

What's the Harm? Examining the Stereotyping of Indigenous Peoples in Health Systems

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Abstract

This research study examined how stereotyping of Indigenous Peoples impacts health service provider attitudes, actions and services to Indigenous Peoples. This was done by assessing incidents posted by health service provider participants in the BC Provincial Health Services Authority (PHSA), *Saṅ'yas* Indigenous Cultural Safety (ICS) program. The data were coded and analyzed for the frequency of specific stereotypes, attitudes, type of harm, and sites of harm. Anonymous demographic identifiers selected by health service providers were also analyzed as secondary data to provide information regarding the standpoint and perspective of participants observing the harms in health services. These data provide a better understanding of stereotype harm and Indigenous-specific racism in Health Systems on both an organizational and individual level. This study may also assist system design and service delivery to become safer for Indigenous Peoples and to address unparalleled inequities between Settler Canadians and Indigenous Peoples. The intent was to assist Settler service providers to understand how unexamined stereotypes can seriously harm Indigenous Peoples. I conducted qualitative research followed up with quantifying the results. This method of study of the incidents provided by participants produced data to examine and better understand the frequency, impact, and context of Indigenous-specific stereotyping incidents.

Research questions:

1. What stereotypes of Indigenous Peoples are reported by health service providers?
2. Where are stereotypes toward Indigenous Peoples occurring within health care systems?
3. What attitudes towards Indigenous Peoples are reported by health service providers?
4. What types of harm towards Indigenous Peoples are reported by health service providers working in health systems?

Keywords: Colonization, Indigenous Cultural Safety, stereotype harm on service delivery, Indigenous-specific racism, critical race theory, Settler identity development, critical Whiteness, colonial dynamics.

Dedication

This research has been mentored by many Indigenous and Settler allies and colleagues who continue to teach me about who I am and what I do not face. I am especially grateful for Dr. Cheryl Ward. This work began when she mentored me thirteen years ago in social work education, and it is a reflection of her leadership. This work is dedicated to Dr. Snitelwet Deborah Jacobs of the Squamish Nation and also Carol Linda McFadden of the Tshimsian Nation. Although they are no longer here, they continue to teach me.

This research is because of the many Indigenous Peoples who continue to face racism today—they are the real teachers, and so much more than the “data” that I studied.

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Chapter 1. Introduction

1.1. Prologue—Emerging from the Colonial Whiteout: How I Came to See My Authentic Racial and Political Identities

As a non-Indigenous educator and researcher, and more specifically growing up in Canada as a *White Settler*¹ in a society established by Europeans on non-European soil (Razack, 2002), I learned late in my adult life that what I was taught in public school about Indigenous Peoples and my peoples' history was incomplete and inaccurate. I was taught that the colonization and genocide of Indigenous Peoples was in the past and had nothing to do with me. Razack noted that:

A quintessential feature of white settler mythologies is the disavowal of conquest, genocide, slavery, and the exploitation of the labour of peoples of colour [and added] in North America it is still the case that European conquest and colonization are denied, largely through the fantasy that North America was peacefully settled and not colonized. (p. 2)

Growing up and attending school in Canada I consumed the same ideas that Battell Lowman, and Barker (2015) described, that Indigenous Peoples “were weak, backward, and in need of civilizing” (p. 33). These authors further explained that “Canadians come to see their own systems as superior and therefore justified in displacing Indigenous ways of being on the land” (p. 33).

The history I was taught exalted and romanticized pioneer ancestry and necessarily degraded Indigenous Peoples to rationalize land theft (Thobani, 2007). This version of Canada's history as benign and benevolent has been exposed as dangerously incomplete and yet is still taught explicitly by the glorification of European explorers and also by the omission of teaching about Canada's violent colonial harms of genocide and exploitation (Alfred, 1999; Thobani, 2007; Razack, Smith, & Thobani 2010; Baldwin, Cameron, & Kobayashi, 2011). The ideology of colonial denial is embedded into education and impacts the socialization and therefore the beliefs of children growing up in Canadian society. As Thobani (2007) described it, “the foundational narrative of

¹ I capitalize the terms *White* and *Settler* to denote the importance of these terms as identifiers for Canadians with European ancestry occupying Indigenous land. This will be explored further in the definitions section below.

Canadian nationhood is a romance of pioneering adventure, of the overcoming of adversity through sheer perseverance and ingenuity” (p. 33). Essentially this curriculum, in both the omission of colonial genocide of Indigenous Peoples and glorification of White European Settlers, teaches Indigenous-specific racism.

I learned to believe that I was better and smarter than any other racialized group because of my White European ancestry. This colonial ideology of “warranted” White power over others becomes fundamentally dangerous to relationships when White people work with Indigenous Peoples in any service provision context. In working for Indigenous organizations initially in child welfare and then in health education, I had to examine and evaluate what I was bringing to the table in terms of my own socially invisibilized racial baggage, that is, my attitudes, metaphors, beliefs, and values about Indigenous Peoples (Papps & Ramsden, 1996).

Researchers have identified several key components in a developmental learning process that supports safer services for Indigenous Peoples. This learning process is known as Indigenous Cultural Safety (ICS). In ICS development, learning about Canada’s history of violent harms and the indisputable systemic powers that Settlers hold over Indigenous Peoples is a starting place. Racial identity development and critical race studies have also been described as necessary components within this process. In a literature review entitled “*Marking the White Terrain in Indigenous Health Research: Literature Review*,” White Settler Australian authors Martin-McDonald and McCarthy (2007) stated that “to achieve useful research outcomes that influence the well-being of indigenous populations necessitates that non-indigenous researchers stringently examine their own racial and social positioning. Without doing this we, consciously or otherwise, hold up white hegemony and racist inequality” (p. 126). Another key component in this ongoing learning process is teaching service providers to recognize and understand the dynamics of cultural, personal, and professional power and how they shape service relationships (Richardson & Carryer, 2005). The ultimate goal of Indigenous cultural safety is health equity, which can be supported by education including anti-Indigenous racism strategies in service delivery and this is achieved when Indigenous Peoples feel safe and when their needs are met.

The contrast between views and reality has been spoken to and actively resisted by Indigenous Peoples since contact with European Settlers; Indigenous Peoples have

always challenged racist and discriminatory practices that prevent them from participating fully in decision-making processes that affect their lives at all levels of society. Yellow Wolf, a Nez Perce warrior (1877) quoted in Thobani (2007), makes an important point about this: “The whites told only one side. Told it to please themselves. Told much that is not true. Only his own best deeds, only the worst deeds of the Indians, has the white man told” (p. 40). Indigenous author, educator, and activist Alfred (1999) in his book, *Peace, Power and Righteousness: An Indigenous Manifesto*, reminds us that change by Indigenous Peoples has been happening for decades in Canada and globally: “In the past two generations Indigenous people around the world have broken the rusty cage of colonial oppression and exposed the injustices imposed on them. Brave and powerful leaders have challenged the European’s self-proclaimed right to rule and ruin our nations” (p. xiii).

I was socialized to believe that all people have the same access to health and wellness, which is untrue on so many levels and has been proven to be false in measures over many years. Mackrael (2018) published an article in the *Globe and Mail*, “*Close the gap between Canada and its aboriginal people: AFN chief*” and reported that “Canada regularly places well on the UN human development index, which measures living conditions in all countries. But development experts say that inequalities within the country—particularly in relation to aboriginal Canadians—could come under scrutiny when the next set of global-development goals come into effect in 2016,” and quoted Assembly of First Nations Chief Bellegarde, who stated, “In Canada, it’s all about closing the gap, and right now, there’s a huge gap between indigenous peoples and non-indigenous peoples.”

Battell Lowman and Barker (2015) affirm that “Settler colonialism structures all lives in Canada, not just Indigenous ones” (p. 89). This means that Settler Canadians must all examine the impact of colonization on our beliefs and our lives, and how this ongoing force has created and continues to reassert gaps in health measures between Settlers and Indigenous Peoples. It is important to note that some Settlers (both White and non-White) have come to Canada under extremely diverse circumstances, many escaping indescribable trauma, and those who are not White will also face the personal violence of stereotyping and discrimination and will not have the same access to the benefits of Indigenous land theft as Whites. However, the suffering of Settlers does nothing to diminish the theft of Indigenous land and rights nor ongoing impacts.

The inequity between Indigenous Peoples and Settlers of any race has been inaccurately defined as “Indigenous” inequities, leaving out the impact of the control comparison. In their book *Determinants of Indigenous Peoples’ Health in Canada: Beyond the Social*, de Leeuw, Lindsay, Greenwood, and Reading (2015) note that “the wellbeing of [Indigenous] individuals and communities is linked to a much broader dynamic than typically assumed by the individualistic, biomedical approaches to health that have long dominated non-Indigenous medicine” (p. xi). I contend that we must look at the relationships and dynamics between both populations in Canada’s health assessment. The experience and access to health of Indigenous Peoples, which is at the lowest end of the spectrum, does not exist in isolation but exists *in relationship* and comparison to that of non-Indigenous Settlers, whose health and wellbeing is consistently much better. McGibbon and Etowa (2009) noted that access is politically controlled by funding decisions that are determined across government-managed social systems by White normativity (Baldwin, Cameron, & Kobayashi, 2011). White normativity is not biological but a term that has been used to reference how “Whiteness” is central to racial classifications in North America, and White people are understood to be the norm and are therefore not a race (Morris, 2016). It is important for White people to recognize that we have a socialized race because this cannot be separated from our power over non-Whites, and to see how our race relates to inequities with Indigenous Peoples and our shared colonial history and present-day relationship as Settlers.

Henry and Tator’s (2006) book *The Colour of Democracy: Racism in Canadian Society* defines colour-blindness or colour evasion as “a powerful appealing liberal discourse in which White people insist they do not notice the skin colour of a racial-minority person” (p. 25). They quote Gotanda (1991) to explain that the idea of not seeing race is a “technical fiction” that teaches Canadians that all people are equal and have equal rights and opportunities. Frankenberg (1993) noted that “colour-blindness or colour evasion leads to power evasion” (as cited in Henry & Tator, 2006, p. 25).

White Settler Identity and Indigenous Cultural Safety

Learning about who one is as a White Settler Canadian is a part of Indigenous cultural safety development, and a lifelong process with no graduation point. The *San’yas* program was created by Indigenous scholar and critical race specialist Dr. Cheryl Ward (Namgis) to provide non-Indigenous service providers with foundational

knowledge, self-awareness, and skills to offer safer services for Indigenous Peoples. This training was initially created for the health sector and has since expanded to mental health, child welfare, and justice service contexts. The diversely racialized San'yas team has enriching discussions exposing power and privilege and the ways in which race impacts our lives every day.

As a member of the San'yas team, I have learned how Indigenous cultural safety goes beyond cultural awareness or multicultural or diversity education. I learned that incomplete educational contexts create a risk of being taught (or enculturated/groomed) into learning stereotypes, and a paternalistic one-sided examination of inequities, when we are taught that the inequity problem lies with Indigenous Peoples as “the other.” An incomplete education process that does not include critical analysis of race and power, leaves the Indigenous person as bringing or being the problem in their need for services, and omits the biases in services and the Settler service provider as a potential contributor to Indigenous health inequities.

From my work with San'yas, from my research, and from working relationships with Indigenous educators and allies, I now know that Indigenous-specific racism is embedded into Canadian socialization and has contributed to a racial divide that has had unique and serious consequences in service relationships. To address Indigenous-specific racism, it is necessary to understand Settlers and for Settlers to understand themselves (Lavallee, 2017). Allan and Smylie (2015) note that: “the process of colonization has resulted in ongoing and entrenched racism against Indigenous peoples” (p. 2) and that “racism and colonization are inextricably intertwined” (p. 5). McLean (2013) references Kobayashi and Peake (2000), Coleman (2006), and Thobani (2007) in noting, “Numerous studies have revealed the ways in which white spaces are pervasive in Canadian institutions” (p. 355). The power of decision-makers who are predominantly White, and have been socialized to not talk about race or colonial realities, makes one wonder how Indigenous-specific racism can ever truly be addressed. Adams (1987) observes, “It is difficult to be sat on all day, every day, by some other creature, without forming an opinion on them. On the other hand, it is perfectly possible to sit all day, every day, on top of another creature and not have the slightest thought about them whatsoever” (n.p.). There is no divide between being a scholar and being a citizen of Canada. As Todd (2016) notes, “what happens within our classrooms and our

conference halls and within our journals is intimately linked to the things happening within the lands and territories we live and work in” (n.p.).

The White and non-White Settler population of Canada have unquestionably benefited from colonization at the expense of Indigenous Peoples and this advantage is demonstrated in research literature. Reading (2013) makes the point that identifying race in research can help to reveal unequal social constructions: “Research employing critical race theory has been used to reveal how the social construction of race influences the health and well-being of racialized groups by supporting the inequitable structuring of privilege for some groups and disadvantages for others” (p. 2).

All of this is a part of the missing context that many Settler people embody, do not understand and need to personally examine. As Thobani (2007) affirms,

Nation building was steeped as much in the epistemic ejection of Aboriginal peoples from the category human as it was in the dispossession of Aboriginal peoples from their land . . . While the colonial state instituted itself as the sole authority, colonizers and settlers enacted and realized authority on the ground. (p. 55)

This means that the examination of stereotype harm that is happening today cannot occur as an isolated area of study, and is a continuation of the enduring colonial agenda of control over Indigenous Peoples across Canada. This examination is about more than interrupting individual incidents; it is about changing views and understandings of identity and relationships, and addressing rights. As Tuck and Yang (2012) noted, “decolonization specifically requires the repatriation of Indigenous land and life” (p. 21).

Researchers have established that Canada has a serious Indigenous-specific racism problem in service delivery (Health Council of Canada, 2012; Reading, 2013; Allan & Smylie, 2015). The inequities remain unparalleled and unacceptable, just as they were when first exposed decades ago in the 1996 Royal Commission on Aboriginal People (RCAP). It is hoped that the data and information from this dissertation will make the problem so clear that the enforcement of safer services for Indigenous Peoples will be the only logical outcome.

1.2. Introduction to the Research Problem: Access to Health Care and Indigenous Peoples

Canada has a national and international reputation for having one of the best health care systems, consistently ranking within the top ten of the world (United Nations, 2009). Furthermore, many Canadians are proud of their access to good health care and see this as a cornerstone of what it means to be Canadian. One of the core beliefs many Canadians have about their country is that publicly funded health care is universally applied and accessible to all Canadians equally. Despite this reputation of health excellence and a national commitment to universally accessible health care service, the reality of the inequities experienced by Indigenous Peoples in Canada persists and remains significant and even growing in some locations (Adelson, 2005; Canadian Institute for Health Information, 2004; Frohlich, Ross & Richmond, 2006; Health Council of Canada, 2008; O’Neil, 1998). McGahan et al. (2017) observe that “the complexity of health care delivery and funding for population subgroups is an important field of study—even within Canada’s ‘universal’ health care system” (p. 1106).

■ Inequities between Indigenous Peoples and Settler Canadians.

It is broadly recognized that Indigenous Peoples are the very first inhabitants who thrived on their land, which is now known as Canada, from time immemorial and before contact with European colonizers and Settlers (Freeman, 2000; Wright, 2009; Dickason & Newbigging, 2019). McGibbon and Etowa (2009) describe colonial ideology in stating that “history tells us much about ourselves. One of the most successful ways to perpetuate racism is to ensure the erasure of historical facts and stories” (p. 32). They also note,

Much of our current understanding of racism can be traced to the era of colonialism, which began in the 1400’s. When Europeans began colonizing Africa and the Americas, the White settlers adopted the idea that they were superior to the other races they encountered. The false notion that Africans and indigenous peoples were inferior (in addition to the desire for economic power) justified the Europeans’ taking land and enslaving people. (p. 32)

Kortright, (2003) reports that colonization is based on the doctrine of cultural hierarchy and supremacy (n.p.). The insertion of the word “culture” at any given time in discussing inequity can avert the Settler gaze once again from being fundamentally racially based

in power and dominance. Daniels, (2018) notes that, “ the term “‘cultural’ hierarchy can be problematic in that it leaves the learner thinking that Settler hierarchy is ‘culturally based and subverts race/racism/racialization’. Population numbers can become part of the veneer that subverts race” (personal communication Nov, 2018). The point about cultural hierarchy can be used to explain away dominance as rational and based purely in population numbers, but dangerously misses the reality of systemic power and control. The idea of White dominance being about population ratios alone is attached to the myth of the “dead and dying Indian” which is linked to Darwinian idea of evolutionary theory of “survival of the fittest”. The hierarchy of White supremacy is at the root of the formation of this country and the control of Indigenous Peoples is rooted in the ideology that Indigenous Peoples were savages and “less than human” (Sartre, 1963). This idea exits the analysis systemic racism from inequity and Settler responsibility.

One can look to these roots to see the source of beliefs about Indigenous Peoples that inform stereotypes, attitudes, and actions today. It is well-established and documented that because of colonization, Indigenous Peoples can experience the poorest health and significant disparities compared to all Settler Canadians (Adelson, 2005; Health Council of Canada, 2012; MacMillan, MacMillan, Offord & Dingle, 1996). I argue that unexamined and socially normed stereotypes about Indigenous Peoples are dangerously harmful and in part contributing to inequities across all health measures today. This is why there has been a need for systems to examine Indigenous-specific racism and also to provide education on anti-Indigenous racism as strategies to address unique and pervasive inequities.

The topic of differential treatment of Indigenous Peoples has been studied in some depth and there are volumes of publications that have taken considerable time, funding, and effort confirming Indigenous inequities in health. Reports highlighting unacceptable rates of illness and distress have been made by authors with significant levels of influence, including the Royal Commission on Aboriginal Peoples (1996), the Transformative Change Accord First Nations Health Plan (British Columbia Ministry of Aboriginal Relations and Reconciliation, 2005), the First Nations Health Plan Memorandum of Understanding (Government of Canada, 2006), and more recently, the United Nations Declaration on the Rights of Indigenous Peoples (Government of Canada, 2010), The Canadian Truth and Reconciliation Commission Calls to Action

(2015), and a Declaration of Commitment by health regulatory bodies (First Nations Health Authority, 2017).

For over 20 years, the United Nations Human Development Index (UNHDI) (Cooke, Beavon, & McHardy, 2004), and the Community Wellbeing Index in British Columbia (Government of Canada, 2015) have tracked these inequities and demonstrated a gap that is not changing, showing how deeply rooted these inequities are and indicating that they should be a foundational consideration in the way Indigenous Peoples experience health systems and also individual service delivery today. As an example, the UNHDI, which measures socioeconomic indicators related to quality of life, report that “Canada was found to rank eighth but when the same criteria was applied to Indigenous people in Canada this ranking slipped to forty-eighth on the same scale” (United Nations, 2009, p. 108). More recently the Truth and Reconciliation Commission of Canada (TRC) (2015) published extensive findings and prepared a complete historical record on the racist operations and policies that created Indian residential schools. These extensive reports have produced thousands of pages and volumes of work that expose inequities and more recently the fact that Indigenous Peoples continue to face and now explicitly name systemic racism in Canada as a significant health inequity factor. This raises a serious question as to whether research, publication, and reporting can be effective in interrupting systemic racism without naming racism and recognition of the need for education and accountability measures.

The health care sector has been highlighted in some of these reports, and the Health Council of Canada (2012) points out that “one of the barriers to good health lies squarely in the lap of the health care system itself” (p. 4), indicating that “many Aboriginal people don’t feel safe from stereotyping and racism” (p. 4). Marmot, Friel, Bell, Houweling, and Taylor (2008) state that “understanding the role that stereotypes play in health inequities experienced by Indigenous Peoples needs to be examined”, and that is what this dissertation intends to do.

Racism as a determinant of health.

The reality that racism is occurring, in health (and other) service systems, indicates that it is a systemic problem that requires an examination of its impact on all elements, roles and relationships within the system. There are, however few reports that

focus upstream to isolate, examine, and measure the frequency and the impact of Settler service provider stereotypes about Indigenous Peoples on service delivery in health care systems. I use the metaphor of a circulatory system in describing how colonial beliefs and stereotypes about Indigenous Peoples flow in a cycle throughout systems to influence attitudes that can lead to discriminatory actions. With a critical anti-Indigenous racism lens one can see how beliefs about Indigenous inequities inform education (curriculum and pedagogy), which in turn defines objectives about learner needs and curriculum for training, which then inform the objectives for service planning and funding, and influence standard procedures to rationalize and normalize differential treatment which can reinforce inequities. This cycle begins anew when the inequities between Indigenous Peoples and Settler Canadians are seen in service delivery and not understood through the context of colonialism and Indigenous-specific racism. This dissertation explores why Settler Canadians have been, and can still be, blind to and even invested in the systemic nature of Indigenous-specific racism.

Roots of Indigenous-specific racism in Canadian soil.

Stories about a peaceful colonial history in Canada have been taught in our education systems and have inhibited critical Settler analysis. LaRocque (2010) uses the term “Civ/Sav” to describe the dichotomy, where, “in Canadian terms, civilization is repeatedly outlined against ‘Indian savagery’” (p. 41). This multigenerational consumption of colonial ideals has allowed paternalism to spread unchecked and to be socialized, taught, tested and normalized into Canadian ideology, generation after generation. The multigenerational consumption of stereotypical beliefs runs parallel to and creates multigenerational harm of colonization and is rarely identified and discussed. Indigenous Peoples, however, have always fought and spoken out against these beliefs, and recently critical Indigenous scholars have begun to teach about anti-Indigenous racism and the need to consider the gaps in Settlers’ knowledge, the importance of their self-awareness, and the ways in which a lack of self-awareness shows up in skill deficits (St. Denis, 2007, 2017; Anderson & Lavalley, 2007; Ward, 2016; Lavalley, 2017). Some academics are teaching from the perspective of critical race and anti-Indigenous racism to explain not only the inequities experienced by Indigenous Peoples but also the equally opposite benefits (privileges) to non-Indigenous

Settlers as part and parcel of the inequitable relationship equation (LaRocque, 2010; St. Denis, 2017).

The disadvantages experienced by Indigenous Peoples are directly related to the benefits experienced by non-Indigenous Settlers; one does not exist without the other. Settlers need to turn the gaze of research on themselves. As Sartre (1963) notes, “The settler that is in each of us is being savagely rooted out. Let us look at ourselves, if we can bear to, and see what is becoming of us” . . . and “face that unexpected revelation, the striptease of our humanism” (p. 24). Sartre asks us to see that “It [colonization] was nothing but an ideology of lies, a perfect justification for pillage; its honeyed words, its affectation of sensibility were only alibis for our aggressions” (p. 25).

In the transformation of connecting my own Settler self to colonial ideology and racism I have been deeply impacted by realizations that have struck me as both accurate and shocking in the obvious injustices that I had not seen. This says a lot about my existing biased presumptions and how I read and understood information that I was taught and how I see the world.

As a facilitator in the San'yas Indigenous Cultural Safety (ICS) online training program for nine years, I have read thousands of deeply disturbing examples of stereotyping and discrimination that were witnessed by health service providers while they were at work. Their first-person accounts validate literature indicating that stereotypes cause dangerous and even life-threatening harm to Indigenous Peoples while accessing health care (Allan & Smylie, 2015; Health Council of Canada, 2008; Lavallee, 2017; Ly & Crowshoe, 2016; O'Neil, 1998; McGibbon, 2012; Reading, 2013).

As part of the San'yas curriculum, participants are asked to describe experiences with stereotyping of Indigenous Peoples in their work. The following comments, posted on a discussion board, reflect this:

My thought was being if they [Indigenous Peoples] don't really care or they don't understand, why tell them more information to confuse them?
(19185)

Racist comments go on all day in my hospital—First Nations' families clogging the halls in the hospital—drunk first nations [*sic*], always in emergency—obese First Nations, higher risk for everything—First Nations getting “everything for free” and on and on and on. (17787)

The oral surgeon looked up from the four-year-old boy on the operating table, turned to me and said, "I'll just pull out the rest of his teeth too, that way he will match all his friends on the reserve too." (19185)

Service utilization.

Examining stereotypical views held by health service providers and their impact on Indigenous patients can provide a better understanding of what is going on in health services. A report by the Health Council of Canada (2012) hypothesizes that health inequities are recognized by Indigenous Peoples as related to feelings of discomfort, powerlessness, and fear when they are trying to access the health care system and that aversion is a natural response to harm to the point that "some avoid going for care, even when they are not well" (p. 9).

While emerging literature identifies a concern about the stereotyping of Indigenous Peoples and the impact on health inequities, not many studies to date have looked at how stereotypes influence the attitudes and beliefs of health care practitioners towards Indigenous Peoples and the treatment and even the harm that Indigenous people experience while accessing health care systems. *San'yas* program Elder Gerry Oleman (2014) has taught that "in order to say goodbye to a problem, we must first say hello." It is the intention of this dissertation to say "hello" to incidents of racism by examining the anecdotal comments posted by participants in the *San'yas* training program and, in doing so, to strategize and learn how to address and say "goodbye" to this deeply disturbing problem.

1.3. Saying Hello to the Problem

After examining hundreds of health care provider comments (n=950) for this dissertation, it has become clear that it is acceptable for some professional service providers to make blatant stereotypical comments about Indigenous Peoples in many public service areas including education, child welfare, justice, and health. For this study the scope was narrowed to examine comments posted regarding stereotypes about Indigenous Peoples as witnessed by professionals employed in health services (n=333).

This kind of critical race research marks a change in how Indigenous and Settler inequities have been understood and examined. Razack (2015) emphasizes how Settler beliefs about Indigenous Peoples have been used to rationalize violence from Settlers:

When inquests and inequities instruct us in the pathologies of Indigenous peoples, states provide themselves with alibis not only for inaction but also for crimes of overt violence. The idea of a disappearing race is also productive for settler subjectivities. Through it, settlers are able to feel Indigenous disappearance and to imagine their own superiority. Perpetually needing assistance into modernity from an enlightened and compassionate European race, Indigenous people are scripted in these moments as remnants, while settlers see themselves as pioneers” (p. 5).

Although many studies examine health inequities for Indigenous Peoples, the literature is just beginning to look at service provider stereotyping as a serious contributor. More recent studies have confirmed that the service encounter relationship can be a dangerous site for Indigenous Peoples where stereotyping contributes to inequities (Allan & Smylie, 2015). It is well known that there are social influences, referred to as the social determinants of health that impact access to health in profound ways before an Indigenous person arrives at the service site. “Indigenous Peoples are the only people in Canada who live within a legalized, politicized, and racialized landscape that predicates the social determinants of their health” (C. Ward, personal communication, August 13, 2013).

McGibbon, Etowa, and McPherson (2008) noted that “social determinants of health (SDH) refer to the social, economic, and political conditions that influence health and well-being” (p. 23). As important as it is to measure and examine the social determinants, the term has been seen to once again mask the harsher truth of racism. Lavallee, who was quoted by MacQueen in a MacLean’s article (2013), describes the study of social determinants as a potential superficial distraction that can prevent deeper examination of the roots of these social inequities. He refers to the study of the social determinants as a “bulls__t” term that masks uglier words such as racism, colonialism, classism, “all those -isms” (p. 2). Examining the source of the inequities must include an understanding of all those “isms” and also an examination of the unique colonial roots, including the systemic reinforcing of Indigenous-specific racism. In a paper published in Goodman et al., (2017) in *Social Science & Medicine* entitled “‘They Treat me Like Crap and I Know it was Because I Was Native’: The Health Care of Aboriginal Peoples living

in Vancouver's Inner City," we see the concern about systemic racism in the health care system:

Without understanding the social and historical contexts of the current health status of Aboriginal peoples, racialized stereotypes (e.g. "drunken Indian") prevail. Internalizing negative assumptions about Aboriginal peoples has allowed for systemic racism and discrimination to permeate many facets of society, including the health care system. (p. 88).

McGibbon (2012) adds that the impact of racism causes both physical and cognitive harm and states that "oppression is inscribed on the body and mind" and "if we are committed to tackling oppression related health outcomes, it is incumbent upon us to reframe the concept of vulnerable people, to 'people under threat'. . . and our task is to identify social pathogens that threaten health" (p.33). She asks, "What and who are creating these risks for 'at risk' people?" (p. 33). Stereotypes have been identified as potentially leading practitioners to think in a particular way that demonstrates prejudice (McGibbon et al., 2008, p. 25).

██████████ A backdrop of resistance and white fragility as a mask for violence.

Addressing Indigenous stereotyping and racism in service provision may not be easy because this is not just about service provision, but about who we are as Canadians. This problem of denying racial implications is socially reproduced even while our race, and what that represents in service delivery, is an integral part of our services and our lives even before we arrive for our day to day work. Our racial identity and the privileges that are granted or not granted accordingly are then confronted with normalized stereotypes in the cross-racial encounter. The stereotyping of Indigenous Peoples can trigger negative attitudes which can result in discrimination when providing services. Changing any socialized thought process is not easy and requires a unique pedagogy because of this aversion of Settlers looking at ourselves. Simply having a public discussion about Indigenous Peoples can be challenging; just have a look at any media blog when discussions about Indigenous Peoples are raised. In 2015, the General Manager and Editor in Chief of the Canadian Broadcasting Corporation (CBC) posted a blog entitled *Uncivil dialogue: Commenting and stories about indigenous people* and temporarily suspended the ability of readers to comment on "Indigenous related stories," noting that

while there are a number of subjects and groups of people who seem to bring out higher-than-average numbers of worrisome comments, we find ourselves with a unique situation when it comes to indigenous-related stories. We've noticed over many months that these stories draw a disproportionate number of comments that cross the line and violate our guidelines. Some of the violations are obvious, some not so obvious; some comments are clearly hateful and vitriolic, some are simply ignorant. And some appear to be hate disguised as ignorance (i.e., racist sentiments expressed in benign language). (McGuire, November 30, 2015)

Indeed, this may be an apt definition for normalized Indigenous-specific stereotypes as; “racist sentiments expressed in [what can be seen by some as] “benign” language. Over the years, many authors have examined the resistance to discourse regarding race and racism in Canada (Cannon & Sunseri, 2011; Carr & Lund, 2007; Dei & Kempf, 2006; Henry & Tator, 2010; LaRocque, 2010; Sensoy & DiAngelo, 2012; Razack, 2002, 2015; Razack, Smith, & Thobani 2010). Henry and Tator (2010) describe how evidence of racism is masked and resisted:

Canada suffers from historical amnesia. Its citizens and institutions function in a state of collective denial. Canadians have obliterated from their collective memory the racist laws, policies, and practices that have shaped their major social, cultural, political and economic institutions for three hundred years. Racist beliefs and practices, although widespread and persistent, are frequently invisible to everyone but those who suffer from them. White Canadians tend to dismiss evidence of their racial prejudice and their differential treatment of minorities. (p. 1)

This dissertation sheds some light on the role stereotypes play on who, what, and how Indigenous stereotyping is occurring in health systems.

1.4. Description of the Research Study

Research outline.

The thesis is organized into five chapters. Chapter One provides an introduction to the dissertation. Chapter Two provides a review of the literature related to the social psychology of stereotyping, discusses Indigenous-specific stereotyping and gaps in the literature, and examines the impact on health and health care access for Indigenous Peoples. Chapter Three, the methodology section, provides detailed information regarding the analytical process, the San'yas Indigenous Cultural Safety program as the site for the research study, the methods used to extract the data, and the steps used in

analysis. Chapter Four, the findings section, presents the results of the study including data samples in response to the research questions, with frequencies, percentages and emerging themes. Chapter Five, the implications section, discusses the research regarding accountability and educational interventions in respect to health systems. This final chapter also discusses the limitations of the study and recommendations for further research and suggests possible conclusions.

■ Research questions.

Data examined for this dissertation came from a review of responses to one task posted by health system service providers while completing the San'yas Indigenous Cultural Safety (ICS) Core Health online training program. A review of their responses to this task raised these four research questions:

- 1) What stereotypes of Indigenous Peoples are reported by health service providers?
- 2) Where are stereotypes towards Indigenous Peoples occurring within health care systems?
- 3) What attitudes towards Indigenous Peoples are reported by health service providers?
- 4) What types of harm towards Indigenous Peoples are reported by service providers working in health systems?

San'yas participant responses provided information about the frequency, type, attitudes, harms, and locations of Indigenous-specific stereotyping in health systems in British Columbia, Canada.

■ Research site: The San'yas program.

As noted, the site of the research study is the San'yas Indigenous Cultural Safety (ICS) training program. The name San'yas is a Kwak'wala term representing the goal for all service providers to be "knowledgeable." Created by the Provincial Health Services Authority (PHSA), the program sits under the Indigenous Health sector and was developed in response to the 2005 Provincial Transformative Change Accord: First Nations Health Plan (TCA) requirement to increase cultural competency within Health Authorities through Action Item 19: "First Nations and the Province will develop a

curriculum for cultural competency in 2007/08 for health authorities” (British Columbia Ministry of Aboriginal Relations and Reconciliation, p.15). The need for Indigenous cultural competency (ICC) training was developed in recognition that Indigenous Peoples are not always safe and can even face harm when accessing health care systems that have been created to support health equity for all Canadians (Allen & Smylie, 2015; Health Council of Canada, 2012).

In response to the TCA directive regarding Action Item 19, Leslie Varley (Nisga’a) was hired by PHSA, and the position of Indigenous Health Director was created. There were considerable challenges in the building of the San’yas training. Initially Varley had concerns with the federal Ministry of Health’s funding development envelope and intention to contract with curriculum experts from outside of Canada. In order to meet the goal of training 100,000 health care workers in British Columbia, it was determined that an online delivery method would be required. Varley knew about Cheryl Ward’s scholarship specialization and pedagogical expertise in the area of facilitating and writing online curriculum on the topic of decolonizing anti-Indigenous racism, and brought her to PHSA from work as an educator in child welfare to develop the online curriculum. Ward is a Namgis woman and she oversaw the design and creation for this program, which was guided by an advisory committee made up of Indigenous leaders, community members, researchers, and others who hold significant knowledge and experience in the area of Indigenous cultural safety (San’yas, 2018).

█ Learner supports.

Another point of importance to note here is that this training was created for non-Indigenous Settlers because they make up the vast majority of service providers. In the data extraction for this research, over 78% of the participants identified non-Indigenous ancestry. For Indigenous participants, it is recognized that learning about Canada’s colonial history and Indigenous-specific racism can be a very different experience, given the potentially personal, familial and relational context of Canada’s violent colonial policies and impacts. Because of this personal nature, which is present in any educational milieu regarding Canada’s history, supports have been built into the program for Indigenous participants. At the time that this research was conducted, Indigenous participants were contacted by phone once they identified as Indigenous on their profile page and introduced themselves as such on the first discussion board. This call was

provided to inform them that the program Elder and their facilitator were available to debrief the material throughout the training. Since that time an information letter with various contacts for support is sent upon registration. This training is facilitated and responses and integration questions are provided for each person throughout the learning process. The facilitation points are monitored by skilled facilitators who use a pedagogy acknowledging that the history of colonization can be new and to provide an opportunity for further dialogue. It is noted that many Indigenous Peoples know this history and its impacts intimately and this program will likely barely touch on what they know and live. There are also participants with Indigenous ancestry who may not know this history because of the interference of colonization and incomplete and inaccurate education in Canada. As well, due to these knowledge deficits, Settlers may be naturally processing some feelings of shock, shame or guilt at not knowing Canada's colonial history and that is why the curriculum and facilitation points have been designed strategically to scaffold information within a supported learning process.

Indigenous scholar St. Denis (2010) reminds us that the difficult nature of anti-Indigenous racism work requires tenacity and courage when she states that "in my work I constantly seek to move forward a racial analysis realizing that the difficulty of the task only makes my committed approach that much more necessary" (in Cannon & Sunseri, 2011, p. viii). It bears noting that although learning about Canada's colonial atrocities can naturally be emotional, discussing race and Indigenous-specific racism is not harmful or unsafe for White Settlers who have not learned about racial difference. As noted in the literature and in findings chapters ahead I would assert that learning about and discussing race is imperative in changing inequities between Indigenous and Settler peoples. DiAngelo (2011) refers to White European Settler aversion to discussing race as "White Fragility";

White people in North America live in a social environment that protects and insulates them from race-based stress. This insulated environment of racial protection builds white expectations for racial comfort while at the same time lowering the ability to tolerate racial stress, leading to what I refer to as White Fragility. White Fragility is a state in which even a minimum amount of racial stress becomes intolerable, triggering a range of defensive moves. These moves include the outward display of emotions such as anger, fear, and guilt, and behaviors such as argumentation, silence, and leaving the stress-inducing situation. These behaviors, in turn, function to reinstate white racial equilibrium (p.55).

In my own experience, this notion of the need for safety and comfort in learning environments has stunted critical analysis discussions and inhibited the advancement and understanding of critical inter-racial realities. Bart (2016) explained that “Oftentimes, in order to truly embrace diversity and inclusion, instructors need to push themselves and their students outside their comfort zones” (p. 2). Even though discussing race can be described as the most uncomfortable topic, Sue (2015) noted that

it has been shown that honest race talk is one of the most powerful means to dispel stereotypes and biases, to increase racial literacy, and critical consciousness about race issues, to decrease fear of differences, to broaden one’s horizons, to increase compassion and empathy, to increase appreciation of all colors and cultures, and to enhance a greater sense of belonging and connectedness. (p. x)

He also noted that there can be “disastrous consequences (anger, hostility, silence, complaints, misunderstandings, blockages in the learning process etc.)” (p. x) when discussions about race are not handled well by teachers and trainers.

Methodology of the research study.

The data for this study were drawn from a randomized selection of 25% of a one-year extraction sample of participant postings during the completion of the Core Health BC Indigenous Cultural Safety curriculum offered by the San’yas training. This process is outlined in detail in the methodology chapter. The data were gathered from two online archived sources:

1. Comments posted by participants who took the training from Monday April 1, 2013, to Monday March 31, 2014, in the San’yas Indigenous Cultural Safety (ICS) BC Core Health course archived on the San’yas online database were analyzed.
2. The demographic identifiers selected by participants, including health authority, position, gender, age range, education level, and ancestry (no personal identifiers were used).

Study design limitations.

The comments that were analyzed were submitted by people employed in health care systems in British Columbia in a one year period. Examples were provided from across a spectrum of health services. The stereotyping described did not always occur in the

specific location of service providers' current employment. The information is therefore limited to first-person descriptions of the nature, frequency, and harm of Indigenous-specific stereotyping as witnessed across a broad spectrum of sites in the health care system.

1.5. Definition of Terms Used

The topic of stereotyping of Indigenous Peoples is inextricably linked to the topic of race and racism. It has become abundantly clear in the literature review and the conduct of this research study that discrete terms such as *culture*, *ethnicity*, and *race* tend to be used interchangeably and can create confusion. The confusion of terms together with a social aversion to identifying and talking about racial difference has interfered with critical analysis and an examination of unquestionable differences in realities that are racially imposed. In *The Colour of Democracy: Racism in Canadian Society*, Henry and Tator (2010) noted that, "One of the first challenges that confront anyone analyzing racism is identifying an appropriate terminology" (p. xxvi).

■ Culture.

Reading (2013, 2014a, 2014b) authored a series of three articles for the National Collaborative Centre for Aboriginal Health (NCCA) on anti-Aboriginal racism in Canada. The first, titled "Understanding Racism", provides various definitions for related terms. She outlines that "Culture has been described as historically and geographically bound patterns of shared beliefs, values and behaviours" (Reading, 2013, p.2).

■ White culture.

In his book, *Race Talk and the Conspiracy of Silence: Understanding and Facilitating Difficult Dialogues on Race*, Sue (2015) references Barongan et al.'s (1997) definition of White culture as "the synthesis of ideas, values, and beliefs coalesced from descendants of White European ethnic groups" (p. 87):

While acknowledging the dangers of overgeneralizing, the European American worldview can be described as possessing some of the following values and beliefs, which often form the foundations of our programs, policies, practices, and structures of institutions: rugged individualism, English language, mastery and control over nature, a

unitary and static conception of time, religion based on Christianity, separation of science and religion, and competition (Katz, 1985; Ponterro et al., 2006). (Sue, 2015, p. 87)

Organizational culture.

The Ontario Human Rights commission has described organizational culture as

shared patterns of informal social behaviour, such as communication, decision-making and interpersonal relationships that are the evidence of deeply held and largely unconscious values, assumptions and behavioural norms. An organizational culture that is not inclusive can marginalize or exclude racialized persons (Ontario Human Rights Commission, 2005, n.p.).

The Commission also recognized that groups within institutional boundaries have cultures as well.

Ethnicity.

Reading (2013) reports that “Ethnicity refers to groups of people who possess shared cultural traits that they characterize as different from those of other groups” (p. 2). American anthropologist Smedley (1998) describes ethnic groups as having “always existed in the sense that clusters of people living in demarcated areas develop lifestyles and language features that distinguish them from others and they perceive themselves as being separate societies with distinct social histories” (p. 691). She adds,

One factor separates many in the contemporary world, at least some of our understandings of it, from earlier conceptions of human identity. That is that “ethnic” identity was not perceived as ineluctably set in stone. Individuals and groups of individuals often moved to new areas or changed their identities by acquiring membership in a different group (p. 691).

Race.

Historically “race” has been seen as having biological merit, yet contemporary scientists have concluded that there is no biological basis for what were called “human races” (Reading, 2013; Smedley, 1998). “Race” is now widely recognized as having socially constructed categories for identification based on physical characteristics and geographic place of origin (Reading, 2013). An important factor in a study about Indigenous stereotyping is reported by Smedley (1998), who states that “We need to

research and understand the consequences of race as the premier source of human identity” (p. 690). Smedley (1998) explains why categories of race were created noting,

Today scholars are beginning to realize that “race” is nothing more and nothing less than a social invention. “Race” emerged as a social classification that reflected this greatly expanded sense of human separateness and differences. As an ideology structuring social, economic, and political inequality, “race” contradicted developing trends in England and in Western European societies that promoted freedom, democracy, equality, and human rights. Europeans justified this attitude toward human differences by focusing on the physical features of the New World populations, magnifying and exaggerating their differences, and concluding that the Africans and Indians and their descendants were lesser forms of human beings, and that their inferiority was natural and/or God-given. “Race” developed in the minds of some Europeans as a way to rationalize the conquest and brutal treatment of Native American populations, and especially the retention and perpetuation of slavery for imported Africans. The creation of “race” and racial ideology imposed on the conquered and enslaved peoples an identity as the lowest status groups in society. (p. 694)

Even though race has been established as having no biological basis, erroneous essentializing beliefs about Indigenous Peoples in Canada are persistent and have profound social impacts that are present in measures across systems. Geneticists and modern-day scientists tell us that “There are far more genetic differences among people who make up arbitrary constructs we call races than there are differences between races” (Wills, 1997, p. 15). Reading (2014a) describes the violence and traumatic nature of ongoing socially sanctioned racism:

Racism must be understood as something that is lived; it is experienced by individuals, families, communities, and nations through interactions and structures of the everyday world. The truth is that the ideologies, social prejudices and words upon which race and racism are built do a great deal of damage. In fact, racism infects the lives of individuals and institutions—sometimes quietly, sometimes covertly, sometimes immediately, and sometimes over long periods of time, but always unjustly. (p. 1)

Even with racial difference being discounted as not scientific or valid, these inequality measures continue to be organized, differences understood, and realities segregated to a significant degree by race. Hence the need to ensure that critical race is a part of educational training across services where stereotypes interfere with safety.

■ Racialization.

Henry and Tator (2010) provided extensive coverage on the topic of racialized discourse, which can be explained as the language and way that race is applied and discussed. They assert that “human beings can be hierarchically classified according to their intellectual and physical abilities; that people can exclude, disrespect, and dominate those whom they consider inferior to themselves; and that institutional regulations and practices can restrict equal access to education, employment, and the other benefits of society. They also explain that “racialized discourse is expressed in many ways, but all serve to support patterns of domination, exclusion, and marginalization (Henry & Tator, 2010, p. 35). Importantly for this study, Henry and Tator (2010) also discuss the pervasiveness of racialization within systems:

Central to racialized discourse is Eurocentrism, or the belief in the dominance of everything European in origin. The belief in European superiority pervades western society and exerts a strong influence on the behaviour of the people who work in institutions and organizations, and also on everyday behaviour of the citizenry. (p. 35)

Of significance in this study is the reality that White peoples are racialized, even though they can be seen as not having a race or be seen as ‘the norm’ or basis for comparison to people of colour. This means White peoples are also a socially constructed race and therefore racialized with factors that impact White people’s lives, life chances and is stratified against people of colour according to race.

■ Racism.

Reading (2013) makes the point that “In order to address racism in Canadian society, we must first understand what racism is, how it became a way to identify people, and the form it takes” (p. 1). Reading (2013) references Dictionary.com in defining racism as a general term used to describe

1. a belief or doctrine that inherent differences among the various human racial groups determine cultural or individual achievement, usually involving the idea that one’s own race is superior and has the right to dominate others or that a particular racial group is inferior to the others.
2. a policy, system of government, etc., based upon or fostering such a doctrine; discrimination.

3. hatred or intolerance of another race or other races. (p.1)

■ Institutional racism and intent.

This dissertation examines the stereotyping of Indigenous Peoples at the institutional level, and the way that racism can be embedded in systems through education, training and passed on by decision-makers at all levels.

At the institutional level, racism by consequence tends typically not to be recognized by “white” Americans, and may not necessarily be triggered by intent. Racism by consequence then is reflected in differential educational opportunities, economic differentials between whites and non-whites, residential segregation, health care access, and death rate differentials between whites and non-whites. (Guess, 2006, p. 652)

■ Anti-Indigenous racism and Indigenous-specific racism.

Although these terms have been used interchangeably in the literature, Lavallee (2018) differentiates: *Indigenous-specific racism* from *anti-Indigenous racism* as: “two different things that need to be studied to address institutional and systemic racism. The first is racism aimed at Indigenous Peoples and the latter, interventions aimed to omit or reduce the impact of Indigenous-specific racism. (Oct, 2018 personal communication).

■ Colonization.

The construction of race began with European colonization of other continents (Reading, 2013). Colonization is defined, and the function described in Oxford *Dictionaries* (n.d.) as “the action or process of settling among and establishing control over the indigenous people of an area” (n.p.). There are two racial groups involved in the colonization of Canada: White Europeans who believed themselves to be superior and the Indigenous Peoples who were believed by the White Europeans to be inferior (Ontario Human Rights Commission, 2005; Reading, 2013; Truth and Reconciliation Commission of Canada, 2015). The term *colonization* is not well understood in Canada due to our incomplete and inaccurate public education and warrants more than a simple definition here. This omission is one that the Truth and Reconciliation Commission of Canada has recommended be rectified. Métis scholar Dr. LaRocque (2006) states,

Colonization can be defined as some form of invasion, dispossession and subjugation of a peoples. The invasion need not be military; it can begin—or continue—as geographical intrusion in the form of agricultural, urban or industrial encroachments. The result of such incursion is the dispossession of vast amounts of lands from the original inhabitants. This is often legalized after the fact. Historically, First Nation peoples (defined as Status Indians by the Indian Act) lost some 98% of their original lands through various legal means such as treaties and the Indian Act. Métis Nation peoples lost some 83% of their Red River lots through the Scrip program. The long-term result of such massive dispossession is institutionalized inequality. The colonizer/colonized relationship is by nature an unequal one that benefits the colonizer at the expense of the colonized. (n.p.)

White.

Henry and Tator (2010) reference Razack (1998) and argue that the language of colour delineates the politics of domination and subordination and that “White is the colour of domination” (p. 11). Henry and Tator and Razack capitalize the term *White* to emphasize the fact that the descendants of the White European colonizers in Canada are also a racial group. Whiteness is a social construct of oppression. DiAngelo (2011), uses “ the terms white and Whiteness to describe a social process” p.56). Frankenberg (1993) defines Whiteness as multidimensional:

First, Whiteness is a location of structural advantage, of race privilege. Second, it is a “standpoint,” a place from which White people look at ourselves, at others, and at society. Third, “Whiteness” refers to a set of cultural practices that are usually unmarked and unnamed. (p. 1)

White privilege.

The Ontario Human Rights Commission (2005), in their *Policy and Guidelines on Racism and Racial Discrimination*, make the point that “in discussing racism, it is necessary to consider the unearned privileges i.e. benefits, advantages, access and/or opportunities that exist for members of the dominant group in society or in any given context. This notion is often termed ‘White Privilege’” (p. 14). See McIntosh (1989) below under the heading Critical Race Studies.

Indigenous Peoples.

This term is used in the study to refer to all groups of status or non-status peoples who are Indigenous to what is now Canada including Aboriginal, First Nations, Inuit, Métis and “Indians.” Critical race scholar Sherene Razack, in her book *Race, Space, and the Law: Unmapping a White Settler Society* (2002), explains, “I use the term ‘Indigenous’ peoples as it is the international term most commonly selected by Indigenous peoples to describe themselves” (p. 259). The plurality of the term indicates that there are many groups that have their own unique identifiers, origin stories, and histories and all have relationships with colonizers and have been impacted by colonization. The ethnic diversity of Indigenous nations is greater than that of Europe and Indigenous Peoples hold “legitimate political authority as nations entitled to treatment as such” (Henry & Tator, 2010, p. 97). I capitalize Indigenous Peoples, to counter dehumanizing ideologies and to emphasize that they are indeed human.

Aboriginal people.

The term *Aboriginal people* has been used by other scholars and is sometimes used interchangeably in literature regarding Indigenous Peoples.

Settler.

I use the term *Settler* to signify the relationship that all non-Indigenous Peoples have with Indigenous Peoples and the land in what is now called Canada, regardless of the extremely diverse circumstances of their arrival. I do this to acknowledge that Canada, as a nation, is dependent on the land taken from Indigenous Peoples, as are Settlers living in Canada. Battell Lowman and Barker (2015) make the point that

Canada as a land is dependent on the land taken from indigenous nations, land that those nations still contest, and colonialism is about the need to secure those lands at all costs. This positions Canada and Canadians directly at odds with Indigenous peoples, who have not just prior, but competing claims to the land. And despite what most Canadians would like to think, those claims are valid. (p. 3)

This term signifies the necessity for Settler Canadians, regardless of ancestry, to not only confront, but also to stop the racial stereotypes and injustices that Indigenous Peoples, scholars, and leaders have been speaking to and resisting for far too long.

Prejudice, stereotype, and discrimination.

This section orients the reader to the ways in which “language” can lead to discriminatory treatment and harm to Indigenous Peoples.

Prejudice.

Dovidio, Hewstone, Glick, and Esses (2013) reference Allport’s (1954) definition of prejudice as “an antipathy based on faulty and inflexible generalization” (p. 5). This means that “being prejudiced” is not simply about holding judgments that are predetermined, but about having judgments that can also accompany a negative attitude, which can then influence discriminatory service provider decision-making, system planning, and actions. Having a prejudiced attitude influences and organizes not only the thoughts of the individual but also, from a sociologist’s view, large-scale social and structural dynamics of intergroup relationships (Dovidio et al., 2013, p. 6). Dovidio references Bobo (1999) and makes the point that “sociological theories consider the dynamics of group relations in economic-and class-based terms—often to the exclusion of individual influences” (p. 6). Group competition is described “as central to the maintenance of social biases” and “race prejudice as a protective device. . . to preserve the position of the dominant group” (p. 6). In practice, certain beliefs and values are explicitly and implicitly taught. There are beliefs and attitudes that result from the strategic curriculum that is taught and tested by the dominant group and also from inferences in the absence of what is seen as right or worthy of study by the dominant group.

Bias.

Dovidio and Fiske (2012) describe biases as “a complex but systematic differing by racial/ethnic group and not limited to love/hate polarities. Such ambivalent and automatic biases can influence medical decisions and interactions, systematically producing discrimination in health care and ultimately in health” (e1). Thiederman (2018), a workplace diversity trainer in the United States, defines bias as an “inflexible positive or negative, conscious or unconscious belief about a particular category of people.” She also explains the term and how it functions:

I use the term “bias” to encompass what most people think of as “stereotypes” and “prejudices” as well as that long list of “isms” that plague our workplaces on a daily basis. From sexism to racism to ageism and lookism, bias is a problem we all share. The tricky thing about biases is that they can be about good or bad qualities. It is as biased to assume, “All Asians are good at math” as it is to believe “All men are sexist.” Whether a good generality or bad, biases are characterized by an inflexibility that leaves the target of the bias inaccurately perceived and, in most cases, badly misunderstood. (FAQ blog tab)

An added risk to service-provider decision making can be the lack of conscious and or critical recognition of biases. Although implicit bias is another term and topic that is being examined in the quest to understand inequities in treatment. There is a questions as to whether biases are unconscious or consciously normalized and accepted. The harm of implicit biases on service provider decision-making has been studied and found to contribute to health care disparities, (Dovidio & Fiske, 2012; Stone & Moskowitz, 2011). Stone and Moskowitz (2011) discuss the unconscious or implicit bias and how this can be triggered without recognition:

Research in social psychology shows that over time stereotypes and prejudices become invisible to those who rely on them. Automatic categorization of an individual as a member of a social group can unconsciously trigger the thoughts (stereotypes) and feelings (prejudices) associated with that group, even if these reactions are explicitly denied and rejected. (p. 768)

This process of stereotypical and biased thought, if not interrupted, can become a part of a trajectory or pathway of harm and negatively impact both a system and individual service provision, resulting in harmful discriminatory treatment. McGibbon et al. (2008) describe this as a “cycle of oppression” where biased information leads to stereotyping and a prejudiced way of thinking. Daniels (2018) noted that “implicit biases may not be so much unconscious as they are more unquestioned” (Personal communication, May 2016). The unquestioned nature of Indigenous-specific racism means that bias can be reinforced with impunity and embedded in power relations where discrimination (in action or inaction) is condoned implicitly or explicitly resulting in oppression that is backed up by systemic power relations (McGibbon, 2012, p. 27).

Confirmation bias.

This term has merit in the definition section because of the unconscious manner in which biases and stereotypes can work together and be preferentially reasserted. Confirmation bias can become a part of teaching and embed stereotypes into services. For example, a nurse may see twenty individual Indigenous people in the emergency room over a shift, and three have health issues related to being intoxicated. The three examples can serve to confirm her bias that Indigenous Peoples are prone to alcoholism, even when the odds say otherwise. If the 20 people were White and 10 were intoxicated, this elevated percentage would not confirm a bias, because there is no stereotype that all White people are prone to alcoholism, and each person would be seen as an individual. Psychologist Shahram Heshmat (2015) notes,

Confirmation bias occurs from the direct influence of desire on beliefs. When people would like a certain idea/concept to be true, they end up believing it to be true. They are motivated by wishful thinking. This error leads the individual to stop gathering information when the evidence gathered so far confirms the views (prejudices) one would like to be true.

Once we have formed a view, we embrace information that confirms that view while ignoring, or rejecting, information that casts doubt on it. Confirmation bias suggests that we don't perceive circumstances objectively. We pick out those bits of data that make us feel good because they confirm our prejudices. Thus, we may become prisoners of our assumptions. (n.p.)

Sapolsky (2017) also describes this cognitive process:

The confirmation biases used to rationalize and justify automatic Them-ing are numerous—remembering supportive better than opposing evidence; testing things in ways that can support but not negate your hypothesis; skeptically probing outcomes you don't like more than ones you do. (pp. 403–404)

He goes on to summarize the explanation of “function” by quoting Crandall et al. (2011): “Our cognitions run to catch up with our affective selves, searching for the minute factoid or plausible fabrication that explains why we hate Them [*sic*]” (p. 404).

Stereotyping and impact.

It has been well-established that stereotyping can cause harm in decision-making (Banaji & Greenwald, 2013; Dovidio, Hewstone, Glick & Esses, 2013; Jackson, 2011;

Allport, 1979). Banaji and Greenwald (2013) describe how “economists, sociologists, and psychologists have confirmed time and again that the social group to which a person belongs can be isolated as a definitive cause of treatment he or she receives” (p. 17).

There is a well-known case in point in which an Indigenous man, Brian Sinclair, died in an emergency waiting room after being ignored for 34 hours while awaiting services for a treatable bladder infection. In response to a deep concern for the racism Brian Sinclair’s death exemplified, a working group of Indigenous educators and allies established an interdisciplinary collaborative for researching, analyzing, and addressing systemic discrimination in the health care system (Browne, Hill, Lavallee, Lavoie, & McCallum, 2017). The health centre where Mr. Sinclair was waiting is one of the most comprehensive facilities in Manitoba and northwestern Ontario and in the time that he was at the centre, 150 other patients came through the emergency department. All were treated or voluntarily left without being seen (Browne et al., 2017).

MacQueen (2013) explains, “Brian Sinclair died a lonely and unnecessary death, but many thousands die with him—casualties of class or race or circumstance” (n.p.). The report of the working group, *Out of Sight*, is visited again in the final chapter regarding recommendations, with the intent to honour Mr. Sinclair’s legacy and to prevent a similar tragedy. Dovidio et al. (2013) also deconstructed racism and described how harm can occur in predictable sequential pathways when stereotypes are not recognized. The thought or prejudgement that is typically conceptualized as an attitude that has an affective component (prejudice; e.g., dislike) also has a cognitive component (stereotype; e.g., beliefs about the target), and results in negative behaviour toward the target group (discrimination; e.g., negative behaviour like avoidance or less treatment) (p. 5).

Stereotyping is a cognitive process or short cut where established pattern or beliefs are applied to every member of a certain group. Burgess (2003) describes a stereotypical belief as being “based on an image (often wrong) about what people in that group are like” (p. 1). This belief can become a default image that blinds the perceiver to other information that would discount the stereotype. McGibbon et al. (2008) describe stereotyping as “an often negative exaggerated belief, fixed image, or distorted idea held

by persons, groups, political/economic decision makers—is embedded in, and reinforced by, oppressive power relations” (p. 27).

Discrimination.

Browne (2007) notes, “The consequences [of discrimination] in terms of clinical practice are not insignificant. Patterns of social distancing, shaped by processes of othering, limit possibilities for therapeutic engagement particularly in relation to patients’ psychosocial, emotional or material needs” (p. 2175). According to Dovidio et al. (2013), “discrimination refers to unfair treatment of individuals due to group membership” and “may involve actively negative behaviour toward a member of a group or more subtly, in less positive responses” (p. 8). Dovidio et al. (2013) also quote Allport (1954), who describes discrimination as “denying individuals or groups of people equality of treatment” (p. 51) and quote Jones (1972), who explains discrimination as “those actions designed to maintain own-group characteristics and favored position at the expense of the comparison group’ (p. 4)” (Dovidio et al., 2013, p.9).

Throughout the history of psychology and sociology, researchers have examined the linked process of prejudice, stereotyping, and discrimination (Allport, 1979; Brewer & Brown, 1998; Dovidio, 2002; Duckitt, 1992; Fiske, 1998) as well as the phenomenon of intergroup bias more generally (Hewstone, Rubin, & Willis, 2002). *The Sage Handbook of Prejudice, Stereotyping and Discrimination*, edited by Dovidio et al. (2013), provide a comprehensive overview and is described as a seminal resource for scholars and students in the topic of anti-racism. The opening chapter portrays a broad and lengthy history of study in this area, which was initially focused in anthropology and sociology. The study of stereotyping is now emerging in allied disciplines as many institutions see the necessity of understanding the factors in a potential pathway that can lead to service discrimination and human rights violations. In examining the topic of stereotype harm, terms and processes can be confusing. Although there is an agreed upon sequence from internal processes that can lead to discriminatory treatment, various authors describe different sequences in the cognitive path before discrimination occurs. Phelan and Rudman (2011) explain that there are various theories that inform this cognitive process: “Cognitive theorists argue that stereotypes come first, and the attitude follows and motivational theorists argue that prejudice comes first. In both cases, prejudice and/or stereotypes are thought to precede discrimination” (n.p.).

Prejudice and stereotyping are biases described by Vescio and Weaver (2013) as working together to create and maintain social inequality. Dovidio et al. (2013) describe bias as “the systematic tendency to evaluate one’s own membership group (the in group) or its members more favorably than a non-membership group (the out group) or its members” (p. 3) and describe the interconnection of three forms of social bias that impact thought, attitudes, and behaviours (p. 5):

- (a) prejudice, an attitude reflecting an overall evaluation of a group;
- (b) stereotypes, associations, and attributions of specific characteristics to a group; and
- (c) discrimination, biased behaviour toward, and treatment of, a group or its members.

These three social psychology terms for attitudes (prejudice), beliefs (stereotypes), and actions (discrimination) are linked and help to explain how people see individuals solely through their membership to a particular group.

Following this cognitive trajectory to discriminatory behaviour, we can see how members of a group, when prejudged as different and then racially stereotyped, can then be essentialized with limitations that can cut off or delay access to life-saving standard procedures and the identification of individual needs in service provision. Jackson (2011) makes the case that “prejudice rationalizes inequality” (p. 16) and that “stereotypes are formed by peoples’ need to explain and rationalize why some groups have lower status than others” (p. 17). What this means is that when standard services for health care have been designed and provided by the dominant White group, any other racial group will be at risk for stereotyping that can allow for, or even prescribe, a deviation from a standard service procedure, i.e. racial discrimination. This study focusses on Indigenous-specific stereotypes and racism because of the unique origins and impact on enforcing unparalleled inequities. For example, the predominant stereotype that Indigenous Peoples are alcoholic or drug seekers can influence the service provider, who therefore rationalizes that the usual dosage for appropriate pain medication should not be prescribed. The trajectory from prejudice to stereotype to discrimination is a potential pathway to service harm and interrupts access to health and wellness for the Indigenous person. It is also where power, combined with colonial

narratives and racial discriminatory action, becomes Indigenous-specific racism (see definition above from Reading, 2013).

After examining this topic over many years, Ward and the San'yas Indigenous Cultural Safety (ICS) team identified and developed a model to explain the trajectory from prejudice to discriminatory practice (Ward, 2016). This model traces a pathway from attitudes (prejudice) and beliefs (stereotypes) to actions (discrimination). While this pathway could be directed towards any marginalized group, such as those who are racialized, disabled, LGBT, female, etc. (Dovidio et al., 2013), there is a different and unique origin of “othering” for Indigenous Peoples. Ward (2016) explains that this pathway is initiated in Canada’s colonial ideology in which unique stereotypes and unexamined colonial beliefs can result in service provider discrimination for Indigenous Peoples. Findings support that “othering” in nursing is a sequential process with a trajectory aimed at marginalization and exclusion, which in turn has a negative impact on patient care and professional relationships (Roberts & Schiavenato, 2016). The colonial ideology is seen as a necessary belief in the othering of Indigenous Peoples and as a requisite for the colonization of Canada. Henry and Tator (2010) define ideology as “a set of beliefs, perceptions, assumptions and values that provide members of a group with an understanding and explanation of their world” (p. 3).

A racist ideology is required in order to continue to occupy Indigenous land without addressing Indigenous inequities and rights. This colonial racial ideology of othering Indigenous Peoples has long been the source of inequities and warranted tensions for Indigenous-White relations in Canada today. Henry and Tator (2010) examine “the relationship from the perspectives of differential values, assumptions and beliefs and show how the racist ideology of the dominant society continues to have a negative impact on Indigenous peoples” (p. 97).

The systematic legal power that systems have over Indigenous Peoples requires significant consideration in this analysis of stereotype harm. Manuel and Derrickson (2017) refer to that measure of control as “the Canadian state claiming 100% control over Aboriginal and treaty lands and Indigenous people” (p.63). The Indian Act still defines who does and does not have legal status and rights as an Aboriginal person. Canada has always used colonial force in the taking of land and rights, which is fundamentally about strategically taking rights and power from Indigenous Peoples to

maintain control over people and the land (Razack, 2002; Alfred, 1999). Section 35 of the Indian Act which legally recognizes and affirms Indigenous rights, is enshrined in the Canadian constitution and the Canadian government has the power to either act, or not act, in support of those rights.

Dovidio et al. (2013) describes the field of prejudice and stereotyping as an area of study that has expanded and is “doubling or tripling from each decade to the next” (p. 4). As this field of study expands, academics and researchers are considering how both social structures of stratification including conscious and unconscious thought processes combine to contribute to biases that separate “other” groups of people into hierarchies of oppression. Loppie, Reading, and de Leeuw (2014) reference de Leeuw, Kobayashi, and Cameron (2011) to discuss the origins of the social structuring of Indigenous and Settler populations, stating that “Within racialized hierarchies in Canadian society, Aboriginal peoples continue to be ‘othered’ by settler groups in an attempt to rationalize colonial actions that disadvantage, oppress, and ultimately harm them” (p. 2). The bias that says that Indigenous Peoples are less than Settlers has been an accepted discourse throughout the entire history of Canada and has been embedded in social consciousness. The study of prejudice and stereotypes about Indigenous Peoples considers how social structures create and justify the biases that permeate social institutions, such as the legal and health care systems (Loppie, Reading, & de Leeuw, 2014; Razack, 2002, 2015).

Indigenous cultural safety.

The concept of cultural safety came from the colonial context of New Zealand. Papps and Ramsden (1996) refer to the Nursing Council of New Zealand’s (1992) standards for registration of nurses and defined cultural safety as “the effective nursing of a person from another culture by a nurse who has undertaken a process of reflection on own cultural identity and recognises the impact of the nurses’ culture on own nursing practice” (p. 491). In an Indigenous-specific service context, this means that a service provider would recognize that their cultural identity will interface with and impact Indigenous Peoples who are accessing their services. This is a long-term lifelong learning process of development that requires that service providers continually assess and attend to their knowledge, self-awareness (including their racial identity), and skill

level to ensure that they provide safe services for Indigenous Peoples. It is Indigenous Peoples who will determine whether services are culturally safe.

Health inequality vs. inequity.

Health inequalities can be misunderstood and are defined as differences in health status or in the distribution of health determinants between different population groups, for example, differences in mobility between elderly people and younger populations or differences in mortality rates between people from different social classes. It is important to distinguish between 'inequality' and 'inequity' in health. Some health inequalities are attributable to biological variations [between men and women for example] or free choice and others are attributable to the external environment and conditions mainly outside the control of the individuals concerned. Martell from the First Nations Child and Family Caring Society of Canada describes this difference: "To be fair is to make sure that opportunities are appropriate for, and relevant to, the unique needs and circumstances of individuals and groups. Equity is about making sure that everyone has the right to access goods, services or accommodations that are generally available to the public in ways that meet their needs" (2013, Information sheet). The point being made here is that, using terms to understand practices can be one sided and ineffective. Lavallee (2018) explains that when terms and contexts are not fully understood within this work they are seriously problematic:

"Cultural safety" and "needs of Indigenous peoples" [are terms that] serve to not hold White people and their systems to account for Indigenous specific racism, the needs of Indigenous Peoples that are the same and more than all other humans, full stop. And any "more needed" refers to the historical and continuing inequities like poverty and oppression . . . the normalized, sterilized and de-racialized "scientific area" of social determinants of health. Language and understanding that racializes the Social Determinant of Health is required that uncovers the unique impact of Indigenous specific racism. (Personal communication, October 2018).

1.6. Summary

This chapter has delineated the research problems of Indigenous-specific racism (and stereotyping) in health systems, the topic of White racial identity development, the topic of Settler identity development, and the fact that these topics have been missing as a foundational part of understanding the relationship between Indigenous and Settler

(non-Indigenous) inequities. It is hoped that these data will provide education about how Settlers are positioned in oppression and why stereotyping specific to Indigenous Peoples occurs. The next chapter explores the literature more closely regarding where stereotypes about Indigenous Peoples in Canada come from and how stereotypes affect service providers, service delivery, health systems. It will also examine the topic of the impact of Indigenous stereotyping harm on access to health in some depth.

Chapter 2. Literature Review

2.1. General Orientation

In this assessment of the literature regarding Indigenous stereotype harm and how this defines and impacts identities of Indigenous Peoples, I reference Morgensen (2014) in noting that it is important to make the point that there are “linked anti-colonial and anti-racist projects that precede, exceed, and contextualize any contributions that I may make as a White settler” (n.p.). I am writing as someone who benefits from racism every day and any knowledge that I have has been learned from antiracism educators of various racial backgrounds, initially and mostly from working with and for Indigenous Peoples and organizations. I source much of my learning about Indigenous-specific racism from relationships with Indigenous educators and know I will always be learning about who I am as a White Settler in relation to Indigenous Peoples and at their expense. Given that the focus of this research is on the stereotyping of Indigenous Peoples, I have necessarily examined how Indigenous Peoples have been represented in literature and in antiracism discourse generally.

Racism in health care has been identified as a significant threat to the health and wellbeing of Indigenous Peoples in Canada (Health Canada Council, 2012; Loppie, Reading, & de Leeuw, 2014; McGibbon & Etowa, 2009; Allan & Smylie, 2015; Tang & Browne, 2008). According to the Health Council of Canada, “Aboriginal people have described feelings of discomfort, powerlessness, and fear when trying to access the health care system . . . they have had experiences like being treated with contempt, judged, ignored, stereotyped, racialized, and minimized” (2012, p. 2). Tang and Browne (2008) explain that “the ideological process of racialization can shape the ways health care providers ‘read’ and interact with Aboriginal patients, and how some Aboriginal patients avoid seeking health care based on their expectation of being treated differently” (p. 109). They urge “those of us in positions of influence in health care, including doctors and nurses to critically reflect upon our positionality and how we might be complicit in perpetuating social inequities by avoiding a critical discussion of racialization” (p. 109). Although the impacts of racism against other non-White, non-Indigenous groups have been researched and are also worthy of examination in addressing service harms because of their destructive nature, this dissertation focuses

on Indigenous-specific racism because of unparalleled gaps in all measures. In this chapter, I provide a review of literature related to the study of Indigenous-specific racism paying particular attention to service provider stereotyping of Indigenous Peoples, the ways in which they affect the attitudes, beliefs, and actions of non-Indigenous service providers and result in gaps in service provision and harms to Indigenous Peoples.

2.2. Canada's failing grade in colonial education: Addressing biased curriculum.

Education is seen as a key antidote to stereotype harm, with the requisite curricula and pedagogy as the linchpins in effectively treating Indigenous-specific systemic racism. The data and literature demonstrate how stereotypes are maintained in institutions through biased education, which fuels practice, which creates inequities.

The literature shows that Indigenous Peoples have worked tirelessly to examine, expose, educate and transform persistent socially and systemically embedded racial inequities. One topic area in current public and postsecondary education appears to have been missed or too lightly touched upon to be effective: Indigenous-specific racism. Canada's education system is rooted in Settler colonial ideologies and negative narratives about Indigenous Peoples, and as a result, educators are at risk of seeing the world through socially and systemically enforced racist colonial ideologies about Indigenous Peoples. White Settler bias is learned from kindergarten on when a glorified explorer version of our colonial history is taught and tested in public school. If educators are unaware of the influence of the colonial ideologies that they have consumed, their research, curriculum, and pedagogy can be unintentionally dangerous and contribute to and reinforce racial inequities between Settler Canadians and Indigenous Peoples. Consequently, many education initiatives such as diversity, sensitivity, and multi-culturalism have been undertaken but have proven to be inefficient and ineffective and have failed to teach about racial and power relationships and the dynamics of colonial ideology, colonial history, and its influence in present-day systems.

█ Culturally responsive approaches.

Many Settler participants came to the San'yas training with a desire to learn about Indigenous culture, specifically about smudging, birthing or end of life practices, or

traditional ceremonies. The term “cultural” in the name of Indigenous cultural safety (ICS) training can be misunderstood and participants can assume that they will learn about Indigenous cultural practices when what is needed is learning about the impact of dominant Western European culture on Settlers beliefs, attitudes and actions as well as the devastating impact on Indigenous Peoples and communities.

Educators and service providers also speak to the need for “cultural training,” suggesting that learning about culture will address service access harm. What they fail to take into account is the incidence of stereotyping and racism which is frequent and has a marked impact on the quality of service delivered. Learning about Indigenous culture does not address Indigenous-specific racism on its own. Culturally responsive approaches provide basic educational frameworks focusing on culture miss the imperatives of power and are ineffective in addressing racism and racial inequities. These approaches can even contribute to “othering,” and the cultural essentializing that leads to stereotyping. Anderson et al (2010) have described a culturalist or culturally responsive approach as lacking in criticality and a failure in knowledge transfer related to understanding how power and privilege manifest in practice. Crandall, Bahns, Warner, & Schaller (2011) also see this approach as problematic in not challenging Settler learners to think self-reflectively outside of their usual comfort zone about who they are, what (unresolved history) they represent, and what lived imbalances they bring with them to work and beyond each day. The literature has also shown that this approach can create stereotypes that are then used to justify short cuts in treatment and preserve a professional self-image.

2.3. Impact of Stereotypical Beliefs on Service Provider Decision Making

“It’s so challenging to work with people who don’t care about their health and don’t want to manage their condition” (Medical preceptor quoted in Ly & Crowshoe, 2015, p. 616).

There is no shortage of text books, reports, and research publications on the topic of stereotyping, the impact on service provider treatment and ultimately contributing to health inequities. A need to determine the contributing factors to these inequities prompted the U.S. Congress to initiate an extensive Institute of Medicine (IOM) study to examine differences in the quality of health care. The report that followed the study is

titled *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare* and provides evidence of consistent health care disparities across a range of health care services and indicates that “ethnic and racial disparities remained even after adjustments for socio-economic differences and access related factors” (p. 5). Smedley, Stith, and Nelson (2003) are the editors of the lengthy IOM report and find that “inevitably, physicians’ subjective understanding of their patients’ needs plays a role; thus, psychological sensitivity, cultural and language competency, and conscious and unconscious stereotypes and biases may also influence therapeutic decision making” (p. 130).

These stereotypes contribute to conditions of decision making which can lead to short cuts and result in conscious and unconscious reliance on stereotypes to determine what treatment is necessary. Balsa and McGuire (2001) as cited in Smedley et al. (2003), outline three mechanisms that produce discriminatory patterns of healthcare: “1) bias (or prejudice) against minorities; 2) greater clinical uncertainty when interacting with minority patients; and 3) beliefs (or stereotypes) held by the provider about the behaviour of minorities” (p. 161). Other researchers have found that time pressure in service delivery can trigger stereotypes and have an impact on attitudes (prejudice), resulting in discriminatory behaviour and contributing to a lower quality of health care treatment. Smedley et al. (2003), note that “under conditions of time pressure, problem complexity, and high cognitive demand, physicians’ attitudes may therefore shape their interpretation of this information and their expectations for treatment, such as the likelihood for patient compliance” (p. 161). Van Ryn and Burke (2000) and van Ryn (2002) (as cited in Smedley et al., 2003) express concern about the common nature of time and resource restraints that can trigger shortcuts which lead “to lack of information, to stereotypes, and to prejudice” (p. 162).

In the literature, terminology regarding stereotype harm in general is incomplete and requires an added layer of analysis to include the unique roots of stereotypes pertaining to Indigenous Peoples. When one considers the ratios of different races among service providers in health care and all other systems, one can see the “in and out group” racial representation referred to by Dovidio et al. (2013, p. 9). Rasmussen and Garran (2016) note that “the majority of the hospital staff are [*sic*] white and furthermore the ranks of manager and senior executives are almost exclusively white” (p. 174). In the status quo of professions related to health care, Indigenous Peoples are

overwhelming outnumbered by non-Indigenous, mostly White Settler populations represented in places of power, decision-making, and service delivery (Browne et al., 2016; Henry & Tator, 2010; Martin-McDonald & McCarthy, 2007). One must look at the colonial context to understand why there are insufficient ratios of Indigenous Peoples in positions of power and why and how Indigenous Peoples are viewed and treated differently when accessing education, employment and services.

How does racism show up in service measures? Once again, we can look back to the IOM report by Smedley et al. (2003) and the U.S. Congress regarding the demographic factors in American health care for literature identifying the harm that implicit bias has on health and access to health care for non-White people. The report reviews approximately six hundred studies in which medical diagnosis, treatments, and health outcomes were examined in relation to age, sex, and race. Banaji and Greenwald, in their 2013 book *Blind Spot*, also refer to the IOM report:

Black Americans and other minority groups suffer health care disparities that resulted in their receiving less effective medical care than did White Americans. These disparities occurred even when minority and White patients were matched on socioeconomic status and were known to have the same insurance coverage. (p. 197)

The IOM report by Smedley (2003) lists discrimination in several service areas, including fewer routine screenings, less pain medication, less surgery, less dialysis, and fewer organ transplants. The lack of preferred treatment for diabetes is particularly disturbing, given the higher rates among “minority populations and the seriousness of complications” which include “higher rates of limb amputations, which could have been averted by earlier diagnosis” (Banaji & Greenwald, 2013, p. 197). The IOM report concludes that implicit bias was “a plausible cause even if not a conclusively established cause” of health care disparities. Nelson, Browne, and Lavoie (2016) analyze negative portrayals of Indigenous Peoples in the media and how they are connected to the gaps in treatment. They note, for example, that pain medication use “among First Nations peoples is seen as a substance use problem rather than a way to manage chronic pain” and this has an impact on prescribing and access to pain management (p. 8).

Whether stereotypes about Indigenous Peoples (or other racialized groups) are conscious or unconscious has been under scrutiny. The harm of implicit or unconscious bias has been well studied and published in the literature for many years. Wells, Merritt,

and Briggs (2009) note that “the social and psychological literature establishes without question the existence of unwitting individual and institutional biases” (p. 1165). Although much of the literature, including the seminal work by Smedley et al. (2003) in the IOM report , has provided conclusive data regarding the correlation between racism and health inequity in the United States, Canadian scholars and researchers have identified similar concerns in examining unparalleled inequities for Indigenous Peoples as a separate and unique group. Allan and Smylie (2015) report that racism has been documented in health care and resulted in discriminatory treatment in Canada. Bresee, Knudtson, Zhang, Crowshoe, Ahmed, and Tornelli (2014) published a paper reporting heart disease and inequitable treatment rates for First Nations patients. The Health Council of Canada (2012) reports that Indigenous Peoples are less likely to access health care and identify interpersonal and systemic racism as a barrier to health. Research shows that Indigenous healthcare experiences in Canada are different from those of other non-White people.

2.4. Not Just Another “Othered” Brown Body: Colonial Ideology as the Unique Source of Indigenous Stereotypes

‘[First Nations people] can have all those medications because they get everything for free, paid for by the government.’ And I don’t respond to those kinds of remarks because this is where I work. I don’t need this kind of stress.” (Interviewee in Browne, A. J., 2007, p. 2174)

What is so different about Indigenous-specific stereotyping? Are Indigenous Peoples not just another group of brown bodies, “othered” and dehumanized by Whites in positions of power? The unjust pain of racism for non-White Settlers has always been real, and so are the benefits of being on this land for every non-Indigenous person. Canada’s colonial past holds an answer to just what is similar and what is different in experiences of racism that is specific to Indigenous Peoples. It is also important to keep in mind that Canada’s colonial racism against Indigenous Peoples is not in the past. According to Czyzewski (2011):

Recognizing colonialism as a determinant of health involves questioning if colonialism is a finished project, one of ongoing unequal relationships, but equally, that these relationships have real negative effects on health. As a result, interpreting colonialism as a determinant of health is related to recognizing its influence on Indigenous lives as multi-faceted. (p.10)

Some people ask how this injustice could happen. White Europeans who colonized the Americas operated from the assumption that the assimilation of Indigenous Peoples was justified because European culture was seen as superior to that of Indigenous Peoples living on land that is now called Canada (Churchill, 1997; Memmi, 1965; Razack, 2002; Truth and Reconciliation Commission of Canada, 2015). Sartre's quote in the preface to Fanon's (1963) *The Wretched of the Earth* describes the colonial ideology that was the driving force that came with and allowed for European expansion and establishment of the legalized continuing and legitimized control over brown bodies across Asia, Africa, and North America. In North America, which includes Canada, the belief that "on the other side of the ocean there was a race of less-than-humans" (Sartre, 1963, p. 26) served to rationalize and, in doing so, promote control and land theft with impunity.

Sartre (1963) describes this perception of people as "less than human" as "nothing but a dishonest ideology, an exquisite justification for plundering; its tokens of sympathy and affectation, alibis for our acts of aggression" (p. vii). This ideology is well documented and recorded in public addresses by leaders holding the highest political power in Canada. For example, Sir John A. MacDonald, Canada's first prime minister, stood in the House of Commons in 1883 to legalize Indigenous-specific racism and the need to remove Indigenous children from their families and homes:

When the school is on the reserve the child lives with its parents, who are savages; he is surrounded by savages; and though he may learn to read and write, his habits and training and mode of thought are Indian. He is simply a savage who can read and write. It is most strongly pressed on myself as head of the Department, that Indian children should be withdrawn as much as possible from the parental influence, and only way to do that would be to put them in central training industrial schools where they will acquire the habits and modes of thought of white men. (Truth and Reconciliation Commission of Canada, 2015, p. 6)

White Peoples' beliefs and ideals regarding their superiority and their overt goal of "civilizing" Indigenous Peoples has had a long history, supported by a stratified and socially constructed racial hierarchy with Whites at the top (Sue, 2015). The use of race to systematically enforce and normalize racial inequity has been well established in the literature (Applebaum, 2010; Delgado & Stefanic, 1997; Goodman, 2001; Okun, 2010; Wise, 2008). Carr and Lund (2007) explain that "slavery, colonialism, of First Nations and other peoples, neo-colonialism, imperialism, and a host of other political, economic, and cultural strategic maneuvers and mindsets have all been buttressed by the

grandiose conceptualization of the White man as morally enlightened” (as cited in Dei & Kempf, 2006, p. 1).

Canada promoted overt racist propaganda and policies specific to Indigenous Peoples deep into Canadian Settler socialization well into the twentieth century, which still have social salience today. In the report by the Truth and Reconciliation Commission of Canada (TRC) (2015), *What We Have Learned: Principles of Truth and Reconciliation*, reference is made to a document written in 1953 by the principal of a Presbyterian school in Kenora, Ontario who stated that “we must face realistically the fact that the only hope for the Canadian Indian is eventual assimilation into the white race” (p. 7).

Carr and Lund (2007) make the connection between White superiority and colonization by quoting several authors and stating,

Supported for centuries by the Christian religion and the drive to expand the Empire, White people have colonized and ravaged much of the planet . . . one need only to look at the indigenous people in North America (Churchill, 1998) to understand the present-day privilege and power held by White people (Dei, Karumanchery, & Karumanchery-Luik 2004; Fine, Weis, Powell Pruitt, & Burns 2004; Lund, 2006a). (p. 1)

Colonization is a violent and long-term systematic dehumanizing process (Sartre, 1963, Memmi, 1965) that has been socially constructed, sanctioned, and strategized into law and sophisticated mechanisms to protect and ensure that White and other racialized Settlers have access to land, resources, health, and wealth (Bakan & Dua, 2014; Lavalley, 2018; Ly & Crowshoe, 2015; McGibbon & Etowa, 2009; Morrison, Morrison, & Borsa, 2014). Kelm (1999), in her award-winning book *Colonizing Bodies*, defines colonization as “a process of power” (p. xviii). She references Frideres (1983) in using the term colonization as a “geographical incursion, sociocultural dislocation, the provision of low-level social services, and, finally the creation of ideological formulations around race and skin colour, which position the colonizers as at a higher evolutionary level than the colonized” (p. xviii).

The unequal relationship between Settler and Indigenous Peoples within the Canadian context has been socialized multi-generationally from our colonial past and continues to fuel and sustain Settler benefits and to oppress Indigenous Peoples in our colonial present. Davis, Hiller, James, Lloyd, Nasca, and Taylor (2016) note that:

The relationship between Indigenous peoples and settler society in Canada has been profoundly shaped and affected by the ongoing and insidious processes of settler colonialism operating within all spheres of mainstream life. Indigenous peoples, grassroots activists, universities, NGOs, church groups and governments have organized many initiatives to educate and provide information to settler Canadians about colonial histories and the contemporary realities of Indigenous peoples. (p. 1)

The inequitable relationship and inequitable health outcomes can be seen as normal rather than a natural result of abnormal and oppressive treatment. A fair question would be to ask how and why it is possible for service providers to accept and normalize these gaps in service. There is a trifecta of influences that work together to create an acceptance of Indigenous inequity, including: White spaces and racial power in education and health service planning and delivery; the lack of Indigenous voices in education and services, including in decision-making spaces; and the socialization of Indigenous-specific racism as the starting place for understanding Indigenous Peoples and behaviour in colonized countries including Canada. The answer to acceptance of inequities relates to how socialized beliefs about Indigenous Peoples inform education, which then informs training and therefore service providers' attitudes and beliefs in the service relationship and actions in delivery. Service providers can be taught to see health inequities of Indigenous Peoples as logical and natural because of the influence of socialization and a dangerous gap in their education. Allan and Smylie (2015) note that:

Stories about Indigenous health in Canada are frequently presented without the context needed to make sense of the information provided. For example, epidemiological data is often gathered, analyzed and shared without inclusion of adequate context related to the historical and present day impacts of colonial policies and determinants of health for Indigenous people. (p. 4)

An added problem is that the majority of university educators are non-Indigenous (McLean, 2013; Trueman, Mills, & Usher, 2011). This means that the voices and perspectives on Indigenous Peoples' health are not provided by people with the lived experiences and realities (Allan & Smylie, 2015). An added challenge is that non-Indigenous educators can resist acknowledging the need for Indigenous-specific education because of stereotyping of Indigenous Peoples and aversion to naming racism as a factor in health inequities in general.

Settlers rely on stereotyping to support themselves as the rightful owners of these lands (Lavallee, June 2017, personal communication). Canadian laws have been created and continue to evolve to continually maintain the power of White Settler society over Indigenous Peoples, beginning with the British North America (BNA) Act in 1867 when the birth of Canada as a nation was created by legalizing the theft of Indigenous lands. Section 91 of the BNA subsection 234 lists “Indians and land reserved for Indians” and indicates how “the Canadian state claims the privilege of exercising 100 per cent control over Aboriginal and treaty land and Indigenous peoples” (Manuel and Derrickson, 2017, p. 63). More recently, the Canadian government has given a permit for Site C dam, which will flood many square kilometres of Aboriginal title lands without the free prior and informed consent of the peoples involved—something that was promised by both the United Nations Declaration of the Rights of Indigenous Peoples (UNDRIP) and the Truth and Reconciliation Commission of Canada (TRC) (Manuel & Derrickson, 2017, p. 267).

Intersectionality and Indigenous invisibility: Erasure in antiracism discourse and education.

The terms commonly used to describe Indigenous Peoples and accepted in society signal ideologies and beliefs that have profound impact on societal norms. These terms can be described as codes or markers of ideological beliefs that have been both censored into “politically correct” terms and blatantly used to divert from rationalized biases and can also be used to support social justice inaction. A particular perspective that sees racism as the same for all non-White people has erased Indigenous Peoples from the history of racism, which begins uniquely with the colonization of Indigenous land and continues with the denial of sovereign right to the lands where all Settlers live, work and play. The replacement of Indigenous Peoples with Settler populations continues today with the steady influx of White Settlers and non-White Settlers in Canada, with attention and funding for addressing Indigenous inequities and rights on their own land placed in the queue along with funding required for refugees. It is true that some non-White Settlers have come here under extreme duress, after being displaced and fleeing war torn countries where they may face discrimination and racism, but it is also true that they will also benefit from the colonization and further marginalization of Indigenous Peoples.

White Settler society has a relationship with colonization that is different from that of non-White Settlers , who come to Canada with various non-Indigenous races and different origins for settlement. Laws have been passed initially to benefit White European Settlers and to control access to any non-White Settler person in the colonial project. Razack's (2002) book, *Race, Space, and the Law: Unmapping a White Settler Society*, "explores how place becomes race through the law" (p. 1):

The national mythologies of white settler societies are deeply spacialized stories. Although the spatial story that is told varies from one time to another, at each stage the story installs Europeans as entitled to the land, a claim that is codified in law. In the first phase of conquest, we see the relationship between law, race and space in the well-known legal doctrine of *terra nullius*, or empty, uninhabited lands. (p. 3)

Another important factor in the making of Indigenous land into what is now known as Canada is the scripting of non-White Settlers as later arrivals who have not played a part in the creation of Settler Canada and therefore do not have authentic Canadian nationality. This explains the difference in the experiences of non-White Settlers and those of White Settlers. Razack (2002) described how "slavery, indentureship, and labour exploitation—for example [that of] the Chinese who built the railway or the Sikhs who worked in the lumber industry in nineteenth-century Canada—are all handily forgotten in an official story of European enterprise" (p. 3).

Non-White Settler Canadians also face a national "othering" belief that only "European Settlers are the original inhabitants and the group most entitled to the fruits of citizenship" (Razack, 2002, p. 2). Wallis, Sunseri, and Galbuzi (2010) call this a problem of legitimacy, where "the Eurocentric character of Canadian society has to be challenged" (p. 344). They make the case that the struggle for recognition of Indigenous rights and anti-Indigenous racism responses to colonial injustices will also support all marginalized and racialized peoples, pointing out that it is imperative to build alliances because "the issue of white supremacy and the utter lack of democratic transparency and accountability affects each and every Canadian" (p. 344). Ironically, every non-Indigenous Settler person, regardless of race, will benefit from Indigenous land, even though their circumstance can be vastly different—from escaping a war-torn country as a refugee, to White settlers with multi-generations of history rooted in playing a part in the original government-orchestrated land theft.

Indigenous land.

The socialization and establishment of Settler Canada on Indigenous land requires rationalization of the dispossession and extinguishing of Indigenous rights to land. Loppie, Reading, and deLeeuw (2014) discuss Canada's colonial ideology in the legal sanctioning of discrimination:

In Canada race-based powers have attempted to socially isolate, culturally assimilate, and politically decimate Aboriginal peoples as a way of rationalizing colonialism. Legally sanctioned discrimination has hindered opportunities for Aboriginal peoples to be self-determining and generations of residential schools promoted racialized hostility towards Aboriginal peoples and offered a curriculum of assimilation into the body politic of Canada. The harm done to the survivors, their children, families, communities, and future generations is immeasurable. (p. 9)

No one can dispute the reality that Indigenous Peoples were here first, yet the myths persist that attempt to discount and deny rights and access to land that has been undeniably inhabited by Indigenous Peoples for millennia. Although the loss of Indigenous lives from Settler interference continues, in truth, the inhumanity endured by Indigenous Peoples demonstrates superhuman resiliency and resistance, which is evident in a prolonged battle for recognition of rights and access to equity in health and wellness. The report of the TRC (2015) points out that “although Aboriginal peoples and cultures have been badly damaged, they continue to exist. Aboriginal people refuse to surrender their identity” (p. 8).

The denial and refusal to see Indigenous right to land is evidenced in common discourse—that Indigenous Peoples were defeated, are dead, have been assimilated, or, the most damaging and delusional, that Canada was peacefully settled rather than violently colonized. The difference for this racialized subject of stereotype harm is that “the Indian body is seen as proxy to the land” (Lavallee, May 2017, personal communication). This means that there is an investment in “Othering” the Indigenous body in order to maintain the justification for living on and occupying unceded Indigenous territory.

It is inexcusable, and even irresponsible, for educational literature to completely discount the legal and political basis of how this country came to be. Battell Lowman and Barker (2015) note,

We talk about being polite and respectful and peace loving. And we lie by omission, because we do not talk about our country being built on the attempted destruction of many other nations. We do not talk about the questionable legal and political basis of our country; our history of profiting from invasion and dispossession. (p. 1)

Acknowledging a colonial context.

Our shared colonial history has impacts today and colonization has been well established as an ongoing contributor to chronic disease, as well as influencing systemic barriers to care and ultimately affecting health, life and even death for Indigenous Peoples. Diffey and Lavallee (2014) state, “Rooted in colonial history, anti-Indigenous racism permeates social institutions, including health care” (p. 2).

Research, education, and training that do not start with an acknowledgment of the colonial context leave the reader or learner identifying inequities and Indigenous Peoples as the problem. This also prevents health issues from being identified and understood as a natural physical and cognitive reaction to an unnatural and ongoing oppressive force (Oleman, personal communication, September 2013). This deflection from colonial realities has been called “the Settler problem” (Battell Lowman & Barker, 2015; Regan, 2010). We can see here where colonial ideologies come from, why they were constructed, and how the Indigenous “other” is invoked to legitimize the colonization of Indigenous land and peoples. Battell Lowman and Barker (2015) expose the continuing illegal relationship that has been hidden in plain sight, denied, and deflected for too long, stating that “Canada, as a nation is dependent on the land taken from Indigenous nations, land that those nations still contest, and colonialism is about the need to secure those lands at all costs” (p. 3).

In this literature, we see the uniqueness of the rationale for stereotypes of Indigenous Peoples: the denial of colonization and personal investment in this ideology for Settlers is a requisite to maintain the status quo and reassert a power over relationship. When the literature shows that colonial beliefs which result in stereotypes about Indigenous Peoples can create prejudiced attitudes that lead to discrimination, we begin to see how both systems and individual service providers are implicated.

2.5. Unexamined Settler Identity: An Opportunity to Return to Humanity—A Personal Journey

Settlers' inequities.

We must ask the question: What and who are creating these risks for “at risk” people? (McGibbon, 2012, p. 33)

The processes, practices, and procedures of Settlers dehumanizing Indigenous Peoples as “Other” is a global colonial phenomenon; the health inequities of Australian Aboriginal peoples and the Maori populations of Aotearoa (New Zealand) are similar to those of Indigenous groups in Canada (Goodman et al., 2017). When researching the unparalleled inequities between Indigenous and Settler (non-Indigenous) Peoples in Canada, the focus tends to be on the quantitative measure between populations rather than the inequitable relationship that is demonstrated by these outcomes. Researchers note that Indigenous Peoples have been researched and studied “to death” (The First Nations Information Governance Centre, 2014, p. 6) and it is time to hold the mirror up for Settler Canadians and researchers. Adams (2013) states that, “It is immoral for any racial group to have better health than any other racialized group” (n.p). All of this means that it is no longer acceptable to research inequities for Indigenous Peoples with a myopic lens that fails to include the flip side of health for Settlers in this inequitable and unresolved colonial relationship. Battell Lowman and Barker (2015) note the imperative of naming Settlers in the relationship with Indigenous Peoples,

We need a name that can help us see ourselves for who we are, not just who we claim to be. For that we need a term that shifts the frame of reference away from our nation, our claimed territory, and to our relationship with systems of power, land, and the peoples on whose territory our country exists. (p. 1)

Settler benefit is represented in every measure of inequity and yet this measure is rarely included in research. The term *Settler* is an emerging identifier for all non-Indigenous Canadians and this identifier needs to be recognized and understood in the process of examining the relationship between Indigenous and non-Indigenous Peoples living on Indigenous land that is now called Canada. Battell Lowman and Barker (2015) note that “the words we use to name ourselves are important” (p. 1). There are well-taught but misguided Canadian narratives that function as cognitive gymnastics in an obstacle

course to avoid guilt and responsibility of the Settler. Regan (2010) describes the well-worn narratives that have been handed down from generation to generation:

I unravel the Canadian historical narrative and deconstruct the foundational myth of the benevolent peacemaker—the bedrock of settler identity—to understand how colonial forms of denial, guilt, and empathy act as barriers to transformative socio-political change. To my mind, Canadians are still on a misguided, obsessive, and mythical quest to assuage colonizer guilt by solving the Indian problem. (p. 11)

Regan further identifies whose problem this is, stating that “the significant challenge that lies before us is to turn the mirror back upon ourselves to answer the provocative question posed by historian Roger Epp regarding reconciliation in Canada: How do we solve the Settler problem?” (2010, p. 11).

How we choose to look at our history as Indigenous and non-Indigenous Settler Peoples has a significant impact on how we see the land and our relationship today. One might ask whether an analysis of the relationship is intentionally missing and even a national phenomenon of government-sanctioned and institutionally enforced delusion or thought suppression. Weiner and Reed (1969) describe thought suppression as “a method in which people protect themselves by blocking the recall of these anxiety-arousing memories” (p. 79). Most people can relate to being opposed to thinking about an unpleasant event and may even be conscious of averting their gaze away from a discomforting subject or topic. What do we not want to see when we spend so much time examining the “have-not” rather than the “have” side of inequity? To change these relational inequities, it is necessary to look upstream, to hold the focus on the beliefs of Settler service providers about Indigenous Peoples. We need to look for the source of stereotype harm, rather than examining only the outcome, which is also important but which occurs after the harm from the source has already taken place.

Impacts on the service delivery relationship.

We are in a reciprocal albeit unequal relationship as Indigenous Peoples and Settler (non-Indigenous) Canadians, and although there is recent literature regarding the violent impacts of racism on Indigenous Peoples, there is a need to examine how stereotypes held by service providers affect their services for the Indigenous

consumer/client/patient. Razack (2015) notes that there have always been ideas about Indigenous Peoples that have been used to rationalize Settler and Indigenous inequities:

The idea of a disappearing race is also productive for settler subjectivities. Through it, settlers are able to feel Indigenous disappearance and to imagine their own superiority. Perpetually needing assistance into modernity from an enlightened and compassionate European race, Indigenous people are scripted in these moments as remnants, while settlers see themselves as pioneers. (p. 5)

Reading (2014a) also describes how stereotype rationalization can appear in the service delivery relationship. For example, “One persistent and particularly damaging depiction is that Aboriginal peoples are willing ‘wards of the state’ dependent on others and ultimately better off when the federal government oversees their affairs” (p. 2).

Regan (2010) says that “this singular focus on the Other blinds us from seeing how settler history, myth, and identity have shaped and continue to shape our attitudes in highly problematic ways” (p. 11). Failing to look at our own identity as half of the current colonial relationship allows us to measure facts and figures in Indigenous inequities, without allowing for a personal or relational impact or impetus for change. Indigenous and Settler population life expectancy disparities are not just numbers that are examined and analyzed each year. Each inequity measure represents a name and link together to mean the difference in life chances and even death for an Indigenous person because of our country’s foundation in colonization and Indigenous-specific racism.

The literature review leads the reader through the many and varied manifestations of Indigenous-specific racism and the ways that ongoing denial or aversion to a colonial context is supported by depictions of Indigenous People. Here we ask, ‘What’s the harm’ and how is it measured?

2.6. Rationale for My Research: What’s the Harm? Examining the Stereotypes of Indigenous Peoples When Accessing Health Care Systems

Tator and Henry (2006) write that “one of the most problematic aspects of racism is measuring its many manifestations. What is acceptable as evidence that racism has occurred, and how can this be evidence be quantified?” (p. 57). That question provided

the impetus for this research study. Tator and Henry (2006) also note the need for further quantitative research on race and racism:

Little research has been conducted in Canada on the issue of measurement. Much evidence of racism must be culled from other indicators. As Weinfeld (1990) notes, data of adequate reliability and validity, transformed into recognized indicators and disseminated appropriately, are not available. Thus most attempts to answer questions such as, "To what extent is Canada a racist society?" are based on partial snapshots, hunches, or the predisposition of the analyst. (p. 57)

Morrison, Morrison, and Borsa (2014) report that "Interpersonal prejudice toward Aboriginal men and women has, to date, received little attention from Canadian social psychologists" (p. 1001). Their study of two data collections using both university and non-university respondents finds that, "large portions of men and women agree that Aboriginal people exploit their cultural traditions to 'secure special rights,' 'should stop complaining about the way they are treated' and make 'excessive demands' to the Canadian government" (p. 1005). The findings in this literature review are reflected by Morrison, Morrison, and Borasa (2014) where they suggest that,

Levels of prejudice toward Aboriginal persons in Canada are alarmingly high. Educational strategies designed to crystalize the abuses that Aboriginal persons have suffered in the past and continue to suffer today; highlight the neglect this group has received from Canadian government; and shatter misinformation about Aboriginal entitlements may serve to engender empathy toward members of this group and, in so doing, attenuate non-Aboriginals' prejudice. (p. 1008)

They also note that

efforts are underway in many parts of the world to develop medical education curricula that address the health care issues of indigenous populations. The topic of stereotypes and their impact on such people's health, however, has received little attention. An examination of stereotypes will shed light on dominant cultural attitudes toward Aboriginal people that can affect quality of care and health outcomes in Aboriginal patients. (p. 612)

One of the issues that have been left out of research and the topic of racism is the reality that systems are made of individual people providing services, and these are people who will naturally reflect normalized and socially upheld beliefs and values about Indigenous Peoples. Tator and Henry (2006) note,

It is difficult to study and measure covert racism in its institutional or systemic form. . . . One of the main problems with the concept of institutional racism is that it does not differentiate the structural features of institutions in society from the actions of groups of individuals. To what extent is racism embodied in institutions, and how can its manifestations be measured? (p. 59)

This literature review confirms the dire concern of stereotype harm documented in the San'yas Indigenous Cultural Safety Training program, in which thousands of deeply disturbing anecdotal examples are given of Indigenous-specific racism causing serious harm.

Although much of the literature demonstrates the reality of stereotype harm in health care systems, to date there are no known studies that have measured the enculturation or the attitudes about Indigenous Peoples and examined stereotyping examples witnessed by health service providers. This literature review has examined how stereotyping impacts health service providers and ultimately health for Indigenous Peoples. Although the literature across several disciplines has been examining racial differences in health for some time, Johnstone and Kanitsaki (2008) argue that “racism as an ethical issue per se and its moral implications for health service providers are neglected issues in health care ethics discourse” (p. 494). Although research has firmly established the foundation of inequity in health measures for Indigenous Peoples amid growing evidence that inequities are due to racism in service, there are few reports that focus upstream to examine the systemic nature and impact of service provider stereotypes on Indigenous Peoples when accessing health care systems. Rasmussen and Garren (2016) also report the need for further quantitative and qualitative examination of racism in health care:

There is little doubt that racism occurs in health care, it is under researched and underreported. Although there is some survey research and considerable anecdotal accounts from all professions, further empirical inquiry is required. What is needed is quantitative study to more fully establish the extent of the problem and qualitative investigation to grasp the subjective dimensions and interpersonal dynamics that lie at the heart of these interactions. (p. 176)

An assessment of incidents provided by health system service providers who have completed the San'yas Indigenous Cultural Safety (ICS) Core Health training program demonstrates the frequency and type of Indigenous-specific stereotyping in health systems, and these data provide a better understanding for organizational service

delivery training needs. This study can inform service design and delivery and also education programs and enable them to become safer and better tailored to interrupt and address systemic racism towards Indigenous Peoples. A content analysis study of the examples provided by participants generated both quantitative and qualitative research data to examine and understand the frequency and context of stereotyping incidents and what is needed in health services to support safety for Indigenous Peoples. As Justice Murray Sinclair (2013), Truth and Reconciliation of Canada commissioner and chair, noted, “Education got us into this, and it is education that will get us out” (p. 4).

Chapter 3. Methodology

3.1. Purpose of the Study

The purpose of this study was to examine how stereotyping impacts health service provider behaviours, health systems, and in particular the health and wellbeing of Indigenous Peoples. Comments posted by Canadian participants in the *San'yas* Indigenous Cultural Safety (ICS) Core Health online training program delivered by the Provincial Health Services Authority (PHSA) of British Columbia were examined to learn about stereotyping specific to Indigenous Peoples. Participants described the frequency, types, attitudes, harms, and locations of stereotypes as occurring during service delivery while they were working within a health care service context.

The intent of this study is to help Settler service providers understand the need to critically analyze their stereotypes about Indigenous Peoples and the ways in which they can unintentionally harm Indigenous Peoples, a population with the greatest health inequities (Tang & Browne, 2008; McGibbon & Etowa, 2009; Health Canada Council, 2012; Loppie, Reading & de Leeuw, 2014; Allan & Smylie, 2015). This study may aid in the development of anti-Indigenous racism curricula to support individual service providers and organizations in monitoring and changing behaviours. The goal is to ensure safer and racism-free health services for Indigenous Peoples. Knowing about the frequency and acceptance of common stereotypes is a key starting point in providing safe services. The data and method of analysis utilized in this dissertation can be replicated and extended to an examination of Indigenous-specific stereotype frequencies in other service situations such as child welfare, mental health, justice, and education service contexts, where the phenomenon of stereotype harm is also being recognized as commonplace.

Research questions.

As a reminder, the research is intended to answer the following four questions:

1. What stereotypes of Indigenous Peoples are reported by health service providers?

2. Where are stereotypes towards Indigenous Peoples occurring within health care systems?
3. What attitudes towards Indigenous Peoples are reported by health service providers?
4. What types of harm towards Indigenous Peoples are reported by service providers working in health systems?

3.2. Methodology / Theoretical Framework: Learning “Who I Am” and “My Place” in Indigenous Cultural Safety

The methodology of a research study explains “the theoretical lens or worldview through which research is understood, designed and conducted” (Walter & Anderson, 2013, p. 42). Given that this is a research study examining Indigenous stereotyping, there are elements that need to be stated including the researcher’s standpoint as a White, Settler, female, cisgender, able-bodied, middle-class researcher. The need to identify the background of the researcher is reflected in findings by Walter and Anderson (2013):

The question of how culture, race, gender and socioeconomic background affect research methodology tends to arise only when the researcher is seen as somehow “other” and not when the researcher is part of the “unmarked” dominant norm. It is critical, however, to insist that these considerations are central to all methodology. (p. 44)

What I bring to this study is fifteen years of experience working in child welfare, education, and health services in an Indigenous-specific context and learning from Indigenous and Settler mentors and educators. For the last nine years I have focused on self-examination as a White Settler educator and facilitator of online and face-to-face discussions. Part of my work has involved co-presenting and learning from Indigenous educators at workshops for mostly Settlers about the stereotyping of Indigenous Peoples across health, child welfare, mental health, and justice contexts. My learning will never end and is attributed to working and personal relationships with Indigenous scholars, leaders and friends as well as with Settler Canadians about colonially imposed inequities and impacts. Years of critical dialogue have informed this analytic process and I credit their teaching for my education and for my White racial and Settler identity development. I also thank Indigenous educators for graciously teaching and mentoring me because the topic of anti-Indigenous racism has not yet been well developed or integrated into

White academic institutions. I realize that teaching me has and always will come at Indigenous educators expense as I learn about the horrible, violent and painful realities they live with.

I use the term 'Indigenous-specific racism' to clearly demarcate this area of study to separate and distinguish Indigenous racism from racism experienced by other non-White racial groups. As a beneficiary of accrued interest gained from the original colonial project, I am a part of Indigenous-specific racism in Canada and will always benefit from this racism whether I do anything or not, even as I confront my socialized racism. Because of what I do not face racially, I will always need to be engaged in an ongoing process of learning about who I am and what I represent in relationship to Indigenous Peoples and non-White people in Canada. My racial privileged access to health and wellness is in violent contradiction to many Indigenous Peoples experiences. For one example my mother will be 95 soon and she has had only excellent healthcare (for those who are questioning this, if she did have poor care, it would not be about her race). I often think of the brutal contrast of my Indigenous friends mother passing at a much younger age, and the racist incidents she has endured throughout her lifetime This includes racism towards her grieving family during her passing in the hospital. I note that there is always a relational contrast and to expose the reality that every racial benefit that Settlers receive—is an act of violence against Indigenous Peoples who receive the lowest measures of care. We might flip the stereotype and ask who is getting the free ride in Canada when we look at the Settler ratios in the determinants of health?

■ Racial identity development.

As a White Settler, I am part of the dominant White racial norm, where White people do not commonly recognize their race because we are seen as “normal.” Delgado and Stefancic (1997) noted that

upon looking into the mirror, whites have found their whiteness both opaque and transparent. Most whites have not thought much about their race. Few, upon being asked to identify themselves by attributes, would name whiteness among their primary characteristics (p. 1).

My intent is to mark the views of dominant society that are taken for granted, and identify and declare them as the underpinnings of the methodology in this research and as essential elements to assess in developing practical skills for Indigenous cultural safety.

Walter and Anderson (2013) noted that a “failure to recognize one’s standpoint in fact magnifies, rather than mitigates, its influence on research practice” (p. 45). When reading any material on Indigenous/Settler inequities, I look for the racial identity of the researcher to determine the standpoint and mark that as an indicator of racial awareness of the author.

In the introduction to the first chapter in Carr and Lund’s (2007) *The Great White North? Exploring Whiteness, Privilege and Identity in Education*, Berry (2007) stated that “The purpose [of her chapter] is to reveal how the power and privilege of Whiteness has been created, circulated, and sustained through a socio-historical process of hegemony” (p. 19), and adds that “as a White, Canadian woman privileged mainly by my immersion in the invisible constructs of whiteness” [she is] “able to disclose not only the authority of Whiteness in Canadian society but discuss how the very invisibility of Whiteness works to generate, circulate and maintain racism in Canadian society and its institutions” (p. 19).

Gallagher (1997) also noted that “race matters because it is racial, not ethnic identity that is bound up in popular culture and the political order” (p. 8). Helms (1990) psychologist and a leading author on racial identity theory, also makes the point that this is an awareness marker that “refers to the quality or manner of one’s identification with the respective racial groups” (p. 5). She explained that, “One’s reference group orientation is reflected in such things as value systems, organizational memberships, ideologies, and so on” (p. 5).

The examination of Indigenous inequities has been limited to a focus on Indigenous Peoples, which misses the ways that non-Indigenous Settlers are also a part of the inequitable relationship. Walter and Anderson (2013) referred to Kerbo (1981), who asked why most “predominantly middle class social researchers tend to investigate topics that concentrate on poorer, less educated segments of population, rather than their own class grouping” (p. 47). My intent was to flip that focus and investigate the attitudes, beliefs and behaviours of White educated service providers regarding the stereotyping of Indigenous Peoples. Frankenberg (1993) defined Whiteness as multidimensional:

First, Whiteness is a location of structural advantage, of race privilege.
Second, it is a “standpoint,” a place from which White people look at

ourselves, at others, and at society. Third, “Whiteness” refers to a set of cultural practices that are usually unmarked and unnamed. (p. 1)

My intent is to examine, expose, and mark White cultural ideologies, attitudes, and practices to prevent stereotype harm in the provision of services to Indigenous Peoples.

Critical Whiteness studies.

I define Whiteness as a social construct of oppression that affords social and political privilege to people who appear to be of White European ancestry. Delgado and Stefancic (1997) state that: “Whiteness is a norm against which all other races are judged” (p.1)

Peggy McIntosh is well-known for her article, “The White Knapsack of Privilege” (1989) and for recognizing her own experiences of racial privilege and how they are embedded into her identity:

As a white person, I realized I had been taught about racism as something which puts others at a disadvantage, but had been taught not to see one of its corollary aspects, white privilege, which puts me at an advantage. . . . I was taught to see racism only in individual acts of meanness, not in invisible systems conferring dominance on my group. (p. 10)

In my Masters of Social Work thesis, “*Self-Assessment in Cultural Competency Development: An Aboriginal Child Welfare Orientation*,” this awareness of my race “led to a realization that no matter how nice I was, or how well meaning, I would never be able to really relate to an Aboriginal person and share in a conversation of race, unless I took responsibility for my racial identity” (Harding, 2010, p. 12). In continuing to think critically about who I am as a White woman, I now see how my Settler identity is a specific additional layer in the analysis of my White racial power and privilege. My goal now, as a White Settler educator in a racialized world, is to assist other White Settlers in seeing themselves as having a race and for non-White Settlers to talk about and expose racial realities that are different for Indigenous Peoples. Both White and Settler identities are linked and separate. They need to be separated to examine the different and similar layers of manifestation and I discussed Settler Identity and impacts in the section below.

Helms (1990), explains that the development of a healthy White racial identity requires an individual to “accept his or her own whiteness, the cultural implications of

being white, and define a view of Self as a racial being that does not depend on the perceived superiority of one racial group over another” (p. 49). Sartre (1963) asserts that stopping racism starts at the Settler source: “To shoot down a European is to kill two birds with one stone, to destroy an oppressor and the man he oppresses at the same time: there remain a dead man, and a free man; the survivor, for the first time, feels a national soil under his foot” (p. 22). As Lavalley (2017) noted in a webinar entitled “*Making the Indigenous Body Human: One Day at a Time*,” “we must decontextualize the focus from the Indigenous body because racism is about understanding the Settler and for the Settler to understand him or herself.” He also noted, “The physical quorum of the Indian body becomes ‘the forever frontier’ upon entering the colonial institution.” The literature mirrors my own experience, showing a strong social aversion to identifying or racializing Whites “as a race” and an opposite normalized determination to essentialize and identify Indigenous Peoples by race (Delgado & Stefanic, 1997; Henry & Tator, 2010).

Gallagher (1997) pointed out, “Whites can be defined as naïve because they attach little meaning to their race, humane in their desire to reach out to non-whites, defensive as self-defined victims, and reactionary in their calls for a return to white solidarity” (p. 6). Delgado and Stefanic (1997) quoted Wildman and Davis (1996) in noting that “privilege is not visible to its holder, it is merely there, a part of the world, a way of life, simply the way things are” (p. 316); they maintain that “White privilege derives from the race power of white supremacy” and privilege may be exercised in silence, and members of privileged groups can opt out of struggles against oppression if they choose (p. 316). Carr and Lund (2007) state that “it is not a matter of anger and guilt to expose the authority of Whiteness in Canada, but an awareness of where it exists as an invisible marker of privilege. To do so interrupts the assumption that Canada is a multicultural society with equity, inclusion, and social justice for all” (p. 30). Authors have written extensively about the social phenomenon of White privilege and discuss the gaps in knowledge, the contradictions in racializing others, and the aversion of Whites to learn about their Whiteness (Applebaum, 2016; Goodman, 2001; Okun, 2010; Matias, 2016; Razack, 2002; Sensoy & DiAngelo, 2012; Wise, 2008). The need for Settler identity development discourse is emerging and yet another matter worthy of discussion.

■ Settler identity development.

Settler identity development is another necessary focal point of this research. Settler privilege is recognized as the benefits accrued from Indigenous oppression. Battell Lowman & Barker (2015) stated that “the structures Settler Canadians are made to inhabit and move within are luxurious by comparison to Indigenous peoples’ assigned spaces—the privileges and benefits that come along with being a Settler Canadian” (p. 89). The term was also described by Thomas (2016), who explained that “Settler privilege, as I’ve understood it broadly, is having specific rights, advantages or immunities granted or available only to a particular group of people (settlers), while the Indigenous groups are excluded from those benefits” (n.p.). It is important to keep in mind that non-White Settlers will not have equal access to the benefits that are gained from Indigenous oppression, because of the dominance of Whiteness and also because non-White Settlers also experience racism while being complicit in accessing resources that are accrued with compounded interest from living on Indigenous land (Jafri, 2012).

Using the term *Settler* as an identifier is about being honest about who we are, (while we recognize differences) as non-Indigenous Canadians. Battell Lowman and Barker (2015) stated clearly that the term “Settler should not be assumed as a pejorative insult” and that “as Settler Canadians [we] need to understand that, in so doing [using this identifier] we are declaring that we benefit from and are complicit with settler colonialism and therefore are responsible, as individuals and collectives, for its continued functioning” (p. 18). They also encouraged Settlers to consider the identifier “Settler” as an interrogative identity (p. 18).

Acknowledging Settler identity means moving away from colonial ideologies of dominance and control and what have been called “moves to innocence” (Tuck & Yang, 2012). They also stated that this identity recognition is only a start and that this must come at a price—land, power, and privilege:

Settler moves to innocence are those strategies or positionings that attempt to relieve the settler of feelings of guilt or responsibility without giving up land or power or privilege, without having to change much at all. In fact, settler scholars may gain professional kudos or a boost in their reputations for being so sensitive or self-aware. Yet settler moves to innocence are hollow, they only serve the settler. (p. 10)

It has always been a point of tension between Settlers and Indigenous Peoples that all non-Indigenous people, both White and non-White, who occupy Indigenous land benefit from this land which is why Indigenous inequities must be addressed by all non-Indigenous Settler Canadians.

Just as there are diverse Indigenous groups in Canada, there are also diverse Settler groups who have come to Canada under markedly different circumstances to seek a better life. Regardless of the reason why, their chances at a better life have and still come at the expense of Indigenous Peoples chances at living a healthy life on their own lands. Battell Lowman and Barker (2015) reminded us of the various experiences and hardships of “refugees who would return to distant homes if only they could, who are marginalized and living precariously within Canadian society” (p. 18). The defining commonality is that all Settler Peoples share a particular relationship of complicity in colonization by living on and benefiting from Indigenous land. This reality can be lost when the focus is on, and filtered through the hardships stories, whether Settlers arrived today or over one hundred years ago, as my own ancestors did.

Critical content analysis.

A critical content analysis was employed to examine the comments posted by participants. Through the coding analysis process, patterns of frequencies appeared through the words chosen to describe stereotyping of Indigenous Peoples witnessed in health services. Saldana (2016) talks about the value of “quantitizing the qualitative” and “transforming qualitative data and/or codes into quantitative representations for exploratory review or statistical analysis” (p.25).

Henry and Tator (2010) describe discourse as the “production of knowledge through language and social practices” (p. 381). They go on to explain that “These meanings serve the interests of that part of society within which the discourses originated. And that “Discourse—often referred to as ‘discursive practice’—is thus a social act that may promote or oppose dominant ideology” (p. 381).

■ Critical race theory.

Critical race theory (CRT) is employed by activists and scholars interested in studying and transforming the relationships among race, racism, and power. CRT is one way of understanding the theoretical and philosophical roots of colonization and how it relates to the topic of social justice and health care inequities. Delgado and Stefancic (2001) report that CRT emerged in the 1970s through the work of Bell (the first African American law professor at Harvard Law School), Freeman, and others committed to racial and social transformation (p. 4). Drawing on critical sociology, neo-Marxism, and postmodern philosophy, they developed a critical assessment of society's racial realities. Similar to critical race studies, critical feminism and critical Whiteness studies look closely at power and social realities. Delgado and Stefancic (1997) noted,

What these approaches have in common is an effort to get beyond received wisdom and to ask basic questions about race, power and society. It is the belief that all people can move toward a more decent, humane society by exposing ourselves to the best minds writing about vexing issues of race and by thinking critically. (p. xviii)

Although critical race theory emerged in the United States with the civil rights movement, it has relevance in Canada. There is a political nature to critical race theory and in Canada there are similar foundations as a movement of social justice for Indigenous Peoples. In this examination of stereotype harm to Indigenous Peoples, it is recognized that power is not equally distributed for Settler peoples and that the “descendants of Anglo-colonizers occupy the top position, usually followed by others of Western European descent, with the Indigenous populations at, or near, the bottom of the hierarchy” (Walter & Anderson, 2013, p. 46). Non-White Settlers occupy a place in this socialized racial hierarchy and experience the pain of racism from White people and the Whiteness embedded into systems in Canada. Yet at the same time, non-White Settlers join White Settlers and participate in the marginalization of Indigenous Peoples when occupying Indigenous land. There have been comments by San'yas participants who were immigrants in which they describe being taught or “groomed” (Ward, 2016) to stereotype Indigenous Peoples by preceptors and educators when coming to Canada for work.

There are Indigenous educators, advocates, and activists who have noted that Canada has not yet had its civil rights movement for Indigenous Peoples (Ward,

personal communication, 2010). Indeed there are also many well-respected Indigenous and non-Indigenous theorists and philosophers publishing volumes about the need for Indigenous justice in Canada. Arthur Manuel, one of the most outspoken Indigenous leaders, along with Grand Chief Ronald Derrickson (2017) wrote in *The Reconciliation Manifesto: Recovering the Land and Building the Economy* that “many Canadians would like to see reconciliation between settlers and indigenous peoples. But that cannot be forced. Reconciliation has to pass through truth. And we still have not had enough of that from this government or from Canada as a whole” (p. 56).

Kovach (2009) confirmed that there is a need for a transformed mutual relationship, stating that “as academic landscapes shift with an increasing indigenous presence, there is a desire among a growing community of non-indigenous academics to move beyond the binaries found within indigenous-settler relations to construct new, mutual forms of dialogue, research, theory, and action” (p. 12).

■ **Anti-Indigenous racism.**

I employed Anti-Indigenous racism as an area of study to inform my methodology and to help me learn about Indigenous-specific racism in Canada. I continue to examine this topic and refer to Loppie (2015) and her National Collaborating Centre for Indigenous Health webinar, *Anti-Aboriginal Racism in Canada: A Social Determinant of Health*. She explored:

anti-Aboriginal racism in Canada—how to understand it in historical context, how it affects individuals and communities, and what programs, policies and strategies exist to combat it. Loppie describes the construction of race as a form of social hierarchy, an overview of expressions of racism as well as the impact of lived and structural racism on First Nations, Métis and Inuit peoples in Canada. (n.p.)

Allan and Smylie (2015) noted that “racism and colonization have been inextricably intertwined” (p. 5). In conducting this study, efforts were made to examine racial realities that are specific to Indigenous Peoples and how this is different from any other racialized group in Canada. Tuck and Ree (2013) made reference to how colonization is connected to the long roots of the present-day harm and ongoing violence that Indigenous Peoples face today:

For the settlers, Indigenous peoples are in the way and, in the destruction of Indigenous peoples, Indigenous communities, and over time and through law and policy, Indigenous peoples' claims to land under settler regimes, land is recast as property and as a resource. Indigenous peoples must be erased, must be made into ghosts. (p. 6)

Given that this study intends to examine service provider stereotype harm on Indigenous Peoples, a broader perspective on decolonizing anti-Indigenous racism that reminds us about the real and violent nature of ongoing colonialism is appropriate as the backdrop to “reveal privileged epistemologies and can work towards instigating change or, at least, mitigating methodological inconsistencies that tend to arise when integrating Indigenous and western methods” (Kovach, 2009, p. 43).

■ Cultural safety as a key theoretical concept: What it is and what it is not.

As defined earlier, Indigenous cultural safety requires knowledge, awareness and skills to work safely with Indigenous Peoples. This theoretical concept was employed as a part of the methodology of this study. I employed these three facets in assessing and examining what participants were saying about the safety of Indigenous Peoples and whether health services are free of racism and discrimination.

Irihapeti Ramsden, a Maori nurse, is recognized as the founder of the theoretical concept of cultural safety. Her work was first published for the Ministry of Education of New Zealand in 1990. Cultural safety requires identity awareness and is defined by the Nursing Council of New Zealand (2005) as

the effective nursing practice of a person or family from another culture, and is determined by that person or family. Culture includes, but is not restricted to, age or generation; gender; sexual orientation; occupation and socioeconomic status; ethnic origin or migrant experience; religious or spiritual belief; and disability. The nurse delivering the nursing service will have undertaken a process of reflection on his or her own cultural identity and will recognize the impact that his or her personal culture has on his or her professional practice. Unsafe cultural practice comprises any action which diminishes, demeans or disempowers the cultural identity and wellbeing of an individual. (p. 7)

Papps and Ramsden (1996) identified that Indigenous Peoples need to define when services are safe; “Cultural safety within nursing and midwifery addresses power relationships between the service provider and the people who use the service. It

empowers the users of the service to express degrees of felt risk or safety” (p. 494). There has been and remains some confusion, even in Canada, about what cultural safety is and what it is not. Settler Canadians have been taught to focus on learning about Indigenous Peoples as the “cultural other” rather than looking at themselves and how their own culture and power dynamics might impact the service relationship. Papps and Ramsden (1996) explain that

cultural safety . . . provides a focus for the delivery of quality care through changes in thinking about power relationships and patients' rights. The skill for nurses and midwives does not lie in knowing the customs of ethno-specific cultures. Rather, cultural safety places an obligation on the nurse or midwife to provide care within the framework of recognizing and respecting the difference of any individual. (pp. 493–494)

Smye and Browne (2002) identified why Indigenous-specific cultural safety has been introduced into health care in Canada and why it has relevance in this context, stating, “Clearly, colonisation has had extremely deleterious effects. It is in this context that cultural safety can be used to examine the health and social relations and practices that are shaped by dominant organisational, institutional and structural conditions” (p. 48).

Education about critical race and anti-Indigenous racism is needed for Settler Canadians and in particular White Settlers to learn about Indigenous-specific racism, themselves, including the barriers and violence that they don't have to confront.

3.3. Research Site

As noted in Chapter One, the San'yas Indigenous Cultural Safety (ICS) Core Health online training program, delivered by the BC Provincial Health Services Authority (PHSA), Indigenous Health was chosen as the site for this research study. The San'yas training maintains a focus on racism, discrimination, and stereotyping and is grounded in critical and decolonizing theoretical perspectives and anti-Indigenous racism pedagogy. In 2010, it was offered by PHSA to five regional health authorities in British Columbia. Since that time, more than 70,000 participants from across British Columbia, Ontario, and Manitoba have completed various curricula in Indigenous cultural safety trainings. Within the training, participants examine complex issues (e.g., Indigenous diversity and aspects of colonial history; Indian Residential Schools and Indian hospitals; the impacts of racism, stereotyping, and discrimination; health inequities, and social determinants of

health) and are introduced to tools for developing effective communication and relationship-building skills.

The ICS Core Health course within the San'yas training explores the experiences of Indigenous Peoples in the context of health and is designed for non-Indigenous health professionals working in organizations within the BC Provincial Health Services, as well as those within the five regional health authorities, the Ministry of Health, and partner agencies. The curriculum is intended as introductory training and is intended to be supplemented by nation-and region-specific training provided by regional health authorities or Indigenous groups.

The version of the San'yas Core Health training that participants completed for this study was facilitated with participants posting in three group discussion boards and two personal journals. Learning is self-paced over an eight-week time frame, available 24/7, and typically takes between eight to ten hours to complete. Skilled facilitators guide and support each participant through dynamic learning modules consisting of interactive activities, quizzes, videos, discussion boards, and individual journal entries. (San'yas [ICS] Training, 2018). Rooted in critical race theory and transformative learning pedagogy, the San'yas curriculum is recognized by cultural safety scholars and educators across Canada, the United States, Australia, and New Zealand and has been recognized as leading practice (Health Council of Canada; 2012, McDermott & Sjoberg, 2016).

Participants.

It needs to be noted that the comments used for this research were taken from secondary data, which means that research participants were not recruited to provide qualitative data in the usual research method by interview or survey sample, etc. Comments that were already posted on an online learning platform were extracted and analyzed from pre-existing data that has been authorized for research use under strict privacy guidelines.

Privacy and protection.

While frank conversations are encouraged, the online platform of the San'yas training has been designed to promote an open learning environment where people can ask questions about Indigenous realities that they have not had an opportunity to explore. To that end, the identity of all participants is strategically protected. In one-to-one journals and for communication purposes they speak directly with their facilitator. On discussion boards, participants are encouraged to adopt a pseudonym. This creates a supported environment where participants can dispel fears of offending and speak frankly about topics they might not otherwise raise in a face-to-face classroom environment. Participants who complete the training have made comments about the supportive and transformative nature of the facilitation and learning process.

Trained facilitators who model critical race language to expose and counter colonial narratives are key to the training. Many Canadians have learned that talking about race and racism is dangerous and inappropriate, and fear that doing so will generate feelings of discomfort. Many terms regarding Indigenous identity, race, and racism are misunderstood which can add to the confusion and build frustration for service providers who have not had an opportunity to develop Indigenous Cultural Safety skills. Contradictions and tensions can arise from exploring Canada's unresolved history. Often, people think that ICS development is all about learning cultural practices, when ensuring cultural safety is actually about considering race relationships and the social constructs of race. This lack of understanding can create confusion which facilitators can address by providing guidance and clarity.

Ethics.

The following principles have guided this research: ownership, control, access, and possession (OCAP™). The OCAP process is a political response to tenacious colonial approaches to research and information management; it has become a rallying cry to many First Nations and should be a wakeup call for researchers to start from a community perspective and to cooperate and collaborate with Indigenous stakeholders (First Nations Information Governance Centre, 2014, p. 4). The principles of OCAP offer a way to mitigate the ethical dilemmas that characterize research by non-Indigenous researchers studying Indigenous relationships and inequities by ensuring Indigenous

Peoples voices are a fundamental part of the research. In this study, while the BC Provincial Health Service Authority has control of the data, the San'yas program is a major stakeholder and is led by Indigenous managers and leaders. Dr. Cheryl Ward (Namgis), now Executive Director of Indigenous Health at PHSA and San'yas program designer, provided consultation and Indigenous voices lead and supported this study. Including San'yas program Elder Gerry Oleman and Dr. Barry Lavallee (Saulteaux/Metis), an assistant professor and physician, is the content specialist member of the research committee for this Doctor of Education study.

Two research ethics boards.

This research study has been approved by two research ethics boards, the University of British Columbia (UBC) and Simon Fraser University (SFU). The principal investigator completed the SFU Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans Course on Research Ethics (TCPS 2: CORE). The research site was a program at PHSA Indigenous Health and all research conducted under PHSA requires UBC research ethics board approval. The researcher is a student at SFU, and therefore the research study also required ethics approval from SFU. Both letters of approval can be referenced in the thesis. In the process of research board approval, a letter confirming that the principal investigator for the study had the qualifications, experience, and facilities to carry out this research was signed by Leslie Varley, (Nisga'a) who was the director of Indigenous health at PHSA during the ethics application process.

PHSA privacy review of the San'yas program.

I also initiated an in-depth privacy review and received approval from the PHSA Information Access and Privacy Office. On the registration page of the San'yas online platform, participants see a privacy notification regarding how their information will be collected and may be used. Participants in the San'yas training were notified by a privacy link on the San'yas platform that their information may be used for research under strict privacy guidelines. The PHSA is governed by the Freedom of Information and Protection of Privacy Act (FOIPPA), the E-Health Act, and other legislation and standards of practice regarding protecting personal information. The FOIPPA in particular provides a framework for upholding privacy and confidentiality of personal

Information. The information privacy and access office at PHSA has indicated that the online comments and demographics have been provided to PHSA San'yas program after a privacy notice, which indicates that their non-identifiable information may be used for research as permitted by law. The following measures have also been put in place:

- 1) As per UBC/C&W BREB policies, only project personnel identified can have access to the data. As mentioned earlier, the data comes from an extraction of online comments submitted during one year by participants who completed the San'yas ICS Core Health training program. The extraction and creation of the data bank is described below.
- 2) All project staff of PHSA have signed a confidentiality agreement (referencing appropriate PHSA privacy and confidentiality policies) in relation to this work.
- 3) PHSA employees have all undertaken privacy training as per the PHSA online training course available through the Learning Hub.

3.4. Methods: Quantifying Qualitative Data

Content analysis method.

Previously posted comments in an online training program were used as secondary research data. Secondary data analysis is an appropriate and valued method of research analysis and is defined by Silverman (2003) as “reusing data created from previous research projects for new purposes” (p.395). The data that were used were initially compiled for educational purposes and can also be used for research to better understand the realities of Indigenous cultural safety in the health care context and under strict anonymity measures.

A hybrid method of fusing and quantifying the qualitative data was initiated to provide not only the measures of stereotyping, in frequencies and percentages, but also to better understand the meaning that individuals within health care services “ascribe to a social problem” (Creswell, 2014, p. 246).

Creswell (2007) describes five main research approaches, including narrative research, which involves exploring the life of an individual; phenomenological research, which is a design of research coming from philosophy and psychology in which the researcher describes the lived experiences of individuals; grounded theory, which

develops a theory grounded in the data from the field; case study, which involves developing an in-depth description and analysis of a case or multiple cases; and ethnography, which involves describing and interpreting a culture-sharing group. Although there were some appropriate characteristics that fit from various approaches, a content analysis approach supported a better understanding of how health service providers are describing incidents of stereotype harm witnessed while working in health services. Specifically, the content of online postings were analyzed deeply. This allowed for an examination of workplace culture in service delivery, the essence of how stereotyping about Indigenous Peoples was described in order to interpret the implications for health services. Therefore, a content analysis of qualitative data was deemed the best fit for this study.

This approach shaped my analysis by confining my focus of examination to answering my research questions in learning more about stereotyping in the health care service experience. In taking this approach, I hope to encourage readers to reflect on the discourse and the incidents described by service providers to engage in similar kinds of study and assessments for safety in their workplaces. The intent is to enlist partners in creating interventions to interrupt racism and create safer services and systems for Indigenous Peoples.

This study examined how stereotyping impacts service provider attitudes, behaviours, and ultimately health services and access to health for Indigenous Peoples. An assessment of examples provided by health service providers (n= 333) who have completed the *San'yas* Indigenous Cultural Safety (ICS) Core Health training program demonstrates the frequency, location, and type of Indigenous-specific stereotyping in health systems. These data provide a better understanding for organizational service delivery training needs.

Quantifying the qualitative data was well-suited to this study because of the sheer volume of the comments and hypothesis that frequency measures could demonstrate the gravity of the harms and also which harms were most prevalent. Secondly, a qualitative analysis of the descriptions could help in the understanding of the phenomena of Indigenous stereotype harm and its impact on health service provider attitudes and actions. The hope of this research is to examine service providers'

understanding of Indigenous stereotyping while they were providing services in their workplace.

The goal is to attempt to create a method that integrates elements of qualitative and quantitative analyses so that the interpretation of the results is less subjective. This can provide evidence of the frequency of the qualitative elements and warranted focus on the topic. A content analysis allowed for a better understanding of differences between treatment and the need for, and impact of an intervention program and the development of frequency and percentage tables in response to the research questions. Saldana (2016) states that “quantitizing of qualitative data is an option available if it will help to meet analytic goals to provide the best answers to your particular research questions” (p.27). This study included a content analysis method to create a rich examination of descriptions of stereotyping witnessed by from health service providers. This process of combining metrics and meaning can form new, whole, and better reasoning of a phenomenon, in this case the phenomenon of Indigenous-specific stereotyping. Saldana (2016) noted that “Quantitative research calculates the mean and Qualitative analysis calculates the meaning” (p. 10).

The intent of this study was to infer the transfer of my data (Saldana, 2016, p. 15), to predict that what was observed in this data set and the findings may be compared or transferable to predict possible patterns in service delivery to Indigenous Peoples in similar or other service provision contexts.

██████ Data extraction process.

I initiated this research study to examine and analyze specific responses to one task in the San'yas training. I chose a one-year sample of comments from one stereotyping discussion board task in the San'yas Core health training program and also analyzed anonymized demographic information. The PHSA internal data were gathered from the online learning platform by a third party. Any individual identifiable information was screened and discarded by the researcher before analysis.

The one-year data extraction yielded (n=3,803) comments. To create a more manageable study, a random sample of 25% of the comments was drawn to refine the study cohort to (n=950) comments. The numbers from one to four were written on

pieces of paper by Dr. David Kaufman, which the senior supervisor of the research study, then turned over and shuffled. I selected one piece of paper, which had the number four on it, and so every fourth numerical identifier from the data bank was selected for comment analysis. The 950 comments were read and screened by the researcher for comments that described at least one stereotyping incident of an Indigenous person within a health service context. If the incident did not mention an Indigenous person or health care in some way, it was discounted. The total number of comments that described stereotyping of an Indigenous person in a health care context was (n=333). The comment data were then coded, thematically analyzed, entered into an Excel spreadsheet, and then into an SPSS program to measure frequencies. The demographic data were also entered into the Excel data base and analyzed for frequencies. The frequency of roles that were lower in frequency were collapsed into a group as, "specified other" in the demographic table to protect identity.

Tables were created with the demographics and comment data to protect identity and for dissemination in response to each of the research questions. (see Appendix A Table 1 Demographics, pp. 137-138).

There are two sources for the data:

- 1) Depersonalized comments posted in an online discussion board by participants who completed the Core Health ICS training program between April 1, 2013, and March 31, 2014.
- 2) Depersonalized demographic information from the same cohort. Demographic information was submitted by participants who self-selected identifiers from a drop box. Categories included education, age group, health authority, gender, ancestry, and service role. Demographic information was submitted by participants upon registration on the PHSA ICS learning platform.

The demographic data provided a snapshot of the perspectives of participants who posted comments regarding incidents of stereotyping of Indigenous Peoples they had witnessed while at work in health service delivery. Their comments were analyzed in response to one question in the online training that asked about experiences of stereotyping of Indigenous Peoples in their workplace or in their personal lives.

The demographic data were measured and quantitatively analyzed for frequencies and percentages to demonstrate and enable a discussion of the workplace

culture, racial ratios in positional power and relational ramifications for Indigenous patients. Although there is a hierarchy of roles in any system, and resistance to change can be diverted by persons in places of power, this research did not analyze comments with this analysis. The participants, as a broad group of service providers, provided powerful perspectives regarding the stereotype harm that they had witnessed in their day to day work and themes were consistent across roles. The analysis and quantifying the qualitative data validated the researcher's responsibility to confirm the gravity of the harms described regardless of role.

█ **Stereotyping discussion board: An IV into stereotyping data.**

There are three discussion boards in the San'yas training and the second discussion board was selected as the site of analysis for this research study. At this point in the training, participants have covered four modules: Introduction, Culture and Indigenous People in Canada, Colonization and its Legacies, and Images of Indigenous People. The data were extracted from responses to a task in the San'yas curriculum, specifically the discussion board entitled *Reflections on Stereotyping, Prejudice, and Discrimination*. Participants are asked to submit a response to these questions:

Think about the settings within which you have worked.

- 1) Have you ever encountered negative stereotyping of Indigenous people? If so, describe the incidents. If not, extend yourself beyond the work setting and think of any examples of negative stereotyping you might have encountered elsewhere.
- 2) How did it impact the service the Indigenous person received?

The posted responses from participants provide a rich source of information regarding stereotyping about Indigenous Peoples in general. I use the acronym for intravenous, "IV" as a metaphor for a direct line into a specific source. For this research study the responses that described health services specifically were selected for analysis. Below is a sample of a San'yas core health stereotyping discussion board.

Participant: One instance of stereotyping at its worst that stands out is a comment made by a faculty member about a nursing student. The comment grouped all Aboriginal young people as tardy (using this particular student as the example) and abusers of alcohol and sniffers of various toxic chemicals. This comment was absolutely appalling. The

student was actually of Mexican heritage and had a well-known valid reason for coming to some classes a few minutes late.

Participant: I have had several “opportunities” to be a part of stereotyping and sometimes I surprised myself to have done it upon reflection not only with Aboriginal persons. Having family members that have no conscience of stereotyping has made me more aware and to keep an open mind . . . this course has definitely made me think more of the different cultures in my community.

Facilitator: Thank you. In this exploration it is important to remember that even with good intentions; we can be complicit in a system that perpetuates the historical pattern of racism through policies, practices, and even familial norms. It is not a reflection on our personal value, but an indication of how deeply entrenched stereotypes of Aboriginal people are in our society. Although our socialization can be powerful, the new information from this training can enable us to be conscious of socialized messages about other groups based on race and enable us to choose different attitudes. What do people think of this idea of "unlearning" how we have been socialized to see Indigenous people?

Participant: In my 16 years as a clinician I witnessed many incidents of negative stereotyping of Aboriginal people. The one that stands out in my mind was a young Aboriginal man who was admitted with multiple traumas after an industrial accident. Several nurses decided he was "drug-seeking" (with no evidence) and would refuse to give him additional pain medication prior to mobilization and exercises even though there were physician orders to support this. However, I also witnessed many positive situations where Aboriginal patients and families received high quality care and respect. My observation is that each situation is influenced by the individual physician(s) and staff involved, and this is why it is so important for all of us to examine and become aware of what stereotypes we may hold, and how these may affect our decision making and interactions. (19527)

Facilitator: Great point. As individuals, we really do have a lot of power in many situations. This boils down to what we can do about the injustices we are seeing. Every action can be a move towards building trust and creating a new relationship between Indigenous and non-Indigenous people (and with health care services in particular).

This is a sample of one discussion board with a comment from the data (19527) out of thousands of discussion boards on this topic. This discourse indicates the need for a multi-pronged systemic response starting with a study on and action plan to ensure accountability measures, along with a dire need for a strategic service provision intervention. This is discussed further in Chapter Five.

■ Data collection: Two sources.

As previously mentioned, there were two sources for the data collection. I will revisit the data source and provide more detail here as a reminder for consideration in the next section on Data Analysis:

- 1) Comments posted by participants in cohorts from April 1, 2013, to March 31, 2014, in the San'yas Indigenous Cultural Safety (ICS) Core Health course archived on the San'yas online data base were analyzed. The initiation for the one-year timeframe from this date was selected because this was the first cohort that was provided with the online privacy notification, advising all participants that their comments may be used for research under FOIPPA restrictions that protect identity. The comments that participants post in the online training are archived on the ICS platform and were analyzed using the numerical identifier from the online platform, which was pulled by a third party to depersonalize the data for the researcher. Comments were coded and entered into SPSS system for frequencies, percentages, and analysis.
- 2) Demographic data, including health authority, position, gender, age range, education level, and ancestry (which does not contain personal identifiers), was also used and attached to the comments by the numerical identifier and included in the study.

■ Data bank and analysis.

The data were extracted from the archived San'yas online learning platform. These data were populated into an Excel document. Column A contains the numerical identifiers for each participant. Column B contained the demographic numerical identifier. Column C contained the raw comment data, which are the responses to the question asking about stereotyping of Indigenous Peoples. The final column D contained the month and year of the cohort from which the data were extracted. Reading across each column on the Excel spreadsheet, one can see the numerical identifier for the participant, the numerical identifier for the comment, the comment posted, and finally the start date for the participant's cohort. I reduced the data to 25% and screened for health care contexts. The remaining material provided 140 single-sided pages of raw data.

■ Coding.

The process of assigning codes and the intent to identify patterns in participant response comments was a core reason for embarking on this research project. I have intimate knowledge and a deep desire to learn more about these types of comments. Saldana (2016, pp. 7–8) noted that the researcher will wear an “analytic” lens and how the data is interpreted will depend upon the “type of filter” used and from “which angle you view the phenomenon.” According to Saldana (2016),

In qualitative data analysis, a code is a researcher-generated construct that symbolizes or “translates” data (Vogt, Vogt, Gardner, & Haeffele, 2014, p.13) and thus attributes interpreted meaning to each individual datum for later purposes of pattern detection, categorization, assertion of proposition development, theory building, and other analytic purposes. (p. 4)

It is noted that coding is naturally an interpretive process and that the researcher’s identity, knowledge, and experiences cannot be discounted in the making of meaning in selecting words and assigning codes. In order to search for patterns, meaning was made and values assigned directly to the words used in the comments that the participant posted. The intent was to keep the words used by participants as codes for meaning-making as much as possible. It is also noted that the codes for this study are identified as being led by and bounded as outcomes from responses to a particular task in the *San’yas* curriculum. Saldana (2016) noted that “coding is the transitional process between data collection and more extensive data analysis” (p. 5). The researcher is removed from the participant in that there is no direct interview process in gathering these data, which is a common qualitative data gathering process.

■ Coding and reliability.

Although it is recognized that coding is not a precise science and primarily an interpretive act (Saldana, 2016), the researcher established some coding reliability in the process of triangulating the data. This was achieved by working with *San’yas* co-worker and lead facilitator Chelsey Branch, who also has extensive experience working in Indigenous cultural safety and facilitating education regarding Indigenous-specific stereotypes. In the process of coding this large data set I was also supported by my

Senior Supervisor. The following steps were taken to establish agreement and increase the reliability of the coding:

- 1) I selected and coded one comment.
- 2) I explained the codes I identified and had the second coder review for codes and we compared and discussed the codes.
- 3) When our codes were the same, we did the next one then compared and discussed.
- 4) If the codes were different, we discussed the criteria and rules used. One would adjust the codes and the researcher would then provide the "baseline."
- 5) This was repeated several times until the codes were the same for both coders and the codes were well understood by both.
- 6) When there was agreement three times in a row, the second coder was given 30 of the comments the researcher had coded for individual coding.
- 7) The codes were compared between both coders. When there was full agreement on the codes for a comment, the comment was assigned a 2; when there was partial agreement, the comment was assigned a 1; when there was no agreement, it was assigned a 0.
- 8) We then calculated a percentage for full agreement and a percentage for partial agreement.
- 9) We continued until we reached 80% agreement over the 30 cases.

We lined a large wall with flipchart paper and created a grid of long columns. The second coder, and I read the same 10 comments each and noted words that stood out as potential codes. When codes were agreed upon, they were placed on the flip chart columns. After the initial coding process of identifying and agreeing upon codes, a mark was made under the code column to count frequencies of agreement. We reached inter-rater agreement of 80% quite quickly. The second coder completed coding on half of the comments. I printed a hard copy of the entire data set of 380 comments and coded in pencil, based on our inter-rater agreement process.

The (n=380) comments were reviewed again and refined to improve rigour. The comments were reduced to (n=333) by excluding incidents that did not specifically name or infer an Indigenous patient/client. Even though the task asks for an example of stereotyping of an Indigenous person, participants can resist doing so and deflect from

the task due to a colourblind ideology; an aversion to talking about or identifying race. Given the explicit nature of the task directions and that some comments posted reference workplace resistance to speaking to stereotyping, one can surmise that n=333/950 comments that were coded is a conservative number of incidents screened for analysis. We can't know if the comments that were excluded actually did involve an Indigenous person without going back to ask each person about the stereotype incident shared. Here is a sample regarding the challenge of addressing stereotypes in the workplace:

I have been exposed to the good and bad in my nursing practice and sometimes it's hard to know what to do or say. I agree with the other writers, when you try to say something either in your professional environment or in your personal circle, you usually are met with defensiveness and animosity. (16154)

I draw attention to the use of the terms 'defensiveness and animosity' used as responses in a discussion specifically about identifying Indigenous specific stereotype incidents. After reviewing this data and doing this work for some time, it would appear that it is harder to correct racism than to be racist in regards to Indigneous-specific racism in the workplace culture (and social settings).

Categories.

Several categories for the data analysis were easily recognized. Demographic data drop boxes were selected as categories for quantitative analysis which included education, ancestry, health authority, gender, age range, and job category. Other categories were taken from multiple representations by linking together common topics or terms as raised by participants. Saldana (2016) described the process of linking ideas in this way: "It leads you from the data to the idea and from the idea to all the data pertaining to that idea" (p. 9). Other categories created in this meaning-making and linking process included stereotypes (n=43), attitudes (n=7), harm (n=23), and location or site of service harm (n=30).

██████ Themes.

Some of the categories were then collapsed into themes when this was deemed relevant for further practical analysis based on frequency, potential impacts that stood out, and service relationship implications. For example, the n=43 stereotypes were collapsed into six themes including addict, noncompliance, denial of colonization, parenting, pathology of culture, and dehumanized.

The harm category was collapsed into physical, emotional, and service access harms. Initially 'culture access' harm was identified as a category, but was dropped due to minimal (n=5) representation. Although the location or site of harm category (n=30) was not collapsed into categories (in order to capture the breadth of services named) the lower frequencies (>5) were collapsed together on the frequency Table 2. Locations to protect anonymity. Of the comments that were coded, n=214/333 or 64.26% comments identified specific locations and n= 123/333 or 36.94% did not identify a specific location but described stereotyping occurring in the 'health care system' in general.

In analysing n=333 comments, patterns became evident that would not have been identified in a smaller sample. Five tables were created to measure frequencies and percentages of various themes (see Appendix A pp.145-157). There were expected categories and also some surprises that emerged in this iterative process, which are described in Chapter Four.

██████ Data frequency tables.

Tables were created in response to the four research questions, with key passages as direct quotes to demonstrate what the data and discourse sounds like (Sullivan, 2012, as cited in Saldana, 2016). (See Appendix A, Tables 1–5; pp. 137–147.)

Chapter 4.

4.1. Chapter Introduction

This chapter presents the findings from the research study examining the ways in which stereotyping of Indigenous Peoples affects service provider attitudes, beliefs and actions, and discusses the impact that such stereotyping has on services, systems and access to health and healing for Indigenous Peoples. In this chapter demographics are presented in quantitative tables and qualitative analysis of the themes presented in the participant comments is also provided in response to each of the four research questions. These data deepen understanding of the context in which services are delivered and expose concerns about training, delivery, and accountability for organizations regarding the safety for Indigenous Peoples when accessing health systems.

I also discuss the following issues related to Indigenous-specific stereotyping:

- Root causes and conditions that contribute to stereotyping;
- Systemic and interpersonal interventions; and
- Considerations for reporting and addressing stereotype harm in health care service specifically.

4.2. Research Question 1: *Which stereotypes of Indigenous Peoples are reported by health service providers?*

Quantitative findings.

During the coding process of these comments 43 stereotypes were identified. This table presents the percentage frequencies of the top 10 out of n=333. The bar graph below reveals that the stereotype around alcohol was by far the most prevalent and was expressed n=101 or just over 30% of the comments posted.

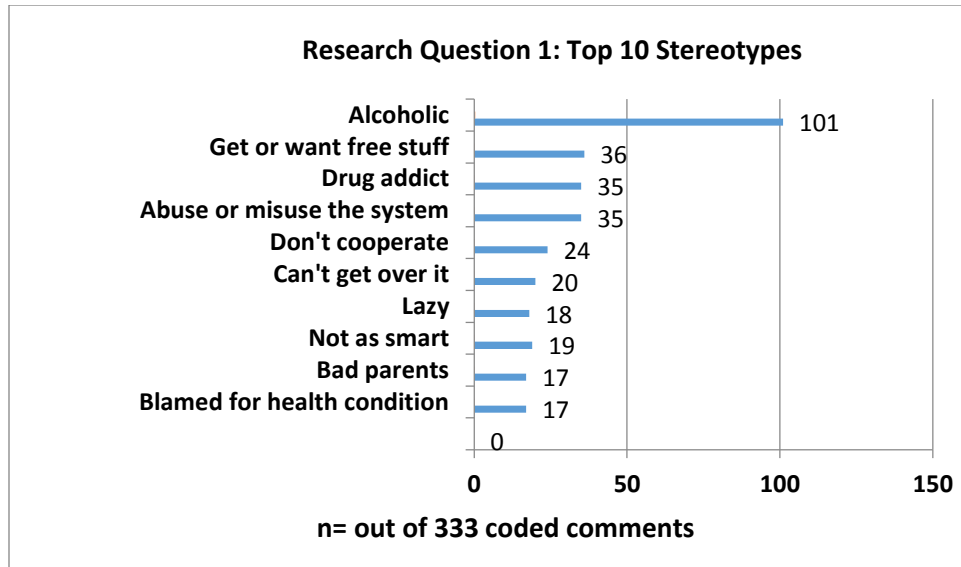


Figure 1. Research Question 1: Top 10 Stereotypes.

(See Appendix A, Table 3, Stereotypes, pp.140–44 for full table of n=43 total stereotypes.)

Six narrative themes were identified in the coding process and they are listed below with frequencies, percentages, and followed by comment samples. Several comments out of the total n=333 named multiple incidents and stereotypes, therefore the numbers and percentages add up to a greater sum than the number of comments posted. The qualitative findings for each theme are provided below with direct quotes to provide samples of the comments described as being witnessed in service delivery and posted online:

Addiction: n=160/333 posted comments (48.04 %): “There’s that drunk Indian in bed XX” (15504).

Denial of colonization: n=144/333 (42.24%): “It’s all self-induced, it’s all their fault” (16093).

Not Fully Human/Dehumanized: n=75/333 (22.52%): “Aboriginal people are illiterate or not as smart” (16239).

Noncompliance: n=84/333 (25.22%) : “They don’t care about their health” (14470).

Pathologizing of culture: n= 52/333 (15.61%): “Don’t expect them to keep their appointments” (16656).

Maternity/parenting: n=32/333 (9.60%) “Aboriginal people are more likely to abuse their children” (15795).

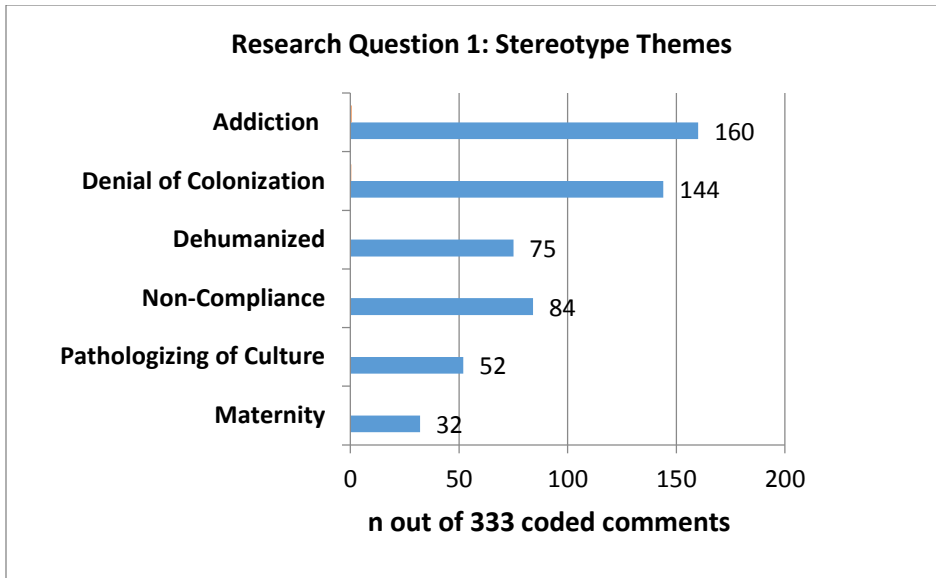


Figure 2. Research Question 1: Stereotypes—Themes

(See Appendix A, Table 3, Stereotypes, pp.140–44 for full table.)

Qualitative findings.

Here are the main points, discussion, and examples of each of the six narrative themes identified in the stereotypes expressed.

Addiction

This data set indicated that addiction was the stereotype about Indigenous Peoples most frequently witnessed by health service providers. This theme was created by collapsing codes that describe alcohol and drug seeking comments. In the examples provided below, we see the ways in which these stereotypes manifest:

I have encountered negative stereotyping at work. There was a First Nations patient who was stereotyped as a “drunk” or “alcoholic.” Just by the first look of the patient. The person had not read the history on the patient and if they had then they would have known that the patient had in fact been admitted to the hospital for other medical concerns. (12938)

I found it common in acute care settings that it is assumed by care providers that Aboriginal people are uneducated and have substance abuse issues. (22756)

While I haven’t encountered negative stereotyping of Indigenous people stereotyping at work, I did see it while in school. While on a practicum I

saw an example of stereotyping when a young man presented with shortness of breath and reported trouble breathing, and the health care provider made the comment that they were native, they were drunk and so they were less of a priority to be seen. Even when questioned upon their view they stuck to it. (18195)

The way in which alcohol use is described is expected and matter-of-fact, as a part of standard practices, as a lack of fortune, and assumed even before medical assessment.

The impacts of these stereotypes on care are illustrated in the following comments:

Unfortunately, I have encountered negative stereotyping of an Indigenous client while working as a student in Acute Care. Although it was unintentional on her nurse's part it did have a profound effect on how we "assessed" the client. We were reading a client's documentation before going in to her room when she noticed "Aboriginal" and "lives on reserve" in the documentation. The nurse told me that these client's sometimes have higher incidences of . . . this and that so we need to ask these questions . . . I won't repeat it as you get the idea. This did negatively impact the care this client received as her [the nurses] language and the questions were stereotypical. Developing a therapeutic relationship of trust and culturally safe care was not going to be possible. As a result, this client was further marginalized. (16472)

Even with the recognition of harm, stereotyping is written off as "unintentional" and there is no discussion shared as to whether this was interrupted or whether the harm was reported or accountable for in the workplace. In another sample, stereotyping about substance use is described as happening "often" leading to a risk for misdiagnosis:

We tend to stereotype certain people as drug seekers, drinkers, whiners, etc. This is unfortunate and happens often. I can remember a time that a young Aboriginal man came into my ER with complaints of abdominal pain and I believe at least three people asked him about his drinking habits and made reference to the fact that he was likely just a drinker, and what are we supposed to do about his pain if he was just drinking all the time. This patient was not a drinker however and ended up having appendicitis, what if we hadn't done our due diligence and just assumed he was lying to us and was a drinker? We might have missed his appendicitis. (13003)

Another comment demonstrates the rationalization of less treatment for Indigenous Peoples:

Having recently moved back to a community with a significant Indigenous population, I have heard several stereotypical and racial comments from colleagues about the Indigenous people in our community. It is not uncommon to encounter Indigenous people in our facility experiencing substance abuse problems. However, I have found that some of my

colleagues will already assume that a person is under the influence from the moment they see them walk in the front door (prior to even assessing them). It is concerning to me because a patient could be walking or acting a certain way because of a medical issue (not because they are drunk). Also, even if it is confirmed that the issue is substance abuse, there is very little effort made to help the person, even if they are requesting help. It is assumed that we would be “wasting our time.” I often wonder how differently that same person would be treated if they were a different race? (15430)

The comment about “wasting our time” points to a concern that even if an Indigenous person does have a substance use issue, their treatment can be filtered through this stereotype. The prevalence of the addict/alcohol stereotype means that an Indigenous person who is in dire need of medical care can be faced with racial discrimination which informs the quality of the care they receive.

Denial of colonization.

Denial of colonial impacts was the second most frequent theme. Indigenous Peoples were described as people who “can’t get over it” (19321), and are “entitled.” (19567). Comments described the stereotype that Indigenous Peoples are to blame for their health problems, while denying colonial impacts. Here is a sample:

I remember doing a practicum for a breastfeeding counselling course at a local hospital. This was a hospital where all of our moms delivered. One of the nurses, when she realized that I worked for the local First Nations, made a comment, “I don’t know why they just can’t get over themselves. We aren’t a bunch of drunks; residential schools were ages ago, like get over it already.” I really didn’t even know how to respond. I was shocked that someone could be so ignorant and so insensitive to Aboriginal people. (16219)

In this example, we see how “blame” is assigned to a patient when she doesn’t “fit in” to the established structure:

I looked after a Residential School and Indian Hospital survivor whose admission to hospital triggered horrific memories of being forced to eat half-eaten food and vomit, as well as other terrible trauma she had experienced as a child. Hospitals are supposed to be places of healing but, for her, her time in hospital was profoundly traumatic and many professionals looking after her physical needs made many false assumptions about why she was withdrawn and distressed. (20296)

We can see that the well-researched and reported health inequities and measures that should be a part of health service education and training are reflected in these

comments. Also, the funding of affirmative action services created to close health gaps seem to be seen as unwarranted.

I often hear prejudice remarks concerning Aboriginal's . . . "they play the victim" . . . "why can't they just get their life together" . . . "they don't pay taxes so why should we give them services," etc. We give them free stuff. I have heard these comments in many areas of my life including at my place of employment and out in public. (17855)

The prejudice that I have encountered at work with regard to aboriginal people is based on perceived special treatment. For example, an Aboriginal mother may be able to have her child's fever medicine covered by their drug benefit plan. (18403)

Throughout my experiences, I have routinely experienced severe stereotyping when it comes to First Nations patients and their families. A few experiences come to mind readily: the family who brought their daughter to the ER with depression, who expressed their emotions differently and were perceived by the ER staff as "not caring for their children" and the mentally ill man brought to psychiatry who was called a "drunk" and a "parasite" because he was so intoxicated, he couldn't walk. He was routinely discharged as soon as he was sober enough to walk because there was "nothing we could do for him"—despite his extreme PTSD from his Residential School experiences . . . this is fairly common discrimination, the belief that "all Indians are drunks." (16181)

I find it so hard to hear people say "s/he got that job because they are aboriginal." It is important to me that the community reflects itself in the work place and I believe that by hiring more aboriginal workers in various environments this will open up dialogue within agencies for change and offer clients/patients the opportunity to see someone represent them in the workplace. (19105)

I have certainly encountered negative stereotyping of Indigenous people in the healthcare setting. Stereotyping as "lazy," having illness that is "self-inflicted" and not being accountable for their own health/welfare were common. I have at times perceived health care workers feeling that some of their care/advice is in vain because of their stereotyping and therefore frustration/less effort put into it. (16022)

Not fully human / dehumanized.

This theme was created by combining comments in which Indigenous Peoples are seen to not be worthy of the same level of care as any other population and where discriminatory treatment was witnessed and described as being without impunity and seen as justified or rational. In this comment data Indigenous Peoples are portray[ed] as "not worth it" (18401) or "'less than' or 'other'" (14664). This reference describes

Indigenous Peoples as being deficit both physically and cognitively from other racialized groups.

Other dehumanizing stereotypes in this category assume that cognitive limitations are expected, genetic, and racially sourced:

There are times when Aboriginal patients came for tests, we automatically think they will be late for the tests and they will be late again for the later tests even though we give instructions to them. The assumption is actually pre-judgement. It is because we don't think the Aboriginal patients could be smart enough to understand the instructions and even if they understand it, they just be late, just like a lot of them do. Because we had those assumption, sometimes we just don't explain the exact procedures to them. My thought was being if they don't really care or they don't understand, why tell them more information to confuse them?.
(19185)

Another common stereotype was identified as having implications for pain management. In this theme there is a belief that Indigenous Peoples are less human and do not feel pain in the same way as others. This creates barriers to the provision of appropriate pain management, and results in unnecessary suffering:

I have worked in many different hospitals in Canada—some with larger Aboriginal populations than others. Regardless, I have witnessed some fairly shocking comments made by health professional colleagues in very off-handish ways in regards to First Nations peoples. I find that often statements or comments aren't made in a malicious way, but I think people do not realize the power of language and the impact of their opinions. For example, recently, while working in an emergency department, one physician commented to me that "all Indians' have very high tolerance to pain." This comment wasn't intended to be negative but I was quite shocked that the individual didn't realize the implications of what he was saying in front of his colleagues. Stereotyping of Aboriginal people is rampant—in subtle and not so subtle ways in health care.
(16439)

Here is another example targeting pain management:

I remember working as a brand new nurse in the hospital, how naive I must have been. One of my patients was a young First Nations women who was experiencing severe abdominal pain. The pain med I was giving her was not helping so I called the doctor to see if the dose could be increased or if an additional or different med could be ordered. When I mentioned the patient's last name [pseudonym removed] the doctor replied, "Don't you know . . . All those Indians ever do is come in to emergency with fake symptoms so they can get drugs. So no, I won't make any changes to her meds" (16262).

In summarizing this category, a participant posted their concerns about what they had seen and their fear of the impacts of not “giving our best”:

Aboriginal people were portrayed to me as being opportunistic, not engaged in their own health, disrespectful and basically not caring much about things in general (lack of self-pride). I was told by this same colleague that they had worked on a reserve (and therefore knew what they were talking about) and that Aboriginal people just didn't care, and we were wasting our time in the clinic. This is a classic example of stereotyping and frankly the idea that we should as healthcare professionals not give our best to a patient is frightening. If as a healthcare professional I enter a consultation thinking I will give the patient the bare minimum, then I am doing a disservice to them and they are not being treated fairly. You cannot expect someone to self-manage their health if they do not have the correct information to do this with. Aboriginal patients do not seem to be treated fairly by healthcare professionals and their health suffers as a result of this. (18401)

The following comment is particularly disturbing:

I had the unfortunate experience of hearing a nurse say to a group of people that “Indians breed like rabbits and should automatically have a tubal when they get pregnant so young.” This nurse was reported and had to take cultural sensitivity training. This experience has remained with me although it occurred nine years ago. I am so appreciative of this course. (17205)

This was a rare comment that indicated that some sort of intervention was initiated. (The next chapter will address interventions more fully). We see a contradiction here, and question whether learning how to be sensitive to culture is a sufficiently preventative intervention to address stereotypes, racism and the seriousness of the harm they cause.

Non-compliance.

The term *non-compliance* is used in health care situations where a person is seen to not comply with a prescribed treatment path or to follow medical advice. The data provided examples where Indigenous Peoples barriers were not recognized and their behaviours were discounted as being “non-compliant” with health service recommendations. These examples such as “I too experience the [comments that] ‘they don't care about their health’ or ‘they mistrust the health care system’ or ‘they are noncompliant’ etc. are quite pervasive.” In addition to promoting the stereotype that Indigenous Peoples “don't attend,” “aren't cooperative,” and “are trouble makers,” these

comments illustrate the belief that the non-compliance of Indigenous Peoples impacts service provider actions and can justify deviation from standard procedures.

The impact of this stereotype on access to health services for Indigenous Peoples is clear:

Before I went in to see an Aboriginal gentleman, I was warned by his nurse that he was simply “non-compliant” with his health issues and that it would likely be a waste of time because he spent most of his time drinking. When people say things like that, it’s difficult to move beyond the perception they have created of the individual—especially when society promotes this image. (18447)

I used to work as an ER nurse and worked with many Aboriginal clients. It is pathetic to say that with many of these clients there would be incidents where staff members would perhaps roll their eyes or shake their heads in pity or pass judgement in one form or another, or go as far as to label the client “noncompliant.” These very actions and assumptions simply erected barriers which resulted in mediocre care provided or accepted by the client. (13979)

These comments illustrate that when an Indigenous person faces racism and leaves without adhering to prescribed treatment; this can be seen as non-compliance and justifies stereotypes and negative service provider actions. This can result in “justified” discrimination and a systemic norm of deviating from standard health service procedures. In the following example we see that, based on racial identity, an Indigenous person will actually get less time with a physician as a matter of accepted systemic time management:

One subtle stereotype that I’ve seen over and over again is that Aboriginal people are always late or often miss appointments. Sometimes this is true due to issues such as transportation to appointments, childcare, etc. however these issues are not isolated to Aboriginal people. The outcome is that in a number of clinics where I’ve worked, those spaces assigned to Aboriginal people are double or triple booked in the expectation that they may not show up. Of course, when they do this means that they may get less time with the physician as the physician now has a busier day scheduled than would otherwise be the case. (19146)

We also see a harm pile up where the intersection of systemic stereotyping in systems collides with social and economic barriers and how this contributes to inequities. In the following example, Indigenous Peoples are perceived as noncompliant, stereotyped as

having an addiction, and viewed as “less than human” which together provides the rationale for providing diminished service:

When Aboriginal patients present themselves—whether it’s in an emergency room or in any health center—they’re not necessarily seen for who they are and consequently they’re not respected, they’re not engaged as fellow human beings and as a result the care they get suffers. As some aboriginal patients avoid seeking care or drop out of treatment programs because of their past experiences, ailments are diagnosed later, when they are harder to treat, and the benefits of preventative care measures, like immunizations and screening tests, may be missed. If they’re not feeling safe or respected, they’re not going to communicate as effectively as they should, and they’re not going to follow up on their treatment plan and they’re not going to come back. (17519)

In summary, stereotyping Indigenous Peoples as noncompliant results in poorer treatment and assigns blame to the patient.

Pathologizing of culture.

The pathologizing of Indigenous cultures arrived in Canada with colonization and the initial contact with European Settlers. This is a lens through which relationships can still be understood today. Pathologizing of Indigenous cultures showed up in the data and this theme was created by compiling stereotype codes that situated the health care problem as rooted in Indigenous culture instead of bias in standard operating procedures and systemic limitations. The following comments which follow described stereotypes and generalized assumptions about Indigenous culture (e.g., “they have large families and different beliefs about time and eye contact,” etc.) as the problem.

The stereotype of being on “Indian time” is well-known:

Several years ago, I lived in a small community on [identifier removed] and knew someone who was a receptionist at a dental office. On occasion when a First Nations client was late for an appointment, she said there would sometimes be a comment from other staff or even the dentist about that person being on Indian time. I am not sure what kind of service this person would have received after this, but I imagine this type of comment lacks tolerance and may create barriers for future encounters between staff and First Nations patients. (16242)

We also see the risk of being unaware of cultural communication patterns in this example:

Here is one example of many . . . I got called into maternity to address concerns by some of the nurses that a new Aboriginal mother was non-compliant and was not bonding with her baby. Upon further investigation, it was revealed that the new mother would not make direct eye contact with the nurse during conversation or when being taught how to breastfeed, because the baby was not latching. In the mother's culture it is not acceptable to look directly into another's eyes for too long and she was embarrassed with the nurse, who was a stranger, being so intimately involved. Culturally-appropriate care for this new mother was discussed. The nurses were relieved and thankful. Now some of the referrals will be to provide culturally-appropriate care instead of non-compliant/bonding issues. (15409)

These comments raise the question of how the service provider is interpreting behaviour when supporting an Indigenous person or family while they are accessing services. The client centered care practice of open communication to meet needs seems to be absent in some of the stereotype incidents witnessed. For example,

I have witnessed racism at my work when a co-worker said that giving suggestions to a parent on their child's behaviour would be a waste of time because First Nations people let their children lead the way. I didn't know how to respond other than to look down at the floor. (14372)

I work in community health and have almost daily interaction with Aboriginal people. There are numerous stereotypes I have heard including comments about "they don't really care about their health so why should we?" to a comment I heard from a nurse about how Aboriginals, "work on Indian time—so don't expect him to be here on time" (in relation to an outpatient appt). Another colleague telling me before I left to see a client on reserve, "you better bring some spare shoes cause [sic] all the houses are filthy." These are just some of the comments I've heard . . . It is my feeling that there is a difference in the level of care Aboriginals receive compared to others. I do not always think it is OVERT, but because there are underlying assumptions, beliefs and prejudice—care may be negatively affected. Sometimes I think there is apathy towards the level of care provided to Aboriginal clients. (18347)

Learning about culture is commonly seen as necessary in providing safer services for Indigenous Peoples, yet learning about culture can also create risk when people are not seen or recognized as individuals coming from vastly diverse cultural groups.

Maternity/parenting.

During the coding process and due to my past experience in child welfare services I was expressly concerned about the potential impact of racism and stereotype harms on mothers, infants and parenting relationships. The data evidenced the potential

interference in parenting when child welfare services were unduly involved, and also on the attachment to services that are intended to support the health of mothers, of vulnerable infants, children, and youths. This final stereotype theme, captured the comments witnessed by participants that portrayed beliefs about Indigenous Peoples as not being caring parents. Comments such as, “they would probably stop having babies if they had to buck up and pay for the childrearing instead of us paying for them...” (17926) reflect this theme. Given the egregious ratios of Indigenous children in government care, the stereotyping of a mother and infant creates a heightened concern for the impact of this stereotype which potentially interrupts access with any social service. The example below offers evidence that health care workers are far more likely to refer Indigenous children to child welfare:

One stereotype that I find striking is the perception that aboriginal people are bad or abusive parents. I have found on multiple occasions that health care providers (including nurses, physicians and medical students) are more likely and more willing to involve child protection services in the case of an injured aboriginal child, than in a similar case involving a white family. Although we all have the responsibility to involve child protection when we truly suspect that a child is in danger, we need to ask ourselves why we suspect this, and whether our reaction is due to a stereotype. Otherwise we risk alienating our patients, creating barriers to care, and perhaps even perpetuating the distrust of medical and social service institutions that many aboriginal people have learned to develop. (16187)

This race-based stereotype can immediately put an Indigenous family under heightened scrutiny which contributes to the abnormally high rates of Indigenous children in government care. In reviewing the data, it appears that there is a stereotype ready for any encounter and that a parent can either be stereotyped as not being able to look after their child (needing to be referred to child welfare services) or not being worthy of a full assessment. An alarming incident witnessed by a health care service provider resulted in the death of a two-year-old:

Their prejudice was clear in their quick dismissal for the need of treatment for her 2 year old [*sic*] little girl. They were sent home with oral antibiotics and told the child would be fine in a few days. This little girl lost her brave battle with a raging infection which if treated in time could have been stopped. This behaviour created deep wounds and permanent scars in this grieving young mother who not only lost her child but most likely any and all trust with the medical system and its providers. (17852)

While this examination of the stereotypes is revealing in the potential for harm, the attitudes that accompany them portray a unique type of individual and systemic violence that is meted out with apparent impunity.

4.3. Research Question 2: *Where are stereotypes towards Indigenous Peoples occurring within health care systems?*

The “health care system” was named generically in n=123 incidents of stereotyping and through the analysis of data, I was able to identify 30 specific health service sites in which stereotyping was described as occurring. The locations that were described in participant comments as prevalent are referred to in n>18 incidents. These include participant comments that described stereotype incidents as occurring in; The health care ‘system’, emergency rooms, hospitals (as a general term), acute care, and the area of maternal care. The quantitative analysis provides a picture of the gravity of the problem, and demonstrates the harm Indigenous Peoples are experiencing when seeking health care. Understanding what harmful behaviours look like and where stereotype harm tends to occur provides insight into the strategies we need to adopt to mitigate harm.

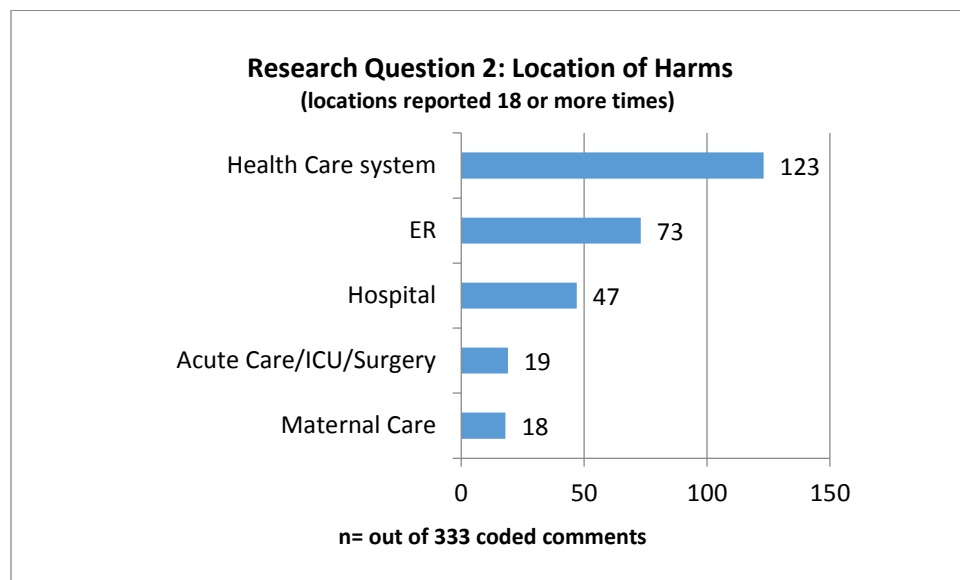


Figure 3. Research Question 2: Location of Harms.

(Thirty locations identified in the data. >18 of n=333. See Appendix A, Table 2, Location of Harms, pp. 139–40 for full table.)

■ Nonspecific location identifier: Health care ‘system’.

I too often experience the “they don’t care about their health,” or “they mistrust the healthcare system,” or “they are non-compliant” etc., comments. Sadly these comments are quite pervasive. (14470)

Stereotyping of Aboriginal people is rampant. (14732)

Sadly these comments are quite pervasive. (14470)

I have witnessed and heard about many instances of discriminatory treatment. (14732)

■ Emergency room.

I work in a small community emergency room and have Aboriginals as patients every day. I am a novice nurse and have only been in this community for about a year. They often get the title “drug seekers.” I just find in general the wait times are longer for them and when they are c/o [complaining of] pain it’s never believed to be what they say it is. (18204)

■ Hospital.

I was also witness to a family member who was dying in hospital, she had many, many family members at her bedside and the hospital staff actually had their engineers take down all the art work in the halls where the patient was until the first nations family left in case, of course, they were going to steal the hospital art work. This was extremely disrespectful to the patient and her family. I hear negative comments on a daily basis about Aboriginal people. (18136)

Working as a bedside nurse, I unfortunately encounter negative stereotyping all too frequently. (14503)

■ Maternal care.

I have experienced many different instances of negative stereotyping in my place of work. “He is first nations he must have been found down drinking.” “She is from the reserve she has nothing to do but have babies.” “She is a first nations mom of course her baby can have juice or pop or whatever else he wants.” “She seemed a little slow on the phone maybe she was high or drinking or just a slow girl from [identifier removed].” I have heard these comments on the job and have always stood up for the person or people. (18136)

4.4. Research Question 3: *Which attitudes towards Indigenous Peoples are reported by health service providers?*

Research Question 3 digs deeper and follows the trajectory from stereotypes to prejudiced attitudes to examine how attitudes towards Indigenous Peoples are reported as having an impact on the treatment provided by service providers and, ultimately on their access to health. This research question was posed to provide information about the basis of stereotypes and also the emotions demonstrated when stereotypes affect service provision.

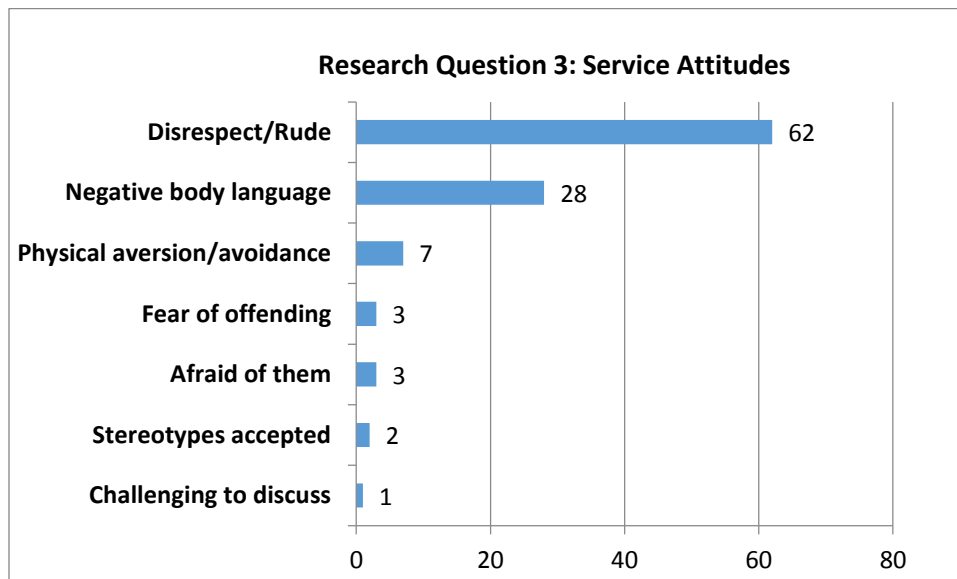


Figure 4. Research Questions 3: Service Attitudes.

(See Appendix A, Table 4, Service Attitudes, pp.145–45 for full table.)

The attitudes described by San'yas participants as witnessed in service delivery towards Indigenous Peoples were organized into three categories: verbalized prejudice, negative physical/body language, and aversion to Indigenous Peoples in general.

Verbalized prejudice: n=62 (18.62%): “There were snickers and snide comments about the patients.” (2150)

Negative body language: n=28 (8.41%): “Eye rolling, head shaking, heavy sighs, etc. when a native person comes into the hospital for help.” (17298)

Physical aversion: n=16 (4.80%): “They're not respected, they're not engaged as fellow human beings.” (17519)

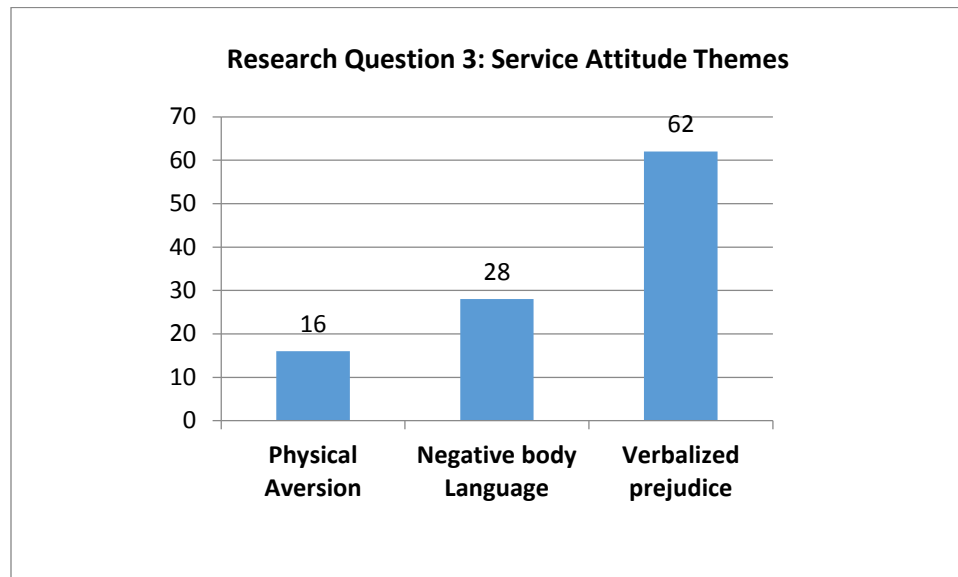


Figure 5. Research Question 3: Service Attitudes—Themes.

(See Appendix A, Table 4, Service Attitudes, pp. 144–45 for full table.)

Verbalized prejudice that describes negative attitudes.

Prejudice influences not only the thoughts of the individual but also, from a sociologist's view, the large-scale social and structural dynamics of intergroup relationships (Dovidio et al., 2013, p. 6). This includes willful disrespect, rude jokes, and derogatory and contemptuous comments (beneath consideration, worthless or deserving of scorn). The following examples illustrate verbal prejudice aimed at both Indigenous patients and staff:

I had a group of students in [identifier removed] hospital doing an 8 wk. practicum on a surgical floor. A number of the patients were Aboriginal. The staffs were not very friendly to them. They would discuss things like “Why can't they go home now that the surgery is done?” There were comments about drinking, alcohol and not working. There were snickers and snide comments about the patients. The nurses would only do what was necessary like give the meds, do the dressings, but nothing extra. It was sad to see. (21530)

At work, I have noticed that some elderly (white) male clients treat any staff who appear Aboriginal with contempt and rudeness. (19003)

I worked in an ER that saw a huge variety of persons and medical concerns come through the door. Although I thought the majority of staff members were pleasant and kind, there was one individual that was particularly rude to Aboriginal people and would even go so far as to not treat their pain when the patient asked for something. This created a very negative environment overall and very few staff members had the gumption to bring up the issue. Many staff, including myself at times, found it easier to ignore the issue than to confront the physician and ask why the patient was receiving this treatment. I feel there is a definite need for leadership to maintain a consistent attitude about aboriginal patient treatment or help create an environment where it is easy to have a dialogue about such issues. (19446)

I have been exposed to racist comments in various workplaces and in my personal life. I don't know whether hospital staff realize the impact of their comments when they generalize by making comments like "they get their free money and want to spend it on alcohol, so go figure they'll drive for an hour to ER to get a Gravol tablet" or "using the ambulance again as their personal taxi" when they get out at the ER door and go downtown, or the usual—"drunk again, he's here for a free meal." This is only a few of the comments I have heard, and I have to admit these types of situations are frustrating and happen more than people would think. (16154)

This participant recognizes the harm done by stereotyping and the need for health care providers to intervene:

At work, although you would think as professionals we would see each other with open eyes and a non-judgmental viewpoint, still, i [sic] have heard inaccurate and hurtful comments. Take for instance . . . alcohol-related medical conditions: "it is all self-induced [sic] . . . see? If they would just stop drinking . . . then that would not happen. It's all self-induced, it's all their faults." "Drunk again . . ." We, as healthcare providers, are in the perfect position to recognize the challenges and assist with providing opportunity for health. As soon as the unfavourable and stereotypical comments stop, then we can begin appreciating each other as individuals with individual merits and qualities rather than lumping each other into pre-conceived judgments based on colour. (16093)

The following comment reveals why service providers feel inhibited from speaking out:

When you don't feel sure, and when you're on the outside of the system, you don't feel confident calling it out (and least of all when you're in an imbalanced power situation where you're relying on someone for medical treatment). It can also be difficult to react when the idea of "playing the race card" has become such a push-back; you're often afraid of being labelled irrational or aggressive or even scheming for questioning the situation. There are some who act as though being accused of saying something racist is somehow worse than being the object of racism, and

that shuts down the opportunities for a learning experience and turns it into conflict. (15433)

Nonverbal physical/body language.

The comments describe the harm of negative body language that sometimes accompanied communication and comments. Health service providers shared how prejudice can be powerfully and automatically applied and portrayed through attitudes and without speaking. The service provider's prejudice can be triggered when a person is identified as Indigenous on a chart or on sight, and negative attitudes can be passed along from service provider to service provider without being documented on a file, with simply a grimace, a grin, a knowing look, a rolling eye, or even a sigh, suggesting complicity between co-workers and an acceptance of racism which, for the Indigenous patient, can have an impact on the duration and entire experience of care:

My experiences include the expressions of body language I see from health care providers towards clients—eye rolling, head shaking, heavy sighs, etc. when a native person comes into the hospital for help. I believe they automatically assume that these people are faking illness to get medications. I have heard the term “frequent flyer” when someone has been in repeatedly for help with pain. I have also heard a patient refuse care from a health care provider who is native, saying things about her that were derogatory. (17298)

While negative comments are a result of stereotyping and prejudice, I have witnessed body language among social and healthcare providers that clearly reflects bias towards Aboriginal people. Delaying service, using different tone, facial expressions serve to communicate bias and discriminatory service. My reaction to witnessing this by a peer is discomfort and disgust. In my younger days I would not say a thing to peers. As I became more confident I would make efforts to engage in conversation that facilitated self-awareness about how our biases are expressed through verbal and non verbal [*sic*] behaviour. (17903)

The nonverbal communication and attitudes were described as subtle, but no less damaging:

I've seen First Nations clients have more difficulty accessing health care services. The specific barriers are not always clear, but I think stereotyping plays a role. No one at my work would make an openly ignorant or racist comment. I think it is a lot more subtle than that. It's the way people are approached and interacted with that can be alienating, even if the care that is provided is competent. Nonverbal communication can sometimes speak volumes. (16376)

One of my co-workers continually serves Aboriginal patients poorly and without the normal pep in his voice. I usually don't like to correct him because I don't want to argue with the person I work so closely with. I notice, however, that the Aboriginal patients are equally impatient with us—probably because over the years they have received such unfriendly service. It's a bad cycle. (13778)

Yes I have encountered negative stereotyping of Indigenous people. At this time I cannot recall specifics but sometimes it was more of an attitude or voice change in the dealing with a client, and tone of voice and body language can set a tone of how the assessment may go. This can affect the service the Aboriginal person received by setting a tone and instigating a negative reaction rather than developing a respectful supportive relationship. (16102)

Thus, negative prejudicial attitudes can be blatant or subtle and are not always communicated in front of or to the patient.

██████ Fear and aversion to Indigenous Peoples or naming of race and/or racism.

An aversion to Indigenous Peoples by health care practitioners might increase health inequities between Indigenous and Settler populations. Here is one incident:

When I came out, the nurse [preceptor] I was working with asked me if the room was a complete mess, because that's how they all are. They are very messy and have no respect or regard for anything. I really think that it impacted this young woman's care because my sense was that most of the nurses almost avoided and didn't spend a lot of time in the room with this patient. (19377)

I was applying for work with the [identifier removed] and I was saddened by the reactions from family and friends, "they are all alcoholics," "it is dangerous to go work there (my answer was, 'Have you worked there? No, so how do you know?')," "they don't care about anything or anybody." Truly shameful comments. (16656)

I had this negative encounter with the daughter of one palliative patient which made me conclude that aboriginals are difficult to deal with; hence I started avoiding them and did not like having them as patients. (16158)

4.5. Research Question 4: What types of harm towards Indigenous Peoples are reported by service providers working in health systems?

In ranking these n=333 incidents, it needs to be stated that there is a risk of rationalizing some incidents as “not as bad as others.” Banaji and Greenwald (2013) conclude that: “Group stereotypes typically consist of traits that are noticeably more negative than those we would attribute to our friends” (p.78). Stereotypes (both negative or positive) can be potentially dangerous and this research points to how unchecked stereotypes can pile up and contribute to systemic flaws when they are not recognized, interrupted or systemically addressed. A rolling eye and/or snide comment can avert a person from attending to health needs when repeatedly experienced by one group of people, and have serious long term impacts that contribute to population health gaps. The first bar graph identifies frequencies of harms that were posted more than 17 times in the 333 coded comments.

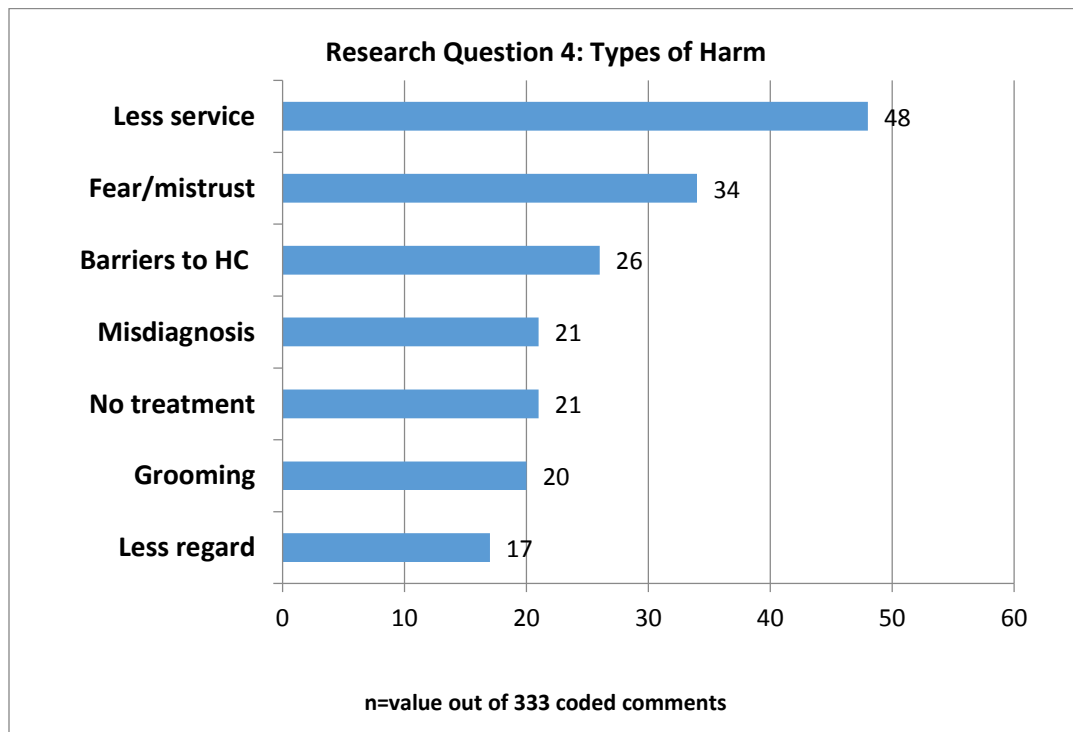


Figure 6. Research Question 4: Types of Harm.

n=23. (See Appendix A, Table 5, Service Harms, pp.145–49 for full table.)

Physical, emotional, and service access harm result from the stereotyping of Indigenous Peoples by health system professionals. The comments below are grouped accordingly. Twenty-three categories were reduced to three themes that demonstrated the impact of service provider stereotypes on an Indigenous person who was seeking health care: physical harm n=151 (45.34%), emotional harm n=94 (28.23%), and service access harm n=80 (24.02%).

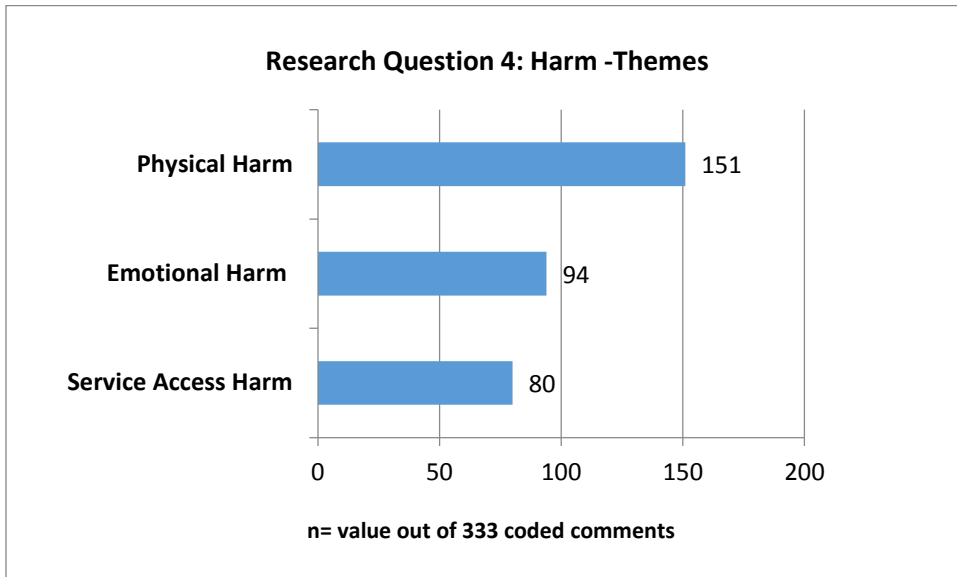


Figure 7. Research Question 4: Harms—Themes.

(See Appendix A, Table 5, Service Harms, pp. 145–49 for full table.)

Physical harm.

There were eleven incidents shared by service providers in which pain medication was withheld, as exemplified in the following comments:

I can think of one example of stereotyping that I witnessed as a nursing student in the hospital, where a First Nations man was typed as “drug seeking” by the nurses, but in fact he had no history of substance abuse and had uncontrolled pain. This resulted in him having to wait longer for analgesics and he suffered through unnecessary pain. (17493)

Tests in the am showed this patient had a stroke and zero blood alcohol level. I am not sure how this nurse missed this information but I believed it was due to prejudices and racist thoughts turned into actions towards First Nations. The patient ended up having abrasions to their wrists, ankles and on their back from not being turned and fighting the restraints. Overall, the medical establishment failed this patient for 12 hours. (18160)

This man came in, was not put in a gown, vitals were taken, some abnormalities noted, but patient left to lie there on the stretcher. A couple of hours went by, this man was left there, a medical student came by, and noted that he was having a seizure and needed suctioning, which he commenced and then staff came to help him . . . making derogatory remarks throughout the whole process, i.e., “What’s the matter with this native guy, why doesn’t he just go curl up and die somewhere, he’ll just be back sometime next week, we are wasting our time.” After a while, the gentleman was feeling a bit better and asked to leave, so was given a bus pass and off he went, with no further follow up offered. (21421)

One of the worst cases of negative stereotyping I have witnessed was on a surgical floor as a student. Admitted to the floor was a First Nations man who became confused and was experiencing visual hallucinations. The assumption made on the floor was that the client was in the DT’s due to alcohol withdrawal and they began treating it as such with administration of benzodiazepines. It was found out much later that the client was actually septic and not withdrawing from alcohol. The client was a victim of negative stereotyping and as a result received improper care. (18591)

Of course, the ultimate physical harm occurs with treatment or denial of treatment that results in the loss of life, as quoted previously: “Their prejudice was clear in their quick dismissal for the need of treatment for a two-year-old little girl who lost her brave battle with a raging infection which, if treated in time, could have been stopped” (17852). The death of Brian Sinclair has been discussed at numerous points in this research as a crucible situation in which concentrated prejudiced forces converged to cause or influence his death. Mr. Sinclair’s experience of being ignored to death in a waiting room in Winnipeg was well-publicized, and several reports have been written calling for systemic actions.

One thing I will say is that the news event that has touched me the most over the past several years is the story of the man in Winnipeg who died in the ER after being literally ignored to death. Brian Sinclair should be alive today but was treated to a succession of failures so catastrophic that I am ashamed to be part of a nation and system that could let this happen. I am haunted by the thought of him sitting in that ER, alone among strangers who either were reluctant to “interfere” or who didn’t feel he was deserving of care or thought. (19698)

Emotional harm.

Stereotyping in service delivery is essentially dehumanizing and can fundamentally lead to emotional harm and mistrust. Although all incidents of

stereotyping can be emotionally harmful, samples were selected by descriptors that clearly indicated the emotional harm and impact on service relationship. Here are some examples:

I can think of a few incidents that have been shared with me by clients. One was mentioned by a young mother who was visiting family in a small First Nations community when she went into labour. She was transferred to a large urban hospital for a pre-term delivery. Because the baby was premature she remained in hospital for several days. She spoke about being treated differently than the other mothers on the ward. She was isolated from family and friends and had no support in that city. Her hospital stay was traumatic for her. She felt that staff was looking at her negatively because she was young, native, and alone. She developed a distrust of large hospitals which later impacted her when she delivered a very premature baby who only survived a few hours. (15595)

Working as a bedside nurse, I unfortunately encounter negative stereotyping all too frequently. I find people are so unaware how little it takes to isolate and shame our patients. I've heard nurses and physicians alike talk about how "they are a drain on the system," not wanting to comply with their medical suggestions, restrictions, medications etc. (14503)

When we got there, a young nurse called him over to speak with him through a Plexiglas window. The way she spoke to him was insinuating that he was wasting taxpayers' money coming to the hospital when it was his own fault that his leg was infected and that he should have gone to a Dr.'s office first. I was really offended by her insinuations and the way that she questioned my friend . . . I explained to this nurse that I knew he would need the services of the hospital and as soon as possible . . . I know many people who do not go to clinics or hospitals for the very reason that they are being stereotyped and judged and not being provided with competent and compassionate care. (15808)

A quote that I recently read from an article in our area, "I never went back to the doctor or to the clinic because I was always afraid of being shamed by them," said a 64-year-old with diabetes. For more than a decade, this woman had avoided the healthcare system. Healthcare professionals in First Nations communities I think hear these stories often. People allow wounds to fester or let chronic diseases spiral out of control due to historical events that have occurred. But I think distrust and fear of the medical system runs deep in people, especially for elders who experienced residential schools and Indian hospitals. Racial stereotyping by some medical staff makes these problems even worse. (19264)

Service access harm.

Eighty-eight of the incidents reviewed described service harm explicitly. One might extrapolate service harm into a much higher frequency when considering that in addition to exacerbating suffering and heightening the need for emergency care, stereotyping and racism prevent Indigenous People from accessing care. Harm, therefore extends beyond the incidents which we are able to track within the system to encompass the harm to those who have avoided accessing health care in anticipation of harm. Research studies have highlighted just how regularly this occurs across Canada (Allan & Smylie, 2015; Browne et al., 2010; Health Council of Canada, 2012; Ly & Crowshoe, 2015). The examples below clarify the reasons for avoidance:

I recently had an Aboriginal client who was calling for health advice. He had been diagnosed with stomach cancer. . . . He had made a trip into ER in the past few weeks and had commented that he had been treated “very racist” and chose to leave because of that. (20326)

Public health nurses ask all new mothers in the new baby assessment if they identify as being aboriginal. If they say yes, they are offered in home assessment and services for new baby and mom. In the past I have noticed that some nurses have said that the Indigenous moms would not be very interested in the education, and teaching provided by the nurse, because they only want to get that information from their own extended family. This can result in less effort from the professional to connect with the family, and consequently the family receiving less service. (12554)

The worst ones are the health care teams’ assumptions that their emerge [*sic*] clients were intoxicated . . . but in reality were dying from aneurysms or strokes. This is experienced in public where people ignore the ill, by the police who choose to arrest the person instead of finding medical help . . . by the nurses and doctors who are acting extremely slowly to do full body assessments because of this stereotype. (16504)

Stereotyping by ER staff, for example, can delay care, damage self-esteem, destroy trust and make a scary medical situation for anyone even worse. Individuals can become reluctant to attend ER again, which of course, could have long term repercussions if an emergent situation arises another time. (16481)

In my working career, one client and his situation really stands out. He is an Indigenous person and before he ever came to the facility, he came “labelled” with what appeared to me to be mostly assumptions and a few perceptions from “well-meaning” professionals. . . . Staff were scared off before they even met him. My personal experience with him was something completely different. When I took the time to interact with him in a non-threatening way and didn’t rush our time together, he was very

calm and gentle and seemed to really relax and enjoy the interaction—which was the exact opposite of what I was led to believe would be his behaviour. Very unfortunate because even as he changed facilities and was relocated closer to family, that “reputation” followed him with his chart and the staff was somewhat misled by the stereotyping without even giving him a chance. (18531)

Working with a marginalized population of people consisting primarily of the Indigenous people, many of whom live with mental health and addictions, I’ve come across situations of stereotyping mostly from hospital ER staff who assume most Aboriginal people living in downtown are drug seeking, mentally unstable, and don’t have any other physical/medical ailments. No offense to any ER staff that may be part of the discussions but this has been the experience of my clients and me. My clients who need actual medical attention due to some kind of unexplained pain or other symptoms are reluctant to visit the ER because of the negative stigma attached to their culture and fear of being judged, discriminated or labelled. My team knows that if we advise our clients to seek higher level of care that can only be provided within a hospital, our clients will most likely not follow through going to the ER. Currently, for our higher risk clients, someone from the nursing team will escort the client if need be to the ER to act as an advocate to ensure the client receives appropriate care. (21017)

Indigenous health care providers themselves also face racist stereotypes while at work. The attitudes of patients and colleagues they encounter can have a significant impact on staff retention and career decisions as illustrated in the example below:

Another time when I was teaching, I had an RN student of Cree descent. I had a terrible time getting patients to accept her as their nurse and the staff would often talk behind her back and not help her when she needed it. There was talk about her being lazy or that they better check the narcotics. She was my best student and was the most caring young lady I had met. We are still in contact. She left nursing (mainly due to poor treatment) and her [sic] and I are talking about her starting a day program in her community for aboriginal elders. (18817)

These indications of the harm Indigenous Peoples are experiencing from service providers demonstrate clear evidence of the contradictions between the intent to “do no harm” and outcomes (the occurrence of harm due to racism within and outside the health system).

The reality that Indigenous Peoples are being harmed while sick and needing health care and while accessing health services, is in itself a contradiction in terms of what service providers are being trained and paid to provide. How this contradiction is understood will be explored in the new themes section under Complacency below.

4.6. Additional Findings

As a researcher who had considerable experience in this topic, I was curious in conducting this research as to whether I would find any new themes. In addition to the information provided thus far, the data also presented four new themes that provide additional insight into Indigenous-specific racism and stereotype harm:

█ Prevalence.

“Prevalence” was the code used to describe the language used to describe the frequency with which stereotype harm was described by participants as occurring in service for Indigenous Peoples. This was coded by extracting and counting comments where multiple frequency terms were used when describing an incident of stereotyping towards an Indigenous person when accessing health services. Although not reported in a table, n=107/333 respondents (32.13%) noted that they observed stereotyping in health care more than once. Samples of prevalence discourse include “this is unfortunate and happens often” (13003); “sadly these comments are quite pervasive” (14470); “working as a bedside nurse, I unfortunately encounter negative stereotyping all too frequently” (14503); “I found it common in acute care settings that it is assumed by care providers that Aboriginal people are uneducated and have substance abuse issues” (22756); “stereotyping of Aboriginal people is rampant—in subtle and not so subtle ways in health care” (16439).

The following statement expands on this theme:

As a member of the ambulance service for many years, I have witnessed and heard about many instances of discriminatory treatment or non-treatment of Indigenous people based on prejudicial stereotypes. This is rampant on the streets of [identifier removed] and in many other communities throughout B.C. (14732)

These examples demonstrate a deviation from the professional ethic to provide universal care to all Canadians. If people are not attending health services when needed or are being pushed out when they do, it will obviously have an impact on their health and further enforce inequities. Reading and Wein (2009) describe the root of exclusion and its impact, stating that “racism and social exclusion have been a reality for Aboriginal peoples since first contact with British colonizers. The colonial system created social

stratification along ethnic lines, with a consequent hierarchical distribution of resources, power, freedom and control, all of which ultimately influenced Aboriginal health” (p. 22).

Stereotypes are “groomed” or enculturated.

In this data set, stereotypes are described as being taught and systemically supported. Some sample comments are below.

Daily workplace enculturation:

On a daily basis I encounter negative stereotyping of Indigenous People—some worse than others. Some things that have been said range from “Wow, natives have such nice thick hair and skin tone,” to “It sure is a busy day must be welfare day so they’re all coming in from their reserves.” (17559)

Service providers trained outside Canada learn the stereotypes:

I hear negative comments on a regular basis about our Aboriginal peoples and their “abuse of alcohol, the system and the expectation that they are ‘owed.’” Even our foreign-trained doctors seem to have picked up these stereotypes. (20360)

The quotes below share examples of how stereotypes were modelled in formal education by preceptors and in training for services for Indigenous Peoples.

Stereotypes modelled in preceptor education² in the hospital setting:

I work as an RN in both the community and hospital setting . . . I will share an example of a comment my nurse preceptor said to me when I was a student and we were working together with a prenatal drug involved First Nations young women. It was the morning, and I just went into the room to introduce myself and give the patient her breakfast tray. Before I put the tray down, I made a spot on the bedside table and cleared a few things away. When I came out, the nurse I was working with asked me if the room was a complete mess, because “that’s how they all are. They are very messy and have no respect or regard for anything.” I really think that it impacted this young woman’s care because my sense was that most the nurses almost avoided and didn’t spend a lot of time in the room with this patient. (19377)

² A preceptorship is an elective mentored experience in which a practicing service provider, such as a nurse or physician, volunteers to give personal instruction, training, and supervision to a student during their formal education.

Stereotypes modelled in preceptor education in a mental health setting:

In one of the mental health settings, we had a young female Aboriginal patient who voluntarily admitted herself to the facility. The staff did not make any negative remarks but once the team reviewed her chart “social history,” many of the team members discussed the underlying factors that impacted her life being Aboriginal. In her social history it was indicated that she was raped in her childhood and my preceptor said that on admission we should ask questions about rape; because, rape is a common incident in this population. (19085)

██████████ Stereotypical treatment is “unfortunate.”

The term “unfortunate” was used to describe stereotyping in 22 comments. Several comments described deeply disturbing incidents. Although, this term is ubiquitous in the English language and has several meanings, when looking closer at the many incidents I began to consider the use of this term, in this context. I question whether this suggested an implicit understanding that stereotyping happens because of individual “bad fortune” rather than the reality that this type of harm is socially and systemically enforced as well as predictable and preventable. Although inconclusive, I began to wonder about the seeming lack of indignant language and description of an intervention. The comments describe what appeared to be an incongruence in emotional response to witnessing prevalent harm or recognition of stereotype harm that contradicts ethical guidelines that have been created to assure safety from racism when any person accesses health services. One might expect that a breach in professional ethics would be followed with a description of an intervention rather than a tone of apparent resignation?

Unfortunately we all have heard and seen stereotyping in our everyday lives and at work in regards to all people. It is easy to make generalizations without first hearing the whole story or taking the time to listen. A specific example in my work setting is to assume that an Aboriginal presenting by ambulance with a decreased level of consciousness is due to high levels of alcohol consumption. When in fact this could be due to a multitude of other health issues (21009).

This lack of connection or registration of the gravity of harm was not uncommon. The tone is curiously ‘matter of fact’ even when witnessed, and described as occurring on a regular basis. I began to question whether this demonstrated a potential for harm to

be consciously and unconsciously enacted, minimized and dismissed—even systemically normalized and taught. This lead to the next category of implications.

██████████ **Complacency.**

The discourse of “misfortune” has implications for inaction. There seems to be a personal disconnect between harm and social justice implications and/or moral/ethical action. Comments suggested a lack of imperative for intervention and action. As revealed in the following comments, competent care is viewed as a matter of resourcing: “The sad truth is that in the emergency setting we don’t always have the resources to provide culturally competent care” (16127) and in another example, “This comes down to time, in order to stabilize the patient or deliver their baby a lot of judgements and stereotypes are created from the lack of time we have” (16597).

Some hospitals have staff designated to advocate for Indigenous patients, an Aboriginal patient liaison (APL), Aboriginal patient navigator (APN), or nurse. We see in the example below where staff expects these “advocates” to attend to and manage the potential for systemic harms and abdicate responsibility for the needs of Indigenous patients, as opposed to all other staff on duty:

I have seen that the care isn’t as complete as it could be, I was very happy that at [identifier removed] there is what was called a First Nations Advocate that we could call upon to make sure the needs were met. (16064)

Johnstone and Kanitsaki (2008) described a failure to intervene as “moral passivism” that contradicts professional ideals, where

individual health service providers might subscribe to the highest moral ideals of their respective professions (especially those proscribing prejudice and discrimination in their practice). Nonetheless, they may never lift a finger to counter the injustices of racism or racialized practices in health care contexts. (p. 493)

This complacency stands alongside and in stark contrast to the implications for every Canadian service provider personally.

4.7. Findings Conclusion / Summary

The research process was intentionally iterative and time consuming. I read and broke down each comment into separate words used to describe Indigenous specific stereotyping incidents looking for commonality. Each code was identified through repeated cycles and triangulation to support data rigour. Having a large data set required concentrated focus and reflection as I assessed and inscribed meaning into incidents described by following the four research questions as predetermined themes. This research provided an unusual opportunity to code, theme and categorize the communication of thought by words; in essence the contemporary discourse about Indigenous specific stereotyping in health services. Adams (2017) refers to Foucault (1972) who describes discourse analysis as: “constituting knowledge, together with the social practices, forms of subjectivity and power relations which inhere in such knowledges and relations between them. Discourses are more than ways of thinking and producing meaning”. He also notes that “discourse is distinctly material in effect, producing what he calls ‘practices that systematically form the objects of which they speak’ (n.p).

As I read and analyzed the discourse, patterns appeared, and I became curious about three themes that emerged regarding power relations, thinking and communication that had not been previously evident in smaller samples of data:

Theme 1: Failure to assign agency. Several of the comments regarding stereotyping implied that harm is not addressed, even when the reality of stereotype harm is seen by the poster to be predictable and systemic.

Unfortunately the stereotypes are so imbedded in our healthcare culture that it's hard to be sensitive to the needs of others and not be called someone who plays favorites. (118546)

One of my coworkers continually serves Aboriginal patients poorly and without the normal pep in his voice. I usually don't like to correct him because I don't want to argue with the person I work so closely with. I notice, however, that the Aboriginal patients are equally impatient with us—probably because over the years they have received such unfriendly service. It's a bad cycle (13778).

In many areas I have heard stereotyping, while at work and in my personal life. One example from work is on a medical floor hearing coworkers discussing a patient and assuming the Indigenous man

created his own issues by drinking. I find others around hearing these comments lack the courage to talk to the speaker about what the comment means or lack the education to correct the statement even if they may know that the statement is wrong to be saying. That is why I think it is important that courses like this are out there and hopefully this type of education becomes more wide spread over time, maybe even into the grade schools and universities (15461).

Theme 2: Freedom to voice Indigenous stereotypes with impunity. In some of the comments witnessed, there appeared to be a personal and professional disconnect and little recognition of injustice and moral or ethical violation. The description of some incidents implied that there are health service staff who have normalized the stereotyping of Indigenous Peoples to the point where they are shared with impunity even described as “shocking”:

I remember doing a practicum for a breastfeeding counselling course at a local hospital (even though I was working in Public Health). This was a hospital where all of our moms delivered; one of the nurses, when she realized that I worked for the local first nations made a comment ' I don't know why they just can't get over themselves. We aren't a bunch of drunks; residential schools were ages ago, like get over it already'. I really didn't even know how to respond; I was shocked that someone could be so ignorant and so insensitive to the Aboriginal people (16129).

I have worked in many different hospitals in Canada—some with larger Aboriginal populations than others. Regardless, I have witnessed some fairly shocking comments made by my health professional colleagues in very off-handish ways in regards to First Nations peoples (16439).

I have witnessed a number of instances of racism so overt they've stood out and clearly made people including myself feel uncomfortable and even shocked. Although these things are very bothersome, I think what I find even more disturbing is the perhaps less obvious culture of racism that I've experienced at the workplace, particularly in the hospital... the kinds of things which go unnoticed by many people and are accepted as the norm (19878).

Theme 3: Colonial narratives at work. There are common narratives used as justification or rationale for not providing care that recognizes the impact of colonization on health and access to health services. The data show that injustice is recognized but justified in narratives such as:

Aboriginals should just get on with the past, “they should be contributing members of society like everybody else”. These comments truly reflect that we haven't learned from our past (18921).

I heard a peer say to the larger group today that he didn't understand why we cannot just get over the native cultural focus and have a broader focus with all other cultures. Essentially a why can't we get over it argument (19321).

Aboriginal people were portrayed to me as being opportunistic, not engaged in their own health, disrespectful and basically not caring much about things in general (lack of self pride). I was told by this same colleague that they had worked on a reserve (and therefore knew what they were talking about) and that Aboriginal people just didn't care and we were wasting our time in the clinic. I was frequently told not to "spend long with them" because it's "not worth it" (18401).

We can see from these findings that stereotype harm in services for Indigenous Peoples is widespread and runs the gamut from inhibiting access to health care to potentially exacerbating preventable conditions. It is again important to note that although some participants recognized stereotypes that they themselves hold and questioned the impact on their Indigenous patients, the majority of examples described a workplace culture where harms were witnessed by service providers while on the job with little indication that they were identified, acted upon or addressed during the incident described.

The data in this study indicate that the health care providers who completed the San'yas Core Health training program have concerns that stereotype harm is occurring frequently and is having a negative impact on health care encounters for Indigenous Peoples across a spectrum of services. The incidents reported demonstrate that stereotypes about Indigenous Peoples affect health assessments and potentially contribute to a workplace culture where discriminatory treatment can occur with impunity. The final chapter will discuss the implications and significance of these findings, with suggestions for interventions at individual and systemic levels to address Indigenous stereotyping in the workplace.

Chapter 5.

5.1. Structural Problems and Solutions

■ Stereotyping costs to Indigenous People's lives.

The differentials of race, positional power and service provider stereotypes can collide with warranted mistrust and lead to practical needs not being met. This recognition can become an integral part of education, services and systemic strategies. The topic of mistrust showed up in n=34 or 10.21% of the incidents that were coded. We can see that the tensions and mistrust will show up in the service relationship and that healing a conflicted relationship history with services is the responsibility of the service provider. If the service provider feels that stereotyping or even respect is a two-way street, the relative power that service providers have over patients can result in a situation that is far from balanced, and the impact of stereotyping and negative attitudes in the healing encounter has distinct differences.

The frequency of these stereotypes means that an Indigenous person in dire need of medical care may be denied care due to racial discrimination and/or viewed as not deserving of the unconditional care that service providers are employed and trained to provide. The comments from participants in this study and the peer-reviewed studies from other researchers indicate that the costs of stereotyping to Indigenous health and lives are myriad.

■ Diversity and multiculturalism as White exits.

The literature review and the data in this study indicate that there is a socialized aversion to looking at race as separate from culture, and a socialized force to ignore the blatant reality that Whiteness is the racial centre of power and control in all systems in countries that have been colonized by White Europeans. This appears in simplistic ideas such as Canada being seen as a cultural mosaic and the USA as a melting pot for all races. The lack of recognition of the dominance of Whiteness and White Western culture has been compared to fish not seeing the water they swim in, or people not being aware of the air that they breathe, and can be exacerbated by White settlers who have minimal

education about Canada's colonial history and the ongoing problems of systemic White bias in Canada.

The belief that Indigenous programs are about one cultural group and therefore not relevant to everyone in Canada living on Indigenous land can lead to the misguided idea that Indigenous cultural education is all that is needed, that inequities are not racially sourced, and that racism is the same for any racialized non-White person.

5.2. Solutions: Disarming the Harm

Education: Professional development priorities.

Racism is a difficult topic to teach when racial ideologies are rigidly held, and for the same reason this can be difficult to interrupt in services. It is actually not education alone that has been missing, but a particular pedagogy including knowledge, self-awareness, and skills along with curriculum that includes critical race education with a focus on Indigenous-specific racism, Settler identity and Whiteness education that has been lacking. Indigenous academic Ward (2018) is a leader in the area of Anti-Indigenous education, curriculum and pedagogy. Her doctoral dissertation, *Teaching about Race and Racism in the Classroom: Managing the Indigenous Elephant in the Room*, addresses this topic in detail.

In addressing normalized stereotyping about Indigenous Peoples, action needs to be taken to teach and to learn in some depth about the truths of Canada's colonial history. Indigenous groups have made considerable efforts, and Settler cooperation and collaboration is required to integrate changes into education systems.

The Truth and Reconciliation Commission (TRC) of Canada calls to action.

The recommendations from the TRC (2015) identify education as an important step in addressing Indigenous and Settler Canadian relations. Graveline (1998) maintained that "we learn in relationship to others, knowing is a process of self-in-relation" (p. 52). The TRC (2015) calls all educators to take action to address systemic injustices. It is hoped that every Canadian will one day receive a more complete and accurate version of the history of Canada. To do so, all education systems are called

upon to collaborate with Indigenous Peoples. The intent of the TRC is to expose the public to the truth about what has happened and what is happening regarding inequities and relationships between Indigenous and Settler peoples. Reports, information and education are not enough. Unless mandates and policies are put into place with sanctions to hold individuals accountable for stereotyping and unsafe behaviour, workplace culture won't change on any level. It is hoped that when people read these findings and vicariously witness the stereotype harms on Indigenous Peoples that they will see themselves in intervening and implementing systemic anti-Indigenous racism strategies. One of the strategies of addressing racism is to see and to name White racial power and privilege. White people need to see themselves as a race, as Settlers and being the source of the race problem, in order to address White Settler power and privilege over Indigenous Peoples.

Indigenous Cultural Safety (ICS) education as an intervention.

Recognition of the need for an educational intervention to address health gaps and improve safety for Indigenous Peoples when accessing health services has gained momentum nationally and is being picked up in aspirational documents by high-level leadership across the province of British Columbia. The imperative for education to support national health equity prompted the *San'yas* training to expand in 2013–14 to include Indigenous contexts specific to the Indigenous territories in the provinces of Ontario and Manitoba, Canada. One can see that many organizations are aware of the racism and investing in changing inequities. There is hope that with the implementation of ICS education as a foundation or starting point across systems, along with accountability measures, that services will be safer for Indigenous Peoples across Canada.

5.3. Ethics and Accountability

When stereotype harm occurs to Indigenous Peoples when accessing health care, the system to which the professional body is accountable for providing ethical care bears the responsibility for resolving the relationship with the people who are being harmed. It is up to the system to make amends to Indigenous individuals, peoples, and communities. Each professional body has its own set of ethical guidelines to adhere to in

ensuring safe quality practice environment. Indigenous-specific racism education and anti-Indigenous racism training needs to be added to education and ethical guidelines

Ethical considerations about the stereotyping of Indigenous Peoples require an examination of the reasoning and markers that have been used to determine whether services are deemed to be ethical or not. The initial step is to ensure that Indigenous Cultural Safety (ICS) education is a part of foundational education. To improve the actual situation in service delivery, it is necessary to introduce and address the topic of racism both systemically for accountability and individually for prevention through education. Discrimination must be addressed systemically with accountability for each racist action and also in the classroom to prevent stereotypes from creating the ideology that allows racial discrimination to be normalized into the practice setting. This requires strategic planning of structures and processes to support safer services for Indigenous Peoples, including a complaint process and policies and guidelines that are recognized as a priority. It also means education for all staff that includes training in the interruption and countering of Indigenous-specific racism and its potential manifestations, the reporting requirements, and the accountability for services.

5.4. Reporting and Documenting

As the social and systemic normalization of the stereotyping of Indigenous Peoples becomes apparent, there are concerning questions about whether individuals are reporting incidents and how systems are addressing them. Stereotype harm can be compared to a chronic condition that can be arrested but never cured, and because there will always be a risk for reactivation, systemic and organizational accountability measures must be put in place to enforce safer services for Indigenous Peoples.

Comments from service providers who were participants in this research study indicate that stereotyping of Indigenous Peoples is prevalent in health care settings. Further research needs to be conducted to answer the question: Do reporting mechanisms reflect this, and are there systemic interventions in place to address them? Allan, Smylie, and Roche (2015, p.16) suggest accessing existing sources of data available in hospital systems, including the need for “accessing and analyzing data collected by hospital ombudspersons” or “patient advocates” and being able to “draw

from administrative data to identify patterns in racism-related complaints within hospitals.”

Allan, Smylie, and Roche (2015, p. 12) compiled a list of priorities for documenting and measuring racism, including:

- Documenting racism in health care experiences and the impact on racism on health care access;
- Measuring racism in health systems and among health care service providers (e.g., pro-White bias; health service provider attitudes);
- Utilizing health disparities as an indirect measure of racism;
- Identifying and exploring health inequities associated with racism beyond the doctor’s office or hospital visits;
- Developing indicators that represent racist attitudes, behaviours and knowledge;
- Identifying current mechanisms by which social and institutional racism and discrimination are perpetrated;
- Measuring the stressors caused by institutional discrimination, such as concentrated poverty, unemployment and underemployment, financial hardship, poor housing conditions;
- Qualitative studies to articulate the specific ways that Indigenous Peoples in Canada experience /are subject to racism and discrimination; and
- Advancing understanding of how Indigenous Peoples conceptualize and respond to racism articulating coping strategies used.

In the province of British Columbia, there is a goal for many organizations to integrate cultural safety as a foundational practice into every service domain. A declaration of commitment was signed by the seven leaders in health care services including five of the regional BC Health Authority CEOs and the Ministry of Health and the First Nations Health Authority (FNHA), demonstrating the commitment to advancing cultural safety within health services. The Declaration of Commitment is on the FNHA website.

Education and training.

Education is an important part of a strategic plan to address the stereotype harm that Indigenous Peoples can face when accessing any service in any organization. The BC Provincial Health Services Authority (PHSA) is developing a strategy to integrate ICS into all program domains to address the need for safety of Indigenous Peoples when accessing any of their organizations (see diagram below). One of the foundational strategies is education and training, as one aspect of an organizational strategy to integrate ICS system wide. This would include learning about Indigenous-specific racism and anti-Indigenous racism response training. In this model training, including the *San'yas* online program is nested in the Human Resources, Training, and Staff Development domain. The full context is available for viewing in a webinar entitled *Setting the Context for Indigenous Cultural Safety: Facing Racism in Health* (Ward, 2016). There are many organizational sites where ICS has a role in supporting staff working in all areas of any system.



Figure 8. PHSA Program domains for system wide ICS strategy.

From Ward, C. (2016). *Setting the context for Indigenous cultural safety: Facing racism in health. ICS Collaborative Learning Series*. Retrieved from <http://www.icscollaborative.com/webinars/setting-the-context-for-indigenous-cultural-safety-facing-racism-in-health>

■ Anti-Indigenous racism education.

The Brian Sinclair Working Group made recommendations that education cannot stand alone, and policies and practices must be adopted to change structures in healthcare and health care delivery in order to eliminate anti-Indigenous racism (Browne, Hill, Lavalley, Lavoie & McCallum (2017, p. 10). This means that anti-Indigenous racism education is required to learn about the unique roots and manifestations of Indigenous-specific racism. The Working Group also recommended unions and nursing and medical organizations issue “unequivocal position statements of zero tolerance of racism in the workplace, and develop further mechanisms for receiving complaints and concerns by Indigenous patients” (Browne, Hill, Lavalley, Lavoie & McCallum (2017, p. 10). Reid and Mate (2018) echoed the need for a systemic response, observing that “Historically and today, health care has perpetuated inequities through experimentation on marginalized communities, segregated care, limiting access to care, and institutionalizing bias and racism. Realizing a high value health system requires a focus on equity” (p. 1).

5.5. Confirming the Literature, Limitations of the Study and Further Research,

The literature indicates that attitudes are not benign and combine with stereotypes as part of a trajectory in a pathway of harm when accessing services. Goodman, Fleming, Morrison, Lagimodiere, and Kerr (2017) conducted research that “demonstrated how healthcare inequalities among Aboriginal peoples are perpetuated by systemic racism and discrimination. Stigmatizing racial stereotypes were perceived to negatively influence individual attitudes and clinical practice” (p. 86). In her paper, “White Resentment in Settler Society,” Schick (2014) also talked about how attitudes in society inhibit critical analysis and the inclusion of relevant discourse about racism when examining inequities: “The teaching about justice issues is not a straightforward matter of how to be a better and more equitable teacher. It isn’t simply a matter of more information or paying more attention to who is in our classes” (p. 1). She expanded on this attitudinal challenge by making the point that “the politics of resentment are used to normalize emotional belonging on the part of a white settler society that sees itself as beleaguered by its excessive generosity and inclusivity” (p. 1). Her article “examines the ways that white supremacy and white racial knowledge are reasserted through the effects of emotional belonging and resentment” (p. 1).

Gordon Allport's classic book *The Nature of Prejudice* was initially published in 1954 and is known as the best general introduction to the study of prejudice. Allport argued, "The course of prejudice in a life seldom runs smoothly. For prejudiced attitudes are almost certain to collide with deep-seated values that are often equally or more central to the personality" (Allport, 1979, p. 326). He made the connection to emotions, stating that even when they are "defeated intellectually, prejudice lingers emotionally" (p. 328). Although relevant to the topic of Indigenous stereotyping and prejudice, an analysis of impulses and the inner conflict of checking internalized racism is worthy of further examination.

Limitations of the Study

The comments describing incidents of stereotyping Indigenous Peoples were made by people employed in health care systems who completed the *San'yas* training in 2014. They described health service encounters and a culture where they witnessed stereotyping while at work. The specific geographical locations of the sites of stereotyping were not named by participants and it is recognized that the type of service described may not necessarily be the sites where they are currently working. The information is therefore limited to first-person descriptions of the frequency, type, attitudes, and harms of Indigenous-specific stereotyping as witnessed across a broad spectrum of sites in the health care system.

It also bears noting that the participants were not asked to describe an intervention when witnessing stereotyping incidents and five comments out of n=333 indicated that someone spoke up during a stereotyping incident they witnessed. The data did not describe many people interrupting the harms, and the frequency is unknown regarding how many people spoke up and/or interfered in addressing Indigenous stereotype harm. Ishiyama (2014), an antiracism response trainer in the Faculty of Education at the University of British Columbia, discussed the consequences of silent bystanders:

It is not uncommon that bystanders do not know what to say and how to respond and cannot think of the appropriate thing to say immediately, when faced with racially discriminating situations where someone else is victimized. Some people get shocked to silence and get immobilized, while some others simply walk away from the situation to avoid direct involvement or further engagement in such situations. As the result,

many bystanders become passive and ineffectual, and fall victim to their own silent reaction. Silent bystanders, who do nothing to confront the situation or to attend to the victim and show support, also perpetuate the vicious cycle of racial prejudice and discrimination. (p. 3)

Further Research

The findings in this study indicate that there is a need for further research regarding interventions to manage Indigenous specific stereotyping, relationships and emotionality in the apparent failure to interrupt Indigenous-specific racism. When racism is enacted all around us and affirmed daily in media, education, and training, and is supported or taught into in service delivery, we can see why it seems to be “easier to ignore racism” (19446). This raises the questions as to whether it is easier to be racist than to interrupt Indigenous-specific racism.

The research question—What is the harm in the stereotyping of Indigenous Peoples when accessing health systems?—requires further research. Areas that would expand the knowledge of systemic stereotyping of Indigenous Peoples would include a replication of this study in other public service systems, posing the same questions asked in this study and expanding to explore any systemic outcomes along with the impacts of stereotyping on Indigenous People’s access to services. Examples of other organizations would be the San’yas Core Child Welfare, Core Mental Health, Core Justice Training in BC, and also core health and mental health curricula specific to colonial contexts in Ontario and Manitoba, which could establish a national qualitative and quantitative analysis of how stereotypes harm Indigenous Peoples. The results could lead to further analysis of organizational safety for Indigenous Peoples and the safety of various service provider profiles across Canada.

5.6. Conclusions

In the final comments of a research study, the researcher usually answers the question “So what?” Indeed, this is an important question given that the literature indicates that racism as a determinant of health for Indigenous Peoples has been reported on in serious depth over many years—even over my own and my parents’ lifetime. One might expect that when people know better, they do better, so why are Indigenous Peoples still experiencing racism in health systems? I question whether

Settlers know what it is they have been seeing in inequities and so need to look closer in an attempt to understand something they do not experience. Will reading these incidents of harm make any difference to addressing racism across services for Indigenous Peoples? This is a question I have struggled with in examining the literature, the data, and in the writing of this thesis. I also ask a few more additional questions in this inquiry. If this research helps, what made a difference—and if not, why not? What do people need to draw attention to in order to hold workplaces accountable in creating a culture of zero tolerance for stereotype harm? There is no quick fix, or as Ward (2016) would say, there is “no magic bullet” in changing a social paradigm. The answer lies in the individual and systemic relationship that Settlers have with Indigenous Peoples, and it is Settlers who need to address the well-warranted, ongoing legacy of mistrust.

In conducting this research I now see the embedded nature and social roots of Indigenous-specific racism in the land to be even more entrenched than I ever considered. As a White Settler conducting this research, I have taken Elder Gerry Oleman’s direction in “saying hello to the Settler problem” deeply in an attempt to share what I know so that Settlers will see themselves as a part of saying goodbye to normalized colonial narratives. In holding myself accountable for what I will never face, I watch for and see the foundations of Indigenous-specific racism reflected everywhere. I hope that in vicariously witnessing these incidents of harm, which were shared by mostly Settler peoples, all people will be outraged and will interrupt the pathway to stereotype harm.

This study is unique in that it demonstrates how the stereotyping of Indigenous Peoples is affecting provider beliefs, attitudes, actions, services, and the resultant gaps in health care for Indigenous Peoples. The question asked in the research title was “What’s the harm? Examining the Stereotyping of Indigenous Peoples in Health Systems,” and the findings suggest that stereotypes are prevalent, even normal, and that the harm to Indigenous Peoples can be violent and has been—and can still be—life-threatening. The data from this research study and the literature review show the predominance of the stereotype harm of Indigenous Peoples in Canada and imply that discrimination can be socially and professionally acceptable. Stereotypes about Indigenous Peoples are reinforced by media and can be triggered in services where professionals bring their personal beliefs and attitudes to the workplace.

Although this study is confined to health care systems, it could be replicated, and the findings applied, in other *San'yas* curricula created for government service contexts including justice, mental health, and child welfare systems.

Addressing racism against any group is not an easy task and, there is an added factor of socially sanctioned systemic racism against Indigenous Peoples in Canada. This research indicates that the specificity of racism against Indigenous Peoples needs to be addressed systemically and with comprehensive strategic planning.

Indigenous health service leaders have been working tirelessly to sound the alarm about stereotype harm for too long, and Settler allies are joining the call to action. In this research we see that, when given an opportunity to discuss colonial realities, Settler service providers are exposing what they witness. It is now time for Settler allies in places of authority to use their voices of power and privilege to cooperate and collaborate with Indigenous leaders and take responsibility for the Settler problem of Indigenous-specific racism. This racial violence demands systemic attention, and every person working in health services can contribute to change.

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Appendix A. Data Tables 1–5

Table 1. Participant Demographics			
Category	Service Organization	n	% of n=333
1. Service organization (as selected from identifier drop box) (n=9)	Northern Health Authority (NHA)		
	Interior Health Authority (IHA)		
	Fraser Health Authority (FHA)		
	Vancouver Island Health Authority (VIHA)		
	Provincial Health Services Authority (PHSA)		
	Vancouver Coastal Health Authority (VCHA)		
	Ministry of Health (MOH)		
	First Nations health Authority (FNHA)		
	Other		
2. Current Position n=23 roles (as selected from current position identifier drop box) in n= 333 coded comments	Nurse	153	45.95
	Physician	26	7.80
	Administration	16	4.8
	OT/PT/SLP	11	3.30
	Social Worker	11	3.30
	Program Director/Manager	10	3.00
	Director	6	1.80
	Nurse Practitioner	6	1.80
	Information Technology	7	2.10
	Project Coordinator	5	1.50
	Student	5	1.50
	Mental Health	5	1.50
	Other specified positions collapsed due to fewer numbers to protect anonymity including: Pharmacy, Education, Human Resources, Paramedic, Dental, Acute Care, Tertiary Care, Patient Quality Care, Policy, Lab Technician.	18	5.40
	Other non-specified positions	54	16.21
3. Gender selected (as selected from identifier drop box)	Female	293	88.00
	Male	39	11.7

	Other	1	.30
4. Age Group (as selected from identifier drop box)	20-29	80	24.02
	30-39	81	24.32
	40-49	84	25.22
	50-59	78	23.42
	Over 60	10	3.00
5. Education Level 95.78 % identify as having post-secondary education. (as selected from identifier drop box)	College, University, Undergrad(CU)	242	72.67
	Post Grad/Grad (PG)	124	37.23
	Hospital on the job training and high school or less (HS)	16	5.40
6. Ancestry (as selected from identifier drop box)	White	224	66.30
	Non-White Settlers (including South Asian, Japanese, Chinese and Black)	36	10.81
	Indigenous (including FN, Métis, and Indigenous other)	30	9.00
	Mixed	29	8.70
	Other non-specified	14	4.20

Table 2. Location of Harm n=30		n	% of n=333
n=30 Locations named in 333 posted comments	Health Care 'System'	119	35.74
	Emergency room (ER)	73	21.99
	Hospital	47	14.16
	Acute Care/ICU/Surgery	19	5.72
	Maternal Care	18	5.42
	Home and Community Care	10	3.01
	Extended care	8	2.41
	Mental Health/Addictions	6	1.81
	Ambulance	5	1.50

	Other specified locations <5 collapsed for anonymity due to lower frequency including: Pediatrics, Tele-health, Public Health, Dental, Palliative care, Cancer care, TB Clinic, Walk-in clinic, Project/Conference coordinator, Policy/Committee planning, Pharmacy, Primary Care, Child/Youth with disability facility, Dialysis, HIV unit, Addictions clinic, Private practice, Medical clinic, Outreach, Child w Special needs aide, Parent Resource Center, Youth Program	21	6.30
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Table 3. Stereotypes codes n=43 themes n=6				
Theme	Stereotype Code *	Example—comment witnessed		%of n=333
1. Addict n=160/333 posted comments (48.04 %)	S1. Alcoholic	“ . . . does their body respond differently?” “ . . . there’s that drunk Indian in bed xx”.	101	30.33
	S2. Drug addict	“ . . . will already assume that a person is under the influence from the moment they see them ... (prior to even assessing) “	35	10.51
	S3. Drug seeking	“The doctor replied, all those Indians ever do is come to emergency with fake symptoms so they can get drugsmany of my coworkers say the same thing.”	9	2.70
	S4. Frequent flyer	“ . . . was a frequent flyer”	15	4.01
2. Non-compliance n=84/333 (25.22%)	S6. Not worthy of services,	“ . . . This groan is followed by the perceived annoyance that they will require more work but at the same time the assumption that the client ,despite being offered every resource available , will not be interested in the service provided”	13	3.90
	S7. Don’t cooperate	“ . . . mess up the schedule/day, demanding”	24	7.21

	S8. Incompetent	“ . . . incompetent of his own care”	11	3.30
	S9. Not interested in our HC services	“ . . . would not be interested in the education & teaching...”	16	4.80
	S10. Don't care about health, make bad decisions, irresponsible.	“ . . . they don't care about their health”	14	4.20
	S11. Don't return for care	“ . . . First Nations women have poor antenatal care and do not go see their doctor...”	6	1.80
3. Denial of Colonization and Racism n=144/333 (42.24 %)	S5. Abuse the system	“ . . . looking for a free ride to town”. “ . . . govt. should be shutting down the baby makers...they would probably stop having babies if they had to buck up.”	35	10.51
	S17. They are sexual abusers/abused	“ . . . this little girl will grow up and do the same thing to her children. “ . . . no charges will be laid, all they do is protect their pedophiles and let the children suffer”.	2	.60
	S18. Get or want free stuff	“ . . . why are we still giving them free stuff?”	36	10.81
	S19. Lazy, don't contribute to society	“ . . . the people are lazy.” “ . . . must be welfare Wednesday”.	18	5.41
	S12. They stereotype us as not caring , they are racist	“They may be stereotyping us at the same time . . .”	9	2.70
	S13. They don't trust us	“ . . . they mistrust the system”	7	2.10
	S20. Blamed for health condition	“ . . . it's all self-induced, it's all their faults”. “ . . . wasting taxpayer's money coming to the hospital when it was his own fault”	17	5.11
	S23. Contempt for us	“ . . . they don't want to work with us.”	3	.90

	S29. Abuse family members	“ . . . the client’s mother and father must also be a drug user and must have abused the client or a family member must have sexually assaulted them as a child...”	4	1.20
	S26. They just need to get over it	“ . . . they play the victim . . . why can’t they just get their life together?’	2	.60
	S34. “Indian” Jokes about behaviour and illness	“Nurses may joke about them or be quick to characterize them as hostile . . .”	2	.60
	S38. Needy	“providing for specific needs is not fair”	9	2.70
4. Maternity/ Parenting n=32/333 (9.60%)	S14. Abuse their children	“ . . . aboriginal people are more likely to abuse their children”	5	1.50
	S15. Bad Parents (14372)	“They are bad parents”	17	5.11
	S37. Have children for money	“ . . . she is having another baby so she can get more money.”	2	.60
	S39. Physically different	“Built to have babies . . . Excellent breast feeders”	8	2.40
5. Pathologizing of Culture and Different HC beliefs n= 52/333 (15.61%)	S21. Make poor choices	“ . . . this client has chosen to suffer the various health conditions and diseases by informed consent”.	8	2.40
	S22. Indian Time	“ . . . there would be comments from other staff or even the dentist about that person being on Indian time.”	8	2.40
	S24. Too many family members	“ . . . I had seen the nurses complaining, and all the people went home. This left the man to be alone . . . and die alone”.	12	3.60
	S25. Won’t show up	“ . . . don’t expect them to keep their appointments.”	10	3.00
	S28. Culturally different, (14372) wise, spiritual, quiet	“They don’t appreciate eye contact”	14	4.20

6. Not Fully Human n=75/333 (22.52%)	S16. Violent	“ . . . treated as though he was violent.”	14	4.20
	S27. Not Smart, have to dumb down.	“ . . . Aboriginal people are illiterate or not as smart.” “But the odd thing was that it was a First Nations person making the comment. 'Darn Indians, don't read'" (18141)	19	5.71
	S30. Liars, thieves, untrustworthy	“ . . . Yeah right, she's native, of <i>course</i> she drank too. They drink like fish, she's probably so used to it she doesn't even realize she's drinking anymore.” “ . . . not stocking diapers because that mom will 'steal' them, and not believing mom for the history she provided.”	16	4.80
	S31. Dirty, messy ,filthy	“ . . . there is a stereotype with cleanliness of homes” . . . “you better bring some spare shoes because all the houses are filthy.”	5	1.50
	S32. Promiscuous (7205)	“ . . . Dr. couldn't trust me not to get pregnant, despite the fact that I was on birth control and not sexually active”	3	.90
	S33. Should be sterilized	“Indians breed like rabbits and should automatically have a tubal when they get pregnant . . .”	2	.60
	S35. All at risk, can't get over it	“I don't know why they can't get over themselves . . . ; residential school were ages ago, like get over it already.”	20	6.01
	S36. High tolerance for pain, stoic	“ . . . all Indians have very high tolerance to pain” . . . “they don't show signs of distress like other people”	4	1.20
	S40. Fat	“I do see many judgements from nurses	2	.60

		and physicians, in comments and patient care as a whole. I see this judgement . . . frequent flyers, drug addicts, alcoholic, fat, etc.”		
	S41. Diabetic Removed with second data sweep	“. . . they are all diabetic because of all the unhealthy food they choose to eat”	2	.60
	S42. Have TB	“We always seem to think that if it is an aboriginal patient they are probably there with TB or drug abuse issues.”	1	.30
	S43. Mentally unstable	“. . . hospital ER staff who assume most aboriginal people living downtown are drug seeking, mentally unstable, and don’t have any other physical/medical ailments”	1	.30

*A note on prevalence frequency: Although not reported in a table, n=107/333 respondents (32.13%) noted that they observed stereotyping in health care more than once. A sample of comments include; “This is unfortunate and happens often” . . . “I have witnessed and heard about, many instances of discriminatory treatment,” “Sadly these comments are quite pervasive”; “Working as a bedside nurse, I unfortunately encounter negative stereotyping all too frequently”; “I found it common in acute care settings”; “Stereotyping of Aboriginal people is rampant—in subtle, and not so subtle ways in health care.”

Table 4. Service Attitudes codes n=7 themes n=3				
Theme	Attitude Code n=7	Example comment	n	% of n=333
1. Verbalized prejudice stereotype (as described in comments posted) n=62/333	A1. Disrespect/ rude/derogatory comments	“There were snickers and snide comments about the patients.” “One of my co-workers continually serves Aboriginal patients poorly and without the normal pep in his voice.”	62	18.62

18.62%				
2. Negative Body language 28/333 n=8.41	A2. Negative body language	“ . . . eye rolling, head shaking, heavy sighs, etc. when a native person comes into the hospital for help.”	28	8.41
3. Avoidance of Indigenous Peoples or naming race and/or racism n=16/333 (4.80%)	A3. Physical aversion	“ . . . I started avoiding them and did not like having them as patients.” “ . . . they're not respected, they're not engaged as fellow human beings and as a result the care they get suffers.”	7	.60
	A4. Fear of offending	“People are afraid to ask the questions for fear of being labeled racist” . . . “everyone is so worried about being PC that we can't discuss our views openly”	3	.90
	A5. Afraid of them	“ . . . nurses are quick to characterize them as hostile, this feels like maybe a fear reaction.” “Staff was scared off before they even met him.”	3	.90
	A6. Challenging to discuss	“ . . . really challenging to point out discrimination” (15795)	1	.30
	A7. Stereotypes are accepted	Stereotypes are not harmful, if “behind closed doors” or not directed at a patient / Stereotypes are accepted / “ignorant to the fact that stereotypes are racist” (20915)	2	.60

Table 5. Service Harm codes n=23 themes n=3				
Theme	Harm Code	Example comment	n	% of n=333
1. Service resulting in or implying or describing <i>Physical harm</i>	H1. Triple booked space—less time with doctor.	“ . . . in a number of clinics spaces assigned to Aboriginal people are double or triple booked in the expectation they may not show up . . . when they do this means less time with the physician.”	7	2.10

n=151 (45.34%)	H3. Misdiagnosis, improper procedure.	“. . . a young aboriginal male came into my ER with complaints of abdominal pain . . . at least 3 people questioned him about his drinking habits . . . This patient was not a drinker and ended up having appendicitis”	21	6.31
	H4. Delay, denial of service	“Delaying service, using different tone, facial expressions serve to communicate bias and discriminatory service.”	15	4.50
	H5. Hard to get assessment	“He fought and had another assessment and was deemed to be fully competent and highly intelligent. How terrible his first several months were at the hospital just because a doctor judged him incompetent.”	10	3.00
	H6. No treatment, no medication	“. . . an elderly First Nations woman had severe abdominal pain going on several months and visited emerg. many times and it was not improving. I . . . couldn't help but wonder why was she sent home in the state that she was?”	21	6.31
	H7. Less effort	“I was frequently told not to spend long with ‘them’ because it’s ‘not worth it.’”	48	14.41
	H8. Condition minimized	“It took a really long time for someone to come and see her. Her situation was really downplayed.”	14	4.20
	H12. Withheld pain medication	“A nurse seemed to dismiss his pain and didn't provide pain medication in a timely manner. It turns out that the man had a serious medical problem requiring surgery. In the end the man suffer from unnecessary suffering due to this negative stereotyping.”	11	3.30
	H13. Death	“. . . a young mother brought her small child into the emergency department . . . Their prejudice was clear in their quick dismissal for her 2 year old little girl. This little girl lost her battle with a raging infection which if treated in time could have been stopped.”	3	.90
	H14. Physical harm	“. . . tests in the am showed this patient had a stroke and zero blood	1	.30

		alcohol level. I am not sure how this nurse missed this information but I believed it was due to prejudices and racist thoughts turned actions towards First Nations. 2. The patient ended up having abrasions to their wrists, ankles and on their back from not being turned and fighting the restraints. Overall, the medical establishment failed this patient for 12 hours.		
2. Emotional Harm n=94 (28.23%)	H10. Created mistrust	Her hospital stay was traumatic for her. She developed a distrust of large hospitals which later impacted her when she delivered a very premature baby who only survived a few hours.	34	10.21
	H11. Less regard	“There is a difference in the level of care Aboriginals receive compared to others. I do not always think it is <i>overt</i> , but because there are underlying assumptions, beliefs and prejudice—care may be negatively affected. Sometimes I think there is apathy towards the level of care provided to Aboriginal clients.”	17	5.11
	H15. Stereotyping on the job, taught on the job	“As an obviously Aboriginal person I have had not only patients but fellow staff members say things to me that were inappropriate (patient asked who's squaw I was/co-worker said that the lab had its 'token' Indian staff member).”	20	6.01
	H16. Barrier to family support	“. . . sometimes the woman will be supported by many family members during her labour...we sometimes are quick to judge and put down another culture's way of doing something, especially something so natural as childbirth...”	5	1.50
	H17. Fear the system, traumatized	“. . . Fear of the medical system runs deep in people, especially for elders who experienced residential schools and Indian hospitals. Racial stereotyping by some medical staff makes these problems even worse.”	11	3.30
	H19. Self-esteem damaged	“I have heard occasional stereotyping being used in my work place (ER). I have heard the term 'drunk' and	7	2.10

		‘abuser of the system.’ This stereotyping has a huge impact on someone’s self-esteem.”		
3.Service Access Harm n=80 (24.02%)	H2. Blamed	“ . . . It felt like the nurse was blaming her for her sickness or that she was not sick enough to be in the hospital.”	3	.90
	H9. Barriers to access	“My clients . . . are reluctant to visit the ER because of fear of being judged, discriminated or labelled . . . someone from the nursing team will escort the client to the ER to act as an advocate to ensure the client receives appropriate care.”	26	7.81
	H18. Discrimination named	I recently had an aboriginal client who was calling for health advice. He had been diagnosed with stomach cancer . . . He had made a trip into ER in the past few weeks and had commented that he had been treated "very racist" and chose to leave because of that.	11	3.30
	H20. Gossip	“ . . . a stereotype that First Nations people are more likely to prostitute themselves. I would consider/detect the lower tone of voice to potentially be gossip.”	11	3.30
	H21. Grooming Enculturated: the process by which people learn the requirements of their surrounding culture and acquire values and behaviours appropriate or necessary in that culture. [1] As part of this process, the influences that limit, direct, or shape the individual (whether deliberately or not) include parents, other adults, and peers.	“I hear negative comments on a regular bases about our aboriginal peoples and their ‘abuse’ of alcohol, the system and the expectation that they are ‘owed.’ Even our foreign trained doctors seem to have picked up these stereotypes.”	20	6.01
	H22. Systemic culture—protection needed from staff	“One stereotype that I find striking is the perception that aboriginal people are bad or abusive parents. I have	3	0.90

		found on multiple occasions that health care providers (including nurses, physicians and medical students) are more likely and more willing to involve child protection services in the case of an injured aboriginal child, than in a similar case involving a white family.”		
	H23. Paternalistic	“We are often in powerful positions with respect to healthcare access attempting to impart paternalistic/ colonial views on how our patients & families should be acting/responding.”	1	0.30

Appendix B. Ethics Approvals



**CHILDREN'S & WOMEN'S HEALTH
CENTRE OF BRITISH COLUMBIA**
AN AGENCY OF THE PROVINCIAL HEALTH SERVICES AUTHORITY

UBC C&W Research Ethics Board
A2-141A, 950 West 28th Avenue
Vancouver, BC V5Z 4H4
Tel: (604) 875-3103 Fax: (604) 875-2496
Email: cwreb@bcchr.ubc.ca
Website:
<http://www.phsa.ca/researcher/ethics-approvals/research-ethics-approval>

ETHICS CERTIFICATE OF DELEGATED APPROVAL: RENEWAL

PRINCIPAL INVESTIGATOR: Laurie Jean Harding	DEPARTMENT: Children's & Women's Health Centre (CWHC)	UBC C&W NUMBER: H14-00527
INSTITUTION(S) WHERE RESEARCH WILL BE CARRIED OUT:		
Institution		Site
Other locations where the research will be conducted: On the PHSA Corporate, Indigenous Cultural Competency (ICC) Online training program.		
CO-INVESTIGATOR(S): David Kaufman		
SPONSORING AGENCIES: N/A		
PROJECT TITLE: What's the harm? Examining the stereotyping of Indigenous peoples in health systems		
REMINDER: The current UBC Children's and Women's approval for this study expires: December 4, 2018		
APPROVAL DATE: December 4, 2017		
CERTIFICATION: In respect of clinical trials: 1. The membership of this Research Ethics Board complies with the membership requirements for Research Ethics Boards defined in Division 5 of the Food and Drug Regulations. 2. The Research Ethics Board carries out its functions in a manner consistent with Good Clinical Practices. 3. This Research Ethics Board has reviewed and approved the clinical trial protocol and informed consent form for the trial which is to be conducted by the qualified investigator named above at the specified clinical trial site. This approval and the views of this Research Ethics Board have been documented in writing.		
The Chair of the UBC Children's and Women's Research Ethics Board has reviewed the documentation for the above named project. The research study, as presented in the documentation, was found to be acceptable on ethical grounds for research involving human subjects and was approved for renewal by the UBC Children's and Women's Research Ethics Board.		
<i>Approved by one of:</i>		
Dr. Marc Levine, Chair Dr. Caron Strahlendorf, Associate Chair		



Annual Renewal Approval

Study Number: 2014s0212

Study Title: What's the Harm? Examining the stereotyping of Indigenous peoples in health systems.

Annual Renewal Date: 2018 March 21
Principal Investigator: Harding, Laurie
SFU Position: Graduate Student

Expiry Date: 2019 March 21
Supervisor: Kaufman, David
Faculty/Department: Education

SFU Collaborator: n/a
External Collaborator: n/a
Research Personnel: n/a
Project Leader: n/a

Funding Source: n/a
Funding Title: n/a

Document(s) Approved in this Application:

- Annual Renewal Form

The approval for this study expires on the Expiry Date. Failure to submit an annual renewal form will lead to your study being suspended and potentially terminated. If you intend to continue to collect data past the term of approval, you must submit an annual renewal form at least 4 weeks before the expiry date.

This letter is your official Annual Renewal Approval documentation for this project. Please keep this document for reference purposes.

The annual renewal for this study been approved by an authorized delegated reviewer