

Written Submission May 28, 2021**Quebec Coroner's Public Inquiry**

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1. Biography and Overview of Expertise

I am submitting this report while working and living on the traditional, ancestral, occupied and unceded territories of the xʷməθkʷəy̓əm First Nation. This land has always been a place of learning for the Musqueam people, who for millennia have passed on their history and knowledge with a spirit of generosity, and with a view to improving the world in which we live.

I extend my deepest condolences to the family of Ms. Joyce Echaquan. I would like to acknowledge the grief and pain they continue to endure during this Inquest, and the generosity of spirit they convey by permitting us to engage in these discussions.

I am a Professor and Distinguished University Scholar at the University of British Columbia (UBC) School of Nursing in Vancouver, BC, and have been a Registered Nurse since 1986. My program of research builds on my experience as a clinical nurse who lived and worked within remote, northern First Nations and Inuit communities. My research focuses on health and healthcare inequities, with a particular focus on implications for Indigenous peoples. More specifically, I conduct research on strategies to improve the quality of care provided to Indigenous and non-Indigenous people, including: interventions to address systemic racism and other forms of discrimination, strategies to support cultural safety and trauma- and violence-informed care, and approaches for changing healthcare agencies and organizations to enhance health equity. My work is aimed at promoting health equity for Indigenous and non-Indigenous peoples through improvements in nursing practice, healthcare delivery, and health policy.

I have held nursing leadership roles in the academic health sciences including: leading national and international funded research initiatives in the field of Indigenous health and health equity; serving on major peer review panels particularly the CIHR Institute for Indigenous Peoples' Health; and serving as Associate Director of Graduate Programs at the UBC School of Nursing. I provide local and international leadership on research projects that address priority concerns to Indigenous peoples. At UBC, I have served as the principal or co-principal leader on over \$7.5 million of funded research in my field of study, including studies conducted in emergency departments. I have been invited as a co-investigator on an additional \$5.7 million of funded studies. I have authored over 100 peer-reviewed journal articles, numerous book chapters, and I am the editor of a leading nursing textbook on health assessment. My publications include evidence-based strategies for improving the quality of care provided to Indigenous peoples, with a particular focus on Indigenous women.

I was provided with reports and documents relevant to the case, including medical reports and nursing notes, and received extensive, detailed notes of the testimonies during the inquest. To ensure the relevancy of my analysis in the context of Quebec, I have retained as a consultant Dr. Amélie Blanchet Garneau, inf., PhD, Professeure adjointe, Assistant Professor, Faculté des sciences infirmières, Faculty of

Nursing, Université de Montréal, Titulaire de la Chaire de recherche autochtone en soins infirmiers-IRSC / Indigenous Research Chair in Nursing-CIHR, Centre de recherche en santé publique (CRéSP). Dr. Blanchet Garneau is a White settler of French ancestry living and working on the unceded territory of the Kanien'kehá:ka nation. She has been a Registered Nurse in Quebec since 2004. In partnership with Indigenous and non-Indigenous scholars, leaders, and practitioners, her research program is aimed at decolonizing nursing practice and education toward Indigenous health equity.

2. Overview of Systemic Racism in Canadian Health Care Settings

Systemic racism impacts all aspects of Canadian society, including the health care system. Systemic racism can operate in explicit ways and in much less visible ways, for example, through the workings of what is called “democratic racism” [1-6], which helps to explain how Canadians, including nurses, doctors, nursing care aides, and social workers, among others, can hold stigmatizing views of particular groups of people, such as Indigenous peoples, while at the same time espousing democratic principles of equality, tolerance, and fairness [5-18]. These principles are epitomized in the phrases, “I treat everyone equally”, “I mean no harm”, “I am color blind”, “systemic racism doesn’t occur in my setting”, or “biases do not affect the care I provide” [6-8, 10, 11, 14, 15, 17-32].

Recent events in Canada surrounding the tragic death of Ms. Joyce Echaquan in Quebec, the investigations in British Columbia into emergency department staff playing ‘games’ to guess blood-alcohol levels of Indigenous patients, and the decades-long investigation into the death of Mr. Brian Sinclair in Manitoba, have catalyzed attention to the harms of Indigenous-specific racism -- harms that continue to deepen and perpetuate inequities and poor health outcomes for Indigenous peoples. Against this backdrop are repeated calls for mitigating the effects of anti-Indigenous racism in Canadian healthcare systems [28-30, 33-37].

In liberal democratic societies such as Canada, beliefs about egalitarianism and multiculturalism paint a picture of our nation and our institutions as free from racism and other forms of discrimination. In this context, critical discussions of racialization as a key determinant of health and social inequities are often viewed as unnecessary or unwarranted. At the same time, there is a large and growing body of research that continues to demonstrate how misinformed assumptions regarding ‘race’ as a social category, and racism as a social process, have profound negative impacts on health, access to health care, quality of care, and quality of life [4, 5, 7, 8, 10, 37-47]. The health status of Indigenous¹ peoples in Canada and globally represents an important case in point. Despite Canada’s commitment to primary health care (PHC) and principles of social justice, inequities in access to care and health outcomes among Indigenous peoples remain a pressing national concern. Although Indigenous peoples have thrived in the face of ongoing colonial policies and structures, Indigenous populations experience significantly higher morbidity and mortality rates compared to non-Indigenous populations, and the health status of Indigenous peoples falls significantly behind that of other Canadians on virtually every measure. These inequities are not attributable to poor lifestyle choices, poor health behaviors, or cultural factors: rather, they are embodied manifestations of the complex interplay of social, historical, political, and economic determinants of health and access to health care. As emphasized in the report of the United Nations Special Rapporteur, compounding these health status disparities are the persistent and multifaceted

¹ Consistent with accepted terminology used in landmark international reports, the term Indigenous peoples is used to refer to the diversity of populations throughout the world. In Canada, and in this report, Indigenous peoples includes First Nations, Métis (people of mixed European and Indigenous ancestry), and Inuit.

forms of racism and discrimination experienced by Indigenous peoples globally: “such discrimination is intimately interconnected and mutually reinforcing with the spectrum of violations experienced by Indigenous peoples” [48] (p. 10). Racism and intersecting forms of discrimination shape Indigenous peoples’ experiences in the health care system, and must be considered determinants of health for Indigenous peoples [41, 48-51]. The recent Public Inquiry in Quebec, the “Viens Commission”, has come to the same conclusion in relation to health care services in Quebec [37].

The issues discussed in my report are national-level issues. No province, territory or health care institution is exempt. Over the last three decades there have been numerous national commissions, inquiries and calls for addressing the harms of systemic racism. These reports, for example, signal the national scope of the problem:

- Public Health Agency of Canada. (2019). *Addressing stigma: Towards a more inclusive health system. The Chief Public Health Officer's report on the state of public health in Canada 2019.*
- Public Health Agency of Canada. (2020). *From Risk to Resilience: An Equity Approach to Covid-19. The Chief Public Health Officer's report on the state of public health in Canada 2020.*
- Government of Quebec. (2019). *Public Inquiry Commission on relations between Indigenous Peoples and certain public services in Quebec: Listening, reconciliation and progress. Final Report.* Retrieved from Quebec: <http://www.cerp.gouv.qc.ca/>
- National Inquiry into Missing and Murdered Indigenous Women and Girls. (2019). *Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls, Volume 1b.* Retrieved from Ottawa: https://www.mmiwg-ffada.ca/wp-content/uploads/2019/06/Final_Report_Vol_1b.pdf
- Truth and Reconciliation Commission of Canada. (2015). *Final report of the Truth and Reconciliation Commission of Canada.* Retrieved from Winnipeg, MN: <http://www.trc.ca/websites/trcinstitution/index.php?p=890>
- Royal Commission on Aboriginal Peoples. (1996). *Report of the Royal Commission on Aboriginal Peoples: Volume 3, gathering strength.* Retrieved from Ottawa, ON: <http://caid.ca/RRCAP3.0.pdf>

I would also like to acknowledge the context of nursing shortage in Canada, and in rural communities in particular [52, 53]. It is challenging to achieve adequate staffing levels in rural hospitals, and the challenges associated with practicing nursing or medicine in rural communities are widely known and widespread across Canada. This cannot, however, excuse the provision of poor quality of care, or care that contravenes minimum, basic standards for practice.

3. Common Stereotypes Impacting the Care Provided to Indigenous Peoples

a. Stereotypes about Indigenous Peoples

The evidence-based literature continues to demonstrate the extent to which stereotypes and misinformed assumptions about Indigenous peoples actually *organize* health care providers’ practices, and organizational and institutional policies, practices, discourses, and norms [8, 19, 41, 54-62]. These stereotypes are evident throughout institutions in Canada, including health care. The following are examples of common stereotypes operating in health care:

- One of the most ubiquitous and harmful stereotypes pervading Canadian people’s viewpoints is founded on assumptions about Indigenous peoples as being more prone to alcohol or substance

use than other Canadians, despite the scientific evidence refuting this myth [57, 63, 64]. This stereotype is particularly harmful in healthcare settings because it can result in inaccurate health assessments, misdiagnoses, and missed diagnoses. Indigenous people are often subject to stigma related to substance use, regardless of whether or not they use substances. Research shows, for example, that Indigenous people who come to emergency departments and present with symptoms such as unsteady gait or slurred speech are often assumed to be using alcohol or other substances, and treated as such, when they may be experiencing a stroke or other serious health issue [7, 8, 10, 28, 29, 65].

- Misinformed stereotypes about Indigenous peoples “getting everything for free” continue to fuel resentments by health care providers about Indigenous peoples as being undeserving recipients of care [5, 28, 66-68]. Messages about Indigenous peoples being less deserving of care than other people are conveyed to patients through verbal and non-verbal messages from nurses, doctors, security guards, social workers and other members of the health care team. These judgements are perceptible to patients and their family members or friends, and cause people to feel unwelcome and negatively judged when seeking help at clinics, hospitals or emergency departments [7, 10, 65, 69].
- Enduring stereotypes about Indigenous women as irresponsible and incompetent parents continue to underpin the state’s widespread removal of Indigenous children from their families and communities [46, 61, 70-74]. In health care interactions, this can manifest as paternalistic attitudes and high levels of suspicion toward Indigenous women, contributing to mistrust between providers and patients. In many cases, Indigenous women avoid seeking care because of fear of being negatively judged and reprimanded by health care providers, or being placed under surveillance that can result in removal of their children from their care [11, 12, 19, 23-25, 43, 72, 73, 75, 76].

b. Stigma Toward People Who Use Narcotics or Other Substances

Intersecting with the stereotypes described above is the stigma experienced by people who either use, or are assumed to be using, drugs, narcotics, and other substances. This form of discrimination is known as substance use stigma. As noted by the Chief Public Health Officer of Canada [29] substance use stigma involves:

the labeling of differences and negative stereotyping of people, creating a separation between “us” and “them.” Those who are stigmatized are devalued and subjected to discrimination, which is unjust treatment....Stigma can be seen as both a cause and an effect; it continues to justify the devaluing of people through stereotypes and exclusion...In the health system, this power dynamic also exists between health care providers and patients (p. 23).

Stigma and discrimination associated with substance use contribute directly to poor health outcomes and major barriers to care [29, 77]. When substance use stigma involves Indigenous peoples, the harms can be significant and result in tragic outcomes [28, 31, 78]. Research that I and others have conducted in various parts of Canada demonstrate that a frequent concern expressed by Indigenous peoples is that they will be viewed as “drug seeking” when, from their perspective, they are seeking help for legitimate health issues, and even when they do not have a history of using drugs or other substances [7, 8, 10, 29,

43, 69, 76, 79, 80]. These constellations of stereotypes have a direct impact on provider-patient interactions: because of the pervasiveness of negative attitudes toward people with substance use issues, many people are negatively judged and treated in dismissive, disrespectful or discriminatory ways in health care settings. To avoid these experiences, people who use substances often delay or avoid seeking care at emergency departments and other health care settings. Ironically, when people do come for care, for example, when their symptoms become acute or unbearable, they are often blamed by health care providers for not seeking care earlier, further contributing to negative health care experiences and undermining the development of trusting health care relationships.

c. Stigma Toward People Experiencing Chronic Pain

Chronic pain² (also referred to as persistent pain) is among the most common reasons for seeking health care, and is among one of the most stigmatized health conditions. Chronic pain is largely invisible, and those affected often feel disbelieved and stigmatized. Living with chronic pain can take a tremendous toll on sleep, physical functioning, mental health, and social relationships. Research shows that within the general population, chronic pain remains poorly recognized, underestimated, undermanaged, and associated with social stigmas [81-84].

The role of gender and sex in chronic pain is well established, indicating that women disproportionately experience persistent pain when compared to men [81, 85, 86]. Also recognized is the pervasive gender bias in the treatment of persistent pain. Gender biases in health care with regard to the treatment of chronic pain is referred to as the “gender paradox of pain” [81] (p. 2). These gender biases show that:

- Women are more likely than men to be undertreated.
- Women’s reports of pain experiences are often labeled by health care professionals as hysterical, fabricated, or nonexistent, resulting in women generally being diagnosed with psychological conditions when they present with persistent pain.
- There is a demonstrated co-occurrence between psychiatric disorders and persistent pain, which is commonly relied upon to explain women’s symptoms as psychosomatic.
- Women with a history of trauma, violence, or abuse report significantly more abdominal pain, pelvic pain, headache, and back pain compared to women who do not have this history.
- Women experiencing chronic pain often experience co-existing mental health issues such as depression and anxiety.

Research also repeatedly demonstrates that there are significant mismatches between the needs of people living with chronic pain (help with managing chronic pain symptoms and quality of life), and the services provided at emergency departments [7, 87]. Exacerbating the situation is the lack of available resources in the community (e.g., in the primary care sector) designed to help people deal with chronic pain. This especially the case for people who experience mental health issues such as anxiety or depression.

² When pain persists for longer than 3 months, it is defined as chronic. The World Health Organization (WHO) in its 11th revision of the International Classification of Diseases (ICD-11) includes chronic pain as a diagnosis in its own right, further categorizing chronic primary pain and chronic secondary pain. Chronic primary pain refers to pain that exists despite complete tissue healing, or pain that has no identifiable cause. Chronic secondary pain occurs in association with underlying diseases (e.g., rheumatoid arthritis).

4. How Racism, Stigma and Other Forms of Discrimination Intersect to Influence Quality of Care: An Analysis of Ms. Echaquan's Case

Systemic racism operates in health care to perpetuate stereotypes, assumptions, misperceptions and misinformation about Indigenous peoples, influencing how providers interact, assess, examine, and treat patients. Organizational cultures influence whether racist, discriminatory or stigmatizing practices are acceptable or tolerable, or not. Racism, stigma and related practices thus become embedded in the culture of health organizations and reinforced by clinical and non-clinical staff (e.g., administrative, management and support staff) [29]. Taken together, the social dynamics described above can have profoundly harmful effects on Indigenous peoples in the health care sector, as I explain in the specific case of how Ms. Echaquan was treated, based on the materials I have reviewed.

a. Impact on Patient-Provider Relationships

Trusting patient-provider relationships are essential to the provision of quality care; they are the basis of quality nursing care. In the discipline of nursing, a basic Practice Standard (as a minimum requirement for safe nursing practice) is the nurse-client relationship:

The nurse-client relationship is the foundation of nursing practice across all populations and cultures and in all practice settings. It is therapeutic and focuses on the needs of the client. It is based on trust, respect, and it requires the appropriate use of authority....Within the nurse-client relationship, the client is often vulnerable because the nurse has more power than the client....A nurse may violate a boundary in terms of behavior related to favouritism, physical contact...chastising and coercion. Nurses who put their personal needs ahead of their clients' needs misuse their power. ([Boundaries in the Nurse-Client Relationship \(bccnm.ca\)](http://bccnm.ca))

The materials I reviewed indicate that there are violations with regard to practice standards for nurse-client relationships. Nurses' notes indicate that staff negatively judged Ms. Echaquan's behaviours, including those indicating that she was experiencing a high level of distress. Their notes also indicate a lack of critical thinking about how to professionally document a patient's signs and symptoms of emotional distress.

On May 25, 2021, a testimony provided by a patient who was in the emergency room in close proximity to Ms. Echaquan described Ms. Echaquan yelling, "I'm in pain", becoming agitated and banging on the wall, yelling "I'm going to leave my body", and "I'm going to die, I'm going to die!". In that testimony, the patient describes feeling concerned that the nurses "left her [Ms. Echaquan] like that, by just coming and telling her not to scream, it seemed like forever, until I thought to myself, 'why aren't they helping her?'" In the testimony, this patient describes what staff said to Ms. Echaquan in the course of interacting with her: "you are old enough to control yourself", "you are going to stop screaming like that, you disturb everyone here, we are not in a daycare here, we do not manage babies". The testimony indicates that this person experienced secondary trauma from observing Ms. Echaquan's expressions of distress, and staff members' responses to and interactions with Ms. Echaquan.

The video recorded by Ms. Echaquan on September 28 illustrates staff members' use of patronizing tones of voice, chastising statements, and use of power over Ms. Echaquan as expressed through their verbal statements, which were demeaning, dismissive, disrespectful, and blaming. For example, video

recordings of staff member's statements, spoken when they were directly interacting with Ms. Echaquan, mirror commonly used stereotypes about:

- Indigenous people as both costing the system and draining resources from the system:
 - "We are ones who pay for that; Who do you think is paying for that?" *"Surtout que c'est nous autres qui paie pour ça »*, « *Qui tu penses qui paie pour ça toé? »*
- Indigenous women as irresponsible:
 - "That is better for f___ing than anything else". *"Bien meilleur pour fourrer que d'autres choses ça ...hen?"*
 - "You made wrong choices, my dear". *"T'as fait des mauvais choix ma belle!"*
 - "Hey! You are very stupid". *"Hey! T'es épaisse en calisse".*
 - "What would your children think to see you like that?" *"Qu'est-ce qui penserait tes enfants, te voir comme ça ! Pense à eux autres un peu".*
- Indigenous people as undeserving of care:
 - "It's better dead, this thing [referring to Ms. Echaquan]". *"C'est juste bon mort ça".*

These statements cannot be analyzed as innocuous, or as spoken only because staff were overworked or stressed. Rather, as stated in the Chief Public Health Officer's 2019 Report,

Language is a powerful tool that reflects and perpetuates biases in society. Words communicate assumptions, values, judgements, and stereotypes that create and reinforce negative portrayals of devalued groups (p. 30).

The evidence I reviewed indicate that implicit biases were operating to influence the quality of care provided to Ms. Echaquan. Implicit bias refers to attitudes and stereotypes that occur unconsciously and inform people's thinking, beliefs, and behaviors with regard to particular groups of people. Implicit bias occurs involuntarily and beneath the level of conscious awareness [29, 88-90]. Implicit bias occurs when professionals are unaware that their language or actions are stigmatizing. Conscious bias occurs when an individual believes and reproduces negative stereotypes and stigmatizing myths about particular groups or individuals, resulting in discriminatory language or practices. Biases appear to have influenced how Ms. Echaquan was treated – particularly in the last hours of her life.

Although it is concerning that health care professionals hold these views, the organizational culture in which these comments are expressed also requires scrutiny – particularly when that organization frequently serves Indigenous peoples. When these kinds of stereotypes are shared among members of the health care team, they are difficult to recognize, describe, and question. This helps to explain how members of the health care team do not necessarily see their practices as racist, discriminatory or stigmatizing. However, regardless of whether team members recognize their attitudes, beliefs or practices as racist or not, system-level responses must be initiated [91].

b. Inattention to Past History and Experiences

A key feature of systemic racism is its denial as a feature of Canadian society, including its existence in health care. The denial of racism is a key reason that interpersonal and systemic racism continues to be perpetuated, affecting the quality of care. This is why many Indigenous peoples, Ms. Echaquan included, experience anxiety, fear and trepidation when going to emergency departments, and may try to avoid seeking care for as long as possible. In Ms. Echaquan's case, she relied on the hospital for essential services (e.g., for her cardiac condition), and as a result, had to come to the hospital frequently

and regularly. Her family described that she was often afraid to come to the hospital, fearing that she would be given medications without the staff treating her for what she viewed as her most significant problems, such as the chronic pain she experienced.

The fact that Ms. Echaquan had past negative experiences at this hospital appears not to have factored into the care provided to Ms. Echaquan. Staff interacting with Ms. Echaquan did not appear to make efforts to reassure Ms. Echaquan, or acknowledge her distress by responding with empathy. Rather, they expressed irritation at having to interact with her, and implied that she was less than deserving of care than other people. In so doing, they were not only failing to acknowledge the increasing levels of agitation and distress she exhibited, they failed to use routine de-escalation techniques to help Ms. Echaquan feel less agitated.

Responding to patients who are in emotional or psychological distress does not necessarily require more time, or additional time on top of a pre-existing heavy workload. Rather, time can be used differently and more effectively. Evidence-based literature shows that responding appropriately to patients in distress does not take more time, and in fact, it can actually save time. For example, in response to Ms. Echaquan expressing verbal dismay about “my heart my heart!”, “I’m in pain!” or “I’m going to die!”, staff said, “Try to control yourself”; “If you keep going, we are going to shoot you [give you an injection]”. Instead, staff could have used the same amount of time to reassure Ms. Echaquan, for example by saying, “I see you are in distress; you are safe with us; we are here to help you”.

The statements that were used during the course of interacting with Ms. Echaquan worked in direct opposition to de-escalation approaches; it is reasonable to anticipate that they would have further agitated her. Lack of time or resources cannot serve as an excuse for these types of patient-provider interactions, particularly for patients in distress or experiencing an acute health crisis. Providing appropriate nursing care in the areas discussed in this report would not necessarily have taken more time.

c. Impact on Clinical Care

As discussed above, stereotypes, implicit biases, and mistaken assumptions can affect providers’ clinical judgement and decision-making, and ultimately, the quality of care provided to patients. The following are examples with regard to the clinical care provided to Ms. Echaquan.

Inappropriate Responses to Signs and Symptoms of Distress

Nurses and other staff, particularly those working in emergency departments, can expect and anticipate that patients often will become agitated, cry out for help, or express irritation and frustration toward staff members for a variety of reasons. These include, for example, if they are in pain or discomfort, if they believe they have been waiting for a long period of time, if they feel are not being treated appropriately or if they perceive that their concerns are not taken seriously. The ability to respond appropriately to people who become distressed, irritated or frustrated is a basic nursing competency. Through effective verbal and non-verbal communication, nurses and doctors can help to de-escalate situations that might otherwise lead to aggression or violence. These techniques are referred to as de-escalation approaches.

Principles of trauma- and violence-informed care (TVIC) are increasingly recognized in nursing and medicine as the basis for de-escalation approaches, particularly for patients who show signs of distress,

irritation, and frustration with the care they are receiving or are perceived to be receiving [27, 92-95]. At a conceptual level, trauma- and violence informed care (TVIC) is based on:

- Understanding that people disadvantaged by systemic inequities (including inequities resulting from system and interpersonal racism) often experience multiple forms of violence that have ongoing traumatic impacts
- Recognizing the effects of interpersonal and structural (e.g., poverty, racism) forms of violence as intersecting, with compounding impacts on health
- Shifting the emphasis from disclosures of traumatic experiences to creating a safe environment, including for those most traumatized [27]

In the context of clinical practice:

Trauma- and violence-informed care means that the responsibility for the physical, cultural and emotional safety of the person accessing care or services rests with the organizations and professionals providing care. This can be thought of as a universal approach to ensuring that individuals do not suffer further harm when seeking care and are helped in ways that are based on their strengths and capacities and offer meaningful choice and collaboration. This is differentiated from trauma-specific services, where interventions are provided to those identified with trauma symptoms, and expands on trauma-informed practice, where the focus is on individual-level traumatic experiences and responses. TVIC includes explicit attention to structural and systematic violence, with a focus on people's life conditions as well as their trauma and violence experiences [96] (p. 5).

Further, nurses and other members of the health care team who are familiar with the principles of TVIC demonstrate knowledge awareness of [95-97]:

- The prevalence of different types of trauma and violence and the physiological, psychological and social impacts of these on physical and emotional well-being, including the cumulative effects of violence and trauma over the lifespan.
- The common actions by providers, and/or environmental conditions that may be re-traumatizing for people who have experienced various forms of structural or interpersonal violence and trauma, and their effects.
- The importance of maintaining a respectful, non-stigmatizing and non-judgmental attitude towards all people.
- How to convey compassion and positive regard for people while promoting safe decisions and behaviors.
- The need to examine, with humility, their own role in the dynamics and impact of structural violence and stigma.
- A non-judgmental, anti-discriminatory and non-stigmatizing attitude as a fundamental aspect of their professional roles.

Based on the evidence I have reviewed, it appears that staff caring for Ms. Echaquan were not acting in ways that demonstrated an understanding of TVIC. Further, even without understanding the principles of TVIC, it appears that basic, appropriate de-escalation strategies were not used to reassure Ms. Echaquan, despite clear indications that Ms. Echaquan was becoming increasingly distressed on September 28. Overall, in the care provided to Ms. Echaquan, it appears that nurses in partnership with

the interprofessional team did not implement de-escalation or crisis management techniques, nor did they mobilize the appropriate resources to promote safety and mitigate risk of harm in response to escalating signs of distress.

Inappropriate Use of Restraints

Regarding the use of restraints, nurses are expected to play a significant role in client safety through implementation of alternative strategies to prevent the use of restraints [98, 99]. A key principle with regard to use of restraints is that nurses, in collaboration with the interprofessional team, must assess and know their client's history (for example, their history of past trauma, their past experiences with restraints, their current emotional and mental status, etc.) [99]. From the materials I have reviewed, it appears that nurses may have used restraints to prevent Ms. Echaquan from falling, though "the use of physical restraints to prevent falls and injuries has not been proven and might even increase risk of falls" [98] (p. 19). Staff may also have decided to use restraints because they were concerned that Ms. Echaquan was a threat to herself, other patients, or staff, though evidence-based literature states that, in mental health settings, use of restraints is not associated with improved safety for healthcare providers [100], and non-pharmacological interventions yield more positive effects compared to restrictive practices [101, 102].

Current clinical guidelines emphasize prevention, assessment, and alternative approaches including use of de-escalation interventions and crisis management. Restraint use is widely recognized to be a last resort only after all other alternatives have proven ineffective. These guidelines reflect a decade-old paradigm shift towards a restraint-free culture that focuses on alternatives to restraint, rather than just minimizing restraints [98].

Importantly, the use of restraints must be considered in light of the therapeutic relationship that should be established between clients and staff. Nurses must establish a therapeutic relationship with a client who is at risk of harm to self or others to help prevent the use of restraints [98, 99, 103]. Because the fundamental nurse-patient relationship in relation to Ms. Echaquan's care was violated, it follows that the nurses' critical thinking and clinical judgement regarding the use of restraints were similarly compromised and flawed. In addition to inadequately assessing Ms. Echaquan's emotional and mental status, it appears that the administration of Haldol by one of the nurses may have been used primarily as a chemical restraint. This seems significantly out of proportion given the extent to which Ms. Echaquan was described as needing primarily emotional support to keep herself or others safe.

Inappropriate Responses to Suspected Withdrawal Symptoms

Research shows that people living with chronic pain are often denied help or effective treatments because there is no observable, organic source of pain, or because they are assumed to be "drug seeking" [7, 8, 104, 105]. Similarly, people who experiences pain associated with withdrawal symptoms (for example, from opiates) are often stigmatized and treated with disdain for bringing such symptoms "onto themselves" – and judged negatively for their presumed drug use. This too contributes to a breakdown in trusting, therapeutic relationships between caregivers and patients.

In recognition of the need to avoid the harms of substance use stigma in hospital settings, practice standards for nurses, doctors, and other team members now require competencies related to substance use stigma and managing withdrawal symptoms [84, 106, 107]. For example, the Canadian Nurses Association (2020) requires nurses to:

- Understand the situation from the other person’s perspective
- Avoid bias based on nurses’ personal values when providing care
- Not use language or actions to punish or guilt the client for their situation
- Integrate understandings of past, current and intergenerational experiences of violence and trauma into practice
- Communicate with clients in a way that maintains their dignity ([Harm Reduction \(cna-aicc.ca\)](https://www.cna-aicc.ca)).

Regarding caring for patients with substance use disorder (SUD) (in the context of the opioids crisis), the Quebec College of Physicians, the Ordre des infirmières et infirmiers du Québec, and Pharmacists Order mention the following guiding principles [107]:

- To promote the primacy of clinical and professional judgment.
- To provide treatment based on a harm reduction approach aimed at reducing the negative consequences of drug use without eliminating drug use altogether. Accept that abstinence is not an absolute goal; target responsible use first.
- To encourage and maintain the commitment of the person and his or her significant family members to the treatment, using a patient-centred approach.
- Avoid stigmatization of people with SUD. SUD is considered a chronic disease.
- Avoid implementing measures with punitive intent. Unsupervised dosing or withdrawal, or urine testing, is part of the treatment plan and should not be used for punitive purposes.
- Ensure access and continuity of care, including sharing of information among professionals and use of technology.

These practice guidelines are particularly important in hospital settings, where opioid withdrawal can occur when opioids are stopped abruptly or the dose is substantially reduced.

Suspicious about Ms. Echaquan being “in withdrawal” arose repeatedly; however, the care provided to Ms. Echaquan appears to directly contradict the guidelines listed above. This is noteworthy because substance use stigma often intersects with systemic racism to affect the care that Indigenous peoples receive when seeking help at emergency departments, and at other agencies [5, 7, 10, 11, 13, 27, 28, 65, 69, 72, 76, 79, 108]. What evolved in relation to Ms. Echaquan’s care illustrates how substance use stigma intersects and overlaps with negative judgements about Indigenous people to result in a lack of appropriate care, and in overtly poor care. The specific mechanisms of stigma pertinent to the care provided to Ms. Echaquan include, for example, the staff members’:

- Use of demeaning and inappropriate language
- Reduced empathy toward her possible withdrawal symptoms, and other symptoms
- Disregard for the distress she expressed including her cries and pleas for help
- Apparent lack of motivation to provide reassurance
- Apparent lack of motivation to establish a therapeutic provider-patient relationship

In contrast to how Ms. Echaquan was treated (for what the staff suspected were withdrawal symptoms), the goals of treating withdrawal, as identified in current clinical guidelines, are “to alleviate unnecessary distress, maintain the therapeutic alliance between patient and provider, and facilitate treatment of the primary reason for admission” [106].

In treating possible symptoms of withdrawal, basic pain management principles apply, including assessing pain with standardized assessment tools. In patients with moderate to severe acute pain who use opioids, the aim of management is to provide adequate analgesia and prevent opioid withdrawal – with the aim of preventing patients from experiencing further distress and agitation. The materials I reviewed indicate that the staff were working at cross-purposes to these goals. The statements made by staff indicate that the stigma associated with withdrawal (which is ultimately about substance use) shaped their responses to Ms. Echaquan, their judgement about Ms. Echaquan’s deservedness with regard to receiving care, and the lack of empathy and care conveyed to Ms. Echaquan when she was clearly in distress.

Lack of Adequate Pain Assessments

Nurses play a pivotal role in pain management by using current knowledge about pain assessment and relief measures [109]. Based on my review of the materials provided to me, it appears that pain assessments did not guide nursing care – even though pain is routinely recognized as the “fifth vital sign” and known as an essential component of basic nursing assessments.

Pain assessments can be done efficiently, quickly and frequently, particularly for patients who are agitated. In clinical settings, pain is often assessed using a scale of 0-10 before and after administering pain medications. Doing so is a basic nursing competency, and is used to ascertain baseline intensity, track changes, and give some degree of evaluation to a treatment modality.

Basic nursing care also involves acknowledging patients’ expressions of pain as legitimate and real – regardless of the origin of the pain. For example, nurses could have said to Ms. Echaquan, “I am sorry you are experiencing so much pain; we will work with you to help you feel better”. Acknowledging peoples’ pain as real is part of the process of caring for someone who is experiencing pain. The documentation that I reviewed indicate that while analgesics were provided to Ms. Echaquan, pain assessments were not conducted before or after the administration of such medications. My sense is that because the source of Ms. Echaquan’s pain was unknown, this reinforced her care providers’ suspicions that the pain was associated with withdrawal symptoms. Because of the stigma associated with withdrawal, Ms. Echaquan’s voiced concerns about pain were not taken seriously and were not appropriately assessed. I suspect that the combined impact of: (a) stigma regarding Ms. Echaquan’s chronic pain of unknown origin, (b) the gender paradox of chronic pain, (c) the stigma associated with suspected substance use and withdrawal, and (d) negative stereotypes about Indigenous women intersected to shape the nursing staff’s apparent lack of attention regarding pain assessments as part of basic nursing care.

Lack of Critical Thinking and Clinical Judgement in Response to Rapid Changes in Level of Consciousness

Viewing a patient as stigmatized, and potentially as less deserving of care than others, is likely to have contributed to the apparent lack of recognition of Ms. Echaquan’s rapidly diminishing level of consciousness on Sept. 28, 2020. Nurses and other health care professionals are trained to recognize the signs and symptoms of someone whose physical health status is rapidly deteriorating. For example, breathing problems, diminished respiratory movements, mental status changes (decreased alertness, decreased level of consciousness) and vital sign concerns require immediate action. Nurses and health care professionals are expected to identify those signs and symptoms on the basis of rapid assessments and act accordingly. More specifically, the Ordre des infirmières et infirmiers du Québec (2017) states

that “Assessing the physical and mental condition of a symptomatic person is the nurse reserved activity that forms the basis of nursing practice” (<https://www.oiq.org/en/l-evaluation-clinique-cet-incontournable>). It appears that Ms. Echaquan’s care providers did not use their assessment skills, their critical thinking abilities, or their clinical judgement to respond to Ms. Echaquan’s condition in a timely way, particularly in the hours before her death.

Lack of Team Effectiveness

Effective teamwork is a critical enabler of safe, high quality care, particularly in emergency departments. One of the main strategies for responding to increasingly complex needs of patients presenting at emergency departments is to improve staffing and workforce flexibility through the formation of interdisciplinary care teams [110]. In busy clinical settings such as an emergency department, it is crucial for clinicians to create an environment in which the health care team members can share concerns about patients’ care and alert each other about undesirable or unsafe situations [110, 111]. In the materials reviewed for this report, it appears that that team was not working in a coordinated way to cross-check one another’s assumptions, to question their approaches to care, to cross-check the dosage of medications administered (for example, Haldol, Metoprolol), or to think critically (as a team) regarding the use of restraints as a last resort. It is not unreasonable to assume that the breakdown in team effectiveness was impacted by the negative stereotypes and misinformed assumptions that were circulating among staff about Ms. Echaquan, her health status, her medical conditions, and her needs for emotional support.

When considered in relation to their combined, cumulative effects, the factors discussed above contributed to the provision of poor quality of care, and particularly in the last hours of Ms. Echaquan’s life, her deteriorating health status, and ultimately, her death.

5. Recommendations to Improve Health Care, Health Outcomes, and Protection of Human Life

a. Implement Antiracism and Cultural Safety Training: Necessary but Not Sufficient

Understanding the principles of cultural safety will help health care institutions and providers to practice from an anti-racist and anti-discriminatory stance. In tandem with trauma- and violence-informed principles, cultural safety is about mitigating the potential harms, traumas and lack of safety that people may experience as they seek help at any given health care setting.

Cultural safety was initially developed in New Zealand by Māori nurse leaders in consultation with Māori communities as a pragmatic tool for moving health care practices and policies beyond the notion of cultural sensitivity to more actively address inequitable power relations, racism and stigma, and the ongoing effects of historical injustices on health and health care [112]. The value of framing recommendations in relation to cultural safety lies in the potential to shift attention away from patients/families’ or communities’ presumed cultural differences or cultural practices as source of barriers to quality care, and onto the culture of health care as the site for improvement and transformation [6, 27, 50]. Increasingly in Canada, the United States, and Australia, cultural safety is mandated as an essential element of health care involving Indigenous peoples [6, 113-117]. In New Zealand, cultural safety is legislated as a basic requirement of nursing and medical professional education [116, 118, 119].

Although the word ‘cultural’ is used, cultural safety is not the same as cultural sensitivity. Instead, cultural safety is about counteracting the everyday impacts of racism and other forms of discrimination on peoples’ lives. Key features of cultural safety are that it:

- Locates the primary problem in health practices and policies – not with cultural issues/practices/barriers
- Focuses on strategies to mitigate the harmful effects of interacting with health systems, practices and policies
- Actively counteracts racism, stigma and others forms of discrimination by working against power differentials, stereotypes, and structural violence
- Draws attention to the often-harmful effects of ‘cultural sensitivity’ training, which can further entrench stereotypes

For example, the *San’yas*³ *Indigenous Cultural Safety Training Program* (www.sanyas.ca) is an Indigenous-led, policy-driven and systems-level educational intervention to foster health equity and mitigate the effects of systemic racism experienced by Indigenous people in health and other sectors. Currently, *San’yas* is being widely scaled-up across Canada, and is offered in health authorities and public service sectors, child welfare services, correctional services and elsewhere, including in British Columbia (BC) since 2010, in Ontario (ON) since 2013, and in Manitoba (MB) since 2016. Participants are guided through the training programs through a process of facilitated engagement with highly trained educators, learning activities, individual and group discussions, and access to Indigenous Elders and knowledge keepers, and are provided with facilitated opportunities to generate strategies for implementing cultural safety in ways that align with participants’ varied work and service sector contexts.

Resources must also be devoted to develop guidelines and strategies to assist leaders within organizations to address and respond to the inevitable discomforts, disruptions, and often, secondary traumas that can result when engaging with issues regarding racism and other forms of discrimination, the root causes of health and social inequities, and policies and practices that shape Indigenous peoples’ experiences and outcomes [6, 47, 120, 121]. Recognizing the known limitations of antiracism educational interventions in affecting sustained behavior and policy change, and in the face of continued system-level factors and social determinants that significantly impact the health of Indigenous populations, educational efforts must be integrated within larger, multi-level change processes [116, 120].

b. Embed Training and Education as Part of Broader System Change

Educational interventions alone cannot transform systems, and shifting knowledge, attitudes and behaviors of individuals is not sustainable without organizational supports, policy directives, accountability mechanisms, and whole-system actions [122]. Health authorities, government sectors, organizations and institutions cannot view training programs as stand-alone programs; commitments to addressing anti-Indigenous racism and improving health care for Indigenous people will require full-scale policy and organizational transformations [6, 47, 119, 120]. Any and all training must be embedded as part of broader system transformation. This requires multiple approaches, policy directives,

³ *San’yas* is a Kwak’wala word meaning “to know” or “knowing”.

accountability mechanisms, and interventions that can be maximally disruptive of systemic racism and stigmatizing discourses about Indigenous peoples.

Directing funding only to nursing or physician training overlooks the evidence showing the extent to which all types and levels of healthcare staff, including physicians, nurses, social workers, security guards, healthcare aides, among others can (often unintentionally) become caught up in perpetuating systemic racism. Given the extent to which healthcare is delivered by interprofessional teams, efforts toward supporting antiracism education in health professional education would need to include health professions generally, including nursing. Furthermore, research continues to show that education, while valuable, is insufficient without broader structural transformation in conjunction with accountability mechanisms, policy directives, and organizational change [120, 123].

c. Conduct “Health Equity Walk-Throughs” On a Regular Basis

A Health Equity Walk Through ([Equity Walk Through - EQUIP Health Care | Research to Improve Health Equity](#)) is designed to prompt organizations, agencies, and hospitals to consider how their settings might impact Indigenous peoples. It is designed to help administrators, leaders, and staff at all levels consider the extent to which people are likely to feel welcome, and culturally and emotionally safe, especially for those who are most likely to feel unwelcome and unsafe. Health Equity Walk-Throughs are not one-time efforts. Rather, they are designed to be conducted on a regular basis, given the groups of people who are most likely to come to any given setting and the demographic profile in any given jurisdiction. The questions posed in a Health Equity Walk Through can be tailored and adapted to optimally suit the space and realities of any health setting or workplace.

d. Recognize that One-Off Responses to Racist Incidents Are Not Effective

Although the Canadian and Quebec Charter of Rights and Freedoms guarantees that every Canadian and Québécois is entitled to constitutional and human rights protections against discrimination, the ongoing harms and poor health outcomes affecting Indigenous peoples within healthcare systems demonstrates an ongoing denial of basic human dignity that is deeply rooted in Canada’s history of colonialism. Lawyers advocating for the Sinclair family’s position regarding the death of Mr. Brian Sinclair are continuing to argue for system-level changes. Unfortunately, it is often the most recent tragic incidents that catch the attention of officials and decision-makers responsible for health care services. While these incidents require a full analysis, in the process, attention is potentially diverted from the everyday experiences of racism and discrimination that Indigenous peoples experience in the health care sector. The risk in conducting inquests is in overlooking everyday experiences of racism and the everyday taken-for-granted practices that give rise to negative health care experiences. These concerns were recently reiterated by the Chief Commissioner of the Ontario Human Rights Commission who observed that one-off legal responses to racist incidents in healthcare are not an effective way to address racism as an inherently structural issue [124]. Instead, multi-tiered actions must be designed and initiated to address the routine, everyday ways in which Indigenous people experience health inequities as they:

- Avoid interactions with the health care system because of negative, stigmatizing judgements
- Do not receive appropriate diagnostic work-ups or follow-ups
- Receive misdiagnoses or no diagnoses
- Receive poorer quality of care compared to others
- Experience poor or tragic health outcomes

e. Implement Antiracist Accountability Mechanisms

One of the key features of systemic racism is the manner in which it is perpetuated by denying or remaining silent about the existence of racism. Hence, organizations and institutions need to acknowledge, as a strategic priority, their commitment to addressing the harms of anti-Indigenous racism at all levels.

Dedicated resources in the budget must be available to support anti-Indigenous racism work. Structures, policies, and processes related to hiring, performance evaluation, recognition, compensation, continuing education, the conduct of staff meetings, etc. must be reviewed and adapted accordingly with respect to antiracism.

Conversations that challenge the status quo will be required to reconsider how, for example, complaints or concerns about racism or other forms of discrimination are handled, how apologies are offered, and what kinds of locally relevant transformative actions can ensue. In recognition of the UN Declaration on the Rights of Indigenous Peoples [125], this must be done in collaboration with, and taking guidance from local communities and leaders, such as the Conseil des Atikamekw de Manawan, and Conseil de la Nation Atikamekw. Recent examples of institutional-level apologies can serve as exemplars, as recently occurred in BC [126]:

As the leaders of the four largest health regulatory colleges in British Columbia, we offer our apology to the Indigenous people and communities who have experienced racism while engaging with us and with the health professionals we regulate.... As leaders, we will:

- Apologize to Indigenous people for the harms suffered in a racist health-care system, of which we are a part
- Be anti-racist leaders who will foster a speak-up culture, where stereotypes, discrimination and racism are called out and eliminated
- Establish clear accountabilities for cultural safety and humility within our leadership teams (p. 1)

While apologies by hospitals or health authorities are important symbolically, and can be meaningful for families and communities [127], clear and concrete action plans must be designed, resourced, and implemented. Processes for addressing complaints could include, for example, restorative justice processes or healing circles. Importantly, accountability mechanisms aimed at redressing anti-Indigenous racism will require organizations and institutions to set minimum requirements for engaging Indigenous peoples and communities who have lived experiences of racism and other forms of discrimination, both in advisory capacities and as full partners, to work toward the ideals of reconciliation. The recommendations outlined in Joyce's Principle [36] represent important starting points for building accountability mechanisms.

6. Conclusion

It is critically important to understand experiences of racism and other forms of discrimination described by Indigenous peoples as reflecting broader social dynamics in Canada. These broader social dynamics are given expression through practices and policies that are entrenched in health care organizations and institutions, and in Canadian society through media, public conversations, and everyday practices. Situating Indigenous people's experiences in the wider socio-political landscape will preempt the denial of racism that might otherwise occur when the problem of racism is constructed primarily as reflecting

individual-level reactions or opinions. What is needed to address systemic and interpersonal forms of racism and discrimination as it pertains to Indigenous peoples in healthcare systems are strategies, policies and interventions that can be maximally disruptive of: the deep-seated patterns of power and paternalism operating in health care; the racist and stigmatizing discourses about Indigenous peoples that remain pervasive; and the dismissive, unwelcoming, and often demeaning practices and policies that so profoundly impact peoples' experiences [5]. *This* is where the problems must be located, and transformative actions instituted, if racism and other forms of discrimination are to be tackled and dismantled in the context of health care delivery.

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