Understanding Discrimination, Oppression, and Inequity in Physiotherapy

Physiotherapy Alberta
College + Association

Discrimination, oppression, and inequity are pervasive in Canadian society and the Canadian health system. Structures and systems of inequity perpetuate discrimination on the basis of many different identity factors. Bias, both conscious and unconscious, frequently lies at the root of these structures and systems of inequity. The result of this bias and discrimination consistently includes negative health outcomes, up to and including limited access to health services and reduced life expectancy.

There is no reason to imagine that these issues are less pervasive within physiotherapy than in other health professions, nor that patients seeking physiotherapy services are less likely to experience bias, discrimination, oppression, or inequity than when they are seeking other health services. However, despite high-profile cases that have resulted in patient harm, one can work their entire career without discussing and confronting discrimination, oppression, and inequity within one's practice setting and patient interactions. While egregious cases spark outrage and questions of "how could this happen?" subtle instances of discrimination, oppression, and inequity often go unrecognized and unchallenged by individuals in positions of privilege and power.

Due to the pervasive nature of bias and the severe negative effects of discrimination, oppression and inequity on people seeking health services, addressing this topic is in the public interest and is an urgent need.

Acknowledging our Role

As stated in Physiotherapy Alberta's Statement Regarding Discrimination, Oppression and Inequity, the College has a duty to address discrimination and identify and deconstruct structures and systems of inequity, with the goal of fostering equity, diversity and inclusion within the health-care system and society at large.

However, Physiotherapy Alberta is not an expert on these topics. We acknowledge that we are on a learning journey and have committed to sharing what we are learning with our regulated members and with other regulatory organizations. In so doing, we lean heavily on experts from within the physiotherapy profession and beyond who have spent decades studying these issues and advocating for change.

Physiotherapy Alberta acknowledges that regulated members will all have different levels of familiarity with this topic. Some of our regulated members may have significant lived experience of discrimination, oppression, and inequity. This topic is not new to people who live this each day. Other physiotherapists may have developed their knowledge of these issues independently due to their own personal interest, or as a result of their work with historically marginalized communities.

At the same time, some regulated members may not have delved into this topic in the past, and many people are uncomfortable with discussions of discrimination, oppression, and inequity and need encouragement to engage with this subject.

We recognize that all these experiences are true. We also recognize that there is a minimum standard of knowledge that all physiotherapists must share in order to serve their patients well.

Why does this matter?

The Life and Death of Brian Sinclair

TW: Death, anti-indigenous racism, ableism

Brian Sinclair was a marginalized, indigent, and very vulnerable Aboriginal man. He was cognitively impaired and incapable of advocating for himself. As a double-amputee, he was confined to a wheelchair, and was also afflicted by chronic illness and by the consequences of a former substance addiction. He had many challenges, but he was a human being. He did not deserve to be ignored to death in a Manitoba, Canada hospital for 34 hours due to medical professionals making false racist assumptions about him.

On September 19, 2008 at 14h15, Brian Sinclair attended a community health clinic in Winnipeg (the Health Action Centre) complaining of abdominal pain, no urinary output in the previous 24 hours, and possible problems with his catheter. The physician gave him a referral letter and directed him to immediately attend the Emergency Department of the Winnipeg Health Sciences Centre for further urgent assistance and treatment.

Mr. Sinclair arrived at the Health Sciences Centre at 14h53. A hospital employee at Triage spoke with Mr. Sinclair, made some notes, and then directed him to wait. Mr. Sinclair obediently wheeled himself into the waiting room. He remained there in his wheelchair in the waiting room for 34 hours, in considerable discomfort, vomiting, and slowly succumbing to sepsis. No medical staff ever spoke with him during that 34 hour period, even when strangers and non-medical staff tried to get the nurses to help Mr. Sinclair.

On September 21, 2008, shortly after midnight, a good stranger in the waiting room noticed that Mr. Sinclair appeared not to be breathing, was very distraught by the fact that no one seemed to care, and finally literally grabbed a security guard and told him to do something. Finally, medical staff kicked into action. They wheeled Mr. Sinclair to the treatment area where an emergency doctor attempted resuscitation, but it was much too late. Brian Sinclair was pronounced dead at 00h51 on Sunday, September 21, 2008. At this time, the referral letter from the physician at the Community Health Clinic was found in Mr. Sinclair's pocket.

The medical cause of Brian Sinclair's death was "acute peritonitis due to severe acute cystitis due to neurogenic bladder." This condition was treatable.

Brian Sinclair would have lived if he had been provided with the prompt and appropriate emergency care he so badly needed, and the necessaries of life such as food and water, at the Winnipeg Health Sciences Centre.[1]

Source: Sinclair Working Group. Ignored to Death.

Brian Sinclair was ignored to death more than a decade ago by health-care staff who "were quick to explain that he was not sick, but rather sleeping or intoxicated. The blindness to Mr. Sinclair's experiences allowed him to die in plain sight."[2]

Would Brian Sinclair have died if he were not indigenous? If he were not cognitively impaired? If he were not poor? Those are unanswerable questions.

What the Research Says

When Physiotherapy Alberta uses the term identity factor, we are referring to the social groups that an individual is a part of, how they define or identify themselves or how society categorizes them. These include but are not limited to aspects of a person's identity such as their age; gender identity and expression; physical attributes, abilities, and body size; sex and sexual orientation; race and ethnicity.

Research tells us that many of Mr. Sinclair's identity factors are linked to health inequities and discrimination in health care. This is true for many social identities, for example:

Race:

- "In Manitoba, the infant mortality rate for First Nations is almost double that of non-First Nations. At the other end of the spectrum of life, the mean life expectancy for Aboriginal men is projected to be 70.3 years compared to 79 years for other Canadian men. Life expectancy for Aboriginal women is predicted to be 77 years compared to 83 years for other Canadian women."[3]

Socio-economic status:

- "Only 47% of Canadians in the lowest income bracket rated their health as very good or excellent, compared to 73% of Canadians in the highest income group"[4] and "ill health has emerged as one of the main reasons cited by individuals as the cause of their household's poverty."[5] In this way, health and socio-economic status exist in a cyclical relationship.[6]

Gender identity and expression:

- Transgender men are more likely to report discrimination in the health-care system in their lifetime, to rate their health as poor, and to have discussed mental health concerns with a health-care provider.[7]

Body size:

- "The prevalence of weight discrimination has increased by 66% over the past decade, and is comparable to rates of racial discrimination, especially among women."[8]
- "One longitudinal study has also shown that perceiving weight discrimination is associated with a 60% increase in mortality risk."[8]

These are just a few of the many examples from published literature that illustrate that identity factors, particularly belonging to an historically marginalized group, can have a significant affect on a person's health and well-being.

Mitigating Harm Through Health Professional Diversity

American research has shown that diversity in health-care providers can increase health-care utilization, particularly if there is a match between patient and provider on the basis of ethnic identity.[9] While the same is likely to hold true on both sides of the border and for other identity factors, research into race and ethnic identity appear to have attracted the most attention to date. Very limited information is available regarding the diversity of health-care providers, specific to the Canadian health-care system.

While there may be a clear stereotype of a Canadian physiotherapist: "young, athletic, blond, and female,"[9] we lack data regarding the social identities and diversity of Canadian physiotherapists. For example, while American census data clearly shows a discrepancy between the distribution of racial identities of American physiotherapists as compared with the general population,[10] comparable Canadian data is lacking.

Arguably, we cannot know if efforts to recruit a more diverse group of individuals into the profession are effective without having the data regarding our current state. However, whether and how we should gather data on the social identities of physiotherapists, what data should be included, who should gather that data, how it should be used to inform policy decisions, and the risks and potential unintended consequences of doing so are all important things to consider and discuss as a profession.

To have these and other essential conversations as a profession, we need to have a shared understanding of the issues and a shared language with which to engage in these discussions.

Language Matters

One of the barriers to having discussions about these issues is a lack of understanding of the correct terms to use and their definitions. The following glossary of terms has been compiled to address this need. Additional resources to support your learning of terminology are available through the following sources:

- The Alberta Civil Liberties Research Centre - Calgary Anti-Racism Education. Glossary. Available at: https://www.aclrc.com/cared-1
- The Canadian Race Relations Foundation. CRRF Glossary of Terms. Available at https://www.crrf-fcrr.ca/en/resources/glossary-a-terms-en-gb-1

Bias: "A subjective opinion, preference, prejudice, or inclination, often formed without reasonable justification, which influences the ability of an individual or group to evaluate a particular situation objectively or accurately."[11] Biases can be implicit or explicit. Implicit or unconscious bias refers to "varying degrees of stereotyping, prejudice and/or discrimination that occurs below one's conscious awareness, and usually in a way that benefits one's group."[12]

Discrimination: "The denial of equal treatment and opportunity to individuals or groups because of personal characteristics and membership in specific groups, with respect to education, accommodation, health care, employment, access to services, goods, and facilities. This behaviour results from distinguishing people on that basis without regard to individual merit, resulting in unequal outcomes for persons who are perceived as different. Differential treatment that may occur on the basis of any of the protected grounds enumerated in human rights law."[11]

"There are three kinds of discrimination: overt discrimination, unequal treatment, and systemic discrimination:

- Overt discrimination: the granting or denying of certain rights to certain groups of individuals.
- Unequal treatment: the differential treatment of one group in comparison with another because of certain characteristics (i.e., paying lower wages to women in comparison to men for work of equal value).
- Systemic discrimination: the policies and practices entrenched in established institutions that result in the exclusion or promotion of designated groups."[13]

Equity: "A condition or state of fair, inclusive, and respectful treatment of all people. Equity does not mean treating people the same without regard for individual differences."[11] Equity differs from equality. "Often the discourse of equality is used to perpetuate discriminatory practices because there is a focus on same or equal treatment, which is perceived as fair by dominant culture."[13] To achieve equity, differences between individuals and groups need to be taken into account, with a focus on the result of balancing of power, rather than focusing on equal or same treatment.[13]

Intersectionality: "The experience of the interconnected nature of ethnicity, race, creed, gender, socio-economic position etc., (cultural, institutional and social), and the way they are imbedded within existing systems and define how one is valued."[11] These systems of inequality "interact to produce complex patterns of unearned disadvantage and advantage. Importantly… different systems of inequality will matter more or less in different contexts, and depending on their intersection with other patterns of inequality."[14]

Oppression: "The systemic, institutionalized or individual subjugation of one individual or group by a more dominant individual or group; it can be overt or covert. Put simply, it is an abuse of power that is justified by the dominant groups' explicit ideology. To uphold this unequal dynamic, physical, psychological, social, or economic threats or violence are often used. The term also refers to the injustices suffered by marginalized groups in everyday interactions with members of the dominant group."[13]

Prejudice: To "pre-judge" an individual or group.[13] "A state of mind; a set of attitudes held, consciously or unconsciously, often in the absence of legitimate or sufficient evidence."[11] "Oftentimes, prejudices are not recognized as stereotypes or false assumptions and through repetition, become accepted as 'common sense'. When backed with power, prejudice results in acts of discrimination and oppression against groups or individuals."[13]

Privilege: "Refers to unearned benefits, advantages, or rights for belonging to the perceived 'normal' or 'natural' state of the 'mainstream' and/or dominant culture. Privilege allows for active, persistent exclusion and the devaluation of those who are 'othered' or 'marginalized'."[13]

"Privilege is not [only] about race or gender, but … it is a series of interrelated hierarchies and power dynamics that touch all facets of social life: race, class, gender, sexual orientation, religion, education, gender identity, age, physical ability, passing, etc."[15]

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