

**SADHEE SEHAYTH (OUR HEALTH) PROJECT**

**HEALTH INEQUITY IN CANADA'S UNIVERSAL HEALTHCARE SYSTEM THROUGH THE  
EXPERIENCES OF THE PUNJABI SIKH DIASPORA LIVING WITH CARDIOVASCULAR DISEASE**

**by**

**Harminder Bindy Kaur Kang**

**B.A., Simon Fraser University, 2002**

**M.A., Simon Fraser University, 2007**

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The following individuals certify that they have read, and recommend to the Faculty of Graduate and Postdoctoral Studies for acceptance, the dissertation entitled:

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the degree of Doctor of Philosophy  
in Interdisciplinary Studies

**Examining Committee:**

Colleen Varcoe, Professor, Nursing, UBC

Co-Supervisor

Sunera Thobani, Professor, Asian Studies, UBC

Co-Supervisor

Minelle Mahtani, Associate Professor, Institute for Social Justice, UBC

University Examiner

Judith M. Lynam, Professor Emeritus, School of Nursing, UBC

University Examiner

Sheryl Reimer-Kirkham, Dean, School of Nursing, Trinity Western University

Supervisory Committee Member

## Abstract

The *Sadhee Sehayth (Our Health) Project* investigates how British Columbia's health authorities support diversity, anti-racism and equity for patients and their families. I selected Post/Colonial, Critical Race and Feminist Theories to analyze the complex and pervasive ideologies that inform institutional structures. Using a *Critical Ethnographic* approach, I addressed the following research questions: 1. How are institutional diversity discourses and actions constructed, and how do they shape healthcare experience for racialized communities?; 2. How do institutional diversity discourses and actions shape experiences for one racialized diaspora community, the Punjabi Sikh Diaspora when seeking cardiovascular healthcare, and 3. what does this analysis tell us about how systemic structures are conceptualized and might be improved for healthcare delivery for racialized communities? Phase one examined the diversity commitments of health authorities through an analysis of mission statements, visions and values. The analysis revealed that health equity is not prioritized in the institutional statements for 7 of the 8 health authorities. The absence of these markers reaffirms that anti-racist ideologies are not conceptualized into the institutional identities of British Columbia's healthcare delivery organizations. Phase 2 concentrated on the diversity practices of 4 health authorities. Diversity workers faced numerous obstacles including organizational resistance to maintaining diversity programming, negligible funding and minimal staffing. The most promising finding was the number of informal diversity workers who volunteered to act as diversity liaisons and educators. To gain a patient perspective, Phase 3 focused on Punjabi Sikh Diaspora patients who had experienced a myocardial infarction and recently discharged from a local hospital. Despite the availability of diversity, spiritual care, interpreter and cardiac rehabilitation programming, these participants were not asked about

their cultural or religious needs; not offered spiritual care services; interpreter support was minimal to non-existent; post-surgery treatment and care plans were not adequately communicated; and they were not offered information or referrals to cardiac rehabilitation programs. The dissertation concludes with a list of recommendations to improve health equity for racialized communities.

## **Lay Summary**

Phase 1 found that seven of the eight health authorities did not share anti-racism mandates in their mission statements, values and visions. In phase 2, I found there were far more diversity workers doing this work without resources and support from their health authorities. This showed the need for diversity work even when health authorities didn't support this work. In the final stage, I spoke with Punjabi Sikh CVD patients to understand their hospital experiences. None of them were asked if they had any cultural or religious needs. Additionally, most of them needed interpreter support but only 2 of them were offered interpreters when they were being taken in for heart surgery, and no one was offered interpreter support after their surgeries. I wrapped this research up with a list of suggestions for health authorities and governments to make healthcare and Canadian society safer, more equitable, and not racist.

## **Preface**

I conducted all the research work associated with the three phases of this research project. Phase 1 of the doctoral research project involved analyzing publicly available online data; therefore, this phase did not require ethical approval. Research ethical approval was obtained from UBC Behavioural Research Ethics Board for phase 2 and phase 3: Our Health Project Phase 2 (H15-03371) and Our Health Project Phase 3 (H15-03381) as these phases involved participant observation and interviews. I led and completed all aspects of the research project: conceptual development, obtaining ethics approval, recruitment, data collection, analysis, dissertation writing, and manuscript composition. Three of the chapters will be edited and submitted to academic journals as manuscripts. Drs Colleen Varcoe (primary doctoral supervisor) and Sheryl Reimer-Kirkham (member of doctoral committee) have and will continue to contribute by providing manuscript edits to these three manuscripts. I will develop and write subsequent manuscripts as lead author with invitations extended to my doctoral committee.

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## **Dedication**

I dedicate this to my ancestors including Harnam Singh who arrived on the shores of Vancouver on the Komagata Maru but was turned away, forced back to India, fired upon by British soldiers in British Occupied India and imprisoned for attempting to settle in another British colony like other British subjects. After being released, he became a freedom fighter for the Ghadar Movement. He took his last breaths as he rallied fellow Punjabi ancestry folks to seek freedom from oppressive British forces, and to seek independence from colonization.

My parents: Bhupinder Singh Kang and Surinder Kaur Basra-Kang who have gifted me with so many privileges and above all, inspired me to persist, to be of service, and to always work hard and thoughtfully.

I also dedicate this to the children I will be an ancestor to. Currently, I am fortunate to have my nephew, Taran Daya Singh Aujla; my niece, Naseeb Deeya Kaur; and my children: Dayven Kaur Kang-Dhillon and Naryan Arav Singh Kang-Dhillon inspire me to leave the world better. You are my guiding stars.

## Chapter 1: Introduction

I begin this doctoral dissertation with a humble declaration that I carry the sacred honour of being born and raised, living, working and raising my own children on the unceded, stolen lands of Coast Salish Indigenous Peoples as an uninvited settler. This doctoral dissertation *Sadhee Sehayth (Our Health) Project* provides a prevue of my doctoral journey as I delved into understanding how health equity is taken up in Canada's universal healthcare system. Through a 3 phased research project, I sought to understand how anti-racism and cultural safety approaches and praxis inform how a racialized community: the Punjabi Sikh Diaspora, experience healthcare during life-threatening cardiovascular linked hospitalizations. I focused on four specific inquires:

1. How are institutional diversity discourses and actions constructed, and how do they shape healthcare experiences for racialized minority communities;
2. How do systemic structures in which local healthcare systems operate impact the healthcare experiences of racialized patients?;
3. How do healthcare experiences of one well-established racialized and religious minority patient community: Punjabi Sikh Diaspora align or differ from the institutional diversity mandates, philosophies, intentions and actions of institutional diversity discourses and actors?;
4. What does an analysis of this one racialized community tell us about how systemic structures are conceptualized and might be improved for healthcare delivery for ethnic and religious minority communities?

Before delving into the research project, this introductory chapter contextualizes Canada's healthcare system and the inequities that persist for racialized communities, particularly the Punjabi Sikh Diaspora living in Canada. The purpose of my doctoral work has been to understand how healthcare racism is addressed in the Canadian province of British Columbia.

I specifically sought to understand how anti-racism and cultural safety are articulated and performed through institutional identities including institutional documents and websites; how anti-racist programming is taken up to establish safe and equitable healthcare processes; and how anti-racist policies and programs are experienced by a long-standing racialized<sup>1</sup> community: Punjabi ancestry Sikh affiliated British Columbians. I was born into this community on the unceded, stolen lands of the Coast Salish Indigenous Peoples and straddle my identity of being Punjabi Sikh and a Canadian.

Canada proudly touts a universal healthcare system maintained by billions of dollars of dedicated government funding<sup>2</sup> when globally, safe, effective and quality healthcare access remains a precarious challenge for many countries. Despite the regnant ideology of equal access, Canada's healthcare system is saturated with inequities (Beavis et al, 2015; Browne et al, 2016; Browne et al, 2021; Collins & Hayes, 2007; Goodman et al, 2017; Kitching et al, 2020; Markham et al, 2021; Nestel, 2012; Phillips-Beck et al, 2020; Varcoe et al, 2009; Weerasinghe, 2012). Further, the recent Covid-19 global pandemic revealed stark inequities for vulnerable individuals and communities worldwide (WHO, 2021). For many patients/families, critically informed public health researchers, advocates, front-line healthcare providers, and healthcare leadership – unequal access and differences in received care were not surprising but another reminder of the

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<sup>1</sup> The Canadian census uses the term visible minority to identify non-Indigenous and non-European racialized communities; however, the term 'visible minority' is contested by critical race scholars for removing the notion of race but simultaneously creating a sense of hyper visibility with the use of 'visible' for racialized communities who continue to contend with racism and are racialized. I will use the term racialized people/communities to identify People of Colour and Black People to acknowledge the racializing processes they experience.

<sup>2</sup> Canadian Institute for Health Information reported that Canada paid 308 billion dollars on. Healthcare in 2021 (November 4, 2021) retrieved on May 28, 2022 from <https://www.cihi.ca/en/news/covid-19-expected-to-push-canadas-health-spending-beyond-300-billion-in-2021>

numerous inequities faced by vulnerable individuals and communities. “The conditions in which people are born, grow, work, live and age and their access to power, money, resources have important impacts on health differences across population groups” - are known as social determinants of health (WHO, 2021, p. iv). One such social determinant of health is ethnicity – specifically how racism operates in its many forms including systemic, implicit, explicit, “institutional and individual practices that create and reinforce oppressive systems of race relations whereby people and institutions engaging in discrimination adversely restrict by judgement and action, the lives of those against who they discriminate” (Krieger, 2003, p 195). Alongside ethnicity, particular religions undergo a racialization process whereby “phenotypical features are associated with a group and attached to a [racialized community]” (Joshi, 2006, p.216) such as the Sikh Diaspora, exacerbating ethnoreligious oppression for minority communities in Christian dominated nation states such as the case for Punjabi Ancestry Sikh Affiliated Diaspora in Canada.

I selected the racialized community: Punjabi Ancestry Sikh Affiliated Diaspora for their long-standing settlement in British Columbia, and my intimate affiliation with this community. These two identity markers are interconnected for numerous reasons. Punjab is geographically located in the Northern province of India where Sikhi was founded. Prior to British colonization, this province and nearby areas constituted a separate Sikh kingdom governed by Maharaja Ranjit Singh and later his son: Maharaja Duleep Singh. Even today, Sikhs constitute the majority religious group in Punjab. Punjabi serves as a distinct language spoken in Punjab and in many Punjabi Diaspora families around the world. The script used to write Punjabi is identified as Gurmukhi. The sacred texts of the Sikh community are written in Gurmukhi. While Sikhs may hold



a slight majority in Punjab, they are a minority community in India. The Punjabi Sikh community has faced significant state led violence particularly in 1984 when thousands of Punjabi Sikhs were massacred during a well-attended religious event at Siri Hari Mandir Sahib (also known as the Golden Temple) in Amritsar, Punjab; following this attack, the Indian army proceeded to abduct Punjabi Sikh boys and men aged 15-25 from Punjabi villages (Pettigrew, 1995). These boys and young men were never found but Punjabi Sikh human rights activist: Jaswant Singh Khaira identified 25,000 Sikhs killed and cremated by the state before being abducted and killed by Indian police personnel in 1995<sup>3</sup>. The coupling of these two identity markers is significant in honouring their ancestry, experiences and ongoing oppression in India and their Diaspora communities.

With migration starting in the early 1900s from British occupied India and substantial ongoing settlement, the Punjabi ancestry, Sikh affiliated community is well recognized in healthcare delivery organizations as a prominent patient community in Western Canada's province of British Columbia. While the wider South Asian ancestry community<sup>4</sup> is one of many ethnic communities that substantiate Canada's multicultural population<sup>5</sup>; European ancestry Canadian communities continue to dominate the national and provincial populations. This dominance is not just about numbers but also frames the political, societal, linguistic, religious and philosophical narratives of the Canadian state. This dominance also informs how Canada's institutions, including healthcare, are structured.

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<sup>3</sup> <https://ensaaf.org/jaswant-singh-khalra/>

<sup>4</sup> The Punjabi ancestry community is included in the umbrella identity marker: South Asian Diaspora

<sup>5</sup> The lower mainland of Vancouver is home to many ethnic communities including European Ancestry (51.5%) Chinese Ancestry (17.6%), South Asians (12.2%), Philippines Ancestry (4.6%) and those with Indigenous ancestry, the original inhabitants, (3.6%).

Further, I focused on patients living with cardiovascular disease (CVD) as considerable research has established that the South Asian ancestry community faces a higher prevalence and younger age of onset of CVD and have higher rates of death when compared with other ethnic ancestry communities (Bainey & Jugdutt, 2009; Fraser Health report, 2014; Joshi, Islam, Pais, Reddy, Dorairaj, Kazmi, Pandey, Haque, Mendis, Rangarajan & Yusuf, 2007; Sheth et al, 1999; Singh & Gupta, 2005; Yeolekar, 1998; Yusaf, Hawkin, Ounpuu, Dans, Alvezum, Lanas, McQueen, Budaj, Pais, Varigos, Lishing & Interheart Investigators, 2004; ). With substantial evidence of CVD prevalence in this community, I reasoned that healthcare providers would be primed to provide adequate CVD care when Punjabi Sikh patients were hospitalized for CVD treatment.

The impact of Covid-19 has yet again illuminated the adverse physical, social and economic exposures that harm the health of Indigenous, Black and People of Colour. With communities of colour representing a larger proportion of essential workers in Canada such as bus drivers, security guards, grocery clerks/cashiers, warehouse staff, and food manufacturing plant workers (who could not work from home), they faced more public exposures to Covid-19; subsequently, when their neighbourhoods were identified as Covid-19 hot spots<sup>6</sup>, far too frequently, it was suggested that people of colour were not adhering to the public health orders to keep themselves and their broader communities safe (Global News, November 18, 2020) (Thompson, 2020). Further, as Covid-19 was popularly believed to have emerged from China and

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<sup>6</sup> <https://globalnews.ca/video/7469761/coronavirus-brampton-mayor-addresses-citys-test-positivity-rate>  
<https://www.thestar.com/news/canada/2020/11/29/spread-of-covid-19-in-brampton-linked-to-systemic-factors-experts-say.html>

later identified as Kung Flu and the Chinese Virus<sup>7</sup> by the former President of the United States (Nakamura, 2020), the rise in anti-Asian racism was prominent across North America.

Alongside the pandemic, Canadians witnessed the rise of social justice movements centered on land and environmental stewardship and race such as *Idle No More*<sup>8</sup> and *Black Lives Matter*<sup>9</sup>. With 1,946 reported and identified criminal incidents of hate in 2019, racially motivated hate was also increasing in Canada. Incidents of racism targeting specific communities has also been notable (Moreau, 2021)<sup>10</sup>. Indigenous people dying while seeking healthcare has been highlighted with cases such as Joyce Echaquan's death. Ms. Echaquan was repeatedly devalued by healthcare staff with one nurse telling her she was stupid, a drain on the health system and better off dead<sup>11</sup> prior to her untimely death due to inadequate healthcare (Banerjee, Canadian Press, May 20, 2021). Disturbingly, other Indigenous people are disproportionately killed by Canadian police organizations such as Julian Jones who was shot and killed during a wellness check<sup>12</sup> (CBC News, February 28, 2021). These two recent deaths highlight the persisting legacy of historical colonial violence against Indigenous peoples. Alongside these tragic deaths, the unearthing of mass graves of Indigenous children killed during their forced placements in

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<sup>7</sup> [https://www.washingtonpost.com/politics/with-kung-flu-trump-sparks-backlash-over-racist-language--and-a-rallying-cry-for-supporters/2020/06/24/485d151e-b620-11ea-aca5-ebb63d27e1ff\\_story.html](https://www.washingtonpost.com/politics/with-kung-flu-trump-sparks-backlash-over-racist-language--and-a-rallying-cry-for-supporters/2020/06/24/485d151e-b620-11ea-aca5-ebb63d27e1ff_story.html)

<sup>8</sup> The Idle No More Movement started in November of 2012 by Indigenous Treaty People, led by Indigenous women in Manitoba, Saskatchewan, and Alberta to protest the Canadian government's changes to environmental protection laws. Idle No More calls on all people to honour Indigenous sovereignty to protect the land, water and sky. <https://idlenomore.ca/about-the-movement/>

<sup>9</sup> The Black Lives Matter (BLM) movement was founded as a response to the acquittal of Trayvon Martin's murderer. Trayvon Martin was a 17-year-old boy living in Florida when he was fatally shot by a man. BLM was started in 2013, to eradicate white supremacy and to honour the liberation of Black lives. <https://blacklivesmatter.com/about/>

<sup>10</sup> <https://www150.statcan.gc.ca/n1/pub/85-002-x/2021001/article/00002-eng.htm>

<sup>11</sup> <https://montreal.ctvnews.ca/i-know-i-was-mean-and-i-apologize-quebec-nurse-tells-inquiry-into-death-of-joyce-echaquan-1.5436281>

<sup>12</sup> <https://www.cbc.ca/news/canada/british-columbia/tofino-death-rcmp-1.5931241>

Canada's Residential school system<sup>13</sup> has amplified the awareness of injustices faced by Indigenous communities. While most Canadians including Prime Minister Justin Trudeau have marked the discovery of these unmarked graves as heartbreaking and acknowledged the pain and grief felt by Indigenous peoples, Canada has been slow to implement the calls for action offered by the *Truth and Reconciliation Commission*<sup>14</sup>. Modest recommendations to identify these graves, commemorate and honour the children who were killed, and reburying them (if desired by families) in home communities alongside setting up a *National Residential School Student Death* registry (Truth and Reconciliation Commission, 2015<sup>15</sup>) have yet to be met.

These failures by our Canadian institutions are not restricted to Indigenous communities. Non-European ancestry communities continuously have faced historical and contemporary racism in Canada including the notable Chinese Head Tax, Japanese Internment, and the Continuous Journey regulation implemented to prevent Indian ancestry individuals from entering Canada despite being British subjects. Recently, retired Justice Selwyn Romilly was having his morning walk around Stanley Park when he was approached by 5 police officers and handcuffed as they were looking for a suspect with dark skin in his 40s to 50s. As a retired British Columbia judge (the first Black judge to be appointed in British Columbia), 81 years of age, he was embarrassed that he was racially profiled and handcuffed. While he was released shortly after

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<sup>13</sup> The Canadian Indian Residential School system spanned a period of more than 150 years whereby more than 150,000 Indigenous children were removed from their families to attend Church run schools far from home. The children faced harsh punishments and thousands endured emotional and physical abuse as well as rape.

<sup>14</sup> <https://www.rcaanc-cirnac.gc.ca/eng/1450124405592/1529106060525>

<https://nctr.ca/records/reports/>

<sup>15</sup> [https://ehprnh2mwo3.exactdn.com/wp-content/uploads/2021/01/Calls\\_to\\_Action\\_English2.pdf](https://ehprnh2mwo3.exactdn.com/wp-content/uploads/2021/01/Calls_to_Action_English2.pdf)

explaining he was a retired judge, numerous people saw Justice Romilly handcuffed (Proctor, 2021)<sup>16</sup>.

Often viewed as more pervasive in the USA, racial profiling is also present in Canada. Canadian police forces have also been critiqued for profiling and unnecessarily traumatizing African ancestry individuals. For example, Dean and Angela Simmonds were driving from their home in Preston, Nova Scotia to get groceries, they were randomly stopped by the police. Dean was ordered out of the car with his hands up, while the other officer pointed a carbine rifle at him. After several moments, Dean was able to identify that he too was a police officer and served as the superintendent for the Halifax Regional Police. Angela Simmonds, a lawyer and community advocate, also had recently been appointed as Liberal candidate for Preston is quoted saying this incident is “another brutal reminder of the broader system of systemic racism within the RCMP, and it further erodes trust between police and Black communities in Nova Scotia” (Canadian Press, 2021)<sup>17</sup>.

No one anticipates that these routine activities could expose them to potentially dangerous situations – nor did the Afzaal family when they went out for their Sunday evening stroll in a residential neighbourhood of London, Ontario. While they waited to cross a busy suburban road, a man driving a black pick-up truck mowed down the South Asian ancestry, Muslim faith family. A grandmother (74 years old), her son (46 years of age), her daughter in

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<sup>16</sup> <https://www.cbc.ca/news/canada/british-columbia/black-judge-handcuffed-racism-1.6033332>

<sup>17</sup> <https://www.thecoast.ca/halifax/black-police-officer-and-liberal-candidate-pulled-over-at-gunpoint-by-rcmp/Content?oid=26797823>  
<https://www.halifaxtoday.ca/local-news/police-officer-wife-launching-complaint-for-driving-while-black-stop-by-rcmp-3962294>

law (44 years old), and granddaughter (15 years old) were killed, and her 9-year-old grandson recovered from serious injuries in hospital. The man was later arrested and charged with 4 counts of first-degree murder and 1 count of attempted murder, and police superintendent Paul Waight stated that “[there was] evidence that this was planned, premeditated act and that the family was targeted because of their Muslim faith” (Lupton & Dubinski, 2021)<sup>18</sup>. This 9-year-old boy is left without a family and the traumatizing experience of watching his beloved family die from an act of racist violence that was also meant to take his life.

Many Canadians mourned this family’s senseless deaths, and our Prime Minister stated “if anyone thinks racism and hatred don’t exist in this country ... [how] do we explain such violence to a child in hospital” (Syed, 2021)<sup>19</sup>? Despite these compassionate public statements and acknowledgement of racism in Canada, Canadian officials have not fully invested in anti-racist practices across the country. For instance, in 2019 Quebec banned public employees from wearing religious symbols, defined as “any object, including clothing, a symbol, jewellery, an adornment, an accessory or headwear ... worn in connection with a religious conviction or belief ... [or] reasonably considered referring to a religious affiliation” (Bill 21, 2019)<sup>20</sup>. As noted by the Canadian Liberties Association, this “unfairly targets people who express their faith through what they wear” (CCLA, 2021)<sup>21</sup>. For those who honour their faith through the daily wearing of religious identity markers like the kippah/yarmulke, turban, habit, or hijab, they are not permitted to wear these symbols while working in government, legal or education sectors (Bill 21, 2019). Removing

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<sup>18</sup> <https://www.cbc.ca/news/canada/london/london-muslim-family-attack-what-we-know-1.6057745>

<sup>19</sup> <https://www.theguardian.com/world/2021/jun/09/canada-muslim-family-killed-islamophobia>

<sup>20</sup> <https://ccla.org/wp-content/uploads/2021/09/2019-06-16-Bill-21-Passes-and-Becomes-Law.pdf>

<sup>21</sup> <https://ccla.org/major-cases-and-reports/bill-21/#timeline>

symbols such as wearing a Christian Cross, or an *Ek Onkar* pendant may be easy enough for many to do but for those who wear religious clothing, headwear, or symbols as a part of their faith – this restriction inhibits their ability to be a part of pivotal professions in Quebec such as teaching, law making, and legal governance. Although this Bill applies to Christian communities too, Christian women and men who wear a habit (e.g. a nun or a friar) or a collar (e.g. a priest) typically work in religious centered roles or affiliated roles such as teaching at a Christian private school - not in public sector roles. It is argued that limiting the inclusion of any religious community from public sector roles diminishes their capacity to contribute to Quebec’s political, legal and education sectors and violates the Canadian Human Rights Act<sup>22</sup> (that prohibits discrimination on the grounds of religion) (1985) and the Canadian Charter of Rights and Freedoms<sup>23</sup> (that guarantees the right to religious thought, belief and expression (1982)). When asked about this, Prime Minister Trudeau didn’t feel that Quebec’s ban was discriminatory or would fuel racist hate (Syed, 2021)<sup>24</sup>. Yet, this ban clearly does not support a multicultural, inclusive society.

Despite the proud national adoption of the Multiculturalism Act (1985<sup>25</sup>), the legacy of colonial violence and rampant current day racism highlights that the racist structures upon which Canada was established as a nation state - are very much present, persisting, and oppressive. Some will highlight the displays of anti-racism solidarity on many Canadians’ social platforms as progressive and moving towards a racism free culture; however, these fleeting postings of Black

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<sup>22</sup> <https://laws-lois.justice.gc.ca/eng/acts/h-6/>

<sup>23</sup> <https://laws-lois.justice.gc.ca/eng/const/page-12.html>

<sup>24</sup> <https://www.theguardian.com/world/2021/jun/09/canada-muslim-family-killed-islamophobia>

<sup>25</sup> <https://laws-lois.justice.gc.ca/eng/acts/c-18.7/page-1.html>

Lives Matter<sup>26</sup> or Every Child Matters<sup>27</sup> are not impactful actions to uphold equity for all of those living on these unceded Indigenous lands.

I am the daughter of immigrants from the Northern Indian state of Punjab and my parents took up residence on these unceded lands as a safer place to live and raise their children. I was born, raised, continue to live, and raise my own children on these unceded lands and negotiate my colonial identity while confronting various forms of racism. As a member of the Sikh faith, a minority religious community in India, I am aware of state led and sanctioned violence (similar to other religious minority communities) in India. Comparatively, Canada has been a safer home nation for myself and many immigrant, refugee, Diaspora and racialized individuals and communities despite our persistent negotiations with racism. This acknowledgement is a site of friction for me. I have read countless accounts of the violence faced by the Sikh community in India from being burned alive by mobs, the abduction and killing of Sikh boys and men by the Indian government (their bodies were never returned to their families or acknowledged as being held by the state), being gunned down while worshipping, to the rape and torture of Sikh girls and women by mobs and government officials. I know I am privileged and safer because I don't live through those particular threats of violence.

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<sup>26</sup> Black Lives Matter movement was founded in 2013 in response to the murder of Trayvon Martin and has grown into a global moment with a strong presence in Canada. <https://blacklivesmatter.com/about/>

<sup>27</sup> Every Child Matters movement started by Phyllis Webstad in 2013 to honour the Indigenous children forcibly removed by the Canadian nation with the aid of Christian Churches to residential schools whereby the children faced horrific forms of abuse including mental, physical and sexual. As a survivor of the Residential school system, Webstad wanted to commemorate all of the children who endured the residential school system and spearheaded Orange Shirt Day. When the unmarked graves of many of the children were located in 2021, Indigenous artists including Andy Everson (of the K'ómoks First Nation in B.C.) created art to commemorate the children with the Every Child Matters logo.



I have heard many Elders from racialized communities, including my parents, who cite far more frequent and oppressive forms of racism when racialized communities first migrated to Canada. Public buses would not allow Punjabi Sikh men to board, Punjabi Sikh women were spit on while grocery shopping with their children, businesses would refuse to serve South Asian ancestry individuals, hateful statements would be yelled at South Asian children and adults, and many racialized children would face daily acts of violence at school from peers.

As Canada embraced Multiculturalism in the 1970s, forms of racism have evolved to be stealth, insidious and treacherous and often leave People of Colour questioning – ‘was that racist?’ as they experience unequal treatment in hospital emergency units or are made to wait in a restaurant while other customers seated after them are served first or their requests to volunteer or join parent school committees are ignored. These systemic forms of racism may be harder to identify as racist and often challenged because they lack overt racial epithets; But they exist and leave their trauma on the bodies, minds and hearts of racialized peoples. Alongside these covert forms of racism, People of Colour still contend with overt racism. Recently, a turbaned, young, Sikh security guard for a Covid-19 vaccination provincial health clinic was targeted by a racist anti-vaccination protestor who told Anmol Singh to go back to where he came from (Berry, 2021)<sup>28</sup>. On August 1<sup>st</sup>, 2021, South Asian ancestry children and grandmothers at a public park faced racial slurs, threats, and garbage being hurled at them by a couple who told them to go back to where they came from (Judd & Garcha, 2021)<sup>29</sup>. The ‘go back to where you

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<sup>28</sup> <https://infotel.ca/newsitem/kelowna-security-guard-who-handled-tirade-of-racist-remarks-gains-positive-attention-worldwide/it84387>

<https://www.cbc.ca/news/canada/british-columbia/kelowna-protester-vaccine-clinic-racist-rant-1.6104776>

<sup>29</sup> <https://globalnews.ca/news/8081684/surrey-bc-racism-aspen-park-video/>

came from' trope is frequently deployed to mark white superiority, entitlement, and ownership of Canada by European ancestry individuals; and meant to thwart belonging for racialized people - requiring them to consistently prove they are Canadian. However, the fact remains that all of us non-Indigenous people are uninvited to these lands.

My deeply held belief that racialized peoples (especially Indigenous peoples) matter and our lives, bodies, hearts and minds should never be subjected to racist harm continues to be the impetus for my doctoral journey. Well over 2 decades ago, I took my father to a hospital emergency unit. Despite his many health concerns, my father was stoic and never complained unless he was in extreme pain. He was diagnosed with diabetes in his 20s and I hold memories of him constantly checking his glucose levels and injecting insulin to regulate his health. He also lived with asthma and always carried an inhaler in his pocket. He was later granted long term disability when he could no longer work in the sawmills as he had severe reactions to sawdust. Along with diabetes and asthma, he later lived with cardiac illness. One Friday night long ago, my father had asked my mother to take him to emergency. He was struggling to breathe despite using his inhaler and his chest was hurting. He was released a few hours later without any indication of why he was experiencing shortness of breath and chest pain. On Saturday, my sister took him to emergency for the same symptoms and he was released hours later without any diagnosis or treatment.

On Sunday morning, I took him to emergency at Vancouver General Hospital. I was very clear in articulating that he was exhibiting classic heart attack symptoms. When we were sent back to a smaller room to speak to a nurse, she asked the exact same questions that were posed on Friday and Saturday including what medications he was taking. He had numerous medications

and she was writing quite slowly. My father's laboured breathing was so clearly amplified in this room and he looked like he was about to fall off his chair. I asked if there was any way the nurse could look up his medical records from the Friday and Saturday as he was clearly having a heart attack, and if we could get him treated immediately since this was his third visit in 48 hours for the same symptoms. Her response: "if you can't cooperate, I can take a really long time, it is up to you, the longer you take to learn to cooperate, the longer it takes me to get him in, what do you think, want to keep this bitchy attitude up?". I gave her the painstaking responses as my Dad was visibly struggling to breathe. I was a young adult. I had dealt with overt, implicit and systemic racism but not like this – not when my father's life was being held ransom for a white woman's need to dominate and show her superiority and power. She did drop my Dad's file in the emergency doctors' bin and in minutes, a doctor came rushing in: "why isn't he in a wheelchair, he is obviously having a heart attack".

I was so utterly grateful that this doctor was taking this seriously and I told him, I asked for a wheelchair, but I was told I was being dramatic. In seconds, he brought over a wheelchair and wheeled my Dad towards a bed. He told me to stay in the waiting room and they would let me know once I could come in and see my father. My Dad received treatment including emergency surgery that day by an overwhelmingly White team of medical professionals. During that 48-hour period, it was confirmed that he had been having heart attacks starting with a mild one on Friday. My father lived for many years after that emergency encounter. While this story highlights one healthcare provider who exhibited toxic and life-threatening racism, my father's healthcare experiences were overwhelming dominated by responsive, equitable and culturally safe care – but it only takes one incident or one healthcare provider to obstruct equal, equitable,

safe access to necessary healthcare. That one experience intimately exposed me to the idea that systemic racism could and would kill people despite Canada's infrastructure of universal healthcare and multiculturalism. Over the years, that experience has lingered in my heart and mind as I interacted with the healthcare system, infrequently for my own healthcare but far too commonly on behalf of family members; and when I worked on numerous health research projects, I witnessed and heard experiences that made me shudder. It made me realize that the frequency of racism in healthcare is higher than I have been able to evidence in publications or reports, and again led me to explore why there is such silence. This current research project was born out of those realizations and queries; I have been inspired me to pursue a multi-phased study to expose why health inequity linked to racial disparities happens in Canada's universal healthcare system and what can be done to eradicate these types of inequities and transform our healthcare system to deliver equitable, culturally safe care for all Canadians.

The next chapter of this dissertation outlines the 3-phased study process with a summary of methods for each phase. The Western province of British Columbia was the site of our data collection where 8 healthcare delivery organizations oversee the provision of publicly funded healthcare to all British Columbians. Phase one evaluated how the 8 healthcare delivery organizations included diversity and equity for non-dominant racialized patients and families in their institutional identities described in their mission statements, values and visions. The detailed approach and findings for this phase are shared in chapter 3. For phase 2, I focused on interviewing diversity workers to assess what diversity activities, programs and efforts were carried out by healthcare delivery organizations. Chapter 4 provides an in-depth overview of this phase and findings. The last phase of the study involved interviewing an exemplar racialized

community: Punjabi ancestry, Sikh affiliated CVD patients to assess how diversity mandates, programming, activities, and efforts were experienced by this one community. Chapter 5 describes phase 3's research methodology and results. The University of British Columbia's Graduate Studies department encourages doctoral students to "publish work from their research during the course of their degree programs<sup>30</sup>; and chapters 3, 4 and 5 are being submitted as manuscripts for publication in peer reviewed journals (with some modification in formatting and word count allowances). The dissertation concludes with Chapter 6 that features reflections and recommendations on this doctoral research process and dissertation.

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<sup>30</sup> <https://www.grad.ubc.ca/current-students/dissertation-thesis-preparation/including-published-co-authored-or-collaborative>

## Chapter 2: Healthcare Racism and the Research Project

In this chapter, I provide an overview of healthcare racism, the Canadian healthcare system and my doctoral research process including the theoretical framework, methods, questions, and ethical considerations. As noted in the previous chapter, my experience of healthcare racism is not an anomaly but sits alongside reported cases and countless undocumented cases, like mine that have never been reported. Here are 2 cases that were reported and responded to by the healthcare system:

*In British Columbia, a 70-year-old Canadian man was shot during a gas station robbery and was taken to Royal Columbian Hospital for care. In the middle of the night, while the patient was semi-conscious, front line healthcare providers shaved his beard off without his consent or his family's consent. As a devout Sikh, Gurdev Singh Grewal maintained the outward markers of the Sikh faith as well as upholding the philosophical tenets including participation in seyva and daily meditation. One of these very public markers was his unshorn hair. The significance of having his long, white beard removed without his consent and without medical necessity rests in the forced removal of this visible identity marker that acknowledges his commitment as a devout, Amritdhari Sikh. In 2008, several apologies and promises were made by Fraser Health Authority to better educate their staff; yet 2 years later, in 2010, an 86-year-old resident in Fraser Health's long term facility: Queen's Park Centre had his long beard shaved off after food spilled on it, without his consent, and without his family's consent. Fraser Health Authority officials acknowledged that there was a misunderstanding and the "nurse thought she had more consent than she actually did from the family ... a terribly unfortunate human error" (Rankin, CBC, 2010). As a part of the institutional "damage control" efforts, Fraser Health authority officials: David Plug (FHA's VP of Communications) and Nigel Murray (FHA's CEO) acknowledged that it was "unfortunate mistake" and made promises that FHA would "redouble" their efforts to be more culturally sensitive. The elderly resident stopped eating after his beard was forcibly removed, and died 2 weeks later. Poignantly, Gurdev Singh Grewal's grandson, Sukhminder Singh Virk reiterated his frustration that similar apologies and similar promises were made to their family in 2008; and he indicated that there continues to be a "big lapse in what is being said and what is being done" (Dhillon, Link Newspaper, 2010) (Rankin, CBC, 2010).*

These 2 Canadian Amritdhari-Sikh Punjabi-Ancestry men had spent most of their lives with long, flowing beards that mark their public and personal identity of being Sikhs<sup>31</sup>. For these

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<sup>31</sup> Adult Sikhs, who decide to deepen their commitment to the Sikh faith, can pursue the path of the Amrit ceremony whereby the individual takes vows to wear the 5 physical outward identity markers including unshorn

men, maintaining their head, facial and body hair was not an aesthetic personal choice, or a cultural identity marker, but a religious commitment they personally made to honour their faith practice. These two incidents were reported to the media, and garnered significant attention in the Sikh community through Punjabi language media (i.e. radio and print); however, there are other similar incidents that go unreported<sup>32</sup>. The distressing question posed by the family, local Sikh community and the CBC reporter regarding the 2010 incident: “why this happened at all” produces a sophisticated institutional response by European-ancestry healthcare officials who feverishly make media appearances to acknowledge the human error and promise to enhance cultural competency education for their staff. The possibility of racially linked bias, either implicit or explicit, is omitted from these conversations; instead emphasis is placed on the culture of these Punjabi Ancestry Sikh patients.

Within the trail of promises to do better, there is no mention of race, or an interrogation of race dynamics (including the racialization of particular religious identities), or an evaluation of how historical and contemporary race-based-ideologies influence healthcare encounters between racialized patients and the healthcare system. This focus on their culture eliminates the need for healthcare authorities and their staff to evaluate the historical and contemporary context of how racialized individuals are received into the Canadian milieu. Rather, these scenarios are positioned as belonging to a post-race Canada whereby race and its appendages of

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hair, and also undertake a practice of daily meditations, abstinence from narcotics, alcohol or tobacco use and to live by the philosophies of the Sikh way of life (upholding social justice, *seyva* (selfless service), and being an active steward in their families and communities, etc).

<sup>32</sup> For instance, a family friend was fortunate to have a family member walk in as healthcare providers were about to cut his hair and explaining that he was an Amritdhari Sikh and keeping unshorn hair was a part of this religious commitment. Another family acquaintance, who was also an Amritdhari Sikh, had his beard and mustache removed while hospitalized.

race-based discrimination, oppression and violence have been sanitized by the introduction of Canada's Multicultural policy.

### **Race/Ethnicity as a Social Determinant of Health<sup>33</sup>**

Race/Ethnicity is a significant socio-determinant of health (Brasolotto, Raphael & Baldeo, 2014; Dunn & Dyck, 2000; Frohlich, Ross & Richmond, 2006; Kennedy & Morgon, 2009; Lebrun, 2012; Raphael, Brasolotto & Baldeo, 2014; Schoen & Doty, 2004). Further, scholars have argued that religion should be considered a social determinant of health as religious affiliation like ethnicity/race, "[affects] health status" (Idler, 2014, p. 1). While the intersection of ethnicity and health has garnered considerable attention, there has been considerable focus on identifying differences between minority and dominant cultures. In response, critical health researchers have called for a holistic evaluation of health inequities linked to racial disparities that include examining structural barriers and the influence of social-political-historical processes and beliefs. Drawing on the *Ecosocial Theory* of disease distribution, leading embodiment researcher, Nancy Krieger describes, "how we literally biologically embody exposures arising from our societal and ecological context, thereby producing population rates and distributions of health" (Krieger, 2012, p. 936). This ecological context, whereby dominant race ideologies influence how racialized communities are constructed and responded to, has a considerable impact on the health and well-being of these communities [i.e. depressive symptoms (Schulz, Gravelle, Williams, Israel, Mentz & Rowe, 2006), higher rates of blood pressure (Karlsen & Nazroo, 2002), higher rates of

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<sup>33</sup> Literature searches for this category were done with the following search texts: ethnicity and social determinants of health; race and social determinant of health; social determinants of health; Canada and social determinants of health; healthcare racism; healthcare equity; ethnicity and health. The intent was to provide a summary of previous scholarship in this area.



infant mortality (Sondik, Huang, Klein & Satcher, 2010) and greater prevalence of CVD (Lukachko, Hatzenbuehler & Keyes, 2014)]. Environments structured by racial discrimination resulting in “inequitable distribution of power, income, goods, and services” (Marmot et al, 2008, p. 1661) are stressful, triggering “... pathogenic pathways, mediated by physiology, behaviour, and gene expression, that affect the development, growth, regulation, and death of our body’s biological systems ... culminating in disease, disability, and death” (Krieger, 2012, p. 936). The reality of living in dominant-race-based societies is that the well-being of racialized communities is influenced by their everyday experiences negotiating the context of Canadian society.

Experiences of health inequity have frequently been framed as an inadequate understanding of minority culture and faith-based beliefs resulting in discrimination. Research evaluating healthcare encounters between healthcare providers and patients reveals that both implicit and explicit bias operate (Burgess, 2011; Smedley, Stith, Nelson & Institute of Medicine, 2003) and these biases directly impact healthcare access (Paradies, Priest, Ben, Truong, Gupta, Pieterse, Kelaher & Gee, 2013) and patient outcomes (Artuso, Cargo, Brown & Daniel, 2013). Canadian health authorities have addressed ethnic differences through diversity mandates and the establishment of diversity programs and budgetary support for diversity workers. This approach indicates institutional support for health equity; however, whether these institutional commitments are effectively addressing the needs of racialized patients is unclear. For instance, findings that South Asian (SA) ancestry individuals were 70% less likely to present to emergency departments after the onset of classic heart attack (King, Khan & Quan, 2009) or less likely to attend cardiac rehabilitation programs (Banerjee, Gupta & Singh, 2007) than their European ancestry counterparts – suggest that healthcare access barriers continue to exist. Research has

also shown similar discrepancies in access to care for a myriad of other health issues for South Asian ancestry people including breast and cervical cancer screening (Islam, Kwon, Senie & Kathuria, 2006); mental health access (Ahmad, Shik, Vanza, Cheung, George & Stewart, 2004); referrals to ophthalmologists/optometrists for assessment and treatment of diabetic retinopathy (Yang, Nijjar, Quan, Shah, Rabi, Ignaszewski & Khan, 2014); and palliative care (Worth, Irshad, Bhopal, Usher, Usher, Brown, Lawton, Grant, Murray, Kendall, Adam, Gardee & Sheikh, 2009).

### **Backdrop of the Canadian Healthcare System<sup>34</sup>**

The Canadian healthcare system is built upon societal-political-cultural-religious-institutional structures that emulate the hegemonic positioning that Canada is a White-European-Christian dominated nation state. The legacy of Canadian settlement situates European explorers as arriving and discovering “terra nullius” (empty lands) (Coulthard, 2013; Alfred, 2009) without acknowledging that these lands were already settled by sovereign Indigenous nations. The violence of colonization has often been unspoken; however, murder, rape, mutilation of living and deceased bodies and strategic warfare practices (i.e use of blankets infected with the smallpox virus to infect Indigenous communities and subsequently reduce Indigenous populations; trading with alcohol supported the colonization project with immediate deleterious effects and long-term genocidal impact; and the forced expulsion of Indigenous children to residential schools where countless atrocities of abuse have been well-documented) – served as powerful tools to perpetrate physical, cultural, emotional, linguistic and spiritual

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<sup>34</sup> This section provides a summary of relevant historical events that contributed to early nation building ideologies and continues to permeate contemporary Canadian society.

genocide of Indigeneity and continue to inform the experiences of individual, generational and collective trauma for Indigenous communities (Furniss, 1999; Maracle, 1996; Blackstock, 2009).

Colonizing Indigenous communities was part and parcel of establishing a White Canada (Dua, 2007; Kazimi, 2012). Building a white nation required the development of a European “political and ethical reserve” such that Europeaness (and Christianity) became the normative operating agenda (Victoria Daily Colonist, February 20, 1912); which simultaneously led to the further development of white privilege and authority through ongoing colonizing tactics. When ‘Oriental’ bodies: Chinese, Japanese and Indian arrived to the coastal province of British Columbia, Canadian officials and the general public saw them as threats to the white-nation-building project – endangering Canada’s wholesome European-Christian nature. Due to the lack of European-ancestry labour, the *Yellow* (Chinese and Japanese) and *Dusky* (Indian) *Perils* were marginally welcomed by Canadian officials for their nation building labour; but as soon as their labour was not needed, measures to limit or deny their entry to White Canada were erected (i.e. *Chinese Head Tax*, Agreement with the Japanese Government to limit Japanese migration; and the *Continuous Journey Regulation* for British Indian subjects) (Gilmour, 2014; Kazimi, 2012; Mawani, 2010). This idea that People of Colour invade Canada has not vacated the psyche of many White Canadians as many racialized communities consistently hear ‘go back to where you came from’ despite generations of Canadian citizenship.

### **How History Translates to Contemporary Canadian Institutions**

The historical context of colonizing Indigenous communities and establishing a White

Canada<sup>35</sup> informs and structures contemporary Canadian institutions as there has been limited attention paid to critiquing, analysing and dismantling these former mores, values and ideologies. Further, through the structure of settler colonialism, there is a “persistent drive” to “effectively repress, co-opt, and extinguish Indigenous alterities, and productively manage ethnic diversity” (Veracini, 2011, p 3). In a recent article, American scholars, Joe Feagin and Zinobia Bennefield powerfully critique the limited attention that has been paid to who controls organizational decisions in institutional settings, and how this is linked to ongoing racial-disparity-informed healthcare inequities in the USA (2014). These dynamics are also seen in the Canadian context despite a universal healthcare system, with immigrant Canadians who are eligible for medical coverage and reporting unmet medical needs and lack of a regular family physician when compared to Canadian citizens (Siddiqi, Zuberi & Nguyen, 2009); African Ancestry Canadians describe how subtle and overt forms of racialized violence disrupt their health and well-being (James, Este, Bernard Thomas, Benjamin, Lloyd & Turner, 2010); Moreover Indigenous women confirm that their encounters with the Canadian healthcare system are entrenched with discrimination and structural inequities (Browne & Fiske, 2001; Browne, 2007; Tang & Browne, 2008). For most Canadians, the idea that race-based discrimination continues to exist is contradictory to the widely adopted paradigm that Canada has moved beyond race with the adoption, and subsequent recognition as a global-leader, of Multiculturalism; whereby residing cultures are perceived to live in a harmonious relationship to the nation state and fellow residents (Thobani, 2007).

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<sup>35</sup> The ideology behind John A. MacDonald’s (serving as Canada’s Prime Minister from 1867 to 1873 and 1878-1891).

However, as Sadhana Bery asserts “in the absence of collective struggles to dismantle the apparatus of white supremacy, multiculturalism can reproduce dominant racial/racist ontologies, epistemologies, and practices, albeit in new disguises” (Bery, 2014). Echoing a similar critique of Canadian multiculturalism, leading critical race feminist scholar: Sunera Thobani traces Canada’s strategic maneuver to adopt Multiculturalism to transcend former racist policies as a means to participate in the United Nations and strengthen global economic relationships (Thobani, 2007). Crafted to appear non-racist and inclusionary, the resulting immigration policies allowed Third World immigrants to meet the ongoing national demands for labour (Thobani, 2007); Canada’s Multiculturalism positioned “[the] new Canadian social and political subject” into “visible minorities” (Bannerji, 2000 p. 30) and those with European ancestry, were raised to the status of “Exalted Subjects” (Thobani, 2007). This nuanced visible minority identity uniquely stresses the “features of being non-white and therefore visible in a way whites are not, and of being politically minor players” (Bannerji, 2000, p. 30) and reconfigures the “hard edges” and “criticality” of “race” into a “celebration of difference” (Bannerji, 2000, p. 31-32). Despite losing the language of race, this move to hyper-visibility reinforces race for non-white Canadians. Like Canada’s Multicultural policies, when health authorities are suspended in dominant race and religious structures (Feagin & Bennefield, 2014), “led and controlled by [those with dominant privilege and power]”, without critical challenges to those power and privilege structures, diversity and cultural safety work in Canada’s healthcare system will continue to “reproduce dominant [racial] ontologies, epistemologies, and practices” (Bery, 2014); resist the social justice work underpinning diversity policies, mandates and programs; and merely perform “institutional lip service” (Ahmed, 2012).

## What We Know and Don't Know<sup>36</sup>

*There is a mountain of evidence to suggest that racism has the persistence of ragweed in a spinach patch. It has insidious, daily effect on people of colour [and Indigenous people] – and by extension all people in our society – that simply won't go away ...* (James, Este, Thomas Bernard, Benjamin, Lloyd & Turner, 2011, p. 19-20)

We have adequate evidence that health inequities linked to racism exist within white-colonizer-nation states and their associated healthcare settings (Beavis et al, 2015; Browne, 2007; Browne & Fiske, 2001; Browne et al, 2016; Browne et al, 2021; Burgess, 2011; Collins & Hayes, 2007; Heaman, Goodman et al, 2017; Gupton & Moffat, 2005; Kitching et al, 2020; Markham et al, 2021; Nestel, 2011; Phillips-Beck et al, 2020; Tang & Browne, 2008; Varcoe et al, 2009; Weerasinghe, 2012 ). Healthcare provision does not occur in a societal vacuum but within the real world where dominant forces of racism impact healthcare encounters and access to life-saving services (Varcoe, 2006). Racism exists in the wider sphere of Canadian society and as noted by critical race feminist scholar, Sherene Razack, individual encounters between unequal groups are never “fresh” but are tied to historical processes of exclusion, oppression, and racism (1998). Healthcare structures and processes (like any public institution) enact the dominant racist ideologies that are passed down through long standing beliefs and practices and influence how healthcare is delivered.

Much of this research is centered on the healthcare encounter and the people involved: healthcare providers and patients. While it is imperative to reveal what happens during healthcare encounters, most scales, questionnaires and surveys measuring racial discrimination

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<sup>36</sup> Literature searches for this category were done with the following search texts: healthcare racism; racism and health; patients and racism; Canada healthcare racism; British Columbia healthcare racism; healthcare equity; healthcare access; embodiment and race; anti-racism and healthcare; cultural safety and healthcare; systemic racism and healthcare; ethnicity and health. The intent was to provide a summary of previous research in this area.

draw on individual, self-reported responses that rely on an “individuals’ ability to attribute experiences to racism” which often leads to minimizing their own experiences of racism (Browne, Varcoe & Ponc, 2013). We know racism causes a great deal of harm as it is an avoidable, socially constructed and maintained system whereby racial discrimination reinforces disadvantages for racialized individuals and communities in all aspects of their existence from housing to education, employment to earnings, healthcare to accessing well-being activities, walking down the street without being racially profiled and the criminal justice system. We know it is a stressor and effects the mental health of racialized peoples but it also impacts biomarkers of disease and well-being, allostatic load, telomere length, cortisol regulation, and inflammatory markers (Bailey, Krieger, Agenor, Graves, Linos, Bassett, 2017) which leads to disease and shortens not only the quality of peoples’ lives but how long they live (Krieger, 2012). Despite this evidence-based knowledge, and advocacy position statements from key health organizations such as the Canadian Public Health Association whereby racism is acknowledged and calls for action (e.g. anti-racism education for staff) are in place<sup>37</sup>; it is unclear if systemic and interpersonal racism have been reduced during healthcare encounters. As noted by critical health researchers, there “has been scant, and even less work done to assess the health impacts of the few interventions and policy changes that could help dismantle structural racism” (Bailey, Krieger, Agenor, Graves, Linos & Bassett, 2017). We know very little about the institutional commitments of healthcare delivery organizations regarding racism, and when anti-racism policies, programming and interventions exist, if and how they translate to reducing and thwarting racism. Further, there has been minimal research on how South Asian ancestry Canadians experience healthcare racism (Johnson, Bottorff, Browne,

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<sup>37</sup> <https://www.cpha.ca/racism-and-public-health>

Grewal, Hilton & Clarke, 2009). In a recent report to document racism experienced by Indigenous ancestry patients in British Columbia's healthcare system, South Asian ancestry British Columbians shared their healthcare racism experiences, but these were not included in the review. However, the report acknowledged that while "those ... fell outside the Review's mandate", "racism is experienced by other racialized groups is yet to be fully revealed, much less addressed" (Turpel-Lafond, 2020). Without purposeful tools and interventions to dismantle the many facets of racism, systemic racism will continue to reign, and Canadian institutions will continue to recycle the performative strategy of 'doing something' by acknowledging racism without exorcising our colonial and contemporary racial ideologies through sustainable and effective measures.

### **Theoretical Framework**

Healthcare systems have often relied on "simplistic, homogenized and frequently pathologized notions of social groups and difference – which has disastrous implications for social justice" (Archer, 2004, p. 469) and health equity when attending to patient diversity. With the drive towards evidence-based practices in healthcare institutions, health researchers are often impelled "to be theory-free, simplistic and user-driven" (Archer, 2004, p. 470); however, inequities do not occur in isolation, "but often in ways detrimental to the aims of achieving sufficiency of well-being in all of its essential dimensions" (Johnstone and Kanistaki, 2008, p. 113) – from employment inequity (Pendakur & Pendakur, 2011) to healthcare inequity (Tang & Browne, 2008). Like Louise Archer, many critical health researchers call on their colleagues to "engage with the complexity of the social world" (Archer, 2004, p. 470) to bridge a multi-dimensional understanding of how societal-political-cultural systems are structured and



influence institutions – to mirror the lives of patients. I argue that a critical theoretical approach is needed to take into account the historical, social, political, economic and cultural mechanisms that sustain disparities and that only holistic analyses can challenge the “totality of social arrangements that, in aggregate, contribute to the combined adverse effect of various inequities” (Powers & Faden, 2006, p. 9).

Moving towards a holistic framework that accounts for the social-cultural-political-historical context of healthcare encounters, I have purposefully selected three theoretical approaches: Post/Colonial, Critical Race and Feminist Theories as this ‘critical triad’ provides a powerful platform to analyze complex and pervasive ideologies that inform institutional structures. Post/Colonial theory offers a “critique of knowledges” (Seth, Gandhi & Dutton, 1998, p. 8) through historical and contemporary examinations of colonization. While the ‘post’ in Post/Colonial theory has been rightly contested as we continue to be imbedded in past and contemporary forms and processes of colonization; “attempts to make sense of and ultimately to change the oppressive power relations in the name of race, nation, empire, as well as those of gender, class and sexuality” continue to be essential (Lewis & Mills, 2003, p. 2). Critical Race Theory (CRT), founded in the intellectual scholarship of Black/African legal scholars, requires critical race practitioners to confront the intersectional systemic and institutionalized processes that affirm dominant race ideologies – as well as encouraging CRT practitioners to embrace a social-justice, solution-driven focus. While Feminist theory continues to be “grounded in experiences of gendered social life” (Ramazanoglu & Holland, 2008, p. 3), the long-standing tradition to critique unequal power relations allows contemporary feminist researchers to continue to address “complex intersections that organize social relations” (Anderson, Khan and

Reimer Kirkham, 2011, p. 16) including various “axes of power and privilege” (Frisby & Creese, 2011, p.2). These three theoretical approaches (the critical triad), further the analysis of intersecting oppressions (Collins, 2000) that are relevant to this dissertation, particularly how ethnicity, religion and health status shape the experiences of the Punjabi Sikh community seeking CVD healthcare. As noted in chapter one, minority religious communities may experience a racialization process whereby their physical characteristics (e.g. brown skin, long dark hair, facial hair) and outward religious markers (e.g. head coverings, Indian clothing, turbans, khardaa (silver bracelet)) are linked to ethnic ancestry (Joshi, 2006). In the case of Sikhs, they are linked to South Asian, Indian, and Punjabi ancestry, and subsequently face another layer of racialized oppression.

Together, the critical triad supports the movement to include subjugated knowledges, particularly voices that have been silenced, marginalized, or skewed; to interrogate the process of knowledge production; to challenge the inherent power and privilege in the researcher-researched relationship; and for researchers to confront their own gaze through critical reflection. Collectively, the critical triad “provides a theoretical lens that allows access to the everyday experiences of marginalization, as structured by the micropolitics of power and the macrodynamics of structural and historical nature” (Reimer-Kirkham & Anderson, 2002, p. 2). All decisions related to the research project were enacted with the influence of this critical triad – from conceptualizing the project to how participant interviews were analyzed. Including the Punjabi Sikh Diaspora in British Columbia, a minority racialized well-settled community, was purposeful as this community has experienced various “experiences of marginalization” (Reimer-Kirkham & Anderson, 2002), othering (Johnson, Bottorff, Browne, Grewal, Hilton & Clarke, 2004) and racism (Mawani, 2018, Wallace, 2017; Kazimi, 2012; Johnston, 1989). This community has

also been the subject of numerous health behaviour research projects including their inclination to exercise following a myocardial infarction (Galdas, Oliffe, Kang & Kelly, 2012); participation in cardiac rehabilitation (Galdas & Kang, 2010); lifestyle choices (Galdas, Oliffe, Wong, Ratner, Johnson & Kelly, 2011); and food selection (Oliffe, Grewal, Bottorff, Dhesi, Kang, Ward & Hislop, 2010) with minimal focus on how healthcare racism may impact healthcare access for this racialized community.

To understand how systemic and institutionalized processes operate to limit equitable access for racialized communities, pursuing what local healthcare institutions identified in their institutional identities (phase one of the study) and diversity practices (phase two of the study) was necessary to understand existing equity commitments; and to uncover if these commitments made it to racialized patients, I included the experiences of the Punjabi Sikh Diaspora when hospitalized for cardiovascular treatment (phase 3 of the study). Within each phase of the study, I applied the guidance of the critical triad to ensure diverse voices were included. In phase one, all of British Columbia's healthcare authorities were included even the First Nations Health Authority – that does not provide direct care. In phase 2, I included informal diversity workers to capture the diversity work that was being shouldered by healthcare providers without institutional resources. In phase 3, it was imperative to include both Punjabi Sikh women and men to ensure women's voices were equally included as there has been more emphasis on men's cardiovascular experiences. These three theoretical traditions also provided the framework to integrate my experiences as a racialized woman; previous employment as a diversity worker; a member of the Punjabi Sikh Diaspora, and healthcare research I have facilitated with various racialized communities including this one. Guided by these critical theories, I considered the

subtle and underpinning processes that have and continue to construct people into racial categories, and in turn impact how they are treated. These critical theories provide the necessary guidance to address legacies of historical oppression, contemporary systems of intersecting oppression and inequities resulting from discrimination and oppression (Crenshaw, 1996; Collins, 2000; hooks, 2000; Kirkham & Anderson, 2002; Smith, 2005; Thobani, 2007; Reimer-Kirkham & Anderson, 2010; Varcoe, 2006; Varcoe et al, 2011).

### **Research Method**

This study was conducted in three phases using a *Critical Ethnographic* approach informed by *Post/Colonial, Critical Race and Feminist theories*. Conventional ethnographic approaches evaluate “what is” happening; whereas *Critical Ethnography* (CE) begins with the question: why is this happening and what can be done about it (Cook, 2005, p. 132)? In the case of this research study, the driving question became: why are health inequities linked to racism happening in Canada’s universal healthcare system? Embedded in the acknowledgement that all assumptions are constructed, critical theorists advocate for an alternative epistemology and challenge the inequality, particularly oppressive and dominant powers in society, to “[confront] the ruling structure on such grounds as racism, sexism and classism” (Cook, 2005, p. 132; Carspecken, 1996; Madison, 2005).

Data was collected in 3 phases to understand how British Columbia’s healthcare system embraces anti-racism. Data collection included: retrieval of online text associated with the province’s health authorities; qualitative interview data with diversity workers and patients; and observations in healthcare sites. Interviews were completed in either English or Punjabi. The English interviews were transcribed into English text. The Punjabi interviews were simultaneously

translated and transcribed into English text with special attention on maintaining the meaning of phrases and unique terms. A second bilingual reader/translator reviewed the translated transcripts to ensure meaning was maintained. Given the substantial data collected, coding was completed in each phase of the study. Preliminary coding was completed on hard copies of the online text, interviews, and observations. Once coding themes were finalized, data was organized using Nvivo™ (a qualitative data management software program). For my purpose, I focused on evaluating how truth/knowledge is constructed and operationalized about health inequity stemming from racial disparities and how diversity discourses and actions are meant to promote health equity.

## **Research Questions**

This study aims to evaluate how Canada's Western province of British Columbia addresses racism in its healthcare system with the following guiding research questions. I specifically sought to understand (1) how anti-racism and cultural safety are articulated and performed through institutional identities including institutional documents and websites; (2) how anti-racist programming is taken up to establish a safe and equitable healthcare processes; and (3) how anti-racist policies and programs are experienced by a long-standing racialized community: Punjabi ancestry Sikh affiliated British Columbians. As noted previously, I opted to focus on Punjabi Sikh Diaspora patients requiring CVD related hospitalizations to glean how they receive care for a life-threatening illness that is disproportionately prevalent in this community. I sought to unpack the following diversity questions:

*1. How are institutional diversity discourses and diversity actions constructed? Why has the term diversity replaced racial inequity/racism in healthcare discourse and programming? What is the*

*relationship between diversity discourses and diversity actions? How do diversity discourses and actions shape healthcare experience for racialized ethnic and religious minority communities?*

*2. How do the systemic structures in which local healthcare systems operate impact healthcare experiences for patients from racialized, ethnic and religious minority communities (from guiding organizational mandates to front-line healthcare provision)?*

*3. How do institutional diversity discourses and diversity actions in local healthcare authorities shape experiences for one heterogeneous, racialized, ethnic and religious diaspora community, the Punjabi Sikh Diaspora, when seeking cardiovascular healthcare?*

*How do the healthcare experiences of these patients align or differ from the institutional diversity mandates, philosophies, intentions and actions of institutional diversity discourses and actors?*

*4. What does an analysis of this one heterogeneous, racialized ethnic and religious Diaspora community tell us about how systemic structures are conceptualized and might be improved for healthcare delivery for ethnic and religious minority communities? What does the intersection of cardiovascular healthcare and ethnic and religious identity tell us about systemic structures for equitable cardiovascular healthcare delivery?*

### **Three Phases of the Research Project**

Phase one focused on the Western province of British Columbia's 8 healthcare delivery organizations (HDOs): First Nations Health Authority, Fraser Health Authority, Interior Health Authority, Island Health Authority, Northern Health Authority, Providence Health Authority, Provincial Health Services Authority and Vancouver Coastal Health Authority. These HDOs

provide publicly funded, universal healthcare to the province's 5 million residents<sup>38</sup>. To examine the diversity commitments of B.C.'s HDOs, we analyzed mission statements, visions and values with a list of 23 health equity markers to understand how organizations included diversity, anti-racism and equity mandates in their guiding institutional discourse. Chapter 3 of this dissertation provides a detailed scope of the research and findings for this phase.

Phase two concentrated on the diversity practices of 4 of the HDOs: Fraser Health, Providence Health, Provincial Health Services and Vancouver Coastal Health. Fraser Health, Providence Health and Vancouver Coastal Health provide direct health care through hospitals, long term care homes, palliative care, public health units and clinics while the Provincial Health Services Authority provides overarching provincial guidance and oversees particular programs such as the British Columbia Cancer Agency that operates 6 BC Cancer Agency Centres and several hospital-based clinics across the province. The four health authorities were selected as they serve ethnically and religiously diverse communities including the Punjabi Sikh Diaspora who were selected to be interviewed for phase 3 of this project. After a preliminary environmental scan of diversity programs in the 4 selected HDOs, I estimated interviewing 1-3 diversity workers in each of the HDOs (approximately 4 to 12 diversity workers) and 1-2 spiritual care providers in each HDO (approximately 4 to 8 spiritual care providers). The early one-to-one interviews with diversity workers quickly led to the realization that there were far more unofficial diversity workers facilitating cultural safety work, and there were a greater number of spiritual care providers. I was fortunate to have 28 diversity workers and 30 spiritual care providers (n=58)

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<sup>38</sup> <https://www2.gov.bc.ca/gov/content/data/statistics/people-population-community/population/population-projections>

including Indigenous Elders speak with me for one-to-one interviews. Chapter 4 of this dissertation provides an overview of phase 2 including a description of who was interviewed, summary of the thematic analysis and a discussion of the findings.

To gain a patient perspective, Phase 3 focused on Punjabi Sikh Diaspora patients who had experienced a myocardial infarction (heart attack) and recently discharged from a hospital in either in the cities of Vancouver (located in the Vancouver Health Authority), Delta or Surrey (located in Fraser Health Authority), British Columbia. These patients were interviewed regarding their experiences receiving healthcare in these hospital settings. Building on the findings from phase 1 and phase 2 findings, I attended to how institutional diversity mandates (identified through mission statements, values and visions) and diversity work (work of diversity workers, spiritual care providers and programs) translated into the healthcare encounters of this patient community. Vancouver was selected as it has been home to the Punjabi Sikh Diaspora community since the late 1800s. With two long standing *Gurudwaras* (Sikh places of worship): Akali Singh Sikh Temple<sup>39</sup> and Khalsa Diwan<sup>40</sup> Society, Vancouver continues to be home to many early settled Punjabi Sikh community members; Delta and Surrey have become home to a substantial (and growing) Punjabi Sikh Diaspora population reflected by the establishment of several *Gurudwaras* and businesses catering to the South Asian community (i.e. Indian-food-caterers, banquet halls, clothing and grocery stores). In total 15 Punjabi Sikh Diaspora patients were invited and agreed to participate in one-to-one interviews. All of the patient interviews were conducted in Punjabi,

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<sup>39</sup> One of the earliest Sikh Gurudwaras in Canada

<sup>40</sup> In the early days of settler/colonizer migration (early 1900s), Khalsa Diwan Society held an important community and activism space for the broader South Asian community, and currently houses not just a Gurudwara but a daycare, seniors' center, Punjabi language classes, and a permanent exhibition of the Komagata Maru commemoration (when 376 passengers from British occupied India were denied the opportunity to disembark in Vancouver and were instead sent 'back' to India in 1914).



and later translated and transcribed from the digital recordings. Chapter 5 will detail the recruitment process and highlight the findings from the thematic analysis of the interview transcripts and field notes.

### **Ethical Considerations**

In line with *Critical Ethnography's* mandate to make a difference (Carspecken, 1996; Madison, 2005), this research project aimed to balance the “charge to enunciate and clarify the obscurities of injustices and then thoughtfully offer just alternatives” with an “ethical responsibility to carry out change” (Madison, 2005, p. 109). Poignant lessons drawn from fellow ethnicity and health researchers regarding the struggle to make sense of differences without “[succumbing] to racialization, Othering, and reinforcement of existing power inequities” was actively examined throughout the research process (Reimer-Kirkham & Anderson, 2002, p. 9). As this project is centered on illuminating systemic health inequities linked to racial disparities, I have focused on being an “advocate” and not a “ventriloquist” to ensure the voices of the Punjabi Sikh diaspora are not “muted” while my voice is “amplified” as a well-meaning researcher (Madison, 2005, p. 98). Drawing on Maria Cristina Gonzalez’s *Ethics of Postcolonial Ethnography* (2003), I have critically considered my “accountability” to advocate - whereby I am not narrating a one-dimensional ethnographic tale of health disparities but include how this knowledge is constructed – how I am situated and construct this evidence as findings.

As I bear witness to social injustices and health inequities, I carry the responsibility of responding to these inequities in a manner that affords opportunities for change (i.e. dialogue, learning moments, critical engagement despite differing values and stances) without speaking for and eliminating agency. To avoid the “ethical offense” of the “custodian’s rip-off” whereby

“researchers are only concerned with getting what they want for themselves and for their projects, with little or no consideration of how their presence affects the dignity, safety, traditions, order, economy and health of the people they meet” (Madison, 2005, p. 143); this accountability has required me to carefully consider what it means to raise the silenced issues of systemic racism for those who are most impacted by these institutionalized practices. Self-preservation is an essential survival strategy for those who are marginalized in hegemonic systems. I was careful with how I asked questions of experienced racism as even subtle insinuations of naming racism can have harmful consequences or trigger painful memories. I sought permission to contact participants in phase 3 following their interviews for an opportunity to debrief. During the debriefing, I inquired if there was any distress in discussing their healthcare experiences and if they would like to speak with a professional counsellor. None of the participants felt the need to speak to a counsellor. Additionally, my accountability to the institutions involved in this study requires that I stay in this project after it is formally completed to offer knowledge translation activities. I have been in contact with Vancouver Coastal Health to share findings and will offer similar opportunities to the other health authorities.

A salient factor in working with this community is derived from my shared identity with the Punjabi-Ancestry Sikh Diaspora and shared linguistic capacity with those who continue to speak Punjabi. Similar to Kirin Narayan, I hold liminal insidership whereby “[even] as insiders or partial insiders, in some contexts we are drawn closer; in others we are thrust apart” (Narayan, 1993, p. 291). While I honour the shared and overlapping identity spaces with this community, as a researcher I had to remember not to rely on my narrow understanding of the Punjabi Sikh Diaspora. Also, as the one wielding academic power and privilege, I actively tried to understand

how my privilege and power was impacting data recruitment, data collection and how I interpreted findings. Evoking critical reflexivity is part and parcel of the ethical obligation researchers must carry whether we are insiders, outsiders or somewhere in between; and my hope is to write about this part of my dissertation journey at a later point.

As a womyn-of-colour, I also experience “different points along power’s spectrum” whereby I simultaneously hold certain privilege and power and also experience hegemonic power and privilege in oppressive ways (Madison, 2005, p. 98). During the interview process with diversity workers and spiritual care providers, it was clear that speaking about diversity (i.e. racism) was more comfortable for some than others. Some did not believe racism existed in Canada much less in healthcare settings, while others insightfully spoke about systemic racism and their own experiences. For participants who also identified as People of Colour, my embodiment as a noticeable Punjabi Sikh Diaspora womyn allowed relatively more conversations around race to occur; but simultaneously, my embodiment also made it challenging for some people who identified as having European ancestry to safely discuss their observations, experiences, and beliefs. There were a few European ancestry participants who had clearly spent considerable time learning about anti-racism, cultural safety, and how to be allies and advocates; and People of Colour who blended their lived experiences of being racialized with their professional diversity positions into meaningful and critical roles in their health delivery organizations to advocate for health equity. Their advocacy was often plagued with ‘eye rolling’ when they brought up equity issues, particularly racism. These reflexions were included in the observational field work and accounted for in the analysis, but a further exploration of this data would be useful in the future.

## Enhancing Credibility

I drew on Sally Thorne's *Interpretive Descriptive* evaluation criteria on qualitative research credibility as Thorne goes beyond a set of rules and offers a holistic evaluation of what is being assessed, how it is being assessed, how findings are interpreted, and how meaning is made of the findings (Thorne, 2008, p. 223). This is particularly necessary in health science research as results can influence clinical applications and have an impact on patients and their wellbeing. Thorne's four principles of qualitative research standards are epistemological integrity, representative credibility, analytic logic and interpretive authority. As noted by Thorne, "for findings to be credible, the research process must reveal a research question that is consistent with the stated epistemological standpoint" (Thorne, 2002, p. 224). My research questions and related "decisional strategies" (Thorne, 2002, p. 224) reflected epistemological integrity of the critical triad: feminist, critical race and postcolonial theories, and the direction of the study. These theoretical traditions seek to uncover inequities and power dynamics, provide a platform for subjugated voices, and confront systemic and institutionalized processes that affirm dominant ideologies. These characteristics informed the overall purpose of this research project - to understand how local health authorities addressed dominant ideologies that may persist in institutionalized processes and impact healthcare for racialized patients. As noted by Thorne: "[study] findings based on prolonged engagement with the phenomenon are more likely to be afforded credibility". The three phases of this research project allowed me to delve further into how healthcare racism was addressed; and I was able to "triangulate" different data sources through the three phases to "convey substantive completeness" (Thorne, 2002, p. 224). As the research pathways were detailed in all three phases, this serves as an audit trail and allows

another researcher to replicate the study and confirm analytic logic. To ensure interpretive authority, Thorne recommends that qualitative researchers “build in systems to check our interpretations against those of our [participants]” (Thorne, 2002, p. 225). During the diversity worker and patient interviews, clarity was sought to ensure I had accurately understood the participants’ perspective. When I concluded the interviews, I reviewed the main points shared by participants to ensure I had accurately captured their responses. After each interview was completed, I listened to the recording and included my reflections into my observational notes. If I was unsure about responses, I scheduled a follow up phone interview to clarify participant responses. These multiple check ins supported interpretive authority.

Thorne’s *Interpretive Description* also provides a set of evaluation criteria: moral defensibility, disciplinary relevance, pragmatic obligation, contextual awareness, and probable truth for a “subtle critique” of qualitative research products (Thorne, 2002, p. 226). Due to the practical implications of health science research that can lead to potential changes in how patients are treated for illnesses and injuries, *moral defensibility* requires researchers to critically consider why they are extracting information from participants, and how that information will be utilized. In the case of my research project, I had to weigh the cost of asking the Punjabi Sikh Diaspora patients about their healthcare experiences particularly if and how they experienced culturally unsafe care. Experiencing racism, particularly during medical encounters can be highly traumatizing. Putting in safety measures such as checking in with participants, noticing how they were responding to sensitive questions, following up with patient participants after the interview and offering counselling services were crucial to addressing the stress and trauma of narrating those experiences. I proceeded with the participant interviews as the benefit of having evidence

of culturally unsafe care could improve future healthcare experiences for these patients and other racialized patients. In regards to the second evaluation criteria, this project has a high degree of *disciplinary relevance* as healthcare racism creates considerable harm for racialized patients, and there has been greater attention on healthcare racism with numerous regulatory colleges adopting a practice standard to support cultural safety and anti-racism including British Columbia College of Nurses and Midwives; College of Physicians and Surgeons of BC; College of Pharmacists of British Columbia, College of Speech and Hearing Health Professionals of BC; College of Physical Therapists of BC; College of Occupational Therapists of BC; BC College of Oral Health Professionals; and British Columbia College of Social Workers. Thorne's *pragmatic obligation* asks qualitative researchers to consider our "findings "as if "they might be applied to practice" (Thorne, 2002, p. 227); for many of us who are invested in promoting anti-racism, equity and social justice, eradicating racism is an aspirational hope. It is my hope that my findings contribute to the mobilization of anti-racism and equity policies and praxis in all healthcare encounters. *Contextual awareness* requires qualitative researchers to examine our assumptions, especially if they are "invisible" so that we do not perpetuate dominant ideologies. Even as a racialized individual aware of various forms of racism, I constantly interrogate my own assumptions about race and racism. Critically reflecting on how race is constructed and how racism operates is vital as different settings can conjure different ways race is operationalized. As a minority, racialized community: the Punjabi Sikh Diaspora exists on the margins of Canadian society despite their long history of residing in Canada. I took care in including this historical, social and political context in which this community experienced healthcare. Thorne asks researchers to "accept that there is considerable value in [recognizing] ... some kinds of

knowledge as probable truth” while simultaneously acknowledging that some knowledge claims may be proven untrue as a part of the *probable truth* criteria (Thorne, 2002, p. 230). I developed a three phased research project, with multiple data sources, to have a rich data set to examine the research questions and to contribute to the growing body of knowledge on healthcare racism in Canada. A foundational step towards equity is to acknowledge and candidly discuss racism. This research project offers evidence, and probable truth to foster equity building progress.

## **Conclusion**

Developed through a social justice lens, this research project is hinged on promoting health equity. When there is an “unequal distribution of power, income, goods, and services ... the consequent unfairness in the immediate, visible circumstances of people’s lives – their access to healthcare and education, their conditions of work and leisure, their homes, communities, towns, or cities – and their chances of leading a flourishing life” are jeopardized (Marmot, Friel, Bell, Houweling, Taylor & Commission for Social Determinants of Health, 2008, p. 1661). As defined by the World Health Organization, health inequity is a result of “avoidable inequalities in health”<sup>41</sup> that is influenced by “immediate and structural conditions in which people are born, grow, live, work and age” (Marmot et al, 2008, p. 1661). This research project addresses the call to action outlined by the *Commission on Social Determinants of Health* to close the health gap by evaluating how systemic racism impacts health in/equity. Further, the analysis of the facilitators and barriers to delivering equitable healthcare will be useful to local healthcare authorities and frontline healthcare providers to support patient-centered care. This will not only benefit the local health authorities in evaluating how their policies and practices are meeting the needs of

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<sup>41</sup> [http://www.who.int/social\\_determinants/thecommission/finalreport/key\\_concepts/en/](http://www.who.int/social_determinants/thecommission/finalreport/key_concepts/en/)

racialized patients but offer healthcare policy makers insights on how to restructure healthcare systems to address the needs of marginalized communities. Lastly, healthcare racism “violates a fundamental and universally accepted principle of health professional ethics ... to do no harm” (Johnstone & Kanistaki, 2010, p. 491); and this project is one contribution towards addressing the serious harm of systemic racism that covertly operates in the Canadian public healthcare system.



### Chapter 3<sup>42</sup>

#### Equity, Anti-Racism and Social Justice: Mission Statements, Vision and Values of British Columbia's Health Delivery System

*“Words, whether spoken or written, do things ... Texts also circulate: they move around ... Words might get repeated and this repetition might increase or decrease their value depending on how they are received” (Ahmed, 2009)*

Healthcare organizations convey their identity, purpose and commitment through specific institutional ‘words’ particularly the strategic triangle: mission statements, visions and values that ideally drive institutional decisions and policies. These institutional “words ... do things” – perform particular roles and functions (Ahmed, 2009), and portray the institutions’ overall story: who they are, what they value and where they are going. Part of the institutional story of Canadian healthcare delivery organizations is that healthcare is a right (Romanow, 2002) and as such, Canada has committed to universal healthcare coverage (Canada Health Act, 1984) to advance health equity (CSDH, 2008; Piece, 2012). Further, the Canadian state embraces an inclusive diversity narrative with the adoption of the Multiculturalism Act that “[recognizes] and [promotes] ... the cultural and racial diversity of Canadian society and acknowledges the freedom of all members of Canadian society to preserve, enhance and share their cultural heritage” and “[promotes] the full and equitable participation of individuals and communities of all origins” with a commitment to “assist them in the elimination of any barrier to that participation” (Multiculturalism Act, 1985). In addition, as a signing member to the World Health Organization’s constitution, Canada has committed to delivering the “highest attainable standard of health [as

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<sup>42</sup> Chapter 3 is written as a stand-alone research paper. As this chapter includes co-authors Colleen Varcoe and Sheryl Reimer-Kirkham, I use the pronoun: we instead of the third person. This chapter is in the process of being submitted in a peer-reviewed journal.

a] fundamental [right] of every human being ... without distinction of race, religion, political belief, economic or social condition”<sup>43</sup>. With landmark legislation (i.e. *Canada Health Act* (1984)<sup>44</sup> and the *Multiculturalism Act* (1985)<sup>45</sup>) and global health commitments, Canada embraces a necessary institutional framework intended to ensure equitable healthcare access and health outcomes for all Canadians; Yet, despite these philosophical commitments, legislation and considerable resources, health disparities persist. In this paper, we report the disjuncture between Canada’s expressed national and global commitments and institutional realities with an analysis of mission statements, values and visions of healthcare delivery organizations in Canada’s most western province of British Columbia. To foreground our findings, we provide a brief overview of health inequities; ideologies that underpin Canada’s universal healthcare; the organizational significance of mission, vision and value statements; and British Columbia’s healthcare structure.

### **Healthcare Inequities Persist Despite ‘Universal’ Health Coverage**

Despite the provision of universal health care coverage, healthcare inequity is still evidenced in Canada (Frohlich, Ross & Richmond, 2006; Kennedy & Morgon, 2009; Lebrun, 2012; Markham, et al, 2021; Phillips-Beck, Eni, Lavoie, Knew, Achan & Katz, 2020; Schoen & Doty, 2004;

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<sup>43</sup> Constitution of the World Health Organization, 1946 <http://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf?ua=1>

<sup>44</sup> Canadian *Constitution Act* (1867) and the *Canada Health Act* (1984) identify the process whereby the federal and provincial/territorial governments provide primary care for Canadian residents.

<sup>45</sup> Canada espouses a national multiculturalism philosophy that “[recognizes] and [promotes] ... the cultural and racial diversity of Canadian society and acknowledges the freedom of all members of Canadian society to preserve, enhance and share their cultural heritage” and “[promotes] the full and equitable participation of individuals and communities of all origins” with a commitment to “assist them in the elimination of any barrier to that participation” (Multiculturalism Act, 1985).

Wolfe, 2006). There is ample evidence to suggest that healthcare encounters between non-dominant racialized patients and healthcare providers include 'racial profiling' (Henry, Tator, Mattis & Rees, 1998; Tator & Henry, 2006) and other forms of racial bias, prejudice and stereotyping that result in health inequality (Adelson, 2005; Frohlich, Ross & Richmond, 2006; Humphries & van Doorslaer, 2006; Institute of Medicine, 2003; Mahabir, O'Campo, Lofters, Shankardass, Salmon, & Muntaner, 2021 O'Neill & O'Neill, 2008; Pardies, Truong & Priest, 2013; Paradies, Priest, Ben, Truong, Gupta, Pieterse, Kelaher & Gee, 2013; Tang & Browne, 2008). These racially discriminatory interactions are not one directional but also experienced by racialized non-dominant healthcare providers in multiple ways, ranging from derogatory racial remarks (Cottingham et al, 2018; Ejaz, Rentscn, Noelkar & Castora-Binkley, 2011; Kirkham, 2013) to being perceived as less competent than European Ancestry healthcare providers (Cottingham et al, 2018; Das Gupta, 2009; Lo & Bahar, 2013) and being purposefully excluded from work-related interactions, preferred work sites and promotions (Das Gupta, 2009; Iheduru-Anderson, 2020). As a system of power, racism permeates across the everyday movements and interactions of racialized non-dominant individuals stretching across social, cultural, political, economic and spiritual realities. Growing evidence highlights that when people experience inequities including racial discrimination, there is a direct cost to their well-being culminating in illnesses with diminished quality and quantity of life (Bailey, Krieger, Agenor, Graves, Linos & Bassett, 2017; Krieger, 2016; Krieger, 2012; Lukachko, Hatzenbuehler & Keyes, 2014; Safaei, 2007; Schulz et al, 2006; Sondik et al, 2010; Williams and Mohammed, 2008).

Collectively evaluated, the healthcare experiences of racialized non-dominant patients and healthcare providers narrate a pattern of marginalization and differential treatment; and for

patients, this translates to differences in health outcomes. These inequities partly stem from the systemic race dynamics in which Canada, as a nation state, has been established and developed. Canada is founded in the violent and genocidal colonization of Indigenous Peoples which seeded ideologies of white supremacy, privilege and power that have continued to perpetuate denigrating individual, collective, political, cultural and societal racism towards Indigenous communities – culminating in denying Indigenous Peoples their personal and collective sovereignty (Alfred, 2009; Coulthard, 2014; Lawrence & Dua, 2005; Maracle, 1996). This racial hierarchy has also led to the inferior societal positioning of racialized non-European communities such that European ancestry Canadians (i.e. those who are perceived to be ‘white’) are elevated to the status of ‘Exalted Subjects’ (Thobani, 2007) and constructed as the ‘true’ citizens of Canada. Through rituals of questioning belonging (i.e. ‘where are you really from’), asserting dominance (‘why do they not speak English’) and the classification of non-European ancestry Canadian citizens as ‘visible minorities’<sup>46</sup> (Thobani, 2007), racialized non-dominant Canadians are understood to be “politically minor players” – reinforcing that they are enduring ‘outsiders’ (Bannerji, 2000, p. 30). These historical and contemporary ideologies related to race reveal the longitudinal influence of Canada’s 1867<sup>47</sup> founding aspiration to be a ‘White Man’s Country’ (Dua, 2007, p. 446; Kazimi, 2012; Wallace, 2017) and contribute to contemporary systemic racism;

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<sup>46</sup> ‘Visible minorities’ is a terminology employed by Statistics Canada and designated to identify racialized communities of colour, who are visibly perceived as non-white. In the most recent Canadian Census (2016), over 7 million Canadians identified as ‘visible minorities’. <https://www12.statcan.gc.ca/census-recensement/2016/as-sa/fogs-spg/Facts-can-eng.cfm?Lang=Eng&GK=CAN&GC=01&TOPIC=7>

<sup>47</sup> As a nation, Canada was built on ideologies of white supremacy with the first Canadian Prime Minister: John A. MacDonald (1867-1873; 1878-1891) identifying Canada as a “White Man’s Country”. To maintain this ideology, Indigenous Peoples and People of Colour have been positioned as lesser in comparison to European ancestry Canadian subjects (Thobani, 2007).

which privileges dominant racialized communities, while comprehensively and actively subordinating non-dominant individuals and communities. Despite the progressive adoption of *Multiculturalism* and liberal ideologies, Canada continues to struggle with systemic inequities for racialized communities which translates to differences in quality of life and well-being (Bryant, Raphael, Shrecker & Labonte, 2011; Creese & Wiebe, 2009; Lightman & Gingrich, 2018 ; Mikkonen & Raphael, 2010; Pendakur & Bevelander, 2016; Pendakur & Pendakur, 2014; Pendakur & Pendakur, 2011; Pendakur & Pendakur, 2002; Ross, Garner, Bernier, Feeny, Kaplan, McFarland, Orpana & Oderkirk, 2012) and these ideologies serve as the foundational building blocks of Canadian institutions – including healthcare delivery organizations.

### **Canada's Healthcare Vision and Diversity**

Canadians “consider equal and timely access to medically necessary health care services” as a basic need and a “right of citizenship, not a privilege of status or wealth” (Ramonow, 2002)<sup>48</sup>. Canadian Commissioner Roy J. Romanow’s report: *Building on Values: The Future of Health Care in Canada* (2002) provided a poignant report on the Canadian health care system, and this report continues to be relevant today – 17 years later. Romanow’s report emphasized the need for quality health care, defined as “delivering the best possible care and achieving the best possible outcomes for people every time they deal with the healthcare system or use its services” (Romanow, 2002, p.150).

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<sup>48</sup> Building on Values: The Future of Health Care in Canada – Final Report by Commissioner: Roy J Romanow (2002)

For patients, high quality health care means that their needs and expectations are being met. For health care providers, quality health care means their diagnoses are accurate, they are part of a well-functioning system, and the care they provide is appropriate and effective. For our society as a whole, it means that the overall health of Canadians improves. (Romanow, 2002, p. 150)

Among the recommendations, the report identified that “governments, regional health authorities, and healthcare providers should continue their efforts” to “address the diverse health care needs of Canadians” (Romanow, 2002, p. 150; recommendation 29, Romanow, 2002, p. 251). This use of ‘diversity’ explicitly includes gender, ethnicity/race, different abilities and newcomer status and plainly acknowledges that “Canada has a diverse population, and that diversity should be reflected in Canada’s health care system” (Romanow, 2002, p. 155). The report also included input from direct care community organizations recommending that:

... health services should be more culturally sensitive, that health promotion materials should be written in more than the two official languages, and that health care professionals should reflect the diversity of Canadian society and understand the ethnic and cultural backgrounds of the populations they serve (Romanow, 2002, p. 156)

Romanow’s call for cultural sensitivity and equal healthcare access continues to be relevant for racialized non-dominant British Columbians; particularly for healthcare delivery organizations in British Columbia as they serve an ethnically diverse patient population, mirroring the multicultural ethnic diversity across Canada. In response to an ethnically diverse population, British Columbia’s healthcare delivery organizations have incorporated cultural competency training (Kang, Varcoe, Thobani and Reimer-Kirkham, in progress); diversity programs (Kang, Varcoe, Thobani and Reimer-Kirkham, in progress); extensive interpreter and translation services (Provincial Health Services Authority); and specific population programming (e.g. Fraser Health Authority’s South Asian Health Institute, Vancouver Coastal Health’s Aboriginal Wellness Program). The implementation of these policies and programs is often embedded in a culturist

framework to explain differences or similarities between ethnic cultural groups (Johnson, Bottorff, Browne, Grewal, Hilton & Clarke, 2004). When policies and programs are designed based on culturist beliefs, healthcare access, treatment adherence and preventative lifestyle ‘choices’ are often linked to ethnic communities’ lack of language fluency, cultural customs, beliefs and traditions – not the structure of our healthcare system, or the social, political and cultural context of our nation. However, with emerging Canadian research, critical health scholars continue to shed light on how systemic forms of racism play out in healthcare (Adelson, 2005; Beavis et al, 2015; Browne & Varcoe, 2006; Browne, Varcoe, Lavoie, Smye, Wong, Krause, Tu, Godwin, Khan & Fridkin, 2016; Browne, Varcoe & Ward, 2021; Goodman, Fleming, Marwick, Morrison, Lagimodiere, Kerr & Western Aboriginal Harm Reduction Society, 2017; Markham, Hunt, Woollard, Oelke, Snadden, Strasser, Betkus & Graham, 2021; Nestel, 2012; Phillips-Beck, Eni, Lavoie, Avery Kinew, Kyoan-Achan & Katz, 2020; Reimer-Kirkham, 2003; Tang & Browne, 2008; Varcoe, Browne, Wong & Smye, 2009; Vukic, Jesty, Mathews & Etowa, 2012; Weerasinghe, 2012) and highlight the impact of the social, cultural and political context in which British Columbia’s healthcare delivery organizations are housed (Anderson and Reimer-Kirkham, 2002; Varcoe, 2006;). Critical health researcher, Colleen Varcoe poignantly identifies that anti-racism and equitable praxis operates in the wider world within intersecting historical, social, political “racist context and broader racializing discourses” (Varcoe, 2006, p. 535). Further, critical health researchers extend calls for health equity to include how diversity policies and programs may inadvertently rely on culturist ideals that rely on “hegemonic systems of domination” and “further marginalize those they are intended to include” (Reimer-Kirkham & Anderson, 2002, p. 252).

In summary, racism-based inequities persist in healthcare despite rhetoric promoting equity. Examining institutional discourse statements reveals how organizational commitments for health equity for non-dominant patients is absent or present in institutional identity. With a focus on British Columbia's health organizations, our research questions were: 1. How does the public institutional discourse (located in mission statements, values and vision) include diversity and health equity for racialized non-dominant patients, families, and communities? 2. How are inclusion and equity discourses constructed in mission statements, values and vision statements? 3. What are the guiding 'truths' that inform these discourses? This analysis provides an in-depth examination of all 8 healthcare organizations' guiding objectives and ideologies in regards to meeting health equity for racialized non-dominant communities.

### **Why Focus on Mission, Vision and Value Statements?**

Mission, vision and value statements of healthcare delivery organizations narrate their organizational identity, objectives, and values. As institutional discourse, the 'words' used in these statements convey the cultural, political, and societal framework that support current day approaches, programs, and initiatives to healthcare delivery in British Columbia, and incorporate strategic priorities set forth by British Columbia's Ministry of Health. Originally designed to promote a corporate organizations' "shared expectations amongst employees and communicate a public image ... to important stakeholders" (Analoui & Karami, 2002), mission statements also define organizational purpose (Greengarten-Jackson, Yau, Gitlow & Scandura, 1996) and goals (Toftoy & Chatterjee, 2004); guide strategic plans (Palmer & Short, 2008), leadership style (Analoui & Karami, 2002) and staff recruitment (Baetz & Bart, 1996); and communicate corporate identity (Leuthesser & Kohli, 1997). In recent years, the non-profit sector has adopted mission



statements as a meaningful technique to communicate core values and activities to stakeholders (Kirk & Nolan, 2010). Healthcare organizations have also embraced the usefulness of mission statements (Bart & Hupfer, 2004; Bart & Tabone, 1998; Grbic, Hafferty & Hafferty, 2013; Ramsey & Miller, 2009) with an emphasis on identifying their purpose (i.e., improving public health), institutional identity, scope of practice, and strategic direction in the mission statement.

Along with the mission statement, many organizations including BC's healthcare delivery organizations include a vision and list of values. Organizational vision and values convey the institutions' core ideology and envisioned future (Collins & Porras, 1996). The vision includes a clear and compelling long-term goal (Khalifa, 2012), a "future destination so strongly appealing that it inspires the wholehearted commitment of all relevant stakeholders" (Bart & Hupfer, 2004, p. 101). The values identify "guiding principles and essential and enduring tenets" (Khalifa, 2012, p. 239) as well as communicate workplace ethic and culture – "attracting and building loyalty among individuals who share and honor the same ethos" (Bart & Hupfer, 2004, p. 101). Collectively, organizational culture is confirmed through these types of institutional discourse statements to communicate "management beliefs, perspectives and approaches ... to employees and stakeholders [patients and families]" (Babnik, Breznik & Dermol, 2013, p. 613) as well as share the broader cultural context: a "view of the physical, political and social environment in which an institution is embedded" (Grbic, Hafferty & Hafferty, 2013, p. 852). Analyzing these institutional discourse statements offers an understanding of organizational culture and ethos that drives the delivery of British Columbia's 'universal' healthcare commitment and possible disjunctures from the principles of accessibility and universality that affirm "the conviction of

Canadians that essential health care services must be available to all Canadians on the basis of need and need alone” (Romanow, 2002, p. 61).

### **Project Context: British Columbia’s Healthcare System**

Located on the Western coast of Canada, the province of British Columbia is home to approximately 5.2 million people<sup>49</sup> and has a budget of 23.8 billion dollars<sup>50</sup> to publicly administer, comprehensive, universal, portable and accessible health care in accordance with the Canada Health Act (Canada Health Act, 1985). While British Columbia’s Ministry of Health is responsible to “[ensure] that quality, appropriate, cost effective and timely health services are available for all British Columbians”, five provincial health authorities (Fraser Health Authority (FHA), Interior Health Authority (IHA), Island Health Authority (IsHA), Northern Health Authority (NHA) and Vancouver Coastal Health Authority (VCHA) provide direct health care delivery (Ministry of Health 2020/21-2022/23 Service Plan, February 2020). Additionally, the Provincial Health Services Authority collaborates with the 5 provincial health authorities to provide specialized province-wide health services such as cardiac and stroke services, oversees BC Ambulance Service and Patient Transfer Network, as well as operates specialized health centers (e.g. BC Children’s Hospital and BC Cancer agencies)<sup>51</sup>. In coordination with the Ministry of Health, Vancouver Coastal Health Authority and Provincial Health Services Health Authority, Providence Health Care also operates in the Greater Vancouver Area to provide specialized care

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<sup>49</sup> <https://bcstats.shinyapps.io/popApp/>

<sup>50</sup> [https://www.bcbudget.gov.bc.ca/2021/pdf/2021\\_Budget%20and%20Fiscal%20Plan.pdf](https://www.bcbudget.gov.bc.ca/2021/pdf/2021_Budget%20and%20Fiscal%20Plan.pdf)

<sup>51</sup> <http://www.phsa.ca/about/who-we-are/our-unique-role>

through 16 healthcare facilities inspired by 5 different congregations of Catholic Sisters<sup>52</sup>. In many ways, Providence Health performs similarly to the other Health Authorities but receives horizontal governance and support from Vancouver Coastal Health (e.g. Vancouver Coastal Health's Aboriginal Wellness program supports Providence Health when needed). Further, the first province-wide health authority in Canada to focus on Canada's Indigenous patients, families and communities: the First Nations Health Authority is dedicated to improving the "health outcomes for BC First Nations". It is important to note that their "work does not replace the role or services of the Ministry of Health and Regional Health Authorities" but instead FNHA "[collaborates], [coordinates], and [integrates] ... respective health programs and services to achieve better health outcomes for BC's First Nations"<sup>53</sup>. Collectively these health authorities are identified as healthcare delivery organizations for the purposes of this paper.

Similar to other formalized, government-directed healthcare bodies, British Columbia's healthcare delivery organizations (HDOs) are structured institutions shaped by federal and provincial leadership, policies and mandates with multiple levels of governance and leadership (e.g. Board of Directors, Senior Leadership, Directors) and accountability platforms (e.g. report cards, strategic directions). Each healthcare delivery organization has a unique leadership team which designs the organizational processes and systems in response to federal and provincial mandates, specific direct care health delivery needs and patient populations. These guiding directives ideally would be reflected in institutional identity, purpose, core values, strategic

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<sup>52</sup> This includes 3 hospitals, specialized supportive care residence for mental health (1), assisted living (1), long term care (2), 1 hospice, 1 medical-grade heroin clinic and 7 community dialysis sites. <https://www.providencehealthcare.org/hospitals-residences>

<sup>53</sup> <https://www.fnha.ca/about/fnha-overview>

direction and scope of care through publicly shared institutional discourse (e.g. mission statements, values and visions).

## **Methods**

### **Data Collection**

This paper draws on a broader qualitative study<sup>54</sup> that has incorporated a *Critical Ethnographic* approach informed by *Post/Colonial, Critical Race and Feminist theories*. Focused on the Western province of British Columbia, we collected mission statements, values and visions identified by all eight of British Columbia's healthcare delivery organizations (HDOs). All of the healthcare delivery organizations share their mission statements, values and visions publicly on their websites. Screen shots were captured to maintain a record of the collected data. Data was organized into three groupings: 1. Mission statements; 2. Vision; and 3. Values.

### **Data Analysis**

Each of the data groupings (mission statements, visions and values) were reviewed through several readings and reflective journaling to identify emerging themes. These themes were collaboratively discussed and followed with another set of readings to conduct thematic coding. Data was also read for specific words and phrases that would identify objectives, priorities, and values regarding health equity for racialized non-dominant patients. The following words and phrases were identified as equity markers addressing health equity for racialized non-dominant communities: culture; traditions; ethnicity; race; cross cultural; cultural safety; cultural humility; cultural sensitivity; cultural competency; cultural proficiency; equity; diversity;

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<sup>54</sup> The broader qualitative study is entitled: Sadhee Sehayth: Our Health Project and serves is a part of Bindy Kang's doctoral work.

inclusion; social justice; anti-oppression; anti-racism; racism; racialized; visible minority; hegemonic; dominant; power; and micro-aggressions. Equity markers were identified through database searches of research articles and gray literature associated with healthcare equity for racialized communities and terms used to name cultural safety programs in healthcare settings. Validity was assessed by correlating how frequently equity markers were identified in the literature and the discourse of cultural safety healthcare programs. To finalize the analysis, we read the data groupings to attend to the research questions outlined previously.

## **Results**

### **Mission Statements<sup>55</sup>**

British Columbia's healthcare delivery organizations offer a distinctive array of goals, sense of purpose and institutional identity through their mission statements. Not surprisingly, 'health' is a key theme that can be traced in all eight mission statements; and confirms their commitment to supporting healthy individuals and communities. Care, particularly the act of 'caring', is also identified as a central theme, albeit not explicitly expressed in all of the mission statements. For instance, Vancouver Coastal Health Authority explicitly identifies 'care': "Come together as one collective team to deliver an exceptional care experience for all"<sup>56</sup>; while others (e.g. Northern Health Authority) infer a caring paradigm: "Through the efforts of dedicated staff and physicians, in partnership with communities and organizations, we provide exceptional health services for Northerners".<sup>57</sup> Only Providence Health identified 'compassionate care'. While 'care' offers positive opportunities for healthcare support, 'compassionate care' advances

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<sup>55</sup> Mission Statements also encompass institutional purpose statements.

<sup>56</sup> <http://www.vch.ca/about-us/strategy>

<sup>57</sup> <https://www.northernhealth.ca/AboutUs/Mission,VisionStrategicPlan.aspx>

care to “sympathetic consciousness of others’ distress ... with a desire to alleviate it”<sup>58</sup> (Merriam-Webster Dictionary, 2019). Additional themes of Education and Research; Innovation; Quality and Safe Care were less prominent though still visible as a part of the organizational purpose.

Patient-Centered care was highlighted as the first priority in the BC Ministry of Health’s *Setting Priorities for BC Health Care* report which tasked healthcare delivery organizations to commit to “[shift] the culture of health care from being disease-centred and provider-focused to being patient centred” (2014, p. 3). Further, the *British Columbia Patient Centered Care Framework* identifies that care will be “built around the individual, not the provider and administration” and acknowledges that patient-centered care will be a “sustained focus that will drive policy, service design, training, service delivery and service accountability systems”<sup>59</sup> (2015). No health authority identified the word ‘patient(s)’ in their mission statements; however, FNHA includes “individuals and families” while FHA identifies “people”, and most made reference to “communities”. Providence Health uniquely refers to patients as “those served” while Northern Health Authority identifies “Northerners” as their service community. The First Nations Health Authority was the only healthcare delivery organization to explicitly identify “working with [people] on their health and wellness journeys”.<sup>60</sup> While many health authorities present patient-centred care as a part of their healthcare delivery model, the mission statements do not reflect this commitment to ‘working with’ patients but rather, mission statements articulate a ‘providing for’ model. Although, patients are essential in the healthcare encounter as they directly receive healthcare through these institutions, patient agency is almost absent in the mission statements.

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<sup>58</sup> <https://www.merriam-webster.com/dictionary/compassion>

<sup>59</sup> [https://www.health.gov.bc.ca/library/publications/year/2015\\_a/pt-centred-care-framework.pdf](https://www.health.gov.bc.ca/library/publications/year/2015_a/pt-centred-care-framework.pdf)

<sup>60</sup> <http://www.fnha.ca/about/fnha-overview/vision-mission-and-values>

In turn, this absence of patient agency positions patients as passively receiving healthcare; and within this framework, when patients (and families) advocate for themselves, they are disrupting the ‘providing for’ model. In response to British Columbia’s Ministry of Health’s priority, patient centered care is featured on the websites of Provincial Health Services Authority <sup>61</sup>, Vancouver Coastal Health Authority<sup>62</sup>, Fraser Health Authority<sup>63</sup>, Providence Health, Island Health Authority<sup>64</sup>, Interior Health Authority<sup>65</sup> and the First Nations Health Authority<sup>66</sup> with explicit acknowledgment that patients and families are to be treated with respect and dignity and encouraged to collaborate with health care teams to be active in their healthcare journeys <sup>67</sup>.

Another term commonly used to signal excellence in healthcare delivery is ‘quality’ as it is rooted in an ideology of delivering good healthcare. ‘Quality’ was frequently featured in the mission statements with Island Health Authority’s mission statement including: “to provide superior health care through ... a commitment to quality and safety”; while Interior Health Authority’s mission statement: “provide needed health services ... to the highest professional and quality standards” (please see Table 1) includes both ‘quality and ‘safety’. Although, there is mention of ‘quality’ and ‘safety’ in these mission statements, it is unclear what is meant by ‘quality’ or ‘safety’. To better understand this, we examined what was meant by ‘patient care

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<sup>61</sup><http://www.phsa.ca/health-professionals/professional-resources/telehealth/using-telehealth/delivering-specialized-patient-centred-care>

<sup>62</sup> <http://www.vch.ca/Documents/Service-Plan-2015-2016-Final-October-2015.pdf>

<sup>63</sup> <http://www.fraserhealth.ca/media/201412PolicyFamilyVisitorsHospitals.pdf>

<sup>64</sup> <http://www.viha.ca/quality/care/clinical/patient/>

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<https://www.interiorhealth.ca/AboutUs/MediaCentre/NewsReleases/Documents/New%20funding%20to%20help%20create%20team-based%20primary%20care%20services%20throughout%20BC.pdf>

<sup>66</sup> <http://www.fnha.ca/about/news-and-events/news/cultural-humility-campaign-launched-as-part-of-national-aboriginal-day-of-wellness-events-in-bc>

<sup>67</sup> Providence Health has 4 guiding principles regarding patient and family centered care which can be reviewed on their website: <http://www.providencehealthcare.org/about-providence/who-we-are/person-family-centered-care>

quality'. All of the healthcare delivery organizations included a *Patient Care Quality* office with the exception of the First Nations Health Authority (which does not directly provide direct care) with explanations on how to file complaints and share compliments but no definitions of what constitutes 'quality' or 'safety' – or identify why complaints would be filed. In 2008, the *Patient Care Quality Review Board Act* was introduced to address patient care quality complaints in “a clear, consistent, timely and transparent approach” in British Columbia<sup>68</sup>. There is no clear definition of what constitutes 'patient care quality' in the *Patient Care Quality Review Board Act*<sup>69</sup> but only that a 'care quality complaint' refers to “the delivery of, or the failure to deliver, health care; the quality of health care delivered; the delivery of, or the failure to deliver, a service relating to health care; [or] the quality of any service relating to health care”<sup>70</sup>. It remains unclear as to what would breach 'patient care quality' and 'safety'.

When we analyzed the mission statements for the twenty-two health equity markers for racialized non-dominant communities<sup>71</sup>, we found only one mission statement that included any. The placement of “honouring traditions and cultures” in the First Nations Health Authority's mission statement signals their institutional commitment to provide culturally safe care for Indigenous patients, families and communities in British Columbia; this is particularly relevant for Indigenous communities who face well-documented health inequities on the unceded territories of present-day Canada. The health equity markers for racialized non-dominant communities that

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<sup>68</sup> <https://www.patientcarequalityreviewboard.ca>

<sup>69</sup> [http://www.bclaws.ca/civix/document/id/complete/statreg/08035\\_01](http://www.bclaws.ca/civix/document/id/complete/statreg/08035_01)

<sup>70</sup> [http://www.bclaws.ca/civix/document/id/complete/statreg/08035\\_01](http://www.bclaws.ca/civix/document/id/complete/statreg/08035_01)

<sup>71</sup> The following words and phrases were selected as markers addressing health equity for racialized non-dominant communities: culture; traditions; ethnicity/race; cross cultural; cultural safety; cultural humility; cultural sensitivity; cultural competency; cultural proficiency; equity; diversity; inclusion; social justice; anti-oppression; anti-racism; racism; racialized; visible minority; hegemonic; dominant; power; and micro-aggressions.



are entirely absent from the mission statements are: ethnicity/race; cross cultural; cultural safety; cultural humility; cultural sensitivity; cultural competency; cultural proficiency; equity; diversity; inclusion; social justice; anti-oppression; anti-racism; racism; racialized; visible minority; hegemonic; dominant; power; and micro-aggressions. This absence indicates that there is a gap in acknowledging the necessity of culturally safe healthcare for all patients in British Columbia served by publicly funded healthcare delivery organizations in a universal health delivery framework.

*Table 3.1: British Columbia's Healthcare delivery organization Mission Statements*

PHSA	Provincial health results through caring, leading and learning together <sup>72</sup>
VCHA	Come together as one collective team to deliver an exceptional care experience for all <sup>73</sup>
PH	Inspired by the healing ministry of Jesus Christ, Providence Health Care is a Catholic health care community dedicated to meeting the physical, emotional, social and spiritual needs of those served through compassionate care, teaching and research. <sup>74</sup>
IsHA	To provide superior health care through innovation, teaching and research and a commitment to quality and safety—creating healthier, stronger communities and a better quality of life for those we touch. <sup>75</sup>
FHA	Purpose: To improve the health of the population and the quality of life of the people we serve <sup>76</sup>
IHA	Promote healthy lifestyles and provide needed health services in a timely, caring, and efficient manner, to the highest professional and quality standards. <sup>77</sup>
NHA	Through the efforts of dedicated staff and physicians, in partnership with communities and organizations, we provide exceptional health services for Northerners. <sup>78</sup>
FNHA	The FNHA supports BC First Nations individuals, families and communities to achieve and enjoy the highest level of health and wellness by: working with them on their health and wellness journeys; honouring traditions and

<sup>72</sup> <http://www.phsa.ca/about/who-we-are/vision-mission-values>

<sup>73</sup> <http://www.vch.ca/about-us/strategy>

<sup>74</sup> <http://www.providencehealthcare.org/about-providence/who-we-are/mission-vision-values>

<sup>75</sup> [http://www.viha.ca/about\\_viha/vision.htm](http://www.viha.ca/about_viha/vision.htm)

<sup>76</sup> <http://www.fraserhealth.ca/about-us/strategic-direction/strategic-direction>

<sup>77</sup> <https://www.interiorhealth.ca/AboutUs/StrategicDirection/Pages/default.aspx>

<sup>78</sup> <https://www.northernhealth.ca/AboutUs/Mission,VisionStrategicPlan.aspx>

	cultures; and championing First Nations health and wellness within the FNHA organization and with all of our partners. <sup>79</sup>
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## Vision

Institutional ‘vision’ defines an organization’s aspirational long-term direction, practices and goals; in essence, ‘vision’ provides imagery of what the institution will be doing in the future. The reviewed vision statements appear to be comprised of honorable aspirations to provide the best in healthcare with terms such as ‘best care’, ‘excellence in health’, ‘excellent care’, ‘better health’, and ‘exceptional care’; however, it is unclear how ‘best’, ‘excellent’ or ‘better’ are defined (please see table 2). For instance, Island Health’s vision is to provide “Excellent care and health for everyone, everywhere and every time”, while Fraser Health’s vision is to support “Better health” and be the “Best in Healthcare”. Not only are ideas of excellent, best and better ambiguous, but it is unclear as to how these care standards are then delivered “everywhere and every time”. While vision achievement is difficult to measure, these guiding institutional ‘words’ are constructed in ambiguous terms that remain vague, overarching end-goals that are challenging to assess for successful attainment. Further, ‘patients’ are an entirely absent word from the vision statements; albeit, Providence Health references “those served through compassionate care, teaching and research” which would ideally include patients; and the First Nations Health Authority identifies “working with” “BC First Nations individuals, families and communities”.

In regard to the twenty-two health equity markers for racialized non-dominant communities, vision statements for Providence Health and First Nations Health Authority

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<sup>79</sup> <http://www.fnha.ca/about/fnha-overview/vision-mission-and-values>

incorporated elements of a health equity framework. Providence Health’s vision statement: “driven by compassion and social justice, we are at the forefront of exceptional care and innovation” explicitly identifies ‘social justice’ as a part of their long-term vision; thus includes an aspirational trajectory towards egalitarianism (Merriam-Webster Dictionary, 2017). The First Nations Health Authority’s vision: “healthy, self-determining and vibrant BC First Nations children, families and communities” emphasizes a future whereby Indigenous communities are empowered and active in their holistic well-being. As a part of holistic well-being, this vision statement acknowledges a transformative shift from the current social and political standing of Indigenous Peoples as advocating for self-determination to a future position whereby Indigenous individuals and communities can have the fundamental right to be ‘self-determining’. The health equity markers that are entirely absent from the vision statements are: ethnicity/race; cross cultural; cultural safety; cultural humility; cultural sensitivity; cultural competency; cultural proficiency; equity; diversity; inclusion; anti-oppression; anti-racism; racism; racialized; visible minority; hegemonic; dominant; power; and micro-aggressions.

*Table 3.2: British Columbia’s Healthcare delivery organization Vision Statements*

PHSA	Province wide solutions for excellence in health, every time <sup>80</sup>
VCHA	Healthy lives in healthy communities
PH	Driven by compassion and social justice, we are at the forefront of exceptional care and innovation. <sup>81</sup>
IsHA	Excellent Care and Health for Everyone, Everywhere and Every time <sup>82</sup>
FHA	Better health. Best in healthcare. <sup>83</sup>
IHA	To set new standards of excellence in the delivery of health services in the Province of British Columbia. <sup>84</sup>

<sup>80</sup> <http://www.phsa.ca/about/who-we-are/vision-mission-values>

<sup>81</sup> <http://www.providencehealthcare.org/about-providence/who-we-are/mission-vision-values>

<sup>82</sup> [http://www.viha.ca/about\\_viha/vision.htm](http://www.viha.ca/about_viha/vision.htm)

<sup>83</sup> <http://www.fraserhealth.ca/about-us/strategic-direction/strategic-direction>

<sup>84</sup> <https://www.interiorhealth.ca/AboutUs/StrategicDirection/Pages/default.aspx>

NHA	Northern Health leads the way in promoting health and providing health services for Northern and rural populations. <sup>85</sup>
FNHA	Healthy, Self-Determining and Vibrant BC First Nations Children, Families and Communities. <sup>86</sup>

## Values

Institutional values identify what is important to the institution, and ideally help guide institutional decisions. ‘Respect’ was the most identified ‘value’ with 6 health institutions including it in their value statements. While, the meaning of ‘respect’ varied slightly from “[treating] people as individuals with unique beliefs, values, lived experiences and cultural norms” (Provincial Health Services Authority, 2017) to “to [valuing] each individual and bring trust to every relationship” (Vancouver Island Health, 2017) – the overall sense of ‘respect’ was to honour the individual and their unique perspectives and experiences. In line with honouring ‘uniqueness’, respect also encompassed the terms: diversity and culture. Placing importance on ‘diversity’ was explicitly identified in three of the value statements. Value statements such as “to give the kind of care we would want for our loved ones” (Vancouver Island Health, 2017) and “[we] are courteous, and treat each other as valued clients and colleagues” (Interior Health Authority, 2017) infer compassionate healthcare encounters. Further, value statements defined what values meant for the organization. For example, ‘trust’ was described as “we behave in ways that promote safety, inclusion and support” (Table 3.3).

The First Nations Health Authority (FNHA) includes ‘culture’ as a value statement that acknowledges Indigenous ancestors and “[draws] upon the diverse and unique cultures, ceremonies, customs and teachings of First Nations for strength, wisdom and guidance” and

<sup>85</sup> <https://www.northernhealth.ca/AboutUs/Mission,VisionStrategicPlan.aspx>

<sup>86</sup> <http://www.fnha.ca/about/fnha-overview/vision-mission-and-values>

affirmation that FNHA “[upholds] traditional and holistic approaches to health and self-care” (Table 3.8). In comparison to the other healthcare delivery organizations, the First Nations Health Authority offers the lengthiest descriptions of their value statements; explicitly defining what these values include. Their value statements included the most health equity markers for racialized non-dominant communities with 5 markers: culture, traditions, equity, diversity and social justice. The markers that continued to be excluded in all of the value statements are ethnicity/race, cross cultural, cultural safety; cultural humility; cultural sensitivity; cultural competency; cultural proficiency; inclusion; anti-oppression; anti-racism; racism; racialized; visible minority; hegemonic; dominant; power; and micro-aggressions. With the presence of culture, traditions, equity, diversity and social justice in the value statements, it signals that the healthcare delivery organizations have an inclination towards health equity; yet the absence of many of the terms underscores that health equity for racialized non-dominant communities is not prioritized.

*Table 3.3: British Columbia’s Healthcare Delivery Organization Summary Value Statements*

PHSA	Respect people; Be compassionate; Dare to innovate; Cultivate partnerships; Serve with purpose <sup>87</sup>
VCHA	We care for everyone; We are always learning; We strive for better results <sup>88</sup>
PH	Spirituality; Integrity; Stewardship; Trust; Excellence; Respect <sup>89</sup>
IsHA	C.A.R.E.: Courage, Aspire, Respect, Empathy <sup>90</sup>
FHA	Respect, caring and trust characterize our relationships <sup>91</sup>
IHA	Quality; Integrity; Respect; Trust <sup>92</sup>
NHA	Empathy; Respect; Collaboration; Innovation <sup>93</sup>
FNHA	Respect, Discipline, Relationship, Culture, Excellence, Fairness <sup>94</sup>

<sup>87</sup> <http://www.phsa.ca/about/who-we-are/vision-mission-values>

<sup>88</sup> <http://www.vch.ca/about-us/strategy>

<sup>89</sup> <http://www.providencehealthcare.org/about-providence/who-we-are/mission-vision-values>

<sup>90</sup> [http://www.viha.ca/about\\_viha/vision.htm](http://www.viha.ca/about_viha/vision.htm)

<sup>91</sup> <http://www.fraserhealth.ca/about-us/strategic-direction/strategic-direction>

<sup>92</sup> <https://www.interiorhealth.ca/AboutUs/StrategicDirection/Pages/default.aspx>

<sup>93</sup> <https://www.northernhealth.ca/AboutUs/Mission,VisionStrategicPlan.aspx>

<sup>94</sup> <http://www.fnha.ca/about/fnha-overview/vision-mission-and-values>

*Table 3.4: Provincial Health Services Health Authority's Value Statements*<sup>95</sup>

Respect People	We treat people as individuals with unique beliefs, values, lived experiences and cultural norms. We value diversity and seek, listen to and respond to suggestions for improvement. Patients and families are at the center of all we do.
Be Compassionate	Whether it's caring for a patient, family member or colleague, being compassionate is fundamental to the work we do. We care about the health and well-being of one another and those we serve. We believe that simple acts of kindness matter.
Dare to Innovate	As an academic health sciences organization, we achieve excellence through knowledge and innovation. We believe in daring to innovate in all areas of our work to provide the best care for patients and families. We encourage one another to be life-long learners. We learn from the experiences of patients and families and value their ideas.
Cultivate Partnerships	Our provincial scope means we foster partnerships wherever possible to improve health outcomes. We collaborate with each other, those we serve and regional, provincial, national and international colleagues. We believe cultivating partnerships also means supporting patients and their families to make the healthcare decisions that are right for them.
Serve with Purpose	Our shared drive to make meaningful improvements in care helps to guide our services. We find joy through serving others. We believe that making a profound difference in the lives of others is our legacy.

*Table 3.5: Vancouver Coastal Health Authority's Value Statements*<sup>96</sup>

We care for everyone	We believe being caring is at the heart of what we do, caring for our patients, their families, our colleagues, and ourselves.
We are always learning	We believe in staying curious, always open to innovate ideas and ways to improve health care
We strive for better results	We believe in achieving better results across all function of health care leading to better patient outcomes and improving health care.

*Table 3.6: Providence Health Value Statements*<sup>97</sup>

Spirituality	We nurture the God-given creativity, love and compassion that dwells within us all.
Integrity	We build our relationships on honesty, justice and fairness
Stewardship	We share accountability for the well-being of our community

<sup>95</sup> <http://www.phsa.ca/about/who-we-are/vision-mission-values>

<sup>96</sup> <http://www.vch.ca/about-us/strategy>

<sup>97</sup> <http://www.providencehealthcare.org/about-providence/who-we-are/mission-vision-values>

Trust	We behave in ways that promote safety, inclusion and support.
Excellence	We achieve excellence through learning and continuous improvement
Respect	We respect the diversity, dignity and interdependence of all persons

*Table 3.7: Island Health Authority's Value Statements<sup>98</sup>*

Courage	To do the right thing—to change, innovate and grow.
Aspire	To the highest degree of quality and safety.
Respect	To value each individual and bring trust to every relationship.
Empathy	To give the kind of care we would want for our loved ones

*Table 3.8: Fraser Health Authority's Value Statements<sup>99</sup>*

Respect, caring and trust characterize our relationships
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*Table 3.9: Interior Health Authority's Value Statements<sup>100</sup>*

Quality	We are committed to safety and best practice.
Integrity	We are authentic and accountable for our actions and words.
Respect	We are courteous, & treat each other as valued clients & colleagues.
Trust	We are free to express our ideas.

*Table 3.10: Northern Health Authority's Value Statements<sup>101</sup>*

General Statement	Value statements guide decisions and actions
Empathy	Seeking to understand each individual's experience.
Respect	Accepting each person as a unique individual.
Collaboration	Working together to build partnerships.
Innovation	Seeking creative and practical solutions.

*Table 3.11: First Nations Health Authority's Value Statements<sup>102</sup>*

Respect	We believe that maintaining respectful relationships is fundamental to the achievement of our shared vision. Respectful relationships are built upon the recognition that we all have something to contribute as individuals, and participants in the First Nations health governance structure. Therefore, we commit to treating each other with dignity and generosity, being responsive to one another, and acknowledging that each entity has their own respective processes and practices. We are also committed to respectful interactions with First Nations, tripartite partners, and other collaborators.
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<sup>98</sup> [http://www.viha.ca/about\\_viha/vision.htm](http://www.viha.ca/about_viha/vision.htm)

<sup>99</sup> <http://www.fraserhealth.ca/about-us/strategic-direction/>

<sup>100</sup> <https://www.interiorhealth.ca/AboutUs/StrategicDirection/Pages/default.aspx>

<sup>101</sup> <https://www.northernhealth.ca/AboutUs/Mission,VisionStrategicPlan.aspx>

<sup>102</sup> <http://www.fnha.ca/about/fnha-overview/vision-mission-and-values>

Discipline	We have the historic opportunity to achieve transformative change in First Nations health and wellness, and an obligation to make the most of this opportunity. This will require discipline amongst us, including through: loyalty to one another and our shared vision; upholding and supporting our roles, responsibilities, decisions, and processes; maintaining and nurturing unity and a united front; integrity and reliability in fulfilling our commitments, and accountability to one another for these commitments and contributions; and, solutions-oriented and active participation.
Relationships	We believe that effective working relationships with First Nations, tripartite partners, and with one another are the foundation for achieving our vision and implementing our health plans and agreements. We commit to fostering effective working relationships and camaraderie underpinned by: trust; honesty; understanding; teamwork; and mutual support. We also acknowledge that humour and laughter are both good medicine, and a good way to build relationships.
Culture	We are here because of those that came before us, and to work on behalf of First Nations. We draw upon the diverse and unique cultures, ceremonies, customs, and teachings of First Nations for strength, wisdom, and guidance. We uphold traditional and holistic approaches to health and self-care and strive to achieve a balance in our mental, spiritual, emotional, and physical wellness.
Excellence	We are humbled and honoured to have been asked by First Nations to work on their behalf to improve health and wellness, and have a moral and personal responsibility to strive for excellence. Excellence means that our outcomes are sustainable, that our processes are professional and transparent, and that we commit to learn continuously – through capacity development opportunities, from each other and from new, different and innovative models worldwide.
Fairness	We work to improve the health and wellness of all First Nations in BC. Our decision-making reflects the best interests of all First Nations, and leads to just and equitable treatment amongst all First Nations communities, First Nations organizations, and across all regions of British Columbia. We are committed to make room for everyone, and are inclusive in our communications, information-sharing, and discussions.

## Discussion

We are here because of those that came before us ... [we] draw upon the diverse and unique cultures, ceremonies, customs, and teachings of First Nations for strength, wisdom, and guidance ... [we] uphold traditional and holistic approaches to health and self-care and strive to achieve a balance ... [respectful] relationships are built upon the recognition that we all have something to contribute as individuals, and participants in health governance ... we commit to treating each



other with dignity and generosity, being responsive to one another ... Our decision-making reflects the best interests of all ... and leads to just and equitable treatment amongst all ... We are committed to make room for everyone, and are inclusive in our communications, information-sharing, and discussions.<sup>103</sup> (First Nations Health Authority, 2018)

These excerpts from the First Nations Health Authority's value statement offer an appealing healthcare delivery narrative that is seeded with mutual respect, inclusion, safety and equity. This idealized narrative is in line with Canada's universal healthcare delivery framework, our landmark legislative and philosophical commitments. While the First Nations Health Authority has made substantial progress in enhancing access to culturally safe and quality health care for Indigenous communities in British Columbia, health equity for British Columbia's Indigenous communities is far from being achieved signalling the ongoing disjuncture between institutional 'words' and patient 'experiences'. It is evident that 'words' can remain in a static state: where their simple existence is enacted as 'proof' that an organization is focused on specific deliverables; but the existence of 'words' can also guide an organization to perform and practice. As such, mining these institutional discourse statements reveals how organizational commitment for health equity for racialized non-dominant patients is absent or present in the institutional identity of British Columbia's health organizations.

As described above, our findings reveal that health equity for racialized non-dominant communities is not prioritized in the mission, vision or value statements that define the organizational objectives and beliefs of the healthcare delivery organizations in BC. In answer to our first research question: "How does the public institutional discourse (located in mission statements, values and vision) include diversity and health equity for racialized non-dominant

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<sup>103</sup> <http://www.fnha.ca/about/fnha-overview/vision-mission-and-values>

patients, families and communities?” the analysis reveals that there is limited inclusion of health equity markers. The value statements included the highest number of health equity markers (n=5) which featured culture, traditions, equity, diversity and social justice. The vision statement analysis included one health equity marker: social justice that was taken up by only 2 of the healthcare delivery organizations. Finally, all but one of the healthcare delivery organizations had no health equity markers in their mission statements. Providence Health, the province’s Catholic-based healthcare delivery organization, and the First Nations Health Authority embraced more of the health equity markers than the other healthcare delivery organizations.

Not surprisingly, institutional documents carry a performative function and discursive power that affirms organizations are indeed institutions fully equipped with institutional characteristics: such as board of directors; budgets; and mission, value and vision statements. Performing as an institution also requires that the organization is abiding by good professional practise (Strathern, 2006). As all of the healthcare delivery organizations are accountable to provincial and federal governments, these institutional documents convey that the healthcare delivery organizations are in ‘order’ to avoid being put in order (Strathern, 2006) and ideally building public trust – which is a significant ideal for healthcare delivery organizations. By relaying their ability to act as ‘good’ organizations, they ‘bulletproof’ themselves to deflect assessment and potential punitive measures (Strathern, 2006). In essence, organizations develop *institutional armour* to legitimize their professional identities and presence, and to deflect concerns of their professional services; and part of that armour is the public institutional discourse (e.g. mission, vision and value statements). This performativity is well documented in Sara Ahmed’s comprehensive study on racism and academic institutions whereby she acknowledges that

despite various layers of performing diversity, “there [are] no proper mechanisms for ensuring compliance” (Ahmed, 2012, p. 98). In this case, B.C.’s healthcare delivery organizations perform the role of ‘good’ organizations— delivering universal healthcare with appropriate institutional documents and infrastructure – which diminishes the need for provincial and federal concerns. Additionally, B.C.’s Ministry of Health has not set forth recent mandates to address health in/equity for all non-dominant racialized communities but has included the necessary commitment to “the principles of reconciliation, cultural safety and humility, and reciprocal accountability” for Indigenous Peoples in the Ministry’s 2020-2023 Service Plan<sup>104</sup>. Even when direct healthcare providers feel that their organizations are not being responsive to the diverse ethnic communities they serve (Gurm & Cheema, 2013), with institutional armour in place and no explicit provincial directives, healthcare delivery organizations are considered to be sufficiently meeting their mandates.

In our analysis, only the First Nations Health Authority stood as an exemplar of how to advocate for non-dominant communities – specifically Indigenous communities. Whilst addressing health inequities for Indigenous communities is a primary goal for the First Nations Health Authority, they operate to address historical and contemporary injustices that have given rise to systemic structures that limit the full and equitable participation and treatment of Indigenous communities in British Columbia. The First Nations Health Authority’s institutional

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<sup>104</sup> It is important to acknowledge that only through the longstanding activism of B.C.’s Indigenous communities and Aboriginal health teams has important programs and policies (eg B.C.’s First Nations Health Authority and cultural safety policies) been championed and realized. The commitment set force by BC’s Service Plan for 2020/21 to 2022/23 in in line with the commitment to support the *Declaration of the Rights of Indigenous Peoples Act and the Truth and Reconciliation Call to Act*. <https://www.bcbudget.gov.bc.ca/2020/sp/pdf/ministry/hlth.pdf>

discourse offers an illustration of how to acknowledge historical and contemporary injustices and oppressions; how to include elements of cultural safety, diversity and dignity; and how to write social, political and health justice into the institutional discourse of a healthcare delivery organization. Naming oppressions and writing in what is needed offers an opportunity to shift the systemic structures away from inequitable healthcare towards equitable healthcare.

In relation to our second question: “How are inclusion and equity discourses constructed in mission statements, values and vision?” our analysis found that there is minimal acknowledgement of the health equity markers but a general sense of delivering the ‘best’ care for ‘all’ patients without consideration of equity, or the social-political-economic-historical context in which individuals and communities experience privileges or challenges/vulnerabilities. The use of subjective quality terms such as “provide superior healthcare”; “better health, best in healthcare” or “to do the right thing” creates ambiguous statements (Strathern, 2006) that perform an institutional speak that says: we got this; However, evidence clearly indicates that our healthcare systems are not providing superior, better or best healthcare to everyone. Using generic terminology provides limited information to stakeholders and provides little strategic direction (Bolan, 2005); however, when mission statements completely omit prominent issues (e.g. health equity), it clearly indicates that a particular issue is not embraced as a priority (Valsangkar, Chen, Wohltjen & Mullan, 2014). A more recent direction for mission statements is to write for end users (i.e. patients) such that it will foster an emotional bond (David, David & David, 2014) between healthcare delivery organizations and patients. By writing mission, vision and value statements for patients and families, healthcare delivery organizations ought to seek meaningful, critical, active and sustainable engagement with patients particularly those who

experience marginalization within dominant society. Social justice and critical equity-oriented perspectives affirm that marginalized voices must be brought into the center so that existing inequities are addressed and not further exacerbated.

Further, the institutional discourse statements fail to acknowledge well-substantiated social determinants of health, social determinants of inequity, or power dynamics which impact health inequities as well as other inequities (i.e. economic, employment, housing, education, etc.) (Marmot, Friel, Bell, Houweling, & Taylor, 2008; Navarro, 2009; Raphael, 2009; Brassolotto, Raphael & Baldeo, 2014). Health inequities that arise from social determinants of health stem from systemic, structural, societal, political and economic arrangements that position some individuals with benefits and others with vulnerabilities; these inequities challenge the ability of a universal healthcare system to provide equitable health care when it is not designed to address systemic barriers. Not only is healthcare access and subsequently the well-being of marginalized individuals compromised, embodiment health researchers clearly identify that social, political and economic inequities biologically impact the health and well-being of racialized communities (Krieger, 2012). Due to this societal context, racialized individuals are exposed to a highly stressful environment that triggers "... pathogenic pathways, mediated by physiology, behaviour, and gene expression, that affect the development, growth, regulation, and death of our body's biological systems, organs, and cells, culminating in disease, disability, and death" (Krieger, 2012, p. 936). The harm that extends from these inequities has long-lasting repercussions on the psychological, physical, social, political and economic well-being for non-dominant racialized residents and Canadians. The absence of attention to social determinants of health in the institutional discourse statements reaffirms that these types of health inequities are not

conceptualized into the institutional identity framework of what healthcare delivery organizations “do”— which limits the ‘institutional will’ (Ahmed, 2012) to address these types of health inequities.

In answer to our final question: “What are the guiding ‘truths’ that inform these discourses?” we found that due to the lack of health equity markers or a health equity framework in the institutional discourse of these healthcare delivery organizations, racialized non-dominant communities continue to be constituted as “politically minor players” (Bannerji, 2000, p. 30) and subsequently marginalized from institutional objectives for equitable healthcare delivery. The conditions in which racialized non-dominant communities live are “effected by macrostructural conditions set by society, such as public policies, social values and spending” (Woolf, 2017). Health inequities for racialized non-dominant communities cannot be understood separately from the broader social-political-economic-historical context. When there is an absence of discourse regarding the social determinants of health, the ‘context’ in which healthcare delivery systems are operating, or health inequity for marginalized communities, healthcare delivery organizations have little organizational motivation to meet health inequities with the provision of culturally safe care.

The absence of health equity markers can be argued to result from not naming fundamental values because they are so firmly embedded in the organizational ethos and need not be named but give rise to secondary values like ‘respectful care’ (Giacomini, Hurley, Gold, Smith & Abelson, 2004). While naming racism can serve as a powerful starting point to build cultural safety, advance anti-racism objectives and challenge various forms of racism from everyday microaggressions to systemic racism; omitting ‘negative values language’ is a well

utilized strategy to focus on the positive (Giacomini, Hurley, Gold, Smith & Abselon, 2004). For instance, utilizing 'diversity' instead of anti-racism softens the critical or accusatory nature linked to racism; hence why we evaluated an array of terms that could be read critically for the presence of health equity. But in the absence of health equity markers, we come up against silence.

Silence is no stranger to racial discourse. In Canada, we live under the ideological umbrella of democratic racism that permits and sustains two conflicting values: “[commitments to democratic principles such as justice, equality, and fairness” against “attitudes and behaviours that include negative feelings about minority groups, differential treatment, and discrimination against them” (Henry & Tator, 1998 p. 23). Dominant communities are not typically socialized to see their own sites of privilege and the ways in which other communities experience marginalization, discrimination, and oppression. Oppressed communities are not encouraged to develop a critical consciousness but to avoid “developing habits of questioning injustices” as it “maladapts people on the bottom to stay there” (Collins, 2013, p. 130). When people who experience racism break their silence – they are often penalized for speaking out; declared ‘too sensitive’; or simply not believed. Particularly under the umbrella of democratic racism, we are socialized to avoid racial discussions and this silence maintains dominant privileges (DiAngelo, 2012) as well as domains of power (Collins, 2013). Further, denial strategies are deliberately utilized to silence discussions around racism and infer that racism is not a widespread, persistent phenomenon taking cultural, institutional, or systemic forms but rather that racism makes rare appearances via isolated cases (Henry & Tator, 1998, p. 223). In lieu of these silences, healthcare delivery organizations must commit to placing these unspeakable truths on every table from

policy development to direct healthcare delivery such that health equity is ‘speakingable’ and explicitly embedded into the identity of our healthcare delivery organizations.

With Canada’s commitment to universal healthcare as a “right of citizenship, not a privilege of status” (Romanow, 2002), health inequities emerging from any of the identified social determinants of health (e.g. ethnicity/race) jeopardize the foundational philosophy of Canada’s universal healthcare system. British Columbia’s healthcare delivery organizations serve ethnically diverse patients, families and communities – and have an increasingly ethnically diverse workforce. Systemic racism experienced by racialized non-dominant patients and or healthcare staff undermines respectful and equitable healthcare delivery and encounters. Although the HDOs acknowledge ‘special populations’ in their catchment communities (e.g. South Asian and Indigenous) the analysis presented in this paper suggests this well-intentioned acknowledgement is not followed through in ways that support the organizations to address health care inequities and provide culturally safe care.

A key component embedded in cultural safety frameworks is to actively recognize and address unequal power relations and to incorporate a “more radical, politicized understanding of cultural considerations” (Brascoupé & Waters, 2009) as opposed to adopting culturist approaches. We recommend that the HDOs of BC (and others) review and revise their guiding documents with a lens of equity, social justice and cultural safety through a transparent process. We also recommend that ongoing education for healthcare leadership, providers and staff include a multi-tiered approach to health equity and social justice which includes but is not limited to mandatory cultural safety training, unconscious bias training and race dialogues with experienced facilitators through the lens of antiracist pedagogy (Acosta & Ackerman-Barger,



2017). While the FNHA offers a model, such revision should not merely be a sterile manoeuvre of replacing old words with new while leaving power unexamined. Rather, we suggest that such revision be undertaken with meaningful and long-term partnerships with the communities served. Alongside including equity into the institutional identity of healthcare organizations, resources will need to be allocated to move equity from a guiding principle into an actionable systemic framework. As poignantly identified by Sara Ahmed, “words, whether spoken or written, do things” and may either “increase or decrease in value depending on how they are received” (Ahmed, 2009); if changes to mission statements, values and vision change with adequate resources to support the uptake of anti-racism and cultural safety, quality monitoring will also be required to ensure that the words and programming do the required work of advancing health equity for all patients.

This paper is an effort to respectfully unsettle healthcare delivery organizations such that the “dynamic space of being unsettled creates space for seeing and creating alternative truths” (Collins, 2013, p 131). Our healthcare institutions are not alone in shying away from acknowledging racism and its inequitable impact on racialized non-dominant communities. Only after a 2017 report by the United Nations’ Committee on the Elimination of Racial Discrimination (CERD, August 31, 2017)<sup>105</sup> that critiqued Canada for not having an anti-racism strategy; did Canada implement Canada’s Anti-Racism Strategy 2019-2022 with 45-million-dollar investment (Canadian Heritage, 2019). While the strategy is in the early stages, it is focused on improving public education and awareness; including an Indigenous approach; addressing hate crimes and

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<sup>105</sup> Report from the CERD – International Convention on the Elimination of All Forms of Racial Discrimination: 93 Session (31 Jul 2017 – 25 Aug 2017)  
[http://tbinternet.ohchr.org/\\_layouts/treatybodyexternal/SessionDetails1.aspx?SessionID=1110&Lang=en](http://tbinternet.ohchr.org/_layouts/treatybodyexternal/SessionDetails1.aspx?SessionID=1110&Lang=en)

combatting online hate; and collecting race-based data. A national and provincial anti-racism framework, alongside actions such as collecting “reliable and comprehensive statistical data on the ethnic composition of the population including disaggregated economic and social indicators for ethnic groups, African-Canadians, Indigenous Peoples, and non-citizens” would allow for a better understanding of “the representation of minority groups in public and political life” and discerning whether communities are accessing their “political, economic, social and cultural rights” – as well as their healthcare rights (CERD, August 31, 2017). National and provincial leadership is an essential component to directing all of our organizations, including our universal healthcare delivery organizations, towards an anti-racism and equity framework. These preliminary steps through Canada’s Anti-Racism strategy are an opportunity to collectively work towards equity and safety for all of us; but will require many steps for sustainable and actual change.

## Chapter 4<sup>106</sup>

### Diversity Work in Healthcare Settings: Institutional Commitments and Resistance

With Canada's proudly touted universal health care system (*Canada Health Act*, 1984) and commitments to *Multiculturalism* (1985) and "fair and equitable access to quality and culturally safe healthcare services" for Indigenous communities<sup>107</sup> (Government of Canada, 2021), Canada is well positioned to serve as a leader in delivering culturally safe and equitable healthcare for racialized communities. Despite this, research reveals that systemic racism continues to negatively impact healthcare access, care and well-being for Indigenous, Black and People of Colour communities (Beavis et al, 2015; Browne, 2007; Browne & Fiske, 2001; Browne et al, 2016; Browne et al, 2021; Burgess, 2011; Collins & Hayes, 2007; Goodman et al, 2017; Heaman, Gupton & Moffat, 2005; Kitching et al, 2020; Markham et al, 2021; Nestel, 2012; Phillips-Beck et al, 2020; Tang & Browne, 2008; Varcoe et al, 2009; Weerasinghe, 2012). In Canada, the historical and colonial nation-building ideology of a "White Man's Country"<sup>108</sup> continues to permeate contemporary Canadian society, systems, institutions, values, and perspectives. With this racist framework, intentions of inclusion and implementation of anti-racism policies (e.g., Anti-Racism Strategy<sup>109</sup> (2019-2022)) can fail to building a more equitable

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<sup>106</sup> Chapter 4 is written as a research paper. This chapter includes co-authors Colleen Varcoe and Sheryl Reimer-Kirkham. For this reason, I use the pronoun: we instead of the third person. This chapter is in the process of being submitted in a peer-reviewed journal.

<sup>107</sup> <https://www.sac-isc.gc.ca/eng/1611863352025/1611863375715> retrieved January 13th, 2022

<sup>108</sup> Canadian Prime Minister: Sir John A. Macdonald held office: 1867-1873; 1878-1891 categorized Canada as a White man's country.

<sup>109</sup> <https://www.canada.ca/en/canadian-heritage/campaigns/anti-racism-engagement/anti-racism-strategy.htm>

society if racial ideologies are not accounted for - particularly how they influence the structure, policies, and processes of Canadian institutions.

The Canadian healthcare system is one institution has not escaped this legacy of colonial history. Serving an ethnically diverse patient base, the Canadian healthcare system attends to the healthcare needs of almost 1.7 million Indigenous peoples<sup>110</sup> and more than 7.6 million<sup>111</sup> identifying as racialized communities<sup>112 113</sup> (Canadian 2016 Census). With a quarter of the Canadian population identifying as Indigenous, People of Colour and Black Communities, it is imperative for Canadian institutions to consider the root causes of inequities faced by these communities and address the harms of racism. One way healthcare institutions have addressed culturally unsafe experiences is through the implementation of diversity policies and programs. Yet, little is known about what healthcare diversity programs do and their effectiveness.

This paper reports an analysis of diversity work in the Western Canadian province of British Columbia. We used the term diversity to encompass cultural competency, cultural

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<sup>110</sup> The figure 1.7 million represents approximately 5% of the Canadian population.

<https://www150.statcan.gc.ca/n1/daily-quotidien/171025/dq171025a-eng.htm>

<https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/prof/details/page.cfm?Lang=E&Geo1=PR&Code1=01&Geo2=&Code2=&Data=Count&SearchText=Canada&SearchType=Begins&SearchPR=01&B1=All&TABID=1>

<sup>111</sup> The figure 7.6 million represents approximately 20% of the Canadian population.

<https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/dt-td/Rp-eng.cfm?TABID=2&LANG=E&A=R&APATH=3&DETAIL=0&DIM=0&FL=A&FREE=0&GC=01&GL=-1&GID=1341679&GK=1&GRP=1&O=D&PID=110531&PRID=10&PTYPE=109445&S=0&SHOWALL=0&SUB=0&Temporal=2017&THEME=120&VID=0&VNAMEE=&VNAMEF=&D1=0&D2=0&D3=0&D4=0&D5=0&D6=0>

<sup>112</sup> The Canadian census has been using the term Visible Minority to identify racialized non-European ancestry individuals. People of Colour and Black Communities do not readily used this term for self-identification and Canadian critical race feminist scholars have critiqued its application (Bannerji, 2000). We adopted the term racialized communities to identify People of Colour and Black communities as it better encapsulates the experiences of being raced. Racialization refers to set of social, cultural, and political processes that deploy racist ideologies upon individuals seen to belong to an ethnic or religious community (Murji & Solomos, 2005).

<sup>113</sup> <https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/prof/details/page.cfm?Lang=E&Geo1=PR&Code1=01&Geo2=&Code2=&Data=Count&SearchText=Canada&SearchType=Begins&SearchPR=01&B1=All&TABID=1>

proficiency, cultural safety, cross cultural, multicultural, equity, anti-racism, and specific cultural community (e.g., Indigenous) or settlement (e.g., refugee, newcomer) programming. We analyzed the diversity commitments and practices of 2 health authorities, both of which serve high proportion of Indigenous and newcomer people, to consider how diversity is addressed, and how these efforts might be strengthened.

### **Cultural Safety**

Cultural safety has been on the forefront of delivering safe healthcare for marginalized, racialized communities. Originally developed to respond to the health inequities faced by Māori communities (Indigenous peoples of New Zealand) by Māori nurses, cultural safety was put into practice with the foundational concept that:

*Being a member of a culture surrounds each person with a set of activities, values and experiences which are considered to be real and normal. People evaluate and define members of other cultural groups according to their own norms. When one group far outnumbers another, or has the power to impose its own norms and values upon another, a state of serious imbalance occurs which threatens the identity, security and the ease of other cultural groups, thus creating a state of disease (Nursing Council of New Zealand, 1992)<sup>114</sup>*

Addressing culture as a holistic construction allows for analysis of multiple intersections that impact people's experiences including ethnicity, language, customs, faith/religion, spirituality, gender, age, sexual orientation, socio-economic status, abilities, class and land-based

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<sup>114</sup> Nursing Council of New Zealand. *Kōwhiri Whakawhā: Guidelines for nursing and midwifery education*. Nursing Council of New Zealand, Wellington, 1992.

connections. This also acknowledges that everyone has culture not just Indigenous peoples, Black or People of Colour communities. Cultural safety can be defined as “an outcome based on respectful engagement that recognizes and strives to address power imbalances inherent in the healthcare system ... [and] results in an environment free of racism and discrimination, where people feel safe when receiving health care”<sup>115</sup> (First Nations Health Authority, retrieved 2018). Further safety is assessed by those who receive healthcare not those structuring or delivering the service.

In the Canadian context, cultural safety has yet to be formally and systemically implemented but cultural safety elements have been adopted through some diversity, equity and cultural competency programming whereby healthcare institutions strive to build trust with marginalized communities; honour their histories, cultures, beliefs and values; and respectfully include them in healthcare decisions and processes. While tenets of cultural safety are not new, shifting towards cultural safety has been plagued with culturalist understandings that culture is static, consequently essentializing communities and reinvesting in stereotypes (Reimer-Kirkham & Anderson, 2002; Reimer-Kirkham, Smye, Tang, Anderson, Blue, Browne, Coles, Dyck, Henderson, Lynam, Perry, Semeniuk & Shapera, 2002). In contrast, a critically informed, cultural safety approach acknowledges that race, culture and religion are socially and politically constructed and can illuminate experiences of racialization, systemic and institutionalized barriers to equitable access to societal resources and well-being. This critically informed approach questions: “How do we make sense of difference in ways that do not succumb to

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<sup>115</sup> <http://www.fnha.ca/wellness/cultural-humility>

racialization, Othering, and reinforcement of existing power inequities?” (Reimer-Kirkham & Anderson, 2002, p. 9).

### **Research Approach**

Our qualitative research study tracked how diversity is taken-up by health authorities through a 3-phased process that evaluated diversity discourse (phase 1), diversity work (phase 2), and how racialized patients received diversity programming and culturally safe care during clinical encounters (phase 3). This paper reports the details of phase 2 which features an analysis of diversity work. Guided by Critical Feminist theories (including Critical Race Feminist, Post/Colonial, Black Feminist, Indigenous and Decolonizing Theories), we considered the subtle and underpinning processes that have and continue to construct people into racial categories, and in turn impact how they are treated. Critical Feminist theories provide the necessary guidance to address legacies of historical oppression, contemporary systems of intersecting oppression and inequities resulting from discrimination and oppression (Crenshaw, 1996; Collins, 2000; hooks, 2000; Kirkham & Anderson, 2002; Smith, 2005; Thobani, 2007; Reimer-Kirkham & Anderson, 2010; Varcoe, 2006; Varcoe et al, 2011).

### **Data Collection and Sample**

Four health authorities, serving large and diverse patient populations, were selected as recruitment sites. We recruited participants from health authority-based diversity programs (e.g. cross cultural, diversity, Aboriginal, South Asian, spiritual health) and various health delivery sites (e.g. hospitals, residential and long term care facilities, acute care sites, outpatient clinics). We started with a list of previously established contacts and used snowball sampling to capture informal diversity work and to identify diversity champions in leadership positions. Informal

diversity workers held various titles such as Vice President, Director, Clinical Lead, Nurse, Physician, Psychiatrist, and Social Worker. Interviews were typically conducted in work sites but a few preferred off-site locations such as coffee/tea shops. Gift cards valued at 25 Canadian dollars were provided to all participants for local businesses with most participants preferring coffee shop gift cards.

The first author facilitated the semi-structured, one-to-one, digitally recorded interviews after participants completed a paper-based consent process approved by the University of British Columbia's Behavioural Research Ethics review board and the health authority research review boards. The first author completed field notes after each interview to document observations and include resources shared by participants such as online diversity training or diversity policies. The field notes provided data for the thematic analysis alongside the 58 interview transcripts. Interviews ranged in length from 36 minutes to 2 hours and 25 minutes. Pre and post-interview discussions were included in field notes with participants' permission. When participants stated answers and reflections were "off the record", this information was not included in the final transcribed interviews. Digitally recorded interviews were transcribed verbatim followed by an accuracy check and removal of "off the record" information.

Participants worked in 27 healthcare sites capturing a broad range of experiences regarding how diversity was championed. As shown in Table 1, participants ranged in age from 28 to 72 (mean age of 53.71 years); 34 self-identified as women while 24 identified as men; and the majority held masters' degrees (44). Most participants identified their ancestral communities as European, and Christianity was the largest faith affiliation. Twenty participants were born outside of Canada and thirty-eight were born in Canada.



## **Data Analysis**

Interview transcripts were reviewed to identify patterns and themes. Research team members discussed themes to refine and finalize the key themes and develop the coding schema. Subsequently, all interview transcripts were initially coded on paper with the coding scheme. After coding was completed, research team members reconvened to discuss the coding approach, finalize themes and develop the thematic analysis. The qualitative software program: Nvivo™ was used to organize the transcript data. A reflective journal on the data analysis process was maintained throughout the study process and included analytic memo writing whereby we documented and reflected on the coding process, our choices and noted our observations (Saldana, 2009, p. 32). Given the volume of data derived from the 58 qualitative interviews, secondary analysis is underway to share further findings.

## **Findings**

Diversity workers played a pivotal role in translating diversity policies and mandates into practice for health care sites. As they carried out their work in addressing organizational gaps in equitable healthcare access and delivering diversity education and support, diversity workers also experienced numerous challenges. Three main areas were identified: 1. Lack of Commitment; 2. Diversity Praxis; and 3. Negotiating Racism with sub-themes.

### **1. Lack of Commitment**

To understand the structural and financial commitments made by health authorities towards diversity, diversity workers were asked about their organizations' resources including staffing, programming and funding. The following three themes illustrate the lack of commitment to build and nurture a culture of anti-racism and cultural safety.

### 1.a. Most Diversity Work is Informal and Unsupported

We used the term *Diversity Workers* to identify staff employed by health authorities to support patients, families and healthcare staff seeking/delivering culturally safe healthcare. Our preliminary environmental scan identified only a few diversity workers: those employed by health authorities to work on cultural competency and safety; promote equity for marginalized and or minority patient populations; and facilitate diversity, anti-racism education. These diversity workers connected us to individuals doing diversity work unofficially. We define this group as informal diversity workers, which was comprised of Indigenous Elders, spiritual care practitioners, directors, healthcare providers, policy analysts, patient safety and language support staff. Of the 58 diversity workers, only 4 held institutionally appointed diversity roles, 13 were community-specific workers (e.g. Indigenous, South Asian) and 41 were informal diversity workers. It is doubtful that the 4 institutionally appointed diversity workers could provide support for the 3.5 million patients served by these 2 health authorities particularly when both health authorities have substantial ethnic, religious and ethnic diversity in British Columbia with 29.7% of the population identifying as racialized<sup>116</sup>, 6% as Indigenous, 27.8% as immigrants (2016 Canadian Census), 66% belonging to a religious community (2011 National Household Survey<sup>117</sup>), and 27.3% speaking a non-official Mother Tongue language (2016 Canadian Census<sup>118</sup>).

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<sup>116</sup> Canadian Census and the National Household Survey uses the term Visible Minority to identify racialized non-European people. Throughout this dissertation, we have used racialized to identify Black and People of Colour communities.

<sup>117</sup> <https://www12.statcan.gc.ca/nhs-enm/2011/dp-pd/prof/details/page.cfm?Lang=E&Geo1=PR&Code1=59&Data=Count&SearchText=british%20columbia&SearchType=Begins&SearchPR=59&A1=All&B1=All&Custom=&TABID=1>

<sup>118</sup> <https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/prof/details/page.cfm?Lang=E&Geo1=CMACA&Code1=933&Geo2=PR&Code2=59&Data=Count&SearchText=vancouver&SearchType=Begins&SearchPR=01&B1=All&TABID=1>

This unexpected number of diversity workers signaled that far more diversity work was being done than organizations were supporting institutionally. Imbued with a grassroots type of advocacy, healthcare and leadership staff were responding to immediate organizational needs at the point of care; revealing a bottom-up rather than a top-down approach. Informal diversity workers commonly referred to their diversity work as being “off the side of their desks” as there was no reprieve from their assigned responsibilities, or budget and staff support. With no organizational support, their capacity to deliver consistent and sustained diversity support was limited. Additionally, if informal diversity workers left their formally assigned roles, their diversity work stopped.

Despite leadership and peer support for informal diversity work, these roles were not formalized. Two informal diversity workers boasted: “there is strong uptake for this because we have promoted [diversity workshops] across the leadership teams, and because we have more direct connections ... to our executive director” (Diversity Participant 08 and Diversity Participant 09). This horizontal access to leadership and executives fostered better support for their diversity work but their work remained dependent on their unpaid labour and voluntary efforts to organize, market, and facilitate the workshops. Although formal diversity workers had more resources and capacity to develop and sustain diversity programming, they faced similar institutional limitations. Ultimately, these challenges in creating and sustaining diversity programming made change towards health equity impossible but insinuated that health authorities were invested in diversity work.

### 1.b. Shifting Priorities in Diversity Programming

Diversity workers often narrated the history of diversity programming as a shifting landscape. In the 1980s, health authorities often started with an ethno-specific model whereby ethnic ancestry and language concordant liaisons were hired to build cultural awareness, sensitivity, and competency capacity during care encounters.

*... originally the objective of the program was to provide services to the big populations which was Chinese, South Asian, Vietnamese, and Latin American, we kind of moved that from having ethno-specific [staff] to saying who are the emerging populations, who is coming in recently, for example, we had the Iranian people coming in or the Iraqi group ... or the Somalia group ... how do we respond to the people coming in...* (Diversity Participant 37)

As noted in this example, health authorities responded to the changing multicultural presence of newcomer communities and structured their programs to reflect a more generic approach to diversity than maintaining “ethno-specific” liaisons. This shift was partly due to the minimal capacity of the program as there was limited institutional investments in diversity programs. As noted by numerous participants, ethnic ancestry concordant liaisons were still needed particularly for established ethnic communities such as the Chinese ancestry or Punjabi ancestry communities in British Columbia. While these programs shifted to meet newcomer needs, diversity workers had to collaborate with community partners (e.g. settlement agencies) to sustain the needed ethno-specific programming. Further, volunteers, practicum students and short-term contractors were recruited to facilitate program development and meet the diversity needs of staff and patients. These strategies are precarious, “Band-Aid” solutions that lack the

capacity to build-up a program with the necessary structural changes that would support a consistent cultural safety paradigm.

Further, changes in leadership, government mandates, or new institutional mantras (e.g. innovation) consistently required healthcare staff to navigate a constant flow of changes: “there are so many hidden agendas, objectives change so frequently, that people are always off balance, there is no continuity of anything ... people are fed up, we restructure, then we change the structure” (Diversity Participant 23). In many cases, diversity roles were eliminated as they were perceived to be “value added, not essential work ... because clinical settings are entrenched cultural settings ... more about the physical body, and how people live is entirely irrelevant to the efficacy of clinical practice” (Diversity Participant 14).

These changes have a cumulative impact on preventing organizations from embedding cultural safety praxis. When institutional ideologies re-emerge to support diversity programming after a diversity program has been terminated, there is no program structure or legacy to draw from. This continual process of starting up does not permit any policies, programs or education to take hold and sustain cultural safety ideologies and practices. Even when diversity workers are mindful of having a diversity legacy and attempt to build programs with incessant documentation (e.g. reports, research articles and program manuals), their diversity programs remain precarious. One diversity worker went to great lengths to ensure her community-based programs were sustainable as she partnered with individuals and community organizations, raised funds within cultural communities and received in-kind and monetary contributions to build resources. Even with the successful uptake of numerous resources, this diversity worker’s role was suddenly eliminated; subsequently, the still-needed resources are no longer delivered by the health

authority. This cyclic movement of momentarily prioritizing diversity, downsizing diversity, shifting the diversity focus, eliminating diversity programming and re-introducing it as a new program does not allow for consistent progressive movement towards cultural safety; rather, this lack of organizational commitment inhibits meaningful implementation of anti-racism, cultural safety and equity paradigms.

*... when you are working within a system that is always changing, systemic change doesn't guarantee those changes will be in place 5 years down the road especially with fields like diversity ... maybe in 6 or 7 years they hire a new VP, they eliminate the diversity positions, fire the old people, then they reinstate for some reason, they have new people hired ... no continuity ...* Diversity Participant 14

### **1.c. Precarious Funding**

Formal diversity workers identified that allocated budgets were insufficient to support existing needs in their health authorities. Inadequate budgets meant few staff which led to minimal productivity and diversity contributions to the organization; subsequently, there was little policy, resource and education development; little ongoing critical cultural safety education and training; little capacity to support leadership, strategic teams and committees in incorporating a diversity and equity lens; little advocacy for cultural safety for patients, families and staff; few audits of diversity practices and policies; and negligible attention to systemic racism.

Prior to meeting with participants, we often did a targeted media search on the associated diversity program. One program was well publicized as delivering culturally responsive care through a methodically structured program; upon meeting the director of this newly founded

program, we learned that there was no physical location for the program and the program was simply added to the director's existing clinical portfolio. In this case, there was a small budget to contract one employee for a finite period, which contradicted the health authority's advertised commitment to diversity and sustaining the program. As another participant noted:

*Diversity is supposed to be part of the way you do business [in health authorities], but clearly not, if they allocate even one position, how long can that be sustained ... how can one person do it, they have to be creative, but you need a budget, and then you have other [value added] programs that have budgets, so why isn't diversity getting a budget?*

(Diversity Participant 57)

"Being creative" included training volunteers to facilitate non-clinical aspects of diversity programming, fundraising within communities, applying for funding, collaborating with diversity advocates, overseeing student practicums, and contracting consultants when they could secure short term funding.

A senior diversity leader described tirelessly "holding the line", having to constantly "watch every dime ... or [the diversity program] may erode" as a result of changes: "they get to decide if they want to carry on the commitments of the previous CEO" and if they don't, "your foundation crumbles" (Diversity Participant 7). With few staff, there was little to no continuity when programs downsized or positions were eliminated; further, diversity programs were persistently seen as "non-essential" and frequently terminated due to budget cuts. With such dramatic instability, diversity workers felt unable to facilitate meaningful change: "I'm on high alert all the time ... I will leave this job, because it's not set up so that you can just keep going" (Diversity Participant 35).

Diversity workers decried the “inability to hard-wire” diversity into the health authority’s structure (Diversity Participant 13 and Diversity Participant 14). These diversity workers also acknowledged that identifying “budgetary” reasons was an institutional strategy to divert attention away from the lack of commitment to diversity:

*... it wasn’t a budgetary issue, to be blunt about it, it was a leadership issue ... with any of these programs, you do need to have a champion or a leader, always vigilant and looking for services for ethnic minorities or emerging populations otherwise the system doesn’t see it as important because it is a large system and they feel that they are providing services to everyone, irrespective of culture ... (Diversity Participant 37)*

Simply put, if there is no money to build and sustain culturally safe healthcare, diversity cannot be “hard-wired” into the healthcare system. This point is further evidenced by the substantive diversity work being done as informal diversity workers are not funded to do this work or provided with operating budgets and staff support. Diversity work is riddled with barriers to success as participants are required to create diversity programs, resources and training while simultaneously facilitating diversity support and education for large health regions with millions of residents and thousands of staff members. Further, diversity workers not only require expertise in critical race theories and praxis but must be able to weave cultural safety into every healthcare encounter and process to actively counter systemic racism. Even the most well-staffed diversity team (a team of 3 staff) could not adequately meet the demands of their health region. Minimal funding signals little institutional investment towards anti-racism.



## 2. Diversity Praxis

Diversity workers reported their notable efforts to move diversity ‘talk’ into action, and the strategies they implemented. Although they were for the most part not supported by formal roles, organizational policy, strategic direction, or funding, they nonetheless found ways to enact their commitment to equity and diversity work. This section describes the strategies diversity workers used including developing and deploying policy and working with diversity champions to broaden the scope of diversity work.

### 2.a. Diversity Workers Strategically Develop and Deploy Diversity Policy

Diversity workers developed and deployed diversity policy to advance diversity praxis. Generally, policies provided a framework for healthcare staff and leadership to support diverse practices, rituals, customs and beliefs. As one participant noted: *“policy work, it’s very important because [it] provides some guidance around how people should respond to diversity”* (Diversity Participant 01). Although simply having diversity policies did not promote culturally safe care, policies were concrete tools that signalled institutional positioning on these matters; and in turn *“policy certainly makes [diversity workers’] jobs easier”* (Diversity Participant 54). For instance, when patients were discouraged or not permitted to include cultural practices during hospital stays, diversity workers could point to diversity policies.

*If they have a patient who wants to smudge and they start communicating with the staff about it, and they get all like, ‘well, you can’t do that, blah, blah, blah, ventilation, blah, blah, blah’ they can then pull the cultural competency policy and say, ‘You are required to make space for this, based on this policy’* (Diversity Participant 32)

When diversity workers experienced resistance from staff and healthcare administrators, pointing out diversity policies enabled diversity workers to better advocate for patients:

*... if we're in a situation where we're advocating on behalf of a specific patient or a specific practice, we will push it out. But if we weren't there to push it out, I'm sure it would just sit there lifeless. It helps. It makes it harder for the resistant people to say, 'Oh, we don't have time for this or we don't have the resources for this'. It makes their argument harder to make, ours easier to make (Diversity Participant 17)*

Further, leadership staff could apply diversity policy frameworks into present and future organizational decisions. One participant shared that their *"cultural safety policy has been able to provide leverage into systemic change that [the organization] wouldn't have had if the policy wasn't there"* (Diversity Participant 12). For instance, a cultural safety policy was used to remind planning teams to support spiritual practices such as smudging when consulting on a new hospital. Even when diversity policies were in place, not all leadership and staff were aware that diversity policies exist: *"if I was to survey leadership right now at a director or executive director level and ask them if they know about the [cultural competency policy] ... maybe half of them would know"* (Diversity Participant 03). Many of the informal diversity workers and those who worked with specific populations were not aware of their organization's diversity policies. In contrast, the four formal diversity workers knew about diversity policies because they were often involved in policy development or took direction from it. Simply having a diversity policy in place does nothing if it is not known and cannot be accessed by patients to self-advocate. Not publicizing such policies prevents staff from executing the organization's formalized support for

culturally safe care. constituting another tactic to limit the adoption of anti-racism, cultural safety, and equity into the organization's culture.

## **2.b. Diversity Champions 'Give Diversity Legs'**

All participants underscored that diversity champions were needed at every organizational level to give diversity value. We define diversity champions as those who support and advocate for equity, anti-racism and cultural safety. Participants explained that they needed to be at every possible decision table so that strategic plans, procedural changes and policy changes could reflect a cultural safety lens:

*I'm there to inform [and] ensure that they've applied [a cultural safety] lens. I'm not there to provide [clinical support] and do the [clinical procedural] work. There's a whole team of ... operational people that will do the work. My job is just to help them to understand what role they play in decision-making and programming for [marginalized communities]*

(Diversity Participant 07)

Diversity workers also cited examples of needing to enter planning and decision-making conversations early so that they *"get [their] foot in the door and get on the radar"* or they would *"miss the opportunity and ... never get [colleagues] to go back and adjust anything"* (Diversity Participant 05).

Participants noted a significant difference when senior leadership was diversity oriented and when they were not. *"We need to have leadership that takes it on as their profile, not everyone is doing it, it is not natural, there needs to be some targeted strategic plan and objectives"* (Diversity Patient 19). A lack of buy-in at the executive level constrained diversity workers from doing the necessary diversity work. For example, one diversity worker developed

a proposal for a handbook in response to staff feedback. It was not passed and instead, they were sent to do “*busy making*” work and told to “*go look for some workshops and online resources*” (Diversity Participant 23) which would never advance to concrete programming or resources. Another diversity worker had carefully developed community responsive, effective programs over many years with ongoing support of the health authority; the programs were abruptly terminated when the health authority redefined their approach to diversity.

With limited resources and staff, formal diversity workers were often overwhelmed with the multitude of responsibilities their roles required of them: “*it is like I am building a plane, learning to fly it and flying it at the same time*” (Diversity Participant 01). These diversity workers acknowledged they could not be at every meeting or provide the substantial workshops needed to meet the staffing demands; much less address systemic racism. Long-standing diversity champions strategically recruited diversity allies:

*... there is only one of me right now ... I can't accommodate every single invite that I have ... our team is very, very small ... my intention is to spread knowledge and understanding so I don't always have to be in every room ... I find my champions and my allies, and then I work with them to coach them so that if I'm not there, they can raise the importance of [cultural safety] ...* (Diversity Participant 34)

Having allies also distributed the weight of diversity advocacy. Diversity champions frequently noted that they witnessed “eye rolling” when they addressed racialized inequities. Thus, they encouraged their white allies to share in the advocacy work:

*... my [white] colleague ... felt it was important and sometimes she would bring it ... sometimes [I would] nudge her, we would go into a meeting and I would say the [person*

*of colour] shouldn't be raising this every time ... otherwise you become the squeaky wheel ... because you can't do it alone ... (Diversity Participant 37)*

For diversity workers and champions with lived experiences of racial discrimination, their professional work was embedded in challenging the social and political constructions regarding race in healthcare settings. This double consciousness of living through discrimination and working towards advocacy demonstrated their courage and bravery; but also left them vulnerable to precarious employment. Participants noted the danger of being the “squeaky wheel”, of constantly getting the “eye rolls” and experiencing the changes to their positions packaged as budget changes, downsizing, moving to a new direction or their roles becoming obsolete. While many started their diversity work journeys with an abundance of optimism, they grew to understand that their work was fraught with challenges.

*I think it needs a person to lead it and champion ... [and] that person needs to be willing to challenge the status quo ... you have to be a troublemaker and agitate ... I've been comfortable with that in my career ... going through [lived experiences of discrimination] and working with colleagues and learning over the years how to manage micro-aggression and, then also learning how important it is to stand up and say when something's wrong or not acceptable. ... it [is] moments of discomfort that I've learned to live with (Diversity Participant 33)*

Simply having diversity policies, statements supporting culturally safe care, and offering access to online diversity education were not enough to activate cultural safety practices during healthcare encounters. Diversity champions were necessary to take up diversity issues, and advocate for patients, families, and racialized staff to address all forms of racism.

### **3. Negotiating Racism**

The word and the concept: racism is often met with reluctance and silence in Canada, and it was no different for diversity workers. This section details how diversity workers navigate the word racism, the consequences of using racism in their anti-racism work, and the ideology that the Canadian healthcare system is beyond racism.

#### **3. a. Diversity Workers Tiptoe Around Racism**

Diversity workers used a series of semantic strategies to foster the survival of their work: softening their wording; avoiding the word racism; and re-framing racism as ignorance. A key strategy was to employ words such as diversity, inclusion or cultural competency as opposed to the language of anti-discrimination and anti-racism. Diversity workers acknowledged that softening their language was necessary to enable diversity work to happen: *“I really wanted to say racism and white supremacy, but I didn’t, because ... it would not go over well”* (Diversity Participant 22). Alongside softer terms, diversity workers avoided naming and acknowledging the presence of racism even in diversity training resources: *“You can see ... they’re getting at the anti-racism stuff ... just not using that word, they’re doing everything but using that word”* (Diversity Participant 02).

Diversity workers who openly challenged systemic racism or identified encounters as racist or breaching cultural safety, were frequently reprimanded or penalized for taking this direct approach. In one case, a diversity worker was consistently asked by their direct supervisor to be silent at meetings and not to share ideas of advancing equity for racialized patient communities. In other cases, diversity workers who sought to address racism in healthcare settings were shuffled into different roles that would limit or prevent their diversity contributions

such as Diversity Worker 27: *“it was clear that they were trying to force me out by putting me in a highly demanding role, outside of my scope of practice and would not allow me to continue with [diversity role] even though I offered to include it in my portfolio”*. Others had their positions terminated such as Diversity Worker 12: *“I was doing a lot of good work that was having a meaningful impact ... and then I was blindsided, and told my role was no longer relevant to the health authority”*. Understandably, diversity workers developed strategies to ‘stay in the game’ to meaningfully advance health equity.

There were different understandings among diversity workers about racism and how it operated in healthcare systems and the wider society. The majority of diversity workers who were racialized were apt to acknowledge the existence of racism; while many of the diversity workers who self-identified as having European ancestry and affiliated with Christianity, held the belief that cultural competency education would remedy culturally unsafe healthcare encounters. These diversity workers frequently affirmed that healthcare providers had good intentions and were not purposefully racist. Several diversity workers identified that staff were simply missing pertinent information and training to deliver culturally safe care: *“all staff want to be effective, and staff realize that ‘I don’t know what I don’t know’, and that is a struggle for all [clinicians], we all have limitations”* (Diversity Participant 11). Diversity workers, who delivered diversity training, noted that clinicians often expressed their frustration about not knowing about cultural practices of racialized and faith-based communities. The deficit being addressed was limited knowledge, not acts of implicit or explicit racism. Consistently, we heard that once education was put forward, mistakes could be remedied: *“we all make mistakes, sometimes they are diversity ones, and we need to learn from them”* (Diversity Participant 53).

### 3. b. Seeing Healthcare as Beyond Racism

Participants described the philosophical juxtaposition between having diversity programs and the expectation that all healthcare staff should be doing diversity work as a part of their everyday work. This expectation was premised on the idea that cultural competency training has been extensively facilitated in healthcare institutions and is now firmly embedded in healthcare culture: *“we have a universal health care system and treat everyone the same, we don’t need to specialize because everyone should be culturally responsive, culturally competent, everyone should be providing that care, this is present day philosophy”* (Diversity Participant 18). This belief also informed the lack of anti-racism education for those who received healthcare complaints. When patient safety staff were asked if and how they were trained to read for systemic and subtle forms of racism in patient complaints, they stated it would be obvious: *“people will say its racism”* (Diversity Participant 52). One senior leader stated that cultural competency was *“becoming the way of being”* in healthcare whereby everyone is perceived as *“equal”* and *“it doesn’t matter about the colour of your skin, your gender, your sexual preference ... and so on”*, and that there is a *“move towards a culture of acceptance and a culture of treating people equally”* (Diversity Participant 41).

This “present day philosophy” that healthcare sites have achieved cultural competency was echoed by the majority of participants; yet almost all of the participants agreed that diversity programs need to exist in health authorities. One participant noted:

*Our organization says we should be culturally competent but what does that mean if you don’t provide the actual education to everybody and make it a part of the culture, it doesn’t happen* (Diversity Participant 20)



Another described the challenges of doing informal diversity work without the support of a diversity program and formal diversity workers:

*Yes, staff have to know who to contact ... it's also a lot to carry [for] one person ... I've got this massive portfolio and to also bear the weight of that [informal diversity work] is difficult, because we're not the experts ... I think having someone who's got the time and effort to have that kind of strategic oversight would be really useful. And also have that one contact department and person for our patients and families to know ... this is a safe space for you to tell us what went wrong with your care ... because a lot of people are very frightened of the formal mechanism of making a complaint. (Diversity Participant 33)*

While the majority of participants supported establishing and maintaining formal diversity programs, opinions on the content of diversity programming was varied but significantly highlighted a need for “education about minority communities” (e.g. how does the Buddhist community address death; how do we support smudging for Indigenous communities; how do we care for people’s hair respectfully). Some of the participants wanted itemized lists that characterized people according to their cultural communities; while others emphasized the need for anti-racism education.

*... diversity training and multiculturalism is resting on the idea that if we know each other's sacred cultural traditions, somehow you're not going to be racist towards me ... where's the evidence for that ... what I have seen is evidence exactly to the contrary... I say quite publicly, what part of my cultural tradition is going to stop you from being racist towards me? And I think we can agree there's nothing. So that's not the issue, it's not about teaching culture or teaching culture harder, it's about talking about racism. What's it*

*going to take for you to see me as a human being and not a savage, ignorant, lazy, alcoholic, prostitute ...* (Diversity Participant 42)

This regression to culturalism reinforces the idea that racialized and faith communities are homogenous entities without variation in how they practice their faiths or cultures, and frequently showcase the negative stereotypes. Premised on the idea that Canada has a universal healthcare system, a *Multiculturalism Act*, and British Columbia's health authorities have had cultural competency programs in the past, most participants thought that the dominant understanding was that health care is "beyond race" but as astutely articulated by the participant quoted above: it is apparent that learning about people's sacred traditions, beliefs and customs has not created racism-free, safe healthcare encounters.

### **Discussion/Conclusion**

The most promising finding was the sheer number of diversity workers, particularly the extensive informal network that facilitated diversity work off the sides of their desks. This signaled that there was a need to have institutionally driven diversity programming; to address this gap, healthcare staff were piecing together diversity programming. The commitment of diversity champions was admirable as they navigated numerous barriers to carry out diversity labour. Despite the need, diversity work was largely unsupported. Withholding institutional support for diversity whether it be a minimal budget or resistance to establishing and maintaining diversity programming as a core part of the institutional culture of health authorities – demonstrates to the lack of institutional commitment to anti-racism, equity, and cultural safety. As we have detailed, limited or non-existent diversity programming cannot operationalize any effective anti-racism and cultural safety education to the thousands of health authority staff

much less provide advocacy for the millions of patients health authorities serve. Further, if we cannot even name racism, how do we address the various forms of racism including colour-blind racism, implicit racism, explicit racism, interpersonal racism, internalized racism, structural/systemic racism. The findings clearly demonstrate that health authorities do not allocate adequate resources and supports to implement anti-racism, equity, and cultural safety much less address systemic racism. Implementing ambiguous terms such as diversity, culture and safety do not lend to intuitive applications whereby healthcare leaders and staff can easily implement cultural safety practices. Translating cultural safety from a critical theory of care to direct healthcare delivery and practice is not straightforward (Browne, Varcoe, Smye, Reimer-Kirkham, Lynam & Wong, 2009), and requires health authorities to provide guidance on how to be anti-racist and culturally safe.

For cultural safety to even have a chance to be enacted, health authorities must “actively [examine] social, economic, political positions, and power differences in healthcare” to build an institutional culture that recognizes and unmistakably addresses how these constructions lead to a “culturally unsafe healthcare environment [that reifies] institutional racism, [dehumanizes], and [rec-creates] trauma in vulnerable populations” (Ramsden & Whakearuruhau, 1993). Part of the reason why diversity workers have to tiptoe around essential concepts such as race, racialization, racism, discrimination and oppression (that are at the heart of cultural safety and anti-racism work) – is that health authorities have yet to embrace cultural safety as a paradigm. This glimpse into the Canadian healthcare system suggest that it reflects the broader societal resistance to discussing and addressing racism; consequently, diversity workers navigate the tension between implementing cultural safety without being able to name the cause of cultural

un-safety. Without acknowledging the existence of racism and its harm, and the necessary commitment to obstruct its everyday and overarching movements, we cannot advance anti-racism praxis and the tenets of cultural safety.

To understand how different provinces and territories across Canada take up diversity programming in their health authorities, more exploratory work is needed. While this was beyond the scope of our investigation, future research would provide broader insights as each province/territory has different Indigenous, racialized and newcomer communities, and differing views on diversity and anti-racism commitments. A comparative analysis would be useful to understand whether ethnically concordant care yields better outcomes for patients. Another important avenue for diversity programming research would be to interview racialized patients and racialized healthcare providers from diverse communities to understand how different racialized communities experience the gaps and successes of existing diversity programming. How end users experience this programming is paramount in the delivery of culturally safe healthcare.

Alongside the recent covid-19 pandemic, we have seen an increase in racism awareness particularly with the advocacy of *Black Lives Matter*; Indigenous advocacy for *Truth and Reconciliation* - exceptionally the recent uncovering of unmarked graves of thousands of Indigenous children; government requested reports about anti-Indigenous racism (e.g. *In Plain Sight* (Turpel-Lafond, 2020); *Reclaiming Power and Place* (2019); *Truth and Reconciliation Reports* (2015); escalation of various forms of publicly displayed racism; and the rise of hate crimes in Canada. Simultaneously, there has been a noticeable response to racism with organizational anti-racism statements being publicized, news media reporting racist encounters more frequently,

advertisers featuring more ethnically diverse actors, and Canadians videotaping their experiences with racist individuals and posting on social media.

Notably the *In Plain Sight* (Turpel-Lafond, 2020) report that documented anti-Indigenous racism in British Columbia has steered the British Columbia College of Nurses and Midwives and the College of Physicians and Surgeons of BC to develop a practice standard on Indigenous Cultural Safety, Cultural Humility and Anti-Racism<sup>119</sup> (January 28, 2022). Most recently, the BC College of Nurses and Midwives, College of Physicians and Surgeons of BC, the College of Pharmacists in BC, and the College of Dental Surgeons of BC issued an apology to Indigenous peoples and communities regarding the racism they have experienced while engaging with health professionals they regulate with promises to act<sup>120</sup>. These are important measures to address racism, but as many Indigenous and racialized communities have found, adopting even the most basic recommendations like those found in the *Truth and Reconciliation* reports or in the *Reclaiming Power and Place* report (regarding Missing and Murdered Indigenous Women and Girls) have been problematically slow. For instance, last year the Native Women's Association of Canada announced that "it [had] lost confidence in the federal government and [walked] away from the "toxic, dysfunctional" process"<sup>121</sup> (Kennedy, 2021) as they were "denied a seat on key working groups that [provided] input on the plan, and were subjected to lateral violence, rude comments and hostile email exchanges"<sup>122</sup> (Deer, 2021). Creating challenging environments for

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<sup>119</sup> <https://www.bccnm.ca/bccnm/Announcements/Pages/Announcement.aspx?AnnouncementID=337>

<sup>120</sup> <https://www.bccnm.ca/bccnm/Announcements/Pages/Announcement.aspx?AnnouncementID=357>

<sup>121</sup> <https://www.thestar.com/news/canada/2021/06/01/indigenous-womens-group-wont-work-with-government-on-mmiwg-action-plan-citing-a-toxic-dysfunctional-process.html>

<sup>122</sup> <https://www.cbc.ca/news/indigenous/nwac-mmiwg-action-plan-1.6047671>

advocates is a frequently used tactic and exposes the lack of institutional and government will to do the work required.

Further, despite this momentum, many of British Columbia's organizations do not enact their statements. For instance, a Vancouver Coastal Health (VCH) vascular surgeon and Adjunct Professor with University of British Columbia (UBC): Dr Jason Marc Faulds was driving while impaired on July 18, 2021 and struck a car being driven by 2 South Asian ancestry men. A tiktok video was posted with Dr Faulds telling the South Asian ancestry men "It's no big deal, just get the f\*\*k out of here, you can crawl back to [a community known to have a large South Asian ancestry population]"<sup>123</sup> (Daflos, 2021).

Both UBC and VCH responded to media inquiries that the "individual's comments do not reflect [their] views" and affirmed their institutional commitments to inclusivity (Daflos, 2021). If there was no video evidence posted on social media, Dr. Faulds racist beliefs and ideologies would continue unchecked while he served ethnically diverse British Columbians as a surgeon and a professor. When a surgeon is featured making racist comments directly to racialized individuals, our public health system owes it to British Columbians to identify the "appropriate actions and discussions" that were taken. As a womyn-of-colour with South Asian (Punjabi) ancestry, the first author of this paper can attest she would feel unsafe if Dr. Faulds was providing her surgical care or was her professor given his views. Further, when other doctors publicly support Dr Faulds as is the case with internal medicine specialist Dr Kevin McLeod:

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<sup>123</sup> <https://bc.ctvnews.ca/crawl-back-to-surrey-vancouver-surgeon-s-comments-under-scrutiny-1.5508117>

*“he’s an amazing surgeon. Excellent physician. We all make mistakes in life. If I had a major vascular problem he would be the guy I’d see. No one is more thorough or competent” (Daflos, 2021)*

This colour-blind racism tactic minimizes the racism witnessed in the video. This defense for Dr. Faulds falls in line with tone policing whereby dominant groups “chastise the communication style of marginalized people who challenge their oppression” (Davis & Ernst, 2017, p. 3); in this case, Dr. McLeod emphasizes the life-saving expertise of Dr. Faulds and by suggesting “we all make mistakes”, the racism is deemed insignificant and unnecessary to draw attention to. This also falls in line with racial gaslighting whereby racialized people are deemed too sensitive and should ignore the “political, social, economic and cultural process that perpetuates and normalizes a white supremacist reality” by “pathologizing those who resist” (Davis & Ernst, 2017, p. 3).

Diversity workers proficiently understand “there are huge risks in writing or speaking about racism” (Ahmed, 2012, p. 149) and healthcare racism has real and dramatic inequities for racialized patients (Beavis et al, 2015; Brasolotto, Raphael & Baldeo, 2014; Browne, Smye, Rodney, Tang, Mussell & O’Neil, 2010; Browne et al, 2016; Browne et al, 2021; Burgess, 2011; Collins & Hayes, 2007; Dunn & Dyck, 2000; Frohlich, Ross & Richmond, 2006; Goodman et al, 2017; Heaman, Gupton & Moffat, 2005; Kennedy & Morgon, 2009; Kitching et al, 2020; Krieger, 2012; Krieger et al, 2013; Lukachko, Hatzenbuehler & Keyes, 2014; Markham et al, 2021; Nestel, 2012; Paradies, Priest, Ben, Truong, Gupta, Pieterse, Kelaher & Gee, 2013; Phillips-Beck et al, 2020; Raphael & Baldeo, 2013; Schoen & Doty, 2004; Smith, 2012; Varcoe et al, 2009; Weerasinghe, 2012). Similar to Sara Ahmed’s findings in her groundbreaking research on diversity

practices in academia, diversity workers encounter institutional “walls” (i.e. resistance and blocks) despite the presence of institutional commitments. Diversity policies act as proof of institutional commitments such that “[if] organizations are saying what they are doing, *then you can show they are not doing what they are saying*” (Ahmed, 2012, p. 121). When diversity workers cannot even name racism in their work; or the landscape of diversity programming is persistently shifting; or there are little funds to support diversity programming, Ahmed’s concept of the wall is apparent to diversity practitioners but not to everyone:

*Only the practical labor of “coming up against” the institution, allows this wall to be come apparent. To those who do not come up against it, the wall does not appear – the institution is lived and experienced as being open, committed, and diverse* (Ahmed, 2012, p. 174)

This juxtaposition between coming up against the wall and invisibility of the wall is echoed in democratic racism whereby “[commitments] to democratic principles such as justice, equality, and fairness ... coexist with attitudes and behaviours that include negative feelings about minority groups, differential treatment, and discrimination against them” (Henry, Tator, Mattis & Rees, 1998, p. 23). For those who come up against racist micro-aggressions, differential treatment and discrimination, the wall blocking equity is not only seen but experienced.

The findings presented in this paper demonstrate in the Canadian health care context a lack of “institutional will ... to transform a situation in order not to reproduce what would habitually be produced” (Ahmed, 2012, p. 128). Our social and political culture continues to reproduce racism. *Multiculturalism* has not fixed racism; rather it “[reproduces] dominant racial/racist ontologies, epistemologies, and practices, albeit in new disguises” (Bery, 2014).



Within the framework of a celebratory *Multiculturalism*, non-European Canadian citizens, permanent residents, immigrants, and refugees continue to negotiate processes of racialization and systemic racism - alongside the rhetoric of a welcoming, benevolent multicultural host country (Bannerji, 2000; Thobani, 2007). These dueling paradigms work on the Canadian healthcare system, like other Canadian institutions, formulating dominant racialized structures (Feagin & Bennefield, 2014) that are “led and controlled by [those with dominant privilege and power]”; and subsequently resist the social justice work underpinning diversity policies, mandates and programs; and merely perform “institutional lip service” (Ahmed, 2012). Without critical anti-racist diversity programming that names and addresses systems of oppression, and nurtures cultural safety as an essential element in every healthcare encounter, we are locked in this perpetual cycle of health inequity that culminates into distrust and disease - born out of a system that is meant to care for people.

*Table 4.1 Diversity Workers Demographic Tables*

<b>Number of Participants</b>	58
<b>Age</b>	
Age Range	28 to 72
Mean Age	53.71
<b>Self Identified Gender</b>	
Women	34
Men	24
<b>Education</b>	
High School	2
Post Secondary	3
Bachelor Degree	3
Master's Degree	44
PhD Degree	6
<b>Birthplace</b>	
Canada	38
Outside of Canada	20
United Kingdom	7

<i>India</i>	5
<i>United States of America</i>	4
<i>Finland</i>	1
<i>Guyana</i>	1
<i>Hong Kong</i>	1
<i>Singapore</i>	1
<b>Those Born Outside of Canada Years in Canada</b>	
<i>Range of Years in Canada</i>	12 to 58
<i>Average Number of Years</i>	35
<b>Ancestral Ethnicity *</b>	
<i>Indigenous</i>	9
<i>Black</i>	1
<i>South Asian</i>	13
<i>Asian</i>	4
<i>European</i>	51
<b>Religious Affiliation</b>	
<i>Indigenous Spirituality</i>	4
<i>Buddhism</i>	1
<i>Christianity</i>	30
<i>Hinduism</i>	1
<i>Islam</i>	1
<i>Jainism</i>	1
<i>Jewish</i>	3
<i>Sikhi</i>	5
<i>Not Affiliated</i>	12

\*A few participants self-identified 2 ancestral ethnicities

## Chapter 5<sup>124</sup>

### **At the Intersection of Diversity Commitments and Actions: Racialized Patients' Experiences of Universal Healthcare in British Columbia**

As the managing supervisor of an industrial manufacturing company, Amarjeet Singh held an *Industrial First Aid certificate* for over two decades. During a recent trip to India, he assisted a fellow passenger who collapsed from a heart attack. He administered first aid while assigning airport personnel to seek physicians for medical assistance, and to call for an ambulance. A year later, while sitting in his living room reading a newspaper, Amarjeet knew he was having a heart attack. When the paramedics arrived, Amarjeet shared his symptoms (e.g. shortness of breath, chest pain, tightness in his chest, dizziness). The paramedics did not believe he was having a heart attack. Amarjeet Singh insisted he was, explained he held industrial first aid certification, and narrated his recent experience at the airport. The paramedics conceded but warned Amarjeet Singh that he would have to pay for the ambulance. He agreed to pay the ambulatory fees. The paramedics refused to take him on the stretcher requiring him to walk down 3 flights of stairs. In the ambulance, the paramedic did an ECG and realized Amarjeet was indeed having a heart attack. The paramedic quickly administered lifesaving procedures per protocol. When asked, why do you think they didn't believe you, Amarjeet said: "I think they think us Indians just complain for no reason, so they don't believe us, but in the end, they helped to save my life, as soon as they realized, they helped me and took very good care of me".

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<sup>124</sup> Chapter 5 is written as a research paper. This chapter includes co-authors Colleen Varcoe and Sheryl Reimer-Kirkham; hence why I use the pronoun: we instead of the third person. This chapter is in the process of being submitted in a peer-reviewed journal.

Systemic and subtle forms of racism impact the lives of racialized<sup>125</sup> minority communities everyday (Feagin & Bennefield, 2014; Krieger, 2012; Roberts, 2011) by limiting access to equitable health care, housing (Auspurg, Schenck & Hinz, 2019; Motz & Currie 2019), employment (Pendakur & Pendakur, 2007) and education (Marom, 2018; Grewal, 2016). Race and racism are social determinants of health (Government of Canada, 2020<sup>126</sup>); yet despite this, healthcare racism is under-researched in Canada. Ethnicity data is not widely collected by Canadian healthcare institutions (Rummens, 2003); and therefore, researchers are less able to analyze differential experiences and measure systemic inequities. Even though Canada has been slow to pursue healthcare racism research, there is mounting evidence that health inequities persist for racialized Canadians (Frohlich, Ross & Richmond, 2006; Kennedy & Morgon, 2009; Lebrun, 2012; Schoen & Doty, 2004). There is also ample evidence that healthcare encounters between racialized patients and healthcare providers includes racial profiling (Tator & Henry, 2006) and subsequently health inequality (Adelson, 2005; Frohlich, Ross & Richmond, 2006; Humphries & van Doorslaer, 2000; Safaei, 2007; Tang & Browne, 2008). When people experience racial discrimination, they experience greater depressive symptoms (Schulz et al, 2006), higher rates of blood pressure (Karlsen & Nazroo, 2002), infant mortality (Sondik et al, 2010) and greater prevalence of cardiovascular disease (Lukachko, Hatzenbuehler & Keyes, 2014). They also exhibit

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<sup>125</sup> Racialized is used here to identify ethnic, cultural or religious communities who are ascribed characteristics of belonging to a community based on their skin colour/tone, religious garments or cultural traditions. These socially constructed racial categories and subsequent characterizations are often understood to be enduring traits. Those perceived to belonging to a racialized community are considered to have behaviours, beliefs, values, traditions and ideologies that are ascribed to that community. For instance, South Asians are vegetarian. Individuals and communities who are racialized are perceived to belong to a racially grouping and considered to hold values, beliefs and ideologies of the group by those holding social and political power.

<sup>126</sup> <https://www.canada.ca/en/public-health/services/health-promotion/population-health/what-determines-health.html>

poorer health than those who do not experience racism (Williams and Mohammed, 2009). Racism not only impacts the capacity to receive equitable healthcare but also negatively impacts the physical and mental well-being of racialized individuals (Feagin & Bennefield, 2014; Krieger, 2012; Roberts, 2011; Turpel-Lafond, 2020).

The COVID-19 pandemic has exposed these inequities further with African Ancestry, South Asian ancestry, and Asian ancestry individuals being more likely to contract the virus and more likely to die as a result (Yaya, Yeboah, Charles, Out & Labonte, 2020). In response to these inequities, 11 out of 14 Canadian human rights commissions<sup>127</sup> have advocated for the collection and analysis of disaggregated race-based data but have encountered federal and provincial resistance (Yaya, Yeboah, Charles, Out & Labonte, 2020). Not only are there gaps in understanding how systemic racism impacts the well-being of racialized Canadians, but there is also a lack of data on racialized healthcare experiences. Informed by critical race feminist theories, we conceptualized this research study to understand what happens when racialized individuals and healthcare systems meet; Specifically: how do racialized patients experience equitable healthcare commitments in the province of British Columbia?

This paper details phase 3 of a larger study entitled *Sadhee Sehayth: Our Health Project*. Phase 1 was an analysis of publicly available diversity commitments of health authorities in British Columbia. During phase 2, we interviewed diversity workers regarding equity commitments and the delivery of culturally safe care. Phase 1 identified institutional commitments, while phase 2 revealed institutional actions towards health equity. This final phase featured one exemplar

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<sup>127</sup> <https://cashra.ca/national-strategy-for-the-collection-of-disaggregated-health-data/>

community: the Punjabi Ancestry, Sikh Affiliated Canadian<sup>128</sup> community, well-established racialized minority community in British Columbia. The first author shares ethnic ancestry, language, and religious affiliation with this community. Further, we focused on patients living with cardiovascular disease (CVD) as considerable research has established that the South Asian ancestry community faces a higher prevalence and younger age of onset of CVD and have higher rates of death when compared with other ethnic ancestry communities (Bailey & Jugdutt, 2009; Fraser Health report, 2014; Joshi, Islam, Pais, Reddy, Dorairaj, Kazmi, Pandey, Haque, Mendis, Rangarajan & Yusuf, 2007; Sheth et al, 1999; Singh & Gupta, 2005; Yeolekar, 1998; Yusuf, Hawkin, Ounpuu, Dans, Alvezum, Lanas, McQueen, Budaj, Pais, Varigos, Lisheng & Interheart Investigators, 2004). Although physiological markers have been associated with this higher risk of CVD (Fernando, Razak, Lear & Anand, 2015), CVD inequity also plays a role. Alongside notable cultural safety breaches in healthcare settings (CBC News, 2010<sup>129</sup>) and questionable healthcare access (Desibuzz Canada, 2022<sup>130</sup> Indo-Canadian Voice, 2022<sup>131</sup>), this community has faced historical racism and continues to negotiate contemporary racism (Aujla, 2000; Dua, 2007; Das Gupta & Nagpal, 2022; Hirji & Beynon, 2000; Kang, 2007; Kang, 2013; Kazimi, 2012; Mawani, 2018; Wallace, 2019).

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<sup>128</sup> The Punjabi-Ancestry Sikh Diaspora community is comprised of diverse individuals with unique her/histories, cultural influences, languages spoken, religious commitments, and worship practices. We cautiously use the term 'community' as a means to honour the shared ancestry and religious affiliation that brings Punjabi-Ancestry, Sikh-Affiliated Diaspora individuals together. While it is difficult to extrapolate the number of Punjabi ancestry Canadians as Punjabi ancestry is encompassed under the South Asian umbrella on the Canadian census, Punjabi was the third most common non-official Canadian language spoken at home with 568,375<sup>128</sup> speakers and 454,965<sup>128</sup> reported belonging to the Sikh faith.

<sup>129</sup> <https://www.cbc.ca/news/canada/british-columbia/apology-issued-after-nurse-cuts-sikh-s-beard-1.923803>

<sup>130</sup> <https://desibuzzcanada.com/post/fraser-health-apologizes-to-indo-canadian-woman-forced-to-give-birth-in-smh-lobby>

<sup>131</sup> <https://voiceonline.com/fraser-health-investigating-after-pregnant-south-asian-woman-delivers-baby-on-surrey-memorial-hospital-lobby-floor/>

## Recruitment and Data Collection

People with Punjabi Ancestry who followed the Sikh faith were recruited from cardiac rehabilitation programs, seniors' groups and using snowball sampling. The first author presented the research study at Punjabi language cardiac rehabilitation sessions and Punjabi ancestry seniors' groups in the lower mainland. She also placed posters and pamphlets in hospitals, health clinics, Gurudwaras and community centers. Recruitment criteria included: identifying as having Punjabi ancestry; following the Sikh faith; being 19 years or older; living with cardiovascular disease (CVD); and being hospitalized in the last year for CVD related reasons. For this paper, we also drew on interview data collected from phase 2<sup>132</sup> with diversity workers regarding cultural safety, interpreter services and spiritual care support. Diversity workers were recruited from British Columbia hospitals, residential and long-term care facilities, acute care sites, outpatient clinics and diversity programs (e.g. cross cultural, diversity, spiritual health).

The first author facilitated the semi-structured, one-to-one, digitally recorded interviews after participants completed a paper-based consent form approved by the University of British Columbia's Behaviour Research Ethics review board and two health authority research review boards. A Punjabi language professor translated recruitment materials and consent forms for the Punjabi ancestry patients. All the Punjabi Ancestry Sikh participants preferred to be interviewed in Punjabi. These participants were asked to narrate their CVD journeys from diagnosis to their most recent hospitalization with opportunities to elaborate on diversity and cultural safety experiences. They understood the purpose of the study was to examine their CVD healthcare

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<sup>132</sup> Our broader project: Sadhee Seyath: Our Health Project features 3 phases. Phase 2 focused on the diversity work carried out by healthcare delivery organizations and involved interviews with diversity workers.

experiences, how their identity as Punjabi ancestry Sikhs impacted their healthcare experience, if they experienced cultural safety breaches such as hair cutting, and if they received any specialized services such as interpreter or cultural safety support. Individual, semi-structured interviews ranged from 30 minutes to 2 hours (with an average length of 65 minutes). The bilingual first author completed the interviews in Punjabi and later translated/transcribed the interviews to English. A bilingual Punjabi-English speaker completed the accuracy checks and paid special attention to reviewing the translation of cultural phrases, terms and idioms. Diversity worker interviews which were conducted in English ranged in length from 36 minutes to 2 hours and 25 minutes. Digitally recorded interviews were transcribed verbatim followed by an accuracy check. Following each interview, the first author documented observations in field notes.

### **Participant Sample:**

The 15 Punjabi Ancestry Sikh participants ranged in age from 45 to 73 (with an average age of 64.4 years). Participants self-identified as women (8) and men (7); all identified the Northern Indian state of Punjab as their birthplace; and their years in Canada ranged from 7 to 49 years. Their preferred language was Punjabi, with 6 participants reporting they had enough English language fluency to navigate daily routines but only 1 participant reporting being fully bilingual. All the participants held Canadian citizenship and resided in the province of British Columbia at the time of their interview. Education ranged from grade 5 to university bachelors' degrees. All received cardiac medical interventions with 11 participants undergoing scheduled cardiac-related surgeries, 2 were rushed to hospital for angioplasty and 2 arrived via ambulance due to cardiac arrests. Hospital stays varied from one to ten days, and all 15 patients had undergone a surgical cardiac procedure in the last year.



The 58 diversity workers ranged in age from 28 to 72 (mean age of 53.71 years); 34 self-identified as women while 24 identified as men; and 44 (75.9%) held masters' degrees. Most of the 58 diversity workers identified their ancestral communities as European and Christianity as their faith. Thirty-eight participants identified as being born in Canada, and for the 20 not born in Canada, years in Canada ranged from 12 to 58 (with an average of 35 years in Canada).

## **Analysis**

For this analysis, racialized patient voices are prioritized as they are experts of their healthcare experiences. Cultural safety is premised on patients determining whether diversity commitments are being met for culturally safe care (Ramsden & Whakearuruhau, 1993; Ramsden, 2002). Diversity worker interview data and observation were used to provide context and a fuller understanding of healthcare encounters, dynamics, systems, and processes. We reviewed the Punjabi Sikh patient interview transcripts to identify pertinent themes. Team members discussed the possible themes in relation to the research question and highlighted repeating patterns to develop the coding schema. Patient interview transcripts were coded with the finalized coding schema. The same coding schema was then used to code the diversity worker transcripts to provide context for patient experiences. The first author reviewed post-interview field notes and coded applicable data using a qualitative software data program: NVivo™. After coding both sets of interviews and field notes, the authors reconvened to discuss the coding approach, compared and contrasted patient experiences with available equity-oriented healthcare services, and developed the thematic analysis. A reflective coding journal was maintained throughout the study process and included analytic memo writing whereby we

documented and reflected on the coding process, our choices and noted our observations (Saldana, 2009, p. 32).

## **Findings**

To understand the supports for and gaps in equitable access and culturally safe health care, we attended to how these racialized patients experienced healthcare during a recent cardiac surgery related hospitalization. Three major findings with sub-themes will be detailed below: withholding essential medical services; cultural unsafety; and advocacy strategies.

### **1. Withholding Essential Medical Services**

This section details the withholding of essential medical services that were experienced by this participant group. Almost all required interpreter support to communicate essential information regarding their health, to provide informed consent, to receive necessary information about how their treatments, and to obtain life-saving, preventative information about their cardiovascular chronic illness.

#### **1.a. Interpreter Support for Patients Was Minimal to Non-Existent**

Despite the need for interpreter support, only 2 of the participants were asked if they required interpreter support at hospital intake and none thereafter. Six of the participants reported some English language fluency but added that they could not adequately convey the “full meaning” of what they wanted to say or ask:

*“I can mostly understand, and I can understand my doctor when she speaks very slowly but sometimes I have to bring my husband or daughter-in-law to help me, we are all educated in Punjab, have some English from there, but not Canadian English, I don’t know if we get everything we need to understand” (Punjabi Sikh Participant 02).*

Eight participants regularly required family members to arrange appointments, speak to healthcare staff and explain relevant medical and treatment information due to language discordance. Participants utilized different strategies to meet their interpretation needs such as having physicians speak to adult children over the phone and booking specialist appointments when adult children could attend. The majority didn't advocate for professional interpreter support as they did not wish to burden the healthcare system; further, they reserved family interpreter requests for critical appointments because they didn't want adult children to take time off from paid work and lose necessary income. When asked why they thought interpreter support was a burden to the healthcare system, the majority emphatically stated: "interpreters are expensive" and "they never ask".

During this recent hospitalization, only 2 participants were asked if they needed such support at intake before their cardiac surgeries. One of the two, declined as she felt her spouse could provide interpreter support. When the first author facilitated the interview with this participant, it was evident that the spouse had minimal English language fluency; therefore, it is unclear how much information was adequately translated and communicated to the patient regarding her surgery. The one participant who accepted interpreter support prior to surgery, did not receive any further offers during her hospitalization or discharge. While explaining the upcoming surgical procedures and acquiring informed consent are vital, it is also imperative to explain how the surgery went, attend to any post-operative questions or concerns, relay post-operative treatment plans and care, and provide discharge information. As one participant noted, both receiving and seeking information are impaired when there is language discordance:

*“Sometimes, I am not sure I have the full meaning when I talk to the doctor or nurses, but I can’t say the full meaning of what I want to ask or say, so it isn’t their fault”* (Punjabi Sikh Participant 11).

A minority of the participants encountered Punjabi-speaking healthcare providers, but this communication was focused on direct care during or following surgical procedure: *“At the hospital, there was a Punjabi nurse, she took very good care of me”* (Punjabi Sikh Patient Participant 03). Two thirds of the participants (n=10) had family physicians who spoke Punjabi. These participants reported being able to communicate and understand their health issues particularly pre and post surgeries. All 15 participants were hospitalized in sites where interpreters are easily accessed through a phone service or scheduled for in-person interpretation without a direct cost to the hospital. Diversity workers frequently identified multiple barriers to interpretation services including assumption of fees; requirement to schedule interpreters far in advance; and the idea that working with an interpreter is difficult. In response, the provincial language support team<sup>133</sup> has spent considerable effort to offset the idea that hospitals or clinics directly pay for interpreter services:

*“[there is a] centralized budget, people don’t need to worry about the money, [they] need to worry about efficiently using the service, if you need it, you certainly should call”* (Diversity Worker Participant 27).

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<sup>133</sup> One of British Columbia’s health authorities: Provincial Health Services Authority has a language support team which oversees spoken language Interpreter services in 150 languages via in-person, on the phone and videoconferencing. Costs for interpreter services for the health authorities serving this participant sample are funded under a centralized budget to enhance accessibility; therefore, hospitals providing care to these patients would not be billed for interpreter services.

<http://www.phsa.ca/health-professionals/professional-resources/interpreting-services>

Further a diversity worker questioned the lack-of-time excuse: *“I hear ...there’s no time, there’s no time ... I get that everybody’s busy, but ... why is there no time for this, but there is time to wait for an X-ray ... there is time to wait and send somebody to an MRI, or there is time to wait around for the doctor to come, it depends on what importance you put on something, and therefore you will make the time”* (Diversity Worker Participant 33). Further, the provincial health services authority<sup>134</sup> recommends that healthcare providers utilize interpreter support as a necessary (not optional) communication tool when language challenges are present as *“communication is the key”; without it, patients “don’t understand what’s going on, that’s scary ... people just don’t think it’s a priority or needed ... [healthcare providers] think I can get the healthcare done and I don’t really need to worry about what they’re understanding”* (Diversity Worker Participant 16). This approach objectifies patients as it removes their personhood, agency and involvement in their healthcare.

### **1.b. Post-Surgery Care Plans Not Adequately Communicated**

As noted above, this participant sample did not receive English to Punjabi interpretation support despite the need. Healthcare providers could not have communicated surgical success and complications; include patients in post-surgical evaluations to assess how patients are recovering; and to pass on discharge information including at-home treatment plans, medications, and cardiac rehabilitation referrals. Five participants received referrals from their Punjabi speaking primary care physicians and attended a Punjabi language cardiac rehabilitation

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<sup>134</sup> Provincial Health Services Authority (PHSA) is responsible for specialized health services (e.g. cardiac, trauma, perinatal, and stroke) which are delivered across the province in collaboration with regional health authorities. PHSA also oversees BC Ambulance Service and Patient Transfer Services as well as Interpreter services.

program<sup>135</sup>; the remaining 10 were not aware of the program and requested contact information from the first author at the time of their interview to register and attend. All 15 participants received cardiac surgeries in hospitals with established cardiac rehabilitation programs; and would have benefited from knowing this information. Participants recounted their concerns about exercising after their surgeries and reported needing more information about preventing further cardiac incidents (e.g. diet, nutrition, stress management, accessing medical supports and resources) and developing better cardiac health literacy – which is all covered in cardiac rehabilitation programming. Further, at least 50 Punjabi language CVD related documents exist online for patients in local health authorities including *Heart Services; Exercise and the Heart; and Your Heart Surgery Journey*<sup>136</sup> but none of these useful, language concordant documents were provided to these participants. When cardiac patients do not receive needed information to promote their recovery, poor outcomes are inevitable.

Several diversity workers identified gaps in service provision for language discordant patients because of the language barrier. Language discordance limits the “*extra information being shared*” such as cardiac rehabilitation programming when healthcare providers are busy attending to “*biomedical, acute and urgent issues*” (Diversity Worker Participant 01). Medical interpreters are ideally suited to support healthcare providers to fill this information gap. Given the availability of Punjabi language interpreters in British Columbia and language equity

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<sup>135</sup> In the Province of British Columbia, there is one Punjabi language cardiac rehabilitation program facilitated through Fraser Health Authority with Punjabi speaking healthcare providers including nurses, pharmacists, occupational therapists and physiotherapists. It is a well-attended program as there is a substantial population of Punjabi speakers in the Fraser Health catchment.

<sup>136</sup>[https://patienteduc.fraserhealth.ca/search/results?q=cardiac+&f\\_language\\_facet=Punjabi&q2=&q9=&q3=&q10=&q4=&q7=&q5=&q6=&sort=score+desc&p=2&ps=10&bu=%2Fsearch%2Fadvanced](https://patienteduc.fraserhealth.ca/search/results?q=cardiac+&f_language_facet=Punjabi&q2=&q9=&q3=&q10=&q4=&q7=&q5=&q6=&sort=score+desc&p=2&ps=10&bu=%2Fsearch%2Fadvanced)

mandates, diversity workers were often dismayed that they had to continue to advocate for interpreters to provide essential medical information:

*... we have a language access policy, it is part of our picture, there needs to be funding allotted for that ... [but] I'm finding that [I'm] constantly having to find those moments and wave the flag, Hello, remember us ... language is always an afterthought ...but there's umpteen number of research [papers] ... [if] You can get it right the first time, there's no repeat visits, they're not waiting to go to Emergency, where costs are escalated right away, you're not having providers do 10 tests, where if they just could talk to the person they would have done the one test that was needed, I think that there's a lot of evidence that supports this ... (Diversity Worker Participant 27)*

We questioned diversity workers regarding why this resistance persisted when evidence favoured interpreter support to reduce healthcare costs and dramatically improve healthcare equity. A few diversity workers identified the use of the indefatigable North American trope: “why don’t they learn English”: *Staff have always been really nice to my face, always very supportive of diversity programming, and I have never heard someone say extremely racist comments to me, but we did this anonymous survey, and I was really disheartened to [read], ‘why do we need diversity services, interpreter services, why don’t they learn to speak English’ ... (Diversity Worker Participant 12).* Another senior diversity worker aptly noted that “*these sorts of attitudes ... get in the way of equity*” and explained that healthcare systems do not see language support as “*essential*” to the medical encounter but “*nice to have*” (Diversity Worker Participant 36).

## 2. Cultural Unsafety

Meeting the needs of diverse patient populations from various cultural, ancestral and religious backgrounds has been emphasized in the Canadian healthcare system, yet these Punjabi Sikh CVD patients did not receive any inquiries about their cultural and religious needs.

### 2.a. Patients are not asked about their cultural and religious needs

Despite the noticeable characteristics of belonging to the Punjabi Sikh Diaspora<sup>137</sup>, none of the participants were asked about the articles of their faith or how to support faith-based commitments, or if they required any support for cultural practices during their hospitalizations. This directly breaches a central tenant to delivering culturally safe care as healthcare providers are meant to seek cultural knowledge from patients (Brascoupe & Waters, 2009; Ramsden, 1993; Ramsden, 2002;). Participants also reported that no such inquiries had ever been made by family physicians, specialists, or hospital staff during medical appointments or hospitalizations. Repeatedly, participants were surprised by our questions regarding cultural sensitivity and awareness about their Sikh faith. As one participant noted: *“Sikhs have been here for a very long time, our Gurudwaras<sup>138</sup> have been here for a long time, so many Gurudwaras now, but many people don’t know about our faith, why we wear turbans, what we believe in”* (Punjabi Sikh Participant 13). It is notable that despite the Sikh community’s long-standing settlement in British Columbia (since the late 1800s), these participants reported no evidence of awareness of their community’s religious needs or cultural practices.

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<sup>137</sup> Participants could easily be read as belonging to the South Asian diaspora with their identifiably Punjabi first and last names, Sikh middle names of Kaur or Singh, brown complexions, brown eyes, and hair colour ranged from black, grey to white. Further, six of the participants wore head coverings to honour their Amritdhari

<sup>137</sup>commitment to the Sikh faith (2 women and 4 men) and maintained the 5 articles of the Sikh faith including keeping hair unshorn.

<sup>138</sup> Sikh place of worship



Given the prominence of hair cutting incidents in healthcare settings, we specifically asked if participants experienced this directly. None of the 15 participants experienced hair cutting during their recent hospitalization but 7 participants shared stories of family members or friends who had experienced this. One participant had direct experience intervening when a healthcare provider was about to cut his adult son's hair. The son had kept his hair unshorn since birth and participated in the commitment ceremony to be an Amritdhari Sikh. After the participant's son had a stroke, he was being cared for at an inpatient facility. The participant walked into his son's room as a healthcare provider held a pair of scissors while the participant's son shook his head sideways in a 'no' motion. The healthcare provider explained that it would be easier if they could cut his hair as it was heavy and burdensome. The participant offered to take care of his son's hair and felt that "*there was no proper education*" (Punjabi Sikh Patient Participant 05) for healthcare providers. While a few accounts have been featured in Punjabi language and local media (i.e. newspapers and radio), this data reveals that these incidents happen frequently.

Diversity workers also raised the hair-cutting incidents and stated that new teaching tools were introduced such as Fraser Health's *Providing Diversity Competent Care to People of the Sikh Faith* which "provides important information on the Sikh faith" including "Sikh beliefs, values and practices" (Fraser Health, 2013). However, a senior diversity worker reported that after yet another hair cutting incident and mandatory diversity training for all staff, there was an ongoing climate of "apprehension"; "*you can cut the tension with a knife, and people don't know what to do with this community*" (Diversity Worker Participant 05). Clearly, the mandatory diversity training did not result in a climate of cultural and religious safety for Punjabi Sikh patients but

further alienated this community from healthcare staff, and reduced organizational will to ensure culturally safe care.

Most diversity workers were disturbed that these incidents continue to happen.

*“... it is mind boggling that they wouldn’t even consult the family...we have such a big Punjabi [Sikh] community<sup>139</sup> and anyone who works there would be in contact with the Punjabi community, its not like there are a 100 people there and we don’t know their culture, but the Punjabi community has been here for hundreds of years ... because that is really going to the core of someone’s beliefs, and religion, and culture ...”* (Diversity Worker Participant 20)

Given the substantial Punjabi Sikh population in this region, it is unclear how healthcare staff would not have basic Sikh religious literacy; but even if they did not know that maintaining unshorn hair was an article of faith, simply asking the patient or their family would have prevented this from happening. In 2010, a nurse cut the hair of an elderly Amritdhari Sikh man who had never cut his hair prompting a public apology by the associated health authority<sup>140</sup>; a family member called into a Punjabi radio station program indicated that he stopped eating after the incident and died shortly afterwards. The CBC corroborated that the man died shortly after the incident, but the cause of his death was not made public (CBC, 2010). The loss of religious identity associated with a faith-based commitment can have dramatic consequences for a patient who is already vulnerable with failing health, in a long-term care facility.

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<sup>139</sup> The local Punjabi community in British Columbia predominantly identifies their religious affiliation as Sikh so often being Punjabi encompasses the idea of following the Sikh faith as noted by this participant when they spoke about the Punjabi Sikh community. It is useful to remember that those having ancestral connections to Punjab may also be connected to the Hindu or Muslim faith.

<sup>140</sup> <https://www.cbc.ca/news/canada/british-columbia/apology-issued-after-nurse-cuts-sikh-s-beard-1.923803>

A few other diversity staff felt that cultural safety has never been breached and that racialized people always receive respectful and equitable healthcare. When known incidents were shared, one diversity worker emphatically denied that such incidents “*would and could*” occur (Diversity Worker Participant 42) even when an article from the Canadian Broadcast Corporation was presented revealing a public apology from a health authority regarding a breach in cultural safety.

## **2. b. Spiritual Care Services Were Not Offered**

Given the level of medical intervention the participants experienced, spiritual care services should have been offered to support these patients. Participants repeatedly shared feelings of distress including: “*I was scared, my family was scared*” (Punjabi Sikh Participant 03), and the majority were afraid of dying. A key reason for spiritual health support is fear of death and contending with stressful medical issues; yet none of the 15 participants were asked if they needed spiritual support. “*No one came to me about this ... no one offered ... no one asked me ‘we have Gurudwara service once a week, would you like to attend’, do you need anything to support your prayers, or even anyone to talk to*” (Punjabi Sikh Participant 12). Further, none of the participants was aware that spiritual care was offered in hospitals but reported they would have appreciated speaking with a spiritual care practitioner.

Spiritual care practitioners reported that despite the continued dominance of Christianity in the spiritual health care field, spiritual care workers provided support to non-Christian patients and families. While this participant sample had never received spiritual care during hospitalizations, spiritual care practitioners reported working across language barriers and religious differences - citing numerous examples of finding religious clergy to visit patients if there

was religious discordance. Spiritual care practitioners noted that gaps in spiritual care provision could be attributed to an inadequate number of spiritual care practitioners in health authorities; and when they are able to provide spiritual support, they struggle to be included as a part of the healthcare delivery team as they are often considered a non-essential service.

*... one thing I appreciate about [Catholic healthcare site] is the ratio of [spiritual care] staff to beds, it allows us to be more integrated into the care teams, so we're not just parachuted in ... but we're able to establish a trusting working relationship with staff ... the more exposure people get to spiritual health, the less prejudice there is, which is a one of those general truisms ... not all authorities have a history of well-trained staff, even prior to the spiritual health framework in BC ... (Diversity Worker Participant 08)*

Alongside the inadequate number of Spiritual Health Practitioners to serve substantial patient populations in British Columbia healthcare sites, there is also a lack of diversity in spiritual care. Out of the 30 Spiritual Health Practitioners (SHPs) interviewed, 25 identified Christianity as their religion. SHPs are required to complete Clinical Pastoral Education and hold a Master's degree in Theology. Locally, the University of British Columbia's Vancouver Theology School offers such a degree but continues to offer mostly Christian based courses. As SHPs are expected to *"be grounded in their own faith first"* (Diversity Worker Participant 48), they are expected to take university courses in their faith tradition. A non-Christian identified SHP reported:

*I had to take the 3 required courses in [my faith tradition] outside of Canada because there was nothing in Vancouver, or in any university in British Columbia that would adequately cover my requirements and I checked with my department, the university registrar, and other departments that may have these types of course offerings, and in the end, I did the*

*courses outside of Canada, and paid separate tuition fees at the other universities*

(Diversity Worker Participant 48)

Spiritual Health leadership is well aware of the need for mirroring the faith-based population in British Columbia, and have actively recruited non-Christian, qualified SHPs as noted by one Spiritual Health leader: *“if you want to have diverse staff, you have to be flexible, find ways of supporting them, advocating for them, and we need them, they are more representative of our population”* (Diversity Worker Participant 55).

SHPs (and leadership) reported that increased diversity of faith traditions in spiritual health delivery could also contribute to enhancing religious literacy particularly for end-of-life support. Punjabi Sikh Participant 08 felt highly criticized by healthcare staff prior to her spouse’s death: *“[my husband] was on life support, and I sat with him every day, and they would say to me, why are you making him suffer, you are being selfish, but I thought, maybe he may wake up, and I didn’t feel it was up to me to decide when he died but that is up to Waheguru<sup>141</sup>”*.

### **3. Advocacy Strategies**

#### **3.a. Patients’ Self Advocacy is Limited With Language Discordance**

Not having language concordance and fluency played a pivotal role in how patients could advocate for themselves— particularly when they felt that their medical needs were not being adequately addressed. These misalignments led to distressing consequences for patients and their family members including inaccurate diagnoses, deficient medical care, lack of at-home support, inadequate compensation for workplace injuries and driver’s licenses being suspended. In one case, the participant’s spouse fell taking public transit because of his awkward footing and

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<sup>141</sup> Waheguru is a Punjabi term commonly used in Sikh scripture and conversations to identify the Divine

the speed in which the bus moved when he was putting his wallet back into his pocket. The transit company asked him to visit their doctor as a part of their investigation, and subsequently the doctor filed a report that resulted in the participant's spouse losing his driver's license. The couple has lost mobility and independence: *"now the [adult children] must take us, before we could go on our own, but now, we can't even go to appointments or to social events on our own, and he has never had a car accident, his driving record is perfect"* (Punjabi Sikh Participant 7). Neither the participant or her spouse is fluent in English, and if an interpreter had been present, this misunderstanding could have been prevented. Currently, the adult children are seeking explanations and attempting to have their father medically assessed by the driver's license issuing authority as the couple cannot self-advocate given their language discordance.

In another case, a participant had reoccurring abdominal pain. She had seen her language concordant physician numerous times regarding this and a language discordant specialist, but they were not able to determine the reason for the pain. When the pain was unbearable, she would go to a local hospital's emergency department. On several occasions, they would monitor her for a few hours, provide pain medication through an IV and send her home again. During her 5<sup>th</sup> visit, she refused to go home:

*"I said 'I won't go', and they said, 'you have to leave', and I said, 'no, when I die, is that when you will take me seriously' and the nurse threatened to call my specialist and tell him I wouldn't leave, I said go ahead, call him, something is wrong with me and no one is figuring it out. My specialist came at 10 pm and said, after I do my surgery, I will have to do surgery on you too ... now it has been 2 years, and I have had no pain"* (Punjabi Sikh Participant 14)

Despite her language limitations, she was able to advocate for herself but this is not the case for every participant. One of the participants with adequate language proficiency was not able to successfully advocate for herself during discharge:

*“I help other women go to their doctor’s appointments ... I can speak enough English to talk to them, read it and write it ... but when I was being released from the hospital, they refused to listen to me, I told them, you can’t send me home, I live alone and my one son is in India, there is no one to take care of me, but they put me in a taxi and sent me home, it took me so long to walk up my own stairs ... I fell on the couch and did not move for 2 days ... I couldn’t reach the phone, I was in so much pain, after 2 days, I was finally able to get up, and call my friend, she came ...they helped me ... and got my medication, but the hospital did not care ... (Punjabi Sikh Participant 11)*

Long-standing diversity workers affirmed these experiences as they reported that language discordance often led to miscommunication. One solution to address language discordance in hospital settings is to have bilingual healthcare staff act as interpreters. Reliance on these staff to provide interpreter support is not ideal as healthcare providers have demanding and existing responsibilities associated with healthcare provision; and language concordant healthcare providers are not always available when needed. Coaching healthcare leadership to define interpreter support as an essential component to healthcare when language discordance presents, as well as training healthcare providers to work with interpreters and providing culturally safe care was identified as an important educational issue by diversity workers.

*I think we’re still at the very beginning stages of having a comprehensive, systematic, strategic approach to diversity, it has to begin with the ...professional healthcare*

*education system, and then it has to be reinforced in each of the different settings on how we actually do this ... we have to respect the individuality and identity and the dignity, and it's in the level of every communication that needs to take place...* (Diversity Worker Participant 29)

Diversity workers also highlighted that these communication tools could be quite simple: *"when we start hearing [patients] say ... could you at least slow down your speaking" or "could you try and find words that are not as complicated"* (Diversity Worker Participant 08); they are reminding healthcare staff that *"not everybody in the world is master's educated in English"* (Diversity Worker Participant 08) or fluent in medical jargon. Additionally, the notion of informed consent was questioned for not only patients with no or limited English, but for all patients:

*... if we were to talk seriously about informed consent, then just simply saying words in the presence of a person doesn't mean that they are informed, so how do we make sure that information is conveyed and understood? So, it's really sort of slowing down, checking assumptions ...* (Diversity Worker Participant 38)

Part of this "checking assumptions" entails critically evaluating if information is indeed being understood; when there is language discordance, it is unclear how assumptions are checked.

### **3.b. Presence of Family Members to Validate Good Care**

A key strategy employed by the participants was to have family members present during specialist appointments, emergency care and hospitalizations. On the advice of their primary care physician, Punjabi Sikh Participant 10 and their family always bring a family member to medical appointments and hospitalizations.



*“Our doctor said we should always bring in a family member, if they see that your family is taking good care of you, they will do it too, otherwise, they don’t have to, and who will know if they do or don’t, if you have someone there, they can see if the care is good or not. So we never leave our family members alone in the hospital, someone always stays with them. When my Papa Ji (father) was in the hospital, someone stayed by his side at all times, and he didn’t know English, so it was really important that we stayed with him”*  
(Punjabi Sikh Participant 10)

Another participant noted the same strategy when she was in a car accident and brought to the hospital via ambulance. She was living in a smaller rural community in northern British Columbia, and requested an interpreter as she was not able to effectively indicate what the pain felt like and where it was located. She simultaneously called her daughter (who had a newborn child) and who had to drive a substantial distance to get to the hospital. When the interpreter finally arrived, the interpreter did not speak Punjabi. Her daughter arrived shortly afterwards with a crying newborn and was able to interpret for her mother. The emergency care team was focused on her foot injury but the participant was also experiencing abdominal pain. After a great deal of advocacy from the daughter, the emergency physician finally attended to the abdominal pain and discovered a tumour that was immediately addressed. This participant noted that *“people who have advocates, get help, the rest don’t”* (Punjabi Sikh Participant 06).

After a distressing medical encounter 20 years ago, Punjabi Sikh Participant 05’s family consistently insisted on attending all future medical appointments. This participant was also admitted to the hospital after being in a car accident. Her injuries were not life threatening and she was conscious during the ambulance ride and during her emergency care. She was scheduled

for an emergency surgery but the participant was unclear what the surgery was for. Before the surgery occurred, the participant was transferred to another hospital without an explanation or being asked if she wanted to be transferred. She did not have a cell phone and was unable to immediately call her family; and she did not receive interpreter support. While language discordance further exacerbates the problems identified in this medical encounter, the Health Care and Care Facility Act clearly identifies that patients have the “right to be involved... in planning and decision making” as well as “giving or refusing consent to health care” (Health Care and Care Facility Act, 1996)<sup>142</sup>. Clearly there was no collaboration around planning this participant’s healthcare, and she was excluded from decision making and did not provide informed consent. The participant reported that her family’s presence during medical encounters has yielded better care. Notably, even those with English language proficiency felt having a family member present was useful as it illustrated that they had someone “*willing to talk on [their] behalf*” (Punjabi Sikh 10) and felt that this increased the quality of care they received.

## **Discussion**

Healthcare equity is premised on three key dimensions: availability of services, accessibility to services and acceptability of services (Mador, 2010). The existence of diversity programming and mandates (e.g. cultural competency policies, diversity programs, cultural safety training), provincially mandated spiritual care, professional medical interpreters, and cardiac rehabilitation programs reveal that these services are available. However, this group of participants were not asked about their cultural or religious needs; not offered spiritual care services; interpreter support was minimal to non-existent; post-surgery treatment and care plans were not

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<sup>142</sup> [https://www.bclaws.gov.bc.ca/civix/document/id/consol27/consol27/00\\_96181\\_01](https://www.bclaws.gov.bc.ca/civix/document/id/consol27/consol27/00_96181_01)

adequately communicated; and they were not offered information or referrals to cardiac rehabilitation programs. The findings clearly reveal that access to these equity-promoting services is compromised for this racialized community.

Research indicates that inequities persist for patients who do not speak the official language of a society. Those with little or no English language proficiency delay seeking healthcare (Browne, 2001); receive fewer interventions (Fields, Abraham, Gaughan, Haines & Hoehn, 2016) and fewer preventative services (Marshall, Wong, Haggerty & Levesque 2010). They are more likely to use emergency departments (Gallagher, Porter, Monuteaux & Stack, 2013), experience medical errors (Divi, Koss, Schmaltz et al, 2007) and report unmet medical needs (Marshall, Wong, Haggerty & Levesque (2010). They receive inadequate disease management information (Poureslami, Rootman, Doyle-Waters, Nimmon & Fitzgerald, 2011) which may partly explain their greater risk of adverse pharmaceutical reactions (Bowen, 2001). Further, these patients reported less trust in healthcare providers and healthcare systems (Haines & Hoehn, 2016); greater patient dissatisfaction (Gallagher, Porter, Monuteaux & Stack, 2013); poorer quality of care (de Moissac & Bowen, 2018; Pitkin Derosé, Escarce & Lurie, 2007); and identify concerns with patient safety (Pitkin Derosé, Escarce, Lurie, 2007). Without adequate interpreter support, delays in appropriate care often result in healthcare issues exacerbating into acute health issues (McKeary & Newbold, 2010).

Our findings echo this research- notably participants experienced unmet medical needs; did not receive support to access interventions and preventative services; experienced medical errors; and did not receive adequate disease management information. Language policy mandates are in place in British Columbia to support interpreter services to prevent adverse such

outcomes; yet our participant sample received little to no interpreter support. Similar to Karliner, Auerbach, Nápoles, Schillinger, Nickleach & Pérez-Stable's (2012) research with patients with low English proficiency, our participant sample did not receive necessary information regarding their medical status, treatment plans during discharge, and required family to interpret discharge information. We also observed that family members may not have adequate language proficiency in English to effectively interpret, as noted by other researchers (Abraham & Fiola, 2006).

Reliance on language concordant healthcare providers was common as the majority of participants sought out Punjabi speaking primary care physicians, and all the participants attended or planned on attending the Punjabi language cardiac rehabilitation program. Language concordance between healthcare providers and patients has shown greater patient satisfaction, less miscommunication and fewer errors, and better understanding of diagnosis and treatment plans (Ngo-Metzger, Sorkin, Phillips, Greenfield, Massagli, Clarridge & Kaplan, 2007). However, minority-language-speaking healthcare providers, who are commonly racialized, are frequently expected to provide immediate requests for interpretation (Patriksson, Nilsson & Wigert, 2022) in addition to their existing duties without relief or compensation. Instead of recognition for these additional contributions to healthcare teams, they contend with negative comments from patients, colleagues, and managers for speaking non-dominant languages (Ali & Johnson, 2017) and face various forms of racism including overt (Das Gupta, 2009; Scammell & Olumide, 2012; Reimer-Kirkham, 2003). Further, racialized healthcare providers are often assigned to racialized patients presumed to share ethnic ancestry even if they do not have language concordance while simultaneously contending with workplace racism. The extra work

of communicating across language barriers, providing unsupported impromptu interpretation without adequate training, and or providing culturally safe care is disproportionality shouldered by racialized healthcare providers.

Interpreters were not sought during language discordant medical encounters despite being readily accessible, the fact that hospital sites do not incur associated costs, and an abundance of research demonstrating health disparities can be lessened when language barriers are eliminated. Diversity workers connected this resistance to the critique that racialized, non-English speaking residents were not adequately assimilating into Canada with the frequently asked question: why can't they learn English. Reimer-Kirkham also found this line of questioning directed to racialized nurses (Kirkham, 2003). Similarly, De Moissac and Bowen (2017; 2019) narrated that healthcare providers held patients accountable for language barriers. Non-dominant language speakers were frequently identified as "difficult" and instructed to bring their own interpreters during follow-up medical appointments. Abraham and Fiola (2006) also identified attitudinal resistance to including interpreters with healthcare providers expressing their annoyance with those not able to speak English, and often encouraged these patients to take English language classes and purposefully provided less interpreter accommodations in examination rooms. Placing the onus on patients to facilitate communication across a language barrier shifts the responsibility of equitable healthcare communication from the healthcare system to individuals (who are often experiencing multiple vulnerabilities). The dominance of the English language and the rhetoric of "why can't they learn English" is premised on the ideology that English is the language of British Columbia's healthcare system. Foregrounding this rhetoric is Canada's colonial history whereby colonization privileged Europeans, their language, their

religion their ways of being and their ethos (Thobani, 2007); which catalyzed English to its current status as one of Canada's official languages and the language that is expected for the majority of Canadians to be proficient in. With this line of reasoning and historical legacy, limitations in accessing and receiving equitable healthcare due to language discordance becomes the fault of the patient for not learning English adequately. Failure to provide interpreter services and providing Punjabi language CVD documents when there is a need and ready access – should signal our healthcare systems to question their diversity commitments to ethical healthcare practices and the provision of healthcare equity.

Within Canada, a multi-cultural and multi-faith society, it is important that the healthcare system adopt religious literacy standards that include a comprehensive understanding of non-Christian religions. “[Religious] literacy is more than knowing facts or trivia about religion- it is a civic competency” and it is a “set of teachable skills ... that equip citizens with knowledge of how religion and spirituality inform everyday life” (Walker, Chan & McEver, 2021). Religious literacy offers opportunities to critically engage with religion and spirituality to “dispel stereotypes” and “counter gross generalizations” about how others practice their faiths (Walker, Chan & McEver, 2021); and offers healthcare providers an opportunity to assess they may explicitly or implicitly impose their beliefs or the beliefs of the dominant societal religion. In Canada, Christianity served as the dominant and preferred religion during nation building efforts and has contributed to the violent and genocidal colonization of Indigenous peoples. Over the last year, Canadians have witnessed the detection of children's unmarked graves around federally funded, Christian-run residential schools that were once designed to assimilate and Christianize Indigenous children by forcibly removing them from their families and communities. Additionally, since non-Christians

compromise only 10.4% of the Canadian population and 63.2% Canadians are affiliated with the Christian faith<sup>143</sup> (Cornelissen, 2021), Christian ideologies are still prominent. Further, when spiritual health practitioners are mostly affiliated with Christianity, spiritual health provision is embedded in a Christian framework. These ideologies are entrenched in our society, and influence the “political, economic, social and cultural spheres of our society” (Chan & Sitek, 2021); and how healthcare is experienced by those who are not Christian or have no religious affiliation. For those affiliated with racialized religions such as Sikhi, their outward identity markers such as wearing a khardaa (silver bracelet) or head coverings increase their visibility and subsequently, experiences of racism and cultural unsafety. Religious literacy supports healthcare systems and providers to be more responsive and incorporate basic information about sacred texts, major holidays, dietary restrictions and end of life customs (Chan & Sitek, 2021).

Our study highlights gaps in healthcare care provision and inaction in the context of demonstrated need. For racialized communities, these systemic inequities are linked to systemic racism, defined as “... embedded in the ethos of organization that readily ignore ... ethnoracial inequities and underscore the failure of ethnic groups to attain the values and practices of dominant society (Essed, 1991). Systemic racism positions any failures to access equitable healthcare as the fault of the racialized patient and their communities not the healthcare system. Equitable cardiac care is needed by this community as they face higher rates of cardiovascular disease; earlier age of onset; 3 to 5 fold increase of premature death resulting from a myocardial infarction; and greater risk of further coronary complications following a myocardial infarction when compared with European ancestry communities (Joshi et al, 2007; Sheth et al, 1999, Yusaf

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<sup>143</sup> <https://www150.statcan.gc.ca/n1/pub/75-006-x/2021001/article/00010-eng.htm>

et al, 2004,). Undoubtedly, the lack of culturally safe care and failure to provide services such as spiritual care reveal systemic inequities experienced by this racialized community; when patients cannot fully communicate and understand their diagnosis, treatments or care plans – there is a clear absence of patient centered care. When there is language discordance and no attempt to provide professional medical interpreter support or language concordant written information, racialized patients do not receive the life-saving and well-being promoting information they need. Cardiac rehabilitation programs have been well evidenced to improve quality of life (Yohannes, Doherty, Bundy & Yulfani, 2010); reduce hospital admissions (Dalal, Doherty & Taylor, 2015); and increase survival (Graham, Lac, Lee & Benton, 2019). Previous research demonstrates better outcomes for Punjabi ancestry CVD patients when they attend cardiac rehabilitation (Banerjee, Gupta & Singh, 2007; Galdas & Kang, 2010; Sriskantharajah & Kai, 2007). In the case of these patients, none of them were informed or referred to cardiac rehabilitation programs during discharge or by their cardiologists.

We were successful in recruiting 15 Punjabi Sikh CVD patients we set out to interview. While a larger patient participant sample may have bolstered our results, the prominent themes were experienced by the majority of participants and conceptual themes and patterns could easily be identified. The first author has worked extensively with the Punjabi Sikh community; and has noted that those born and raised in India prominently evaluate the healthcare they receive in Canada as far superior to the care they would have received in India; and often downplay any access issues. A comparison of how different racialized communities including European ancestry communities experience cardiac care, hospitalization, discharge and post-operative management would provide further insight on systemic barriers to receiving care.



Returning to our guiding question: “how do racialized patients experience equitable healthcare commitments in the province of British Columbia?”, our findings reveal considerable gaps in the provision of equal and equitable healthcare for racialized communities demonstrating a consistent pattern of systemic racism. Without operationalizing the entwined principles of anti-racism and cultural safety, health care inequities will continue in the forms reported by our study: absence of service provision to racialized communities despite the existence of such services and programming. With over 7 million Canadians identifying as racialized (Canadian Census, 2016<sup>144</sup>) and future estimates that by 2031, 29-31%<sup>145</sup> of the Canadian population will identify as racialized (Statistics Canada, 2018), it is more than evident that British Columbia’s healthcare system will continue to serve an ethnically diverse patient population. At minimum, moving from rhetoric to permanently embedding health equity for racialized communities into our healthcare system would require a holistic and sustainable implementation of anti-racism philosophy – operationalized throughout every layer of the healthcare system – from auxiliary services (e.g. custodians, security, receptionists, accounting) to healthcare provision (e.g. paramedics, music therapists, spiritual care practitioners, nurses, physicians) and healthcare decision makers (e.g. policy makers, directors and politicians). Well-positioned to be leaders in healthcare equity, British Columbia’s healthcare organizations have an opportunity to acknowledge, respond and adopt anti-racism and cultural safety as a means of transforming into equity-oriented healthcare systems.

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<sup>144</sup> <https://www12.statcan.gc.ca/census-recensement/2016/as-sa/fogs-spg/Facts-can-eng.cfm?Lang=Eng&GK=CAN&GC=01&TOPIC=7> We have utilized racialized communities instead of the term used in the Canadian census: visible minorities as Canada’s continued use of this contested term to identify non-European racialized communities is not widely recognized.

<sup>145</sup> <https://www150.statcan.gc.ca/n1/pub/11-402-x/2011000/chap/imm/imm-eng.htm>

## Chapter 6: Conclusion

This concluding chapter revisits my personal entry point into this research project; summarizes the key findings from all three phases of my doctoral research study: *Sadhee Sehyath: Our Health Project*; and concludes with recommendations.

I entered this doctoral journey acutely cognizant of the ubiquitous presence of racism for racialized people like myself; I have and continue to feel the sting of racist words, behaviours, actions, processes and structures. The subsequent harm to my body, mind and spirit is a reality I must negotiate daily; a reality that is often minimized or silenced by the broader Canadian society I live amongst. I have directly witnessed problematic medical encounters, and amazingly safe medical encounters. With my assortment of privileges including English language fluency, education and citizenship, I have a high level of capacity to self-advocate and advocate for my loved ones. At the intersection of healthcare and research, I was hopeful to find a willingness to be anti-racist. I had hoped our healthcare and research systems would employ people who would be willing to eagerly enter anti-racism praxis so that we have equitable systems focused on acknowledging and subsequently eradicating racism. The Canadian healthcare system is publicly funded to provide reasonable healthcare access to all Canadian residents, and in doing so, it is the people's healthcare system. I chose to title this dissertation to include the Punjabi term: *Sadhee Sehayth* as it reflects the language of the Punjabi Sikh Diaspora participants who generously contributed to this study, and the language I was born into. *Sadhee* translates to 'our' and *Sehayth* translates to 'health'. In ideology, Canada's universal healthcare system is positioned to improving 'our health'.

This doctoral research study was developed to understand how one Canadian province (with an ethnically diverse population<sup>146</sup>) addresses racism in its health authorities. I specifically sought to understand how anti-racism and cultural safety are articulated and performed through institutional identities including institutional documents and websites; how anti-racist programming is taken up to establish a safe and equitable healthcare processes; and how anti-racist policies and programs are experienced by a long-standing racialized community: Punjabi ancestry Sikh affiliated British Columbians. What we found: 1. none of the 6 frontline health authorities included equity oriented and anti-racism language in their institutional discourse (i.e., mission statements, vision and values); 2. formal diversity programming was negligible in health authorities but a substantial number of healthcare staff provided diversity programming informally without adequate institutional support or resources; 3. Punjabi Ancestry Sikh affiliated patients living with cardiovascular disease reported almost no offers for diversity, spiritual or language support despite recent hospitalizations for serious cardiac treatments. In other words, health authorities did not commit to anti-racism and cultural safety in their institutional identity discourse; nor did they provide adequate and sustainable anti-racism and cultural safety training, support and resources for healthcare staff and patients; and subsequently, patients from one racialized community did not receive adequate language, spiritual and cultural safety support during their hospitalizations. While most health authorities had diversity policies, a majority of informal diversity workers did not know about such policies nor were the policies publicly

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<sup>146</sup> The Canadian census uses the term visible minority to identify non-Indigenous and non-European racialized communities; however, the term 'visible minority' is contested by critical race scholars for removing the notion of race but simultaneously creating a sense of hyper visibility with the use of 'visible' for racialized communities who continue to contend with racism and are racialized. I will use the term racialized people/communities to identify People of Colour and Black People to acknowledge the racializing processes they experience.

accessible for patients and families to access and use for advocacy. Indigenous liaisons (who only worked with Indigenous patients) often used these policies to advocate for their clients; but no other racialized communities had liaisons.

Patient safety offices have been provincially mandated in all health authorities to address patient and family complaints, but staff do not receive training to identify systemic racism or implicit bias complaints. Even when there is an explicit complaint filed, patients' complaints are often dismissed (Crosbie, McDougall, Pangli, Abu-Laban & Calder, 2022; Gallagher and Mazor, 2016); and subsequently patients are dissatisfied by the complaint process and the outcome (Daniel, Burn & Horarlk, 1999; Kee, Khoo, Lim & Koh, 2018; O'Dowd, Lydon, Lambe, Rudland, Hilton & O'Connor, 2021; Martin, Chew & Dixon-Woods, 2021; Truong, Allen, Chan & Paradies, 2021). Even when patient safety staff address a complaint, solutions can be limited to addressing the immediate issue (e.g. a healthcare worker apologizing for their communication) and or providing a unit with education (e.g. re-education on how to test epidural blocks or delivering a workshop on *Providing Diversity Care to People of the Sikh Faith*<sup>147</sup> or *Muslim Faith*<sup>148</sup>). As noted by Canadian researchers: Liu and colleagues, the intent of improving healthcare provision can be lost when "most complaints do not reach an organizational level where they could be analyzed more systemically and addressed proactively" (Liu, Rotteau, Bell, & Shojania, 2018, p.5).

As encouraging as it was to see a substantial amount of informal diversity work being done by healthcare staff, it is clear that this work serves to temporarily address gaps in health

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<sup>147</sup> <https://www.fraserhealth.ca/-/media/Project/FraserHealth/FraserHealth/Health-Professionals/Professionals-Resources/Diversity-Services/Providing-Diversity-Competent-Care-Sikh.pdf?rev=d05290b5fe814648bd7c2e618fa6eaa3>

<sup>148</sup> <https://www.fraserhealth.ca/-/media/Project/FraserHealth/FraserHealth/Health-Professionals/Professionals-Resources/Diversity-Services/201609ProvidingDiverseCaretoMuslimClients.pdf?rev=ca670de6a55c4e79b59704db0ea6e217>

authorities as superficial appearances of action. This advocacy-oriented work is liminal as it is reliant on a few staff members who facilitate diversity training and support “off the sides of their desks” and is not a part of their paid, institutional work. Even those who hold formal diversity roles, face precarity as diversity programs in healthcare settings are minimally supported. There is limited sustainable institutional commitment to anti-racism and cultural safety in British Columbia’s health authorities; therefore, it is no surprise that this one racialized community did not receive any diversity support during their hospitalizations.

This lack of commitment to anti-racism has often been linked with popularized notions that there is no racism in Canada, or that Canada is a multicultural country that embraces everyone or that Canada is beyond race. However, a recent coroner’s report identified the death of a 37-year-old Indigenous woman: Joyce Echaquan (hospitalized for severe gastric pain) to have been the result of systemic racism. The mother of 7 children recorded hospital staff verbally hurling their racist views including “you are as stupid as hell”; “she is only good for sex”; and “are you done acting stupid yet” while Ms. Echaquan is seen and heard screaming from gastric pain. Staff had assumed she was a drug addict and did not provide care for her serious health condition as evidenced by the live feed video Ms. Echaquan shared on Facebook before her untimely death when staff stated: “you made some bad choices” and that she was a “drain on the health system”<sup>149</sup>. This neglect subsequently led to her death. Another nurse testified that she heard the care team state “now that she is dead, we will finally have peace”. It was clear to the coroner that there was a failure to provide necessary life-saving treatment to Ms. Echaquan by healthcare

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<sup>149</sup> <https://globalnews.ca/news/8243732/quebec-coroner-systemic-racism-joyce-echaquan/>  
<https://www.theglobeandmail.com/canada/article-indigenous-woman-records-slurs-taunts-of-quebec-hospital-staff-before/>

staff. *Canadian Health Care Policy* clearly identifies that Canada's public healthcare system serves to "protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers" (Canada Health Act, 1985)<sup>150</sup>. Unmistakably, Ms Echaquan faced racist barriers to reasonable access to health services, and healthcare providers did not protect, promote and restore her physical and mental well-being. The coroner's recommendations included "recognize the existence of systemic racism within our institutions and make a commitment to contribute to its elimination". Instead of embracing this recommendation, Premier Francois Legault refuted claims that there is systemic racism in Quebec but stated: "I am capable to say that what happened to Ms. Echaquan is terrible, and a few employees, not only one, a few employees didn't deliver the right services to her and it is unacceptable" and agreed that "we have to admit there is some racism in Quebec" but "it is not as worse as some places [like] in the United States".

Arguing against the finding of systemic racism tabled by Coroner Gehane Kamel, the Premier denied that Canada has a deeply rooted racism problem that impacts an array of societal spaces and creates inequitable circumstances and often dangerous outcomes for racialized peoples. Denying the existence of systemic racism and minimizing it to suggest that it was a "few employees" applies the "bad apples" argument whereby a few individuals are the problem but not the broader healthcare system or society. As a nation state, Canada is established and built on the theft, oppression and genocide of Indigenous peoples. With widespread claims of terra nullus (empty lands) (Alfred, 2009; Coulthard, 2009; Thobani, 2007) and the strategic application of evolutionary theory whereby Europeans were and are seen as superior to other ancestral

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<sup>150</sup> <https://laws-lois.justice.gc.ca/eng/acts/c-6/page-1.html>

communities including Indigenous peoples, colonization followed a systematic process involving but not limited to rape, pillage, purposeful spreading of disease (biological warfare), murder, mutilation, and forced removal of children (e.g., residential school system and contemporary child welfare systems that disproportionately remove Indigenous children) to disrupt the continuity of Indigenous languages, spiritualities, cultures, beliefs, family structures and bonds and ways of life. Although the desired settlers to Canada were to have European ancestry, Chinese, Japanese and Indian ancestry men were permitted precarious entry and residencies to support early nation building efforts with clear demarcations regarding who had legal rights to be Canadian and who didn't. While racialized peoples have migrated alongside Europeans and many hold the same legal rights today, the legacy of who is perceived to be Canadian persists with racialized Canadians still being asked questions of "where are you from?" or "where are you really from?" despite being here for generations like Europeans immigrants.

These systems of oppression, as identified in Joe Feagin's theory of Systemic Racism, are purposefully erected to provide political, social and economic power to those of European Ancestry (Feagin, 2006). In colonizing, establishing, and maintaining the Canadian nation state, critical race feminist scholar, Sunera Thobani, aptly identifies the transformation of White colonizers into Canada's *exalted subjects* (Thobani, 2007) positioning Indigenous, Black and People of Colour communities as inferior. The power and privilege tendentiously granted to European Ancestry Canadians is safeguarded by long-standing institutionalized practices whereby the majority of European Ancestry Canadians are better able to access quality education, secure adequate employment, timely and appropriate healthcare, safe housing and food security. How is it that some of us can clearly see that an individual's social gradient status

can broker health prevention and promotion capacities, as well as impact healthcare access and subsequently health in/equity as we have witnessed in the case of Ms Echaquan? And others, such as Quebec's Premier, see it only as "terrible" and a peripheral issue confined to a few problematic individuals? In this case, the Premier's denial is one way to safeguard existing privileges and not challenge existing systemic racism.

Conceding to the existence of racism in all its form and accepting that it "is structured into the rhythms of everyday life" and "it is lived, concrete, advantageous for whites, and painful for those who are not white" impacting "every part of the life cycle, and most aspects of one's life" (Feagin, 2001, p. 2) is the imperative first step in undoing racism. As many diversity workers noted, saying the word racism, or alluding to the existence of racism was discouraged and often ended conversations. Instead of a serving as a starting point, acknowledging the existence of racism thwarted conversations meant to encourage acceptance, inclusion, equity and cultural safety for diversity work. Systems that continue to be overseen and controlled by those who are privileged by racism and or those who have absorbed (implicitly or explicitly including internalized racism) dominant racist ideologies are not structured to challenge systemic racism. Those who work in such systems are hard pressed to see and hear racism, and often limit acknowledging racism even when it is overt or caught on video; as seen by Quebec's Premier Legault's response to the coroner's report regarding Ms. Echaquan. Additionally, to withstand racist systems, racialized people are often silent or minimize racism to survive these systems; and to limit further trauma.

If Ms. Echaquan did not live feed that video on Facebook, would there have been an investigation? And if there had been, would healthcare providers have admitted to their words



and behaviours without video evidence? How do we assess for systemic and institutionalized forms of racism, particularly when there are no overt racist words or slurs caught on recordings? Expanding the study of racism particularly in how it can be identified in systemic and institutionalized systems is key to addressing the harms of systemic racism. “This expansion should include under-studied forms of racism, their intersections, and integration of data systems ... and [only] through such an expansion might we see below the tip of the iceberg and effectively change the course of health disparities” (Gee & Ford, 2015, p. 14). In British Columbia, there have been numerous calls to collect race-based data particularly during the Covid-19 pandemic. British Columbia’s Office of the Human Rights Commissioner was called by BC’s Premier, John Horgan, “to provide recommendations on how to collect, store, use and disclose disaggregated data in a way that furthers the aim of substantive social equality without reinforcing marginalization” (BC Human Rights Commission, 2020, p. 6). Recommendations included implementing a decolonizing and human rights-based approach to data collection with the need for data sovereignty. The report also highlighted the historical and contemporary impact on structurally oppressed communities when data is collected and “used as a tool for control and surveillance, leading to further stigma and marginalization” (BC Human Rights Commission, 2020, p. 35) as well as reinforcing deficit narratives that structurally oppressed communities are “less than, different than, not engaged in” and less able to decide for themselves (Heather Walkus, quoted in Human Rights Commission, 2020, p. 43). Again and again, the report cites community voices advocating for disaggregated data to be utilized as a tool to measure racism (Gwen Phillips, quoted in BC Human Right commission, 2020, p. 24) - shifting the focus away from individual failures towards systems failure for “the purpose of reducing systemic racism and oppression,

and achieving equity” (p. 23). To support the recommendation of developing a process, standards, teams and governing committees to contend with racism (BC Human Rights Commission), Premier Horgan has appointed Rachna Singh, Parliamentary Secretary for Anti-Racism Initiatives, to engage with Indigenous, Black and People of Colour (IBPOC) communities so that the proposed anti-racism data legislation meets their needs and “does not exacerbate existing systemic issues” (Rachna Singh, 2021<sup>151</sup>).

The collection of disaggregated data will provide numbers that can evidence systemic racism but racialized communities also face “everyday racism” which includes implicit bias, micro aggressions, explicit statements, racist practices and behaviours, hate crimes, racial segregation, and purposeful and implicit exclusion from social, economic, political, educational and well-being opportunities. While racism is often executed by individuals, it is backed by a system established to reward individuals belonging to socially constructed, dominant racial groups and to penalize those who are perceived to belong to non-dominant racialized communities. Dismantling racialized hierarchies to create more equitable societies requires a holistic systemic shift by people who can not only see, hear and acknowledge racism but also will enact change. The burden to see, hear, acknowledge, learn about racism and advocate for equity, anti-racism, cultural safety and justice should not fall solely on the shoulders of marginalized, racialized individuals or communities; this is a societal matter that requires all of us. Learning and actually applying antiracism principles into actionable processes is foundational to eradicating these avoidable inequities such as pointing out racist policies and practices in institutions; embedding anti-racism into the organizational culture and identity not only enables the institution to breathe

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<sup>151</sup> <https://news.gov.bc.ca/releases/2021AG0128-001732>

equity into institutional life; it also affirms the importance of this to individuals interacting with institutions; ensuring all staff and institutional partners are trained in anti-racism, cultural safety principles and required to put this learning into their everyday interactions and practice; allocating adequate, permanent and sustainable resources to do anti-racism organizational work by people who are aware and able to apply critical race principles; when complaints are filed that allude to racism and or explicitly name it, these are forwarded to a specialized review board who can honour and implement intersectional, anti-racism, critical race, and cultural safety theories and practices; and when people (including staff), key stakeholders and businesses have views and values that are antithetical to promoting equity, there needs to be policies in place to recognize this, reconcile<sup>152</sup> if possible; terminate employment or stakeholder relationships if not possible.

This research project illuminates resistance to anti-racism uptake. When anti-racism is absent from institutional identity, it is not a focal point for health authorities to address. Providing token diversity resources has been a frequently employed tactic as it simultaneously suggests that the institution is doing something but without adequate staffing, budgets, programming, and uptake – it doesn't actually combat racism or change the culture of the institution to be safer, equitable, culturally safe and above all anti-racist. When there was a clear lack of commitment to the anti-racism, it is not surprising that racialized patients did not receive needed and readily available language support or spiritual care support or inquiries by healthcare providers on how provide culturally safe care. It is notable that in the absence of language

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<sup>152</sup> I use reconcile to acknowledge the necessity of working with people and organizations to advocate for equity building practices and policies. Sometimes people are unaware of the harms they are individually doing or how an organization's policies, practices and culture are unsafe, harmful and inequitable. Acknowledging and working with people to shift their understanding is paramount to shifting societal culture and equity building.

concordance, essential medical information can be missed - jeopardizing necessary care and treatment.

### **Future Research**

While beyond the scope of this investigation, an analysis of institutional identity discourse: mission statements, values and visions of public healthcare organizations throughout Canada would illuminate how various provinces take up equity, particularly for Indigenous and racialized communities. Further, how diversity programming and spiritual health care is facilitated in different regions across Canada could inform a professional standard for anti-racism, cultural safety, religious literacy and equity programming for all Canadian public healthcare sites. Observational data would have bolstered my understanding of what diversity and spiritual health labour looked like in action and may have identified further obstacles and also the strategies employed by diversity workers, spiritual health and patients. Interviewing diversity workers and spiritual health staff who were terminated from their roles would have advanced my understanding of tactics used by healthcare leadership to maintain the status quo and limit the advancement of anti-racism and equity in healthcare settings. As noted in chapter 5, interviewing a larger patient sample would have bolstered our results but also interviewing different well-established racialized communities would have highlighted how racism unfolds with different communities. Further, observing Punjabi Sikh patients receiving care would have provided a richer analysis as this community is often reluctant to complain about their healthcare especially experiences of racism. As noted earlier in the dissertation, the Punjabi Sikh community has been targeted with state led violence, numerous injustices and do not have equal rights in India. Canada has provided safe harbour for many Punjabi Sikhs, and far better healthcare access

than India. Many of my Elders have reminded me that the overt racism my ancestors faced during their migration/uninvited settlement was far more challenging to negotiate. Current experiences of racism, while harmful, are often more subtle. There is also trauma in telling and re-telling racist experiences and observational data allows those experiences to be evidenced without traumatizing racialized individuals. Another tangent to explore in future research is to understand how racialized Canadians born in Canada experience healthcare, as well as how Punjabi Sikh healthcare providers experience workplace racism.

### **Recommendations**

The findings of this 3-phased-research project unmistakably reveal that anti-racism is not embraced in theory or practice by British Columbia's health authorities. We have gathered and identified the following specific recommendations in the hopes of moving towards equitable and safer healthcare systems for all:

1. Healthcare authorities and their associated delivery sites should state their anti-racism commitments in their institutional identity: mission statements, values, and visions. All health authorities should have cultural safety, equity, anti-racism policies that explicitly address racism and how to promote anti-racism.
2. Healthcare authorities and their associated sites should have adequately staffed and supported diversity programs that feature anti-racism, religious literacy and cultural safety education; hire diversity staff fluent in critical race, anti-oppressive, anti-racism and cultural safety understanding; directly address patient and family concerns and complaints about racism or cultural safety; address racism complaints from racialized healthcare staff and provide system wide supports to address workplace racism; develop

the role of diversity advocates including patient navigators who support racialized patients and families to gain equitable access to healthcare services such as interpreter services; include diversity directors at organizational meetings to ensure that diversity is incorporated into organizational decisions; develop and maintain an accessible brick and mortar diversity office whereby patients, families and staff can meet with diversity personnel; and develop and maintain a publicly accessible online resource with diversity policies, commitments, advocacy resources, and educational offerings. New staff members should receive mandatory anti-racism and cultural safety training a part of their orientation. Existing staff should be provided with this training as a part of their professional development training every 5 years. While many may argue that the uptake of the *San'yas Anti-Racism Indigenous Cultural Safety Training Program*<sup>153</sup> with 156,000 BC residents partaking in the program (Browne, Varcoe & Ward, 2021) signals progress towards anti-racism for Indigenous communities; it is not a mandatory program for health authority staff. Four of British Columbia's health authorities<sup>154</sup> and the Ministry of Health support their staff in participating in the *San'yas* program by paying the registration fees. Mandating the completion of the *San'yas* training program alongside broader anti-racism educational interventions would advance an anti-racism ethos in British Columbia's health system.

3. Increase the number of spiritual health practitioners in each health authority and require diversification of who provides spiritual health care to improve religious literacy and

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<sup>153</sup> <https://sanyas.ca/home>

<sup>154</sup> Provincial Health Services Authority, Interior Health Authority, Fraser Health Authority and Vancouver Island Health Authority will pay the registration fees for their staff.

challenge the dominance of Christianity in spiritual care. This will involve theological schools expanding their course offerings to include Indigenous spiritualities and other world religions.

4. Mandate interpreter services as an essential component to the medical encounter when language discordance is featured. Patients and families should be informed that interpreter services are readily available and encouraged to access interpreters when language discordance presents. New healthcare staff should receive mandatory training on existing language access policies and provide practical education on how to work with interpreters. Existing staff should receive this same training to support their professional development.
5. Diversity audits should be done to ensure that all patients are able to access services such as spiritual care; and if inequities are revealed, systemic change is funded, supported, and implemented to ensure equitable access for all patient communities.
6. Actively seek and support racialized patient feedback to assess gaps in healthcare service and ensure racialized patient experiences and voices are incorporated to improve health equity in British Columbia.

Alongside these specific recommendations, provincial and national commitments are needed to “dismantle the “racial structure” of society ... [this] means that the practices responsible for social, economic, political, and cultural domination must be extirpated from society and we must work toward the development of a new, non-racist, multicultural culture” (Bonilla-Silva, 2022, p. 246).

## Conclusion

While many may argue that we have made progress through numerous routes of advocacy, there continues to be a great deal of “lip service” as “individuals, organizations and institutions are far more committed (at a subconscious level) to maintaining the status quo” (Henry, Tator, Mattis & Rees, 1998) than to anti-racism. Even with the appearance of public uptake of various anti-racism movements led by Black, Indigenous and People of Colour communities including *Black Lives Matter*, *Missing and Murdered Indigenous Women and Girls* and *Every Child Matters* substantial change towards anti-racism is absent. Appropriate steps have been taken by BC College of Nurses and Midwives and the College of Physicians and Surgeons in BC in response to the *In Plain Sight* report (Turpel-Lafond, 2020) such as their public apology acknowledging the harm Indigenous communities have faced at the hands of those they regulate: nurses, midwives, physicians and surgeons are developing a professional practice standard to address anti-Indigenous racism: Indigenous Cultural Safety, Cultural Humility and Anti-Racism. Irrefutably, it is imperative to name anti-Indigenous racism, acknowledge the historical and contemporary harms Indigenous peoples have and continue to experience, and to earnestly commit and act to eradicate the genocidal, violent racism Indigenous peoples have experienced for time immemorial; however, there should also be a practice standard that supports culturally safe, anti-racist care for all racialized people, and those who face intersecting oppressions. Oppression in any form is harmful and perpetuates inequities. Numerous types of discourse are employed to resist anti-racism uptake including the discourse of denial, decontextualization, colour blindness, blame the victim, binary polarization, balkanization, tolerance, tradition and universalism and political correctness (Henry, Tator, Mattis & Rees, 1998). It is my hope that



these steps continue to progress forward, and those who have fought diligently for equity, anti-racism and cultural safety witness positive, sustainable and transformative changes in their lifetime. In solidarity with many communities including Indigenous, Black and People of Colour – it is time to work towards anti-racism and equity through sustainable actions and a holistic, serious commitment by all societal organizations.

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