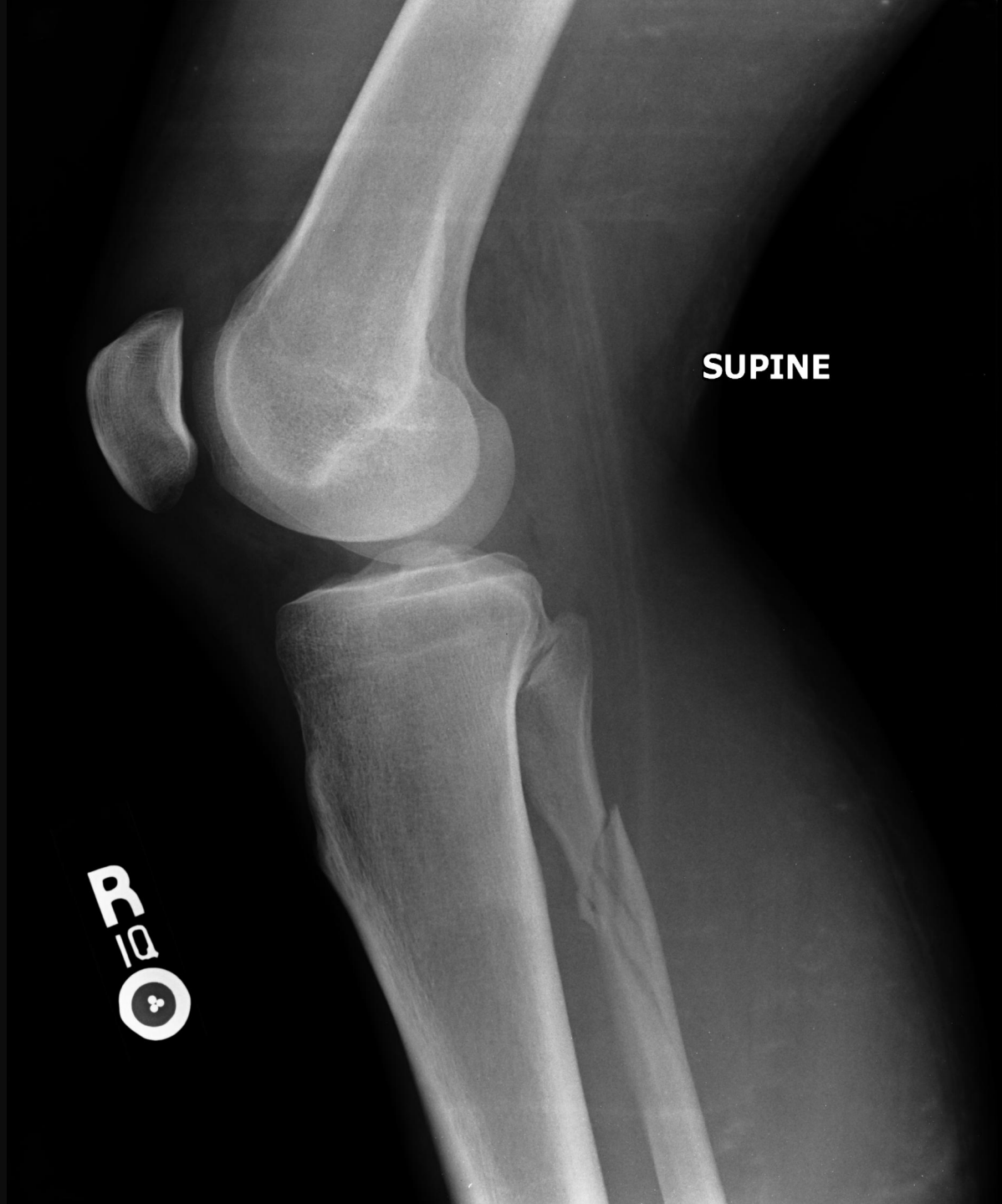
Why did the patient leave without physician assessment in the ED visit?

- Needed to get ready for work the next day
- No analgesia offered[1]
- Poor interactions with staff at Medical Imaging

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

You go to assess the patient, and he is wearing his coveralls as he had just left his work site. He is frustrated about his ED experience 3 days ago.

On further assessment, the patient fell sideways with an entrapped foot. After changing the patient into a gown and doing a lower extremity exam, there is proximal fibular tenderness with tenderness along the medial ankle. There is swelling and bruising around the ankle. X-ray of the tibia and fibula show a Maisonneuve fracture.



You explain that you would like to offer immobilization of the lower extremity with non-weightbearing status and refer the patient to the orthopedic surgeon on call for likely operative repair. The patient did not offer much response to the plan that you've explained.

When you specifically asked what the patient thought of the plan, he expresses concerns about experiences with anti-Indigenous racism that his family members have had with the surgeon on call.

Ultimately, the patient would not feel safe being treated by this surgeon. Weighing the risk of the patient declining follow up on his unstable fracture, you arrange consultation with another orthopedic surgeon

Make earning trust an explicit clinical objective from the very start

Acknowledge the poor experience

Explicitly commit to help

Begin by meeting immediate needs such as analgesia

Explain your assessment process

Perform a Physical Exam

- Rule out alternative diagnosis
- Rule out more severe complications
- Validate patient concern
- Build trust
- Increase likelihood that the recommended treatment will be accepted

"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 answer back."[1]

Silence may not mean agreement, consent, or lack of concern

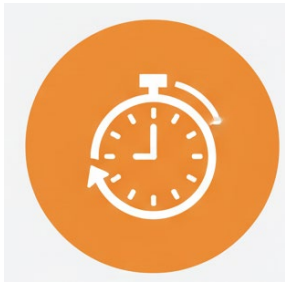
Choose to remain quiet or make few demands in an effort to present themselves as undemanding "good" patients[2]

1. Towle A, Godolphin W, and 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;64:2165-2176

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

- Ensure that the need for analgesia is not determined based on stereotypes
- Order “first dose ASAP” if appropriate

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

Prescribe OTC Analgesics

- Many over-the-counter medications are covered under FNHA benefits
- Requires physician prescription

Prescribe medical supplies & equipment

- Splints, braces, offloading boots, walking aids, wheelchairs, transfer aids, and more are covered by FNHA benefits
- Require physician prescription

Consider Cultural Safety in 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

Case 2

A 47-year-old man registers at your UPCC for the first time for a cough. At registration, his vitals were found to be within normal limits. He was seen to be fairly drowsy in the waiting room and seems to fall asleep in the chair. The staff has tried to get him into a room a few times but he seems to wake up briefly and asked to be left alone.

You are nearing the end of your day and would like to see him and complete this visit. You ask the staff to check his glucose and bring him into the exam room. His glucose was normal.

The staff tells you that he is still drowsy and didn't want to come into the exam room. The staff tells you that there were a few people accompanying him earlier, who were known to use substances.

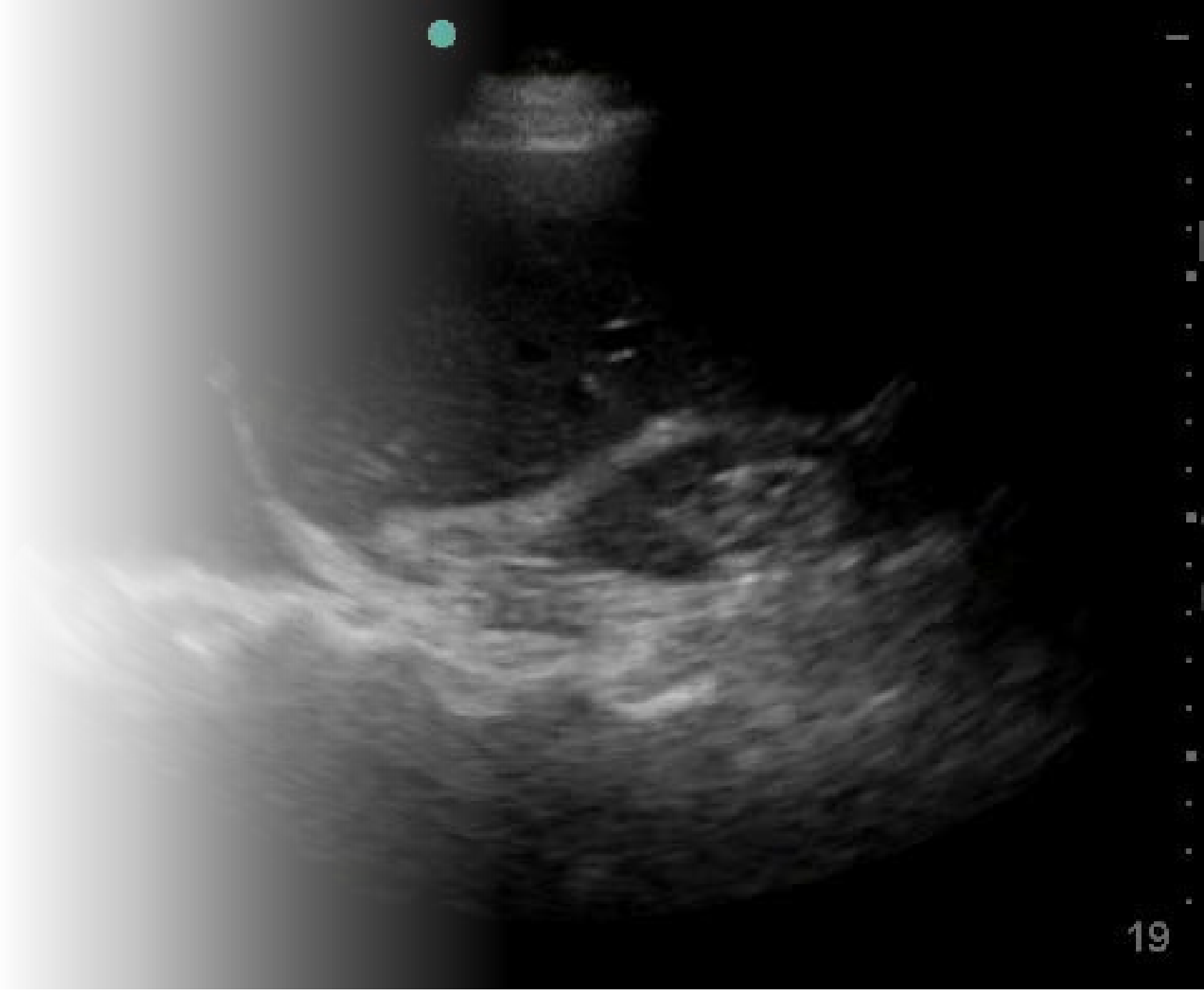
They suspect that he is intoxicated and would like to have security remove him.

You go out and assess him in the waiting room. You were able to wake him up, but he is still drowsy. He tells you that he is here because his chest feels tight and he has a cough.

He tells you he has longstanding untreated sleep apnea and is on no medications. He does not use recreational substances.

You were able to get him into a more private area and do a physical exam. He was found to have diffuse crackles on lung auscultation. There was significant pedal edema.

Point of care ultrasound revealed moderate bilateral pleural effusion



You speak with him about going to the hospital for further assessment and he agreed.

He was found to have decompensated heart failure with mild hypoxemia and hypercapnia. He required admission for diuresis.

First Nations patients were **less likely to receive a higher CTAS score** compared to non-First Nations patients, including for presentations involving **long bone fractures**

(OR 0.82, 95% CI 0.76-0.88)

McLane P, Barnabe C, Mackey L, Bill L, Rittenbach K, Holroyd BR et al. First Nations status and emergency department triage scores in Alberta: a retrospective cohort study. CMAJ 2022:194(2):E37-E45

Transmission of 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

- 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 health care system

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

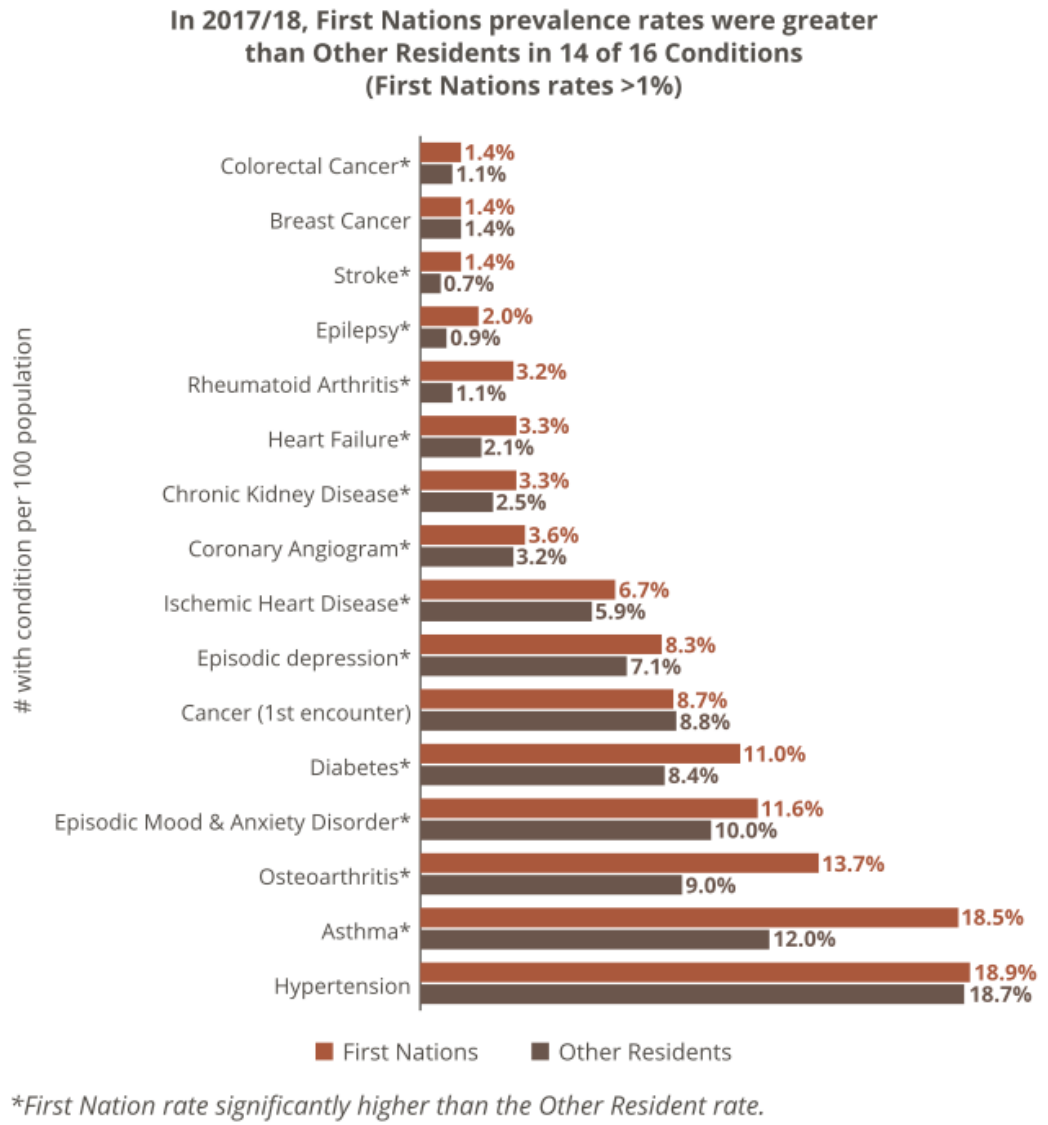
Turpel-Lafond ME. In Plain Sight: Addressing Indigenous-specific racism and discrimination in BC Health Care. 2020. Available: https://engage.gov.bc.ca/app/uploads/sites/613/2020/11/In-Plain-Sight-Full-Report.pdf

Recognize the impact of stereotypes

- When primed with images of black faces, physicians reacted more quickly for stereotypical diseases
- Ensure that data points informing clinical decisions are based on patient facts rather than stereotypes and assumptions

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

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

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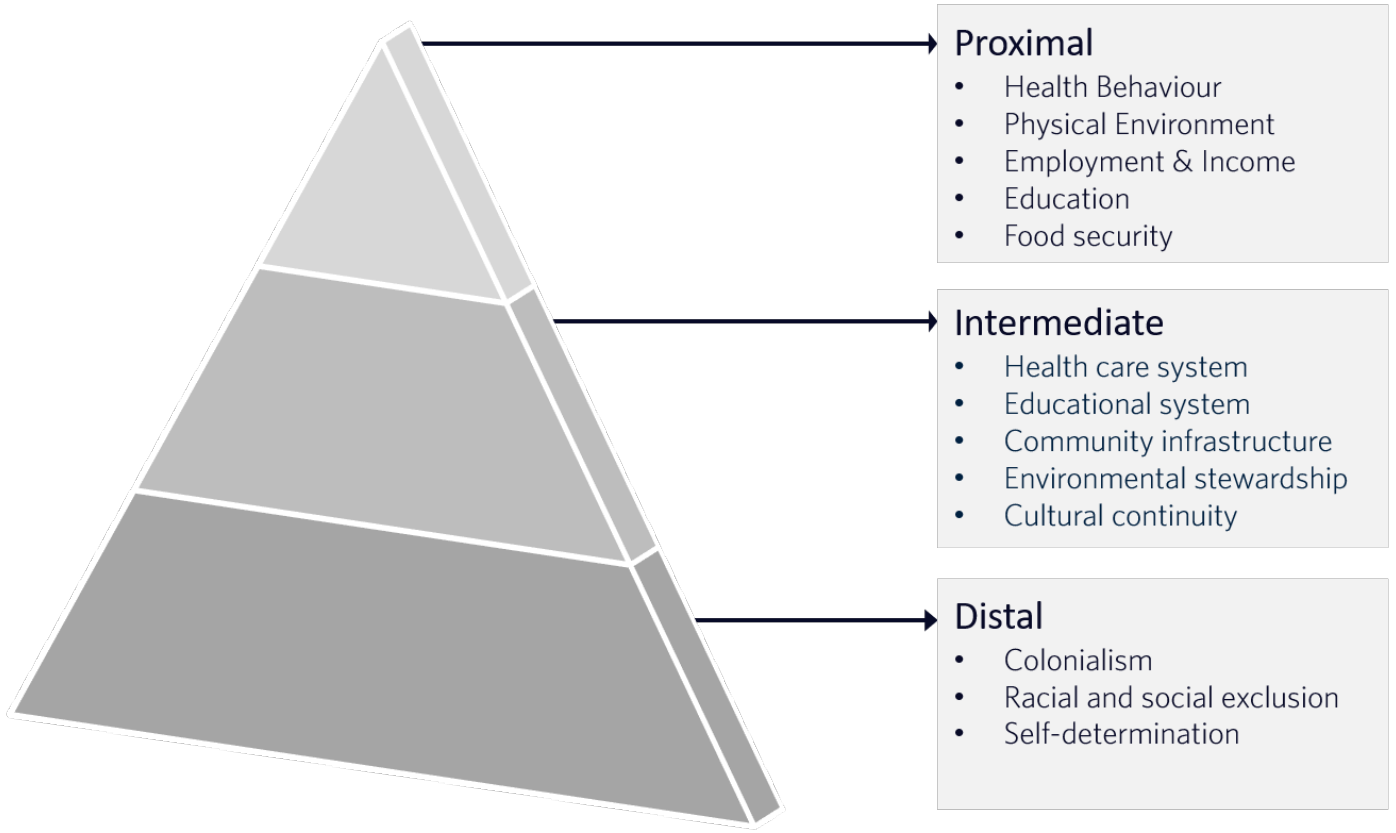


Using Determinants of Health as a risk prediction model was accurate for all cause hospitalization and death

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

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

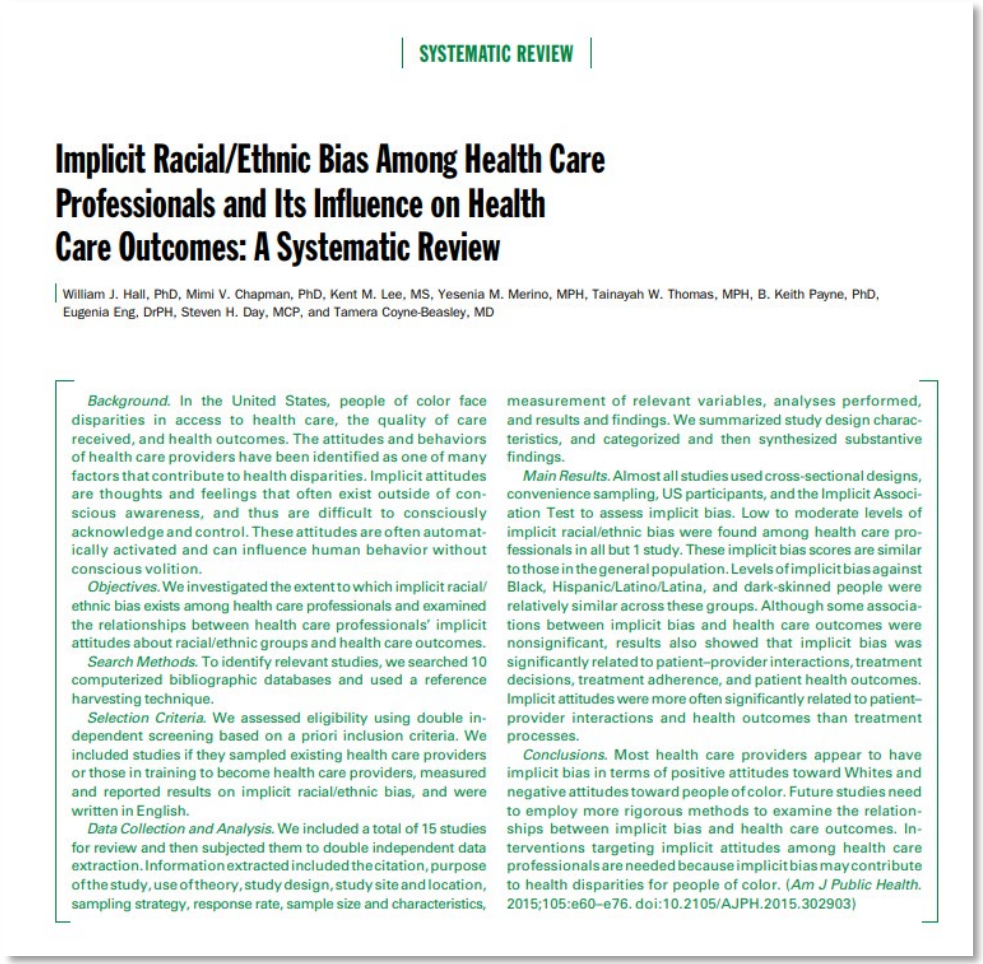
FitzGerald C, Hurst S. Implicit bias in healthcare professionals: a systematic review. BMC Medical Ethics. 2017;18:19. doi:10.1186/s12910-017-0179-8.

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

- 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**

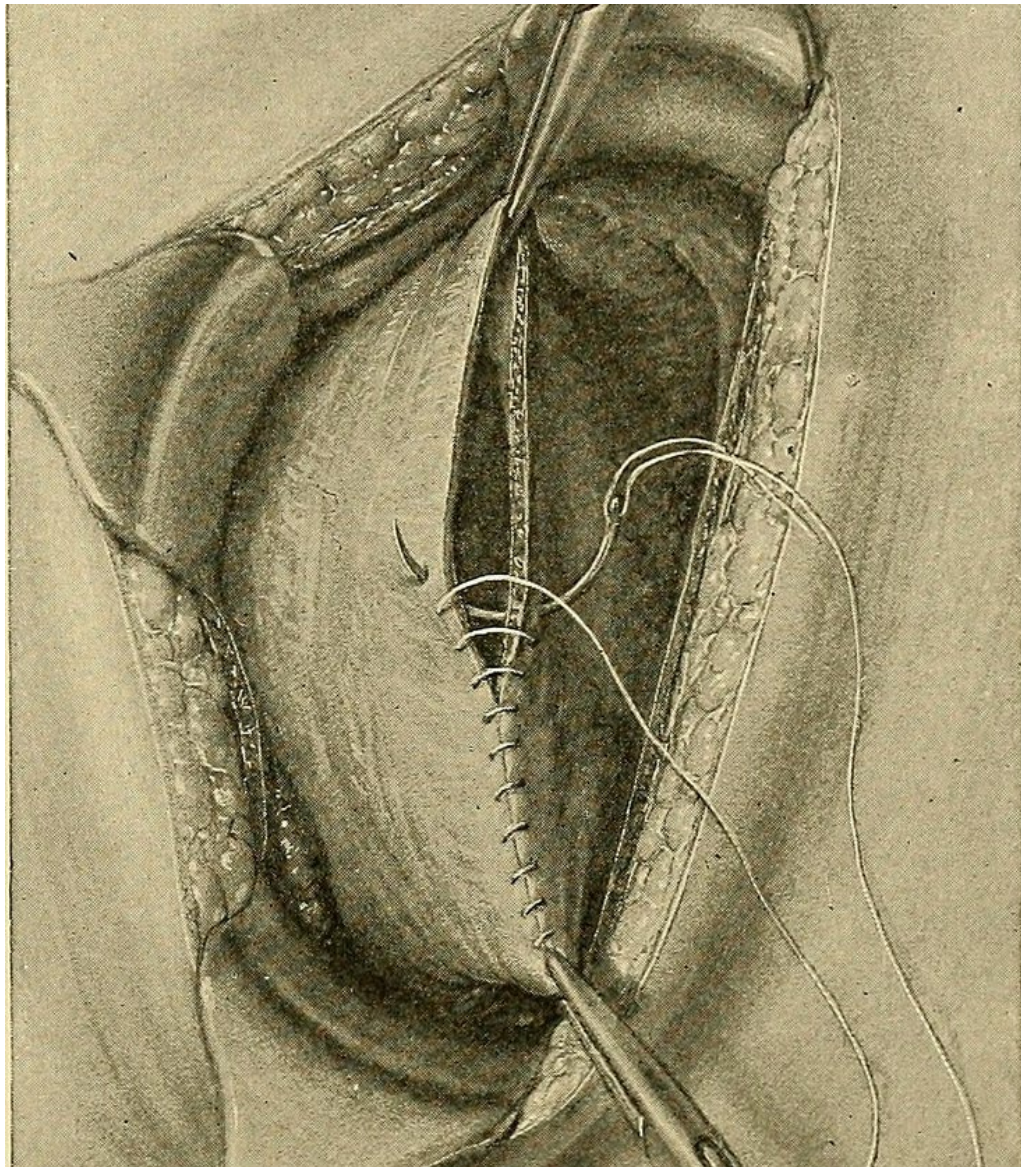
CLINICIANS WITH LOW IMPLICIT AND EXPLICIT BIAS IS OBVIOUSLY PERCEIVED THE BEST

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

Disparities in 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

Avoid termination of care

- Incomplete care 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

“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

Case 3

You are assessing a 72-year-old woman who had fallen twice in the past week at home. The last fall was 2 days ago. There is some generalized pain but she seems to be able to ambulate and conduct her daily activities without significant impact.

As you try to speak with her to get more history, she complained that the room is too bright. You drew the blinds in the clinic room to darken the room. She complained that you knocked her bag over when you were doing so.

You apologized for knocking her bag over, and you offered to help her set it down where she prefers. You then tried again to take a history.

She replied: “They already asked all this at the front already. Why didn’t you read the notes before coming in to see me?”

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

Manifestations 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

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

TRAUMA-INFORMEDCARE

HOW TO PRACTICE TRAUMA-INFORMED CARE

Physical + Emotional Safety

Attend to the patient's immediate needs
Consider food, transportation, child care, medical concerns, housing, and clothing. What does the patient feel is important? You might not be able to address all the needs, but you can validate what a patient feels is important.

Be as transparent, consistent and predictable as possible
Follow through on promises in a timely manner, explain why before doing something.

Limit trauma-related information to a need-to-know basis
Do not ask for details out of curiosity, only if needed for current care.

Obtain informed consent and explain limits to confidentiality
Explain how the information would be shared, and with whom.

Collaboratively develop grounding strategies
Use open questions to develop a plan together. "What have you found helpful to calm down and get focused when you're feeling anxious?"

Choice + Control

Work through details together
How to contact the patient, the time of appointments/meetings, how and whether messages can be left.

Explore and problem-solve barriers to participation and attendance
Brainstorm ideas together to remove or reduce barriers such as childcare, transportation, language, etc.

Elicit the patient's priorities and expectations for treatment
Find out what is the most pressing for them and what their hopes are for treatment.

Use statements that make collaboration and choice explicit
"I'd like to understand your perspective", "Let's work through this together".

Work in a feedback-informed way
Purposefully elicit feedback from patients and family e.g. "What was it like for you to get here today?".

https://www.bccsu.ca/wp-content/uploads/2022/01/LOUDintheED-Trauma-Informed-Care-in-ED.pdf

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

When looking for the reasons that can cause someone to fall, we consider things like pain, loss of strength from conditions like a stroke, loss of feeling in the feet, and any medications or substances that can worsen balance.

We’ve talked about the other causes already, and I am wondering if I can ask whether you take any medications, or substances such as alcohol or cannabis which can affect your balance?

Be mindful of the use of language

- Be cautious of “benign assumptions”
  - “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 helps with normalization and de-stigmatization
- 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

- 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

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

When interacting with minority patients, physicians…

HAVE POORER INTERPERSONAL SKILLS

PROVIDE LESS INFORMATION

ADOPT A NARROWLY BIOMEDICAL COMMUNICATION PATTERN

USE LESS PARTICIPATORY DECISION-MAKING STYLES

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

Consider elements of nonverbal communication that may affect rapport:

E	M	P	A	T	H	Y
Eye contact	Muscles of facial expression	Posture	Affect	Tone of voice	Hearing the whole patient	Your response

Riess H and Kraft-Todd G. EMPATHY: A tool to enhance nonverbal communication between clinicians and their patients. Academic Medicine. 2014:89(8);1108-1112

“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

Patient Care 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.

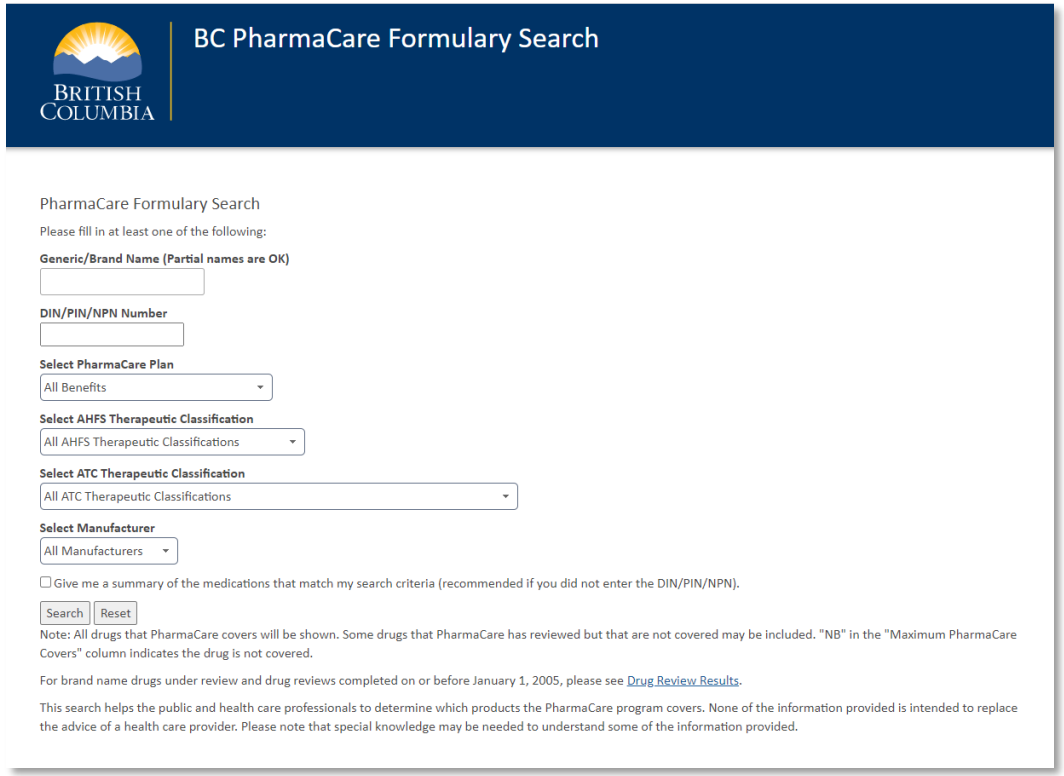
Ensure you and your team are aware of resources available to patients and their families. Start with Canada Benefits and 2-1-1.

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

more interventions on reverse

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

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



- 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

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

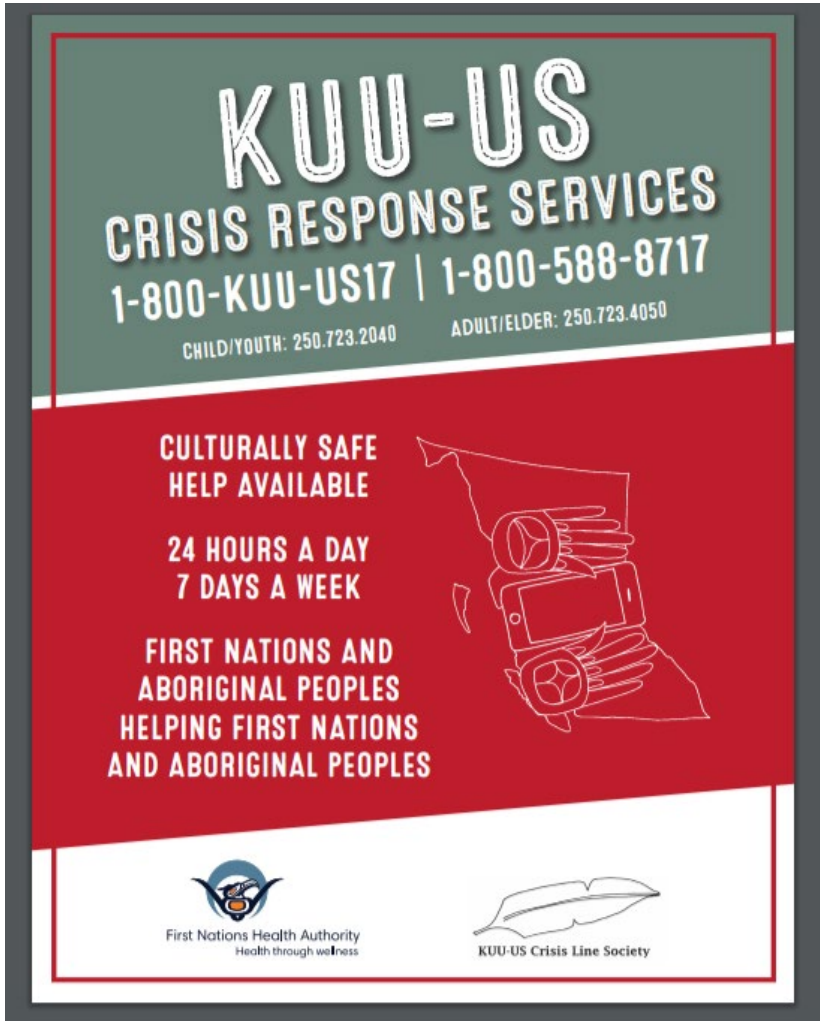
- social worker
- land-based activities
- personal support worker
- specialized summer camps
- respite care (individual or group)
- specialized programs based on cultural beliefs and practices

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

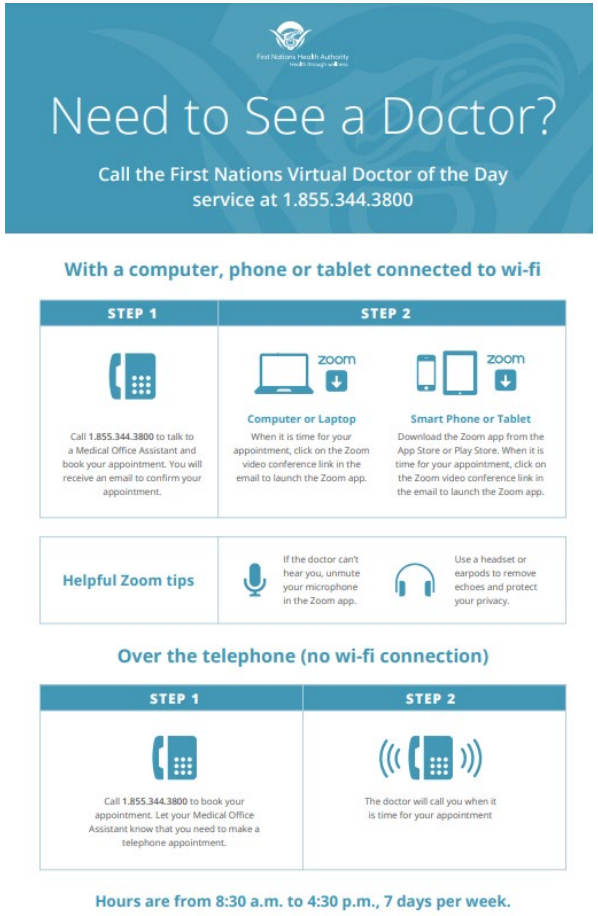
- Engage mental health support
  - Kuu-us Crisis Line
    - 24/7 crisis line providing risk assessment, monitoring, and outreach
    - Youth: 250-723-2040
    - Adult: 250-723-4050
  - Métis Crisis Line
    - 24/7 crisis line providing risk assessment, monitoring, and outreach. Can also refer to Métis 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
  - Virtual Substance Use & Psychiatry Service
    - Addictions: M-F 13:30 to 17:30
    - Psychiatry: M-F 10:00 to 15:00
    - Referral Forms:
      - Substance use: https://www.fnha.ca/Documents/FNHA-SUPS-Substance-Use-Referral-Form.pdf
      - Psychiatry: https://www.fnha.ca/Documents/FNHA-SUPS-Psychiatry-Referral-Form.pdf
  - Residential Schools Resolution Health Support Program
    - 24/7 emotional support for residential school survivors
    - 1-866-925-4419

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

Structural Considerations

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/

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

Offer 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
  - Physician note fees
- Physical environment
  - Explicit display of religious symbols

Offer 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

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
  - Indigenous 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

Summary

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

Ensure appropriate clinical suspicion

Recognize external bias

- Bias conveyed by other professionals
- CTAS scores

Recognize the impact of stereotypes

- Be aware of prevalence of stereotypes
- Acknowledge that stereotypes can affect decision-making

Consider whether there is higher pre-test probability

- Higher prevalence of adverse determinants of health

Optimize assessment

- Prioritize earning trust
- Convey a caring attitude
- Be mindful of the use of language
- Commit to communication
- Be attentive to power differential
- Be aware of disparities in rates of investigations

Optimize management

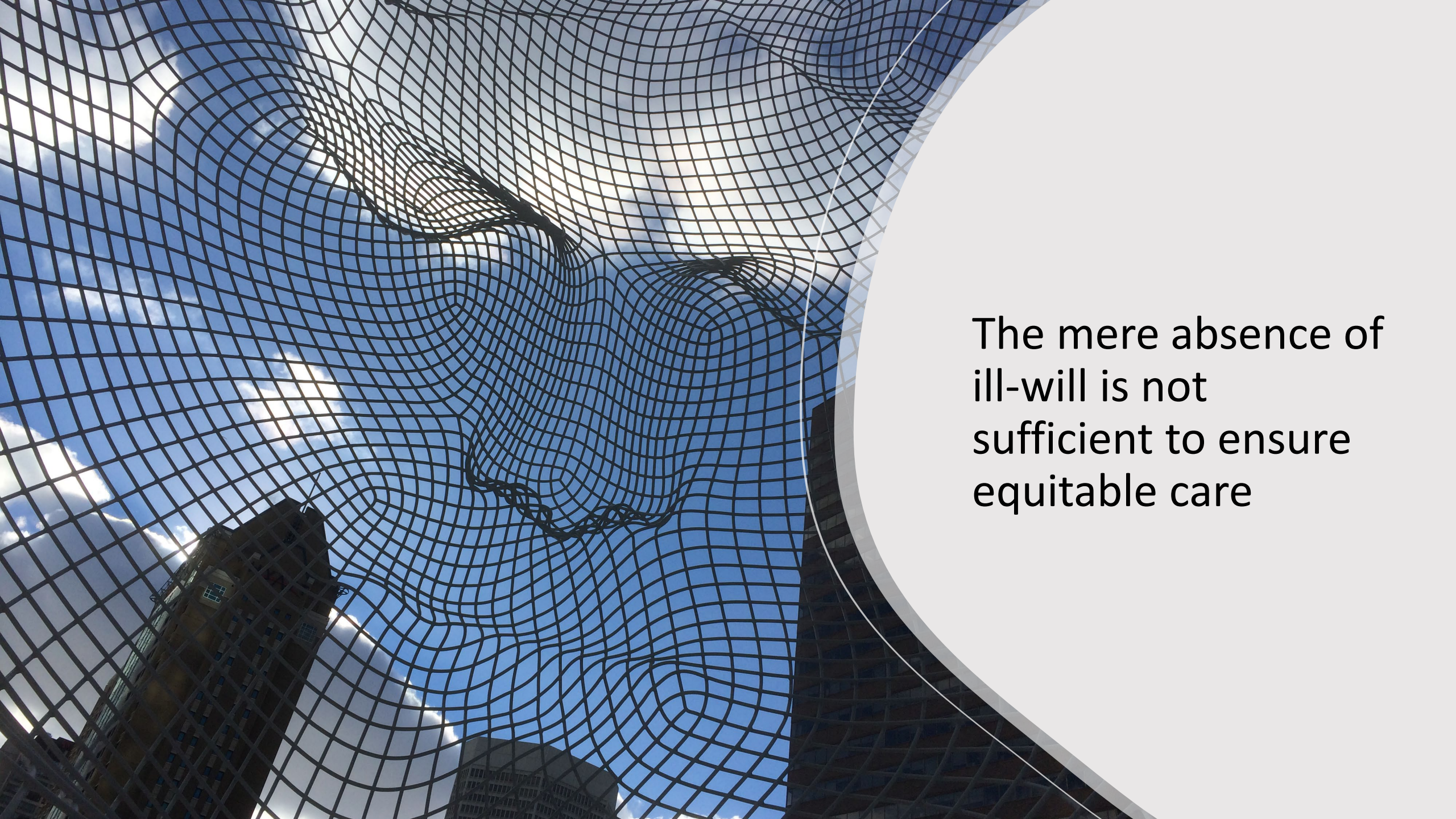
- Manage pain and symptoms
- Offer low barrier care
- Use resources to mitigate barriers in determinants of health
- Engage mental health support
- Avoid termination of care
- Provide written information and reference materials

Key Take-Aways

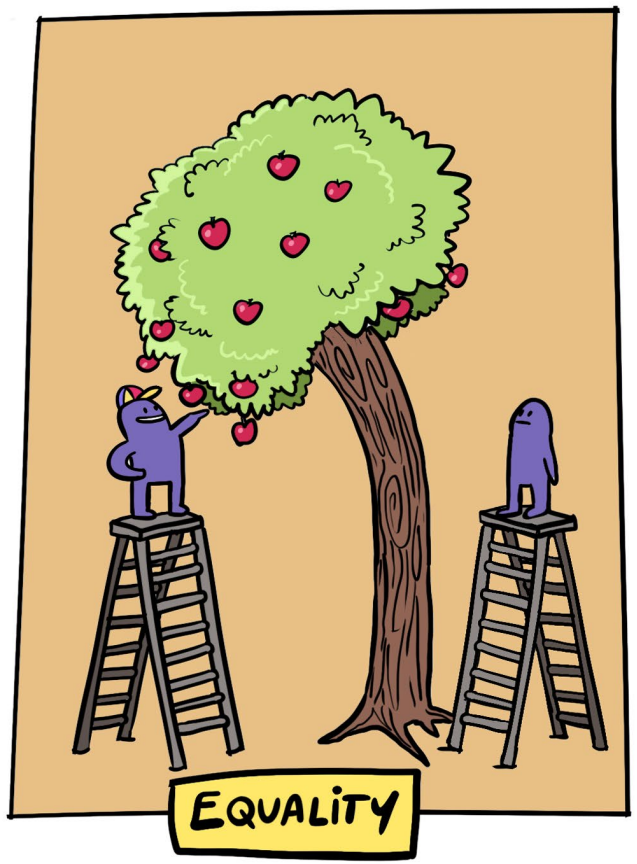
Providing health care that integrates personal context may take more time. View this as a legitimate use of time.

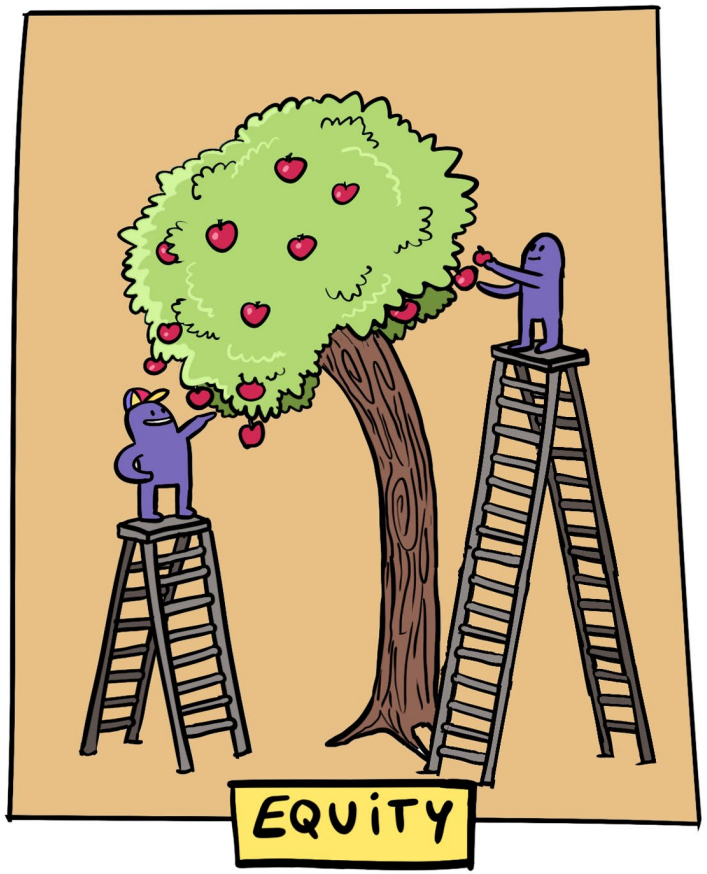
Systemic Racism

When a system meant to serve the public, while functioning as intended, produces different outcomes based on the system user's race



The mere absence of ill-will is not sufficient to ensure equitable care





Illustrated by Armin Mortazavi

Thank you

✉ james.liu99@gmail.com

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*.

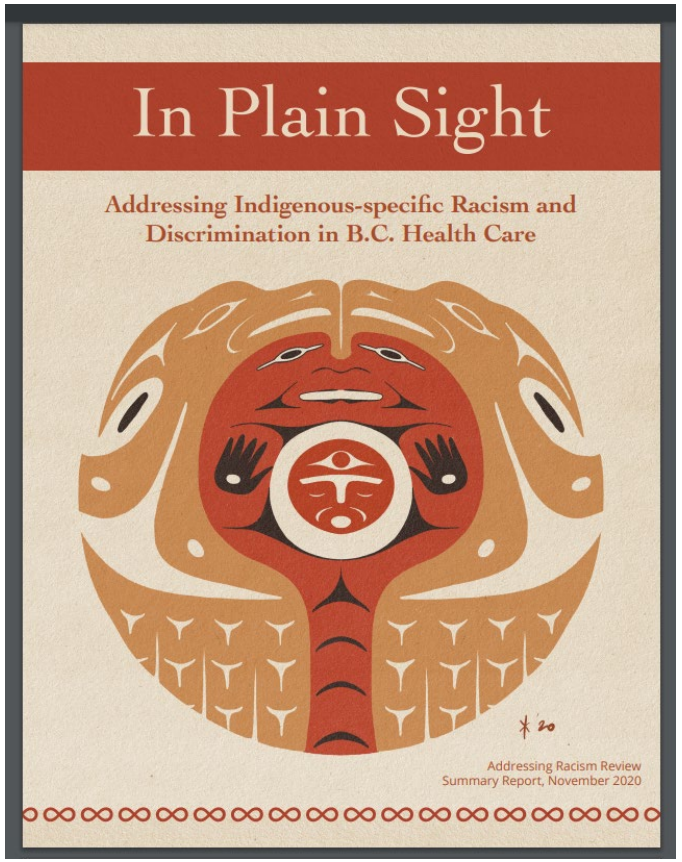
Registrants may seek guidance on these issues by contacting the College or by seeking medical legal advice from the CMPA or other entity.

Working with Indigenous Patients

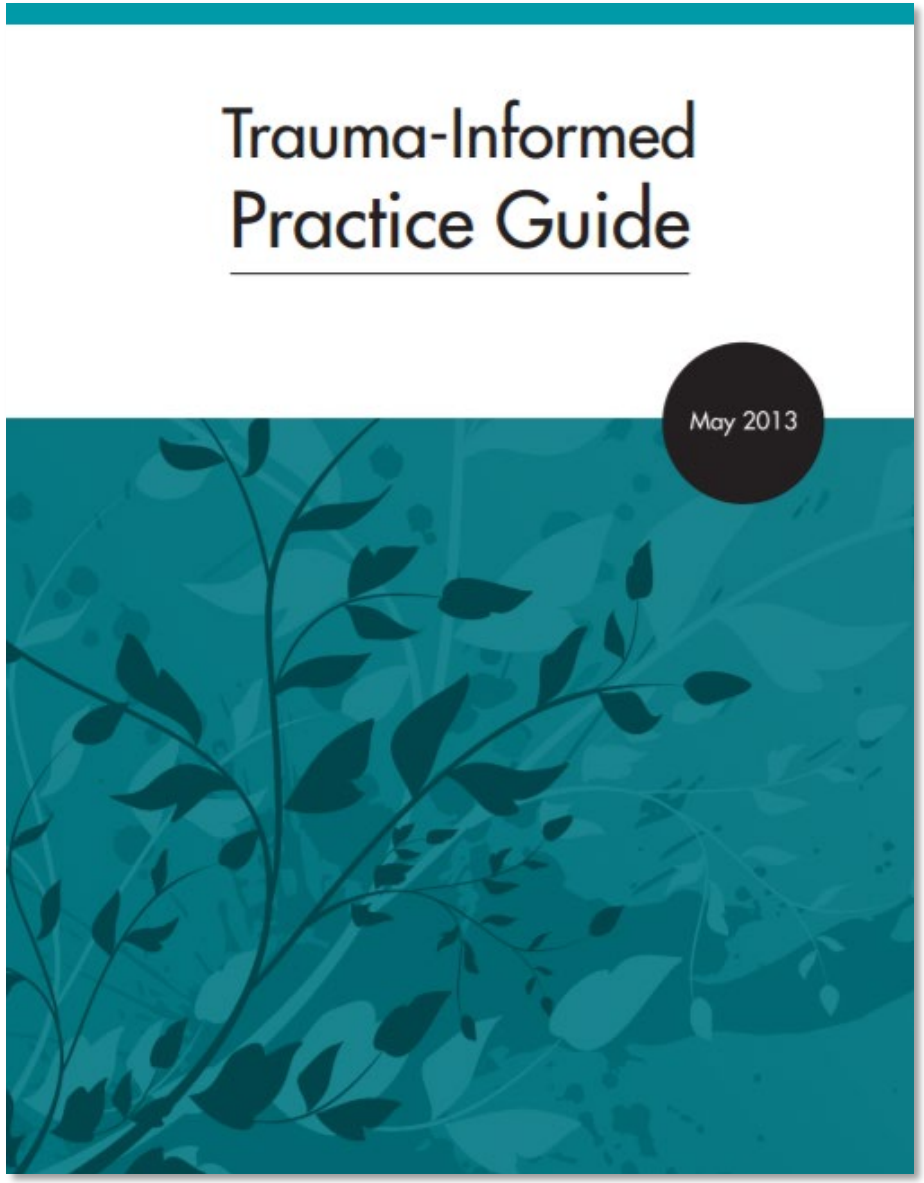
- Advice to health care providers from patients

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



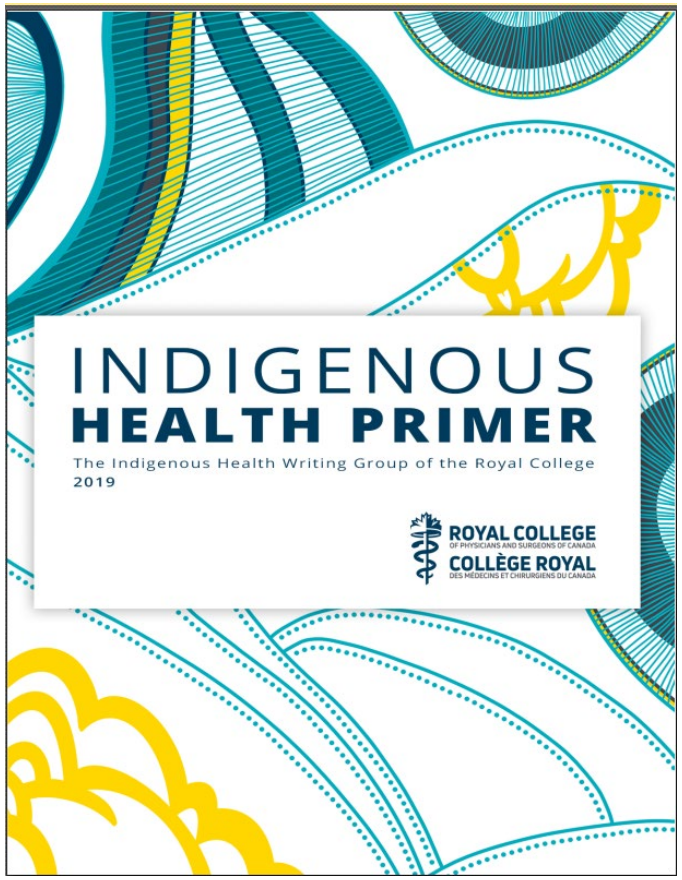
Trauma-Informed Practice Guide



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

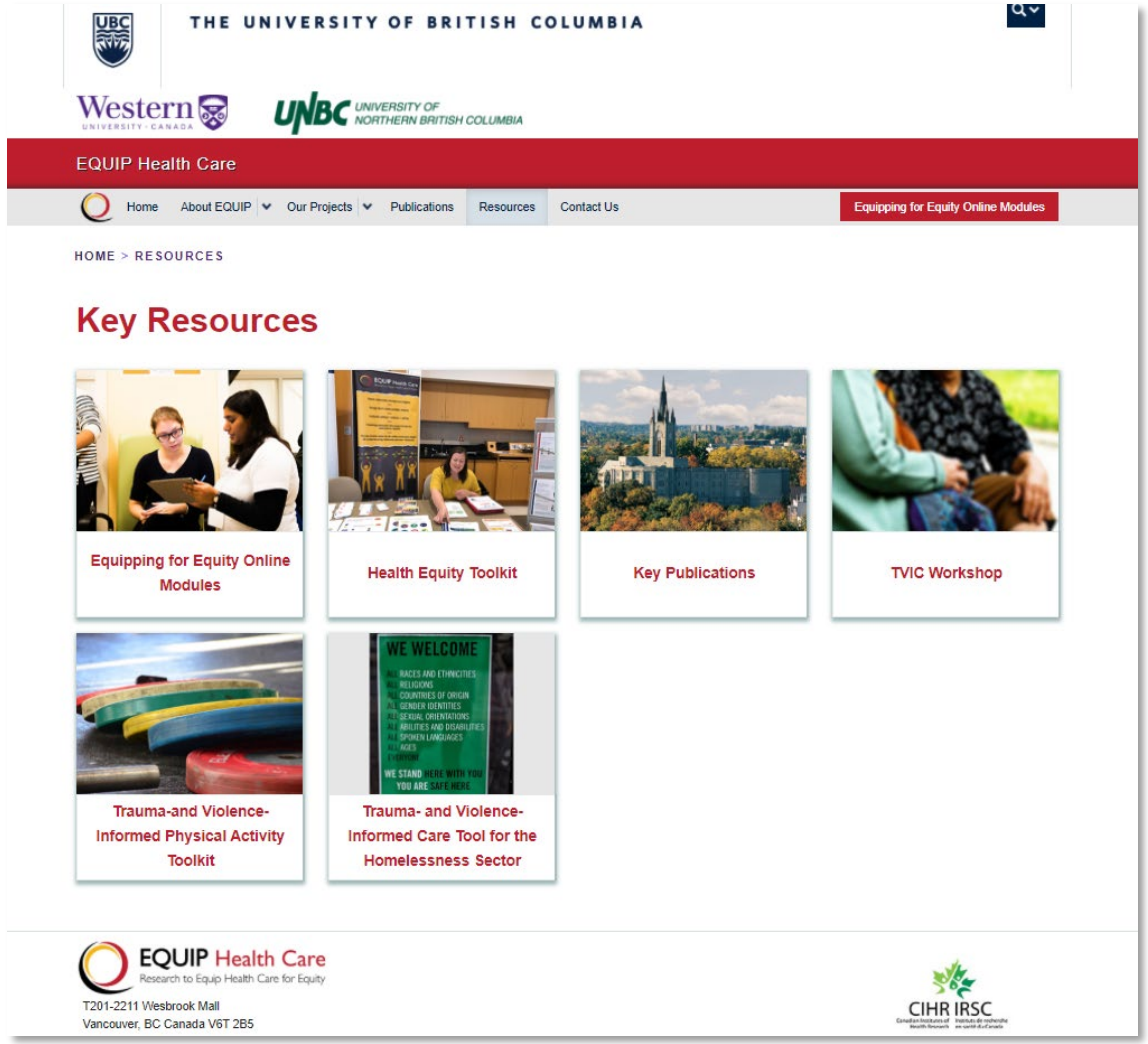
Indigenous Health Primer

- 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



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

Cultural Safety Resources

- Royal College – Walking Together
  Online course reviewing colonialism, determinants of health, and systemic inequities
  https://cpd.royalcollege.ca/learn/courses/259/walking-together-understanding-indigenous-health
- 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/

Ongoing personal development

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
  - Move towards a holistic understanding of the patient’s context
  - Improve a sense of 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

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