

# Unequal Treatment: The effect of social position on patient-provider interactions

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**Abstract.** This paper is a reflective examination of literature, theory and recent news media to explore how one's social position impacts patient-provider interactions in Canadian healthcare. I argue that the compounding factors of racism, classism and gender bias influence the way patients' symptoms are perceived and treated by healthcare providers; due to the intersectional nature of this phenomenon, low-income racialized women are disproportionately impacted. The multiple forms of stigma these patients face can affect the way providers view their credibility, the seriousness of their symptoms and their 'worthiness' to receive diagnostic testing and treatment. I provide evidence that patients' comfort, safety and health outcomes are directly impacted by such experiences, and have even resulted in cases of death in Canada. I suggest that these findings cannot be separated from the White male identity and rigid biomedical framework, which continues to dominate medicine. I conclude with reflections regarding the need for change and propose that in order to address the root of these issues, we must deconstruct the prolific nature of racism, classism and sexism in our society more generally.

## Introduction

On September 28, 2020, Joyce Echaquan – 37-year-old woman from Atikamekw Nation and mother of seven – live streamed the last moments of her life at a hospital in Joliette, Quebec. The video, posted on Facebook, shows Echaquan in clear distress and crying out in pain while hospital staff can be heard in the background calling her “stupid” and saying she “would be better off dead” (Lowrie and Malone 2020: para. 2). Echaquan died shortly after the video was taken. While the investigation into her death is ongoing, the video sparked national and international criticism about the way Indigenous peoples are treated in Canadian healthcare more generally. As stated by Senator Yvonne Boyer

in a recent news media article, "for every Joyce Echaquan that comes forward, there's a hundred that have not been heard" (Lowrie and Malone 2020: para. 4). Importantly, mistreatment does not only manifest in experiences as overt and horrific as Echaquan's but is also present in more subtle — and often implicit—patient-provider interactions. This includes whether or not a patient's pain is taken seriously, what assumptions are made about their medical history; ultimately, a provider's willingness to deliver adequate treatment and compassionate care. These issues are of particular salience during the COVID-19 pandemic when hospitals are overcrowded and under-resourced. Providers must make quick decisions regarding resource distribution meaning that now, more than ever, implicit and explicit biases may be the determining factors in whether or not a patient receives the lifesaving care they need. For these reasons, it is deeply important to understand how a person's social position can shape their encounters with healthcare providers. This paper is a reflective examination of literature, recent news media, and sociological theory to explore the effect of social position on patient-provider interactions. I focus specifically on experiences within Canadian healthcare. I argue that compounding factors of racism, classism and gender bias influence the way patients' symptoms are perceived and treated by healthcare providers and that due to the intersectional nature of this phenomenon, low-income racialized women are disproportionately impacted.

## **Understanding Patient-Provider Interactions Through an Intersectional Lens**

The concept of intersectionality recognizes the overlapping axes of advantage and disadvantage, which are embedded in an individual's social position and have a multiplicative effect when placed onto one another (Hankivsky and Christoffersen 2008). For example, the combined impacts of gender, race and class work together to uniquely shape an individual's life experiences. Intersectionality not only helps us to understand the role of structural inequalities in shaping a person's health, but it is also critical to understanding micro-level social interactions. Symbolic interactionists, for example, argue that human behaviour is based on learned, individually ascribed meanings, which one associates with different things (Cockerham and Scambler 2010). This includes ascribed meanings which are rooted in stigma, stereotypes and prejudice towards certain social identities. They act as 'mental shortcuts' which simplify the reality of others and can be used to make fast decisions about how to interact with different people based on very small amounts of—incorrect—information. While most people use 'mental shortcuts' in their daily life, they are particularly harmful when used by those in positions of power, including healthcare providers, who hold a significant amount of social control (Conrad 1992). Medical knowledge is positioned as superior to patients' lived experiences and providers act as gatekeepers who determine what information and technology patients get access to (e.g., prescription medications, diagnostic tests, surgery etc.) (Conrad 1992). Therefore, to

understand the differential treatment patients receive in healthcare settings, we must consider the various social identities and power structures at play, which work together to uniquely shape each interaction between a patient and provider. For the purpose of clarity, this paper will analyze the influence of race, gender, and class one at a time. However, it is critical to note that people always hold numerous social identities, and their combined effects are different from, and more impactful than, any one identity on its own (Hankivsky and Christoffersen 2008). Moreover, intersectionality does not presume one social identity to be more significant than another (Hankivsky and Christoffersen 2008).

## **The Impact of 'Race'**

While 'race' is a socially constructed phenomenon, it has real, tangible effects on the lives of racialized people. In the colonial society of Canada, Black, Indigenous and people of colour (BIPOC) frequently experience what Goffman (1963) calls 'tribal' stigma. Despite the outdated and (at best) questionable use of the term 'tribal' here, Goffman's concept remains highly relevant to understanding this form of stigma. Tribal stigma refers to the "othering" and dehumanizing of a person based solely on their group identity such as religion, nation or race (Goffman 1963). Thus, this form of stigma is attached to a whole group, or a collective identity, rather than a specific individual. This stigma — which leads to discrimination and reduction of life chances — is particularly significant due to the unconcealable nature of racial identity for many BIPOC peoples.

Importantly, research supports the assumption that people in Canada are treated differently by healthcare providers based on their race. For example, there is strong evidence to suggest that Indigenous peoples frequently experience discrimination in healthcare (Wylie et al. 2019). In fact, a recent investigation into Indigenous-specific racism in British Columbia found that 84% of Indigenous respondents had experienced some form of discrimination within the province's healthcare system (Turpel-Lafond 2020). The report, titled *In Plain-Sight*, found widespread stereotyping against Indigenous patients including being labeled as: 1) "less worthy" of care in comparison to White patients, 2) having substance-use dependency disorder, 3) having ulterior motives for wanting pain medication, and 4) misusing or overusing the healthcare system. This stereotyping can have direct results on patients' quality of care and health outcomes. For example, the B.C. investigation found that, among other harms, patients were commonly denied medical services, experienced their concerns being minimized, and would not receive appropriate medication for pain management (Turpel-Lafond 2020). It is extremely critical to recognize that these harms can also be fatal. In fact, 12 years before the death of Joyce Echaquan, Indigenous man Brian Sinclair died from a treatable bladder infection after spending 34 hours unassisted in a Winnipeg emergency room (Lowrie and Malone 2020). Sinclair was ignored by hospital staff who "assumed he was homeless or intoxicated"

(Lowrie and Malone 2020: para. 16) – two other stigmatized identities which apparently justified him being ignored.

Previous experiences of discrimination also reduce a person's likelihood of accessing healthcare in the future; this is another important factor which impacts health outcomes and exacerbates race-based health inequities (Hall et al. 2015; Turpel-Lafond 2020; Wylie et al. 2019). Under-using health services can be understood as a means of stigma coping (Goffman 1963), where one responds to anticipated stigma with withdrawal or avoidance of potentially rejecting situations. In this case, stigma coping may take the form of only accessing health services in acute situations. For example, a qualitative study conducted in Alberta, found that Indigenous patients with rheumatic disease often delayed seeking specialist care until symptoms were extremely severe due to previous experiences of racism in healthcare (Thurston et al. 2014). However, non-Indigenous providers in the study made assumptions that patients didn't access care because their culture did not 'value' Western medicine, or the individual didn't know enough about their own disease. These assumptions are very damaging because they are rooted in the idea that the patient is to blame for their own pain and disease progression, which reinforce negative attitudes towards Indigenous patients. The providers in the study more readily saw individual or 'cultural' failings (negative perceptions which they assign to Indigenous peoples as a whole) as the problem rather than recognizing the systemic factors at play and their own role in constructing the issue. Moreover, these assumptions perpetuate a cycle of racism in patient-provider interactions and only make patients less likely to access care again in the future (Thurston et al. 2014).

In some cases, past experiences of racism can be so significant that individuals avoid seeking healthcare at all costs. As powerfully stated by an Indigenous woman in British Columbia "I know many elders who will absolutely refuse to go to health-care. They [would] rather die than access care. . . this is because of their past trauma." (BC Women's Health Foundation 2019:6). Such a quote embodies the profound impact of discrimination in healthcare settings as well as the extent to which colonial violence continues to manifest in medical institutions.

I want to emphasize here that while research in the preceding paragraphs have referred specifically to the experiences of Indigenous peoples, racism in healthcare impacts all racialized Canadians. However, due to problematic gaps in the collection of race-based data in Canada, there is a general lack of literature specific to this area. Black Canadians are particularly impacted by data erasure, including those data related to health inequities (Black Health Alliance 2020). This leads to a context where, "acknowledgment of racism and discrimination toward Black Canadians remains limited (at best)" (Mpalirwa et al. 2020: 51), including acknowledgement of, and research on, racism within healthcare settings. Despite a lack of formal literature on the topic, there is no question that anti-Black racism is being experienced in Canadian healthcare at large — this is something which is being increasingly brought to light by Black healthcare providers and community ac-

tivists (Black Health Alliance, 2020; Dryden and Nnorom 2021). Additionally, research from other countries has demonstrated how the nature of race-based stigma means all non-White patients are commonly labeled as ‘other’. For example, Hall et al. (2015) conducted a systematic review examining implicit bias among healthcare providers in the US and concluded that “most healthcare providers appear to have implicit bias in terms of positive attitudes toward Whites and negative attitudes toward people of color” (Hall et al. 2015:60). Such biases were found to impact patient-provider interactions as well as treatment decisions. In this study, negative attitudes towards Black, Latinx, and ‘dark-skinned people’ were relatively similar across each racial group (Hall et al. 2015), again illustrating the generalized ‘othering’ of racialized patients by their healthcare providers.

## The Impact of Gender

BIPOC women are particularly impacted by discrimination in healthcare settings due to overlapping axes of racism and sexism (Hall et al. 2015; Turpel-Lafond 2020; BC Women's Health Foundation 2019). For example, one of the key findings from the In Plain Sight report was that Indigenous women and girls are disproportionately impacted by Indigenous-specific racism in the provincial healthcare system (Turpel-Lafond 2020). In addition, other research conducted in British Columbia has found that 1 in 3 women do not feel their needs are being treated effectively in healthcare, but the rate is even higher for Indigenous women and women who are immigrants (BC Women's Health Foundation 2019). To fully understand the experiences of BIPOC women in healthcare, it is important to first highlight the significance of gender as a determinant in itself.

The significance of gender is well illustrated by the fact that half of all women have experienced their symptoms being diminished or overlooked by a physician (as cited in BC Women's Health Foundation 2019). This tendency for women to be taken less seriously than men can be located in misogynistic stereotypes about the ‘overly sensitive’ or ‘hysterical’ woman. For example, in a theory guided literature review on gender bias in healthcare, Samulowitz et al. (2018) found that in comparison to men, women are more likely to be perceived as hysterical, emotional, complaining, malingering and only experiencing pain in their heads. Likely as a result of such biases, physicians are less likely to admit women who are in pain for medical testing, are more likely to diagnose their pain as psychological in origin and tend to give women less pain medication than men (as cited in BC Women's Health Foundation 2019). This is particularly concerning due to the fact that women actually have higher rates of chronic and acute conditions than their male counterparts (Bird & Reiker 1999). This paradox is summarized well by Samulowitz et al (2018)

“Compared to men, women have more pain, and it is more accepted for

women to show pain, and more women are diagnosed with chronic pain syndromes. Yet, paradoxically, women's pain reports are taken less seriously, their pain is discounted as being psychic or nonexistent, and their medication is less adequate than treatment given to men." (Samulowitz et al 2018:10)

These findings may help explain why a number of conditions which are predominately suffered by women - such as endometriosis and fibromyalgia - remain relatively under-explored, undertreated and 'contested' in medicine. 'Contested illnesses' are conditions with unclear causes or treatment, invisible symptoms and ultimately disputed medical legitimacy (Barker 2008). Interestingly, women account for 70% of patients with "medically unexplained" symptoms (as cited in BC Women's Health Foundation 2019). In these cases, patients have to fight for diagnoses and effective pain management (Barker 2008).

Based on these data reported above, I would argue that women in general, and racialized women in particular, often face similar challenges as those with 'contested illness' regardless of how medically recognized their symptoms or condition may be. In other words, gender and race-based biases mean that women's symptoms (even if they are 'standard' or 'medically accepted' symptoms) can be automatically questioned or contested in healthcare, and they must frequently fight for their concerns to be taken seriously.

Recent events have highlighted the dire consequences that arise when patients are not taken seriously in healthcare and how these consequences have been fatal for BIPOC women in Canada. Just months after the death of Joyce Echaquan, 44-year-old Mireille Ndjomouno— a mother of four originally from Cameroon — passed away at a hospital in Montreal, Quebec (Spector 2021). In a video posted to social media, Ndjomouno can be seen in clear distress with significant swelling in her face, telling viewers that she had been administered penicillin despite repeatedly telling her doctors that she was allergic to the drug (Spector 2021). Ndjomouno died a couple days after the video was taken. While authorities are still conducting an investigation into her death, I argue that the situation cannot be separated from Ndjomouno's social position as a Black woman and the findings explored so far in this paper, which suggest patients, due to race and gender biases, frequently receive lower-quality care and experience their concerns being minimized. In fact, there are eerie similarities between this case and Echaquan's, providing insight into the horrifying realities of being a racialized woman in Canadian hospitals. Both women had serious medical concerns dismissed by their healthcare providers, as reports indicate that Echaquan also communicated concerns about the level of morphine administered to her before her death (Turpel-Lafond 2020). Moreover, both women desperately took to social media for help, presumably due to an overwhelming feeling of voicelessness within the healthcare system itself.

## The Impact of Class and Cultural Health Capital

While there is less research examining the role of socioeconomic status (SES) in patient-provider interactions, existing evidence suggests that it is an important factor, especially in exacerbating or protecting against other biases. For example, patients who display distress and emotion in clinical interactions, are often perceived as ‘not credible’ and have their pain taken less seriously, particularly if they are women. But, importantly, research shows that the impacts of these ‘distress cues’ are reduced when the patient is of higher SES (Brandão et al. 2019). Presumably, a higher level of education and income are associated with a greater level of credibility, and this helps to legitimize a patient’s pain when they are presenting as ‘overly emotional’.

I would argue that SES may also act as a buffer when race-based stigma is present. This is powerfully illustrated in the first-hand account of a young Indigenous woman in British Columbia: “I’m afraid to go to any hospital, when I do, I dress up like I am going to church [in order to receive proper treatment]. It’s ridiculous” (Turpel-Lafond 2020:23). This quote shows that dressing in one’s best clothes, to signal a professional middle-class identity, is perceived to be a protective factor against racism in healthcare. According to Goffman (1963), this can be understood as a stigma coping strategy, where one conceals labelling info (employing the strategy of ‘secrecy’), or tries to separate themselves from the stigmatized group – in this case, low-income Indigenous peoples (employing the strategy of ‘distancing’). If one is questioning the significance of SES in patient-provider interaction, recall how Brian Sinclair was ignored by emergency room staff and subsequently died of a treatable condition because he was ‘assumed to be homeless’ (Lowrie and Malone 2020), which, to staff, appeared to mean he was not worthy of their attention.

Healthcare providers also tend to value patients with greater levels of cultural health capital – something that is significantly easier for upper-middle class groups to obtain. Cultural health capital (CHC) refers to a “a specific repertoire of cultural skills, verbal and non-verbal competencies, and interactional styles that can influence health care interaction” (Shim 2010:2). Among other characteristics, CHC includes knowledge of medical topics and medical vocabulary, knowing what information is relevant to share, and ability to intelligently and efficiently communicate this health information to providers. CHC can be used strategically or it may be mobilized unconsciously based on the way one is ‘used to acting’ with doctors and other clinicians. Either way, evidence suggests that when it is employed, CHC results in more positive healthcare relationships (Shim 2010).

However, access to such cultural resources is often shaped by race and class-based inequalities such as those related to educational attainment and employment opportunities. As stated by Shim (2010), “the distribution of CHC often follows racial and socioeconomic lines, reinforcing providers’ existing beliefs about minority patients, and, in turn, providers’ interpretations of health-related information and interpersonal behav-

iors” (2010:8). In other words, the absence of CHC can have compounding effects on patients who already experience stigma and stereotyping in healthcare, particularly those who experience multiple forms of discrimination such as racialized women. Additionally, healthcare providers can play an important role in helping patients to develop CHC (Shim 2010). For example, they may help explain different medical terminology to patients or teach strategies on how to effectively communicate one’s symptoms. But, importantly, this will not happen if providers have automatic biases towards certain patient groups and deem them “unworthy” of their ‘teaching time’. Overall, this suggests that those who will benefit the most from CHC may be the least likely to obtain it, while those who are already in positions of relative power (e.g. White upper-middle class patients) will be most likely to. CHC and socioeconomic status can therefore be understood as mechanisms which have the power to widen and exacerbate already unjust differences in patient treatment and care.

## **Examining the Social Identities of Medical Professionals**

When considering the different social identities of patients, it is equally important to critically examine the social identities of healthcare providers. As human behaviour is often based on ascribed meanings developed through one’s own experiences and interactions, a provider’s own identity can play a significant role in shaping their personal biases. For example, we can infer that a BIPOC female doctor is more likely to be understanding and compassionate towards a BIPOC female patient than a doctor who is White, upper-middle class and male. This is why the Truth and Reconciliation Commission explicitly calls for an increase in the number of Indigenous healthcare providers as a means to ensure cultural safety for Indigenous patients in Canada (as cited in Wiley et al. 2019). However, the field of medicine largely continues to function as an ‘old boys club’ with the overrepresentation of White male physicians, particularly in positions of authority (Mpalirwa et al 2020).

Not only are Black and Indigenous doctors significantly underrepresented in Canadian healthcare, but they also report facing frequent discrimination within medical institutions themselves. For example, half of Indigenous healthcare workers in British Columbia have experienced workplace discrimination, whether from patients, co-workers, supervisors or another person in a position of authority over them (Turpel-Lafond 2020). Similarly, in survey research conducted in Ontario, 70% of Black physician respondents reported negative experiences at work based on their race (Mpalirwa et al 2020). The authors found that Black physicians commonly experienced being ‘othered’, such as being frequently stereotyped, being regularly mistaken for floor aids, receiving a lack of mentorship from supervisors, and less access to growth opportunities than their White peers (Mpalirwa et al 2020).



A key concern is that during these discriminatory interactions, BIPOC healthcare workers receive minimal support from bystanders and White colleagues. Research suggests a professional culture where healthcare providers are often reluctant, or unwilling, to call out problematic behaviour when they witness it, and those who experience discrimination first-hand do not feel safe reporting it (Mpalirwa et al 2020; Turpel-Lafond 2020). This prevalence of racism in medicine, and the wide-spread fear of reprisal in speaking up against it, can perhaps be better understood through locating the roots of Western medicine in its history as a White colonial institution as well as its role in facilitating the oppression of BIPOC people. Within the context of Canada, there is also an important (but lesser-known) history of medical schools across the country barring Black students for several decades (Osei-Yeboah 2020). In fact, Queens University didn't formally repeal their ban on Black medical students until 2018 (Osei-Yeboah 2020).

Additional insight into the 'culture of medicine' can also be drawn from firsthand accounts of BIPOC health care providers, who are increasingly taking to media outlets to share their personal experiences. For example, South Asian medical student Vidya Viswanathan wrote in VOX about her experiences as a woman of colour and the lack of support she has received when it comes to facing racism from patients and supervisors. She states, "[there is] a reluctance in medicine to take a stand on issues of social justice and equality, and an idea that caring too much about equal treatment gets in the way of practicing the science of medicine" (Viswanathan 2019: para. 20). Though in relation to Viswanathan's personal experiences in the US, I argue the same statement is true in Canada as it speaks to the underlying values of Western medicine as a whole. It demonstrates how ideas about practicing 'good' medicine are rooted in the biomedical model. This model reduces health to the individual level and to biological processes, discounting social and structural determinants, including the role of providers' own implicit biases in shaping their treatment decisions. In reality, social conditions are one of the most powerful drivers in shaping a person's health and therefore, social justice approaches are fundamental to improving the health outcomes of individuals and communities.

Of course, there are many healthcare providers that do care deeply about these issues and who work hard to provide equitable, compassionate care to all of their patients. In fact, positive experiences with healthcare providers are present in nearly every study analyzed for this paper. However, evidence suggests that gender, race and class still have a powerful influence on the majority of patient-provider interactions. This cannot be separated from the fact that values underlying medicine are "deeply biased by the practice situations and social characteristics of the dominant group of medical professionals and physicians" (as cited in Bird and Reiker 1999:748). In other words, to understand the issues discussed so far in this paper, they must be analyzed in relation to both the biomedical model and the White male identity that Western medicine is rooted in, and that continue to dominate the medical profession.

## Reflection and Conclusion

This paper has presented data, theory and examples from news media exposing the significant impact that race, gender and class-based discrimination have on patient-provider interactions. They influence how a provider views a patient's credibility, the seriousness of their symptoms, and their 'worthiness' to receive diagnostic testing and treatment. Patients' comfort, safety and health outcomes are directly impacted by these experiences. In some cases, the consequences can be fatal - whether a patient is ignored to death like Brian Sinclair, their medical histories/concerns overtly dismissed like Joyce Echaquan and Mireille Ndjomouno, or they simply avoid seeking healthcare at all costs due to traumatic experiences of racism in the past. This reflective examination has shown that these issues are particularly salient for low-income BIPOC women as they experience compounding forms of stigma and discrimination. The examination of a racialized and gendered experience together is uniquely different from, and more impactful than, the impact of any one identity on its own.

While we cannot separate provider biases from the larger structures of colonialism and patriarchy, a symbolic interactionist perspective offers hope for change. Humans are active agents in the construction of behaviours and the creation of knowledge, meaning that we can be active agents in its deconstruction as well. More diversity in medicine and mandatory training for cultural safety and humility are critical tools for deconstructing the widespread discrimination which occurs in healthcare and the overall dominance of the White male identity in medicine (Wiley et al. 2019; Turpel-Lafond 2020).

However, it is important to note that such biases do not start or stop within the walls of medical institutions. They are learned at a young age and reinforced throughout the course of one's life. Therefore, getting to the root of discriminatory interactions in healthcare requires thinking critically about how individuals are socialized in our society more generally. For example, encouraging children to disrupt gender norms and implementing a mandatory comprehensive education of colonial history in schools across Canada is a crucially important start. Overall, individuals – particularly those that hold a considerable amount of power in their social position - must be exposed to an equity-based understanding of the social world so that they do not automatically 'other' and, ultimately, dehumanize, groups with a different social identity from their own. In order for this to happen, policy makers must take seriously, and commit to implementing, calls-to-action developed by the communities most impacted including those from the Truth and Reconciliation Commission, the Black Experiences in Healthcare Symposium and The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls.

It is important to note that this examination of social identity on patient-provider interaction is far from exhaustive. Although this paper has focused specifically on race, gender, and class, an intersectional framework points to many other overlapping axes

of advantage and disadvantage, which are equally as important in understanding patient experience. For example, research suggests that women in Canada face higher rates of discrimination in healthcare when they are trans, queer, migrants who experience language barriers, are living with HIV (as cited in BC Women's Health Foundation 2019), or even if they are overweight (Bombak et al. 2016).

Moreover, discrimination in micro-interactions is also only one layer of how social position impacts a person's health. It is one element in a larger web of structural inequalities including access to education, employment, income, housing, food security and environmental racism among other social determinants, which shape the health outcomes of Canadians. Paradoxically, the presence of such health inequities means that the groups who are disadvantaged the most in patient-provider interactions are also those who tend to face the highest burden of disease. These issues emphasize the complexities of health and illness, and the way in which our lives are so deeply shaped by the social world around us. To improve health outcomes, policy must embrace these social complexities, listen to the needs of marginalized communities and focus on upstream solutions (developed in partnership by those most impacted) to deconstruct the prolific nature of racism, classism and sexism in our society as a whole.

## References

- Barker, Kristin K. 2008. "Electronic Support Groups, Patient-Consumers, and Medicalization: The Case of Contested Illness." *Journal of Health and Social Behavior* 49(1):20–36. doi: 10.1177/002214650804900103.
- BC Women's Health Foundation. 2019. *In Her Words: Women's Experience with the Healthcare System in British Columbia*.
- Bird, Chloe E., and Patricia P. Rieker. 1999. "Gender Matters: An Integrated Model for Understanding Men's and Women's Health." *Social Science & Medicine*, 48(6):745–55. doi: 10.1016/S0277-9536(98)00402-X.
- Black Health Alliance. 2020. *Black Experiences in Health Care Symposium*. North York, Ontario. (<https://static1.squarespace.com/static/5a0d40298dd041f9a60bb3a7/t/5ea9a317983eca78fd95ee6d/1588175652047/Full+Report+-+Black+Experiences+in+Health+Care+Symposium+2020.pdf>)
- Bombak, Andrea E., Deborah McPhail, and Pamela Ward. 2016. "Reproducing Stigma: Interpreting 'Overweight' and 'Obese' Women's Experiences of Weight-Based Discrimination in Reproductive Healthcare." *Social Science & Medicine*, 166:94–101. doi: 10.1016/j.socscimed.2016.08.015.
- Brandão, Tânia, Lúcia Campos, Lies de Ruddere, Liesbet Goubert, and Sónia F. Bernardes. 2019. "Classism in Pain Care: The Role of Patient Socioeconomic

- Status on Nurses' Pain Assessment and Management Practices." *Pain Medicine* 20(11):2094–2105. doi: 10.1093/pm/pnz148.
- Cockerham, W. C., and G. Scambler. 2010. "Medical Sociology and Sociological Theory." in *The New Blackwell Companion to Medical Sociology*. Blackwell Publishing Ltd.
- Conrad, Peter. 1992. "Medicalization and Social Control." *Annual Review of Sociology*, 18:209–32.
- Dryden, OmiSoore, and Onye Nnorom. 2021. "Time to Dismantle Systemic Anti-Black Racism in Medicine in Canada." *CMAJ*, 193(2):E55–57. doi: 10.1503/cmaj.201579.
- Goffman, Erving. 1963. *Stigma: Notes the Management of a Spoiled Identity*. Englewood Cliffs, N.J.: Prentice-Hall.
- Hall, William J., Mimi V. Chapman, Kent M. Lee, Yesenia M. Merino, Tainayah W. Thomas, B. Keith Payne, Eugenia Eng, Steven H. Day, and Tamera Coyne-Beasley. 2015. "Implicit Racial/Ethnic Bias Among Health Care Professionals and Its Influence on Health Care Outcomes: A Systematic Review." *American Journal of Public Health* 105(12):e60–76. doi: 10.2105/AJPH.2015.302903.
- Hankivsky, Olena, and Ashlee Christoffersen. 2008. "Intersectionality and the Determinants of Health: A Canadian Perspective." *Critical Public Health*, 18(3):271–83. doi: 10.1080/09581590802294296.
- Lowrie, Morgan, and Kelly Malone. 2020. "Joyce Echaquan's Death Highlights Systemic Racism in Health Care, Experts Say." *CTVNews*. Retrieved December 8, 2020 (<https://www.ctvnews.ca/health/joyce-echaquan-s-death-highlights-systemic-racism-in-health-care-experts-say-1.5132146>).
- Mpalirwa, Joseph, Aisha Lofters, Onye Nnorom, and Mark D. Hanson. 2020. "Patients, Pride, and Prejudice: Exploring Black Ontarian Physicians' Experiences of Racism and Discrimination." *Academic Medicine*, 95(11S):S51–57. doi: 10.1097/ACM.0000000000003648.
- Osei-Yeboah , Clara . 2020. "How Queen's School of Medicine Barred Black Students for 40 Years." Retrieved March 28, 2021 (<https://inkspire.org/post/how-queens-school-of-medicine-barred-black-students-for-40-years/-M2ix2zV7yw8Y-V-XUQ>).
- Samulowitz, Anke, Ida Gremyr, Erik Eriksson, and Gunnel Hensing. 2018. "'Brave Men' and 'Emotional Women': A Theory-Guided Literature Review on Gender Bias in Health Care and Gendered Norms towards Patients with Chronic Pain." *Pain Research and Management* 2018:1–14. doi: 10.1155/2018/6358624.
- Shim, Janet K. 2010. "Cultural Health Capital: A Theoretical Approach to Understanding Health Care Interactions and the Dynamics of Unequal Treatment."

- Journal of Health and Social Behavior*, 51(1):1–15. doi: 10.1177/0022146509361185.
- Spector, Dan. 2021. “Quebec Coroner Investigating Death of Woman Who Posted Distress Video from Hospital.” *Global News*. Retrieved March 28, 2021 (<https://globalnews.ca/news/7693673/quebec-coroner-investigating-death-mireille-ndjomouo-video-hospital/>).
- Thurston, Wilfreda E., Stephanie Coupal, C. Allyson Jones, Lynden FJ Crowshoe, Deborah A. Marshall, Joanne Homik, and Cheryl Barnabe. 2014. “Discordant Indigenous and Provider Frames Explain Challenges in Improving Access to Arthritis Care: A Qualitative Study Using Constructivist Grounded Theory.” *International Journal for Equity in Health*, 13(1):46. doi: 10.1186/1475-9276-13-46.
- Turpel-Lafond, M. E. 2020. *In Plain Sight: Addressing Indigenous-Specific Racism and Discrimination in B.C. Health Care. Independent Investigation*. Government of British Columbia.
- Viswanathan, Vidya. 2019. “‘Are You a Doctor?’ The Unchecked Racism Faced by Physicians of Color.” *Vox*. Retrieved December 8, 2020 (<https://www.vox.com/first-person/2019/1/2/18144979/doctor-racism-delta-airlines-dr-tamika-cross-fatima-cody-stanford>).
- Wylie, Lloy, Stephanie McConkey, and Ann Marie Corrado. 2019. “Colonial Legacies and Collaborative Action: Improving Indigenous Peoples’ Health Care in Canada.” *International Indigenous Policy Journal*, 10(5). doi: 10.18584/iipj.2019.10.5.9340.