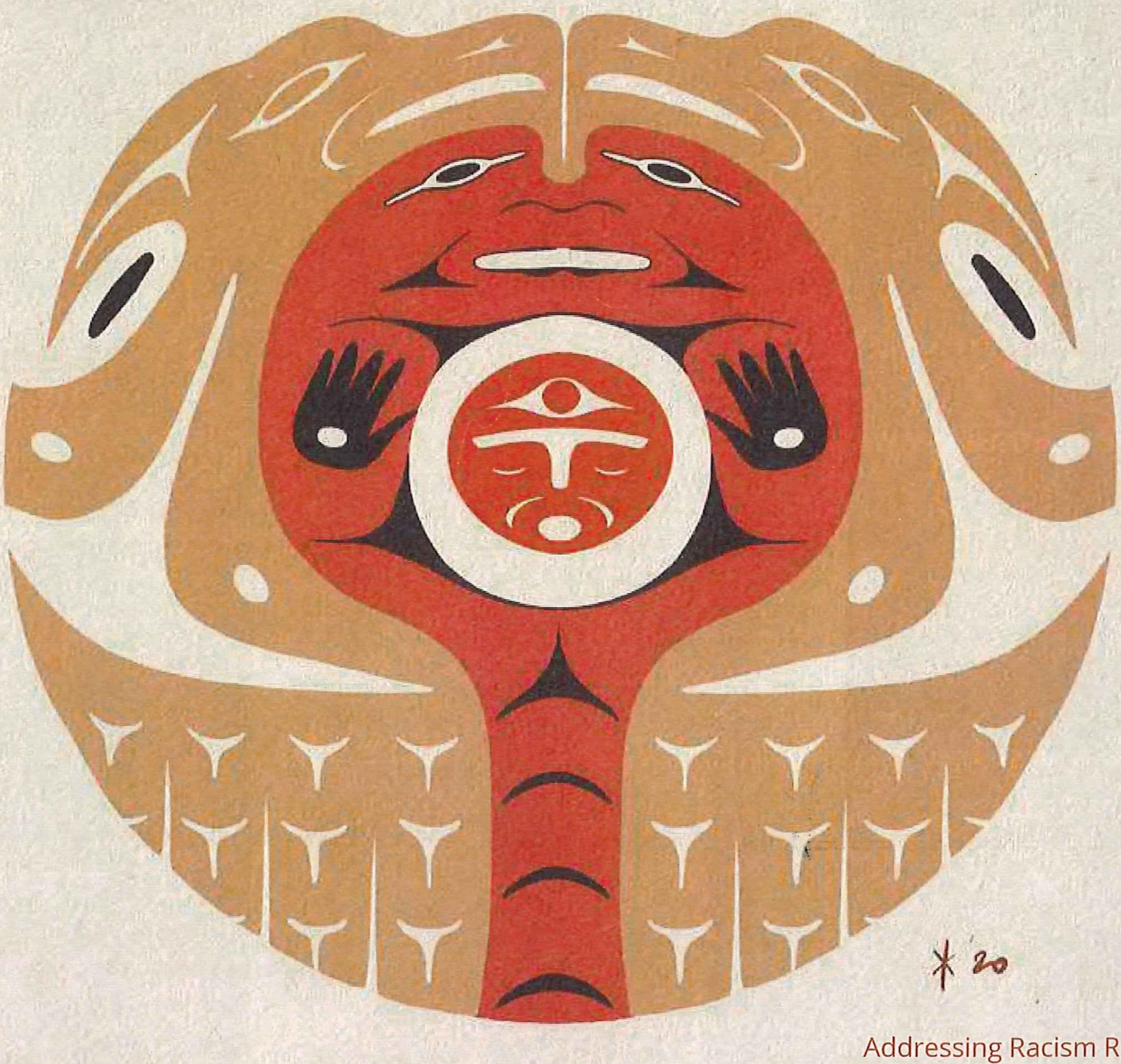
In Plain Sight

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



Addressing Racism Review
Summary Report, November 2020

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How We Worked

Before you absorb this report and begin 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

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**

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.

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 center 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 in a manner that is safe 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.

Racism Felt Across Generations and Communities

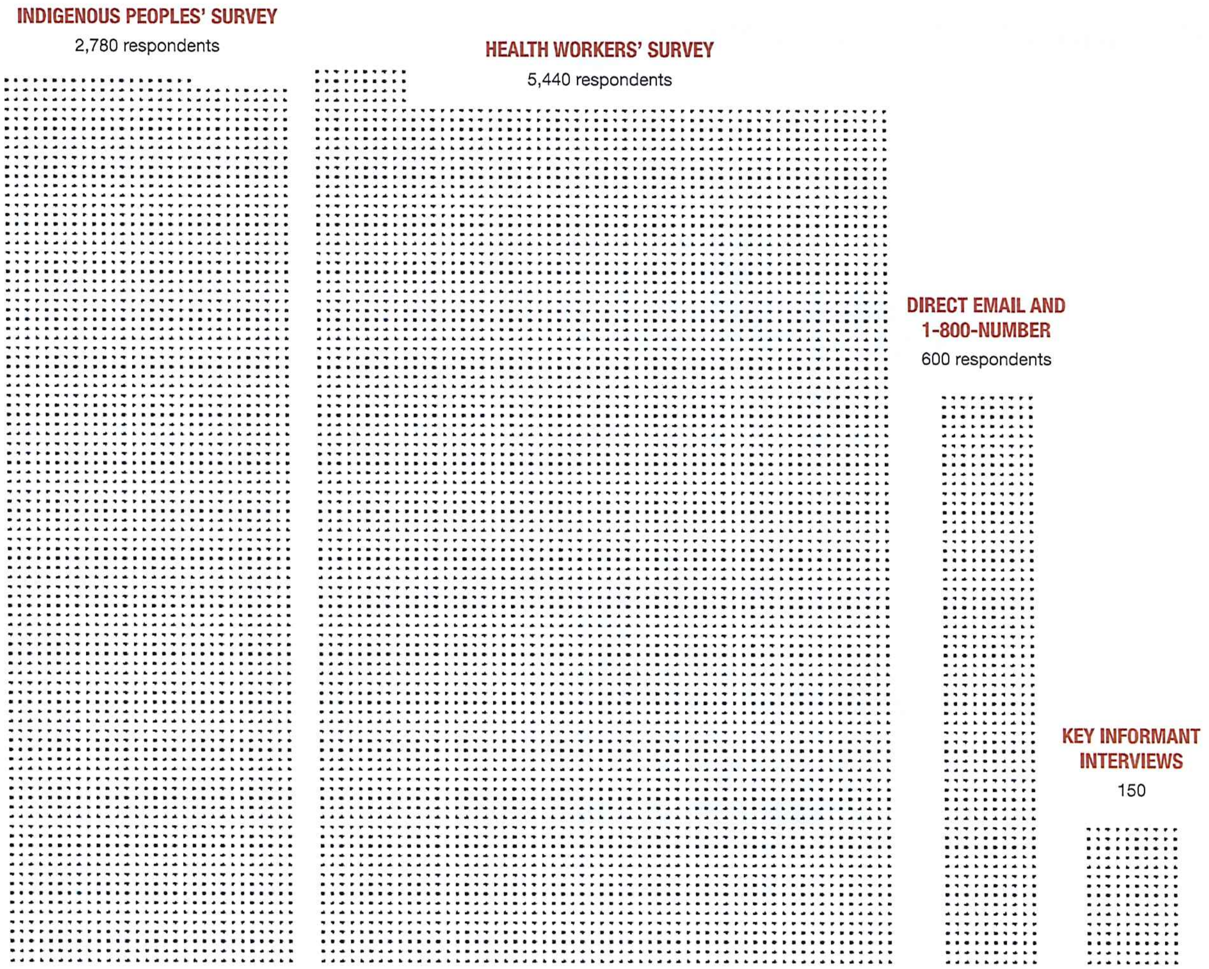
An Indigenous Elder spoke to the Review at length about her family's experiences with racism in the health care system over generations. Here are some of her recollections:

- 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 ER 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 Wynrib, 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)

WE HEARD FROM ALMOST 9,000 PEOPLE



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.

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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 ER allegations

Investigation of other select cases

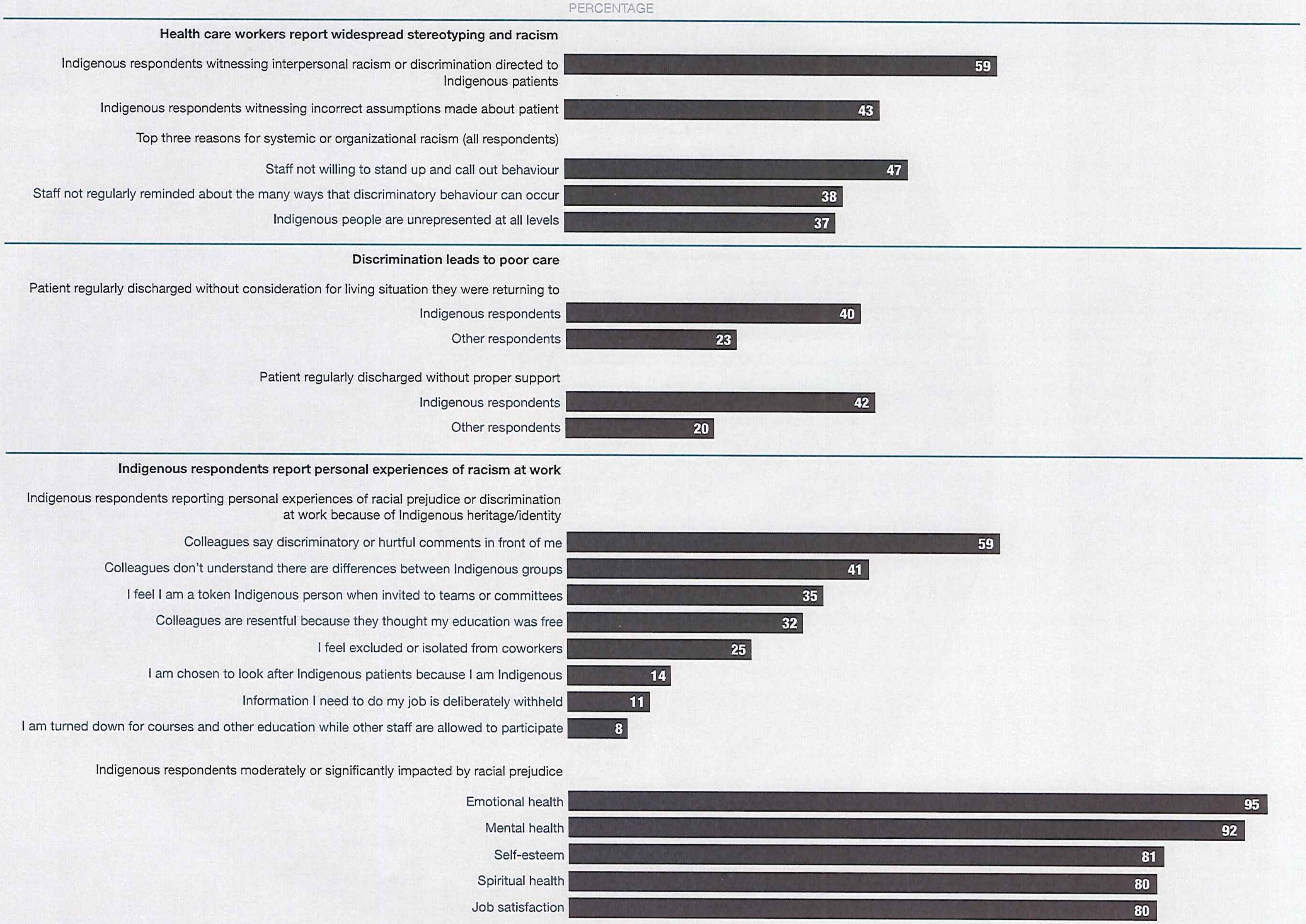
Extensive literature review of previous investigations, inquiries, and academic or historic findings

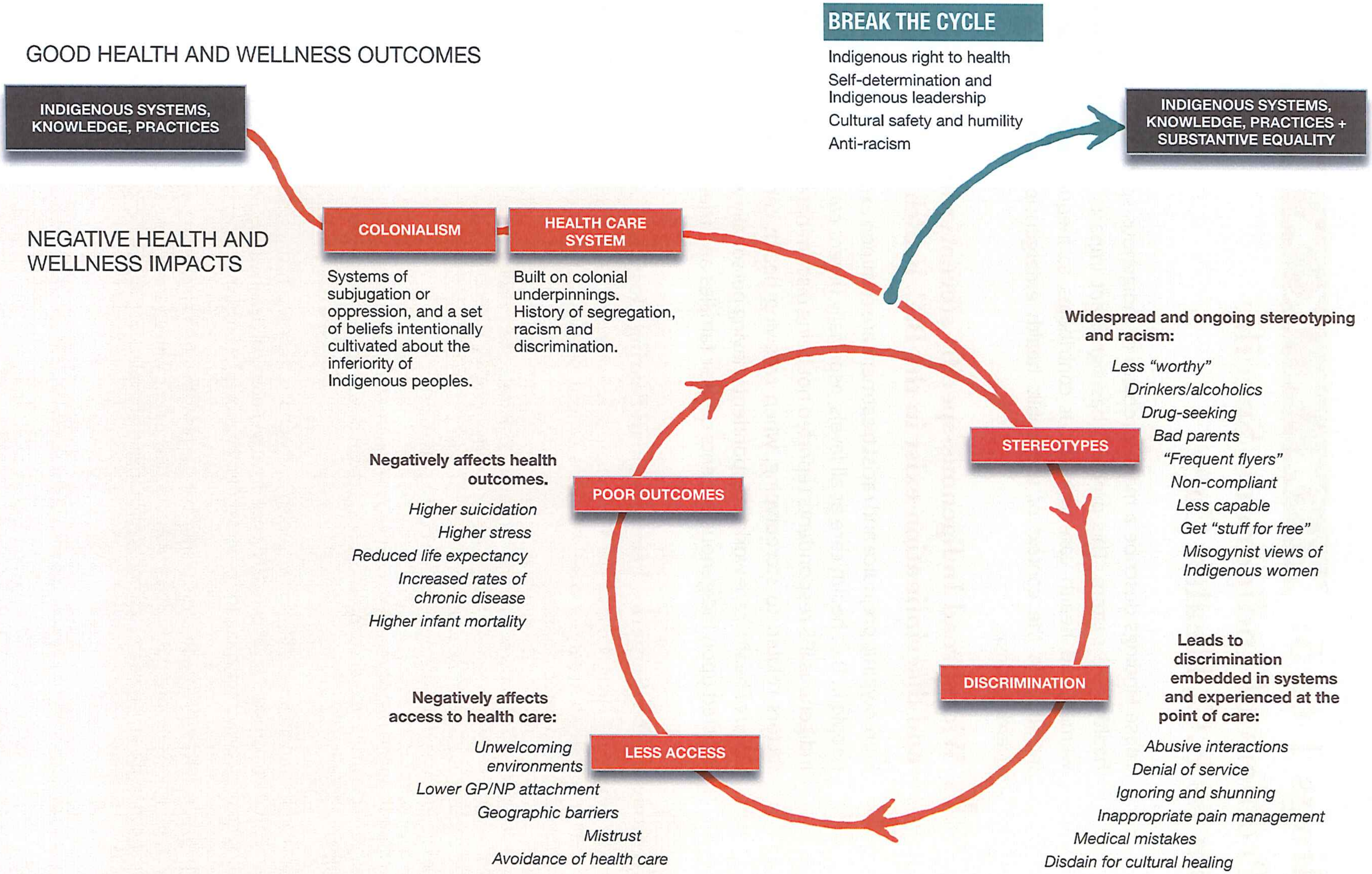
Dialogue with experts in Indigenous rights, Indigenous health/wellness, UNDRIP

Review of existing anti-racism/cultural safety initiatives already underway

HEALTH CARE WORKERS' SURVEY

What we heard





GOOD HEALTH AND WELLNESS OUTCOMES

INDIGENOUS SYSTEMS, KNOWLEDGE, PRACTICES

NEGATIVE HEALTH AND WELLNESS IMPACTS

COLONIALISM

Systems of subjugation or oppression, and a set of beliefs intentionally cultivated about the inferiority of Indigenous peoples.

HEALTH CARE SYSTEM

Built on colonial underpinnings. History of segregation, racism and discrimination.

STEREOTYPES

Widespread and ongoing stereotyping and racism:

Less "worthy"
Drinkers/alcoholics
Drug-seeking
Bad parents
"Frequent flyers"
Non-compliant
Less capable
Get "stuff for free"
Misogynist views of Indigenous women

DISCRIMINATION

Leads to discrimination embedded in systems and experienced at the point of care:

Abusive interactions
Denial of service
Ignoring and shunning
Inappropriate pain management
Medical mistakes
Disdain for cultural healing

LESS ACCESS

Negatively affects access to health care:

Unwelcoming environments
Lower GP/NP attachment
Geographic barriers
Mistrust
Avoidance of health care

POOR OUTCOMES

Negatively affects health outcomes.

Higher suicidation
Higher stress
Reduced life expectancy
Increased rates of chronic disease
Higher infant mortality

BREAK THE CYCLE

Indigenous right to health
Self-determination and Indigenous leadership
Cultural safety and humility
Anti-racism

INDIGENOUS SYSTEMS, KNOWLEDGE, PRACTICES + SUBSTANTIVE EQUALITY

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 ER
- **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".

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.

> “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

"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 ER 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.

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 are 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.

Family Searching for Answers After Lengthy Mental Health Detention

In late-June 2020, 23-year-old Canadian Armed Forces member Connor Sutton[2] 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 ER. 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 ER 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.

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[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.

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."*

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 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.

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.

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.

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 ER.

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**

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.

↑ Up
~ Stable
↓ Down
🪶 First Nations
∞ Métis
– Data not available
♂ Male
♀ Female

	Indigenous[1]	Other Residents (OR)	Indigenous/ OR Rate Difference	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	40.7% 🪶	23.0%	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% 🪶 48.4% ∞	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 🪶	↓	–

> “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, kʼʷunəmɛn, 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.

"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 ER 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

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.

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.

> **“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 holistic 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.”*

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.

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 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

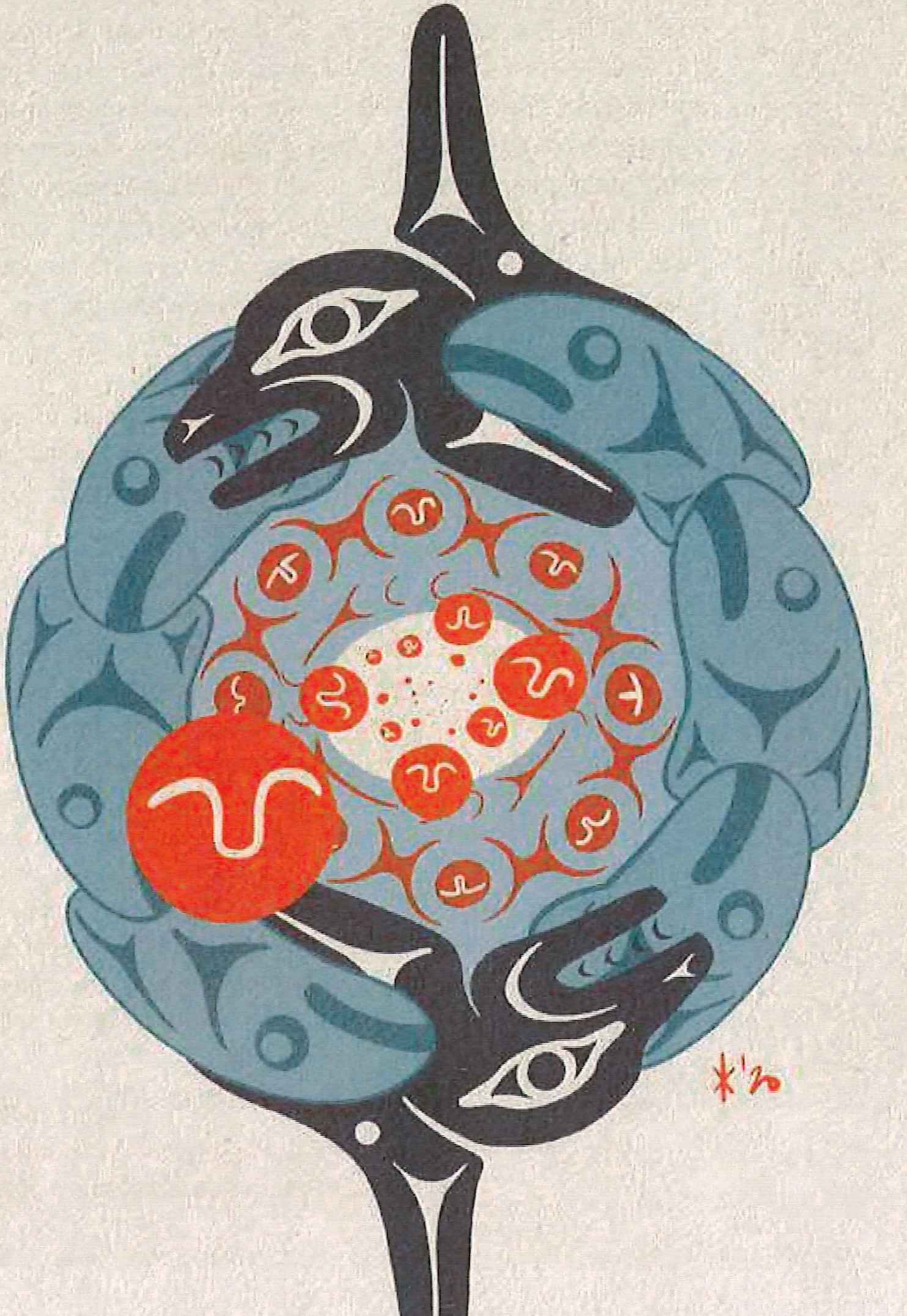
Indigenous identity information is not sufficiently collected in health care. In B.C., there has been an effort to standardize the collection of self-identification information through the *Government Standard for Aboriginal Administrative Data* supported by the FNLC and MNBC. The Ministry of Health 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.

What's Needed



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.

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 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.

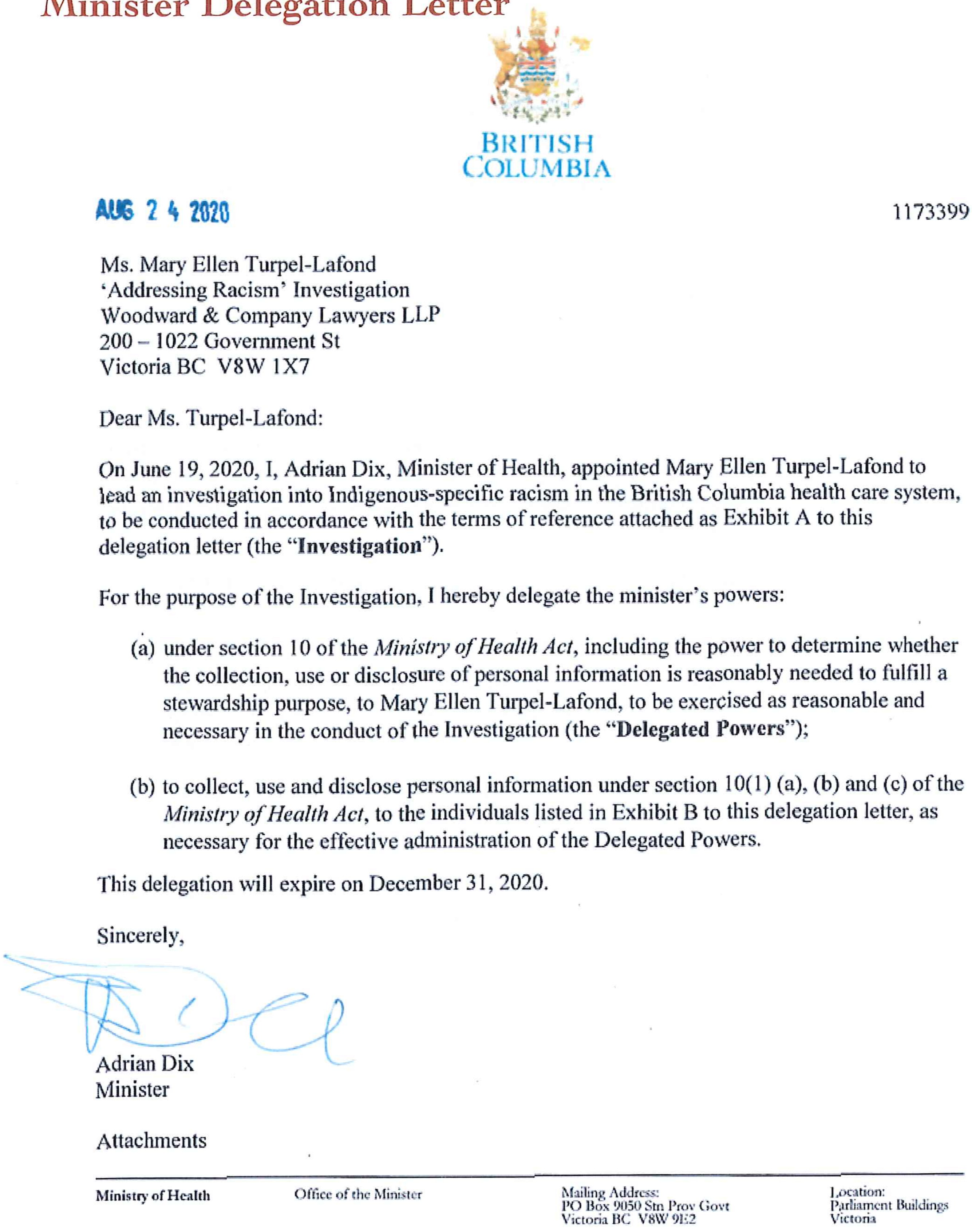
Implementation of Recommendations

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

Appendix A

Minister Delegation Letter



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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,

Adrian Dix
Minister

Attachments

Ministry of Health
Office of the Minister
Mailing Address:
PO Box 9050 Stn Prov Govt
Victoria BC V8W 9E2
Location:
Parliament Buildings
Victoria

   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.

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 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