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# “They treated me like crap and I know it was because I was Native”: The healthcare experiences of Aboriginal peoples living in Vancouver's inner city

Ashley Goodman<sup>a</sup>, Kim Fleming<sup>a</sup>, Nicole Markwick<sup>a</sup>, Tracey Morrison<sup>b</sup>,  
Louise Lagimodiere<sup>b</sup>, Thomas Kerr<sup>a, c, \*</sup>, Western Aboriginal Harm Reduction Society

<sup>a</sup> British Columbia Centre for Excellence in HIV/AIDS, Vancouver, British Columbia, Canada

<sup>b</sup> Western Aboriginal Harm Reduction Society, Vancouver, British Columbia, Canada

<sup>c</sup> Faculty of Medicine, University of British Columbia, Vancouver, British Columbia, Canada

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## ABSTRACT

There is growing evidence that Aboriginal peoples often experience healthcare inequalities due to racism. However, research exploring the healthcare experiences of Aboriginal peoples who use illicit substances is limited, and research rarely accounts for how multiple accounts of stigma intersect and contribute to the experiences of marginalized populations. Our research aimed to explore the healthcare experiences of Aboriginal peoples who use illicit drugs and/or illicit alcohol (APWUID/A) living in Vancouver's inner city. Using Indigenous methodologies, a community research team comprised of APWUID/A led the study design, data collection and analysis. Peer-facilitated talking circles explored community members' experiences accessing healthcare services and patient-provider encounters. Using an intersectionality framework, our research demonstrated how healthcare inequalities among Aboriginal peoples are perpetuated by systemic racism and discrimination. Stigmatizing racial stereotypes were perceived to negatively influence individual attitudes and clinical practice. Participants' experiences of medical dismissal often resulted in disengagement from care or delay in care. The findings suggest healthcare providers must understand the structural and historical forces that influence racial disparities in healthcare and personal attitudes in clinical practice. Adequate clinical protocols for pain management within the context of illicit substance use are urgently needed. The valuation of Aboriginal peoples and cultures within healthcare is paramount to addressing the health gap between Aboriginal and non-Aboriginal Canadians.

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## 1. Introduction

Significant disparities in health and access to healthcare persist in a range of settings globally regardless of levels of income or development (Beiser and Stewart, 2005; Boutain, 2005). This is true of Canada, which despite being praised for its universal healthcare system, still fails in meeting the healthcare needs of many of its most vulnerable citizens. Such inequalities in care are concerning given healthcare access is an important determinant of health status (Marmot et al., 2008).

Studies have revealed that access to healthcare, including ability to obtain required services and quality of care delivered, is not equal across populations; for example, marginalized groups such as racial and ethnic minorities, substance users, the homeless, and the poor have less access to and utilization of healthcare services (Knowlton et al., 2001; Chitwood et al., 1999, 2001). Due to an overburden of health and social disparities (Adelson, 2005; Reading and Wien, 2009; Frohlich et al., 2006; MacMillan et al., 1996; Allard et al., 2004), Canada's Aboriginal groups, who refer to the Indigenous people of Canada including First Nations, Métis, and Inuit peoples, represent a population that is particularly vulnerable to healthcare inequities (Adelson, 2005). Aboriginal peoples experience significant disparities in health status, morbidity and mortality rates, and healthcare access compared to their non-Aboriginal counterparts (Adelson, 2005; MacMillan et al., 1996; Shah et al.,

\* Corresponding author. British Columbia Centre for Excellence in HIV/AIDS, Vancouver, British Columbia, Canada.

E-mail address: [uhri-tk@cfenet.ubc.ca](mailto:uhri-tk@cfenet.ubc.ca) (T. Kerr).

2003; Waldram et al., 2006; Marrett and Chaudhry, 2003). Moreover, these inequities are not evenly distributed within the Aboriginal population with urban populations experiencing greater disparities than those living on-reserve (Tjepkema, 2002; Young, 2003). With comparatively higher rates of homelessness, suicide, tuberculosis, HIV/AIDS, and diabetes, and an increased risk of substance abuse (Public Health Agency of Canada, 2014), urban Aboriginal peoples are likely to experience immense vulnerability to health-related harms. This is of concern for two reasons: firstly, off-reserve communities are of the largest and fastest growing Aboriginal communities in Canada with more than half of the total Aboriginal population living in urban areas (Statistics Canada, 2011); and secondly, improved access to healthcare is one of many reasons why Aboriginal peoples choose to relocate to urban centres (Peters and Newhouse, 2003).

Vancouver is home to the largest urban Aboriginal population in British Columbia, as well as Canada's poorest urban postal code – the Downtown Eastside (DTES) (Cardinal and Adin, 2005). The DTES is a neighbourhood characterized by high rates of poverty, homelessness, substance use, mental health issues, and violence, as well as immense social and economic marginalization (Webb et al., 2010; Kazempour and Halli, 2000; Miller et al., 2002; Spittal et al., 2002; Wood and Kerr, 2006; Shannon et al., 2008). Such chronic inequalities can be understood as a manifestation of “multiple historical and interlocking mechanisms of poverty and exclusion” (Schatz, 2010), which are revealed in the overrepresentation of Aboriginal peoples in the DTES with at least one-third of the city's total Aboriginal population residing in or near the impoverished area (Cardinal and Adin, 2005). For Aboriginal peoples, these mechanics are controlled and maintained by ongoing colonial processes inherently racist by nature. These grave inequities signal the ways in which the colonial legacy has perpetuated the devaluation of Aboriginal peoples as Canadian citizens, undeserving of equal human rights.

The Canadian Health Act stipulates that all citizens should have access to timely and medically necessary care based on need rather than income (Health Canada, 2012). Access to appropriate healthcare services is essential to addressing the health disparities facing Aboriginal peoples (Adelson, 2005). For Aboriginal peoples, access to healthcare is not only defined by physical access, but is mediated by wider social and historical contexts, and clinical practice (O'Neil, 1989; Browne, 1995; Cameron et al., 2014a). Mainstream healthcare services, medical services relying on western medicine and conventional public health approaches, tend not to address the social and economic determinants that greatly affect individual health, and rarely do services accommodate for cultural differences. Without understanding the social and historical contexts of the current health status of Aboriginal peoples, racialized stereotypes (e.g., ‘drunken Indian’) prevail. Internalizing negative assumptions about Aboriginal peoples has allowed for systemic racism and discrimination to permeate many facets of society, including the healthcare system (Elliott and de Leeuw, 2009).

In the emerging literature, racism and stigmatization are identified as being at the forefront of Aboriginal peoples' healthcare experiences (Browne and Fiske, 2001; Browne et al., 2011; Anne Van Herk et al., 2011). Much of the current research focuses on First Nations, and in particular First Nations women (Elliott and de Leeuw, 2009; Browne et al., 2011; Benoit et al., 2003; Fiske and Browne, 2006; Denison et al., 2014), while primarily examining hospital care (Shah et al., 2003; Wood and Kerr, 2006; Browne and Fiske, 2001). In doing so, there is limited understanding of encounters with other actors within the healthcare system and alternate important points of care such as general physicians, walk-in clinics, medical laboratories, and pharmacies, and the experiences of the Métis and Inuit or those who identify more broadly

under the Aboriginal umbrella.

Despite the mass evidence of Aboriginal health disparities and the growing indication of healthcare inequalities in North America, and among other colonized Indigenous groups (e.g., Australia and New Zealand) (Marrone, 2007), research exploring the healthcare experiences of Indigenous peoples who use illicit substances is limited. Furthermore, to the best of our knowledge, no other group of Indigenous peoples who use substances has ever executed a similar study as the one presented here. As is being increasingly recognized, it is important to understand how multiple accounts of stigma (e.g., illicit substance use, homelessness, poverty) intersect and contribute to the experiences of marginalized populations. As Bowleg (2012) notes, such intersecting social identities are typically examined as independent systems opposed to interlocking mechanisms that work together to shape individual health, and policy and research often do not acknowledge “how the intersection of multiple interlocking identities at the micro level reflects multiple and interlocking structural-level inequality at the macro-levels of society” (p. 1267). This is a pressing issue given the immense disparities affecting Aboriginal peoples. The dearth of public health research that uses intersectionality as a framework may partially account for why efforts to address these appalling health and social inequities have failed. Using an intersectionality framework, this article seeks to explore how multiple forms of discrimination and oppression shape the healthcare experiences of Aboriginal peoples living in a marginalized community.

## 2. Method

In response to a critique of the appropriateness of traditional research methods typically used in the DTES, the Western Aboriginal Harm Reduction Society (WAHRS) partnered with the British Columbia Centre for Excellence in HIV/AIDS (BC-CfE) to conduct the research presented here. WAHRS is an Aboriginal organization who represent Aboriginal peoples who use illicit drugs and or illicit alcohol (APWUID/A), current and former users, dedicated to harm reduction. Illicit alcohol is defined as alcohol that is not intended for human consumption (e.g., mouthwash) or is illegally produced (e.g., homemade alcohol). In an effort to further counter the historical power imbalance between research institutions and community partners, the community organization determined the research topics, the methods used, and led all data collection and analysis using approaches that drew upon Indigenous ways of knowing and sharing. The BC-CfE researchers provided academic and research support, which included a designated research coordinator for the project.

Talking circles were chosen as a culturally appropriate research method, and represent a common form of intragroup communication among many North American Indigenous groups and are intended for collaborative learning and decision-making (Hodge et al., 1996; Strickland, 1999). A total of three talking circles took place in the DTES at the Vancouver Area Network of Drug Users, each averaging 60 min in length. Convenience sampling was used to recruit participants, which was undertaken during the organizations' weekly membership meetings. During the meetings, members were invited to participate in the talking circles. As each talking circle was limited to ten participants, the names of those who were interested in participating were entered into a draw to be selected. This selection process is an approach adopted by the organization regularly to provide equal opportunity to their membership for involvement in research and various other activities, and was employed in this research to accommodate the group's regular practices and avoid intragroup conflict. In total, 30 individuals ranging from 19 to 70 years of age participated in the talking circles. With the exception of the first talking circle, which

included eight men and two women, each circle included 10 participants represented equally by males and females. Each talking circle was facilitated by two community researchers, who also participated by contributing their own lived experiences. To ensure the research captured a diverse set of experiences, both community researchers' and participants' participation was limited to one talking circle. All participants provided informed consent prior to participating, and the research was undertaken with appropriate ethical approval granted by the Providence Healthcare / University of British Columbia Research Ethics Board. In respect of Aboriginal oral traditions, participants provided informed consent verbally.

During the talking circles, community researchers invited participants to share their experiences accessing healthcare services (e.g., emergency room admissions, hospital stays, walk-in services) to uncover patient-provider encounters. At the start of each talking circle, a community researcher introduced the discussion topic to the group and then initiated the talking circle by sharing a personal story of accessing healthcare as an APWUID/A and who lives in the DTES. Research ethics were not obtained to audio record the talking circles. However, the research coordinator and an assistant took extensive field notes to document participant quotes verbatim during the circles. At the end of each talking circle, the two community researchers and research coordinator reviewed the field notes for accuracy and identified preliminary themes.

Upon completion of the series of talking circles, the research team conducted a multi-phased qualitative analysis of the data. Two community researchers were assigned to lead data analysis. Field notes were reviewed individually by each community researcher and coded line-by-line by hand to identify common themes. Both researchers then repeated this step together by reading the field notes aloud and selecting quotes representative of the themes. Following consensus on key themes, the researchers compiled a number of high-level recommendations and implications based on participants' stories and personal experiences as APWUID/A. The community researchers then presented a summary of the analysis, findings, and preliminary recommendations to participants for validation. A total of 35 participants attended the presentation, who included talking circle participants and general members who had not participated in the research previously. As such, the greater WAHRS membership was able to contribute to the recommendations and further validate the findings. This consultation process allowed the wider WAHRS membership to have a voice in the outcomes of this research, while honouring the stories shared by participants within the talking circles.

Following data collection and analysis, the data and research findings were provided to BC-CfE researchers for the purpose of drafting an academic peer-reviewed research article. Given the academic nature of the peer-reviewed article, BC-CfE researchers were primarily responsible for authorship. The first author, an Indigenous scholar, applied an intersectionality framework to present the findings. However, the author made all efforts to maintain the integrity of participants' stories and perspectives throughout the article by presenting the data as shared and interpreted by the community. Several joint meetings were held to discuss the writing process and to share the manuscript drafts for the community organization's review and input. The final draft of the manuscript was shared with all WAHRS Board Members prior to submission. This iterative process ensured the presentation of the findings in this article is an accurate portrayal of community members' healthcare experiences, analysis and interpretation of the data.

### 3. Results

While the intent of this research was to explore experiences of

accessing healthcare services among APWUID/A living in the DTES, including both negative and positive encounters, the majority of stories shared by participants reveal overwhelmingly adverse care experiences. In fact, only one participant provided an example of affirming care. Nonetheless, the following narratives offer valuable insight to what constitutes positive and culturally safe healthcare provision for APWUID/A.

#### 3.1. "They treated me like crap and I know it was because I was Native": perceptions of racism in healthcare settings

An overarching theme made evident in participants' stories was the social and historical context of their healthcare experiences that reflected the ongoing impacts of colonization. All participants repeatedly referenced feelings of being "treated differently" in their healthcare interactions. For example, one participant shared her demeaning experience with a nurse at a safe injection site, the story of which speaks to racial notions of superiority that are embedded in the nation's ongoing colonial legacy:

So [the nurse] showed me how to [inject], but she was so mean about it. She was not accommodating. She said I should know how to do it myself. They treated me like crap and I know it was because I was Native. We all know because of the look - there's a look. When you need the medical care we put up with it. We shouldn't have to. We bleed the same way, we birth the same way. We have no choice. Could be like [participant name], hasn't been to a doctor in 25 years. Can't all do that. [Female participant #1, Talking circle #1]

Individuals drew upon a seemingly collective narrative about how others before them have experienced adverse care, which informed personal understandings and experiences of healthcare:

When I first came [to Vancouver] I went to [Hospital X] with my Mom. She had HIV. She got pretty sick and spent a lot of time at [Hospital X] because she went there almost once a week. Things she told me were bad about being there because she had HIV and because she was Native. They didn't treat her well at all. She was always scared to be there. I had to go check up on her almost every day. She passed away five, six years ago. She was at [Hospital X]. [...] I haven't really been back since. I never liked that hospital. [Male participant #6, Talking circle #1]

Participants shared numerous examples of being threatened by hospital security or dismissed by staff. One woman described an encounter where her attempt at social niceties resulted in her involuntary discharge from the hospital:

I was doubled over in pain. [The doctor] asked for a scale of 1–8 [for pain]. [Participant replied] 8. [...] A Slavic man and nurse came to assist me. I noticed his accent. I [dated] a Slavic guy. Asked where he was from? [He answered] 'None of your business!' and I said, 'What's the problem? Is it my skin colour or my postal code?' He kicked me out. [Nurse responded], 'You're outta here!' I've never been kicked out of anything except a bar. [Female participant #1, Talking circle #1]

While the above are examples of interpersonal interactions where participants experienced racism and discrimination, more subliminal forms of institutional racism were also made evident. One woman spoke to the detriments faced by many Aboriginal women (e.g., poverty, substance use), while at the same time alluding to the negative impacts of cultural disintegration. She

continued on to express how hospital policies exacerbate cultural barriers to health and wellness for Aboriginal peoples:

Just recently had a chance to be in a hospital with young babies, but moms are from down here [DTES] and they're drinking and using drugs, and they're at the hospital and babies aren't smudged, not bathed in sage water. They should do that even in a hospital. How are you able to smudge? It's very important. It's how we connect with Creator and it's how we heal. They can't smoke in hospitals so can't even smudge. [Female participant #1, Talking circle #3]

Recently, Hospital X devoted facility space for Aboriginal cultural purposes (e.g., smudging, drumming). However, not one participant mentioned use or awareness of the facility, and further investigation uncovered the space is locked, and only accessible by security personnel and a few designated staff.

### 3.2. "I think she thought I wanted painkillers, but I was really hurt.": the consequences of multiple stigmatized identities in clinical practice

Acts of discrimination were often felt as two-fold or noted as the "double whammy" effect, whereby participants felt stigmatized for being both visibly Aboriginal and a DTES resident. Participants perceived stereotypes linking Aboriginal peoples to substance use were fortified by the stigmatization of the DTES known for its 'open drug scene'. When such stereotypes prevail, participants' routine requests for pain medications were often overrode by 'drug-seeking' narratives. The following excerpt illuminates how overlapping stigma form stereotypes, which subsequently influence clinical decisions:

I ended up at [Hospital X] with pneumonia. [...] [Doctor] asked me what I drank first thing. I said beer and whiskey, but he wanted me to say Listerine. Comes back next day, asks me same thing. I said, 'You want me to say rubbing alcohol?' They kicked me out the next day. I had pneumonia! [Male participant #5, Talking circle #1]

Participants perceived healthcare providers as more concerned with confirming their assumptions about patients' illicit drug use rather than providing medical care. For example, one man described his experience of being denied analgesics, which he attributed to the physician's presumptions about those living in the DTES:

I reached out on my right side and it really hurt. I went to a [DTES clinic] to the doctor and she told me to walk it off. I went to sleep and woke up and thought I was dying - big pain in my chest. I collapsed a lung. I think she thought I wanted painkillers, but I was really hurt. [Male participant #8, Talking circle #3]

Often health concerns were described to be trivialized by healthcare providers and many reported being discharged without treatment. Participants also critiqued the nature of hospital discharges, and healthcare providers' disregard of the social determinants of health and individuals' life circumstances. For example, a few highlighted concerns for personal safety when being discharged in the middle of the night, as many were forced to walk several kilometers home after being refused the provision of taxi vouchers or transit fare by hospital staff.

Even when substance use was the primary concern of the patient, healthcare providers appeared indifferent towards

individuals suffering. Instead, participants described staff negligence, as one described with his experience accessing care during an episode of delirium tremens (i.e., severe form of alcohol withdrawal):

I have real problems with [Hospital X]. I experienced one time for a seizure and they let me out and no sooner was I out that I went into another seizure. I was really drunk and there I was on the sidewalk, and back into the hospital I go. I'm just another person down here [from the DTES] to them. Just another drunk Indian. Where is the care? They should hold us in until we are capable to walk out ourselves. [Male participant #10, Talking circle #2]

Another spoke to an unexpected experience of 'equal' treatment in which he was treated like a human being rather than a stereotype:

Once they find out why, they treat me like another drunken Indian. Only one crew treated me like a human. Even asked about half a diazepam and they wouldn't give it to me. At [Hospital X] I was treated by on duty staff with dignity. They treated me for what was needed. [Male participant #9, talking circle #3]

In these stories, one can observe how living in the DTES, a history of substance use, and being visibly Aboriginal manifest as interlocking identities in the eyes of the stigmatizer.

While most acknowledged physicians' fears of abuse or diversion of narcotics as a contributing factor to clinical decisions, many perceived additional beliefs swayed decisions to prescribe analgesics:

I hurt my knee. When I asked my doctor for Tylenol he swore at me, 'bullshit' he said. I said he was unprofessional! Doctors down here won't even give Tylenol. Doctors tell you to fuck off and tell you we are a drain on the taxpayers' money. That's my experience. I'm now trying to get a new doctor. [Female participant #5, Talking circle #2]

The final excerpt displays how a lack of empathy, alongside incompetent addiction medicine training, can leave individuals vulnerable to poorer health outcomes and in this case, death.

Had two people come to me with HIV. I took them to [Clinic X] and just because they were drunk, they kicked them out. Next day he was dead. Not just him, two people dead. Just because people are drunk or on drugs [they] still need to be cared for. [Male participant #4, Talking circle #1]

### 3.3. "I tell them as little as I can.": mitigating for discriminatory healthcare practices

While some participants were able to "put up with it", others avoided the healthcare system altogether. Through avoidance individuals eliminated the risk of further traumatic, discriminatory clinical experiences, which often resulted in untreated illness and pain. Several reported only seeking healthcare once their illness or symptoms had become severe. One woman recounted how her fear of being judged reinforced her reluctance to engage with healthcare services:

For me it's really hard to go to the doctor. I only go if I really, really have to. So I went to get this [blood test]. I fasted and stuff,

and went there and they said I couldn't do it. I got discouraged. I have a very, very hard time when it comes to seeing professionals. I tell them as little as I can. They treat us different - Native, Downtown Eastside. It makes me feel shame or something. [Female participant #2, Talking circle #2]

Another shared his difficulties receiving care for medical complications arising from his alcohol use. However, he recalled positive interactions with a physician that he perceived was competent in addictions medicine. Thus, having one's needs understood promoted a sense of equitable care.

I love Dr. [anonymous]. He knows addiction, but I'm really finding we need an addictions specialist. We really don't have one. Apparently they have at [Clinic Y], but I can't go because [Clinic X] is my clinic. They tell me I can't, but I wonder is it because I live in the DTES? Or because I'm Native? Or [emergency medical services] tells them not to take me? 'Get the fuck out of my office', doctor told me when I needed meds to stop seizure. So first thing, I went to the liquor store so I wouldn't have a seizure. I saw an aura. Doctor didn't put it together. I don't think there are enough people qualified in this country on addictions. It's sad to say. [Male participant #9, talking circle #3]

Both individuals articulated how a convoluted and confusing process exacerbated existing discomfort with the health system, ultimately creating a cycle in which the patient becomes less and less likely to engage positively with care following each painful interaction. Consequently, the anticipation of adverse clinical interactions and medical dismissal deterred most individuals from accessing care (i.e., disengagement from care or delayed access); as mentioned earlier, one participant had not accessed healthcare services for 25 years as a result.

For most, divulging personal information to a healthcare practitioner was perceived as a liability and caused distrust. For example, participants feared if providers were aware of their illicit substance use, the likeliness to receive adequate treatment would be further decreased and they would be subjected to greater discrimination.

I lie to my doctor about drugs I use. They have no idea what I'm on, but because of the area [DTES] I'm in he doesn't want to give me as much and wants to lower my dose. I have Crohn's Disease and cocaine takes care of it so I sell medication too. [Male participant #3, Talking circle #2]

#### 4. Discussion

Despite inhabiting a country that prides itself in its public healthcare system, Canada's Aboriginal peoples continue to contend with inequalities in access to healthcare and service utilization (Adelson, 2005; Shah et al., 2003; Cameron et al., 2014b). Evidence of such differential treatment appears to be mounting; in a national poll on Aboriginal health and healthcare, only 64% of First Nations respondents provided a positive rating for the quality of healthcare received within the previous year in contrast to 84% of non-Aboriginal Canadians (National Aboriginal Health Organization, 2003). Other colonized Indigenous groups have provided very similar experiences of inequalities. For instance, both Australia and New Zealand have reported similar healthcare inequities. Australian Aboriginals are 2.6–5.0 times more likely to report negative racially based adverse treatment (Larson et al., 2007), and the Maori population are nearly ten times more likely

to experience discrimination in healthcare settings (Harris et al., 2006). However, an exclusive focus on health disparities between Indigenous and non-Indigenous peoples is not adequate, as race alone does not operate as a single determinant of health. Focusing solely on ethnicity as research often does, not only risks further stigmatization of a population, it elides the immense diversity of Indigenous peoples' experiences (Hankivsky and Christoffersen, 2008). It is this diversity that we must recognize as there is no singular Indigenous or Aboriginal experience. In alignment with the core tenet of intersectionality, this research explores the experiences of a marginalized population within their own context (Bowleg, 2012) rather than understanding their experiences in comparison to the "norm", whether it be other Indigenous peoples or non-Indigenous peoples. As outlined in the introduction, we draw upon intersectionality as a framework to elicit a deeper understanding of the complexities of healthcare inequalities among APWUID/A by exploring what is experienced at the intersection of multiple forms of oppression (i.e., race, socio-economic status, substance use) (Bowleg, 2012). From this perspective, our research illustrates how experiences of being Aboriginal, impoverished, and a person who uses illicit substances intersect to shape how participants both perceive and make sense of their healthcare experiences.

We begin our analysis recognizing that there is "no common Aboriginal experience" (Hankivsky and Christoffersen, 2008). However, we must acknowledge the common experience of "race" among Indigenous populations and their subsequent collective experience of colonization, of which race has been a fundamental component. The ongoing impact of colonization continues to shape Indigenous lives in complex ways (Young, 2001; Anderson et al., 2006), and therefore cannot be separated from the discussion of Indigenous peoples' experiences. In North America, researchers have linked the intergenerational impact of residential schools and historical trauma to a number of social and health inequalities experienced by Indigenous peoples, including substance abuse, violence, and poverty, alongside feelings of inferiority and lack of self-worth (Stout and Kipling, 2003; Lavalley and Poole, 2010; Smith et al., 2005; Myhra, 2011; Evans-Campbell, 2008). Without understanding of the historical, political and social determinants of Aboriginal peoples' experiences, racialized explanations of social and health inequalities are reinforced (Adelson, 2003). For our participants, racialized stereotypes (e.g., "drunken Indian") were understood as prevalent and were perceived to influence providers' professional judgement and interpersonal interactions. Although our study did not include the perceptions of healthcare providers, we do know that common misperceptions do exist. A study exploring family medicine residents' attitudes towards providing healthcare to Aboriginal patients found 69 percent of respondents felt they held stereotypes of Aboriginal peoples (Larson et al., 2011), with the most cited being alcoholism and low socio-economic status. While these stereotypes are certainly generalizations, poverty and substance use were common experiences among our participants, and factors in which we sought to investigate to better understand their intersections with race in producing healthcare inequalities.

Participants' stories suggest that residency in the DTES may, in the mind of the provider, have simply corroborated their stereotypes of Aboriginal peoples as substance users and therefore exacerbated discrimination and stigma that Aboriginal peoples generally are subjected to. As Link and Phelan (2001) note, "successful negative labeling and stereotyping is a general downward placement of a person in a status hierarchy" (p. 371) as they are connected to undesirable traits and his or her status reduced. For our participants, being both Aboriginal and living in the DTES were felt by participants to lessen their credibility in the eyes of

healthcare providers as each 'identity' intersected with discrimination and stereotypes, primarily tied to drug use. While only one participant alluded to an experience of HIV stigma, others may have also experienced additional layers of stigma that were not discussed during the talking circles. For example, HIV and hepatitis C are both prevalent in the DTES and have been linked to compounded stigma in healthcare settings among Indigenous peoples. In Australia, study participants reported similar broader societal assumptions, which caused 'automatic' expectations linking Aboriginal peoples to hepatitis C and other stigmatized diseases (Treloar et al., 2016; Crofts and Louie, 1997). It is such racialized stereotypes that reveal how racism intersects with stigmatizing identities to contribute to the marginalization of Aboriginal peoples in healthcare settings leading to unsafe care and poorer access to healthcare services.

The most prevalent colonial discourse encountered by participants was that of Aboriginal peoples having "a propensity to like narcotics" (Browne, 2007). Ironically, seemingly well-intentioned clinical practices to avoid substance misuse and/or deception by the patient served to reinforce illicit substance use and diversion of narcotics among this population. However, the resale of prescriptions was often a means to afford alternative narcotics to self-medicate. Similar findings have been revealed elsewhere. Recently a local study found that being refused pain medication was associated with high risk methods of self-management of pain among people who use drugs, including the acquisition and use of diverted prescription opioids and heroin (Voon et al., 2014). Throughout the talking circles, not one participant discussed substance use for recreational purposes. Instead, substance use reflected the degree to which participants had given up on mainstream healthcare to treat for pain and trauma, and demonstrated individuals' accommodation for unmet health needs within the context of poverty and trauma.

While we know both substance users and ethnic minorities are vulnerable to discrepancies in care, including analgesic practice and quality of patient-provider communication (Chitwood et al., 1999, 2001; Breitbart et al., 1996; Balsa and McGuire, 2003), our participants often contemplated the cause of discrimination endured (i.e., their social positioning as members of an ethnic minority or a stigmatized community). This confusion speaks to the complexities of multiple intersecting identities encountered by those historically oppressed and marginalized populations. While we do not claim our findings are representative of all Aboriginal peoples, nor would such a claim be congruent with an intersectionality perspective, other studies have provided very similar accounts in which Aboriginal patients describe feelings of being lessened as a person and having analgesics withheld (Browne, 1995; Cameron et al., 2014a; Browne et al., 2011; Tang and Browne, 2008; Baker et al., 2000; Kurtz et al., 2008). Fiske and Brown (Fiske and Browne, 2006) note this 'lessening' is embedded within the social discourse that construes Aboriginal peoples as "discredited medical subjects who lack legitimacy in healthcare settings" (p. 91). This said, the existing literature suggests that in the case of Aboriginal peoples, Aboriginal ethnicity is automatically interlocked with multiple social categories and identities, which intersect with social discrimination to create disparity and social inequality in health.

Indeed, providing patient care in the context of substance use is complex. While substance-using patients may interpret a physician's inconsistent clinical protocols as intentional mistreatment due to discrimination - as many did here - several participants also recognized that such inconsistencies may be tied to physicians' fears of being deceived, as well as a lack of clinical tools to address pain and addiction management. Interestingly, in one study observing care interactions with opiate-addicted patients, physicians attributed clinical discrepancies to these exact fears and

shortcomings (Merrill et al., 2002). As our findings suggest, such incompetency and uncertainty can leave APWUID/A vulnerable at the hands of healthcare providers.

Clinical uncertainty is concerning and some argue it is the most important factor influencing physician behaviour and attribute it to healthcare disparities (Balsa and McGuire, 2003; Wennberg, 1985). With uncertainty comes the need for clinical discretion, which is shaped by subjective influences (Balsa and McGuire, 2003; Pletcher et al., 2008; Van Ryn and Fu, 2003; Burgess et al., 2008), such as the unfavourable stereotypes and prejudices shared by participants. In order to avoid the consequences of clinical uncertainty, adequate clinical protocols for pain management within the context of illicit substance use (Merrill et al., 2002; Portenoy et al., 1997) are needed, alongside widening clinician understanding beyond biomedical concepts through approaches like 'structural competency' or 'cultural safety'. Cultural safety draws attention to the influence of racism and power imbalances on individual health and access to services (Polaschek, 1998; Papps and Ramsden, 1996; Smye and Browne, 2002), whereas structural competency may serve to address stigma and inequalities in healthcare by educating clinicians to recognize how both health (i.e., clinical symptoms) and clinical interactions are shaped by structural or upstream forces (Metzl and Hansen, 2014).

At the institutional level, participants' narratives spoke to the impacts of cultural racism present within the healthcare system. Cultural racism is easily unnoticed by those individuals whose values shape social norms and institutional behaviour— that is Euro-centric, white middle class men. One glaring example, is the exclusion of Aboriginal cultural and medicinal practices from healthcare settings. Despite the presence of chapels and prayer rooms in hospitals, similar spiritual spaces for Aboriginal peoples remain rare. These observations underscore the manner through which healthcare inequities are shaped at both the micro and macro-levels of society point to the need to address structural factors, alongside a consideration for social and historical factors influencing the healthcare experiences Aboriginal peoples.

## 5. Conclusion

Before concluding, a few limitations deserve mention. Because this research represents only those experiences of Aboriginal peoples who are current or previous illicit substance users living in an impoverished urban neighbourhood, the findings do not necessarily reflect the experiences of Aboriginal peoples elsewhere. However, the emerging literature suggests similar care experiences are common among other Aboriginal populations regardless of economic status or substance use. Furthermore, given the nature of this research, the degree to which ethnicity and known substance use affects clinical practice in terms of clinical diagnoses and course of treatment cannot be substantiated here. Finally, this research did not include the perspectives of healthcare providers and was limited to those perspectives of Aboriginal patients. Therefore, it is possible that important contextual information that influenced patient care was overlooked. In light of these limitations and the noted disparities between the two urban hospitals, further research into the perspectives of hospital staff regarding the care of Aboriginal peoples would be of great interest.

While concepts such as cultural safety are indeed valuable, we must ensure that such training is not merely superficial, but rather is embedded at all levels of the healthcare system from policy makers to physicians, medical trainees, educators, support staff and security personnel. Transforming healthcare settings into environments that support and encourage the valuation of Aboriginal peoples and cultures will be paramount to addressing the health gap between Aboriginal and non-Aboriginal Canadians. In practice

this calls for an integrated healthcare system that acknowledges the use of traditional Aboriginal medicines and cultural practices in mainstream healthcare services. Of importance, is to ensure policies are in place to facilitate equitable access to healthcare and cultural services for all Aboriginal peoples, including substance-using patients (e.g., allowing patients under the influence access to services). Given the novelty of these initiatives, program evaluations will be fundamental to further justify and secure funding for larger scale implementation. The adoption and acceptance of Indigenous practices by the mainstream healthcare system would represent a valuation of Aboriginal knowledges and peoples by challenging the perceived superiority of western medicine, and as such would prove momentous in achieving health equity for Aboriginal peoples. In this respect, healthcare may become a place of cultural strength versus denigration.

This research revealed the healthcare inequities experienced by APWUID/A are complex and influenced by multiple factors, such as interrelated stigma and racism constructed by wider social discourses underlain by the legacy of colonization. As Hankivsky and Christoffersen (2008) state, “intersectional approaches are essential to developing policies that respond to the multiplicity of social locations and lived experiences” (p. 279) and embrace the complexities that are essential to understanding inequities. To effectively close the health gap, racism, discrimination, and prejudice towards Aboriginal peoples must be *acknowledged* and *addressed* by policy makers, educators, and leaders in the healthcare sector in collaboration with Aboriginal peoples to ensure the Canadian healthcare system serves its mandate of equitable care for all. While healthcare policy reform must take place, it is only one stride towards achieving health equity for Aboriginal peoples. As long as racial stereotypes and stigma surrounding substance use and poverty continue to exist and be reinforced by society, ethnicity and stigma will continue to shape the health experiences of this population.

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