

A Disability Justice Perspective in Addressing Medical Racism

**Experiences and Recommendations
from the Community**

January 2025

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Introduction/Background

What is DJNO and Who We Are

The Disability Justice Network of Ontario—hereinafter referred to as DJNO—is a non-profit organization, with a physical office located in what we now call Hamilton —also known as the traditional territories Erie, Neutral, Huron-Wendat, Haudenosaunee, and Mississaugas. Our vision at the DJNO is to create and build a world where disabled people are free to be.

At the DJNO, we aim to build a just and accessible Ontario, where disabled people

- Have personal and political agency;
- Can thrive and foster community;
- Build the power, capacity, and skills needed to hold people, communities, and institutions responsible for the spaces they create.

We have a list of six values that are used to guide our work at DJNO.

Accountability: Our work is community-led and accountable to disabled people.

Building Community Capacity: We work collaboratively with local community members, movements, and organizations to seek equity and justice for disabled people.

Justice: We work beyond current legislation to prioritize access, empowerment, and liberation for disabled people, including the creation of sustainable support systems.

Open Door: Our door is always open. We welcome all people who support DJNO's vision, mission, and values regardless of ability, race, religion, age, sexual orientation, gender identity, or economic status.

Resource Sharing: We are committed to supporting those with the least resources first and addressing the dynamic needs of our communities equitably.

Self Determination: We respect and support disabled people and the choices they make to build better futures for themselves and their collectives. This includes the choice to disclose, discuss, and manage their disability.

Glossary of relevant terminology

- Medical gaslighting: Acts that invalidate “a patient’s genuine clinical concern without proper medical evaluation, because of physician ignorance, implicit bias, or medical paternalism.” (Ng et al. 2024) Or “when health care professionals seem to invalidate or ignore your concerns. It can be linked to missed diagnoses, delayed treatment, and poor health outcomes. It might damage your trust in the healthcare system and make you less likely to seek care.” (Godman 2024)
- Ableism: A belief system and practice that devalues disabled people, seeing them as less capable, worthy, or valuable. Ableism is embedded in institutions, systems, and culture, limiting opportunities and inclusion for disabled people (Ontario Human Rights Commission, 2016).
- Racism: As defined by Ruth Wilson Gilmore as “the state-sanctioned and/or extralegal production and exploitation of group-differentiated vulnerability to premature death” (Gilmore, 2007).
- Medical racism: The systemic racism that racialized people experience when interacting with the medical system. This includes experiences where patients may not be believed or their pain is undermined as a result of biases or stereotypes due to someone's race.
- Systemic barriers: Attitudes, policies or practices that lead to unfair treatment or exclusion of individuals from specific groups or areas like work, services, or programs. This is often the result of discrimination or bias. There are tangible and material implications to systemic barriers including job security, and overall well-being (Government of Canada, 2024).
- Tone-policing: A silencing tactic often used by those in positions of privilege or power to derail conversations and shut down opposing viewpoints. Instead of engaging with the substance of an argument, they nitpick the way it’s expressed—focusing on tone, word choice, or delivery—to shift attention away from the actual issue. This strategy is often disingenuous, serving to avoid meaningful discussion, dismiss marginalized voices, and reinforce control in a conversation. (MacLachlan, 2022).
- Differential treatment: Differential treatment refers to when individuals or groups of people because of their race, gender, disability or ethnicity (*Differential treatment – definition and explanation* 2024).

Purpose of the toolkit

McMaster University Research Shop students conducted a scoping review in 2022 exploring Black disabled people's experiences of ableism and medical racism in healthcare. This report explored these experiences across both Canada and the United States. Based on their findings,:

“The [9] qualitative studies reported different experiences with racism in health care such as delayed referral, and denying treatment. When discrimination was evaluated quantitatively on [a] likert scale, Black individuals with disabilities reported higher ratings of discrimination compared to their [W]hite counterparts. In addition, such experiences of discrimination were associated in some studies (but not all) with negative health outcomes and decreased trust in the health care system. However, it is not entirely clear if the poorer outcomes were entirely associated with medical discrimination or other contributing or confounding factors” (Goraya et al., 2023).

Students conducting this research identified a particular gap around the lack of available data and research on the experience of Black and racialized disabled people in Ontario. This served as the impetus for the work that was conducted at the DJNO.

Since 2022, the DJNO has hosted 9 focus groups sessions to hear directly from racialized and disabled people across Ontario about their experiences with the healthcare sector. We have spoken with a total of 65 people, who have self-identified as disabled and racialized and/or Black. The purpose of this toolkit is to highlight those experiences as well as share the recommendations that have been provided by those who we have interviewed throughout our focus group process.

For the medical racism and ableism project team, our research project was about a few things:

- Connecting the dots: We were looking to highlight a pattern of common experiences among Black and other racialized disabled people's experiences within the healthcare sector
- Justice and accountability: We were considering the ways that we can hold institutions and individuals accountable for the conditions they create in the process of improving the outcomes for marginalized groups accessing healthcare
- Proactive and restorative approaches: We are aiming to put together tools and resources that can be used and promoted in the healthcare setting to prevent negative experiences based on medical racism and ableism

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Many people in our communities are dedicated to health equity and this report and work could not have been done without the integrity, dedication, and knowledge of so many people who believe in building a healthcare sector that meets the needs of every single patient in our community.

Research Methodology

In presenting this work, we framed *A Disability Justice Perspective on Addressing Medical Racism* as working to engage residents in Hamilton to get a better understanding of racism and ableism in healthcare. DJNO, in collaboration with community partners, hosted focus groups with Black and racialized disabled community members to inform the creation of a toolkit and training materials around combating medical racism and systemic ableism in healthcare. These will be distributed by local healthcare providers and community groups for medical professionals and community members. This toolkit will be hosted on the DJNO website for public use by community organizations in an effort to address and combat systemic ableism and medical racism in our communities.

Each focus group had two facilitators, one notetaker, and one project coordinator present. Our outreach strategy consisted of postering in Hamilton, Ontario, as well as using our social media for outreach. All of our focus group sessions were virtual.

Prior to participation, each participant was required to sign a confidentiality agreement document. This was required for due diligence to protect participants' privacy and confidentiality, honour the experiences and feedback shared, and to protect the stories and safety of participants in ways that we could.

Participants in the focus groups were asked five questions. These questions were

1. What made you want to join this session?
2. Can you tell us about a time you felt you were treated differently in healthcare because of who you are?
3. What happened next?
4. How has this experience affected your interactions with the healthcare system now?
5. What changes would you want to see in the system?

How do Medical Racism and Ableism Frame Interactions with the Healthcare System?

Ontario Healthcare System

Publicly funded medical care in hospitals was introduced in Ontario in 1957, followed by the public funding of physician-provided healthcare in 1969. The Ontario Health Insurance Plan (OHIP) was officially established in 1972 and integrated under the terms of the federal *Canada Health Act, 1984*, thereby banning

user fees and mandating publicly funded medically necessary hospital and physician services. Since then, various policies, programs, and frameworks have been developed and expanded to enhance service delivery and monitor healthcare outcomes for Ontarians (Lavis & Mattison, 2016).

Although seemingly universal, publicly-funded healthcare has historically neglected marginalized communities, forcing them to be vulnerable to poor health status. In a literature review completed by the research shop at McMaster University, it was revealed that although Canadians have access to universal healthcare, there is unequal access to the healthcare received by Black and racialized patients (Goraya, 2022).

Over the last few decades, research has begun to unpack the various ways race has been linked to social inequities in the healthcare sector (Mahabir et al., 2021). Historically, race-based data collection in Canada has been sparse, which means that data of experiences of race and racism is not widely available (Mahabir et al., 2021). Therefore, most studies looking at race and health disparities have relied on immigration status and population per region (Mahabir et al., 2021). Recently, research has begun to draw connections between people's identities and lived experiences in the healthcare sector.

Who was the system designed for? Who does it leave out?

Focus group participants shared instances that exposed them to the flawed design of healthcare and healthcare education that neglects and/or differentiates Black and other racialized disabled people.

“Because [of] my job [...] I had to learn how to do blood draws... There were different dolls that we were practicing on. And the nurse who was teaching the class said that the Black doll doesn't actually look anything like what real Black people look like. She said that it's not actually a useful tool for teaching.”

“Even our kidney failure test is racist and we don't get treatment as early. I got my blood test back and realized that it's been adjusted for race.”

One participant commented that:

“A doctor wrote in my chart that it was ‘unlikely that she has this medical condition because she's Arab’. [The doctor claimed that] our people don't have this condition which is factually medically incorrect. That's not how medicine works. [Moreover,] I'm not even Arab but they see me as a brown woman with a hijab and so they assume”.

Because of these experiences, participants shared that they often have to take the initiative to find medical professionals who understand and cater to their specific needs just to receive adequate care. They also described having to learn medical

terminology and become highly informed about their bodies and potential health issues to avoid being dismissed or facing delayed treatment. This is especially concerning because language barriers, communication disorders, cognitive disabilities, and limited access to resources can make it significantly harder for Black and other racialized disabled people to access and communicate this type of information. Additionally, the burden of constantly advocating for one's own care is overwhelming and exhausting, making many healthcare settings inaccessible.

Experiences with the Healthcare System

Medical racism and ableism collective experiences

Based on our focus group discussions, we identified recurring themes related to medical racism and ableism that resonated with participants. These themes will be explored further in this section.

Disbelief, dismissal, and medical gaslighting

A common thread of experiences tie back to systemic neglect of racialized, disabled people. These experiences act as precursors for disabling conditions and often lead to a cycle of similar experiences with a number of healthcare professionals. Lack of attentiveness to symptoms and details of illness can fail people within and outside of healthcare (e.g., OSAP, disability funds). Participants have shared the following stories with us:

“When I speak with authority about my body I get questioned time and time again even though I have lived this way for 37 years. I am not believed and then need to check out of the hospital and go to another one.”

“[...] they consistently asked me if I was over-stating my pain or if I was exaggerating or if I was lying about the things that I could or could not do.”

“[...] if you are in an environment of constant gaslighting, eventually you start to downplay what you're experiencing too.”

“My doctor thought I wasn't being honest and that I was a drug addict.”

“I went to my family doctor at a clinic to get approval for my OSAP for disability funds. I have this disease called ulcerative proctitis. It is a permanent disease which targets inflammation in the colon. And mind you, it's permanent but my doctor labeled it as... he didn't label it as something that was permanent.”

“Those experiences of not being believed from a race, gender, and age perspective serve to minimize my experience. When I challenge doctors, I then get told I am intimidating and that it’s my fault. When I say “hey can you stand on this side, because I can’t turn my neck” I have to ask five or six times, but it’s taken as me being rude. It goes back to not being believed and feeling dismissed. Those requests don’t come just for the sake of asking.”

Breaking this cycle requires systemic changes, including anti-racist and anti-ableist training for healthcare providers, more inclusive diagnostic criteria, and a fundamental shift toward believing and valuing the lived experiences of Black and other racialized disabled individuals. Only then can we begin to dismantle the barriers that perpetuate healthcare inequity and its far-reaching consequences.

Weak accountability structures

Another point of discussion is the lack of structures in place for accountability and follow-up following negative experiences with the healthcare system. This flaw is evident even when patients attempt to access patient experience systems or procedures in a hospital. One of the participants cited that “I reported my case to a customer care personnel but I felt like it was swept under the carpet.”

When patients have attempted to file reports, there is often no report back or opportunity to redress the situation. One participant shared that after their experience, they filed a report but never heard back on whether or not there was follow up. They shared that the “whole thing just was so negligent. Like, I have no idea what happened with my report. I don’t know if there were any consequences at all. There’s just nothing on that.” Similarly, another participant shared that “I reported it once, but the management said that they’d talk to the doctor to make sure that it doesn’t happen again and the doctor was not even summoned to either confirm or deny the complaints I had and it was embarrassing and humiliating to report negligence and no action was taken.”

- Need for greater transparency within patient relations, tracking, and accountability measures. This would ensure that patients feel heard and supported when and if they experience racism and/or ableism in the healthcare sector. A question for those in the healthcare sector and in our communities would be: what would a restorative justice model look like when addressing medical racism and ableism?

Double standards and differential treatment

The experiences of our focus group participants reveal how double standards and differential treatment are deeply embedded in the healthcare system, thoroughly affecting Black and other racialized disabled people. Systemic racism and ableism shape how healthcare providers perceive and interact with patients. This also results in the dismissal of the expertise that Black and other racialized disabled people have over their own bodies, even when they clearly communicate their needs. This reflects a broader pattern of racialized patients being seen as less knowledgeable or less compliant, leading to inadequate or delayed medical care.

“I think with our safe injection sites, I think that is like a good path to go to. But I also think that we can do more. And ensuring that people aren't dying when it comes to false information being provided because of the way we look, the way we were treated.”

“When I am sick and I am wearing my durag and my tracksuit, I get treated like I am dumb even when I tell the doctors what to do and how to treat my pain, and what side of the ER I normally go to, they still will say no.”

“And especially as a Black woman, it was very jarring to see how some providers would talk to me, and then I would observe how they talk to a white person shortly after, and it's like night and day difference of the tone, the readiness and the willingness to provide whatever it is that they're looking for, even spend more time with them in the office.”

“[...] the treatment towards people of colour in a rehab or even in the hospital is different and it's not going to be extremely noticeable until you really know what's going on.”

“[...] they do kind of talk down to you a bit, which I think can be condescending, assuming somebody's mental capacity just because they're in a chair or something is always something that's pissed me off. Ever since I was a little kid.”

Stereotypes about criminality tied to race result in racialized drug users being treated with suspicion or disregard, increasing their risk of harm or death. It also results in non-drug users being dismissed and gaslit when they experience pain. This is a clear example of how systemic racism operates within public health interventions, creating unequal outcomes based on race.

Power dynamics in the doctor-patient relationships

We heard from community members that the power imbalance that exists between the patient and the healthcare provider, often the doctor, leads to experiences of medical gaslighting, tone-policing (oneself or from the provider), dismissal, denial, delaying and blame. Patients often feel pressured to present themselves in a calm

and non-confrontational manner to be taken seriously, which can lead to self-censorship and emotional distress. When patients' concerns are dismissed or denied, it not only delays diagnosis and treatment but also erodes trust in the healthcare system. These power dynamics create an environment where patients are left feeling powerless, unheard, and, at times, blamed for their health conditions.

Additionally, coercing a patient to share information with a larger circle of care—such as the reason for an appointment request with the receptionist—is another way that power is used against racialized individuals. “Receptionists have to respect that,” shared one participant. “You don't want to tell them what the appointment is for. And then when I tried to call again [the receptionist] told me to respect him.” Racialized patients may feel pressured to disclose personal details they would prefer to keep private, and refusal to do so can result in hostility or refusal of service, further exacerbating the power imbalance.

A participant shared their experience resorting to contacting their local member of provincial parliament with whom they have connections and using their authority for better treatment in the hospital unit—“They switched up because they realized we were in some way connected, that we could advocate for ourselves, that we could advocate for my father[...] Tests were happening faster, the treatment immediately changed...” This incident reflects systemic biases and illustrates how racialized patients are often forced to navigate power structures creatively to ensure their basic healthcare needs are met.

What are the consequences?

During our focus groups, we heard from many participants about the various consequences they or their loved ones have experienced as a result of medical racism and ableism.

The first theme that we identified was the delaying/denial/dismissal of testing and treatment. The consequences of this have led to poor health treatment and outcomes for many Black and racialized patients. The delaying or denial of treatment also has long term consequences on disability and the worsening of chronic conditions.

During one of our focus groups in 2022, one of the participants shared that “I had a chest crisis (sickle cell) and the doctor accused me of seeking drugs. I could have died. I called my doctor who is now a high up administrator and I got treated in seconds. My brother passed away in the same situation because he didn't have a person to call.”

Another participant shared that their sibling had passed away from diabetic ketoacidosis. Prior to their death, they had been in and out of the hospital complaining about abdominal pain and foot swelling, all signs of Type 1 diabetes which were ignored. The participant shared that they could have been diagnosed earlier and it would have saved their life. The participant shared that their sibling was neglected because of their Blackness and gender identity.

Another participant shared that their father was being treated for lung cancer. The doctor tried to get the patient to sign a paper to move him into a nursing home. The patient said he would not be signing any paperwork until his daughter had arrived. Their father later passed away in the nursing home. What this experience captures is how often racialized and disabled patients aren't granted autonomy around decision making and the space to decide what the next steps will be. Many non-western cultures have different ways of dealing with sick or elderly family members that don't involve a nursing or long term care home. Many participants highlighted that their preferences were not always taken into account because of what doctors often assumed was in the best interest of the patient.

Racialized and disabled participants shared that they often encounter experiences of being dismissed by healthcare providers who perceive their conditions as less urgent or important. They shared that there is often an assumption that their pain is something that can be tolerated or will get better with time. Racist stereotypes about absence of pain perception plays into historically racist and dehumanizing tropes that have especially impacted Black patients for decades. This harmful, erroneous belief is still pervasive amongst medical professionals, and in educational and clinical settings (Hoffman et al., 2016). This kind of neglect not only exacerbates the symptoms but leads more broadly to a distrust in the system. Patients shared that these experiences make them feel unworthy or ignored. One participant shared that "when I experienced the symptoms at first and went to the hospital, the doctors were kind of dismissive of that, citing that I should give it a few days, weeks, maybe months to see if I get better. I have been wondering since then how I was to get better without any treatment or care? The condition got worse and I lost my ability to move around. And I have, since then, blamed the health care system for neglect and making me feel like I was not worthy of getting cared for."

Disillusionment and Distrust

"I no longer trust the healthcare system. I could be in the most gut-wrenching pain. I'd rather suffer than go to a hospital. I don't receive the care I actually need anyway, so it's quite pointless. I definitely interact less

closely with healthcare professionals now than I used to. The trauma cuts too deep.”

These experiences lead to overall disillusionment and distrust. Participants shared that they are less likely to seek out care for issues that require attention because of either previously lived experiences of neglect or the worry that they will not be taken seriously.

Many participants shared having to switch hospitals, specialists, and clinics multiple times in order to receive adequate care, which delayed their ability to receive testing and treatment. One participant shared that their initial rheumatologist was cutting them off mid-sentence and spent “one minute or less” ruling out the same autoimmune condition they were diagnosed with 5 years later by a different specialist.

Navigating the Healthcare System

What to do when faced with medical racism and ableism

- Keep records of times and situations of incidents while accessing any part of the healthcare system (physician name, name of clinic/hospital, date/time of appointment, time you saw the physician, describe the incident).
- If you are concerned about medical negligence: “I’m very concerned about the (medical negligence/unprofessional conduct/inadequate care) that’s happening here today and I’m prepared to contact the relevant college to report and discuss the incident. (from focus groups) *Also, if you threaten this and it doesn’t work, make sure you follow through and lodge a complaint to the professional college, and this is not limited to medical negligence – this complaint can be for any ethical issue including but not limited to medical negligence, poor bedside manner, failure to communicate a diagnosis, and a variety of other medical and ethical concerns.
- Request they document specific items related to your care/visit. For example, if they decline a referral or treatment option, ask them to document it in your chart, then a copy of that chart can be requested to verify this was completed if the care provider does not change their mind or listen.
 - In Ontario, you have the right to request access to your medical records under the Personal Health Information Protection Act (PHIPA)
- Persist as long as your illness does. It can feel easy to give up and say that there’s no point, but every time you speak up it creates an opportunity for

your care provider to listen to you. Sometimes they don't feel they have the information they need to consider your illness problematic – remember, they don't see how bad it is every day, so this must be emphasized. Reiterate when you need to that you and/or your support network know what you are talking about and cite or tell the doctor where your research came from,

Local Community Resources:

Additionally, there are many resources in the community to reach out to if you are looking for support or for more information.

- **Refuge Newcomer Health:**
 - Refuge Newcomer Health is comprised of “client-focused, community driven, diverse interdisciplinary healthcare professionals who provide comprehensive healthcare services to Hamilton’s new immigrant and refugee populations.” The focus at Refuge is to provide and address health disparities specific to the needs of newcomer populations. Refuge also provides primary healthcare services including “initial multidisciplinary health assessments of families recently arrived in Hamilton; primary care and ongoing care. The Centre’s team of specialists provide follow up to clients with complex medical issues, within a community setting, thereby reducing barriers to access.”

- **HCCI**
 - The Hamilton Centre for Civic Inclusion is a charitable organization driven by a mission to mobilize all Hamiltonians to create an inclusive and welcoming city. Founded in 2006, HCCI has undertaken an extensive number of initiatives that have made a measurable impact on the vision of building a united community that respects diversity, practices equity, and speaks out against discrimination. To achieve this, the organization engages with partners and supporters and works hard to be both proactive and responsive as society evolves and new challenges emerge.

- **HARRC**
 - The Hamilton Anti-Racism Resource Centre (HARRC) is committed to advancing education about race, racism, discrimination, racial equality, and anti-racist theory and practice in Hamilton. Their website includes a section where anybody can report acts of racism or hate in Hamilton as a witness or victim. Additionally, they provide various resources for understanding, challenging, and dismantling

racism in our community, including educational materials, support services, and/or ways to take action

- **Hamilton Board of Health:**
 - The Hamilton Board of Health, a public health unit, uses a single tier governance model that consists solely of members of city council. Currently, they oversee public health programs and services in the city of Hamilton and serve to protect and promote the health and well-being of the population. Hamilton Board of Health is actively addressing medical racism through several initiatives, including providing health equity, Indigenous Cultural Safety, and anti-racism training to healthcare professionals, developing health policies with Equity, Diversity, and Inclusion (EDI) principles, and addressing medical racism and related topics at their monthly meetings.
- **Black Health Primer:**
 - A course which supports the “unlearning” of anti-Black racism to create responsive health care professionals who are guided by anti-racist practices.
 - [Black Health Primer | BHEC](#)
- **Toronto Metropolitan University (TMU) Department of Disability Studies:**
 - Courses offered as program credits or as standalone options provide a great way to explore historical disability studies, disability representation globally, and disability in fields such as healthcare and social work, particularly for those who prefer a more academic approach to learning.

Cultivating an Anti-Racist, Disability Justice Perspective in Healthcare

Reading list

- [First Peoples, Second Class Treatment – Toronto](#)
- [‘A lack of compassion’: Canada’s shameful history of medical colonialism – The Conversationalist](#)
- [Racism in Canada’s health-care system was a risk to BIPOC Canadians before COVID-19](#)
- [LEAF statement in solidarity with Regis Korchinski-Paquet and her family](#)
- [SRHR and systemic racism: Examining inequities faced by BIPOC communities in Canadian health care – CanWaCH](#)

- [‘It was unnecessary’: Death of Indigenous mother sparks bias concerns in Ontario healthcare | Globalnews.ca](#)
- [Some staff at St. Catharines Hospital ‘fearful’ of treating Indigenous patients: report](#)
- [D’Andre Campbell fatally shot by police in Brampton home after calling for help, family says | Globalnews.ca](#)

Recommendations from participants for institutions and healthcare workers

1. Patient Follow-Up and Communication

- Follow up with patients after specialist appointments to discuss what happened, share the specialist’s report, and, if necessary, write a letter to correct any discrepancies.
- Medical professionals should not charge patients for copies of their medical files, ensuring equitable access to personal health information.

2. Anti-Racism and Anti-Ableism Initiatives

- Implement an anti-racist policy requiring medical practitioners who exhibit racist behavior to undergo a structured follow-up plan.
- Mandatory and continuous anti-racism and anti-ableism training for all healthcare staff.
- Establish reporting systems to track and address any racist behaviours within healthcare settings.
- Non-tokenistic representation of marginalized groups in educational, academic, and healthcare settings, ensuring that diversity is meaningful and impactful.

3. Patient Advocacy and Support

- Introduce patient advocates as healthcare allies who can be present from the moment patients arrive, ensuring immediate support and advocacy for patient rights.
- Patient advocates should be empowered to take action on patients’ rights on the spot.

4. Commitment to Disability Justice and Patient-Centered Care

- Commit to disability justice by prioritizing the experiences of disabled patients and ensuring their voices are integrated into healthcare systems and policies.
- Involve disabled people and service users in the vetting process for medical school applications to influence who gains access to medical professions.

- Disseminate information using a disability justice lens, recognizing and addressing the impacts of systemic and structural violence.
- Advocate for safe injection sites and an increase in harm reduction
- Increase staff capacity to be able to identify, address and redress environmental, attitudinal or structural barriers that many exacerbate accessibility to clinical care

5. Educational Reforms and Institutional Accountability

- Integrate the lived experiences of marginalized patients into medical curricula and institutional policies.
- Include stakeholders from marginalized communities at board and management levels to influence decision-making.
- Conduct training and workshops to help medical practitioners understand patient uniqueness and encourage consultation when encountering unfamiliar cases.

6. Holistic Health Considerations

- Recognize the impacts of colonization, structural violence, and systemic inequities in health and metrics of health. This includes cultural considerations about food consumption and dietary habits.

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