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The piece that follows has been composed for *BC Studies* readers by the authors of *In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in BC Health Care*

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IN JUNE 2020, the British Columbia (BC) Minister of Health commissioned an independent review examining systemic Indigenous-specific racism in the provincial health care system. The final reports of the Review are available as follows:

- Summary report (https://engage.gov.bc.ca/app/uploads/sites/613/2020/11/In-Plain-Sight-Summary-Report.pdf)
- Full report (https://engage.gov.bc.ca/app/uploads/sites/613/2020/11/In-Plain-Sight-Full-Report.pdf)
- Data report (https://engage.gov.bc.ca/app/uploads/sites/121/2020/11/In-Plain-Sight-Data-Report_Dec2020.pdf1_.pdf)

A six-month Review process involved surveys among more than 8,000 Indigenous people and BC health care professionals, examination of hundreds of submissions, undertaking of dozens of key informant interviews, and extensive qualitative and quantitative analysis of data related to 185,000 Indigenous individuals (see Methodology in the Full Report, p.11). The fact that the Review was Indigenous-led was critical to building trust in the process among Indigenous peoples. The methodology was comprehensive and required commitment of the health system and the Review team, but was not complex; as such, it is certainly replicable again to determine progress in BC health care, and could be employed to examine this same problem in other sectors and jurisdictions.

The Review, released on November 30, 2020, made eleven findings that clearly confirmed the problem of Indigenous-specific racism in BC's health care system, that it is pervasive across all regions and health care settings, and that the current solutions in place are not working well or fast enough (see Table 1 for a summary of Findings). But the Review sought to do more than demonstrate that the problem exists. It sought to identify and explain

the origins of this problem so that it can be permanently uprooted. By illuminating the relationship between Canada's settler-colonial past and the present-day problem of anti-Indigenous racism, and by providing the language and tools to discuss this problem, the Review has charted a clear pathway to disrupt racism in ways that systemically and meaningfully advance reconciliation and Indigenous human rights.

TABLE 1: IN PLAIN SIGHT FINDINGS

The "problem"

1. Widespread Indigenous-specific stereotyping, racism, and discrimination exist in the BC health care system.
2. Racism limits access to medical treatment and negatively affects the health and wellness of Indigenous peoples in BC.
3. Indigenous women and girls are disproportionately impacted by Indigenous-specific racism in the health care system.
4. Current public health emergencies magnify racism and vulnerabilities, and disproportionately impact Indigenous peoples.
5. Indigenous health care workers and students face racism and discrimination in their work and study environments.

Examining "solutions"

6. Current education and training programs are inadequate to address Indigenous-specific racism in health care.
7. Complaints processes in the health care system do not work well for Indigenous peoples.
8. Indigenous health practices and knowledge are not integrated into the health care system in a meaningful and consistent way.
9. There is insufficient hardwiring of Indigenous cultural safety throughout the BC health care system.
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.
11. There is no accountability for eliminating all forms of Indigenous-specific racism in the BC health care system, including complaints, system-wide data, quality improvement and assurance, and monitoring of progress.

LISTENING: INDIGENOUS-SPECIFIC RACISM IN HEALTH CARE

> *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 co-exist.*
>
> — Te'ta'in, the Review's Knowledge Keeper (ii)

The Review's final report reveals the truth of Indigenous-specific racism "in plain sight" in BC's health care system in order to lay the foundation for healing, action, and reconciliation. Only 16 percent of all Indigenous respondents to the Review's survey reported never having been discriminated against while receiving health care. Eighty-four percent of White health care worker respondents reported this racism in health care to be "somewhat," "very," or "extremely" prevalent, or were unsure. Beyond this work to establish the existence of racism, through detailed analysis of multiple data sources, the Review also sought to further identify and explain what exact forms this racism takes, how it is perpetuated, and what its impacts are (see Figure 1 for a visual depiction).

Stereotyping and profiling is at the root of anti-Indigenous racism. Analysis of submissions and multiple data sources gathered by the Review revealed that the most prevalent stereotypes about Indigenous persons in BC's health care system are that they are "less worthy" of care, have substance use issues (are alcoholics or drug seeking), are "bad parents," are incapable or non-compliant, and "get stuff for free" (see Finding 1 of the Full Report, 36). There is another set of misogynist beliefs layered on top of these stereotypes for Indigenous women, who are often profiled as sexually promiscuous or sexually available, and as having a higher pain tolerance (see Finding 3 of the Full Report, 72).

Consciously or subconsciously profiling Indigenous persons – often subtly predetermining that they are less worthy, less capable, and substance-dependent – results in discriminatory treatment of Indigenous patients. Again across multiple data sources, the Review found that discriminatory treatment of Indigenous patients most commonly takes the form of improper and abusive personal interactions (including name-calling and rough physical treatment), misdiagnoses or missed diagnoses (for example, misattributing a stroke diagnosis to intoxication), and inappropriate pain management (often withholding pain medication on the belief that Indigenous patients have a higher pain tolerance or are faking symptoms to secure pain medication). There was less effort to communicate with Indigenous patients and their families, as well as outright ignoring and shunning. The belief that Indigenous health and

Figure 1. In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in BC Health Care. *Source*: Full Report: https://engage.gov.bc.ca/app/uploads/sites/613/2021/11/In-Plain-Sight-Full-Report.pdf.

medicinal practices are inferior also led to disdain or open disrespect of cultural practices.

It is, therefore, unsurprising that Indigenous persons consistently report poorer experience of care in all data examined by the Review which leads to mistrust and even avoidance of the health care system. When compared to other patients, First Nations were many times more likely to leave BC hospitals against medical advice and have much lower rates of attachment to primary care services (see Finding 2 of the Full Report, 55). This is compounded by present-day health care access issues that are a legacy of colonialism, such as the forced relocation of many First Nations communities to geographic areas that are now underserved by health care services, and the triggering of intergenerational trauma given the physical resemblance of many health care settings to Indian hospitals and residential schools.

Taken together, the result is inequitably poor health system performance for Indigenous people, which is one key driver of a multitude of inequitable health outcomes for Indigenous populations. The Review clearly demonstrated lower life expectancy among the First Nations population, a higher rate of infant mortality, and increased rates and earlier progression and complexity of chronic disease, to name a few (see Finding 2 of the Full Report, 55). Indigenous women shoulder a particularly disproportionate burden, experiencing uniquely misogynist stereotypes, experiencing very deep and acute feelings of unsafety in accessing health services, and facing the most disproportionate gaps in health outcomes of any population segment examined in the Review (see Finding 3 of the Full Report, 72).

These health outcome disparities often directly reinforce anti-Indigenous stereotypes, thereby perpetuating the damaging cycle depicted in Figure 1. Gaps and disparities in health outcomes for Indigenous populations are often reported without any associated context about how these disparities arise, and these disparities are seldomly attributed to their root causes – racism, unwelcoming health services, and the legacy of colonialism – or recognized as being entirely without accurate evidence or pattern of conduct by Indigenous peoples. Without this context, health outcome disparities such as lower rates of life expectancy perpetuate the racist belief that Indigenous persons are "non-compliant" or "less capable" of taking care of themselves; higher rates of infant mortality among First Nations populations feed into persistent prejudicial attitudes and profiles of Indigenous persons as "bad parents", unconcerned about the health and development of their

children and families. Illuminating and telling the truth about this cycle is necessary for breaking its destructive pattern.

LEARNING: THE ROOTS OF INDIGENOUS-SPECIFIC RACISM

> *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.*
>
> — Te'ta'in (ii).

There is a direct link between the uncomfortable history and experience of colonialism in BC and the challenges of racism within the health care system today. Racism is fuelled by structures, norms, and patterns that often have been taken for granted for generations. Today, many struggle to recognize a glimmer of these patterns, let alone how rooted they are in decades of a race-based approach to health care, and the devaluing of Indigenous peoples' knowledge, bodies, and life expectancies. Understanding this colonial history helps us recognize and uproot their lineage in our present-day institutions. The anti-racism mindset required to comprehend these persistent patterns of discrimination and denial of access to equal health care to Indigenous peoples must be developed and nurtured by the health care system. It would be a mistake to put this responsibility on the Indigenous peoples who are targets of racism and discrimination.

Colonialism is a structured and comprehensive form of oppression intended to extinguish Indigenous peoples and gain access to their lands and resources. In Canada, colonialism was justified through the creation and perpetuation of racist beliefs about the inherent genetic, cultural, and intellectual inferiority of Indigenous peoples. Indigenous peoples were deemed to be weak and dying off, incapable and primitive, poor users of land without a proper land tenure system or social organization, and incapable of managing themselves, their children and families, and their governments. These beliefs were offered as evidence to justify the imposition of colonial systems such as the Indian Act, residential schools, and segregated Indian hospitals, enabling the state to enact policies to segregate, assimilate and govern all aspects of the lives of Indigenous peoples and make way for the priorities of settlers and settler governments.

These racist beliefs were further entrenched through health care systems in which Indigenous peoples were treated apart and separate, through a segregated health system, and were treated as objects of research and experimentation rather than as patients for whom the system

existed to care. Segregated facilities, underfunding, low standards of care, violations of individual integrity and autonomy – including of the physical bodies of Indigenous individuals, also injuring their mental, emotional, and spiritual domains in the process – and a failure to address needs expressed by communities and support Indigenous self-determination are all part of Canada's own story of health services for Indigenous peoples (see Contextualizing the Findings and Recommendations in the Full Report, 154). These policies and practices of colonialism, including residential schools and Indian hospitals, have lineage today, triggering intergenerational trauma response among Indigenous patients in health care interactions and settings.

Yet this history is not well understood, and in this space of ignorance, racist beliefs persist and evolve in a widespread way across Canadian society, including in health care. A lack of readily available factual information, knowledge and understanding about the history and experience of colonialism feeds racist assumptions that endure about why certain social conditions and issues exist. Negative social attitudes about Indigenous peoples thus continue to be held and expressed through discriminatory behaviours anchored in such beliefs. In turn, these general negative social attitudes enable the continuation of racist and neglectful policies that serve to shame and blame Indigenous peoples for health issues and suggest they and their communities are not worthy of the investment required to achieve substantive equality. This cycle – the legacy of colonialism – serves to hold the status quo in place.

An anti-racist mindset is needed to comprehend this history and appreciate the connection today between disparate access to health care services by Indigenous peoples, and the legacy of a system of denial of basic services to Indigenous peoples for generations. We must appropriately challenge beliefs and excuses for anti-Indigenous racism that have accepted this colonial regime as somehow the responsibility of Indigenous peoples. Instead, history shows us that it was imposed on Indigenous peoples and the trauma, suffering and disrespect of Indigenous health and wellness, as well as respect for Indigenous peoples' agency and choices in health care, have been driven by these failed colonial policies. It is not the individual choices of Indigenous persons that have resulted in the disparate outcomes and racism today. Rather, it belongs to the system; leadership in the system, as well as all health professionals, must take on the responsibility to address it. Reconciliation requires us to confront the legacy and proactively eliminate it from our institutions and our personal and professional relationships.

TABLE 2. PROBLEMS, SOLUTIONS, AND DESIRED OUTCOMES

The Problem:

- **Racism** is the belief that a group of people are inferior based on the colour of their skin or their culture. It leads to both (a) **prejudice** – a negative way of thinking and attitude towards a socially defined group and towards any person perceived to be a member of the group, and (b) **profiling** – a pre-set negative idea of a group in society applied to individuals who are members of that group.
- Racism, prejudice and profiling lead to **discriminatory** behaviours and policies that oppress, ignore or treat racialized groups as "less than" non-racialized groups.
- **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.
- **Systemic racism** is enacted through routine and societal systems, structures, and institutions such as requirements, policies, legislation, and practices that perpetuate and maintain avoidable and unfair inequalities across racial groups.

Solutions:

- **Anti-racism** is the practice of actively 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" but involves taking action to create conditions of greater inclusion, equality and justice. As related to anti-Indigenous racism, anti-racism must necessarily involve decolonization.
- **Cultural humility** is a lifelong process of self-reflection and self-critique. Cultural humility begins with an in-depth examination of one's own assumptions, beliefs and privilege. It requires curiosity and a commitment to lifelong learning about oneself, as well as the equally legitimate worldviews and practices of those of other cultures.

Desired Outcomes:

- A **culturally safe** environment is physically, socially, emotionally and spiritually safe, as defined by the patient, and without challenge, ignorance or denial of their identity. A culturally safe environment upholds the unique human rights of Indigenous peoples – including the right to access care free of racism and discrimination, the right to one's language and identity, and the right to traditional medicine and cultural practice.
- **Substantive equality** refers to the requirement to achieve equality in opportunities and outcomes, and is advanced through equitable 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 human rights** refer to the specific requirement to ensure that Indigenous peoples enjoy protection of human rights in BC in keeping with the minimal standards for the protection and survival of Indigenous peoples as provided in the *United Nations Declaration on the Rights of Indigenous Peoples*. UN Declaration Article 24 is of particular relevance as it provides that Indigenous peoples must access health and social services without discrimination [2]. As the Province of BC has adopted the UN Declaration by provincial legislation in November 2019, the health care system must shift to align with the standards in the Declaration.

ACTING: SPEAKING UP ABOUT RACISM

> *It is about confronting and acknowledging the negative, while making room for the positive.*
>
> — Te'ta'in (ii)

Talking about anti-Indigenous racism makes people uncomfortable and sometimes defensive. This is not a helpful mindset, and can result in reproduction of the hostility and aggression that Indigenous peoples have experienced in the past. Health workers responding to the Review's survey identified the most common reasons why systemic or organizational racism exists – the top two reasons connect directly to reluctance and discomfort in talking about racism: (1) staff not willing to stand up and call out racially prejudiced behaviour; (2) staff not regularly reminded of the many ways discriminatory behaviour can occur (see Finding 1 of the Full Report, 36). We continue to face significant barriers in having open discussions about racism, and these barriers ultimately serve to hold racism in place.

Because we don't talk about this problem in a widespread and direct way, there is a lack of shared understanding across the health system – and BC society more broadly – about what key terms and concepts actually mean. This perpetuates and contributes to our collective discomfort and inability to make meaningful progress at any level of the health system. At an interpersonal level, it means that incidents of racism and discrimination go unreported. At a service level, it means that the urgent need to create access to culturally safe primary preventative care for Indigenous peoples goes unaddressed, continuing to widen the disparities in health outcomes. At a systems level, it results in a lack of integrated strategy to address Indigenous-specific racism, and an inability to assess results at a systemic level (see Findings 6–11 of the Full Report, 36–152).

Creating a "speak up" culture is therefore a necessary measure in rooting out racism. Speaking up is anchored in identifying racism against Indigenous peoples and not being a bystander or participant in it. This requires a positive environment or health ecosystem which values an anti-racism mindset. This means that all of us have the knowledge and language to identify racism when we see it, the systems to report and address it, and the strategies and tools to counteract it and move towards our desired outcomes. To this end, the Review identified a number of recommendations designed to enhance "speak up" culture across the health care sector, as well as key terms and definitions about the problems, solutions, and desired outcomes (Table 2) under its examination (see Key Terms in the Full Report, 8). These terms support all of us to speak with one another about the problem, the mindsets and tools needed to solve

the problem, and the future state we are collectively trying to achieve in Indigenous health.

RECONCILING: EMBEDDING INDIGENOUS HUMAN RIGHTS

> *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.*
>
> —Te'ta'in (ii)

Over the past decade, public understanding of this history has deepened, in part due to the work of the Truth and Reconciliation Commission (TRC) and the National Inquiry into Missing and Murdered Indigenous Women and Girls. 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 described in the *United Nations Declaration on the Rights of Indigenous Peoples* that have to be implemented to effect that change. Among other relevant standards, the Declaration reaffirms the right to health in Article 24:

> 1. Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals and minerals. Indigenous individuals also have the right to access, without any discrimination, to all social and health services.
>
> 2. Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view to achieving progressively the full realization of this right.[1]

Canadian governments have begun to act upon the TRC's Call to Action 43 to apply the UN Declaration as "the framework for reconciliation."[2]

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[1] UN General Assembly, United Nations Declaration on the Rights of Indigenous Peoples: resolution / adopted by the General Assembly, 2 October 2007, A/RES/61/295, available at https://www.refworld.org/docid/471355a82.html.

[2] Truth and Reconciliation Commission of Canada, United Nations, National Centre for Truth and Reconciliation, and Truth and Reconciliation Commission of Canada. 2015. *Truth & Reconciliation: Calls to Action*.

BC has been at the forefront of this process, in November 2019, passing the *Declaration on the Rights of Indigenous Peoples Act* (*DRIPA*). *DRIPA* affirms the application of UNDRIP to the laws of BC, meaning that the Province and public institutions must consider the human rights of Indigenous peoples when determining how to act in accordance with BC's laws, including in health. The Review therefore shaped its twenty four recommendations to advance the implementation of UNDRIP and compliance with *DRIPA* in BC. These recommendations are designed to support Indigenous peoples to utilize culturally safe health services free of discrimination, access services reflecting of their integrative and interconnected Indigenous understandings of health, and to support Indigenous self-determination in health care.

Implementation of these recommendations, and advancing reconciliation, is inherently an effort that must be done together. While this problem and the required change lie with non-Indigenous individuals, communities, organizations, and governments, those that experience the problem of racism in the health care system – Indigenous peoples – must be intimately involved in developing solutions. The experience and knowledge of Indigenous peoples must guide this work, including illustrating when racism is being successfully confronted. We must apply our learning about colonial history, working together, and not unilaterally, to get to the root of the problem, and firmly embed the right foundation for a just, equitable, and inclusive future.

While the health sector may be poised to lead the way, racism is a broader societal problem rooted in an enduring legacy of colonialism. Confronting that legacy and advancing reconciliation requires substantive, transformative change. We can all be leaders and contributors to that process, through listening to the truth of Indigenous peoples, learning about our shared colonial history, and speaking up against racism in all of its many forms. Indigenous Knowledge Keepers provide guidance on how we must work to create opportunity to shift systems even as we bring the truth and learning about conflict and maltreatment to the forefront and insist that we act to eliminate racism, discrimination, and disparate health services in British Columbia as a measure of reconciliation:

> *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. Nutsamaht (we are one).*
>
> — Te'ta'in (ii)