'Race' matters: racialization and egalitarian discourses involving Aboriginal people in the Canadian health care context

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The major purpose of this paper is to examine how 'race' and racialization operate in health care. To do so, we draw upon data from an ethnographic study that examines the complex issues surrounding health care access for Aboriginal people in an urban center in Canada. In our analysis, we strategically locate our critical examination of racialization in the 'tension of difference' between two emerging themes, namely the health care rhetoric of 'treating everyone the same,' and the perception among many Aboriginal patients that they were 'being treated differently' by health care providers because of their identity as Aboriginal people, and because of their low socio-economic status. Contrary to the prevailing discourse of egalitarianism that paints health care and other major institutions as discrimination-free, we argue that 'race' *matters* in health care as it intersects with other social categories including class, substance use, and history to organize inequitable access to health and health care for marginalized populations. Specifically, we illustrate how the ideological process of racialization can shape the ways that health care providers 'read' and interact with Aboriginal patients, and how some Aboriginal patients avoid seeking health care based on their expectation of being treated differently. We conclude by urging those of us in positions of influence in health care, including doctors and nurses, to critically reflect upon our own positionality and how we might be complicit in perpetuating social inequities by avoiding a critical discussion of racialization.

Keywords: racialization; Aboriginal people; Canada; 'race'/class/gender; egalitarianism; health care access; social inequity; health care inequities

Introduction

Health care, as a social good, strives to provide adequate, safe, and equitable care to people. In Canada, the health care system continues to be guided by the five principles of accessibility, comprehensiveness, portability, universality, and public administration. Canadians pride themselves of the publicly funded health care system irrespective of the ability to pay, and high ratings are given to the performance of health care in general (Coburn 2004). Despite its success, however, health care access continues to be highly problematic for members of some populations. The health and health care experiences of Aboriginal people[1] in Canada represent a case in point. Despite multiple government initiatives, high proportions of Aboriginal people continue to experience mortality and morbidity rates that far exceed the rates for non-Aboriginal Canadians, and they continue to bear a disproportionate burden of poverty, economic marginalization and the

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concomitant effects on health and social status (Dion Stout *et al.* 2001, Canadian Institute for Health Information (CIHI) 2004, Adelson 2005). Life expectancy at birth for First Nations is 7.4 years less for men, and 5.2 years less for women compared to non-Aboriginal populations (CIHI 2004). Rates of unemployment in 2001 were more than three times higher for First Nations than for non-Aboriginal Canadians. Aboriginal people continue to be greatly overrepresented in the HIV epidemic in Canada (Public Health Agency of Canada 2004). Although Canada as a whole ranks highly among nations on the criteria of the UN Human Development Index, Aboriginal people in rural reserves rank 68th and those residing elsewhere in Canada rank 36th (Webster 2006). Inequitable access to health for many Aboriginal people is further complicated by systemic barriers to accessing the health care they need, including racism, poverty, social exclusion and discrimination among other factors (Dion Stout *et al.* 2001, Benoit *et al.* 2003, Culhane 2003, Adelson 2005, Browne 2005, Fiske and Browne 2006, Browne 2007). Given the persisting gap in health and health care access, it is important to ask questions such as: What can we understand about the processes and discourses that perpetuate inequities in health care? How are health care providers responding to social inequity in general and inequitable access to health care in particular?

We are a team of Aboriginal and non-Aboriginal researchers who collaborated to conduct an ethnographic study to understand some of the factors and processes that shape access to health care in general, and primary care in particular, for Aboriginal people in an urban center in Canada. During the process of data collection and analysis in this study, we have been struck by the 'contradiction' in the ways that Aboriginal patients make meaning of their health care experiences and the discourses that are reflected in some health care providers' claims about their practice and about health care in general. While many Aboriginal patients we interviewed wondered if their health care experiences were shaped negatively by their 'Aboriginality' or their racialized background as Aboriginal persons, health care providers tended to take for granted [or presume] that 'everyone is treated the same' irrespective of the patient's background or social positioning. What we seem to be seeing here is some inherent tension between the perceived experience of racism or racialization, and the Canadian liberal democratic ideal of equality where everyone is purported to have equal access to resources and life chances (Henry and Tator 2006).

In trying to work out a methodological entry point for our analysis, we position our reading of the data not with a view to determine the 'accuracy' or 'validity' of the contesting interpretations provided respectfully by Aboriginal patients and health care providers. Instead, we situate *the very act of interpretation as political, that which is complexly organized by and interlocks with the larger socio-political and historical contexts that shape the interpretive framework(s) with which people understand and make meanings about their world and experiences.* Thus, when a patient interprets his/her experience as racially based, we do not minimize it as 'personal bias' or 'false consciousness' nor do we claim 'racism' at face value; instead, we would use that interpretation as a point of entry for exploring the 'race'/class/gender relations that organize that particular interpretation. Conversely speaking, if a health care provider describes health care as accessible and equal, we do not assume that health care is free of injustice or prejudice, but would try to juxtapose those claims against the specific social and ideological contexts in which health care is delivered.

Thus, as Augoustinos and her colleagues (2005) would suggest, the analytic site for this paper 'is not the "prejudiced" or "racist" individual, but the rhetorical and discursive resources that are available within an inequitable society' (Angoustinos *et al.* 2005, p. 318). These rhetorical and discursive resources, as we see it, would include those ideas and images produced and reproduced in the dominating discourses that serve as a 'road map' to 'guide' our common sense-making of our everyday experiences (Smith 1999). Our ability to speak of/to those experiences, as Smith (2004) might argue, is not merely idiosyncratic but manifests a 'social consciousness' expressive of the social relationships and historical conditions that enable and at the same time limit our knowledge of our world. In this sense, differences in the ways that reality is interpreted by different social actors are not really 'contradictory;' rather, they tell us something important about the social nature of our world and how 'race'/class/gender relations organize differential experiences of health and health care.

In liberal democratic societies such as that of Canada, however, the process of racialization and discussions of 'race' and racism seem to have become more obscure because discourses such as that of political correctness and egalitarianism render 'talk' of discrimination a social taboo (Riley 2002, Augoustinos *et al.* 2005, Henry and Tator 2006). However, 'race' as a social category continues to carry enormous social currency (Farmer 2005), and racism is still a lived reality for many members of racialized populations (Mullings 2005, Fee 2006, Tator and Henry 2006). As such, it is even more urgent to understand and unmask what 'remains to be unmasked' (Anderson 2006, p. 9) in terms of the complex and increasingly elusive processes by which racialization (intersecting with other social categories including class and gender) perpetuates inequity in society.

In this paper, we take up the challenge to critically analyze the ways in which 'race' and racialization can operate in local contexts in health care settings. To do this, it is strategically necessary for us to select particular excerpts that have 'analytic currency' or the ability to shed light on the complex ways by which racializing processes unfold in the everyday. As such, the excerpts used in this analysis do not represent 'themes' or generalized experiences and interpretations of *all* patients or *all* health care providers in our study; rather, they have been selected strategically and should be read as '*methodological points of entry*' (Smith 1999) for questioning and 'poking' into those otherwise hidden processes and unequal relations of power that organize everyday interactions and experiences for people coming from different backgrounds. Before we move on, we will briefly describe the study on which this paper is based, as well as clarify how we conceptualize 'race' and racialization in our analysis.

Context: overview of the study

The analytical issues discussed in this paper are based on findings from a larger ethnographic study that explored the factors influencing Aboriginal patients' decisions to seek care at an urban hospital's emergency department (ED) for health issues triaged as stable and 'non-urgent' (that is, for non-acute, non-life threatening conditions). The need for this study was identified by community-based leaders in the Aboriginal health services sector and university researchers with expertise in Aboriginal health who partnered to explore these issues. Using in-depth interviewing

and participant observation, data were collected over a 20-month period of immersion in the 'Fast Track' division of an ED (the area of the ED that provides care to people with stable and "non-urgent" issues on a walk-in basis). The majority of data were collected by three experienced and highly trained Aboriginal research associates (RAs) who, together with other researchers in the team, spent over 300 hours in the ED. The ED, part of a large tertiary hospital, was located near a core area of a large city in a Western Canadian province.

Purposeful sampling was used to recruit a total of 82 participants for interviews and participant observation. These participants included 44 patients who came to the Fast Track, and 38 ED staff who were primarily nurses, physicians, and social workers. Of the 44 patient-participants, 34 self-identified as Aboriginal, and 10 as Euro-Canadian. Inclusion of both Aboriginal and non-Aboriginal patients into the sample is a reflection of the emerging nature of ethnographic studies like this one. Originally, this study was designed to include only Aboriginal patients into the sample. As data analysis progressed, there emerged a methodological need to also recruit a theoretical sample of non-Aboriginal patients coming from the same core area in order to understand how 'Aboriginality' as a racialized category intersects with class (and gender) to shape differential experiences of accessing health care.

Most often, interviews with patients lasted 30–60 minutes and took place within the Fast Track of the ED. To ensure confidentiality and privacy, we conducted most patient interviews in meeting rooms adjacent to the Fast Track, or within clinical examination rooms while patients were waiting to be seen by the doctor or the nurse. In some cases, a second interview was held several days later in a community setting to follow up on issues that patients had discussed in the first interview (e.g., at a community clinic nearby).

Because of the hectic pace of work in the Fast Track, interviews with health care providers tended to be shorter, lasting an average of 15–30 minutes, and took place in the Fast Track when it was convenient for the health care provider to take a break from clinical work. To provide a context for understanding the experiences of patients and health care providers, we also conducted participant observation to explore the institutional context of the ED, and to observe the interactions between patients and health care providers. Observational data were recorded as field notes, and all interviews were tape recorded with permission and later transcribed for analysis. In all cases, written informed consent was obtained from participants prior to conducting interviews or collecting observational data. Consent was also negotiated on an ongoing basis throughout the process of interviewing and observation to ensure that participants were aware of the voluntary nature of their participation. To protect confidentiality, any information that could identify people, health care agencies, communities, or places was removed from the data. Approval to conduct this study in the ED was granted by the ethics review committees at both the hospital and the university.

As noted above, this ED was located near a large core area. As in many core areas, the proportion of people who live below the national poverty line is high. There are also increasing numbers of Aboriginal people moving into urban areas, who, because of the long history of economic marginalization, move into these poorer neighborhoods (Newhouse and Peters 2003). What was striking about the patients who participated in this study was the extent to which their lives were shaped by impoverishment and in many cases, substance use. The embodiment of social

suffering was visibly apparent among many of the patients who came to the ED: many resided in single occupancy slum hotel rooms, transition houses and shelters, or lived on the street. Many were affected by experiences of trauma, dislocation from the home communities, negative residential school experiences, drug addiction, and violence. Thus, patients' life histories and the current circumstances of their lives formed the backdrop against which they discussed their health care experiences, their decisions to seek help at the ED, and their wider social experiences.

Although the Fast Track was the site of this study, the patients' interviews inevitably focused on health care experiences outside of the ED – at community health centers, walk-in clinics, and other EDs in this city and elsewhere. Interviews with the patients focused on their reasons for seeking Emergency care, their expectations and assumptions about the ED, and their experiences seeking services elsewhere. Thus, while the site of the study was one particular ED, the patients discussed their health care experiences at a wide range of health care settings. The interviews with the staff in the ED focused on their experiences working with the Aboriginal and non-Aboriginal patients who came to the Fast Track, and the staff's understandings of why patients with 'non-urgent' health issues sought the services at the ED.

An interpretive thematic analysis was completed using procedures described for qualitatively derived data (Thorne *et al.* 2004). To assess the credibility and relevance of the analysis, the themes reflected in the data were reviewed among the research team members and collaborators (who included community-based leaders in Aboriginal health, members of the ED staff, and providers working in local Aboriginal health organizations), who concurred that the data resonated with the range of issues they have encountered. In addition, particular themes were discussed with patients affiliated with an urban Aboriginal health clinic in the city's core area, who agreed that the insights emerging from the data reflected their experiences of seeking health care. The aim of this paper, however, is not to present a comprehensive overview of the research findings, but rather, to use a combination of interview excerpts and insights gained from participant observation to critically analyze the process of racialization and to unfold some of the ideological processes that obscure critical consciousness of how 'race' and racialization operate in the health care context.

'Race' and Aboriginality as a racialized category

In this paper, we are not referring to 'race' as a physical or phenotypical categorization constructed and reified by earlier theories (such as social Darwinism). Rather, we are drawing on Gilroy's (2005, p. 39) understanding of 'race' as the existence and hegemony of 'raciological thinking' that orders our world and differential access to resources (in this case, resources for health and social well-being) for members of various groups. We are also influenced by Ahmad's (1993) conceptualization of racialization as a process that 'assumes that "race" is the primary, natural, and neutral means of categorization, and that the groups are distinct also in behavioral characteristics, which result from their race' (Ahmad 1993, p. 18). Thus, in drawing upon the experiences of Aboriginal people as our entry point for analyzing the social organization of health care, it is not our intent to suggest that Aboriginal people constitute a 'race.' In fact, we are very cautious of an implicit risk

in racializing Aboriginal people as an essentialized group subject to disadvantaged treatment by perpetuating, even if unwittingly, an image of Aboriginal people as 'victims,' as lacking agency, or at 'risk' of having poor health – thus justifying paternalistic state interventions ostensibly designed to improve conditions of health and health care. As O'Neil and colleagues (1998) explain, the risk lies in contributing to 'an understanding of Aboriginal society that reinforces unequal power relationships; in other words, an image of sick, disorganized communities can be used to justify paternalism and dependence' (O'Neil *et al.* 1998, p. 230). Tait (2000a), for example, has illustrated how epidemiological profiles (such as those constructing fetal alcohol spectrum disorder [FASD] as an 'Aboriginal' health epidemic) may unwittingly serve to undermine claims by Aboriginal people that they are able to take on responsibility for self-government and self-determination. These are some of the ways in which notions of 'Aboriginality,' abstracted from the historical context and political struggle for resisting oppression and re-claiming self-determination and identity, can reproduce unequal power relations between Aboriginal and non-Aboriginal populations and reinforce an essentialized image of those who are visibly or ethnically of Aboriginal heritage (Browne *et al.* 2005).

Thus, in this paper, we draw upon the experiences of Aboriginal people in health care not with the intent to essentialize Aboriginal people, or to inflate the explanatory power of Aboriginality as a fixed index for explaining some phenomena. While recognizing and respecting the cultural specificity and political relationships of Aboriginal people as embedded in a particular history of colonization, we take Aboriginality as a political category subject to be racialized, as well as a contested site imbued with political and colonizing discourses that shape how Aboriginality and Aboriginal people are sometimes 'read' by people from non-Aboriginal backgrounds and/or from the dominant culture.[2] Moreover, we conceptualize Aboriginality as a lived experience that is invariably embedded in the history of colonization and in current political discourses, including racializing discourses that shape policy and everyday interactions. In the analysis that follows, we unfold the complex process of racialization in health care by exploring that 'tension of difference' between perceptions of racialization by patients on the one hand, and the discourses in health care that tend to gloss over or deny its existence on the other hand.

Tension of difference: perception of discrimination and its denial

Patient: 'There is discrimination.'

A common idea that has cut across most of the interviews with the Aboriginal men and women interviewed in this study relates to their concerns about discriminatory experiences in various health care settings. The following story, told by an Aboriginal man who lived in a downtown core area and had quite extensive experience with the mainstream health care system due to his chronic illness, captures some of the complex layering that Aboriginal patients often have to navigate through in order to access the health care they need. These include some prevailing (though often unspoken) assumptions that mediate how health care providers may be reading and interpreting Aboriginal people, and the tensions that can arise in clinical situations because of these differing interpretive lenses.

Patient: You know what happened? I came here [name of the first ED he went to] one night, I had a really bad headache. One of the ladies even told me, she said 'Tom (pseudonym), you looked like you were drunk.' I said, 'I know, I wasn't drunk though,' it was so bad that I was puking and everything. So I came here [name of first hospital], and they didn't believe me ... they put me through a brain scan and they didn't find anything so they sent me home with a bunch of pills. Then the next day, I felt worse so I went to [name of the second ED he went to], they put me in a brain scan, and they said 'you are swollen, you've got a really big problem, your brain is bleeding, so we have to operate within a few hours.'

Researcher: So what made you decide to go over to [name of second ED]?

Patient: Because I knew I was going to get the same treatment that I was having the night before [in the first ED]. I just wanted to get rid of what was happening to my brain because it was so painful and they didn't believe me, they wanted to like kick me out, 'you are a drunk Indian or whatever.' I wasn't drunk or nothing. It was just a bad headache, really bad.

Our intent in presenting this case is *not* to call into question the clinical practices and decisions made at the first hospital. It is entirely possible that the bleeding and swelling had worsened between the time he sought help in the first hospital and later in the second hospital, and diagnoses pertaining to head injuries are complex and not straightforward. Thus, we are not interested in implicating the health care providers or particular hospitals for not doing enough or recognizing the problem earlier. To the contrary, participant observation conducted in the ED during this study revealed that physicians and nurses practiced with a high degree of clinical competence, efficiency and expertise despite working in a very challenging practice environment.[3] Rather, what we want to examine more critically here is the patient's *perception* (and questioning) that the health care providers at the first hospital did not take his concerns and physical complaints seriously *because of his Aboriginality and the ideological reading of him as a 'drunk Indian.'*

We argue that the ways that this Aboriginal man read into how he was being read cannot be reduced as merely idiosyncratic or as arising from his individual personal biases. Rather, we must try to understand how such perceptions are reflective of the larger discursive context in which racialized images of Aboriginal people are constructed and in which many Aboriginal people negotiate their everyday life. The *idea of the Indian*, as Kelm (2005, p. 372) argues, is a discursive construction that has been subject to pathologization and medicalization in how 'the Indian' gets to be understood in the mainstream as possessing certain 'cultural' attributes that contribute to their 'sickness.' As Furniss (1999) and others have explained, the image of the 'drunk Indian' is one of the most enduring colonizing images pervading Canadian public perceptions (Furniss 1999, p. 107). Such images, historically generated,[4] continue to shape Canadian popular consciousness today (Browne 2005). As Furniss (1999) writes, 'Images of the Indian as drunk, licentious, violent, and criminal ... exert a profound influence on Euro-Canadian understandings and attitudes and have devastating consequences in the lives and experiences of Aboriginal men, women, and children' (Furniss 1999, p. 111). For example, recent public awareness campaigns portraying FASD as primarily an Aboriginal health problem have been critiqued for perpetuating public and professional perceptions of Aboriginal women as negligent and uncaring (Tait 2000a,b). In today's context of

often tense negotiations between Aboriginal organizations and the Canadian state, misrepresentations and misinformation become even more visible as issues related to land claims, rights, and entitlements are debated in the media, public venues and everyday conversations (Furniss 1999). These public discourses tend to reify a general assumption that most Aboriginal people come from low socio-economic status, are prone to alcoholism or substance use, have low levels of education, are non-tax paying members of society, and are dependant on social or governmental services (Furniss 1999, Browne 2005, Kelm 2005). This ideological context in which wider social perceptions about Aboriginality are constructed is the same context in which Aboriginal people negotiate the social world and access to health care. It is also within that same discursive context that the Aboriginal man quoted above can be understood as 'returning his gaze' (Bannerji 1993) to the dominant society, by lifting up and challenging the racialized images (e.g., 'drunk Indian') constructed of him and other Aboriginal people in the commonsense discourses of the dominant culture.

Discourses of egalitarianism and individual responsibility: 'We treat everyone the same.'

Contrary to the common perception among many of the Aboriginal patients that their providers viewed them as reflections of dominant stereotypes about Aboriginal people, many of the health care providers we interviewed espoused the view that the social or ethnocultural background of their patients had nothing to do with how s/he would be treated. Reflecting a predominant discourse in Canadian health care that all people are treated equally (Reimer Kirkham 2003, Browne 2005), health care providers often made mention of 'treating everyone the same' including patients who were Aboriginal. Here, 'sameness' carries a specific positive connotation to imply that Aboriginal patients are not only treated the same as other patients, they are receiving *equally good care* as their non-Aboriginal counterparts. As these excerpts from different health care providers suggest,

> *Health care provider #1:* I think the care that we give to Aboriginal people is great, I think it's the same as the care that we give to anybody else here.
>
> *Health care provider #2:* I think Indigenous people, just like everybody else, get *good care* really.
>
> *Health care provider #3:* In this department, there is compassion, *no one is being judged*, and *everyone is treated equally*, it doesn't matter what you are coming in for . . .
>
> *Health care provider #4:* By and large the people that come here are *treated very well*. My approach with Aboriginal patients is no different . . . I don't care what race you are.

So how can we understand the claim of 'treating everyone the same' within the larger discursive and socio-political contexts in which health care is delivered? Specifically, is 'treating everyone the same' an adequate way to respond to inequity including racial discrimination?

At the professional level, we can understand 'treating everyone the same' as reflective of the professional commitment and the ethical standard expected of health care providers to treat all patients equally without discrimination (Canadian

Nurses Association 2002, Canadian Medical Association 2004, Browne 2005). In liberal democratic societies including Canada, premised in the ideology of egalitarianism are the values of equality and fairness, whereby society is assumed to be fair and just, where everyone has come from 'a level-playing field' (Riley 2002, p. 446) enjoying equal access to resources in society. When applied as a professional standard in health care, liberal egalitarianism can have at least two implications for practice. First, health care providers are expected to hold up to the value of equality by 'treating everyone the same regardless of social category membership' (Augoustinos *et al.* 2005, p. 318). This resonates with the common assertion by health care providers in this study that Aboriginality as a social category does not matter in the ways that the patient is interacted with and perceived. In fact, it could be seen as challenging the professional ethics of 'equality and fairness' if someone makes claims about being disadvantaged within the health care system based on his/her social background (Henry *et al.* 2000). Second, assumed in the egalitarian approach to health care is that people are rational, choice-making beings who are able to exercise their rights and potentials as individuals independent of influence of the group to which they belong. Accordingly, the focus of health care interaction will be what Charles Taylor might call the 'authentic person with self-determining freedom' (Taylor 1991, p. 28), who is capable of and responsible for living a good life by making the right choices. From this perspective, those historical processes and structural constraints that shape differential (or inequitable) access to health and health care are subject to be rendered invisible or irrelevant.

While we do not take issue with the moral ideals of health care providers to be just and fair by refraining from discriminatory actions in their practice, we are cautious of how the rhetoric of 'treating everyone the same' might, even if unwittingly, further perpetuate inequity by glossing over the process of racialization in health care. Ironically, the egalitarian ideal and its 'logic' of 'treating everyone the same' can actually work against reducing the inequity gap when favorable treatment for some is seen as breaching the value of equality for 'all.' One health care provider implied that this study, with its focus on understanding and improving health care access for Aboriginal people, ran the risk of being 'unfair' to those who were non-Aboriginal:

> *Health care provider:* It's interesting you are just targeting the Native population because my first thought, to be honest with you, was that here we go, we are going to do more for the Aboriginals again. What about just doing it across the board for everyone? Why do we have to target these people so much? Make it across the board for everyone and look after everyone instead of just going for one particular group.

The sentiment expressed by the provider above is not uncommon among members of the dominant society who interpret state policies such as affirmative action as a form of 'reverse discrimination' against the majority members (Augoustinos *et al.* 2005, Henry and Tator 2006). Warranting an argument for 'same treatment across the board' is the assumption that everyone has equal opportunity and the freedom to make free choices in their lives. Statistics would remind us that there are persistent inequalities in socio-economic and health status among groups who are differently positioned in the social hierarchy, with Aboriginal populations bearing the disproportionate burden of social inequity and ill health in Canadian society (CIHI 2004, Adelson 2005). These health and social status

indicators cannot be explained as 'personal choices' or poor lifestyle patterns (alone); rather, they are 'symptoms' of longstanding discriminatory practices and policies that have exerted their effects at the personal, interpersonal, and systemic levels (Henry *et al.* 2000). At the same time, the ideology of individualism, pervasive as a discourse in health care and in Canadian society more widely, plays a powerful role in mediating health care providers' interpretations of 'personal responsibility.' This discourse was particularly invoked in relation to Aboriginal people who were affected by chronic substance use or additional problems. As one health care provider described:

> *Health care provider:* ... [I]t comes down to their personal choices and I mean if unfortunately some of them are already going to be prone to alcohol abuse and drug addition because it is in their genetic makeup from birth, at some point there comes a time that they are responsible for where they are at. So as I said, you can provide all the stuff in the world yet still they are not able to access it because they just can't, or *they do not want to for whatever reason*.

Reflected in the above account is the pervasive social myth that there is something inherent to Aboriginal people or their biological make-up that makes them prone to alcoholism (Furniss 1999). This stereotype is not merely a reflection of an individually held opinion; rather, it has become part and parcel of wider social discourses in Canada about Aboriginal people. In health care contexts, these discourses become a lens through which patients' individual circumstances are interpreted (Browne 2005, 2007). This naturalization of the substance-using stereotype as a consequence of individual choice is a poignant example of how the dominant society tends to deal with the 'inconsistency' inherent in the societal endorsement of the ideal of *equality* on the one hand, and an unspoken approval of social *inequality* on the other hand (Riley 2002). Specifically, by making recourse to individualism, which places the responsibility for making 'bad life choices' on the person, those historical and socio-economic processes that constrain *equal* access to resources and to a healthy life are relegated to the background.

The hidden process of racialization in everyday health care encounters

Just as the discourse of egalitarianism and individualism can play a powerful ideological function in masking structural inequities, what also tends to be reified in the liberal egalitarian ideal of 'treating everyone the same' is the assumption that 'race' and other socially constructed differences do not exist. This assumption thrives on a reverse (il)logic that, '*since everyone is treated the same, we must all be the same.*' Accordingly, issues of race and racism are often seen as obsolete – and this is particularly true in health care contexts, where taken-for-granted discourses of egalitarianism prevail (Browne 2005). However, we argue that 'race' matters in health care particularly as it can play a powerful role in mediating access to health care for Aboriginal people through some hidden (and sometimes unconscious) processes of 'profiling' based on a person's racialized or ethnic background.

Racial profiling is a fairly new term that typically refers to the policing or surveillance of visibly diverse communities; most recently, it has been used to refer to the various discourses that are articulated by governments, the media, and other authorities in an effort to rationalize racializing practices in liberal principles of

fairness, equality and justice (Tator and Henry 2006, pp. 7–8). However, when we talk about 'profiling' or specifically 'racial profiling' in health care contexts, we are not implying that health care providers are engaged in subversive activities of policing or imposing unjust indictments on racialized populations. Instead, we draw on the work of Tator and Henry (2006) to conceptualize 'racial profiling' as a discursive process of social control and representation that applies to all social institutions (i.e., health care, justice, educational systems, etc.), including the ideological foundations used to rationalize and justify racialized behaviors and practices in the everyday (Tator and Henry 2006, p. 8). Racial profiling, understood as 'another word for racism or racialization' (Tator and Henry 2006, p. 8), has an impact on how a person is *read*, and how that reading can in turn influence how one interacts with that person and how his/her behaviors or needs are interpreted (Anderson 2006). One health care provider described how her particular interpretive lens influenced her reading or 'profiling' of some patients seeking health services in the ED:

> *Health care provider:* . . . Most of the Aboriginal people I see through the ED are from the skids, lower income, maybe can't take care of themselves too well, so as an ED staff person, you tend to have a vision of every Aboriginal person having a drug and alcohol issue, coming from a fairly low social economic background, and having skills to maybe cope in that background, but not necessarily to cope into seeking care or options outside of there.

> *Researcher:* How do you think that kind of a perception might affect the way that nurses or doctors treat patients coming from that background?

> *Health care provider:* Probably more guarded. Probably more the perception that you are going to have an unpleasant dealing with a certain person.

The ways that people from certain racialized groups are 'profiled' have to be understood within the dominating discourses that normalize or naturalize the particular images that the mainstream society constructs of them. People living in impoverished neighborhoods, particularly those from racialized backgrounds, can be particularly disadvantaged by how the media, through their 'strategies of representation,' tends to associate those neighborhoods and their residents with problems of crime, illicit drug use and disease (Culhane 2003). The images or popular notions about Aboriginal people as poor city- or urban-dwellers with problems such as addiction can play a powerful role in 'coloring' the perception of what to expect from 'them' (e.g., 'unpleasant dealings') and how 'they' should be dealt with by 'us' (e.g., 'more guarded'). Even when an Aboriginal patient presents to the health care system with legitimate health concerns, those concerns are subject to (re)interpretation through a wider racializing lens that, as England (2004) may argue, has the power of inscribing social problems onto the bodies of Aboriginal men and women. One Aboriginal man spoke about his perception of being 'visible' as an Aboriginal person coming from a lower social class background, and how this resulted in him and others being denied health care when their sickness was (mis)read as a manifestation of being drunk:

> *Patient*: . . . [Security staff] have grabbed me and escorted me out for no reason and I have had other friends who come here [to one of the EDs in the city] and [security] just

like push them out the door, because they think they are drunk and whatever, and you know, the majority of them aren't [drunk], they are really sick but they don't believe them because they have dirty clothes ...

The experience of another Aboriginal man spoke further to the process of profiling that can take place in some hospitals (particularly by security workers hired to manage potentially disruptive patients in EDs), and how racial profiling can feed into the discriminatory practices of 'othering' by reinforcing the commonsense perception of Aboriginal people as potential 'trouble makers' in the clinical space:

> *Patient:* When I was [in a city hospital] about a year ago for IV antibiotics and I had to come back and forth [to the ED] each day because of the infection, my stomach was feeling sick and I was in the bathroom and I guess I'd been in there for about fifteen minutes and the security [guard] came in and told me I couldn't hang out in the bathroom. I told him 'I'm a patient, I don't feel well and I want to throw up.' He said 'well, I'm telling you to leave;' and just because of his tone and attitude, I got defensive and I said 'well, I'm not going anywhere.' He said 'we'll see about that,' and he came back with another security guard and they didn't even say anything, they just came in ... and they literally just threw me out the door, that's about it.

These incidents can have lasting effects in terms of reinforcing and normalizing the 'stereotyping residues' of racial profiling as patients' charts are labeled in particular ways for future reference. In the case above, the patient went on to describe how the nurses and doctors who were expecting him for IV therapy that day 'were wondering where I was. I explained everything, and after that, they kind of just labeled me as a troublemaker and there was a lot of rough treatment [from security guards on subsequent visits] once I was labeled.'

In addition to regulating access to health care through implicit processes, racialization or racial profiling can have other real consequences. As patients in this study described, previous experiences of discrimination did result in reluctance to access health services, even when they were in urgent need for health care. This Aboriginal man who lived in a core area spoke to how stigmatization of indigent men and substance users in the health care system could deter some people from accessing services:

> *Patient:* I have got a lot of friends that wouldn't come to hospitals if they were on their last leg and it's too sad ... like my one friend Phillip, he's dead now, a lot of times he wanted to come and a lot of times he didn't because of the way he looked, you know, and I have been to detox where I talked to a lot of people ... and they don't like coming into the hospitals because they feel so dirty. It just seems like, 'he has done it to himself, he's going to suffer the consequences.' I am not saying all but a good majority [of health care providers] are very insensitive towards certain things.

The point here is not whether providers do or do not judge certain patients in negative ways, but rather that patients preceived they were being judged because they were indigenous, substance using, or visibly Aboriginal. We are cognizant of the fact that stigmatization and the burden of being judged negatively are not unique to Aboriginal people but are common to people coming from low socio-economic backgrounds. Like 'race,' the visibility of class is an equally powerful force for *social profiling*. As Tator and Henry remind us, 'Poor people are seen and described by the

dominant discourses as dispossessed; furthermore, they are characterized in ways that suggest they are disposable' (Tator and Henry 2006, p. 10). A Euro-Canadian[5] man who we interviewed interpreted his health care experience in terms of classism in society in general, and described how he felt stigmatized by the stereotypical images of people from the inner city as undeserving:

> *Patient:* Like everyday, people just really look at me like dirt. I know there's a lot of bad homelessness and stuff, but there are good people too; because I am one of them. I wouldn't hurt a fly. [But] people treat me like I am dirt or something, like a junkie or whatever. Because in this town, as soon as you are on the street, you are a junkie.

Perceiving that his class background has subjected him to unspoken practices of 'class-based triaging' in the health care setting, he described his sense of others being treated more rapidly because of others' dress codes that profiled them as more 'deserving' of care than indigent people. He continued to recall one of his hospital experiences,

> *Patient:* I came into [name of a hospital] bleeding ... in a total state of shock and I had to lie there on the table for an hour and a half before I had a doctor sew my hand up. Meanwhile [I saw] this guy in an Armani suit came in for a headache, got treated and got out in five minutes ... If I had money to buy an Armani suit, I'd buy food.

It is quite possible that this interpretive perspective could be echoed by any number of patients who live in impoverished circumstances. However, we argue that the burden of 'race' layers onto the burden of class (and poverty) in ways that are complex, such that how experiences of racial profiling unfold for Aboriginal people and other racialized populations defy a linear approach that reduces explanations of complex social phenomena to a single category of 'race' or class or gender alone. In our study, we are reminded of the non-additive ways by which 'race,' class and gender work in organizing different experiences even for people who share a similar ethnic and/or social class background (Collins 1991). For instance, contrary to the Euro-Canadian man above who perceived 'class' as a barrier to accessing timely and respectful health services, we have talked to other Euro-Canadian men and women living in similarly impoverished conditions speaking positively of their health care experiences. Our attention was also drawn to the powerful ways by which the 'visibility of *race*' (England 2004, p. 308) plays out in health care, as racializing assumptions associated with Aboriginality sometimes override the supposed social privilege associated with middle and upper middle classes, and subject Aboriginal people and Aboriginal men in particular to 'surveillance' in dominant institutions such as health care settings. One of the members of our researcher team, a middle-class man who is visibly Aboriginal, experienced such surveillance in fieldwork. On one occasion, fieldnotes recorded how a security guard stared glaringly at him and the Aboriginal patient he sat next to in the waiting room of the ED, in a manner that signaled a high level of suspicion about their presence. As the researcher recalled, 'When he [a security guard] started walking towards us, he stared at me [for a prolonged time] and then stared at the Aboriginal patient. He didn't look at anyone else. Just the two of us.'

Experiences like the one above give testimony to the implicit but powerful process of racial profiling in the everyday, whereby assumptions based on people's physical

attributes can put some people at risk for being treated differently, particularly for those who are in less powerful positions to advocate for themselves or to negotiate their way through the 'ruling apparatus' (Smith 1999) of society including health care. We draw on one final case to illustrate the complex ideological and socio-historical contexts that organize (and limit) some people's access to health and health care. This incident involved a 52 year old Aboriginal man who was living in a core area, was poor (living on social assistance), and who had sustained a head injury because a car had hit him as he was riding his bike. He had come to an ED accompanied by his brother, who, in the process of questioning the ED staff as to why the patient was kept waiting, was evicted by security staff. The brother, who was 48 year old and who disclosed to us as having FASD and a quick temper, recalled the incident as follows:

> *Patient's brother:* [My brother] was bleeding from the head and he was bleeding all over ... We were there and I waited I don't know how long. Because I looked at everybody else and they seemed like they were alright, I finally went up to the nurse and said, 'Aren't heart problems and head problems supposed to be the first to get looked at here?' She said, 'Thank you very much, doctor.' So I said, 'What? What's your name?' And she wouldn't give me her name. I just kept asking for her name. And a guy [another patient in the waiting room] who I don't know starts saying, 'Leave her [the nurse] alone. Leave the girl alone.' I tried to ignore him and I just kept on asking for her name. Finally [the guy] walked up to my face, and I told him, 'Get out, or we're going to be beefing right here.' And so that's about it. And then the [security] guards came. I don't think I was trying to put down her [the nurse's] position at all, you know. I was just trying to say, 'I am worried about my brother and his head's bleeding.'

As in any analysis of clinical encounters, the context is critical to interpreting the dynamics. In this case, the ED was busy at the time, and the patient's brother was, according to the nurse, exhibiting agitated behavior as he was attempting to get the patient medical attention for what he perceived to be 'bleeding all over.'

Safety and violence must be acknowledged as real issues in health care settings, particularly for staff working at the front lines of health care.[6] The point we want to emphasize is not whether the patient, his brother or staff acted appropriately or not. Rather, our interest is in highlighting the ways in which racialized and classed readings of some patients (in this case Aboriginal men who were visibly poor) can generate a certain degree of 'moral panic' (Tator and Henry 2006, p. 54) in terms of security or safety in the clinical context, and how this becomes blurred with the lived reality of poverty and marginalization, including inequitable access to health care.

In the example above, what was intended as *advocacy* on the part of the family member was interpreted by the hospital staff as *aggression,* when the behaviors of the brother (who may have been interacting with some degree of inhibition related to his FASD) were seen as unacceptable and incongruent with the cultural norms of how people should behave in a public space. From the perspective of the nurse involved in this scenario, the patient's head injury was triaged appropriately (as relatively minor) and thus, the waiting time for treatment was congruent with clinical practice guidelines. The tensions that arose, however, were generated in part because of these men's particular social positioning, the approaches they used to advocate for care they felt was not forthcoming, and how their behaviors were read and interpreted by staff. Analyzing these kinds of tense relational dynamics helps to illuminate the

complexity of upholding the ideal of egalitarianism in 'real time' clinical contexts: *people are not the same,* but have been influenced by diverse life opportunities and experiences. As a result, they will have differing abilities to negotiate power relations and the hierarchical structures that are characteristics of clinical settings. As for the two brothers above, their everyday experience of living on the 'margins' of mainstream society is inseparable from the complex historical and socio-political conditions that underpin the wider issues of economic marginalization and poverty affecting many Aboriginal people (and the concomitant health and social issues that ensue, such as substance use and FASD). Yet, egalitarian premises operating in health care continue to de-historicize or 'whitewash' those complex factors that underpin social suffering, and divert attention away from the structural inequalities that organize 'differences' in people's experiences of health and health care. The ideological doctrine of 'treating everyone the same' can actually reproduce social inequities by blinding health care providers to their relative privilege *and* prejudices as well as the unequal power relationships between patients and health care providers, and how such inequality in power can intensify in the face of differences in 'race'/class/gender.

Conclusion

In analyzing the complex process of racialization in health care, we are cautious of the danger of taking on a dichotomous view that implies an over-generalizing assumption that all health care providers are potential 'oppressors' and all patients coming from a racialized background are 'the oppressed.' Our data told us that the tensions that arise in clinical contexts are complex, and we are critically aware that racialization unfolds in a non-linear manner and along various dimensions of difference including ethnocultural background, class, substance use, among others. However, what we want to emphasize is how the process of racial profiling 'structures' inequity including inequitable access to health care, by exerting powerful ideological effects on 'both sides of the encounter' (Tator and Henry 2006), including how health care providers may expect some patients to behave, and how those patients subject to profiling in society may expect to be treated and thus what decision they will make in regards to when, where, or whether to seek health care.

In democratic societies such as Canada where the ideology of egalitarianism paints a picture of the state and its institutions as free of prejudice, categories that speak to difference and injustice, such as 'race' and racism, tend to be seen as obsolete. As Paul Gilroy (2005) argues,

> . . . [T]he signs of 'race' do not speak for themselves and . . . the difficult work of interpreting the system of meaning they create is always likely to appear illegitimate, 'politically incorrect,' sometimes treasonable and usually speculative in the most dismissive sense of that term. (Gilroy 2005, p. 31)

This seems to be the case in health care, where the assumption that 'we treat everyone the same' glosses over the unequal power relationships hinged on socially constructed differences between people coming from different ethnic/cultural back-grounds. However, it is exactly this that tells us something important about the ways our society *treats* 'race' or *suppresses* a critical discussion of racialization and other

inequalities. In particular, political correctness has rendered overt expression of racist or discriminatory sentiments a social taboo, such that discrimination has to take a new form disguised under the coating of 'plausible deniability' (Liu and Mills 2006, p. 84).

We therefore challenge health care providers (and those involved in their professional education) to critically examine their own positionality and how, even if not consciously knowable to them, they are 'embedded with power' (England 2004, p. 300) to exercise 'social control' by controlling the distribution of resources to people in vulnerable positions. In extreme cases, this may take place in terms of controlling the 'spatiality' or patrolling the 'territoriality' of the hospital and other clinical spaces, by exercising the power of eviction. In the more mundane cases of everyday health care interactions, this can take place (in conscious or unconscious ways) through disciplining certain patients by not fully acknowledging their presence or growing agitation when waiting for services, or by failing to explain (in the briefest of terms) why they are continuing to wait. Allocation decisions, no matter how mundane they may appear (e.g., the issuing of taxi vouchers to indigent patients, the provision of snacks to patients who wait for long periods etc), have real effects on the patients who inevitably have to 'embody' not only the suffering of sickness and/or social ill, but also 'embody inequity' (Adelson 2005) by being subject to the consequences of unjust actions and policy. We must question how, through these measures of 'control,' health care providers, and the systems they work within, comply with processes that legitimize and perpetuate inequities through reifying the rhetoric that 'everyone is treated the same' – or conversely, that people ought not to be treated differently – as if social inequities do not exist.

These arguments are not intended to be evaluative, and they must be considered in light of the increasingly challenging clinical environments in which health care providers work. However, we also argue that the personal cannot be separated from the historical. Even if a person (in this case health care staff) does not intend to act in a discriminatory manner, his/her historical location as a member of a privileged group is *implied by and implies the systemic and historical relations that sustain his/her existing location as a privileged member of society.* This may partly illuminate the 'contradiction' that has puzzled us in our reading of the data: the ideological discontent between racism/racialization and the liberal couplet of egalitarianism and individualism, and how patients and health care providers have different perceptions about discrimination in health care. In other words, health care takes place within specific contexts of history, political economy, and 'race'/class/gender relations, and we cannot decontextualize our understanding and interpretation of health care encounters as if we are a-historical and can indeed 'neutralize social differences' (Beagan 2000) inscribed in each of our subjectivity and social positionality as raced/classed/gendered people. We argue that the work of recognizing and mitigating racialization in health care cannot be accomplished by avoiding the difficult discussion of 'race' or by denying the existence of racism and other forms of inequities. As critical health researchers and analysts, we recognize an urgent need to bring to the open what might have been taken for granted, and question the unequal power relations that organize *not only the experiences of injustice, but also the interpretation of those experiences* by people coming from different historical and socio-political locations.

Notes

1. The term 'Aboriginal peoples' refers generally to the Indigenous groups in Canada comprising First Nations, Métis and Inuit peoples, and reflects 'organic political and cultural entities that stem historically from the original peoples of North America, rather than collections of individuals united by so-called "racial" characteristics' (Royal Commission on Aboriginal Peoples 1996, p. xii). In 2001, 4.4% per the total population reported Aboriginal ancestry (Statistics Canada 2003). Currently, the term First Nation replaces the term Indian, Inuit replaces the term Eskimo, and Métis refers to people of mixed European and Aboriginal ancestry. The labels 'Native' or 'Indian,' however, continue to be used in Canadian federal legislation and policy (e.g., the Indian Act), statistical reports, and wider public discourses (Royal Commission on Aboriginal Peoples 1996).
2. Furniss discusses the notion of dominant culture as a 'deeply rooted set of understandings' that are experienced as a 'set of common-sense, taken-for-granted truths' about individuals, society, and social relationships (Furniss 1999, p. 14). These understandings are not static or fixed, rather, they shift and change depending on their representations in media, local contexts, current public debates, one's own life context, and the current political and economic climate (Browne 2005).
3. In Canada, hospital EDs across the provinces are facing a 'crisis' of over-crowding, long waits for treatment, and excessive workload for staff. The reasons for these problems are multiple and complex, including shortages of doctors and nurses, and a lack of acute-care and long-term care beds that create a backlog in the ED and in the hospital system as a whole (see, for example, Cernetig 2006, Time Colonist 2006).
4. As Furniss explains, 'these images have filled the pages of Canadian history books ... and popular literature for centuries' (Furniss 1999, p. 111). Furniss also analyzed current high school texts in a Western Canadian province, and found continued evidence of Aboriginal people constructed as 'inherently weak and incapable of controlling their compulsive thirst for alcohol' to be prevalent (Furniss 1997/98, p. 18).
5. Euro-Canadian is often used in scholarly discourses 'to refer to the dominant segment of Canadian society' (Furniss 1999, p. xi). In this paper, we use the term 'Euro-Canadian' to refer to patient- or staff-participants who self-identified as coming from a European background.
6. According to a recent national survey, in 2005, 29% of nurses in Canada have been physically assaulted by a patient (Statistics Canada 2006).

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