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Discrimination in the Doctor's Office: Immigrants and Refugee Experiences

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Abstract

There is a growing awareness of the role played by discrimination in the provision of health care services to immigrants and refugees across Canada. Very little research, however, has explored how perceived discrimination influences patient relationships with health care providers and the health care system in Ontario. This qualitative study documents perceptions of discrimination from a service user perspective in five small and medium-sized Ontario cities. Results of 26 interviews with immigrants and refugees highlight the complex nature and impacts of discrimination in shaping newcomer experiences as a basis for developing effective public policy in health care and social services.

Key Words: immigration, immigrants, discrimination, Canada

Newcomers represented two-thirds of the total population growth in Canada over the past ten years, with approximately 250,000 admitted each year of which 13 % are refugees (Citizenship and Immigration Canada, 2011). Foreign-born and visible minorities are anticipated to represent 28% and 32%, respectively, of the Canadian population by 2031 (Statistics Canada, 2010). While there is a growing body of research on the health of newcomers, there remains a paucity of research on how discrimination affects newcomers' health status, care experiences, and service utilization behaviours, despite over ten years of advocacy calling for the recognition of discrimination as a key determinant of health (e.g. Access Alliance, 2005; Hyman, 2009; Krieger & Sidney, 1998). These knowledge gaps inhibit comprehensive understandings of population health patterns and conditions across Canada, undermine Canada's mandate of universal access to health care services, and impede efforts to reduce social inequalities.

On average, immigrants experience rapidly declining health status after arrival in Canada and other countries such as the United States and Australia (De Maio & Kemp, 2010; McDonald & Kennedy, 2004). Known as the "healthy immigrant effect," the health advantage enjoyed by newcomers at the time of arrival is quickly eroded due to a number of effects, including the stress of acculturation and difficulty navigating the host country's health care system (Newbold & Danforth, 2003). Barriers to health care, including language, economic, geographic, socio-cultural, knowledge, and transportation barriers, have been widely identified within the literature as inhibiting use of the health care system by immigrants despite increased need for care (Ahmed, Stewart, Teng, Wahoush, & Gagnon, 2008; Asanin & Wilson, 2008; Dunn & Dyck, 2000; Gagnon, 2002; Lawrence & Kearns, 2005; McKeary & Newbold, 2010). Missing from many of these analyses is the potential role of discrimination on the part of health and social service providers and their staff.

The purpose of this paper is to report on immigrant and refugee perceptions of discrimination in health care services in order to further an understanding of the potential impacts of discrimination in the health care environment in five southern Ontario communities. Do immigrants and refugees perceive discrimination when they use health care services? If so, how might these perceptions affect the use, quality, and accessibility of health care services and relationships with health care providers? What changes could be made to health care provision and public policy in order to address the concerns of immigrants and refugees with respect to discrimination and improve health outcomes for New Canadians?

Discrimination, Providers, and the Health of Newcomers

Discrimination takes on many forms at a variety of scales, from conscious and unconscious interpersonal interactions between individuals, to more institutionally engrained practices occurring at the systemic level. It can be defined as any practice, judgment, and action that creates and reinforces oppressive relations or conditions that marginalize, exclude, and/or restrain the lives of those encountering discrimination (Hyman, 2009; Karlsen & Nazroo, 2002; Krieger & Sidney, 1998). Individuals and groups can be discriminated against based on race, ethnicity, language, religion, culture, and other characteristics (Access Alliance, 2007; Carrasco, Gillespie, & Goodluck, 2009).

In the health care setting, documented encounters of perceived discrimination include incidents of insensitive, unfriendly, or ignorant treatment from providers, to racial slurs, stereotyping, and receipt of inferior care (Access Alliance, 2005; Beiser, Noh, Hou, Kaspar, & Rummens, 2001; Johnson et al., 2004; Magoon, 2005; Noh, Kaspar, & Wickrama, 2007; Stewart, Gagnon, Dougherty, Saucier, & Wahoush, 2008; Wahoush, 2009; Wang, 1997; *Women's Health in Women's Hands*, 2003). In some cases, for instance, immigrant women reported instances of health care providers becoming frustrated or angry when asked to acknowledge or respect religious or cultural beliefs and needs, such as a preference for female providers or for privacy and remaining clothed (Reitmanova & Gustafson, 2008). A study examining barriers to health care for refugees in Canada found that some health providers were unwilling to accept refugees as patients, with refugees perceived as more challenging due to complex health needs, linguistic barriers, and/or complicated insurance coverage schemes that can delay payment for services delivered (McKeary & Newbold, 2010). The limited evidence that is available suggests that the majority of discriminatory encounters are generally subtle, elusive or systemic relative to overt verbal and/or physical abuse.

Research demonstrating discrimination's detrimental effects upon health primarily focuses on the experiences of visible minorities and identifies potential pathways through which discrimination impacts health (e.g. disproportionate exposure to hazardous environments, psychosocial stressors, inadequate medical care, economic deprivation, lack of opportunities, social exclusion, etc.) (Branscombe, Schmitt, & Harvey, 1999; Harris et al., 2006; Karlsten, Nazroo, McKenzie, Bhui, & Weich, 2005; Kobayashi, Prus, & Zhiqui, 2008; Krieger, 2001; Krieger & Sidney, 1998; Nazroo, 2003; Taylor & Turner, 2002). Immigrant and newcomer service providers purport that discrimination inhibits educational and occupational achievement, compromises living conditions, reduces health status, and impedes access to health care services (Access Alliance, 2005, 2007; Fenta, Hyman, & Noh, 2006; Hyman, 2009; Kafele, 2004; *Women's Health in Women's Hands*, 2003). Adverse health outcomes associated with discrimination include poor physical health (e.g. self-rated, hypertension, cardiovascular, and respiratory), compromised mental health (e.g. psychological distress, depression, and anxiety), and risky lifestyle behaviours (e.g. smoking and drinking) (Beiser & Hou, 2006; Hyman, 2009; Krieger, 1990; Moghaddam, Taylor, Ditto, Jacobs, & Bianchi, 2001; Noh, Beiser, Kaspar, Hou, & Rummens, 1999; Noh & Kaspar, 2003; Williams, Neighbors, & Jackson, 2003). Whether cases of discrimination are understood as such, perceived negative experiences with health care providers can discourage individuals from seeking or following advice, inhibit meaningful patient/provider relationships, and contribute to feelings of isolation and despair (Beiser et al., 2001; Johnson et al., 2004; Magoon, 2005).

The increasing calls for cultural competency within the health care system suggest that health care professionals (along with patients) are aware of the potential for discrimination (Betancourt, Green, & Carillo, 2003; Brach & Fraser, 2000; Carillo, Green, & Betancourt, 1999; Mulvihill, Mailloux, & Atkin, 2011; Oxman-Martinez, Abdool, & Loiselle-Leonard, 2001). The intent of cultural competency training is to assist health and social service professionals reflect upon their own and others' cultural beliefs, behaviours, and communication strategies to enable practice skills that facilitate non-discriminatory care (Guilfoyle, Kelly, & St. Pierre-Hansen, 2008; Magoon, 2005; Reitmanova & Gustafson, 2008). Indeed, inadequate cultural competency and respect for alternative health values and practices are commonly cited barriers to health care

amongst racialized minority groups in Canada (Carrasco et al., 2009; Fenta et al., 2006; Kafele, 2004; Newbold, 2009; Noel, 1996; Oxman-Martinez et al., 2001; Reitmanova & Gustafson, 2008; Spitzer, 2004; Wang, 1997). Nevertheless, studies on provider attitudes toward immigrants and refugees and implications for differences in care remain very rare (Guilfoyle et al., 2008).

Methodology

This qualitative research is broadly set within the southern Ontario communities of Hamilton, Guelph, Cambridge, and the Kitchener-Waterloo region, which lie slightly to the west and northwest of Toronto, Canada's largest immigrant reception city. As "second-tier" immigrant centers, the area's immigrant population is growing rapidly, owing both to primary settlement as well as to secondary settlement. Hamilton, for instance, attracts in excess of 3,000 immigrants and refugees each year, while Kitchener-Waterloo receives slightly less than 3,000 new arrivals each year (Citizenship and Immigration Canada, 2011). Prospective study participants were identified either through self-selection in response to recruitment posters distributed to various service agencies or through existing informal networks involving the researchers' contacts in the settlement service sector.

In total, 26 semi-structured, in-depth interviews were conducted with adult immigrant and refugee newcomers. The researchers invited participants to identify comfortable locations in their home cities where the interviews took place (e.g., coffee shops, service agencies, workplaces, university campus, or participants' homes). Designed to gauge perceptions of racism and discrimination in the health care environment, the interview guide included questions to generate a demographic profile of each participant and open-ended questions regarding his or her experiences with health care services and providers. Of the 26 individuals interviewed, seven were male and 19 were female. Nine participants self-identified as Middle Eastern, six as African, four as Latin American, three as South Asian, three as eastern European, and one as Caribbean. The age range for participants spanned 25 to 60 years old. Participants' proper names and other identifiers were converted to pseudonyms or removed from data to ensure confidentiality.

A community-based organization studying immigrant health care service gaps was invited to provide input on the interview script so that the project might assist the community's information needs and advocacy endeavors. Standard university ethics guidelines were followed and approved by the University Research Ethics Boards affiliated with the researchers' home institutions. Interpretation of collected data used open coding methods to produce descriptive and thematic codes which were then organized into a coding framework based on thematic patterns, with each theme being further divided into salient subcategories (Lincoln, Lynham, & Guba, 2011). Analysis followed grounded theory methods: constant comparison within and between accounts, with attention paid to the conditions under which phenomena arise and to the consequences associated with the phenomena (Charmaz, 2003, 2011). Grounded theory does not test or apply pre-formed theoretical assumptions; rather, it employs inductive and iterative processes and a systematic approach to qualitative research in order to generate a theory grounded in the lived experiences of the research participants and carefully deciphered through the researchers' immersion in data collection and analysis (Charmaz, 2011; Creswell, 2007). Data analysis resulted in the identification of the four key thematic areas discussed below.

Results

When asked directly if they had “experienced racial discrimination or been treated unfairly by a health care worker or other staff in a hospital or clinic,” 17 out of 26 participants replied they had personally experienced discrimination at least one time when interacting with a health care practitioner or clinic staff in Ontario. Instances of discrimination ranged in severity from overt forms (e.g. verbal abuse) to more subtle forms (e.g. rudeness). Reported incidents were broadly categorized in terms of refusal of health care; staff acting as gatekeepers; and communication barriers and cultural insensitivity. Responses to perceived discrimination also emerged as a key theme during data interpretation.

Refusal of Health Care

Despite Canada’s universal health care system, it was not uncommon to hear cases of refusal of medical services on the basis of immigrant or refugee status. For instance, participants reported being refused as new patients for a family practice. One participant, Lianne, was trying to find a family doctor and called an office where the receptionist asked her, “Are you an immigrant?” When Lianne replied “yes,” the receptionist said, “[the doctor] doesn’t have space” and hung up the phone. Lianne called the Ministry of Health to complain about the incident. She was “shocked” and “miserable” as a consequence of what she felt indicated “serious discrimination against immigrants.” Like Lianne, a number of other participants were concerned that doctors labeled them as “immigrant” patients and turned away such patients because they viewed them as too time-consuming, emotionally overwrought, or exceptionally demanding.

With respect to government-sponsored refugees, Emily explained how she had confronted family doctors who refused to take refugees as patients. Refugees, whose health expenses are covered by the Interim Federal Health Program (IFHP) rather than provincial health insurance plans, experienced “exclusion just because of different coverage” (Emily). Emily had felt it necessary to advocate on behalf of refugee newcomers by informing reluctant doctors that denying service was not acceptable and would be reported to the Ontario College of Physicians and the Ministry of Health. In another case, Jessica, unable to find mental health support in her own community sought assistance through a social service agency in another city only to be told it was “not equipped to provide services.” She felt that she was denied service because she is a “visible minority person” and the agency’s mental health professionals “don’t know how to treat women from other countries.” Jessica subsequently filed a complaint with the Ontario Human Rights Commission.

Staff as Gatekeepers

Lianne’s account of being refused health services by a clinic receptionist points to the potential for staff to act as gatekeepers to the system. The initial screening question posed by the receptionist (“Are you an immigrant?”) would have been made on the basis of Lianne’s verbal expression and/or accent when speaking English, a form of discrimination commonly identified by participants. Participants also noted other forms of differential treatment. James, a black male, reported being treated with suspicion at a walk-in clinic when he forgot his health card at home. The white woman ahead of him in line had also forgotten her health card, but she was not denied

service. James, however, was required to go home and return with his health card. He stated: “I didn’t get the same treatment...When you’re an immigrant, it’s assumed you don’t qualify for health care...you’re not a human being.”

Emily and Gail reported difficulties in booking appointments over the phone to see their family doctor. Gail stated, “[it is] very hard to get an appointment to see the doctor, the secretary acts as gatekeeper and is not friendly.” Emily recounted how her daughter was very sick and she had left messages on the doctor’s office answering machine, but the receptionist didn’t call back. When Emily and her daughter walked into the office, the receptionist didn’t greet them but instead stated “you don’t have any appointment.” Emily responded by confronting the receptionist for being a “rude person,” and the receptionist’s behaviour changed. The receptionist began to listen and respond more politely. Emily’s daughter was able to see the doctor. Emily suspected the receptionist’s rude behaviour was “somehow racist” because of the change that happened when Emily confronted her.

Communication Barriers and Cultural Insensitivity

A newcomer’s language ability, accent and cultural differences were seen as potential sources of discriminatory behaviour not only on the part of clinic staff, but also on the part of health care providers. Nadia, for example, told a story involving two hospital nurses who had used a tone of voice that was “quite stern and seemed angry” when she had asked questions. She explained, “Maybe they thought me and my husband were uneducated, didn’t have language skills.” When Nadia explained that she could speak English to the nurse, the nurse became much friendlier. Nadia felt that initially the “nurses discriminated based on accent.” Other participants reported that they spoke English with an accent and were treated like they were “stupid,” “deaf,” “mentally disabled,” their “IQ level is lower” or they were “speaking gibberish” (Gail, Sophia, Lianne, Janna). Many participants felt that doctors were often “abrupt” or “aloof” and did not listen attentively when they communicated their health concerns (Abby, Amanda). Three participants explained how their health care providers’ behaviour became friendlier immediately after they made known their education level or professional credentials, or after indicating members of their immediate families were health care professionals (Nadia, Janna, Lianne). These accounts further underscore the need for exploring experiences among newcomers who face increased barriers on the basis of language skills, education and socioeconomic status.

Inadequate communication was viewed a major obstacle to accessing health care services, while also compromising the quality of care by disrupting the clear exchange of information required for proper diagnosis and treatment. Poor listening was connected with doctors also not taking the time necessary to provide full medical explanations to newcomer patients less fluent with English. A participant named Mary asked several questions regarding hospital procedures surrounding childbirth. In response, she felt the obstetrician was “sometimes quite aggressive, other times sarcastic about my questions.” Mary concluded the obstetrician was

...applying one system that presumably fits everyone, regardless of faith, culture, upbringing, etc....[The doctor] assumed that I know the system. She never explained. Going to hospital was frightening, unfamiliar to me.

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Maria, by contrast, attributed more intention to doctors' failure to provide information, explaining that "because they know I'm not from here, they don't tell me all I need to know....Doctors never treat me bad, but at the end of the day, it's discrimination—not the same treatment as Canadians."

Other participants were concerned that non-English speakers, who would then not be equipped to follow the doctor's instructions, might not understand issues involving complex medical terminology (Janna, Julia). Participants were also concerned about the risk of miscommunication and inappropriate medical care due to the deterioration of the patient's English fluency under stress. Danielle explained how patients who seek health services when English is not their first language can experience additional stress:

I think even mentally, emotionally, you're then, not only are you then sick physically but you're struggling to know what just happened to you. Going to the hospital, you feel lost...The whole experience before you even get to talk to the doctor can be overwhelming when you don't know the language.

Under such circumstances, a person might repeat the wrong expression, know they are being misunderstood and feel unable to correct the communication problem (Kate). Some participants who struggled with speaking English noted feeling a sense of frustration, even despair, particularly when the doctor's mannerisms and communication style felt "very fast" or "rushed," as if "they don't have time to listen" (Maria). Gail stated, "I felt like I was a burden." Emily recalled being a cultural interpreter in an instance when the doctor interviewed a patient hastily and "left the room in two minutes." She followed the doctor and said, "you need to listen." The doctor came back and sat down with the patient until the situation was addressed. Emily posed the question "what if no other person advocated for them?"

Participants expressed concern that communication barriers were linked to and exacerbated by cultural insensitivity on the part of health care providers. Julia felt a doctor's lack of awareness of cultural differences might result in mental health issues or issues of a sensitive or sexual nature not being addressed. Julia explained, for example, that "women in a multicultural society" with diverse "religions, beliefs, and cultures" may request to be examined by a female doctor. Gynecological exams and routine Pap tests, in particular, would be perceived as "hard on [the women] or avoided." Julia suggested that male family doctors would need to understand this and provide a referral. Participants expressed concern that cultural ignorance might lead to improper care for refugees from war torn countries or immigrants experiencing post-traumatic stress disorder (Jessica, Sophia, Julia). Janna recalled how a doctor's lack of knowledge about a patient's culture led to an instance when the patient stopped taking important blood pressure medication during a religious fast and ended up in hospital emergency. Danielle explained that doctors were attributed a tremendous degree of authority and deference in her culture, and she worried that patients such as her father would nod without actually understanding the doctor because they "don't want to bother the doctor." Consequently, pain or other symptoms might not be mentioned by the patient unless the doctor anticipates and addresses them in a sensitive manner.

Being judged too quickly by a health care provider on the basis of their cultural background was another issue raised by participants. Sophia said Canadian doctors appeared “scared” when caring for African-born female patients who had undergone female genital mutilation. She said some doctors “marginalize or stereotype” the women, while also prescribing for those patients unnecessary Caesarean sections because they don’t know how to attend the women during childbirth. Other participants felt they had been quite clear when communicating with a doctor, but their concerns were still disregarded, sometimes resulting in serious mistreatment. For example, Jack explained how doctors and paramedics ignored his complaints of pain until he presented at the hospital emergency with acute appendicitis. Jack and another participant named Kate wondered if their words had been dismissed as exaggerated or “psychologically disturbed” because they spoke English with an accent or because their expressions differed from Canadian ones.

For several participants, a lack of cultural understanding was associated with depersonalized forms of health care - with refusing to engage people in ways that would “develop a relationship through understanding the context of the client.” Jessica said she repeatedly encountered doctors who would not say her name. In one instance, hospital staff had decided to change her name, using an anglicized form instead of her own name. Another participant named Patricia said:

one doctor even made fun of my last name and advised me to change my last name and make it shorter in Canada ... it was awful...Imagine doctor making fun of your name.

Mary, who described feeling “vulnerable” and threatened by a nurse’s response to her, recounted another example of outright discrimination. Mary was wearing a head scarf when she presented at the hospital with severe pain following a surgical procedure. “The moment the nurse saw me, listened to my accent, the nurse cursed me and said the ‘f’ word...she said ‘f— you. I know you guys very well.’” In response to the nurse’s verbal abuse, Mary started to cry and said, “please don’t be aggressive.” The nurse apologized, and when Mary later spoke with hospital management to report the incident, the manager responded, “What do you want more than an apology?” Mary said the incident “left me with a very bitter experience... I wouldn’t want to go to a hospital...still don’t feel safe.” Since that time, Mary explained that she stopped wearing a head scarf so as not to appear “visibly Muslim” because she felt that “Muslim women who leave home and go into the community become targets.”

Participants also recounted examples of cultural stereotyping and discrimination against their country of origin. For example, one female participant who had been a victim of family violence in her country of birth was asked by a doctor, “Isn’t that normal in your country?” Another participant said that doctors she met had “assumed there is no health care in Egypt.” James said he encountered health care providers who believed there were “no competent doctors in Africa.” James explained, “where you come from matters...we’re the bottom of the food chain, black people.” Mark, also born in Africa, said “because of your origin, you may go through more layers of health checks.” He said “you feel like you are being treated as a foreigner, but...you don’t have the experience of how they treat other clients, Canadian clients.” Mark felt that some health care providers think “maybe because they’re black... they may have, they may be more open to certain types of disease.” James said he would be asked “derogatory”

questions by doctors that implied he “must be poor” or his “diet must be poor.” He added, “they think you have AIDS...it makes you feel terrible.” James explained that perhaps doctors who ask such questions “do it for the right reasons,” but would benefit from “cultural sensitivity training.” He wasn’t sure how his interactions with doctors were influenced by the doctor’s personal perceptions, training, media exposure or culture. Mark voiced similar concerns regarding doctors who assumed he was “diseased...[they] generalize as soon as they know you come from that part of the world.” He explained that it was “not openly racism...it was the same for people from certain groups, not against you as an individual, but prejudice anyway.”

Responses to Discrimination

Participants articulated a range of responses to discrimination. Although some participants acknowledged they felt a doctor’s inattentiveness to their expressed concerns was likely to compromise the quality of care they received, they did not necessarily equate such behaviours with discrimination (Janna, Sara, Martha). One participant said she had repeatedly encountered behaviour which she believed was “not really racism, but it’s just racial ignorance.” Nevertheless, she also commented that stereotypical judgments made her feel like health care providers were “not even seeing a human being” (Jessica). Another participant said subtle negative associations referring to his “background” made him feel that “even though a citizen, you’re still an outsider” (James). One other participant stated unequivocally that “ignorance is a type of racism” (Emma).

Of the 17 participants reporting a discriminatory incident, nine had deemed an incident serious enough to report it to a higher authority, including filing a formal complaint. The fact that one third of our participants took such measures may be reflective of the education levels, language proficiency, or duration of residence within Canada of our particular sample. Most participants expressed uncertainty regarding their ability to determine if one or more incidents involved discrimination. Four participants became visibly distressed when speaking about the negative experiences they associated with health care providers. Lianne, for example, felt her family physician had provided only cursory treatment when told her husband was experiencing severe mental health issues, which eventually led to acute crisis and the need for emergency care:

I don't know how I can complain about [the doctor], how I can complain about the system, its missing parts.... It's really problematic. If doctor ignores somebody, it means it's going be bigger problem later. If the same day, if [the doctor] behave appropriately, my husband didn't go to the emergency and maybe he didn't get this kind of problem or something. We are not in safe hands, you know.

Lianne was not alone among the participants when she articulated the worry and despair she felt in response to a particular incident.

Lianne and others also expressed uncertainty about attributing discriminatory intent to a doctor’s behaviour rather than to dysfunctional aspects of the health care system. A participant named Mark, for example, indicated the difficulty he had with identifying whether a doctor’s actions were discriminatory. Instead, Mark’s primary concern was that he felt the current health care system too often failed to provide health care professionals with training that would create a

greater awareness of the stressors facing newcomers. Mark explained how a lack of patient-focused care has health impacts that can be particularly detrimental for immigrant and refugee patients:

Doctors have a huge responsibility in the system—they are objective, busy, short of resources. They don't realize when they hurt, rush people too quickly, they don't take time to look at service in a wider way, treat a person holistically. Most difficulty is with a lack of understanding of immigrant challenges, processes of immigration itself. People can't see it and don't want to know about it....[As an immigrant] you're fragile, there's frustration feeling included...all of these things that already put you in a situation where you're scared. It's a health issue, the stress attached to the particular situation. It can be missed....the first four to five years were the most difficult. There's nothing to prepare you, little information to prepare you for the health care system, how to navigate, what to expect.

Along with Mark, several participants were unsure if the doctor's behaviour signaled a personal judgment against them, a broader systemic issue regarding lack of time allotted to patient care or a subtle form of discrimination against cultural/language differences. Many were equally uncertain regarding the measures that could be taken to hold the health care providers accountable.

Feeling intimidated or threatened by the attitudes or judgments expressed by health care providers led some participants to avoid seeking out health care services at all (Anne, Kate, Mary, Gail). Emily reported that the hostility of the doctor's office receptionist deterred her from trying to see her family physician and made her reluctant to seek health care services in general. Another participant stated, "I avoid my doctor as much as possible" (Danielle). Other participants felt that going to see a doctor was pointless, except in cases of medical emergency when they would typically use an urgent care facility (Maria, Amanda). Some participants who had a negative experience with a health care provider had discontinued contact with that particular provider, but had sought out health care services with a new provider, although finding a new family doctor for some proved to be a time-consuming and difficult task.

Many participants also described ways in which they had learned "self-advocacy" was necessary in the Canadian health care system (Patricia). Nadia explained how living in Canada for five years made her "feel confident to address issues." Reflecting the staff-as-gatekeepers issue, she explained how she had been speaking with receptionists at a doctor's office whom she felt "were brushing me off. I felt they weren't listening to me. Now I feel able to address this promptly." Another participant named Amanda explained that she had waited for over two years to have a painful health issue addressed. She was told by the doctor who eventually treated her that it "should have been taken care of" sooner. Consequently, Amanda decided to "be my own advocate" and requested a referral to a specialist who shared her cultural background. Other participants enlisted friends or family to advocate for them with health care providers.

It is important to note that not all encounters with the health care system were negative. Participants, for example, mentioned cases when doctors had acted as allies to refugee families by providing care in exceptional circumstances or by helping newcomers navigate the health care

system and access appropriate care (Emily, Jessica). One participant was pleased that her family doctor “made an effort to pronounce my name properly” and that her dentist had “corrected my name pronunciation with the assistant” (Emily). Some health care providers were also viewed as being aware and openly critical of systemic barriers faced by immigrant newcomers (Mark); and while clinic staff, particularly those who book appointments, may act as an obstacle or deterrent to accessing care, it was commonly felt those encounters did not impact the quality of care provided by health care professionals.

Many participants felt that seeing a family physician who spoke their language and/or shared their culture was beneficial to their self-confidence and the quality of care they received (Lianne). They felt a shared background fostered good communication and mutual understanding, while also providing “continuity of care” (Lily). Anne, for example, had found a family doctor who shared her cultural background and was also able to access community-based services that she felt were personally supportive.

Going to a Polish doctor in Toronto makes things a lot easier for me. Also, accessing drop-in services at a place that is anti-oppressive and queer positive makes it easier to use health services. ... [But] having the time to seek out health care that is a greater distance from me makes it difficult to access these services. It is also difficult to access services because the services that I am comfortable using are often under-staffed and over-booked.

Like Anne, other participants reported a lack of services available within their own communities. Consequently, they were travelling to other cities to access health care, including returning to country where they had previously lived (Jessica, Alex, Sophia, Emma, Lily). Many also sought alternative health care services from homeopathic, naturopathic or traditional Chinese medical practitioners (Alex, Danielle, Julia, Emily, Emma). These participants expressed that they found the “preventative” and “holistic” approach used by these health care providers was less alienating and more compatible with their cultural values than Western-style “curative” medicine that focused mostly on physical symptoms (Emily, Lisa). A number of participants endorsed family health teams, nurse practitioners, midwifery services and community health centres in Ontario, which they felt used a more holistic framework for addressing people’s health care needs (Julia, Maria, Emily, and Lisa).

Discussion

Incidents clearly identified as discriminatory were usually isolated events. Yet, the stress of a single incident seemed to increase levels of uncertainty and distrust regarding health care providers and continued to affect some participants’ health and health-seeking behaviours. Participants noted, for example, their decreased use of health care, except in exceptional (i.e., emergency) situations, which could imply much costlier health interventions. Study results therefore echo existing research that discriminatory incidents potentially contribute to overall poorer health (Ng, Wilkins, Gendron, & Berthelot, 2008), lower quality care (i.e., Elliott & Gillie, 1998), and lower levels of health care use within the immigrant and refugee population (i.e., Pérez, 2002). The research also demonstrates how immigrants to Canada are less likely to

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use preventative health care (Woltman & Newbold, 2007), and that discrimination could be one reason why this is so.

In addition to corroborating the negative health implications associated with discrimination, this study lends support to prior research documenting patient uncertainty as to whether differential treatment stems from their own personal attributes/inadequacies, prejudicial attitudes on the part of service providers, or some other factor (Noh et al., 2007; Wang, 1997). These studies suggest such ambiguity invokes additional stress and confusion for patients when determining how to appropriately respond. Difficulty with defining and interpreting behaviour as discriminatory was also evident among this study's participants, some of whom expressed reluctance to state unequivocally that they had experienced discrimination. While the outcomes of this study and others emphasize the value of moving towards a greater incorporation of indicators of discrimination, in future health surveys in order to better determine its impacts upon health status, it will be equally important for researchers to define discrimination carefully to prevent underreporting. Several participants of our study expressed greater willingness to attribute their negative experiences with health care providers at least in part to systemic issues such as work overload.

Systemic Issues

It is important to acknowledge, as did several study participants, that some health care providers may not themselves be discriminating against newcomers, but rather functioning as part of a system that constructs discriminatory barriers to care. One such barrier is the Interim Federal Health Program for refugees, a program which is fraught with payment difficulties. Indeed, the literature notes that the IFHP is a cumbersome entity and that many general practitioners and dentists will turn patients away because they do not wish to deal with the bureaucracy, payment delays, pre-approval process for some procedures and lower financial compensation (McKeary & Newbold, 2010; Merry, Gagnon, Kalim, & Bouris, 2011; Wales, 2010). This could therefore be seen as institutionally reinforced discrimination, as health care providers are deterred from serving patients who may incur extra costs in terms of time and labour.

Another barrier involves a shortage of health care providers and time with patients, leading to additional stress and work pressures that may impact a provider's demeanor. Spitzer (2004) draws similar conclusions, stating that broader health care reforms and cutbacks result in staff and supply shortages which can further compel nurses to avoid patients "presumed" to be challenging due to linguistic and cultural barriers. Likewise, standard emergency rooms procedures may involve extended wait times and patient isolation, which may be experienced negatively by service users and perceived as discrimination (Wahoush, 2009). Avoiding such situations requires rethinking and ameliorating the education, cultural interpreter services, and supports made available to health care providers so they can communicate the rationale behind health care procedures to immigrant newcomers and refugees in a way that minimizes the potential for miscommunication and misjudgment.

In part, the health care system is not yet prepared for Canada's multicultural population. While social workers in Ontario who practice in the health care sector are considered regulated

health professionals (or so-called ‘allied health care workers’) and would have received training in anti-oppressive practice, cultural competency training is often limited within most medical programs. Consequently, there remains need for evaluating whether prescribed adaptations in care provision do in fact improve upon patient/provider relationships and incidences of discrimination. Moreover, concerns about incidents of discrimination voiced by health care professionals themselves may be dismissed. As one key informant who worked at a health clinic offered:

Assumptions about who they are based on skin color. So somebody who’s talking about even the issue of experiencing racism is not taken as a serious health related issue. Because we kind of don’t have that here. We’re accepting. You’re here in Canada, everything is wonderful.

Systemic issues involving the health care of newcomers reported by this study (e.g., inadequate provider/patient communication, lack of holistic, or patient-focused care) reflect broad concerns that are likely shared by both health care providers and Canadian-born service users. Policymakers seem currently unwilling or unable to address such issues, perhaps due to broader institutional influences that compel health policy to focus more narrowly on values such as “efficiency” and “objectivity.”

Most study participants expressed satisfaction once they had established a long-term relationship with a family physician, and all participants indicated they had at least one positive experience with a health care practitioner. Yet, participants were very clear that they felt current education and training did not fully equip the majority of health care providers to address the needs of newcomer patients. It was felt that a health care system that knowingly overlooks the expressed health concerns of a particular group (i.e., immigrant and refugee patients) in the name of treating all patients “the same” is enacting a form of discrimination through refusing to recognize the diverse ways in which health care needs are expressed and met. While Canadian-born and newcomer service users have a reason to complain about systemic inadequacies, it was felt immigrant and refugee patients who were less familiar with Canadian health services and who already faced significant challenges associated with living in a new country would bear disproportionately negative health impacts compared with the general population.

Participants suggested several ways in which current policies, programs, and practices could be changed to better accommodate immigrant and refugee newcomers and decrease health disparities. Eight recommendations, inclusive of both institutional and personal issues, were identified:

1. Provide accurate information about Canadian health services to newcomers;
2. Provide better training and funding for cultural interpreters in health care settings;
3. Expand and sustain support community-based and mental health services for newcomers;
4. Improve cultural sensitivity in health care provision, including training for non-medical clinic staff;
5. Ensure immediate and adequate health insurance coverage for all newcomers;
6. Increase the diversity of health care providers;
7. Establish better monitoring and accountability of health care providers;

8. Provide newcomers with assistance navigating the health care system, including advocacy services.

Future Research

While this paper has moved to address some of the gaps in knowledge around newcomer perceptions of discrimination in Ontario health services, the area remains complex and continues to demand additional analysis. For example, additional insight is required with respect to discrimination across different immigrant classes or minority groups and how perceptions of discrimination change over time. There was some indication that perceptions of discrimination in health care provision may diminish over time, and this shift may be linked to the social integration of newcomers and/or increased exposure to the health care system. If confirmed, this outcome would contrast with U.S. studies indicating that perceptions of discrimination increase with length of residency due to increasing awareness of subservient societal position over time and cumulative impact of multiple discriminatory encounters (e.g., Gee, Ryan, Laflamme, & Holt, 2006). The possibility of drawing a connection between number of years living in Canada and differing perceptions of Canadian health care services could not be addressed by this study, although it should be an area for future inquiry.

Combating adverse health effects and related disparities from discrimination occurring within and beyond the confines of health care settings requires greater recognition of and attention towards systemic norms, structures, and power relationships that constrain the social positionalities and circumstances of newcomer populations. It is therefore imperative to link discriminatory encounters and inequities to wider social and systemic contexts, including employment, settlement, and acculturation. Additional research focusing on particular subgroups, such as older immigrants, refugees, immigrants living in poverty, LGBT immigrants, and so forth, would therefore be of interest. Future consideration should also specify the ways in which social determinants, health care providers, and the health care system influence how relationships with immigrant newcomers and refugees are developed, and how those contexts, behaviours, attitudes, services, and regulations can be changed and/or supported to achieve positive health effects in the lives of New Canadians.

Study Limitations

All participants surveyed for this study spoke English and had received a post-graduate education either inside or outside of Canada. The study, therefore, did not access immigrant newcomers who likely face increased marginalization due to language barriers, education level, or socioeconomic status. Though the researchers made an effort to include non-English speaking participants, a lack of resources for interpreter services prevented broad outreach to these members of immigrant and refugee communities. Consequently, discriminatory incidents may actually be more severe and frequent than reported herein. However, there is also the possibility that participants self-selected to discuss their experiences because they felt they had experienced discrimination. An alternative sampling method would be required to gauge the extent of discrimination in health care settings.

Certain characteristics associated with our sample contributed to strengthening aspects of this study. For example, several participants worked in health care or an allied profession. Among the interviewees were two nurses, 15 social workers or social work students, and 5 settlement workers working in community-based social services. Surveying health care and service providers who were themselves immigrants or refugees, provided rich explications of perceived discrimination in health care services. Participants shared their personal and professional perspectives, while also bringing many of their clients' perspectives into the discussion. Interviewing people who had lived in Canada for approximately 10-15 years and who had several experiences with the health care system contributed to nuanced accounts of discrimination and a sophisticated consideration of systemic barriers.

Conclusion

The purpose of this study was to understand the potential role of discrimination in the health care environment on the perceptions and behaviours of immigrants and refugees in five smaller Ontario cities. Twenty-six interviews were undertaken to identify how discrimination impacts the participants' use of health care services, relationships with health care providers, and attitudes toward the Canadian health care system in general. More than half of the newcomers interviewed reported that they had experienced discrimination at least once when interacting with health care providers or clinic staff, with this paper documenting several types of personal and systemic discrimination encountered by newcomers along with their responses.

Instances of discrimination were related to refusal of medical services (including refusal due to type of insurance, language issues, or immigrant status); staff acting as gatekeepers; and communication barriers and cultural insensitivity on the part of providers and staff (including poor listening, stereotyping, and lack of awareness of social and cultural roles). At the level of provider/patient interaction, discrimination can lead to misdiagnosis and misuse of interventions, under-diagnosis, and the under-utilization of treatment and services. Participants reporting discrimination expressed heightened levels of distress. Some participants searched for another health care provider, while others avoided the health care system. In a few cases, discriminatory experiences prompted self-advocacy for better care.

Recommendations relevant to policymakers, educators, and practitioners in health care and related fields include the expansion of health insurance coverage for refugees and newcomers to Ontario, improved cultural competency training for all clinic staff along with medical professionals, and ensuring the use of trained cultural interpreters. These recommendations are broadly reflective of calls elsewhere in the literature and would help reduce the barriers facing newcomers relative to health care services. This study suggests measures taken to facilitate effective and sensitive communication between health care providers and service users will wield immediate as well as long-term health benefits for all Ontarians, while also improving health outcomes for immigrant and refugee newcomers in Ontario.

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