

In Plain Sight

Addressing Indigenous-specific Racism and
Discrimination in B.C. Health Care



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Addressing Racism Review
Summary Report, November 2020

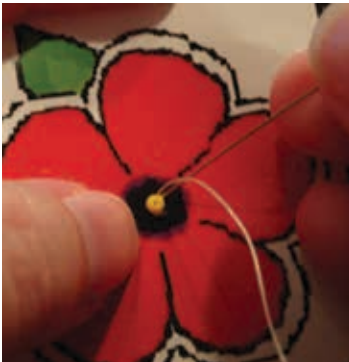




“Métis Nation British Columbia was pleased to work with the Review Team on this report addressing racism in B.C.’s health care system. The Métis Nation needs to be recognized as a distinct people making up one-third of the Indigenous population in B.C.



The mental health and wellness for Métis people is enhanced when they see the word Métis intentionally and authentically used. By working with MNBC, our Citizens see themselves included in provincial and regional policy, planning and strategies.



We are seeing some early progress in starting to have Leadership meetings with health authorities but have very little human resource capacity to respond at the level we need to for our people. We will need to ensure the Métis Nation is engaged and resourced to participate at the appropriate tables to address the health disparities and gaps we face moving forward.”

~ MNBC President Clara Morin Dal Col
Métis National Council, National Minister of Health



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Acknowledgements



Emotional Trigger Warning

This report discusses topics that, for Indigenous peoples, may trigger memories of culturally unsafe personal experiences or such experiences of their friends, family and community. The report is intended to explore the prejudice and discrimination experienced by Indigenous people in the health care system and to make Recommendations that will help eliminate Indigenous-specific racism and create substantive equity in health care experiences, services and outcomes. However, the content may trigger unpleasant feelings or thoughts of past abuse. First Nations, Métis and Inuit peoples who require emotional support can contact the First Nations and Inuit Hope for Wellness Help Line and On-line Counselling Service toll-free at 1-855-242-3310 or through hopeforwellness.ca. The Métis Crisis Line is available 24 hours a day at 1-833-MétisBC (1-833-638-4722). And the KUU-US Crisis line is available 24/7 at 1-800-588-8717 to provide support to Indigenous people in B.C. For more information, visit: kuu-uscrisisline.ca

A Closer Look

This report offers an abbreviated version of the Review's Findings and Recommendations. The full version can be found [here](#).

On June 19, 2020, I was appointed by British Columbia's Minister of Health, the Hon. Adrian Dix, to conduct a review of Indigenous-specific racism in the provincial health care system.

I acknowledge that the resulting Addressing Racism Review has taken place on the territories of First Nations peoples in B.C., and I also recognize the courage and determination shown by thousands of Indigenous people across the province who shared their experiences within the health care system to inform this report.

In addition, I want to acknowledge the work of the skilled, Indigenous-led team who supported the complex and urgent Review that provided the basis for this report. And I would like to thank the First Nations Health Authority, First Nations Health Council and Métis Nation BC for their strong support during the process. I also express my gratitude to the team at the Indian Residential School History and Dialogue Centre at the University of British Columbia, who provided collegial support and research to assist in the preparation of the report.

Finally, I acknowledge that British Columbians and the B.C. health care system are dealing with two pressing public health emergencies – the opioid overdose crisis, and the COVID-19 pandemic. Despite the immense challenges and pressures created by these health emergencies, thousands of health care workers – along with their leaders and organizations – found the time to participate in this Review. I thank them for that, and for their dedication to confronting the matters raised in this report and committing to implement the Recommendations.

Hon. Dr. M.E. Turpel-Lafond (Aki-Kwe)
Independent Reviewer

How We Worked



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Knowledge Keeper's Message

***Te'ta-in (Sound of Thunder) Shane Pointe** is a Musqueam Knowledge Keeper, whose motto is "Nutsamaht!" (We are one). Te'ta-in is a proud member of the entire Salish Nation, the Pointe Family and Musqueam Indian Band. In addition to being a grandfather and great grandfather, he is a facilitator, advisor, traditional speaker and artist. Shane has worked for five different school boards, Corrections Canada, Simon Fraser University, the University of British Columbia and the First Nations Health Authority. He provides advice and guidance on ceremonial protocols for local, national and international cultural events.*

While addressing racism, whether individual incidents or broader systemic issues, we often find the root cause is willful ignorance. The ignorance of distinct cultures and histories as well as the knowledge of bodies, both physical and spiritual – the knowledge of a shared history that, while common to us all, has been experienced very differently by the Indigenous branch of our collective B.C. family.

When the other branches of our collective family think of us, there is a common perception of Indigenous peoples as being less than. Less able to care for ourselves. Less able to achieve. Less able to advocate for the services we need. This report is not about less; it is about unity and the fundamental rights of all peoples. It is about confronting and acknowledging the negative, while making room for the positive.

The Truth is, to be happy and balanced, we must know both the positive and negative aspects of our lives and the systems within which we coexist. When pain and suffering have been inflicted on us, it is necessary to take the time to heal, assess and recover our strength. Positive healing energy will move us forward hand in hand with those who have hurt us. It is this collective energy that will bring true healing to the perpetrator and victim alike.

This Truth is what we build this report on, in structure, it is not to 'name and shame'. Our goal is to build the collective strength necessary to advance as a whole and healthy society. The truths we have collected will help us – all of us – learn from our failures and successes to confront the uncomfortable histories and negative systemic practices that surround us so we can all begin to heal.

Before you absorb this report and begin the excellent work that will follow:

I would like to welcome you to this moment, which is the sum total of the positive and negative truths and histories written and unwritten. The truth of those who freely gave their voices, and of those wonderful human beings who couldn't. I ask you good people to please enjoy this humble moment, learn from it and, with all your integrity, bring dignity to those who have not been afforded it.

I invite you to help redistribute the wealth of cultural safety, dignity and integrity to all my First Nations relatives and others who have suffered the indignity of systemic racism.

Nutsamaht (we are one)

Nutsamaht xwalmox (we are one as human beings from this Earth)

Te'ta-in

Summary of Findings

In June 2020, claims surfaced about a “*Price is Right*” game allegedly being played in some B.C. hospital Emergency Departments (EDs) in which health care workers were guessing blood alcohol levels of Indigenous patients.

The Review Team was asked to investigate the “*Price is Right*” allegations and whether this game or other forms of Indigenous-specific racism are being experienced by Indigenous people using the provincial health care system. The Minister of Health requested the Review to make findings of fact, and “*to make any recommendations it considers necessary and advisable*” (see full Terms of Reference, Appendix B). The Addressing Racism Review was formally launched on July 9, 2020.

Specific to the “*Price is Right*” allegations, the Review did not find evidence of an organized game with this name occurring in B.C. hospitals as originally depicted. The Review has produced anecdotal and episodic evidence of multiple activities in the health care system that resemble these allegations in some fashion, but none of them could be described as coordinated, prevalent, widespread or targeting only Indigenous patients. It is also evident that the guessing by medical professionals of various patient levels – not limited to blood alcohol – is routine and in many cases may be clinically appropriate. However, the Review does find extensive profiling of Indigenous patients based on stereotypes about addictions. (*Please see detailed findings regarding the initial allegations in the full [Review report](#).*)

While the “*Price is Right*” allegations were unsubstantiated, the Review, consistent with its mandate, examined multiple other examples of racism and discrimination experienced by Indigenous peoples in the B.C. health care system. The results are disturbing. Through listening to thousands of voices – via survey results, direct submissions, health care data and interviews with Indigenous people who have been impacted by the health system, health care practitioners and leaders – a picture is presented of a B.C. health care system with widespread systemic racism against Indigenous peoples. This racism results in a range of negative impacts, harm, and even death.

The Review also found that this widespread racism has long been known by many within the health care system, including those in positions of authority, and is widely acknowledged by many who work in the system.

Systemic racism requires systemic action to address it, including to address deficiencies in governance, leadership, education, policy, transparency,

regulation, complaints processes and accountability. The Review Recommendations stress the need for immediate, principled and comprehensive efforts to eliminate prejudice and discrimination against Indigenous peoples. This is essential if we aspire to an accessible and effective health care system. It is also required in order to reach a state of substantive equality in health care and outcomes for Indigenous peoples that adequately address the legacy of colonialism in health care, and enable the expression and enjoyment of Indigenous human rights, consistent with the *United Nations Declaration on the Rights of Indigenous Peoples (UN Declaration)*.

UN Declaration & Indigenous Right to Health

The *UN Declaration* outlines the minimum standards for the survival, dignity and well-being of Indigenous peoples. The Indigenous right to health means that Indigenous peoples should have full access to health care services in ways that reflect and are responsive to Indigenous worldviews and conceptions of health, without discrimination.

The Indigenous right to health is also inextricable from the Indigenous right of self-determination and the inherent right of self-government. Self-determination speaks to control by Indigenous peoples over their health and well-being, including through their own governing institutions, jurisdiction and laws.

The *Calls to Action* of the Truth and Reconciliation Commission identified the *UN Declaration* as “the framework for reconciliation”. In November 2019, the B.C. government passed the *Declaration on the Rights of Indigenous Peoples Act (DRIPA)*. The federal government has also committed to pass legislation to implement the *UN Declaration*.

Upholding the Indigenous right to health, including as reflected in the *UN Declaration*, is now firmly established as the foundation for addressing discrimination and racism against Indigenous peoples in B.C.’s health care system.

This means identifying the work that must be done to implement Indigenous understandings of health, full access to culturally-appropriate health care services for Indigenous individuals, and Indigenous self-determination in health care – including through changes in laws, policies and practices, as well as roles for Indigenous institutions.

“shíshálh Nation remains at the forefront of rights recognition and implementation in British Columbia, as evidenced by the long-term Foundation Agreement we completed in 2018 with the B.C. government. Through that agreement we are on a path of re-setting the relationship based on a clear human rights foundation, as articulated in the *United Nations Declaration on the Rights of Indigenous Peoples*.

Yet, the Foundation Agreement should not give any comfort that the hard work is done. Quite the opposite – the hard work has only just begun. Implementing human rights is a lot harder than merely acknowledging them. It demands change – in how we govern, make decisions, relate to each other, and think and act as individuals. This is as true as ever in health care, where I continue to frequently hear concerns from members about the care they received, a racist or insensitive comment or slight, or obstacles in accessing services to meet their basic health care needs. And then I look across the Province, and Canada, and see that while our Nation has agreed to a path for securing the implementation of our rights, and transforming our current reality, most First Nations remain facing enduring obstacles of rights denial, and lack of recognition of their laws and governments.

We all have an obligation, to honour the sacrifices made by past generations and do what we must for future generations, to ensure that implementing the basic human rights of Indigenous peoples, including the Indigenous right to health, is at the core of all we do. This is our shared work, and our call to action.”

~ hiwus (Chief) Warren Paull

Review Approach

The Review Team was headed by Indigenous women – in particular, the Independent Reviewer and the Executive Director. The team featured a combination of Indigenous and non-Indigenous members with public health and direct clinical experience, including physicians, nurses and public health leaders, and those with extensive knowledge of the health care system, as well as expertise in conducting complex investigations, interpreting data, Indigenous rights, human rights and anti-racism.

The independent Review Team was fully and co-operatively provided with access to all data and information needed to complete its broader review of Indigenous-specific racism through delegation under the *Ministry of Health Act*.¹ Sources of data and information for the Review include:

- An Indigenous Peoples' Survey (IPS) to collect the experiences of Indigenous people using the health care system, and a Health Workers' Survey (HWS) to collect the experiences of health care workers regarding Indigenous-specific discrimination in their workplaces
- Creation of a website and a toll-free phone number and email address for individuals to share their experiences of racism and discrimination in health care
- A detailed examination of the allegations that gave rise to this Review
- Interviews with First Nations and Métis leaders and health advocates, health professionals and educators
- Interviews with leaders across the health care sector including the Minister and Deputy Minister of Health, CEOs of all health authorities, health regulatory college leaders, Indigenous health team leaders from all health authorities and other relevant stakeholders
- Significant analysis of health sector data relating to Indigenous peoples. A separate data report summarizes the breadth of data examined and serves as an important foundational report
- A review of literature, correspondence, and submissions involving more than 900 studies, reviews, articles and other documents
- Dialogue with experts in Indigenous rights, Indigenous health and wellness, and the *UN Declaration*.

¹ See delegation letter in Appendix A.

Expectations and Scope

The scope of the Review was to investigate the “*Price is Right*” allegation, and to examine Indigenous-specific racism – and in particular systemic racism – in the B.C. health care system. We listened to the Indigenous people who came forward, developed key themes, highlighted representative accounts as the anonymized submissions to the Review that appear on these pages, and combined these with other data sources to produce a systemic examination of the issue.

There were other needs and serious issues that came to light during the Review that were beyond the scope of our mandate.

More than 600 people shared their experiences with the Review. Many cases were highly disturbing with people expressing deep frustration and the pent-up need to be heard and their concerns acted upon. Many of the people who made submissions to the Review expected the team to investigate, address and impose remedies with respect to their individual experiences. Although in some cases, the Review Team helped navigate services and made the system confront issues in real time, we acknowledge that many of those who made submissions will be disappointed by the fact that the Review cannot impose remedies, and lacks the statutory authority to impose appropriate consequences in cases. Assurances that case histories shared with the Review would be kept strictly confidential, and sealed following its conclusion, will be honoured, meaning that the Review itself cannot provide an avenue for further investigation of these specific incidents.

Some Review submissions included incidents of racism in sectors other than health, including the education, justice and child welfare systems, which were outside the Review’s scope. Particularly concerning were numerous complaints about Indigenous children and families not receiving proper respect or access to health-related services such as assessment and therapeutic services in the K-12 education system, including psycho-educational testing, speech language therapy or occupational therapy. Government should consider commissioning similar reviews into Indigenous-specific racism in its other public service systems that intersect with health care, and it might be advisable to place a priority on the special needs stream of health supports in the education system.

Individual submissions to the Review also included incidents brought forward by people of other racialized groups, particularly from Black and South Asian populations. Those, as well, fell outside the Review’s mandate. As a result, racism as experienced by other racialized groups is yet to be fully revealed, much less addressed.

Emerging Context

This Review has been conducted in a moment of increasing understanding about the colonial history of Canada and its enduring legacy, and the moment of transition we are in.

Prejudice and racism against Indigenous peoples have roots in colonial beliefs that Indigenous peoples were weak, less worthy of care, dying off, incapable, savage and primitive. These beliefs, embedded in laws and policies for more than a century, have shaped and continue to permeate public services such as health, education, justice and child welfare. A lack of readily available factual information, knowledge and understanding about this history contributes to ongoing negative attitudes and social inequities.

Key Definitions and Context

- **Colonialism** occurs when groups of people come to a place or country, steal the land and resources from Indigenous peoples, and develop a set of laws and public processes that are designed to violate the human rights of the Indigenous peoples, violently suppress their governance, legal, social, and cultural structures, and force them to conform with the colonial state.
- **Race** refers to a group of people who share the same physical characteristics such as skin tone, hair texture and facial features. Race is a socially constructed way to categorize people and is used as the basis for **discrimination** by situating human beings within a hierarchy of social value.
- **Prejudice** refers to a negative way of thinking and attitude toward a socially defined group and toward any person perceived to be a member of the group.
- **Racism** is the belief that a group of people are inferior based on the colour of their skin or due to the inferiority of their culture or spirituality. It leads to **discriminatory** behaviours and policies that oppress, ignore or treat racialized groups as 'less than' non-racialized groups.
- One result of racism is **substantive inequity** – a state in which racialized groups do not have equitable outcomes, or equitable opportunities, to non-racialized groups.
- This is **systemic racism** – where acceptance of these discriminatory and prejudicial practices has become normalized across our society and institutions.
- **Profiling** is creating or promoting a pre-set idea of the values, beliefs and actions of a group in society and treating individuals who are members of that cohort as if they fit a pre-set notion, often causing them to receive different and discriminatory treatment.
- **Substantive equality** refers to the requirement to achieve equality in opportunities and outcomes, and is advanced through equal access, equal opportunity and, the provision of services and benefits in a manner and according to standards that meet any unique needs and circumstances, such as cultural, social, economic and historical disadvantage.
- **Indigenous-specific racism** refers to the unique nature of stereotyping, bias and prejudice about Indigenous peoples in Canada that is rooted in the history of settler colonialism. It is the ongoing race-based discrimination, negative stereotyping and injustice experienced by Indigenous peoples that perpetuates power imbalances, systemic discrimination and inequitable outcomes stemming from the colonial policies and practices.

B.C. remains in the midst of a transition from this colonial legacy of segregation, disempowerment and dehumanization of Indigenous peoples, to an equitable system that is culturally safe, based on the recognition of the basic human rights of Indigenous peoples, including the right to access services without discrimination or profiling. In November 2019, the B.C. government laid an important foundation for such approaches through the passage of the *Declaration on the Rights of Indigenous Peoples Act (DRIPA)* that affirms the application of the *UN Declaration* to the laws of B.C., and requires an action plan to meet the objectives of the *UN Declaration*. This requires shifts to ensure that systems, behaviours and beliefs throughout our society support the basic human rights of Indigenous peoples. We know that achieving this shift in health requires humility, anti-racist mindsets and tools, and human rights approaches.

We all have vital roles to play in confronting this historic legacy, and creating positive change. This Review has been conducted with the goal of supporting momentum for this change. In reading this report, we invite you to examine your own beliefs, build your understanding of the past and present reality of health care for Indigenous peoples, and consider the role each of us can play in building a strong B.C. health care system for all British Columbians.

Key Definitions and Context

- **Anti-racism** is the practice of identifying, challenging, preventing, eliminating and changing the values, structures, policies, programs, practices and behaviours that perpetuate racism. It is more than just being “not racist”.
- To be **anti-racist** involves actively eliminating racism from our policies and institutions, understanding how the present exists upon colonial and racist foundations, and committing to educate oneself and take action to create conditions of greater inclusion, equality and justice.
- **Anti-racist mindsets, tools and skills** target the root causes of systemic discrimination – which lie in structures, patterns of behaviour and attitudes that are legacies of colonialism – and pursue transformative, and not merely superficial or incremental, change.
- **Cultural humility** is a life-long process of self-reflection and self-critique. It is foundational to achieving a culturally safe environment. While western models of medicine typically begin with an examination of the patient, cultural humility begins with an in-depth examination of the provider’s assumptions, beliefs and privilege embedded in their own understanding and practice, as well as the goals of the patient-provider relationship. Undertaking cultural humility allows for Indigenous voices to be front and centre and promotes patient/provider relationships based on respect, open and effective dialogue and mutual decision-making.
- A **culturally safe** environment can only be defined by the Indigenous person receiving care and does not profile or discriminate against the person but is experienced as respectful, safe and allows meaningful communication and service. It is a physically, socially, emotionally and spiritually safe environment, without challenge, ignorance or denial of an individual’s identity. To be culturally safe requires positive anti-racism stances, tools and approaches and the continuous practice of cultural humility.

Colonial Health Care in the History of Canada and B.C.

Colonialism is a structured and comprehensive form of oppression that, in Canada, was justified through creating and perpetuating racist beliefs about the inherent genetic, cultural and intellectual inferiority of Indigenous peoples. These racist beliefs were entrenched through two pernicious propositions that gained structural, legal and policy form: first, that Indigenous peoples should be treated apart and separate, through a segregated health system imposed on them by a dominant regime; and second, that Indigenous peoples could be treated as objects of the health system for the purposes of research and experimentation.

Segregated facilities, underfunding, low standards of care, violations of individual integrity and autonomy – including of the physical bodies of Indigenous individuals – and a failure to address needs expressed by communities and support Indigenous self-determination are all part of Canada's own history of health services for Indigenous peoples.

This includes a history of Indian hospitals, established primarily to allay white settler fears associated with the communicability of tuberculosis (TB). Another major rationale for a segregated hospital system was to help the federal government save money; government found it could operate Indian hospitals at half the cost of caring for First Nations and Métis patients in community hospitals. Three hospitals were located in B.C.: Coqualeetza Indian Hospital in Sardis (1941 to 1969), Miller Bay Indian Hospital near Prince Rupert (1946 to 1970) and Nanaimo Indian Hospital (1946 to 1967).

At the same time, Indigenous peoples were being used for medical research and experimentation, again primarily to aid in the discovery of treatments for the settler population. Residential schools were the sites of many scientific research experiments throughout the 20th century. As sanatoria care increased, these too became places where trials and research were carried out, typically on infants and children who were classified as wards of the state.

The lives of many Indigenous young people at this time were characterized by a shuttling between segregated institutional systems – mandatory attendance at residential schools, exposure to TB as a result of poor living conditions in those schools, followed by legally compulsory treatment at hospitals. The history of these experiences within Indian hospitals has not been as well documented as that in the residential school system. The voices and stories of survivors need to be heard if we are to truly comprehend what must be confronted with respect to Indigenous-specific racism in today's health care system.

“We have to understand the legacy of the Indian hospital in this province. Still to this day, I have people in communities who tell me they do not want to go to the hospital for care because that is where their grandparents died under atrocious conditions. If hospital administrators don't understand that, how can we provide care? If they just say, 'Oh, they're non-compliant. They don't show up for appointments.' Well, yeah. Do you know why?”

~ Health care professional who spoke to the Review

(Photos courtesy of the UBC Indian Residential School History and Dialogue Centre.)



Racism Felt Across Generations and Communities

An Indigenous Elder spoke to the Review at length about her family's experiences with racism in the health care system over generations. Here are some of her recollections:

- Her father and all his siblings were sent to the Nanaimo Indian Hospital. Her mother was held there for nearly 18 years. She recalls that, as a child in residential school herself, the threat of being sent to the Nanaimo Indian Hospital was very real. She says children who were seen to be incorrigible or unteachable were sent there and that electric shock therapy, sterilization and multiple medical experimentations were used on Indigenous patients at the hospital.
- While at residential school, some of her teeth were pulled, resulting in significant pain, and she has had a fear of dentists ever since. She has experienced chronic tooth infections, complicated by Bell's palsy.
- She recalls in May 1993, when her elderly mother was in palliative care and she received a call at 11 a.m. with her mother crying: *"I need you."* She discovered that her mother had been waiting for a bedpan for four hours.
- Another morning, she received a call from her mother who was crying in pain. She discovered that, despite the doctor ordering pain medication every four hours and as needed, she had not had any for 24 hours. The nurses' response was that *"she didn't ask for it."*
- She recalls the premature death of her father at a care home. He required his food to be pureed as he did not know to chew. One day, staff left him with regular food, a piece of apple became lodged in his throat and, by the time they found him, he was in medical distress and subsequently died.
- When she was nearly 20, she was referred to a urologist for chronic interstitial cystitis in the bladder. The specialist was rough with the equipment and, when she cried out in pain, he said *"Come on, you know you native women like it rough."*
- She recalls the many times she has had to use the ED for treatment of the pain and chronic infections in her teeth. She's often heard *"What are you doing here? We don't give drugs."*
- Once, when calling 8-1-1, because of her Bell's palsy and the fact she has only one vocal cord, a nurse told her to *"hang-up and call back when you are sober."*



INDIAN MEDICAL CLINIC ESTABLISHED

Three-year-old Joan Wyse, daughter of Mr. and Mrs. George Rice Wyse, was the first patient to be treated yesterday at the first medical clinic on Nanaimo Reserve No. 1. Mrs. Wyse assisted Dr. Morris Wynrih, staff member of Nanaimo Indian

Hospital, which is the centre for Indian Health Services for this zone. Nanaimo Indian Health committee helped build the clinic which had been approved at the last Band meeting to be chaired by the late Chief Dan Brown. —(Free Press photo)

(News article courtesy of the UBC Indian Residential School History and Dialogue Centre.)

What We Heard



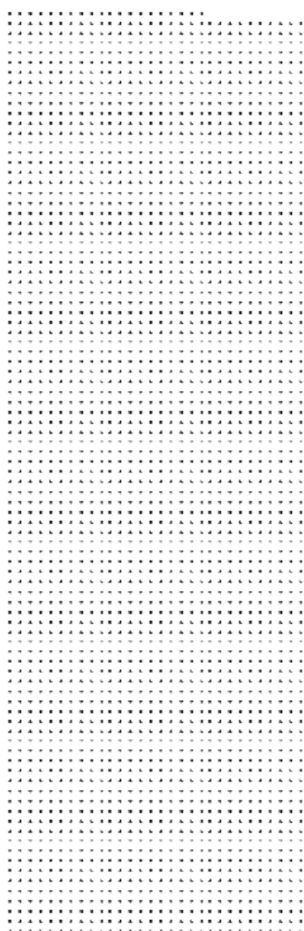
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WE HEARD FROM ALMOST 9,000 PEOPLE

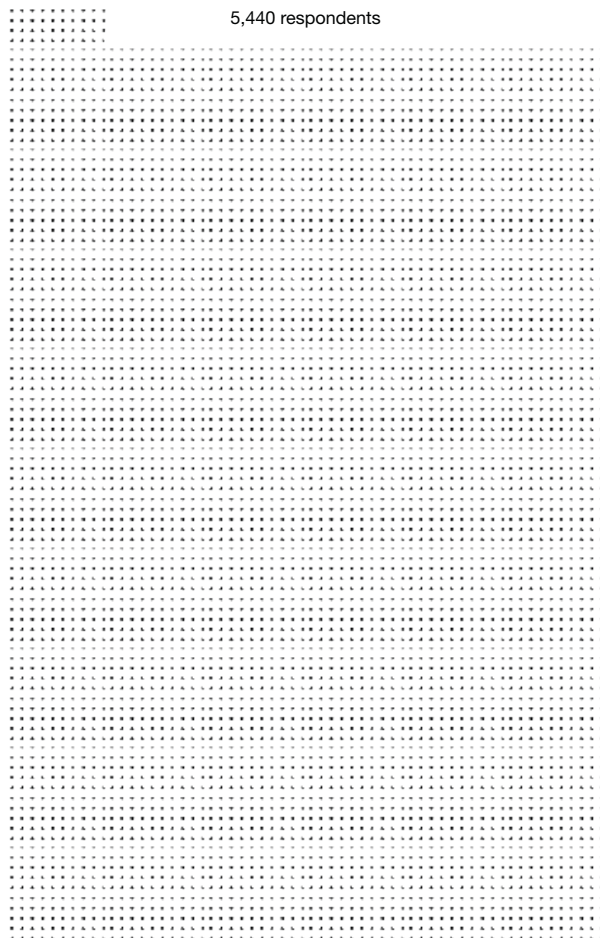
INDIGENOUS PEOPLES' SURVEY

2,780 respondents



HEALTH WORKERS' SURVEY

5,440 respondents



DIRECT EMAIL AND 1-800-NUMBER

600 respondents



KEY INFORMANT INTERVIEWS

150



WE ANALYZED HEALTH SECTOR DATA

185,000

Health utilization and health outcomes of First Nations and Métis individuals.

12,335

Indigenous respondents to the COVID-19 Speak survey.

3,026

Adults in the First Nations Regional Health Survey data.

1,246

Indigenous respondents to a Patient Reported Experiences Measurement Survey of Emergency Departments.

430

Complaints from Patient Care Quality Offices, Colleges and the First Nations Health Authority.

LITERATURE REVIEW

Submissions from health sector and Indigenous organizations
Detailed investigation of specific ED allegations
Investigation of other select cases
Extensive literature review of previous investigations, inquiries, and academic or historic findings
Dialogue with experts in Indigenous rights, Indigenous health/wellness, *UNDRIP*
Review of existing anti-racism/cultural safety initiatives already underway

INDIGENOUS PEOPLES' SURVEY

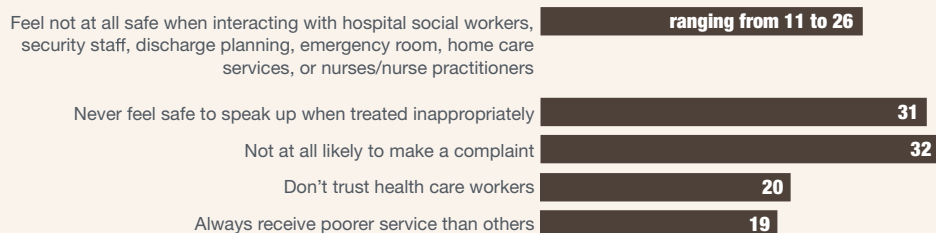
What we heard

PERCENTAGE

Widespread and ongoing stereotyping and racism leads to discrimination at point of care



Discrimination at point of care negatively affects access to health care



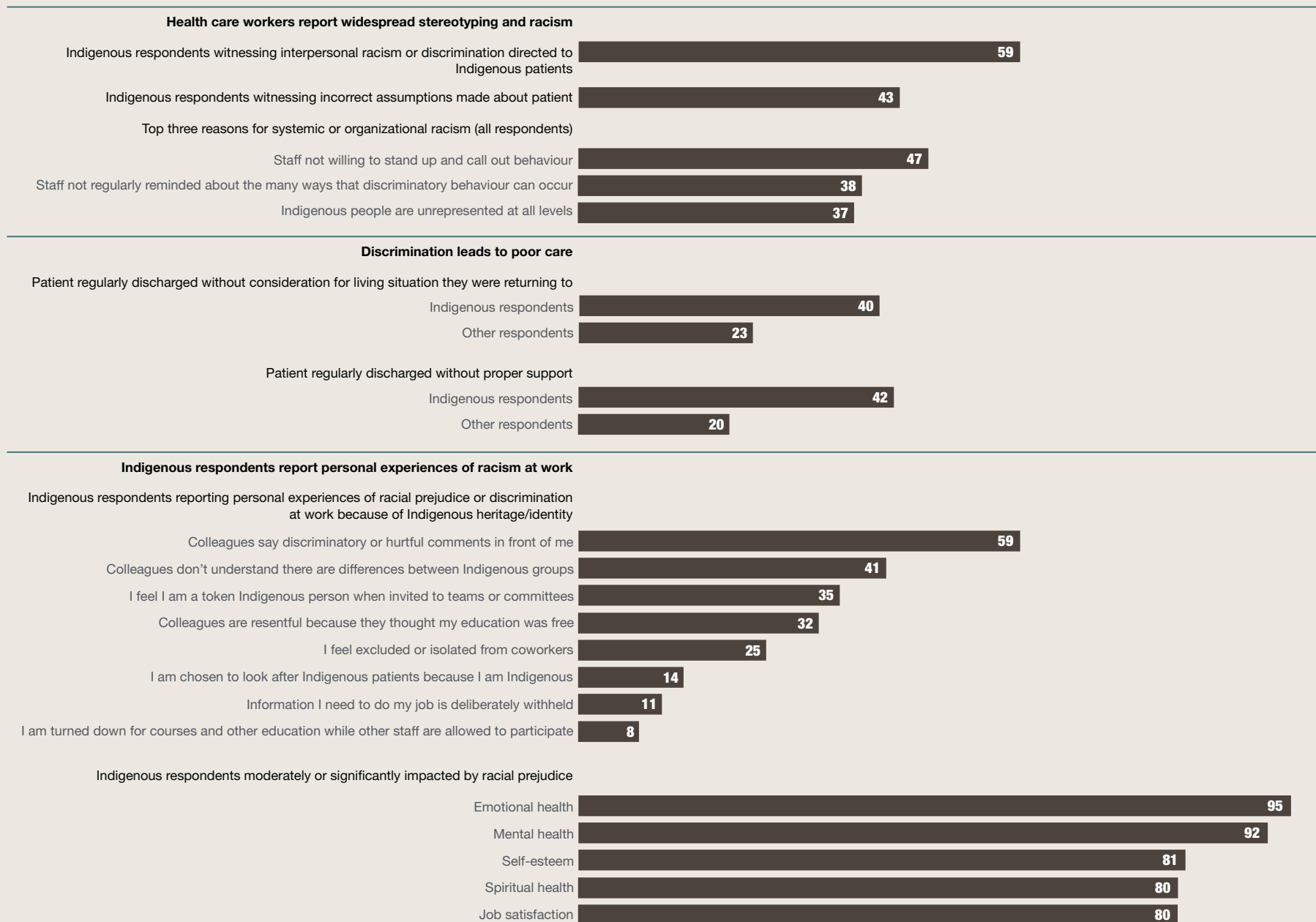
Less access to health care leads to poor outcomes



HEALTH CARE WORKERS' SURVEY

What we heard

PERCENTAGE

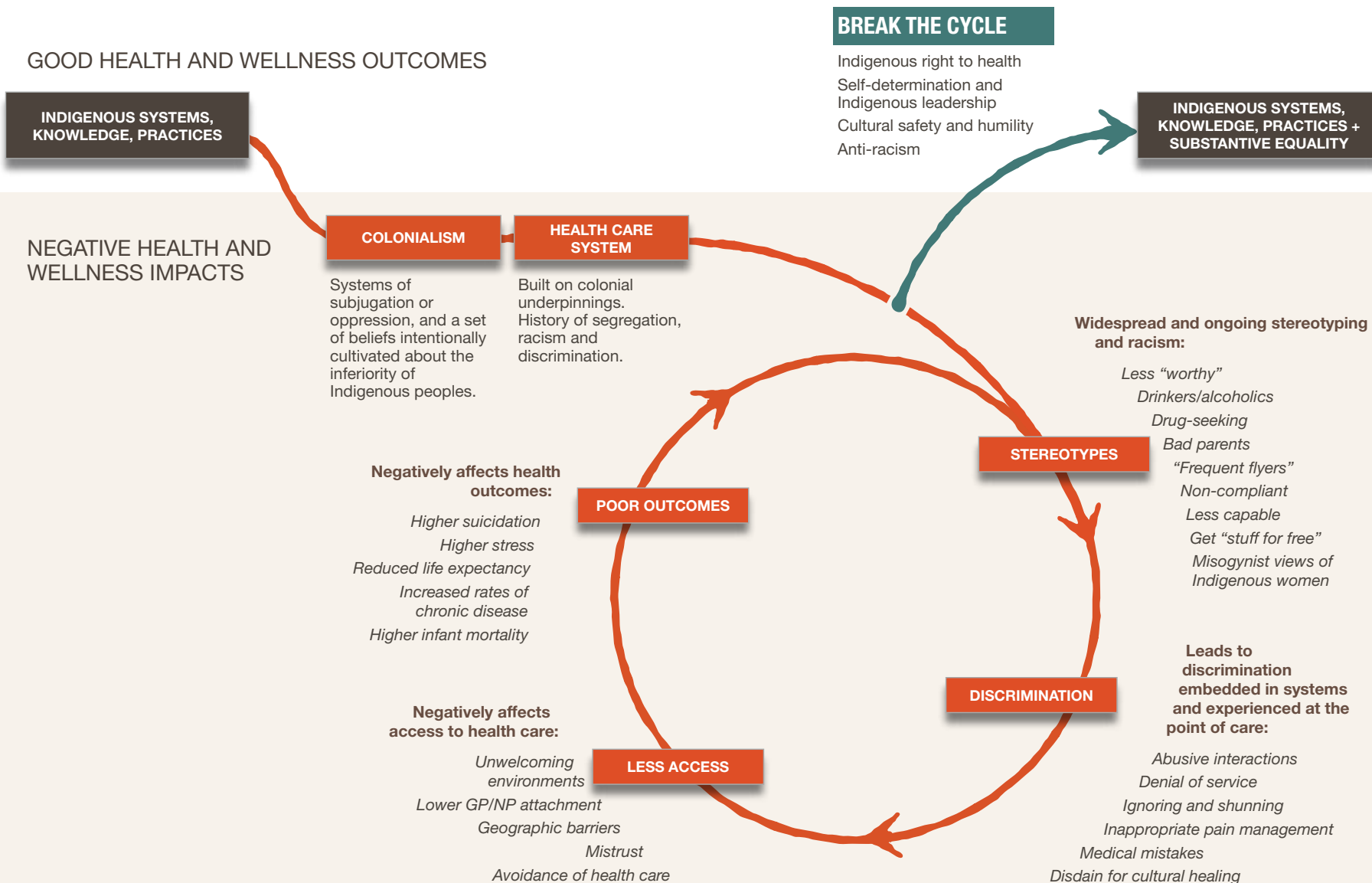


What We Found



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Findings 1 to 5: The Problem of Indigenous-specific Racism in B.C. Health Care

These Findings describe a major problem of Indigenous-specific racism in the B.C. health care system. This problem has significant impacts on Indigenous patients, women and health care workers. It contributes to inequitable health outcomes, including in the context of the public health emergencies of COVID-19 and the overdose crisis.

1. **Widespread Indigenous-specific stereotyping, racism and discrimination exist in the B.C. health care system.**

Stereotyping, prejudice and racist treatment are common experiences for Indigenous people in B.C. health care at all levels, especially urgent care. Only 16 per cent of all Indigenous IPS respondents reported not being discriminated against in any of eight factors related to stereotyping when receiving health care. More than one-third (35%) of health care worker respondents reported having personally witnessed discrimination inflicted upon Indigenous patients or their families and friends.

Racist Treatment After Surgeries Leaves Woman Fearing Hospitals

Within the last two years, an Indigenous woman from a remote community in B.C. has twice travelled to a hospital in a larger centre to undergo surgery for brain aneurysms. On both occasions, she has experienced racist treatment from the recovery room nurses.

The woman describes waking up from the first surgery in 2018 feeling very unwell, needing to vomit but with dry heaves. She recalls one of the nurses yelling at her across the recovery room: *“You’re going through withdrawal; it’s from all the alcohol you people drink; you’ll have to wait for your booze.”* She says she was subsequently moved to a different room for three days where she got no nursing assistance.

The same thing happened in the recovery room in 2019, where she came to feeling very sick and dry heaving. Once again, a nurse made reference to alcohol, suggesting she was going through withdrawal with the comment: *“You people drink too much.”*

The woman hadn't been drinking before either surgery and wonders if she was having a reaction to the drugs used to sedate her. The woman inquired about getting help from an Aboriginal Health worker but was told none were available and no one advised her about the patient complaint process. Complaints to her surgeon went unanswered.

These experiences have left the woman so fearful that she plans to refuse any future surgeries. She feels the risk to her safety is higher attending this hospital than it would be living with an aneurysm. She says she was treated in a way no human being should be treated and is frightened that the lack of treatment could result in her dying.

Stereotyping of Indigenous people is common and widespread in the health care system. Indigenous patients experience widespread racist stereotyping that has evolved from colonial beliefs. These are the stereotypes most commonly identified by the Review:

- **Less “worthy” of care** – Indigenous patients seen as inherently less valuable than non-Indigenous (and particularly white) patients due to a number of generalized, negative perceptions of Indigenous people
- **Drinkers/alcoholics** – Patients presumed by staff to be intoxicated; other reasons for their presentation not considered
- **Drug-seeking** – Patients requiring pain medication presumed to have ulterior motives (e.g., to obtain prescription drugs to use for non-medical purposes or to sell)
- **Bad parents** – Judgments made about the capacity of patients to care for their children
- **“Frequent flyers”** – Patients presumed to be mis-using or over-using the health system, particularly the ED
- **Irresponsible/non-compliers** – Patients seen as unwilling to take responsibility for their health care or to follow through on aftercare instructions
- **Less capable** – Patients seen as lacking the capability to take responsibility for their health care
- **Unfairly advantaged** – Patients seen as *“always getting stuff for free”*.

“I’m sad to say that I experienced racial stereotyping... I was made to feel ashamed and they did not believe that I had food poisoning but in fact [that I] was just wasted. I was so sick I could barely keep my head up but understood the stigma I was experiencing. I felt judged and mistreated. I left feeling shame...”

~ First Nations woman who attended hospital with severe case of food poisoning

A Closer Look

For context and background to contextualize these Findings, including with respect to colonialism and its continuing effects, Indigenous health governance in B.C., and Indigenous human rights, please see the full version of this report [here](#).

Key Definition and Context

A **stereotype** is a fixed image. It refers to an exaggerated belief, image or distorted truth about a person or group; a generalization that allows for little or no individual differences or social variation.

As a result of this stereotyping, Indigenous people experience harm, poorer quality of care and even death. Respondents to the IPS were 2 to 2½ times more likely than non-Indigenous respondents to report “*always*” having adverse experiences across a range of care experience categories. The Review observed that negative stereotyping and profiling shapes common forms of discriminatory behaviour by health care workers. The most common discriminatory behaviours identified by the Review are:

- **Unacceptable personal interactions** – including disparaging and racist comments, “*cold*” treatment and eye-rolling
- **Long wait times/denial of service** – receiving poorer service and/or being made to wait longer than non-Indigenous patients
- **Lack of communication/shunning** – failure to provide appropriate information, being “*shut out*” of care, disengaging from Indigenous patients
- **Not believing/minimizing concerns** – failure to take seriously or dismissing concerns expressed by Indigenous patients, including being accused of “*faking*”
- **Inappropriate/no pain management** – minimizing or ignoring pain or denying pain medication to Indigenous patients, sometimes with explicit reference to the stereotype that Indigenous people were drug-seeking or somehow felt pain differently
- **Rough treatment** – disrespectful and “*manhandling*” treatment, at times resulting in physical harm and chronic pain
- **Medical mistakes** – misdiagnoses and mistakes, often related to falls, and based on the belief that a patient was under the influence of alcohol or drugs
- **Lack of recognition/respect regarding cultural protocols** – health care workers not open to hearing about traditional medicine, denying permission to practise cultural protocols and ceremony, and being intolerant to involvement of family and community.

“One Elder vividly described feeling the ‘*angry hands*’ of health care workers over her lifetime.”

~ Indigenous woman’s submission to the Review

“They Just Thought I Was a Drunk”

One evening in February 2019, a 57-year-old Indigenous man fell while walking to the bathroom in his home. It was nearly midnight and he realized that he was badly hurt, so he called an ambulance to take him to the nearest hospital, where he was x-rayed. Nurses subsequently informed the man that there was “*nothing wrong*” with him and that he had to go home. He protested, insisting he was certain that he was injured and couldn’t walk, particularly since he had left the cane he used – due to a pre-existing spinal condition – at home.

He says two nurses – a male and a female – treated him poorly and made fun of him. “*They just thought I was a drunk.*” Eventually, as the argument with nurses continued, security was called, followed by the police. The man was ultimately arrested and taken to jail for the night.

The next morning, he was released from jail but he was still in pain and couldn’t walk. The man was taken by ambulance back to the same hospital where, this time, he was diagnosed with two cracks in his pelvis. He recalls one of the same nurses commenting sarcastically: “*Well, you were able to walk out of here last night.*”

Another result of stereotyping, profiling and discrimination is mistrust and avoidance of the health care system by Indigenous people, and anticipatory behaviours and strategies to avoid discriminatory treatment. Among Indigenous IPS respondents, lack of trust in doctors, nurses, administrators and the medical system was the third biggest issue in health care. More than one in five Indigenous respondents were likely to feel “*not at all safe*” when interacting with hospital social workers (26%) and security staff (22%), and when using mental health or substance use services (23%) and discharge planning services (22%). They were most likely to report feeling “*not at all safe*” in institution-like settings such as Emergency Departments, other areas of hospitals and assisted living facilities.

“I am afraid to go to any hospital. When I do have to, I dress up like I’m going to church [in order to receive proper treatment]. It’s ridiculous.”

~ Young Indigenous woman who reported being treated with contempt and not receiving the care she needed in the ED after being violently assaulted

Many Indigenous people indicated to the Review that they avoid seeking health care as a result of a negative experience. This is also evident in rates of First Nations patients leaving hospitals against medical advice – First Nations people were more than twice as likely as other residents to leave B.C. hospitals against medical advice in the years 2015 to 2018.

“After the third time, we gave up and I just started taking the kids to every appointment because I am a white male and got better service. Sad, but reality.”

~ Non-Indigenous man whose family gets better treatment when he accompanies them to health care instead of his partner, a First Nations woman

When needing to access health care, many Indigenous peoples employ strategies to counteract stereotyping and prejudicial treatment, and to ‘prove’ they are worthy of care. This includes ensuring they are well-dressed, and bringing a non-Indigenous person with them to ‘witness’ or to advocate on their behalf.

Non-Indigenous Witness Recalls Terrible Treatment of Patient

A non-Indigenous woman remains troubled by something she witnessed while a patient in a hospital ED. She recalls that an Indigenous man in his 40s arrived in the ED via ambulance. He was calm and quiet as he lay on the gurney that the accompanying paramedic had placed in front of the nursing station.

The paramedic turned her back on the man and proceeded to chat with two nurses. At one point during the conversation, the paramedic walked over to the Indigenous man and lifted up his shirt, remarking to the nurses that the man had a large scar – the result of a stabbing incident that had occurred in Vancouver.

The witness says both the paramedic and the nurses then ignored the man while they continued their conversation. Within the course of 15 minutes, the Indigenous man asked twice very politely if someone could help him get to the bathroom. The nurses and paramedic continued to ignore him. The man urinated while lying on the gurney and, when the paramedic turned around and noticed, she yelled at him for “*pissing his pants*” before taking him away.

“I have seen the symptoms of an Indigenous patient go untreated for days despite the concerns voiced by our unit physiotherapist, resulting in this patient having a stroke.”

~ Hospital social worker who contacted the Review

2. Racism limits access to medical treatment and negatively affects the health and wellness of Indigenous peoples in B.C.

One goal of the Review was to collect data that explores connections between racism as reported and overall health outcomes. What is revealed is that, while explicit colonial policies that undermined quality care for Indigenous peoples may no longer be on the books, the extent of Indigenous-specific racism today in the health care system continues similar, enduring, harmful beliefs, and has negative impacts and effects on Indigenous peoples' health and well-being.

Indigenous peoples experience inequitable access to primary preventative care services. Other Residents in the province had higher rates of using physician services and receiving laboratory and diagnostic testing as an outpatient, compared to First Nations people, despite the fact that First Nations have greater health needs. This is reinforced by lower rates of continuity of care and lower cancer screening rates.

The lack of equity in primary care services results in disproportionately high reliance on emergency services, and can result in hospitalization for avoidable reasons. In the absence of accessible primary care, First Nations people resort to Emergency Department (ED) usage and, arguably for the same reason, visit the ED more frequently. Forty per cent of First Nations visited the ED at least once in 2017/18, a rate which was 1.8 times higher than the comparable rate for other residents. On average, they visited the ED between two and three times, a frequency at least in part due to inadequate access to primary care. The hospitalization rate among First Nations for conditions commonly seen as preventable was nearly three times higher than among Other Residents.

Inequitable health care access, compounded by racism, contributes to poorer health outcomes for Indigenous people. Inequitable health care access, which is exacerbated by racism, is implicated in inequitable health outcomes. This inequity is seen in the data related to birth, death, chronic illness and multiple diverse health conditions. This system failure for Indigenous peoples contributes to reduced life expectancy, increased rates of significant early-life health challenges and mortality, increased rates and earlier onset of chronic disease, and increased likelihood of having multiple diverse health conditions.

Racism, prejudice and discrimination in all settings are associated with lower health and well-being. The experience of racism is associated with higher rates of self-reported distress, suicidal ideation, and substance use amongst First Nations people.

“Racism against Indigenous peoples is a malignant disease that has been in the health care system in British Columbia since inception. Every person who works in the health care system, in fact every British Columbian, must acknowledge this reality and work together to ensure health care for Indigenous people is equitable and culturally safe and focuses on the needs of the individual, not the attitudes of the system. It is a glaring fact that Indigenous peoples encounter racism on a regular basis in the health care system and we need an effective mechanism or complaint process to bring the issue to light and have it addressed. First Nations in British Columbia must be protected from all forms of racial discrimination in seeking health care. Racism is not just hurtful words or ideas – in health care, it leaves Indigenous peoples suffering without proper care. In the moment when you need health care, it is too much of a burden to put on the backs of First Nations peoples, having to deal with this racism. That is not compassionate, it is cruel and painful.”

~ Grand Chief Stewart Phillip
President, Union of BC Indian Chiefs

Family Searching for Answers After Lengthy Mental Health Detention

In late-June 2020, 23-year-old Canadian Armed Forces member Connor Sutton² was on leave to attend a funeral on Vancouver Island. The member of the T'Sou-ke Nation was temporarily staying in Maple Bay, near Duncan.

Mr. Sutton began to experience chest pains, as well as nausea, vomiting, speech difficulties, shortness of breath and disorientation, which led him to drive to the Cowichan District Hospital ED. He was admitted to the hospital for the night. Staff eventually determined that a hole in his esophagus was causing the chest pains and related symptoms. He was treated and discharged with antibiotics.

The following day, Mr. Sutton was experiencing the same symptoms, along with significant mental distress. That evening, he again visited the Cowichan hospital and begged to be admitted. He recalls that hospital staff refused to admit him and instead told him to find a homeless shelter, at which point he left. Mr. Sutton returned later that evening in a second attempt to be admitted, however a dispute ensued, a security guard was called and restrained Mr. Sutton against a wall. Mr. Sutton says he hit the security guard in self-defence and exited to the parking lot. Following this, he says he was tackled by multiple security guards, resulting in the RCMP becoming involved and briefly detaining him in cells prior to releasing him to his father's custody without charges.

The following evening, Mr. Sutton's father drove him to the ED at the Royal Jubilee Hospital in Victoria, where he was admitted. It is unclear why, but Mr. Sutton was moved from his admission unit to the Psychiatric ICU five days after he was initially admitted. Ten days later, Mr. Sutton was transferred once again to 2NW (schizophrenia services) in Adult Mental Health. The Sutton family recalls that nurses in the hospital relayed that the psychiatrist had labelled him as a *"highly trained military weapon"* and indicated that he may be dangerous.

Once Mr. Sutton was transferred permanently to 2NW, his family members found it almost impossible to speak with him. They say they were not given a diagnosis, provided updates on his condition, his medications, nor the reasoning for his move from the Cardiac Unit to the Psychiatric Unit and subsequent move to 2NW. The family believes he was heavily drugged during this period.

In an effort to understand why Mr. Sutton had been detained and after he had been alone in hospital for nearly a month, the family pushed for a psychiatric hearing. It is their recollection that, by this point, he was not certified/committed by the Authority, and they feel the doctors were intentionally misleading about his status. Three days prior to the hearing date, the hearing was cancelled and, according to correspondence from the Mental Health Review Board, Mr. Sutton had been decertified. The family says they were told it could be three months before a second hearing could be booked.

In addition to media coverage and a rally for Mr. Sutton, the Canadian Forces became involved and provided a full-time member to be with him until the situation resolved itself. Mr. Sutton was eventually released into the care of the Canadian Forces out of CFB Esquimalt, with the Forces assuming responsibility for his care.

Mr. Sutton and his family are worried that if he has similar physical symptoms in the future, he will not seek treatment due to his negative experiences. The family has retained legal council and is trying to understand which medical decisions were made and when.

While the family has spoken with VIHA leadership, they are still struggling to access the case notes, charts and physicians' orders that led to Mr. Sutton being shuffled out of Cardiac ICU and into Psychiatric ICU. The family notes that the Indigenous liaison they worked with was great, but they felt the liaison had no real power to help them find answers. They feel they were treated as second-class citizens by facility medical staff.

² Unlike other submissions featured in this report, the Review is using Mr. Sutton's name as his case has already been widely reported on in the media.

3. Indigenous women and girls are disproportionately impacted by Indigenous-specific racism in the health care system.

Due to their continuing role as matriarchs and caregivers, Indigenous women interact more extensively with the health care system than Indigenous men, and more regularly for intimate needs related to reproductive health. There are insufficient measures in place to address the unique oppression, violence, risk and racism experienced by Indigenous women and girls in health care.

“I Was So Scared They Would Send That Lady Again in the Ambulance”

A Métis woman in her 60s fell asleep after taking her medication one evening at her home. When she awoke, she was itchy over her entire body and extremely weak. Realizing something was wrong, she called 9-1-1. She managed to get to her front doorstep and collapsed as she waited for the ambulance.

After it arrived, she says the ambulance attendant sternly ordered her to “get up” from where she was lying on the step. She was unable to rise and a fireman who had also attended helped her into the ambulance. The woman recalls that, once she got in, the female paramedic was very rough with her, not allowing her to use a pillow to balance herself in the seat, snatching it away and yelling “That is not for you!” When she fell against a ledge in the ambulance, she recalls the attendant saying: “Get off of there. That’s expensive equipment, sit up, sit up in the seat!” She could feel diarrhea coming on and told the paramedic that she had to urgently go to the bathroom but was ignored.

After they arrived at the hospital, the woman repeated her urgent request to use a bathroom and was again ignored. She was placed on a bed, where she blacked out. She awoke to the sense of having to go to the bathroom very urgently. She recalls sliding off the bed, and slowly making her way to the washroom where she again passed out. She was essentially trapped in the bathroom. When she was found much later by a staff member, she remembers medical personnel calling out “Code Blue.” She says she had gone septic and was having an anaphylactic episode. She was hospitalized for five days. The woman has gone into anaphylaxis twice since this experience and it appears that she has an aspirin allergy.

“I am a professional driver, I do not drink or use recreational drugs ever ... my income and clients depend on me to keep them safe, my licence is how I make a living ... So what the heck went wrong? Did the ambulance driver decide I was just drunk or high on drugs and influence the nurses that was what was happening to me? Why if I was a cardio, as I heard mention, was I just rolled onto a gurney and left there? Would they not have to monitor my heart rate and blood pressure?”

She made formal complaints to the BC Ambulance Service and to the hospital's Patient Care Quality Office. She said the reply she received from the hospital was riddled with errors and that the Ambulance Service responded by saying “they would be sure to have the attendant receive more empathy training.”

“The next two episodes that I had, I drove myself to the hospital holding my epi pen ready to jab myself if I felt I needed to, I was so scared they would send that lady again in the ambulance.”

Indigenous women experience misogynistic stereotyping. Unique stereotypes are applied to Indigenous women, including being described as “squaws”, characterized as sexually promiscuous, and being called bad mothers. This is a devaluing of Indigenous women’s bodies.

Indigenous women feel less safe than Indigenous males in accessing health services. Indigenous men were 83 per cent more likely than Indigenous women to feel “*completely safe*” when visiting the ED, with high differences also received for hospital admissions (75% more likely). In the one specialty women’s hospital in the province, First Nations women in 2017/18 left the hospital against medical advice at a rate that was 11 times greater than that seen with other residents.

Indigenous women are disproportionately affected by poor health compared to their male counterparts, and the health disparities between Indigenous and non-Indigenous women is greater than that seen with males. Indigenous women carry a higher burden of disease than Indigenous males, and the differences between First Nations and Other Resident females’ health service use and burden of disease are greater than the comparable difference with male populations. The disproportionate need of Indigenous women noted in health service utilization and health status data also continues in the context of public health emergencies.

Initiatives and accountability related to Indigenous women’s health are deficient. Despite the unique harms, outcomes, needs and experiences of Indigenous women in health care in B.C., there is no established strategy or plan that would assure continued focus, progress and accountability. This remains the situation despite major studies and commitments – such as the National Inquiry into Missing and Murdered Indigenous Women and Girls – that call for specific actions. The 2019/20 *FNHA Summary Service Plan* included a commitment to publish a report on women’s health in collaboration with the Office of the BC Provincial Health Officer. This report has not yet been released and is overdue.

Witness Shares Account of Racism in the Delivery Room

An obstetrician told this Review about the terrible treatment received by an Indigenous woman who has a history of trauma and sexual assault. The woman attended a B.C. hospital to have a child by C-section.

Prior to the procedure, the obstetrician witnessed an anesthesiologist manhandling and yelling at the patient. The same anesthesiologist later made the statement that “*People like her should be sterilized.*”

“I Do Not Want to be Treated Like Pieces of Garbage When I Go to Get Help”

A First Nations woman in her 50s, living in Vancouver’s Downtown Eastside, told the Review about her recent experience when, after going to the hospital for a COVID-19 assessment, she was mistakenly assessed as suicidal and temporarily detained under the *Mental Health Act*. She said she was held involuntarily, and police were called to watch over her, simply because she was frightened of the virus and given her previous adverse experiences with racism.

The woman, who has recently been working as an advocate for Indigenous women in her neighbourhood, has become deeply afraid of going to the Emergency Department to seek care because of past traumatic experiences in more than one hospital. She told the Review that the only time she has been able to get respectful treatment, and not be assumed to be drunk or high or subject to racism, was when she had a non-Indigenous friend accompany her as an advocate and support person. This was the only time she felt safe, with health care staff focusing on her medical conditions and not on stereotypes of addictions and judgments about her past.

The woman is dealing with a range of health care issues including a seizure disorder, making it necessary for her to seek emergency care on a regular basis. She believes there is something in her file that flags her as a ‘problem’ and that health care workers pre-judge her as an addict or somehow at fault for her medical conditions. *“I do not want to be treated like pieces of garbage when I go to get help,”* she said. *“We don’t deserve this. On the street, these hospitals are called the Death Hospitals because of the bad service and because they throw you back out on the street without any help.”*

Since the pandemic began, some of her health conditions have worsened as services are not open or easy to access for somebody without transportation. She is concerned about being discharged in the middle of the night in a cab into a dangerous neighbourhood – something that has happened to her on previous visits to the ED.

4. Current public health emergencies magnify racism and vulnerabilities, and disproportionately impact Indigenous peoples.

Public health emergencies do not impact all populations in the same way. There are obvious and unique risk factors for Indigenous people, especially based on intersections with factors such as racism, poverty, housing, education and geography. The findings relative to dual public health emergencies in B.C. of COVID-19 and the overdose crisis expose health service frailties that the system must respond to, and legal and policy changes it must address.

First Nations people are significantly more likely to experience an overdose event or death, and more likely to contract COVID-19, than non-Indigenous people in B.C. The gap in overdose-related health outcomes for First Nations people compared to other B.C. residents is wide and continues to grow. First Nations in B.C. in the first 7½ months of the pandemic are experiencing a larger rate of COVID-19 infections than what has been seen in the general population.

COVID-19 Protocols Leave Elderly First Nations Woman in Traumatic Situation

An elderly Indigenous woman who has multiple medical issues – including one that complicates the ability to communicate – and is hard of hearing, made two visits to the local hospital in September 2020. She was experiencing severe abdominal pain, cramping and constipation; she was cold, clammy and could barely walk. Despite her communication challenges, she was not permitted to have a family member attend hospital with her due to COVID-19 policies.

On her first visit, the woman was discharged with laxatives and no further information. After the second visit two days later – when she was also experiencing shortness of breath – a doctor advised the family that their mother was critically ill with kidney and heart failure and that she needed to be medevaced to another city immediately. The woman's first language is a First Nations language, and a translator was provided to help her to understand the seriousness of her condition. But the request for a family member to escort their elderly mother to the larger hospital was denied.

The woman was medevaced by herself while various family members separately made their way to the larger city to support her. When one daughter arrived at 9 p.m. that night, she was permitted by hospital staff to check on her mother for “one minute”. Despite the time limitation, the daughter was able to carry her mother to use the washroom and to interpret for her what was happening. She assured her mother that she was safe and that the medical staff were going to do all that was possible to find out what was causing her severe symptoms. The daughter then reluctantly left the hospital but, prior to leaving, she conducted a spiritual ceremony to help calm her mother, who is a residential school survivor and who was clearly traumatized by being alone in hospital in a strange city.

Another daughter arrived at the hospital the next day but was denied access to visit her mother despite having been reassured by hospital staff that she would be able to do so. She attempted to explain her mother's trauma, her language barrier and her hearing problems, all to no avail. She recalls being abrasively disregarded and dismissed by the nurse after multiple attempts to set eyes on her mother. She left a toiletry bag, a spiritual pouch, paper and a pen for her mother to communicate with hospital staff.

Two days later, the family was advised by a nurse that their mother was much better and would likely be discharged soon. The family was unhappy that promised diagnostic testing, including a colonoscopy, had not been completed and that she was being discharged without a proper medical diagnosis. They were informed that their mother, who resides more than two hours away from this hospital, would be required to return for the colonoscopy as an outpatient sometime in the future.

Upset about this plan, one of the daughters reached out to various individuals to raise the alarm about what was happening. As a result, the mother was kept in hospital until the colonoscopy could be completed two days later. She was discharged the same day as the procedure, with no plan of care or medical diagnosis for the family.

One of the daughters told the Review that her mother has still not received a diagnosis or the results of the colonoscopy. She says that COVID-19 policies need to be revisited, to ensure that those facing significant multiple barriers in understanding their medical needs are not denied that understanding before being treated.

Indigenous people are experiencing disproportionate effects on their mental well-being during the pandemic. Compared to B.C.'s overall population, First Nations and Métis people are more likely to experience stress from the confinement brought on by the COVID-19 pandemic, more likely to express concerns about the health of vulnerable family members, and more likely to express worry that, due to the pandemic, food would run out before they had money to buy more.

A Health Director's Perspective

As First Nations people, we have a vivid memory of pandemics, and this collective fear sets us apart from others. When we experienced a COVID-19 outbreak, it brought out a lot of fear, with a reaction to lock down to protect ourselves and also to know 'who' had tested positive. I was trying to have a wholistic view of protecting our people – ensuring confidentiality, protecting the community from COVID-19, and thinking about the unintended consequences of lockdown, especially for our people's mental health and access to health care. These were, and are, very difficult discussions.

The outbreak and lockdown brought out a lot of racism in other residents including on social media and in monitoring the movement of our people and who was getting tested. Now, our people are avoiding going to the Emergency Room because they are afraid of racism. And because of COVID, they can't bring anyone with them to speak on their behalf.

Our team has had to talk passionately about our fears and fight for ourselves every step of the way to get what was needed. Including for supplies, testing, human resources support, and to be included in decision-making. We have experienced a lot of personal impacts – stress, anxiety, lack of sleep. Much of this came from having to manoeuvre so many issues and barriers. Non-First Nations communities do not have to put up with the same stuff as we have. You can't tell us that this isn't systemic racism. This 'us and them' needs to stop.

All of this exposed the lack of a system for health emergency response. We weren't set up for this – we had no staffing relief options, there was a lack of working protocols, we had six weeks of meetings talking about the same thing and going nowhere. There was lots of passing the buck, *"not our responsibility, you guys get money from FNHA (First Nations Health Authority)."* FNHA was not ready for this, they did provide support in some areas but weren't able to come through on many of our other needs. This was so insecure. No one was taking care of us. We are still working on many of these same issues.

In the middle of the pandemic, we had to come up with agreements to outline how to work together. Those agreements used to exist a long time ago. As a Health Director, I felt safe because I would sign off an agreement developed at the provincial level every year that outlined responsibilities. These said that B.C. would take care of us in an outbreak, as they do with all British Columbians. We need to redevelop those agreements and clarify the role of Health Directors, the FNHA and B.C. There need to be proper policies, mandates, infrastructure and agreements, so that as Health Directors we have clear partnerships to support the health and safety of our communities.

Comparatively more First Nations and Métis people have difficulty accessing, or are avoiding, health care during the pandemic. The Indigenous population is challenged to receive primary health care services on an equitable basis – a disparity that has increased during the pandemic. A higher proportion of First Nations and Métis respondents compared to Other Residents reported that they had difficulties accessing – or were avoiding – emergency/urgent care, their family doctor, counselling services and traditional wellness. Disturbing incidents of Indigenous-specific racism were reported by the First Nations communities that experienced outbreaks, with one result being the avoidance of needed health care.

Jurisdictional complexity is amplified during emergency response, and creates systemic barriers to Indigenous governments in protecting the health and safety of their citizens. Specific challenges reported to the Review included lack of access to data, lack of resourcing for prevention and security, and lack of integration of First Nations in the supply chain for PPE and other necessary supplies in the context of emergencies.

5. Indigenous health care workers face racism and discrimination in their work environments.

Indigenous-specific racism is not only experienced by patients. It is a reality for all Indigenous people who interact with the health care system, including Indigenous health care workers and Indigenous students in health programs of study. These experiences reinforce the reality of Indigenous-specific racism in health care as a systemic reality, that unfortunately in various ways is seemingly normalized and tolerated.

Increasing the number of Indigenous health care workers is a critical strategy to enhance cultural safety within the health care system. Change is necessary to create safe learning and practice environments required to set, strive towards and achieve necessary targets for the training and education of Indigenous health care workers. These environments are also protected under collective bargaining agreements and labour laws to create safe and discrimination-free environments. This is not only something we should strive for, but a legal right, responsibility and obligation of any workplace.

“My 17-year career-long experiences demonstrate that Indigenous-specific racism and discrimination is found at every level of the health care system, and throughout educational and professional environments. This has been both personally damaging, and career-limiting for me.

As an undergrad student, I was told by a faculty member to ‘leave your Indianness at the door’, as a graduate student I was told that my offer to mentor Indigenous students new to nursing was ‘not possible’. I was labeled as ‘one-dimensional’ and ‘too Indian’ for advancing issues of importance to Indigenous people while in nursing leadership positions. Continuous roadblocks and excuses were the norm in response to any ideas related to integration of Indigenous perspectives in both my practice and my nursing leadership roles.

Indigenous patients experience racism as well. In my work as a nurse, I have seen time and again the relief expressed by Indigenous patients when they see that I am working on the day they come to the ER. There have been experiences in my own family where we have been discriminated against and received care that does not meet the standards of care that we have committed to provide as health professionals.

A commitment to care is what draws us all to the health care profession. We are united in our belief in a 'culture of caring'. Nurses do the heavy lifting across the health system, and can lead the work to drive positive change at the front line, where it is most needed. I believe that the nurses of B.C. and nurses across this country can have a critical role in eliminating Indigenous-specific racism and discrimination from our health care system. ”

~ Tania Dick

Dzawada'enuxw First Nations, First Nations Health Council

Indigenous health care workers experience prejudice and racism at work. Over half of the Indigenous respondents (52%) who took part in the HWS stated that they had personally experienced racism at work because of their Indigenous identity. This behaviour was most frequently exhibited by a colleague or fellow student (74%), or an individual in a position of authority over them (58%).

Indigenous staff who were the targets of racist behaviour reported that it limited their career and resulted in negative personal outcomes. Over one-half of respondents said they experienced negative effects from racist behaviour. These negative effects included everything from physical health to self-esteem and chances for promotion. Close to 100 per cent of respondents reported moderate or significant negative effects on their mental and emotional health.

A Doctor's Experiences With Racism

An Indigenous physician offered the Review some personal observations about the racism they have experienced on the job:

- I have been asked to look after my *"drunk relatives"* in the ER or have had Indigenous patients reassigned to me on the wards [who were considered difficult patients] when I was a resident.
- As a resident, I was often required to advocate for Indigenous patients who were scared and frightened due to mistreatment while they were in hospital.
- Within my first six months at one hospital, I had to report two nurses for unethical behaviour: One for continuously going through patients' personal items looking for drugs and/or equipment used for drugs; the other for lying to the patient about how much medication they were giving them.
- I work in a number of remote First Nations communities now and one phrase that has followed me uttered by Indigenous patients/people since I was a resident is a refusal to seek higher levels of care by going to the ED/hospital because *"that is where our people go to die."*
- As someone who supervises many Indigenous and non-Indigenous residents who are allies in health equity, I have heard many accounts from them of racism they have experienced or have witnessed. The accounts are worse for those who look more *"visibly"* Indigenous.
- I have heard Indigenous residents talk about nurses pulling on their braids in the hospital, which is disrespectful; hearing allied health professionals make derogatory comments about their *"Indigenous sounding"* names or appearances; and being told repeatedly or in many different ways that they get a free ride in society/into medicine and that less is expected of them than others.
- My own family members have left without receiving care because they were told they were just *"drug-seeking."*
- I have refused to go to hospital when I've had life-threatening infections because I am scared of the treatment I'd receive and I'm a DOCTOR. It is also so triggering for me due to my own personal trauma in the health care system.

Many Indigenous health care workers did not feel safe reporting the racism they were experiencing or believe that such a report would create change. The collegial environment of the health care system has been reported as chilling and racked with fear of reprisal for raising issues of racism and discrimination. Almost half (45%) of people who responded to the HWS thought that reporting the experience of racism through established workplace processes would have a negative impact on their relationship with their colleagues. Almost as many (42%) believed that making a report would not change the problematic behaviour. Just over one-third (35%) had seen reports previously submitted without it making any difference in the workplace. Similar dynamics were reported in terms of filing a complaint to a regulatory college about racism experienced in the workplace.

There is insufficient effort to recruit, train and retain Indigenous health care professionals. The strategy most consistently ranked by Indigenous respondents to the IPS as “*very important*” was more Indigenous representation in health care positions (82%). The data illustrate that the representation of Indigenous students in health program enrolment is slightly higher than their proportion of the B.C. population. However, the data also show that there continue to be low numbers and/or limited growth in enrollment of First Nations, Inuit and Métis students in many health professional programs, including those that are more specialized and those that are in significant demand amongst Indigenous communities in rural and remote areas. There are very few programs that maintain or successfully meet targets for Indigenous enrollment, and limited data on how many enrollees conclude their degree programs. What is clear from the Indigenous students and health care workers who contributed to this Review is that racism exists in the learning environment, poses challenges to successful completion of their studies, and has negative personal impacts.

“At my very first meeting of a group of physician leaders, within less than five minutes of my arrival, one of the physicians came over and very aggressively started a monologue about how First Nations funding was extreme. She honestly said, ‘First Nations people get everything. You should give your budget over to immigrants.’ I do not take kindly to being schooled by anyone – especially non-Indigenous people – on what Indigenous people must do. It has been my life’s work. I pushed back hard, had lots to say to her, but very quickly several physicians came and stood between us, as if we were having a physical fight. It was quite a welcome, and quite an introduction to physician leadership.

It is a strong memory for me. I am often in places where First Nations people have seldom tread [even though this particular meeting was in my ancestral territory], but this felt like – and still does – a push, a head butt – out of your hallowed halls.

What really stung wasn’t her ignorance – most Canadians have what I consider only a basic knowledge about the history and perspectives of the original peoples of Canada – it was her audacity. Clearly, she felt entitled to her opinion. Her thoughts and conviction were more important to her than what or who stood in front of her. In fact, I would say that her opinion about First Nations people prevailed over mine. I’ve left that group of physicians; I am sure she is still there.”

~ Dr. Evan Adams, Deputy Chief Medical Officer of Public Health
Director General’s Office of Population and Public Health
First Nation and Inuit Health Branch, Indigenous Services Canada

Keegan's Tragic Death Shines Light on Importance of Cultural Safety

Keegan, a 29-year-old First Nations man, died in hospital in 2015 following delayed diagnosis and treatment for an accidental poisoning. He was a high school graduate, a grade 10 pianist, and a chess champion enrolled in a trades college at the time of his death. Keegan also lived with disabilities and was mostly non-verbal by choice. He is remembered, missed and loved by his family, caregiver and those who knew him.

On the afternoon of Sept. 15, 2015, Keegan's caregiver called 9-1-1 after finding him at home slumped, incoherent and covered with vomit. Keegan was admitted to an urban hospital, where he spent the night without receiving a diagnosis or treatment, despite lab results indicating the cause and severe health consequences of his condition being available within three hours of his arrival at the ED.

Those lab results indicated that Keegan had ingested toxic levels of methanol and was experiencing a medical emergency (metabolic acidosis). However, it took more than 12 hours from the time the lab results and the cause of Keegan's condition came in, to the time that he was diagnosed. Missing these results prevented Keegan from getting timely access to treatment. By the time it was determined that Keegan had accidentally ingested methanol – which is highly toxic but treatable if caught in time – his condition had deteriorated while in the care of the health system to the point where he required intubation and was admitted to the ICU. He died on Sept. 26, 2015.

Keegan's caregiver, who is also Indigenous, identified a series of culturally unsafe experiences with the health system that contributed to his preventable and unnecessary death. These included a sense that health care workers had a preconceived bias – *"we know Keegan"* – that affected the way he was cared for, including an initial reluctance on the part of paramedics to even take him to hospital. Once at the hospital, the caregiver felt that her worries about the severity of Keegan's condition were not taken seriously or acted upon.

Six hours into Keegan's hospital stay, with lethal toxicity levels in his system, he was showing increasing signs of illness and was still undiagnosed. No further lab testing was sought, no internal medicine consult had been ordered, and he had still not seen the physician in charge. At one point during this first night in hospital, a resident wanted to discharge Keegan, leaving the caregiver to have to advocate to keep him in hospital. Later that night, the same resident recommended to the caregiver that a DNR order be placed on his file while in the same room with Keegan. His caregiver felt the request for a DNR order reflected that the resident did not feel Keegan's life was worth saving, and only saw him for his disabilities – not his many abilities.

When Keegan's caregiver left the hospital in the evening for a rest, she put trust in the health providers that they would monitor and respond to any issues that arose. However, that night he was restrained, neglected and his condition worsened to the point of critical. Medical directives and protocols were not followed.

continued on next page

“This report on anti-Indigenous racism tragically shows that the system has a long way to go to uphold its commitment to quality care for our people. As we begin this journey, we need to hold each other accountable ‘to do our best’ to be part of a health and wellness system that meets the needs of First Nations people. First Nations Health Authority will continue to push for the necessary change across the B.C. health system, which would include FNHA, guided by First Nations. To achieve progress, we have to influence the overall health system while continuing to develop First Nations specific models of care, which have Indigenous worldview and practices as its foundation. ”

**~ Colleen Erickson
Chair, FNHA Board of Directors**

What We Found

Following Keegan's death, the caregiver was disappointed with both the initial Coroner's Report and the patient safety review conducted by the health authority. She says neither process adequately included her or the family, or recognized the lack of cultural safety for Keegan at the hospital and the significant role systemic racism played in how he was treated. She believes Keegan received inferior care due to the fact that he was Indigenous and lived with disabilities.

Keegan's supporters believe the lack of urgency and neglect that he experienced at the hospital suggested that he was being left to 'sleep it off' and echoes common experiences of racist stereotypes regarding Indigenous people that are shown to lead to discriminatory behaviour in emergency health care settings. Layered on top of this was a failure to effectively navigate Keegan's disabilities. They stress that patients with complex needs, including those related to living with disabilities, substance use, or other challenges that may lead to frequent engagement with the health system, deserve to receive quality health care like anyone else.

In the years since Keegan's death, his caregiver has worked persistently to advocate for changes at the hospital and within the health care system that would prevent discrimination and harm to other First Nations patients, including those with disabilities.

Her advocacy efforts led to a meeting that involved First Nations leadership, First Nations health leaders, and health system leaders that responded with shared commitments to make things right, and work to make things better. A ceremony took place at the hospital where a plaque and artwork were installed in Keegan's honour. Leadership statements were made by the regional health authority acknowledging that systemic racism exists, and their commitment to work with First Nations leadership to eradicate it. This was followed by a longhouse healing ceremony for Keegan's family, community and others involved in his story including the regional health authority, the FNHA, FNHC and the BC Coroners Service.

One of the commitments made by the BC Coroners Service, was to look at Keegan's case again and provide a more detailed report. The revised report affirmed that, despite lab results with critical diagnostic information being available soon after his arrival at hospital, he was not diagnosed or treated for more than 12 hours: *"Following Keegan's accidental poisoning, delay in diagnosis of the cause of his illness (methanol poisoning) resulted in delayed treatment with Fomepizole, and ultimately his death."*

























Keegan's case has been summarized in a report by the FNHA: *Remembering Keegan: A BC First Nations Case Study Reflection*, which said: *"Keegan's ongoing legacy has been to help shape the Cultural Safety and Humility journey that is currently underway in BC's health system. Setbacks and missteps have been part of the journey. Yet, advocacy by the Caregiver and commitments to Cultural Safety and Humility have led the system to pay attention, engage and take steps to make change. There is much work to do."*

Health Indicator Dashboard






























This dashboard provides a snapshot of a selection of indicators presented in this report which are representative of Indigenous health in B.C.

For each indicator, the dashboard shows:

- Indigenous data
- Comparator data (Other Residents of B.C.)
- Gaps in the data between Indigenous people and Other Residents
- Time trends in the Indigenous data
- If there are any disparities between the sexes in the Indigenous data
- Indigenous/Other Resident rate differences are provided only when statistically significant.

	Indigenous ¹	Other Residents (OR)	Indigenous/ OR Rate Difference ²	Indigenous Trend	Sex-Related Difference (Indigenous)
Physician Care					
Pediatrician user rate, non-ED, 0-5 years (%)	19.6% 	24.5%	0.80X 	~	♂ > ♀
MHSU physician rate, a/s, non-ED (%)	18.5% 	15.7%	1.2X 	~	♂ > ♀
ED user rate, a/s	40.3% 	23.3%	1.8X 	↑	♂ > ♀
Chronic and Acute Conditions					
Mood and anxiety disorder prevalence rate, a/s	11.6% 	10.0%	1.2X 	↑	♂ > ♀
Diabetes prevalence rate, a/s	11.0% 	8.4%	1.3X 	↑	♂ > ♀
Diabetes prevalence rate (18+), a/s	12.2% 	10.1%	1.2X 	-	♂ > ♀
Five+ health conditions prevalence rate, a/s	50.5%  48.9% 	25.2%	2.0X  1.9X 	-	♂ > ♀
Women's and Infant Health					
9 or more antenatal visits (rate per total deliveries)	59.0% 	75.5%	.78X 	~	N/A
Midwifery utilization rate (rate per total deliveries)	15.4% 	24.7%	.62X 	↑	N/A
Preterm birth rate (births per live singleton births)	15.2% 	7.5%	2.1X 	↑	-
Infant mortality (deaths per 1,000 live births)	5.8 	3.4	1.7X 	↓	-

What We Found

	Indigenous ¹	Other Residents (OR)	Indigenous/OR Rate Difference ²	Indigenous Trend	Sex-Related Difference (Indigenous)
Screening					
Cervical cancer (PAP) screening rate (distinct clients), a/s	5.3%  8.3% 	7.9%	0.67X 	-	N/A
Colorectal cancer (FIT) screening rate, (distinct clients), a/s	5.5%  7.4% 	7.2%	0.76X 	-	-
Hospitalizations					
Hospitalization user rate, a/s	15.7% 	11.9%	1.3X 	-	♂ > ♀
Cardiovascular conditions* hospitalization user rate, a/s	11.7%  11.9% 	11.1%	1.2X 	-	♀ > ♂
Chronic respiratory conditions** hospitalization user rate, a/s	5.4%  4.4% 	3.7%	1.5X  1.2X 	-	♂ > ♀
Unintentional injury hospitalization rate (cases/10,000), a/s	15.5  11.7 	9.0	1.7X  1.3X 	~	♂ = ♀
Ambulatory care sensitive conditions hospitalization rate (discharges per 1,000 population), a/s	10.7 	4.8	2.2X 	~	♂ = ♀
Public Health Emergencies					
COVID-19 rate (cumulative % positive, tested)	3.2% 	1.8%	1.9X 	↑	♂ > ♀
COVID-19 rate, 18+ years (case rate per 10,000)	14.2% 	23.2%	0.61X 	↑	ISD
opioid overdose mortality rate (deaths/100,000), a/s Jan. 1 to Oct. 31, 2020	158.0 	28.6	5.5X 	↑	♀ > ♂
Other					
Life expectancy (years)	73.4 	82.7	0.89X 	↓	♂ > ♀
Left against medical advice (% of total discharges)	3.7%	1.4%	2.6X	~	-
Experience of discrimination in health system based on ancestry (% respondents)	66.9%	4.7%	14.2X	-	♂ > ♀

¹ Data are between 2015 and 2020 depending on the data source.

² Rate differences are shown when statistically significant.

* heart failure, malformation of the cardiovascular system, cardiac valve disease, coronary artery disease, arrhythmia, other heart disease

** chronic obstructive pulmonary disease, pulmonary hypertension, other chronic lung disease, asthma, respiratory failure

a/s = age standardized; ISD = insufficient data; N/A = not applicable

“While it’s necessary to swiftly deal with incidents of racism, this is not a problem that gets solved one person at a time, or one complaint at a time. It needs systemic solutions that start with committed leadership from all parts of the health system to create the required change. I firmly believe that it is the system’s responsibility to solve this issue, and that Indigenous peoples must be part of the solution given that we are the ones that experience the problem every day in health care and other sectors.”

~ Joe Gallagher, k^wunəməŋ, Tla’amin Nation
Founding & Former CEO, First Nations Health Authority

Findings 6 to 11: Examining the Current ‘Solutions’

There are a range of efforts underway across the health care system to address the problem of Indigenous-specific racism and support Indigenous human rights. This second set of Review Findings deals with the effectiveness of these efforts and the degree to which change levers have been utilized. The main conclusion is that there is a range of well-intentioned efforts and many committed leaders, but little to no change at the front line, due to a lack of a systemic, coherent approach underpinned by accountability.

6. Current education and training programs are inadequate to address Indigenous-specific racism in health care.

There is no consistently mandated training for health care staff on Indigenous cultural safety, Indigenous-specific health care and Indigenous-specific racism despite this commitment being made by the Province 14 years ago, in the *Transformative Change Accord: First Nations Health Plan*. Similarly, there is no mandatory content threaded across professional programs. There is a significant demand for training amongst health care workers and organizations. Various training has been developed and is operating in isolated and independent pockets without an overall conceptual framework, and with no standardization or overarching theory. Access is limited, not timely and not universal. The training is not benefitting from systematic, long-term evaluation and informants do not believe that it is resulting in practice change. The current level of training falls far short of meeting the need and creating systemic change within the health care system.

The San'yas ICS training program requires a reset. There is an important place for standardized and mandatory awareness-raising training for health care workers. San'yas was initially established with this vision in mind, but has drifted in a number of critical ways. It is currently not governed or designed with First Nations and Métis involvement, is not integrated with health authority training offerings, and is not universally offered or funded consistently across the B.C. health care system. The San'yas program has also been conducting some follow-up on potentially serious incidents, which is inappropriate to its function as a training program.

The San'yas Program

San'yas Indigenous Cultural Safety (ICS) training is an online cultural safety training program developed and delivered by the Provincial Health Service Authority's (PHSA) Indigenous Health Program. The program was developed in 2009 in response to the *Transformative Change Accord: First Nations Health Plan* that stipulated First Nations and the Province would develop a curriculum for cultural competency. Although this curriculum was originally envisioned as being mandatory for both Ministry of Health and health authority staff, participation remains voluntary for most organizations.

San'yas ICS training brings together a virtual cohort of anonymous participants with a facilitator. Individuals work through the training modules via individual and group forums. These forums are run by facilitators who lead discussions and provide feedback. Course content is broad and includes culture, stereotyping and the impacts of colonialism. Specific topics include diversity, history (i.e., residential schools and Indian hospitals) and terminology. Participants are encouraged to discuss their lived practice and personal experience of interacting with Indigenous populations, provide examples of these interactions and discuss their views.

“The San'yas training program is one tool, and should be part of a larger toolkit that needs to be further developed. For many years, this has been our only tool available in B.C. and beyond, and is used by other jurisdictions across the country to do basic training on Indigenous peoples history and experiences. It has the advantage of being well-known and recognized. I believe there is a solid foundation for San'yas to be recalibrated and integrated with additional necessary training at the clinical level for B.C. health care workers. This Review has unquestionably demonstrated the problem of individual and systemic racism against Indigenous peoples and our accountability to fix it. I look forward to actively contributing to the implementation of this report's Recommendations, which aim at meaningful cultural safety transformation in B.C. I trust we can collectively achieve world class results in this context.”

~ Benoit Morin
CEO, PHSA

“Racism I Have Witnessed”

A non-Indigenous registered nurse in a senior leadership position offered the Review *“a few examples of the racism I have witnessed”*:

- A patient in acute pain in the ED being told they were drug-seeking and to *“go back to the Rez”*
- An Indigenous female patient being referred to as a *“squaw”*
- An Elder, who complained about her nurse, being left without hygiene support while the three other patients in her room were assisted to wash and bathe
- A nurse mocking an Indigenous senior female about her weight
- A nurse touching and holding an Elder’s ceremonial bundle without asking for permission
- An Indigenous renal patient being considered to be taken off dialysis because *“he can’t comply”*
- Indigenous staff being asked to drum and sing at organizational announcements and events; then told *“You only have five minutes”*.

Health authorities and regulators are independently developing Indigenous-specific racism and cultural safety and humility education and training. Key informants to the Review universally agreed that a coordinated and coherent approach to building understanding and skills for creating cultural safety and addressing Indigenous-specific racism should be a mandatory part of advanced training throughout the careers of all health professionals. However, health organizations are variously and independently developing their own training, none of which is intended to achieve any accepted standard. Inequities and inefficiencies exist as a result of a lack of proactive and resourced coordination and knowledge exchange.

There is inconsistent training about Indigenous-specific issues and health needs in post-secondary health care education and training programs. There is wide variability and inconsistency in education about Indigenous-specific racism, health and cultural safety amongst health profession education and training programs at the post-secondary level in B.C. There is clearly no standard in place to guide education on these issues across or within health professions.

7. Complaints processes in the health care system do not work well for Indigenous peoples.

Review evidence demonstrates that complaints processes are not easily accessible to Indigenous peoples, do not include space for Indigenous cultural processes and methods of dispute resolution, and can be re-traumatizing. The end result is that Indigenous people may be left with little recourse for poor

treatment, reproducing past harms and trauma that have been part of the experience of colonialism in the health care system. An integrated, accessible and culturally appropriate Indigenous complaints process is needed.

Indigenous people find the complaints process inaccessible, and this is reflected in a low number of complaints filed. Over the past three years, only 355 complaints involving Indigenous people were identifiable when searching complaints data, a small number when compared to the many negative experiences shared with the Review. This is consistent with the findings of the IPS, in which Indigenous respondents were significantly less likely to report being willing to make complaints. Indigenous respondents were also significantly more likely to indicate that a key barrier to filing a complaint is the belief that it would not be taken seriously.

Barriers to making a complaint



Indigenous Peoples' Survey

*Significant difference

The types of complaints Indigenous people have filed are most commonly connected to matters related to racism, including negative interactions, stereotypes, denial of treatment and cultural unsafety. This involved complaints about health care providers being disrespectful, rude, informed by stereotypes and engaging in physically rough or assaultive behaviour. Patient histories included being turned away from the hospital, denied treatment and not receiving appropriate assessments or referrals. Poor care outcomes included misdiagnoses, missed diagnoses and the mismanagement of pain.

Most complaints of racism and discrimination by Indigenous individuals are not meaningfully addressed. There was little evidence that complaints officers were routinely identifying the cultural identity of complainants or patients and, in cases where a link was made between poor care and a complainant's Indigenous identity, complaint processes appear ill-equipped to deal with allegations of racism and discrimination. Such complaints are often met by responses about the provider's 'true' intentions and broad statements of the responding body's commitment to cultural safety, or found to be unverifiable because they were not reflected in the health provider's written account of their own behaviour in patient records on which many complaints investigations heavily rely.

“The system has an enormous opportunity and obligation to improve, particularly in how we handle complaints. A complaints process is not just about being heard and addressing the issue raised, it is also about re-building rapport and trust. When people experience harm, they want three things: to know what happened, to receive an appropriate apology and most importantly to know, and be a part of, what will be done to improve and ensure something similar won't happen to others. People are often able to forgive the event itself when these three things are in place. What they won't forgive, or be able to move on from, is how they were treated after the event happened. Modelling after the restorative justice approach that has been used in the legal system will support re-building trusting relationships so that Indigenous people feel safe to seek and receive care. Establishing an approach based on reciprocal accountability will provide a foundation to honour and build upon existing efforts of Indigenous communities as well as the health care system to help eliminate the systemic Indigenous-specific racism that currently exists.”

~ Christina Krause
CEO, BC Patient Safety & Quality Council

Current improvement efforts are uncoordinated and lack a systemic focus. There are a range of organization-specific initiatives and pilot projects to improve the complaints process for Indigenous peoples, and an impending transformation effort related to regulatory college complaints processes. These efforts and complaints processes remain independent and isolated from one another, and do not centre the unique needs and experiences of Indigenous peoples at the core of system design and transformation.

Indigenous Man Dealing With Past Trauma, Alcoholism Also Had to Deal With Assumptions of First Responders

DD lived with his partner in both Metro Vancouver and various communities on Vancouver Island. He had five children, two of whom lived with the couple full-time. DD had worked various jobs for special interest groups both in B.C. and across Canada, as an activist, project manager and chair for a variety of Indigenous organizations including serving as both president and vice-president of the United Native Nations.

His partner describes him as charismatic, and among the most positive people she has ever met – an outlook she credits with helping to get her away from a traumatic and troubled family history. *“He was a very positive and optimistic person about everything in our lives right from the beginning. He was a happy person and wanted people around him to feel happy, especially me and the kids. He always had a smile on face when he greeted someone or met them for the first time.”*

Both of DD’s parents had been abused within the residential school system, resulting in less support during his childhood than he needed. DD experienced some PTSD and bouts of depression over the years, which led to the beginning stages of alcoholism. But he always maintained employment and sustained some periods of sobriety.

One night in 2016, while he was trying to intervene and help somebody involved in a domestic dispute, he was punched in the back of the head at the base of his skull. The resulting concussion changed the lives of he and his family forever. After the concussion, DD was in chronic, excruciating pain and he began to drink heavily to ease the pain. *“He would tell me ‘It hurts so much’ I could see the pain it caused him daily and regularly,”* said his partner. *“After that, I noticed he struggled to find words when he was talking to me about something and it frustrated him. Everything had come so easily to him and now he struggled to find simple words.”*

Around the same time, DD also dealt with the death of his father, worsening his post-concussion state. Following a referral to a concussion clinic, he was told that if, in six months to a year, his symptoms didn’t improve, then he was *“never going to be normal.”* From this point, he settled into an increasingly stronger depressed state with continued pain, feeling sad, scared, irritable and alone. He began to drink more frequently and, as his partner recalled: *“He couldn’t work ‘cause he couldn’t stop drinking and he couldn’t stop drinking ‘cause of the pain.”*

Six months later, DD reported feeling sick and began to vomit up blood. His partner recalls that paramedics and firefighters attended their home *“with their judgment and looks of disgust.”* She said that included their assumptions about the blood DD was throwing up, which one of the responders reacted to by saying: *“I assume he is drinking red wine.”*

“It was heartbreaking because, even when they treated him badly, he answered them politely and honestly and most times with a ‘yes sir’ or ‘no sir’ or ‘yes ma’am’ or ‘no ma’am’. He was never rude or belligerent towards any doctor, nurse or paramedics even when treated poorly... I often wonder how he felt as he sat on the floor in front of the toilet filled with blood he threw up, looking up at those faces of people who were supposed to be helping him...”

In April 2019, DD was hospitalized with a diagnosis of liver cirrhosis due to his struggles with alcohol. He was released, and readmitted in early June 2019 after being told that he had an approximately 45 per cent chance of surviving in the next year. He immediately ceased drinking, entered counselling and received medical assistance to help with cessation. While he was successful in his sobriety, his overall health began to deteriorate as complications from early stage liver failure began to arise.

During a family meeting with physicians, DD was told that, pursuant to a policy (‘Abstinence Policy’), he would not be eligible for a liver transplant until he had abstained from alcohol for six months. DD’s legal team wrote the Ministry of Health, BC Transplant and the PHSA to protest the policy as being discriminatory against Indigenous patients on account of higher rates of substance use arising from the impacts of racism, discrimination and colonialism and requested a policy review and confirmation for DD to be placed on the transplant list.

In September 2019, DD met with physicians and was considered for a liver transplant. However, his condition was by then just below the threshold required for a transplant. DD continued to feel ill, was depressed, discouraged and demoralized. His liver was unable to cope with the stress and, after a period in hospital under induced coma, he died in May 2020 at age 45.

8. Indigenous health practices and knowledge are not integrated into the health care system in a meaningful and consistent way.

Current efforts to enhance access to traditional and ancestral medicine and healing are inconsistent and sporadic across regions, facilities and providers and often driven by a few individuals or experts. They are not rooted in a broad recognition and understanding of the necessity for respecting and utilizing Indigenous approaches to health and wellness as part of creating responsive, more effective, more inclusive and less discriminatory approaches to Indigenous health. A coherent strategy for upholding the minimum standards in the *UN Declaration* regarding the use and inclusion of Indigenous health practices, supported by a clear affirmation of the importance of Indigenous knowledge, is needed.

“My auntie had her traditional medicines hanging up above her bed. I would visit her often. I noticed during the first week she was there that someone had moved her cedar... I asked one of the caregivers and the woman said to me that ‘stuff like that’ isn’t appropriate to be hung up. I asked her what that meant. And she said ‘Well it is not appropriate, so I put it away.’ ”

~ Family member of elderly Indigenous woman who was hospitalized

Integration of cultural healing practices and traditional medicines is important to Indigenous peoples and is supported by health workers. The majority of Indigenous respondents to the IPS rated access to traditional medicine, and Indigenous cultural spaces in health care settings, as “*very important*” to improving health care for Indigenous people. The highest feeling of safety was expressed by Indigenous respondents to receiving care from a traditional healer, with 71.2 per cent reporting that they “*always*” felt safe. This was supported by a large majority of HWS respondents who “*strongly agreed*” or “*somewhat agreed*” with the inclusion of traditional Indigenous practices in patient care plans.

Indigenous Systems of Health and Wellness

Prior to the arrival of Europeans – and, in the case of the Métis, after their distinctive communities formed – Indigenous peoples throughout what is now called Canada had their own health and wellness systems rooted in their diverse worldviews, knowledge and beliefs, and implemented through their own governance system. At the same time, there are certain shared elements or characteristics to the Indigenous worldviews that animate and shape Indigenous health and wellness systems. Often noted is the wholistic and integrative character of Indigenous worldviews, which emphasize the connections, harmony and fundamental relationships between all things. Such a wholistic vision means that: the inner and outer dimensions of health and well-being are indivisible; the well-being of each individual cannot be dissociated from the environments and world around them; our physical, emotional, mental and spiritual well-being are all interdependent; and that our well-being is connected to that of past and future generations.

“Over 45 years ago, I started medical school at UBC – anti-Indigenous racism in our hospitals was a regular occurrence. At that time, few people had knowledge or an understanding of the full history and impact of colonialism in Canada or B.C. Over four decades have passed and during that time there has been so much more awareness and information about the painful history of how our country and province treated First Nations, Inuit and Métis people. As the Chair of Vancouver Coastal Health, I have had many conversations with First Nations leaders from across the province, most of whom at one time or another have shared stories of their own experience of racism or that of a family member in our health system – shameful stories which made me embarrassed as a physician not to mention someone in a position of responsibility for the system. Over the last decade, there has been hard work to enhance cultural safety across our health authorities, but it is not enough. Cultural safety needs to be ingrained in every interaction in the course of care by every member of the health care team and all the other staff supporting them. It’s time, and it can be done. There is a lot of support across our provincial health care system for making it safe and for assuring a quality outcome for all Indigenous patients – it will be a lot of hard work, every day, in every office, every waiting room, every ambulance, on every ward, every critical care unit and in every department in our system – it can be done – it will take a huge effort, but it is our clear responsibility.”

~ Penny Ballem MD FRCP
Chair, Vancouver Coastal Health

There are barriers to the use of traditional medicines and cultural healing practice. Compared to non-Indigenous respondents, Indigenous respondents were significantly less likely to “*always*” receive permission to practise traditional medicine, and significantly more likely to experience that providers are “*never*” open to hearing about traditional medicine.

There is no systemic effort to protect and incorporate Indigenous medicines and practices, even though other ‘complementary’ approaches to medicine have been affirmed. Some largely independent projects have been undertaken to incorporate traditional healing and wellness into various models of care and care systems. These are facing challenges that reveal a lack of systemic supports and approaches, including: determining regulatory, quality assurance and safety approaches; providing training and support for team-based care involving health care experts from Indigenous and non-Indigenous fields of medicine; and addressing the fact that the demand for traditional medicine may soon outstrip the pace of knowledge transmission amongst Indigenous practitioners.

“I was so grateful to be invited by the First Nations Health Authority to join their educational visit to the Nuka System of Care in Alaska. I was truly inspired by their model of dedicated space for Indigenous health and wellness, and culturally safe accommodation for Indigenous patients and families who come from a distance for care. I believe that we can learn from their approaches to create a First Nations Health and Wellbeing Centre at the New St. Paul’s Hospital and Health Campus, which would be a visible demonstration of B.C.’s commitment to reconciliation.”

~ Fiona Dalton
President and CEO, Providence Health Care

One Mother’s Struggle to Find Supports for her Son

An Indigenous woman told the Review about her family’s long and often frustrating experience with the health care system over the past 11 years, following her son suffering a brain injury and mental health challenges.

The son, who is First Nations, was injured in his late-20s, resulting in complex mental health impairments. His family, in particular his mother, have advocated strongly to obtain assessments, services, funding – and at times even the simple courtesy of a return phone call – from medical professionals regarding their son, who suffers from severe anxiety disorder, PTSD and a brain injury as well as a continuing substance abuse disorder. He has been deemed not ‘damaged enough’ to be fully funded for supportive housing and that has resulted in the family’s ongoing struggles to find appropriate, culturally suitable and affordable supports for their son to live life to his full potential.

These efforts have left his family feeling frustrated and exhausted, particularly with having to share their family story over and over again. Without a Representation Agreement, which they feel is culturally biased, many doors have closed, and so the family finally had one put in place. Indigenous families have historically supported each other and been present at family and community events without question or the need for an ‘agreement’. The requirement to have a legal agreement to receive information that is vital to support her son has left this Indigenous mother appalled at the systemic racism within this process. She says there is no seamless system that can help an Indigenous family navigate through all that is required to obtain services for their loved one and themselves and that this type of continual interface with a colonial health system is trauma inflicting. *“I am an educated person and I know how to advocate for my son,” she says. “However, I can only imagine what Indigenous families who don’t have these resources are up against in facing such a confusing health system.”*

The long road for this family has included their son being inappropriately discharged from hospital without a discharge plan or support services. It has included being dismissed by some mental health and medical professionals and treated with some disdain and judgement regarding his alcohol use when it was colonialism that brought alcohol to Indigenous communities. The woman says their son’s wholistic health needs and artistic talents and cultural values, such as family centeredness, have been disregarded or ignored as potential healing avenues. Their journey has also included inappropriate and damaging living arrangements. One service provider actively resisted their son’s harm-reduction approach and showed a troubling lack of understanding about cultural safety and need for family and community involvement that is not ‘managed’ or ‘controlled’.

The young man has recently moved into a much better living situation with an Indigenous caregiver who understands him and provides a safe and loving home. He is also well supported by a strong Indigenous team who approach harm reduction through an Indigenous lens. *“I feel I can finally get a bit of rest because my son is in a caring, supportive Indigenous home of which we need many. I am convinced that this model of Indigenous community and family care is the key. We hope there is some funding to open the doors to others needing this type of supportive environment and community of caring. I hope your report can help with that.”*

9. There is insufficient hard-wiring of Indigenous cultural safety throughout the B.C. health care system.

Hard-wiring describes the intention to meaningfully embed Indigenous cultural safety, the practice of cultural humility, and anti-racism expectations into the core quality, accountability and planning functions of the B.C. health care system. Some efforts have been made to integrate Indigenous cultural safety and humility in different ways. However, the most critical necessary legislative and policy foundations for such hard-wiring are not yet in place. Consistent with the *UN Declaration*, government must take steps to end all forms of racism in health care and other public services. A comprehensive, coherent, systematic approach that lends itself to tracking, monitoring and accountability does not exist, and is critically required.

“Over the past decade, we have worked closely with Indigenous partners and organizations, especially the First Nations Health Authority and First Nations Health Council, to plan for and better serve Indigenous peoples in the health care system in B.C. Many specific activities and collaborative efforts have been underway within the province, and in conjunction with Canada. These efforts have been positive and urgently required. However, I recognize that despite these actions, a system approach remains elusive. The many instances of Indigenous-specific racism that have been surfaced in the independent Review and report tell us that direct, indirect and systemic discrimination and prejudice against Indigenous peoples is in our system. We must put in place a fully responsive system to end all forms of discrimination against Indigenous peoples. I recognize this is not just a moral imperative and sound health policy, but is now a legal requirement with the adoption of the *United Nations Declaration on the Rights of Indigenous Peoples Act*. Everyone in the system needs to reflect on this, change our practices and pull together to root out all forms of racism.”

~ Stephen Brown
B.C. Deputy Minister of Health

Legislation has not been utilized to address Indigenous-specific racism and enhance Indigenous cultural safety. Many opportunities exist and have not been utilized to address Indigenous-specific racism in legislation, including existing health-specific legislation, the *BC Human Rights Code*, and public interest disclosure legislation. *DRIPA* now requires the alignment of B.C. laws with the *UN Declaration*, a critical measure to support ending all forms of racism in health and other public services.

Requirements for cultural safety and humility and addressing Indigenous-specific racism are not adequately embedded throughout policy and standards. There is no overarching policy guidance or expectation on this subject matter grounded in upholding Indigenous human rights. Further, some of what exists is buried within broader efforts on equity, diversity and inclusion. Some, but not all, national professional regulatory bodies have embedded cultural safety, cultural competence, cultural sensitivity and trauma-informed care into national competencies. Within B.C., some of the regulatory bodies have developed provincial professional standards, guidelines and principles, but the smaller regulatory bodies are challenged in this regard, and emphasized the need to consolidate and make such resources available to all organizations in the B.C. health system.

“Cultural change in the medical system requires mindful and purposeful action. We must find ways to create safe and supportive environments for Indigenous physicians to provide leadership within Doctors of BC. We want to understand and serve the needs of Indigenous and Métis communities in a culturally sensitive manner. Many of our members are working to do so, in particular through implementing cultural safety and humility as a required attribute of primary care networks. Doctors of BC is committed to working with First Nations and Métis people to build effective, strategic partnerships moving forward.”

~ Dr. Kathleen Ross
President, Doctors of BC

Mandate letters and service plans have insufficient accountability requirements related to cultural safety and humility and Indigenous-specific racism. Health sector mandate letters show broadening expectations for health authorities regarding Indigenous health, but these expectations are not effectively cascaded into funding expectations, service planning, and measurement and accountability requirements. It is not possible to determine whether the expectations outlined in these mandate letters have been fulfilled, or any measures to indicate that progress is being made.

Change Leadership Strategy on cultural safety and humility has not been effectively and comprehensively implemented. Despite a strategy being developed in 2018 to address the lack of systemic integration of cultural safety and humility and reduce the harms of Indigenous-specific racism, only one of its initial actions has been fully completed. Awareness and integration of the strategy’s implementation team is low amongst the health authorities and regulatory bodies; yet all express the pressing need for this type of support. The strategy has not been effectively led, resourced or positioned to achieve the necessary results.

“We are working on developing tools to effectively and immediately bring change into the health setting and proactively respond to issues. Fraser Health is working with our partners to continue to build trust in a trauma-informed health system. We want to empower all stakeholders in the provincial system, share resources, remain accountable and make change for the better together.”

~ Dr. Victoria Lee
President and CEO, Fraser Health Authority

Racism’s Reach Extends Beyond Clinical Settings

A non-Indigenous woman employed in food services at a hospital told the Review about her experiences with racism in the health care workplace. She says a fellow employee went on a “rant” about Indigenous people, *“and when I informed them that my partner was Native, they doubled down and declared that Native people and their partners (i.e., me) should be ‘sterilized so they don’t have eight kids on welfare.’”*

The woman emailed her supervisor and recalls being told: *“We can’t control peoples’ opinions, sweetie.”* She says the employee who made the comments to her received no correction or reprimand.

The woman knows she is not the only employee who has complained about racism in her workplace. An anonymous complaint resulted in her supervisor sending out a “scathing” response that criticized the complainant. She is now fearful to bring complaints forward herself, knowing she may face similar treatment.

“We have a tremendous amount of work to do and our whole team is committed to do it. I am fully accountable to act and push things forward within my role as CEO and a leader in the health care system.

We believe that by working with our First Nation and Métis partners to provide tools, support and education through direct community engagement powerful change is possible. We want to further build our relationships with First Nations and Métis partners, to truly develop patient-centred care and integrate traditional medicine with the health care system.”

~ Susan Brown
CEO Interior Health

10. Indigenous roles in health leadership and decision-making – both through Indigenous health governance structures and the health care system as a whole – need to be strengthened.

Indigenous peoples have been structurally and systematically disempowered from participating in the systems imposed on them by Canadian and B.C. laws and policies. Fighting through the courts – and hundreds of victorious cases – has taken place over decades to re-establish that Indigenous peoples must be involved in all decisions that impact them. The human rights of Indigenous peoples – including the inherent right of self-government – are now part of the law in B.C. The era of denial and disrespect of Indigenous human rights is now officially over in law, but the health care system will need to implement that shift. What is required, across all sectors, is the establishment of proper Nation-to-Nation and government-to-government relationships and clear structures and mechanisms between them for how decisions will be made.

“The appointment of a Vice President, Indigenous Health has had a profound impact on the senior leadership of Northern Health – she has challenged our thinking while enabling reflective thinking about our unconscious biases and changing how we lead individually and collectively.”

**~ Cathy Ulrich
President and CEO, Northern Health**

The vision of proper Nation-to-Nation or government-to-government relationships is not one of separation and distance. It is a vision of how to work together, recognizing that the realities and well-being of all peoples in Canada are interconnected and interdependent in ways that are grounded in equity, anti-racism and justice. In addition to clarifying the roles of Indigenous governments, laws and jurisdictions, this also requires Indigenous peoples' presence in positions of authority and decision-making throughout the health care system. This is essential to root out racism and all forms of discrimination.

“We must listen to the voices of patients, families and communities. It is time for change, for creating cultural safety, and for embedding it into every level of the system. We want the systems and the resources, to improve care now. We want standardized processes and measurable outcomes. I'm seeing the drive for action and solution in our people.”

It's our work to do now and we're ready. It's my responsibility to ensure we take action in partnership with First Nations, Métis and Indigenous peoples. ”

~ Kathy MacNeil
CEO, Island Health

Implementation of First Nations health plans, agreements and structures must be renewed and strengthened. The formation of the FNHA has been an impetus for increased efforts, yet the work has been impeded by a number of critical factors, and some of the early health systems transformation commitments and actions have not been realized. This is a pivotal moment to renew a focus on founding commitments to systems transformation. This requires stronger structures throughout the health system, including but not limited to the First Nations health governance structure. There is a need to ensure that each component of this structure embodies good governance, required competencies, and rests upon a strong foundation grounded in the standards of the *UN Declaration*.

“In the early days of the work, we had to advocate relentlessly for a place at the table, and the recognition of our rights to participate in health governance in British Columbia. This resulted in opportunity for us to create a new structure for First Nations health services, and establish regional partnership processes. However, what got us here will not get us to where we want to go. This review demonstrates that it is time for us to take stock of the structure, assess the shortcomings, and take action now to strengthen its foundations. We have to refocus and coordinate our work at a systems level, while not losing the importance of regional flexibility and implementation. We have to model compassionate leadership and focus on mentoring and nurturing new generations of Indigenous leadership to carry this work forward. ”

~ Grand Chief Doug Kelly, Stó:lō Tribal Council President
& former Chair, First Nations Health Council

Expanded structures for Métis participation in health decision-making are required to be consistent with the *Métis Nation Relationship Accord II*. Expectations for health organizations to engage with the Métis are not appropriately hard-wired or reflected across key accountability tools and processes of the health system, and MNBC does not have sufficient or standardized senior tables in place with key officials at provincial and regional levels. There remains a lack of capacity for MNBC or Métis Chartered Communities to participate in various health decision-making and service planning efforts.

“It’s time for our society to go beyond simply acknowledging that systemic racism is a part of our health care system. We need to ensure every recommendation in this report is fully operationalized in short order and that Métis and other Indigenous people no longer need to worry about being subject to racism if they require medical treatments. For far too long Métis people have not been treated fairly when it comes to the delivery of health services in B.C. We must use this report as a catalyst to ensure long-standing grievances are properly dealt with and that Métis people are once and for all treated with dignity and respect.”

~ Daniel Fontaine
MNBC Deputy Minister

Organizations across the health system must embed Indigenous people in senior roles and enable them to work with one another in a collegial way, and with Indigenous governments and organizations, on shared priorities. The health system has become highly reliant on First Nations organizations and Métis Nation BC for leadership and perspectives on all matters Indigenous. Indigenous inclusion on board structures throughout the health care system is uneven and there is unclear criteria for the selection of candidates and how they are supported to contribute to health care system transformation. There are few Indigenous individuals in senior leadership positions, resulting in a lack of Indigenous perspectives being present to influence and shape dialogue and decisions inside organizations.

“This investigation reminds us of the daily, lived experience for First Nations in B.C. as they access health care. Our made-in-B.C. health governance structure comes from the wisdom and leadership of our Chiefs and leaders and is grounded in a community-based, Nation-driven approach. Our shared goal of equal access to health care requires each health partner to be accountable to the other for their actions moving forward. This will help ensure that First Nations peoples’ lived experiences with the B.C. health system are free from racism. We will ensure that through our engagement pathways, that our citizens and leaders will be heard and represented in this critical work going forward.”

~ Charlene Belleau
Chair, First Nations Health Council

11. There is no accountability for eliminating all forms of Indigenous-specific racism in the B.C. health care system, including complaints, system-wide data, quality improvement and assurance, and monitoring of progress.

The problem of Indigenous-specific racism has been evident and very publicly acknowledged through Declarations of Commitment signed by health care leaders across B.C. and nationally. Despite widespread knowledge of the serious harms experienced by Indigenous peoples, there has been little taking of responsibility and almost no real monitoring at the patient-care level.

To combat Indigenous-specific racism and create widespread cultural safety in the health care system, measurement and monitoring of progress are critical. The Review found that, despite a recognition of the importance of clear accountabilities and data collection regarding Indigenous-specific racism, the necessary protocols, systems and structures are not in place. There is very little evidence of systemic, timely, replicable and actionable measurement specific to the issue of Indigenous-specific racism and cultural safety. This must urgently change.

“Systems are made up of people; people are capable of applying prejudice when carrying out their work, and let’s face it, some people can be outright racist. Systems must be held accountable and so must the people that make up the systems that provide care for British Columbians. Having data that measures peoples’ performance as part of the systems of care is necessary to affect change at all levels and all points of care. This report is an example of the power of disaggregated data to prompt necessary systems change to better support the health and well-being of Indigenous peoples. B.C.’s sovereign Indigenous Nations need data about their citizens to improve care systems and to better support the health and well-being of their peoples, regardless of where they receive care. It is time – particularly with the *UN Declaration* now upheld as law in British Columbia – to educate people at all levels of the health care system and to build a better system of care. B.C. First Nations governments are intending to hold the provincial systems accountable for change and are proposing to jointly move beyond all of these work-around data arrangements and implement a new data governance model; a Nation-governed, ethical data approach that provides for timely access to quality data to plan, manage and account for outcomes. First Nations governments require meaningful information to support evidence-based decision-making at the Nation, regional and provincial levels; data to hold systems and people accountable.”

~ Gwen Phillips, Ktunaxa Nation
B.C. First Nations data champion

Indigenous identity information is not sufficiently collected in health care. In B.C., there has been an effort to standardize the collection of self-identification information through the *Government Standard for Aboriginal Administrative Data* supported by the FNLC and MNBC. The Ministry of Health is a 'mandatory adopter' of the Standard and endorsed it in principle, but has never made it a priority for funding or implementation, given the high cost and complexities attendant in this process. As a result, the health sector has been slow to adopt the self-identification data standard. Some pockets of data collection are occurring, but a comprehensive approach is lacking.

Indigenous data governance rights must be implemented in a manner that facilitates timely access to necessary data to address Indigenous-specific racism. Existing data governance agreements with FNHA and MNBC have contributed to the visibility of how well the health system is performing with respect to Indigenous peoples, and the resulting impacts on their health and wellness. However, the value of these agreements has not been maximized, with significant delays and cumbersome processes. As well, First Nations data governance processes currently do not reflect recognition of Nations' rights to empower their own governing bodies and institutions to carry out data-related work on their behalf.

Disaggregated data are necessary to highlight health system performance failures for Indigenous peoples. In conducting this Review, a conscious effort was made to remove barriers to accessing disaggregated Indigenous-specific and region-specific level data, and ensure that the Findings and Recommendations are grounded in the best possible evidence. Disaggregation of data is a tool to be used to fight Indigenous-specific racism, and provincial and federal commitments to better collection of disaggregated data must be advanced.

There is insufficient measurement and reporting on Indigenous-specific racism and cultural safety in health care. There are some processes through which various organizations have chosen to measure and report on cultural safety and humility and anti-racism. These efforts are unconnected and uncoordinated. There are major data and information gaps related to the experiences of Indigenous peoples in health care – particularly Métis peoples; and the system is not availing itself of opportunities to systemically examine the issue of Indigenous-specific racism using existing tools and data sets.

“The racism that Canadians are witnessing today in the health care system, such as the events surrounding the tragic death of Joyce Echaquan in a Montreal hospital, highlights that there remain issues with the way health care is governed and delivered to Indigenous populations in Canada. The problem of on-going racism in Canada towards Indigenous peoples in the health care system is an example of the on-going systemic racism that continues to inflict our country more generally. It is a necessary thing for all Canadians to experience the anger, sadness, and horror of racism that has always been present in our communities in order to fix it.

If we want to address systemic racism then we have to confront the racism that remains in our institutions, as reflected in our laws, policies and practices, including the *Indian Act*. Colonialism has created a gap between Indigenous and non-Indigenous health and wellness through disempowerment and interference in Indigenous governments and legal orders. To confront this legacy, and tangibly improve the lives of Indigenous children, families, and communities, we must implement Indigenous rights, including the right to self-determination, which includes the inherent right of self-government. This means Indigenous peoples having control over meeting the needs and well-being of their citizens under their own jurisdictions and laws, clear revenue streams to deliver services like any government, and systems and institutions for governing they have determined through their own laws and traditions.

Here in British Columbia, First Nations individually and collectively have taken important steps towards self-government and self-administration. This includes the creation of their own health institutions; but the work of building systems based on the inherent right of self-government is on-going. First Nations must continue to advance – indeed accelerate – rebuilding and strengthening their Nations and governments, as well as their institutions they determine to work on their behalf in health or any other sector. At the same time, governments must actually get serious about rights recognition and implementation. Confronting racism and colonialism is not enabled by lofty rhetoric. This is an arena of tangible action, and making the hard decisions – much of which we are yet to see.”

~ Jody Wilson-Raybould (Puglaas)
Independent MP, Vancouver-Granville

What's Needed



Confronting the Legacy

A Renewed Foundation

Three foundational principles must be accepted in order for the legacy of colonialism in the health care system to be properly addressed:

- Racism in the health care system is a reflection of a lack of respect and implementation of the basic human rights of Indigenous peoples, including the Indigenous rights to health and the minimum standards in the *UN Declaration*.
- Racism within the health care system is integrated with, and in many aspects indivisible from, broader patterns and conditions throughout society.
- While those who experience the problem of racism in the health care system must be intimately involved in developing solutions, we know that the responsibility and burdens of this work lie with non-Indigenous individuals, communities, organizations and governments.

Addressing Indigenous-specific racism as identified in this report requires attacking the roots of the problem and addressing the underlying causes of racism.

A basic awareness has grown that the current inequities and injustices faced by Indigenous peoples in Canada – such as those examined in this Review – are deeply rooted in an enduring legacy of colonialism, and that confronting that legacy requires substantive, transformative change. An awareness has also grown of the fundamental human rights standards – such as those in the *UN Declaration* – that have to be implemented to effect that change. Indeed, these standards were developed in partnership with Indigenous peoples around the world as part of addressing the enduring realities and impacts of colonialism and racism.

The Recommendations of this Review are designed to confront that legacy, and establish a renewed foundation for Indigenous peoples' access to, interaction with, and treatment by the health care system.

“Our First Nations governments in B.C. are rebuilding, strengthening our Nations and are firmly grounded in the *United Nations Declaration on the Rights of Indigenous Peoples* as the framework for meaningful reconciliation. After the B.C. legislation to adopt the Declaration was passed unanimously in 2019, we have to take another look at this work. How do we strengthen health governance and put in place the necessary lasting structures needed to do this work? While many innovative partnerships were accomplished over the past decade, we can solidify that work and make more permanent change with First Nations co-governance, accountability and protection from racism. The Declaration must guide this now as we are dealing with fundamental human rights.”

~ Lydia Hwitsum, JD
First Nations Summit Task Group Member & Founding Chair,
First Nations Health Authority Board of Directors

Recommendations at a Glance

(For the complete details of the Review Recommendations, please see the [full report](#))

The Recommendations aim to advance an integrated and comprehensive change approach where actions in relation to systems, behaviours and beliefs are purposefully designed in relation to, and to reinforce, one another.

Recommendations: Systems

Recommendation 1: That the B.C. government apologize for Indigenous-specific racism in the health care system, setting the tone for similar apologies throughout the health system, and affirm its responsibility to direct and implement a comprehensive, system-wide approach to addressing the problem, including standardized language and definitions, and clear roles and responsibilities for health authorities, regulatory bodies, associations and unions, and educational institutions.

Recommendation 2: That the B.C. government, in collaboration and cooperation with Indigenous peoples in B.C., develop appropriate policy foundations and implement legislative changes to require anti-racism and “hard-wire” cultural safety, including an *Anti-Racism Act* and other critical changes in existing laws, policies, regulations and practices, ensuring that this effort aligns with the *UN Declaration* as required by *DRIPA*.

Recommendation 3: That the B.C. government, First Nations governing bodies and representative organizations, and MNBC jointly establish the position of B.C. Indigenous Health Officer with co-developed legislative recognition and authority in the *Public Health Act*, and a structured relationship with the Provincial Health Officer.

Recommendation 4: That the B.C. government, First Nations governing bodies and representative organizations, and MNBC jointly establish the Office of the Indigenous Health Representative and Advocate with legislative recognition and authority to provide a single, accessible, supportive, adequately funded resource for early intervention and dispute resolution for Indigenous people who require assistance to navigate, fully benefit from, and to resolve problems within, B.C.'s health care system including all health authorities, regulatory colleges and other health providers. The position should be reviewed in five years after establishment to determine if it has been effective in rooting out racism in the health care system in B.C.

Recommendation 5: That the B.C. government, First Nations governing bodies and representative organizations, and MNBC jointly develop a strategy to improve the patient complaint processes to address individual and systemic Indigenous-specific racism.

Recommendation 6: That the parties to the bilateral and tripartite First Nations health plans and agreements work in co-operation with B.C. First Nations to establish expectations for addressing commitments in those agreements that have not been honoured, and for how those expectations will be met through renewed structures and agreements that are consistent with the implementation of *DRIPA*.

Recommendation 7: That the Ministry of Health establish a structured senior-level health relationship table with MNBC, and direct health authorities to enter into Letters of Understanding with MNBC and Métis Chartered Communities that establish a collaborative relationship with clear and measurable outcomes.

Recommendation 8: That all health policy-makers, health authorities, health regulatory bodies, health organizations, health facilities, patient care quality review boards and health education programs in B.C. adopt an accreditation standard for achieving Indigenous cultural safety through cultural humility and eliminating Indigenous-specific racism that has been developed in collaboration and cooperation with Indigenous peoples.

Recommendation 9: That the B.C. government establish a system-wide measurement framework on Indigenous cultural safety, Indigenous rights to health and Indigenous-specific racism, and work with First Nations governing bodies and representative organizations, MNBC, the Indigenous Health Officer, and the Indigenous Health Representative and Advocate to ensure appropriate processes of Indigenous data governance are followed throughout required data acquisition, access, analysis and reporting.

Recommendation 10: That design of hospital facilities in B.C. include partnership with local Indigenous peoples and the Nations on whose territories these facilities are located, so that health authorities create culturally-appropriate, dedicated physical spaces in health facilities for ceremony and cultural protocol, and visibly include Indigenous artwork, signage and territorial acknowledgement throughout these facilities.

Recommendations: Behaviours

Recommendation 11: That the B.C. government continue efforts to strengthen employee “speak-up” culture throughout the entire health care system so employees can identify and disclose information relating to Indigenous-specific racism or any other matter, by applying the *Public Interest Disclosure Act (PIDA)* to employees throughout the health care sector without further delay.

Recommendation 12: That the Ombudsperson consider including a focus on Indigenous-specific racism in the health care system as a key priority and seek input from appropriate partners on current plans to strengthen this priority through engagement, special activities to promote greater fairness in public services to Indigenous peoples, and reporting to the public on progress.

Recommendation 13: That the B.C. government establish the new position of Associate Deputy Minister for Indigenous Health within the Ministry of Health, with clear authorities including supporting the Deputy Minister of Health in leading the Ministry’s role in implementing these Recommendations.

Recommendation 14: That the B.C. government, PHSA, the five regional health authorities, B.C. colleges and universities with health programs, health regulators, and all health service organizations, providers and facilities recruit Indigenous individuals to senior positions to oversee and promote needed system change.

Recommendation 15: That the B.C. government, First Nations governing bodies and representative organizations, MNBC, the Provincial Health Officer and the Indigenous Health Officer develop a robust Indigenous pandemic response planning structure that addresses jurisdictional issues that have arisen in the context of COVID-19, and which upholds the standards of the *UN Declaration*.

Recommendation 16: That the B.C. government implement immediate measures to respond to the MMIWG *Calls for Justice* and the specific experiences and needs of Indigenous women as outlined in this Review.

Recommendation 17: That the B.C. government and FNHA demonstrate progress on commitments to increase access to culturally safe mental health and wellness and substance use services.

Recommendation 18: That the B.C. government require all university and college degree and diploma programs for health professionals in B.C. to implement mandatory strategies and targets to identify, recruit and encourage Indigenous enrolment and graduation, including increasing the safety of the learning environment for Indigenous students.

Recommendation 19: That a Centre for anti-racism, cultural safety and trauma-informed standards, policy, tools and leading practices be established and provide open access to health care organizations, practitioners, educational institutions and others to evidence-based instruments and expertise and to expand the capacity in the system to work collaboratively in this regard.

Recommendations: Beliefs

Recommendation 20: That a refreshed approach to anti-racism, cultural humility and trauma-informed training for health workers be developed and implemented, including standardized learning expectations for health workers at all levels, and mandatory, low-barrier components. This approach, co-developed with First Nations governing bodies and representative organizations, MNBC, health authorities and appropriate educational institutions, to absorb existing San'yas Indigenous Cultural Safety training.

Recommendation 21: That all B.C. university and college degree and diploma programs for health practitioners include mandatory components to ensure all students receive accurate and detailed knowledge of Indigenous-specific racism, colonialism, trauma-informed practice, Indigenous health and wellness, and the requirement to provide service to meet the minimum standards in the *UN Declaration*.

Recommendation 22: That the B.C. government, in consultation and co-operation with Indigenous peoples, consider further truth-telling and public education opportunities that build understanding and support for action to address Indigenous-specific racism in the health care system; supplemented by a series of educational resources, including for use in classrooms of all ages and for the public, on the history of Indigenous health and wellness prior to the arrival of Europeans, and since that time.

Recommendation 23: That the B.C. government, in partnership with First Nations governing bodies and representative organizations, MNBC, Indigenous physicians, experts, and the University of British Columbia or other institutions as appropriate, establish a Joint Degree in Medicine and Indigenous Medicine. That the B.C. government, in partnership with First Nations governing bodies and representative organizations, MNBC, Indigenous nurses, experts, and appropriate educational institutions, establish a similar joint degree program for nursing professions.

Recommendation: Implementation of Recommendations

Recommendation 24: That the B.C. government establish a task team to be in place for at least 24 months after the date of this report to propel and ensure the implementation of all Recommendations, reporting to the Minister of Health and working with the Deputy Minister and the Associate Deputy Minister for Indigenous Health, and at all times ensuring the standards of consultation and co-operation with Indigenous peoples are upheld consistent with the *UN Declaration*.

“Armed with this report, it’s time that the Government of British Columbia overhaul our health care system to eliminate racism against Indigenous peoples. The BCAFN and our allies will hold the province to account over this, and we will not rest until strong, definite action is taken to protect our peoples’ rights to safety, respect and dignity in seeking assistance from health care providers.”

~ Regional Chief Terry Teegee
BC Assembly of First Nations, Takla Lake First Nation

Appendices



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Appendix A

Minister Delegation Letter



AUG 24 2020

1173399

Ms. Mary Ellen Turpel-Lafond
'Addressing Racism' Investigation
Woodward & Company Lawyers LLP
200 – 1022 Government St
Victoria BC V8W 1X7

Dear Ms. Turpel-Lafond:

On June 19, 2020, I, Adrian Dix, Minister of Health, appointed Mary Ellen Turpel-Lafond to lead an investigation into Indigenous-specific racism in the British Columbia health care system, to be conducted in accordance with the terms of reference attached as Exhibit A to this delegation letter (the "**Investigation**").

For the purpose of the Investigation, I hereby delegate the minister's powers:

- (a) under section 10 of the *Ministry of Health Act*, including the power to determine whether the collection, use or disclosure of personal information is reasonably needed to fulfill a stewardship purpose, to Mary Ellen Turpel-Lafond, to be exercised as reasonable and necessary in the conduct of the Investigation (the "**Delegated Powers**");
- (b) to collect, use and disclose personal information under section 10(1) (a), (b) and (c) of the *Ministry of Health Act*, to the individuals listed in Exhibit B to this delegation letter, as necessary for the effective administration of the Delegated Powers.

This delegation will expire on December 31, 2020.

Sincerely,

A handwritten signature in blue ink, appearing to read "Adrian Dix".

Adrian Dix
Minister

Attachments

Appendix B

Terms of Reference

Establishment of the Investigation

1. An independent investigation into systemic Indigenous-specific racism in health care in British Columbia is established by the Minister of Health.
2. Dr. Mary Ellen Turpel-Lafond (Independent Investigator) is the leader of the investigation.
3. Turpel-Lafond will independently select and assemble a team to carry out the work of the investigation.

Purposes of the Investigation

The purposes of the investigation are as follows:

1. to inquire into and report on alleged incidents of Indigenous-specific racism in Emergency Departments in B.C., situated and examined within a broader context of Indigenous-specific systemic racism in the health care system in B.C.
2. to make recommendations regarding the matters described in section 3.

Scope of the Investigation

1. The investigation is to study data and information, conduct hearings and interviews, and make findings of fact respecting Indigenous-specific systemic racism in B.C.'s health care system, including the following:
 - a. the veracity and extent of allegations of incidents of Indigenous-specific racism in Emergency Departments, and the institutions in which they are housed, in B.C.;
 - b. the potential extent of Indigenous-specific systemic racism in the health care system in B.C.;
 - c. the acts or omissions of regulatory authorities or individuals with powers, duties or functions in respect of the health care sector, or any other relevant sector, to determine whether those acts or omissions have contributed to systemic racism in B.C.;

- d. the scope and effectiveness of initiatives and investments to address systemic racism in Emergency Departments and in health care, including by regulatory authorities or individuals with powers, duties or functions in respect of the health care sector, or any other relevant sector;
 - e. the barriers to addressing Indigenous-specific systemic racism in B.C.;
 - f. any other relevant and necessary matters.
- 2.** The investigation will make any recommendations it considers necessary and advisable, including recommendations respecting the following:
- a. measures to eliminate systemic racism against Indigenous people accessing health care in B.C.;
 - b. measures to uphold the human rights of Indigenous peoples accessing health care in B.C., as articulated in the *UN Declaration on the Rights of Indigenous Peoples*, the *Truth and Reconciliation Commission Calls to Action*, and the *Missing and Murdered Indigenous Women and Girls Inquiry Calls for Justice*;
 - c. measures to resolve barriers to addressing Indigenous-specific systemic racism in B.C.;
 - d. public and health professional education to address bias and eliminate Indigenous-specific racism in B.C. and create space for the exercise of Indigenous peoples' human rights;
 - e. the regulation of the health care sector or any other relevant sector to eliminate Indigenous-specific racism in B.C. and create space for the exercise of Indigenous peoples' human rights;
 - f. processes required to implement the recommendations of the investigation;
 - g. measures to ensure ongoing transparency, accountability and progress in eliminating Indigenous-specific racism in B.C. and creating space for the exercise of Indigenous peoples' human rights;
 - h. any further inquiries or studies.
- 3.** The investigation will summarize the results of its work in a written report submitted to the Minister of Health by no later than Dec. 31, 2020. A phased approach may be taken to development and issuance of the reports.

4. If the Independent Investigator has reasonable grounds to believe that any information obtained during the inquiry may be useful in the investigation or prosecution of an offence under the Criminal Code, or disciplinary action applicable to their regulated health profession, the Independent Investigator must forward that information to the appropriate authorities.

Privacy

1. Recognizing the potential vulnerability of affected individuals and key informants, and the sensitivity of information collected during the course of this investigation, the following measures will be taken:
 - a. The investigation will take all reasonable steps to collect information in a manner that protects the security of the person interviewed and respects their confidentiality.
 - b. The investigation will not disclose personal information of affected individuals without their informed consent.
 - c. All information will be treated confidentially and in accordance with B.C. privacy legislation.
 - d. Investigation records will be sealed and held by the Independent Investigator's law firm.

Data Governance

A core function of the investigation is to collect data and information to understand the presence and extent of Indigenous-specific discrimination in health services in B.C. All data and information which arises from the operating and reporting of this investigation, including surveys, individual incidents and testimonials, interviews, submissions and analysis of pre-existing sources of information are subject to these data governance provisions.

1. The Independent Investigator is the data steward and custodian of all data created as a result of this investigation, on behalf of the Indigenous peoples of British Columbia who own the data collectively.
2. The investigation has instituted processes that ensure access to data and information collected/created as part of fulfilling its mandate is limited to the investigation team, and its use and disclosure is in alignment with applicable provincial privacy legislation. All electronic and paper-based data and information is fully protected in a secure manner.

3. All data and information collected/created by the investigation is confidential, and privacy of individuals will be ensured through anonymous reporting in information products released externally, both informally and formally. In cases which describe individual incidents, the utmost care will be taken to remove any identifying features of the incidents in all reporting, and if reporting verbatim comments, that nothing in the comment, including content, vocabulary and/or style of writing, could serve to identify the individual respondent. Prior approval of the persons who submitted the incident information will be obtained before reporting involving individual incidents.
4. All information and data which is published or otherwise distributed from the investigation is culturally appropriate and for the ultimate benefit of Indigenous people in British Columbia. The investigation team is developing specific policies and procedures to guide the review and disclosure of Indigenous information and data in investigation reports.
5. The Independent Investigator has overall accountability and responsibility to manage all data and information collected/created in this investigation.
6. Following the conclusion of this investigation and submission of the final investigation report, all data and information, including survey responses, will be sealed and will not be available for any use, including further analysis, editing, research or publication. All data and information used by team members in the course of their duties will be returned to the Independent Investigator.

More Information

For the full version of the Review report, see
<https://engage.gov.bc.ca/app/uploads/sites/613/2020/11/In-Plain-Sight-Full-Report.pdf>



About the Artist

Eliot White-Hill (Kwulasultun) is a Coast Salish artist and storyteller from the White family of the Snuneymuxw First Nation. His traditional name – Kwulasultun (Many Stars) – comes from his late great-grandmother, Dr. Ellen White (Kwulasulwut). He has roots with the Rice family of Penelakut and in the Nuuchah Nulth world through the Hamilton family of Hupacasath, from whom he carries the name Kwaayas. He practises traditional Coast Salish art and works to preserve and pass down the teachings he has received. Through all practices, he hopes to share his appreciation for Coast Salish worldview and ways of knowing with others.

Artist Website: www.kwulasultun.com
Instagram: @kwulasultun