Transcription details:

Date:	03-Apr-2023
Input sound file:	ARM Ep20 – Medical Racism and Indigenous Peoples

Transcription results:

Alec Calac: 00:17	[music] Hi, everyone. This is Alec Calac. Welcome back to another episode of the Antiracism in Medicine series of the Clinical Problem Solvers podcast. As always, our goal in this podcast is to equip our listeners at all levels of training with the tools and mindset to practice antiracism in their health profession careers. I'm thrilled to be hosting this episode today with team member Gillette. On today's episode, we are discussing historical figures in medicine and how physicians have advanced the medical profession often at the expense of indigenous humanity. We will also discuss how indigenous knowledge systems are the foundation of modern medicine and share strategies to promote truth and reconciliation with indigenous peoples in North America. Gillette, I'll hand it over to you to start introducing our incredible guests for today.
Gillette Pierce: 01:07	Thanks so much, Alec. I really appreciate that. I'm going to start introducing Dr. Alika Lafontaine. Dr. Alika is an award-winning physician and the first indigenous doctor listed in medical post 50 most powerful doctors. He was born and raised in Treaty 4 territory, Southern Saskatchewan, and has Métis, [inaudible], and Pacific Islander ancestry. Dr. Alika served in medical leadership positions for almost two decades. From 2013 to 2017, Dr. Alika co-led the Indigenous Health Alliance Project, one of the most ambitious health transformation initiatives in Canadian history. He also was led politically by indigenous leaders representing more than a 151st Nations across three provinces. The alliance successfully advocated for $68 million of federal funding for indigenous health transformation is Saskatchewan, Manitoba, and Ontario. He was recognized for his work in the alliance by the Public Policy Forum, where Prime Minister Justin Trudeau presented the award. Dr. Alika continues to practice anesthesia in Grand Prairie, where he has lived with his family for the last 10 years. I'll turn it over to Alec, now.
AC: 02:11	Incredible. Thank you, Gillette. Dr. Nav Persaud, our other guest, is the Canada Research Chair in Health Justice, staff position in the Department of Family and Community Medicine at St. Michael's Hospital in Unity Health Toronto, and Associate Professor in the Department of Family and Community Medicine at the University of Toronto. His research focuses on health equity and fairness, especially as it relates to medicine access. He also compares national essential medicine lists in collaboration with the World Health Organization. Dr. Nav Persaud has dedicated his career to narrowing the health gap between the highest and lowest wealth brackets and to ensuring that everyone in Canada can afford the medication that they need. Today, he is leading the first ever trial providing people with free access to essential medicines, quantifying links between medication costs and health outcomes, and bringing it to light the unfair choices that millions of Canadians are forced to make about their health. I have a personal social media bias towards Dr. Persaud's work and I'm really excited to learn more about his work, but also the connection to this topic. So with all of that, we are going to kick off for today. And just want to provide a bit of a context

and motivation for today's episode. With an estimated 370 million individuals across more than 70 countries, indigenous peoples represent a significant proportion of the global population. The United Nations defines these groups as having distinct social, economic, or political systems, and historical continuity with pre-colonial societies, meaning they predate pretty much every modern government. These communities make up 6% of the global population, but unfortunately, make up 15% of the population experiencing extreme poverty.

AC: 04:05

As we think about the challenges that they face, including lower life expectancy, a higher burden of disease, and lower socioeconomic status compared to non-indigenous peoples, I really think about how these disparities are likely due in part to the disruption of indigenous knowledge systems, inadequate infrastructure, and really poor identification of these groups in health data, rather than a choice that they've made or any individual behavior. And there is action at the global stage with the United Nations Federal Assembly adopting a guiding framework titled the declaration on the rights of indigenous peoples, which talks about the minimum standards and rights to be enjoyed by indigenous peoples, and really the focus here is equity, making sure that every person, especially indigenous peoples, has a right to a long, healthy life. But of course, equity is something we strive for because that is not the reality for indigenous peoples today. Dr. Persaud and Dr. Lafontaine, Nav and Alika, our listeners have heard extensively about American Indian and Alaska Native health in episode 13. That's when I joined the podcast. And we know it can be difficult to discuss centuries of genocide, colonialism, and the effects that structural racism can have on indigenous health. Since you're both physicians in Canada, I'm wondering if you can discuss the health policy landscape and delivery of healthcare for indigenous peoples in Canada. And are there any conversations about frameworks like the declaration on the rights of indigenous peoples as a kind of guiding document to improve indigenous health?

Nav Persaud: 05:52

Thank you so much, Alec. My main area of interest is medication access, as you mentioned in that really kind and generous introduction. And we know that although healthcare services are generally publicly funded in Canada, that indigenous people and other groups facing oppression and discrimination are much more likely to report not being able to take a medication specifically because of the cost. And that's true despite the fact that certain indigenous people, so called Status Indians in Canada, have access to certain medications that are publicly funded by the federal government. And despite that, some studies indicate that indigenous people overall are around twice as likely to report cost-related non-adherence to medicines. And that's because of systemic issues. It's because of discrimination in the workplace and educational system and the criminal justice system in Canada. And we know there are other disparities that play out when it comes to medication access. For example, racialized people in general are more likely to work in the low income jobs where you don't have access to private insurance or public insurance that covers medication. So in Canada, although healthcare services are generally publicly funded, access to medications depends either on private insurance or public insurance for people on social assistance or people over age 65. And then on the other hand, people in higher income jobs, white collar jobs, tend to have private insurance that's tied to their employment. But if you're a taxi driver, a factory worker, if you're a food server, if you're at home taking care of your family, you don't have access to insurance and you may have trouble affording medication.

NP: 07:48

So some people have the impression that there's a safety net in Canada that should provide lifesaving medications, including insulin, that was discovered in Canada more than 100 years ago. And yet, I see every day in my practice, people who are harmed and put at risk of dying because they can't afford lifesaving treatments, and that includes indigenous people. And this is clearly a violation of people's rights. In general, there is a right to access to essential medicines, medicines that everyone needs, and that certainly applies to indigenous people here in Canada.

Alika Lafontaine: 08:28

I'll maybe extend Nav's really nice framing of where things are at just with some historical things here in Canada. So, no, the experiences American Indians is very, very similar to indigenous people in Canada. So in Canada, we split our groups into three broad demographics. There's the Inuit, who are at northern indigenous people. There are the Métis, which is my ancestry, which was a unique culture that developed as a result of a mixing of different cultures through the fur trade, but became its own unique indigenous grouping, and then there's First Nations, who are probably the most similar to American Indians in kind of the structure. And so I expect in the last episode, you probably touched on boarding schools that happened in the US. There was a scoop that happened where children were taken away from their families and put with non-indigenous families, that occurred in the States as well. There's obviously the wars that happened and people being pushed into less desirable geographic locations. And then enforcement that happened where people were actually penalized legally and socially if they left those borders, lack of development of access to healthcare and other basic needs like water, electricity, indoor plumbing, stuff like that. And that was all structural. And in Canada, there was a different approach from settlers than it was in the US. I think the US was very focused on "conquering" through a variety of different means, which included different technologies, but also deception that occurred historically. And then in Canada, a lot of the spreading of settlers across Canada was the result of signing agreements, which were not followed through on or lived up to, right? And this is why we have language trees, etc.

AL: 10:20

The socioeconomic impact, people who come from lower income areas don't have access because of the places that they live, may not have a voice around the table because those voices tend to be excluded. But for indigenous people in Canada, there's also the deliberate design of the system to push people out of these places, to make sure that their voices were suppressed. There's discussions that we're having right now in Canada to continue the conversation that happened in the mid '2000s when we started talking about the truth and reconciliation commission and a settlement between the federal government and those who were put in these boarding schools, who suffered sexual abuse, physical abuse, and things more horrible than that, which is then progressed into conversations that we had about unmarked burials, children who died at these schools and other places who were never acknowledged that these deaths occurred, and to some degree, were covered up in some places, into areas of things like medical experimentation in these facilities called Indian Hospitals. So it may not be known to listeners, but if you were an Inuit kid in northern Canada, there were ships that came through that would do X-rays of you. And if it looked like you might have TB - and there was very poor technology at the time. Sometimes, I'm sure, it was misdiagnosed - you were put on a ship without saying goodbye to your family, and you were off for the next 3 to 10 years. And you were placed in an institution where you didn't speak your own language. You didn't have access to persons who could translate to you. You had no idea where your family was. I've heard about stories that some of these institutions in Ottawa where people

were on the same floor for several years, and they were members of the same family and did not realize until they finally crossed paths years later, after being put in these TB sanatoriums.

AL: 12:10

And so the place that we land right now with disparities in Canada is a mix of where we are right now, but there's also this historical framework of how we actually designed limited access and created these situations where people actually had poor care. And I think in general, in healthcare, people are starting to feel what indigenous peoples have lived through for a very, very long time. The fact that it is harder to access care, the fact that it is more expensive and is now excluding people who otherwise would have been covered five years ago. The fact that people are just burned out and they're unwilling to put in the time that's needed to provide adequate patient care because they're just kind of pushed to their limit. I mean, that is indigenous healthcare in Canada. So I think it's a really great context that now brought together and just extended a bit.

GP: 13:00

Thank you both for that comprehensive overview and framing these complex legacies. So for this episode, we really wanted to focus on the intersection of systemic racism in the beginnings of modern medicine. So Dr. Nav, in 2020, you published an article in the journal of the Canadian Medical Association titled William Osler, Saint in a "White Man's Dominion". You are critical of Osler's legacy and his mistreatment of racialized groups. So can you please discuss your motivations for writing that article, particularly the section that highlights Osler's decision to gift four skulls belonging to British Columbian Indians to German pathologist Rudolf Virchow?

NP: 13:36

Osler is still revered here in Canada. He's probably one of the most prominent historical physicians from Canada because he held a number of prominent positions throughout the world, including the United States and in England. And then a colleague brought to me the fact that Osler had brought remains of indigenous people to Germany as a gift to one of his mentors. And I was shocked that this person, who is held out as an example we should follow, could have done these things. And then I thought, "Is this connected to a pattern of behavior?" So I started doing some research. And it was actually extremely easy to find other instances of racist and sexist misconduct by William Osler. And so I think that says a lot about where we are today and what has happened throughout the history of our profession in medicine. And shockingly, those remains are still in a museum in Germany, and it doesn't seem like they will be returned any time soon. But I think also, I want to connect this to the history that Alika was reviewing for us a moment ago. So Osler lived in the time of number treaties, where indigenous rights were front and center, where First Nations were negotiating terms with The Crown. Osler lived in the time of Louis Riel, who led an uprising, and front page news was made out of indigenous rights during Osler's time. This was in 1885, Louis Riel was executed.

NP: 15:28

And so this idea that it might have been okay for a doctor to bring indigenous remains with him as a gift to a colleague in Germany, I think it's actually ridiculous. I think in Osler's time, he would have known that indigenous people were fighting for their rights, fighting for their lives. He was a well read person who would have been aware of all of those things. And yet, 100 years later, that legacy persists. And I think we need to rethink this esteem that we hold White men like Osler in, within medicine, and think about what are the stories, what's the history that we have missed out on, and what do we need to embrace and rediscover today.

AL: 16:22

Just to bring that along a little bit more, the dehumanization of individuals in the healthcare system, and not just indigenous people, but Black Americans, other persons of color, women versus men, the rich versus the poor, we see this happen across medicine all the time, right? Ableism, ageism, I mean, it's present in all the isms that you could think of. And sometimes we think that this is something that happened in the past, and somehow, we're much more enlightened. In 2015, there was a case around the death of a woman named Cindy Gladue. And that case was particularly striking because in the trial - and she died from vaginal injuries after sex with a truck driver - they actually brought her pelvis into the court and showed it to the jury. Now, all of us sitting around here are kind of like, "What? What did they do?" And there's a few different layers to that that I think apply very directly to medicine. The first is, who didn't realize this was an extremely bad idea? Not only horrifically disrespectful to the body of another human being, but also completely unnecessary in the course of presenting the case and the defense. What could you not get out of photos? What could you not get out of autopsy reports, etc? And I think that this really goes down to the root of where a lot of this dehumanization continues to kind of move on. You have people who look at each other and just don't see each other as the same level of human. And so we take liberties.

AL: 18:18

When you talk about the experience of racism in healthcare when it comes to indigenous people specifically, one of the things that I commonly hear from persons who talk to me-- and I've had my own experiences of racism. My brother almost died because of a misdiagnosis. They often say, "It's the hostility in healthcare. It's like you show up and it's almost like they're only there because they're doing you a favor." No, you're actually accessing healthcare. You are getting paid for what you do as a provider. This is a service that should be equally available to everyone. You should have the same options. You should have the same sort of feedback. And so that's kind of the first level. And then I think there's a second level where folks see these things happening and they just kind of shrug their shoulders and say, "Well, I guess that's just the way that things are." There was another experience that-- there's quite a few experiences that have happened in Canada. Brian Sinclair dying in an ER in Winnipeg, that was probably two decades ago. There was Joyce Echaquan, who died in a Quebec ER after pleading for help. Her experience was actually broadcast on Facebook in a Facebook Live. And I watched the video and it's very disturbing. If anyone goes and watches it, just to warn you, it will trigger you if you've had bad experiences yourself. So just encourage you just to be careful if you do search for that video, which is widely available online. But when I watched the video, at the very end, the person who's providing her "care", because she's not really providing her care, but the person who's there, looks into the camera and realizes that she's being recorded and kind of just shrugs her shoulders. Like, "Oh, well, people find out. This is just normal." And I think that that's the most terrifying thing about being a person of color.

AL: 20:13

That's the most terrifying thing about being in a group that is discriminated, and there's obviously several layers of things that both work for you and against you. I mean, I'm male, I'm tall. English is my first language. I do have privilege, right? But in the same breath, I'm also indigenous and my mom's Pacific Islander and all these other things. And so I think at the core of the humanization and dehumanization of people who go through healthcare, we have to remember that the person across from us is human. And in this conversation, that's often lost in medicine. And it's a big misnomer when doctors somehow think that they're not a part of the medical experience. We separate ourselves out. I think that's one thing Dr. Osler actually did,

had a big part in promoting that idea that somehow you were just a passive observer in the journey of your patient. You weren't actively participating, as if every time that you contacted, advocated or did not advocate for your patient, that had zero effect on their journey through healthcare. There are mixed legacies. And I love that word legacy that you used earlier, Gillette, because I think it's very, very true. There's a mixed legacy of folks in medicine where they moved forward things significantly, but they also harmed a lot of people significantly. And I think we can hold those two truths in our hands at the same time when we discuss these things.

NP: 21:45

So I think what Alika was just saying about the dehumanization of indigenous peoples, unfortunately, is true. And I think you can see that partly through how the indigenous remains that Osler brought to Germany are being treated today. Although there's guidance to these museums that they should be returning appropriately these remains, this museum in Germany has decided to hold on to them. And it seems that in the more than years that they have had them, it's not clear that they've actually been used towards any kind of scientific study or toward any kind of legitimate aim. Instead, they seem to be just hidden away underneath this museum in Berlin, not helping anyone. And instead, serving only as an affront to indigenous rights, to human rights. And I think it's also just some details, I think although it's disturbing to talk about this, I think are important to mention. For example, it sounds like there's writing on these skulls. So someone has instead of attaching a label to the skulls, they have written numbers inside these human remains as a means to cataloging them, as if everything that had already happened was not bad enough. And this museum has also erected all of these barriers to appropriately returning them and has put the onus instead on others to file paperwork, etc, before this museum that could have benefited from or been enriched by the holding of these remains for more than a century, just taking the steps that are needed to appropriately return them.

NP: 23:41

And it's not the case that William Osler went to a cemetery here in Toronto and dug up the remains of White people and brought them as a present to his friend in Germany. He decided to use remains of indigenous people that were dug up and he gave them as a gift. And I think if things were reversed, if these weren't the remains of indigenous people, I believe today, this museum would have a different view about how quickly they should return them. And actually, this museum and an anthropologist who works for this museum continues to talk about how the study of these sorts of remains could be used to, in their term, celebrate diversity, in what I view as a really disgusting example of biological racism.

AL: 24:31

I'll just point out too. At the time that William Osler did this, it was illegal to exhume human remains. So you can not dig up another human without breaking the law, unless you follow very specific guidelines and regulations, go through multiple different levels, get the consent of the family, or whomever, as kind of that role and accountability and responsibility. So it's not just that this is morally horrific. This is actually illegal. And so I think it's the misapplication of laws. And I mean, this extends into other conversations about how persons of color experience different types of applications of policies and regulations. I see in Canada, that when I treat a non-indigenous person or a non-person of color who gets upset, security isn't rising up to come walk over. I will say that as soon as someone gives an angry stare-- and they may be completely justified. They may be having a horrible experience, be in incredible pain . From a human point of view, it actually makes a lot of sense that that reaction is there. The system responds with this overwhelming hostility. And I think that that is one of the ongoing frustrations of persons of color when it comes to

humanization and dehumanization, is it's one thing for William Osler to have gone around and dug up a bunch of bodies and broken the law with a bunch of different people, but the law wasn't even equally applied, even in the age that he was in.

GP: 26:07 Thank you both so much for bringing us deeper into that history, Dr. Nav and Dr. Alika.

AC: 26:12 Thanks, Gillette. It is incredibly disappointing and unfortunate that, for many of our listeners and for some of us on this call, to only be learning about these harms decades and sometimes centuries after the fact. And realizing that it's not really historical. It's really happening today, within the last one to two generations. And Alika, as you kind of bring in the intersection with the criminal justice system, with missing and murdered indigenous women, I think about how that affects me as an indigenous person in California, as a California Indian tribal member, where I go to a medical school that's part of a system that very gradually decides to give back indigenous remains. And that's some of the greatest collections by number in the world. And the reality is like, "Well, am I a student? Am I community member?" Because as a student, I feel a certain kind of way, but as a community member, I feel entirely different about this as someone within this system. And moving into the next kind of topic area. Alika, I widely believe, and I think many indigenous people widely believe, but also just know it to be true, is that modern medicine is certainly built on indigenous knowledge with them, even if it is without credit, which brings this kind of conversation around pharmaco equity and access to medication that Nav talks about even more concerning for indigenous peoples to be cut off and not able to receive life saving medications. But surely, Alika, thinking about your cultural identity and your own personal values and how it informs your work as not just a physician, but as the first indigenous president of the Canadian Medical Association, how do you bring all of that into your work every day?

AL: 28:28 I will say, first off, it's really important to have folks like Nav as part of this conversation because the reason why we can even have these conversations is because we're all pushing at the same time, right? And so we all have, I think, as humans, just this experience of being excluded or discriminated against to some degree. I do think with certain populations, definitely a lot more, maybe more intense or more frequent. And so having us all kind of change things together is the only way we're going to make it better, right? So I'll just note that. I found a lot of strength in knowing my history. And not just from a resilience point, but also like a factual point. When settlers first came to Canada, what did European medicine believe at the time? It believed in four humors. And if you were sick, let's cut you open and bleed you out. That was literally medicine at the time that settlers came to Canada. It was not microscopes and penicillin and all these other things that we think about looking with a modern lens. What was indigenous medicine at the time that settlers came? It was harvesting plants at their peak potency. It was concentrating those plants in teas. It was delivering those medications through oral, transdermal. There was all these different ways. We were creating poultices that went on wounds that then would get rid of infections and other things. I work as an anesthesiologist and half my drugs have natural sources. Atropine, it comes from belladonna. Folks in traditional medicine use belladonna as part of their treatment of conditions where atropine would actually help.

AL: 30:23 When patients were going through delivery, why did they put branches of willow and poplar trees in their mouth? It's because aspirin comes from those plants. My dad has stories of harvesting seneca, that he'd then give to the pharmacist in town for treatment of constipation. So the place that indigenous peoples were at when settlers

first came to the country in the same way that colonization spread out across the world and went into different countries, the local indigenous groups were actually very, very advanced. Where you look at Chinese medicine, East Indian medicine, North American Indians. We get very, very advanced medical systems. And so I do think that being in a place where my voice is taken seriously, just having the role of president of the Canadian Medical Association, I think adds some legitimacy to whatever I end up saying. It's nice to have that historical frame of where these things came from. The second part, and I think you touched on this when you were talking about the United Nations declaration on the rights of indigenous people, when Canada developed its strategy for providing healthcare to indigenous people, it was always rooted in a charitable point of view. It wasn't viewed in a way of providing rights. It was, "We feel bad about you. We're good people, so we will provide you healthcare." It didn't look at the economic, social, legal, human rights frames that come along. And I think even in the conversation that we have about what happened with Osler and the skulls that traveled across the world, we sometimes root that outside of legal frameworks. It was illegal. It is illegal to deny a patient types of care. You can lose your license for doing some of these things that we label as racism.

AL: 32:20

But the way we approach it is, "If only you were nice to me, everything would be better." That seems to be the frame, as of actually asking, "Well, what are you legally required to do?" And I think that that's really empowering us in a different way. And you can hear this in a lot of the advocacy that now is related to healthcare. We're rooting things in frames of rights. We're rooting things in case law and ways that we're supposed to care for each other. And it is important that we always keep our hearts in the right place, but I think a lot of the progress that we've made is because we've started to look that maybe it's not just us being good to each other, but the requirements that we're supposed to have as we interact as human beings.

AC: 33:05

Well said. Yeah, and it inspires me to see you and Nav take on this work and bring to light these inequities and kind of really just go into what we're still fighting for, because as much as we've gained, we have much more to fully implement and realize. And when we think about moral obligations versus legal obligations, it's an entirely different framing on the same issue. And one where you approach indigenous people saying, "Well, justify the need." Like, "There's no need to justify it. Look at what we've lost and what we still continue to not have today." And we talked on our last episode about how American Indian and Alaska Native life expectancy, as of 2021, is the same as the American public in the 1940s. That's abhorrent. That's incredibly disappointing, but as an indigenous person, not surprising. And I wish that I would stop not being surprised. Because I've become so numb to the reality that we live in each and every day, and I'm glad that we have both you and Nav to bring light to these inequities and also challenge your colleagues to be really part of the solution because it shouldn't be on one or a few of us, it should be on all of us. But it should also be on the shoulders of system that have the resources and kind of infrastructure to be able to carry out change. I've used Nav's own article to inform my own advocacy at my medical school, where you may think it's strange for a medical student to take issue with a parking garage, but it's the parking garage that I saw every day named after Sir William Osler.

AC: 35:04

And it made me think, "If our space is a reflect of our values, why do we have a parking garage named after an individual who has no relation to the local community in San Diego, not even the tribal community?" It's because we think about the legacy of the profession of medicine, not where we are in community. Took a few months, all those references were removed. And you can imagine the reception to that. The

students loved it. The faculty, not so much. To this day, I'm still told about conversations where kind of older faculty members are like, "I don't know why. It was pointless." And then the students are like, "Well, if you read the article, he talks about his relationship to this issue and why it's important and how it's not cancel culture. It's an opportunity to really promote reconciliation with indigenous people than to have a conversation that you weren't having the day before." I think once you start to change minds, you slowly start to kind of build the opportunity or open up a window for change. And looking back, we've had dozens of guests who are at the center of really transformative work in their respective domains. And again, sometimes it's positive, sometimes it's negative as to how the colleagues view their work. And Nav and Alika, how do you respond to those you work or interact with that see your work and advocacy as disruptive or "unbecoming of a physician"?

NP: 36:50

I think it can be a good sign. As I think this vague concept of professionalism is often used to oppress people, to police the way that women dress or which pictures they share of themselves on social media, to police how racialized people decide to cover their heads. Those are all criticisms that come under the guise of trying to promote professionalism. And I think it can be-- this vague notion of professionalism can actually be antithetical to a rights-based approach to medicine and healthcare, where I think we want to have a culture in medicine where if someone, a doctor, a nurse, a clerical worker, support staff, cleaning staff at the hospital, notice that a person is crying out in pain or being mistreated, they say something about it and they don't fear repercussions for speaking up and saying, "I think this person needs help. I think something is going wrong here." And I think professionalism can sometimes undercut our ability to be self-critical in a really constructive way. And I think can also scare people off of speaking out and saying, "There's a systemic problem here." Ultimately, I have found in order to get things changed, you do need to speak out publicly because it is really difficult to go through the so called proper channels in medicine and a hospital and a university, which by the way, I always try to do and always take things to people who should be making the changes. But sometimes those changes don't happen.

NP: 38:35

And in the case of, for example, these indigenous remains we were talking about at this museum in Germany, it actually wasn't until the media became involved, the Toronto Star, in this case, that the museum even accepted that they did actually have possession of these remains. Prior to that, with us just writing polite messages, they would say, "Well, we're going to look into it. We have a lot of remains around here. There's a lot of dust on all of these remains. You can't expect us to know exactly what we have here." So yeah, I think this vague notion of professionalism can be used to police people's behavior and keep people quiet in the face of people's rights being abused.

AL: 39:21

Yeah. I 100% agree with what you said, Nav. And it is interesting how this very vague notion of what's acceptable, which I think to a great degree, is the literal definition of what professionalism is. It's really whoever is in control and what they think is normal. Is used to suppress things that leadership doesn't like or to amplify things that leaders think is important. And so I think there's two lessons to that. The first is, that's why leadership is so important. That's why people who come from diverse backgrounds and have varied lived experience and represent the populations that are served by health systems have to be in leadership. Because if they're not, how in the world are we supposed to inform that view of what's normal? And so that's kind of the first point. And then the second point that I'll touch on that, that Nav brought up, is this

whole idea of retaliation. I think unless you've been caught in a system where you have seen people suffer the results of retaliation, you really have no idea how severe it could be. I'll give you one example personally. I reported the hanging of a noose in an adjacent OR, when I was an anesthesiologist, where I work. And there were ministerial investigations on this and all these other things. And I won't go into that. People can read about it if they'd like to. But as a personal experience, at the time, I was nationally known as a leader in antiracism. I sat on the Council of the Royal College of Physicians and Surgeons of Canada, which regulates and advances specialty education. I was sitting on the board of HealthCareCAN. I was in the midst of conversations with ministers of health and minister of indigenous affairs. And I came home at 2:00 AM, woke up my wife and told her, "I think I lost my job." It doesn't matter the amount of privilege that you have wrapped around you as a person of color or as an indigenous person, you know that that cloak can be ripped off you at any time.

AL: 41:21

It's not permanent privilege. It's not privilege that can't be taken away. And how are we supposed to create patient-centered environments, places where providers and patients can thrive, unless we have some sort of permanence to the power and voice that people have? And I do think that especially today, people do conflate bad experiences with racialized experiences, and it's a tough conversation. If people are now waiting 18 hours in emergency to be seen by someone and everybody's experiencing that, is that less likely to be racism? Yeah, it's probably less likely. It could still be racism, but it's probably less likely if everyone is experiencing the same terrible outcome. But when someone's coming forward with this personal experience of having a horrible experience and they feel like it was because of the color of their skin or the way that they talk or the fact that they're wearing a headdress or a variety of different things that can trigger that racialized caricature, I think the onus is on the system to take people seriously and walk them through how to go through those experiences. Because people do not just come up with those feelings in and of their own. They've had a previous experience. They've seen family members go through the same thing. They have been told stories about the harm that comes if you're this person who comes from this place, looking this way. And if we truly want to build the healthcare of the future, where people truly do thrive-- and I'll tell you some environments where racism is eliminated. I mean, those are some of the best places to work because you get rid of oppression. For one, you start to enhance the rights of everyone. And you can't underestimate the impact that that can have on just how great of a working environment that is and the positive effects that it has on patient care.

GP: 43:18

I want to thank you both for sharing on how you dealt with negative comments. We hope it demonstrates to our listeners that there will always be pushback against change, but perhaps pushback, like you said, Dr. Nav, is a sign that your work is important and necessary.

AC: 43:31

Exactly what Gillette just said. I think when people navigate a healthcare system, especially as a member of a racialized group, every experience that you have is often negative or adverse or affects you in some kind of way. And I really hope we can eventually flip that, that every experience is a good one, a great one because everyone deserves healthcare. Everyone is owed healthcare. Indigenous peoples prepaid for healthcare through the lost of life, land, and this culture, our way of life. And to navigate these systems is still very difficult. And for our listeners who are finishing this episode right now and returning to their careers, I think it's really

powerful that we've been able to kind of take them through so many topics and discussions and framings that they often just don't hear every day. And as you have both pointed out, Nav and Alika, that's often by design. Indigenous peoples experiences aren't meant to be everyone else's experiences. I wonder, and this is to both of you, what are some practical applications that our listeners can act on today to better support the diverse communities that they care for?

NP: 45:01

I mean, first of all, let me just say, I mean, as a racialized person who's not indigenous, I'm really grateful to be able to participate in a discussion like this, and I've learned a lot from the discussion and including, of course, from really insightful things Alika has said. In terms of practical tips, I think one is that we need to reflect on what has happened and reflect on all of the work people have done to counter racism and anti-indigenous discrimination over decades or centuries. And I think one of my ongoing frustrations in doing work that's aimed at promoting equity or justice is how some people pretend that it is new to them, that they just learned about racism in the last few years, that there was like a recent racial reckoning that made them realize that this was an issue they had to deal with. When, in fact, there are multiple reports from the United Nations, from individual governments talking about issues, including racism and anti-indigenous discrimination, and there are a number of reports, Alika has alluded to some of the instances in Canada of racism and anti-indigenous discrimination, that have prompted reviews. So I think we need to respect what has happened and read and reflect on what's been done.

NP: 46:42

And as a racialized person who's not indigenous, I recognize that I benefit from the work that indigenous people have done in advocating for fair treatment and advocating for indigenous rights to be respected because we all will be better off in a world where indigenous rights are front and center and respected by everyone.

AL: 47:06

I'll echo Nav's voice and what he just said. And in my own work, I've actually found that the barriers to moving forward with these issues are a lot more simple than we think. And I use my own grouping, there's a lot of different ways to classify this. So this isn't the only way, but the first big barrier and, I think in it, the solution, is that as providers, particularly as physicians, we have deeply entrenched within our personalities this idea that all we do is good. And that if we don't do good, we're somehow bad people. And if we're bad people, what was the point in going through all this training and do all these sacrifices? And so to the listeners that are listening to this episode right now, if you're feeling like you're a bad person as a result of this conversation, that's not the point of the conversation. The point of the conversation is to realize that we're all kind of three dimensional characters in providing healthcare. We provide both health and harm. We do both good and bad in what we do. And if you can recognize, in your practice, the harm that's happening to folks because of the way that you interact with them, something as simple as saying a person's name. I hear from Inuit patients, the common experience that people won't even attempt to say their first name because they say that it's too difficult, or they'll use some sort of nickname. And I know that's common for East Indian folks. It's common for my wife, who's Vietnamese. People talk about having an English name versus having a named rooted in their own language. And that's incredibly dehumanizing, to not provide that. And it's such a simple thing that you can do for patients. You can go on Google. Put in the name and ask Google how to pronounce it. We do have technology that can support you with these things.

AL: 49:01

And then there's big things, like making sure that when a patient is afraid, spend a bit more time, give it a bit more space for them to respond. If they're upset, be a little

less quick to turn on the zero tolerance for hostility policy. I've had lots of experiences where I've had patients get very upset and yell from many different backgrounds and socioeconomic situations. And you giving the space, you may be the only person they ever were allowed to yell at. Everyone else called in security. And then you realize they've gone through this long, traumatic journey to get to where you are, and you're the one person who helped them feel human again. So that's kind of the first part. And the second part is just a recognition that in the course of restructuring power, there are winners and losers. You may not have the same voice that you have around the table, but the reason why you came into medicine was to help people, and maybe the best way to help people is by getting out of the way. That's something that I reflect quite a bit on in the latter half of my presidency at the CMA. In August, I'm going to turn over to Kathleen Ross, who's a White physician from BC. Kathleen's brilliant. She's going to have a lot to say. And passing along that power and structure gives the opportunity for a woman, a person from a different perspective, someone with a different specialty - I'm anesthesia. She's family medicine - to fill that space and have that voice. And that is the purpose of restructuring these power structures, is so we can more effectively help people. So if you don't like what's happening, I'd actually just ask yourself, "Is this helping people in a more effective way?" And I think a lot of these changes, you'll actually find the answer to that is yes.

AC: 50:49 Incredible. Thank you two so much for your time, and I know Gillette and I-- we sometimes say it, but I always say it, where I really just want to keep coming back to this. And it's one thing when you can listen to it, but it's entirely different when you're experiencing it at the time of recording. So thank you. And I'm sure our paths will cross again you.

AL: 51:16 Thanks for having me.

NP: 51:17 Thank you. It was great. [music]