

## **PERCEPTIONS OF DISCRIMINATION IN HEALTH SERVICES EXPERIENCED BY IMMIGRANT MINORITIES IN ONTARIO**

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Citizenship and  
Immigration Canada

Citoyenneté et  
Immigration Canada

# **PERCEPTIONS OF DISCRIMINATION IN HEALTH SERVICES EXPERIENCED BY IMMIGRANT MINORITIES IN ONTARIO**

## **EXECUTIVE SUMMARY**

Recently there has been a growing awareness of the role played by discrimination in the provision of health care services to immigrant newcomers and refugees. Very little research, however, has explored how discrimination influences newcomers' relationships with health care providers and the health care system in Ontario. This three-part study explores the impacts of discrimination on refugees and immigrants through (1) a literature review of existing reports of discrimination in the health care environment; (2) interviews with health care providers who work with New Canadians in Hamilton, Ontario; and (3) interviews with immigrant newcomers and refugees to gauge perceptions of discrimination from a service user perspective in five small- and medium-sized Ontario cities. This report details the complex impacts of racism and discrimination in shaping immigrant experiences with health care providers and the health care system in Ontario.

The literature review surveys a range of research and policy literatures that address discrimination's effects on mental health, perceived experiences of discrimination and differences in perception and response. It also documents attempts taken to mitigate these effects through "non-discriminatory" health care and service provision. Researchers have reported that perceptions of discrimination have a negative mental health impact on service users. Most types of perceived discrimination are subtle, such as being excluded, dismissed or treated rudely, and are therefore difficult for victims to identify. Coping responses vary from passive forms, such as choosing to ignore discrimination or refusing to seek health care to more active forms, such as confronting the health care provider or disclosing discrimination to authorities. Reports of interpersonal discrimination have incited calls for greater cultural sensitivity in health care services. Although institutional and systemic discrimination have also been identified, very little research has focused on how broader systemic factors are interpreted by service users and service providers. The remaining parts of the report address both interpersonal and systemic issues involving discriminatory health care provision.

Key informant interviews with health care providers revealed instances when providers did not accept new patients based on language ability or type of insurance coverage. Informants felt discriminatory health system outcomes reflected widespread discrimination within broader Canadian society, particularly in terms of skin colour, dress, language and religion. Interviews with immigrant newcomers and refugees of ethnic and racial minority backgrounds identified six types of discrimination associated with negative interpersonal encounters with health care service providers. These types are denial of service based on immigrant or refugee status; accent discrimination; language discrimination; cultural discrimination and insensitivity; discrimination based on country of origin; and religious discrimination. The five most prevalent responses taken by immigrant newcomers and refugees who felt they had experienced interpersonal discrimination were not accessing health care services; changing health care providers; seeking health care and medications in other countries; seeking alternative forms of health care; and engaging in advocacy for themselves and others.

In the case of systemic discrimination, participants felt the health care system needed to take into account the differential needs of immigrant newcomers and refugees. There are currently not enough services or time available to address the complex health concerns of New

Canadians. Seven identified sources of systemic discrimination were misinformation about the health care system or a lack of information; lack of designated time for effective communication between service providers and users; unaddressed mental health needs and inadequate mental health services; lack or underuse of cultural interpreter services; lack of credential recognition for foreign trained health care professionals; three-month waiting periods for newcomers before they can acquire provincial health coverage; stressful medical exams required for landed residency status; and a lack of accountability mechanisms through which incidents of discrimination can be reported and addressed.

Ten recommendations arising from the interviews include making provisions for the following: accurate information about Canadian health care services made available to newcomers before and after arrival; expanded health insurance coverage, including immediate health coverage for newcomers and more time for newcomers to communicate their concerns during doctor's appointments; more training and funding for cultural interpreters, including their mandated use; expanded, coordinated and supported team- and community-based health and mental health services; improved doctor training and medical school curricula that highlight newcomer concerns; more doctors and specialists, especially those of diverse backgrounds practicing in smaller communities; expedited foreign credential recognition for trained health care professionals; improved cultural sensitivity training for clinic staff; better supports, monitoring and accountability for health care providers; and increased support and advocacy for immigrant newcomers navigating the health care system. Open public dialogue and enhanced communication between the health care system and community-based immigration and settlement services were suggested to help achieve these recommendations in a timely and effective manner.

Perceptions of discrimination have harmful health effects by compounding the already significant amount of stress experienced by newcomers who are undergoing settlement and integration into Canadian society. Addressing systemic and interpersonal barriers to effective and sensitive communication between health care providers and service users may wield immediate as well as long-term health benefits in the lives of immigrant newcomers and refugees by reducing the potential for misjudgments and perceptions of discriminatory or unfair treatment. It is incumbent upon health care providers and policymakers not to dismiss issues of racism and discrimination as mere matters of "subjective perception" or "miscommunication," thereby inscribing service users as the problem. On the contrary, what is required is a careful examination of how various experiences, sources and contexts of discrimination create and/or perpetuate inequities in access and quality of health care for immigrant minorities in Ontario.

Future research in this area should continue to include newcomers in meaningful ways in the research design, process and outcomes, such that recommendations can be both effectively communicated *and* translated into actions for social change that properly reflect and honour newcomer voices and perspectives. Areas of research that deserve greater attention include the vulnerability of refugees, particularly survivors of war, torture and organized violence, and the nature of the anti-oppressive and/or advocacy roles assumed by health care and allied professionals who provide services and support to New Canadians.

# PERCEPTIONS OF DISCRIMINATION IN HEALTH SERVICES EXPERIENCED BY IMMIGRANT NEWCOMERS IN ONTARIO

## INTRODUCTION

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 conceived as any practices, judgments and actions that create and reinforce oppressive relations or conditions that marginalize, exclude and/or restrain the lives of those encountering discrimination (Krieger & Sidney, 1998; Hyman, 2009; Karlsen & Nazroo, 2002). Individuals and groups can be discriminated against based on race, ethnicity, language, religion, culture and other characteristics (Access Alliance, 2007; Carrasco et al., 2009). Race itself is a socially constructed categorization scheme, and not a reflection of innate biological differences (Hyman, 2009). The concept of “racialization,” i.e. the social *processes* through which categorization takes place, is useful for illuminating the ways in which certain groups face discrimination and are consequently subjugated to differential treatments and access to resources that contribute to socioeconomic, political and health inequalities (Carrasco et al., 2009; Hyman, 2009). 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 (Women’s Health in Women’s Hands, 2003; Kafele, 2004; Access Alliance, 2005; OCASI, 2005; Fenta et al., 2006; Access Alliance, 2007; Hyman, 2009). Some suggest discrimination exacerbates health disparities between racial categories (Kobayashi et al., 2008; Guilfoyle et al., 2009; Newbold, 2009) with disparities persisting even after accounting for differences in age, gender, education, and income (Dunn & Dyck, 2000; Karlsen & Nazroo, 2002).

The small body of research from around the world that has begun to demonstrate discrimination’s detrimental effects upon health primarily focuses on race or the experiences of visible minorities (e.g. African Americans in the US, Maori in New Zealand, or Caribbean and South Asian populations in the UK) (see Krieger & Sidney, 1998; Taylor & Turner, 2002; Karlsen et al., 2005; Harris et al., 2006). These and related works identify potential pathways through which discrimination impacts health and associated disparities (e.g. disproportionate exposure to hazardous environments, psychosocial stressors, inadequate medical care, economic deprivation, lack of opportunities, social exclusion, etc) (Krieger & Sidney, 1998; Krieger, 2001; Nazroo, 2003). A range of adverse outcomes have been associated with discrimination including poor physical health (e.g. self-rated health, hypertension, cardiovascular disease, respiratory conditions), compromised mental health (e.g. psychological distress, depression, anxiety) and risky lifestyle behaviours (e.g. smoking and drinking) (Williams et al., 2003; Hyman, 2009). Racial and ethnic discrimination is thought to impact health through increased and prolonged stimulation of the body’s physiological stress response, which causes negative emotional states that compromise immune and cardiovascular systems and/or encourage risky health behaviours (Hyman, 2009).

Despite widespread advocacy of discrimination as a key determinant of health (e.g. Krieger & Sidney, 1998; Access Alliance, 2005; Hyman, 2009), explicit, focused examinations and understandings of experiences and effects remain surprisingly limited. This is especially true within *Canadian* contexts and in regards to the unique experiences of immigrant newcomer and refugee populations who may encounter multiple and intersecting forms of discrimination.

Newcomers represented two thirds of total population growth in Canada over the past ten years, with approximately 250,000 admitted each year (Statistics Canada, 2010). The largest group is composed of economic immigrants (roughly 60%), including skilled workers and investors. Refugees represent approximately 13% of the inflow, and family reunification arrivals the balance (Citizenship and Immigration Canada, 2010). Foreign-born and visible minorities are anticipated to represent 28% and 32%, respectively, of the Canadian population by 2031 (Statistics Canada, 2010). Despite these figures, there remains a considerable paucity of research on how racialization and discrimination affect newcomers' health status, care experiences and service utilization patterns or behaviours. 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.

As a first step towards addressing these gaps, this report scans the existing Canadian literature, including academic publications, policy papers and other 'grey' literature to review findings of immigrant perceptions regarding discrimination in health access and health care in order to understand what evidence there is to support notions of discrimination in the health care environment and what policies are in place to prevent racism and discrimination. Second, we draw upon key informant interviews with health care providers working with New Canadians in Hamilton, Ontario who identify instances of racism and discrimination in the health care environment from a provider perspective. Third, we report on 26 in-depth interviews designed to gauge perceptions of racism and discrimination in health care services as experienced by immigrant newcomers and refugees in five Ontario cities (Cambridge, Guelph, Hamilton, Kitchener and Waterloo). In doing so, we address questions such as: Do service providers identify racism or discrimination as salient factors in providing health care to immigrant and refugee clients? Do perceptions of discrimination among immigrant newcomers compromise the quality and accessibility of health care services? How might perceptions of discrimination affect level of comfort, communication and interactions with health care providers? What changes could be made to health care provision in Canada in order to address the concerns of immigrants and refugees with respect to racism and discrimination?

## **METHODOLOGY**

### *Literature Review*

Given the infancy of the current state of knowledge, the goal was not to evaluate the robustness of existing studies, but to map out key concepts, themes and types/sources of evidence underpinning this emerging research area in order to clarify knowledge gaps, identify hypotheses and anecdotes from service organizational settings requiring validation and, ultimately, provide recommendations for future research and policy agendas. Consequently, we adopt a more inclusive review methodology, the scoping review, rather than a conventional systematic approach (Arksey & O'Malley, 2005; Kirk, et al., 2010). Various databases (Web of Science, PubMed, Google Scholar, Theses Canada) and the web were searched using combinations of the following keywords: discrimination, racism, health, health care, newcomers, Canada, refugees, immigrants. This yielded a range of empirical analyses and observations situated within peer-reviewed academic journal articles; reports and position papers generated by governmental, non-profit and community-based service providers; and unpublished thesis

dissertations. The latter grey sources of literature are included in this review, given that they comprise much of the existing knowledge-base and contextualize and supplement the paucity of Canadian, peer-reviewed academic literature on this topic. Additional criteria for inclusion were that the sources be published in English and be focused on either the experiences of discrimination against newcomers within Canadian health care settings or the health effects of discrimination upon newcomer populations in Canada. While there is a significant literature documenting discrimination within housing or employment settings, these sources were not included for analysis, despite our recognition of the implications for health and well-being.

### *Key Informant Interviews*

We conducted a series of semi-structured, in-depth interviews of key professionals in the social service and health fields in Hamilton, Ontario. Although originally designed to examine the health needs of Hamilton's refugee population, issues of discrimination were raised in the interviews. Providers included both individuals involved directly in health care and those in social services focused on meeting health needs. Interviewees were selected on the basis of long-term experience and expertise collaborating with newcomers and refugees in particular. All key providers identified by the researchers accepted our invitation to participate in the project, including Executive Directors, Program Managers, Nurses, Physicians, Health Educators, Settlement Workers and Community Health Centre employees. Respondents were offered anonymity and quotes are identified by coded number only to ensure confidentiality, given the comparatively small pool of potential respondents in the city. The recruitment letter explained the premise of the study, outlined the interview process, explained confidentiality guidelines, and provided the investigators' contact information. A total of 14 interviews were conducted with the health care professionals, resulting in approximately 25 hours of transcription. The interviews represent over 20 years of Hamilton 'reception' history. In accordance with the agreed ethics protocols, and with the participants' consent, interviews were recorded. The standard university ethics guidelines were followed and approved by the University Research Ethics Board.

Although flexible, the interviewer worked from a pre-arranged script (see Appendix A) that addressed the major health and health care issues of the newcomer population but from the provider perspective, with the script based on both a literature review and the investigators' experience working within the community. Open-ended questions were favoured so as to maximize discovery and description (Reinharz 1992). Participants were asked to describe their role in the refugee community via their employer and their position within the organization, as well as length of time working with newcomers. Further questions inquired about client demographics, barriers to care, priority health needs, cross cultural health beliefs and definitions, use of alternative and preventative care and the challenges of working with scarce resources within the refugee population. Conversations were recorded, transcribed and thematically analysed using discourse analysis (Cope 2005; Wright 1995). Two authors independently reviewed the data and accompanying emergent themes for relevance and significance.

### *Immigrant and Refugee Interviews*

In the third component of this project, 26 semi-structured, in-depth interviews were conducted with adult immigrant newcomers in five small- and medium-sized cities to discover if perceptions of racism and discrimination in health care services were prevalent and, if so, how these perceptions might impact the participants' use of health care services, relationships with health care providers and attitudes toward the Canadian health care system in general. The

researchers invited participants to identify comfortable locations in their home cities where the interviews subsequently took place: these sites included coffee shops, service agencies, workplaces, a university campus and participants' homes. Prospective 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. Study participants, once interviewed, were invited to recommend individuals they knew as potential participants in the study. These indirect contacts resulted in one interview. A lack of resources for interpreter services was identified from the outset as a project constraint. Consequently, four participants active in ethno-cultural communities or working in a service capacity with immigrant newcomers and refugees were invited to conduct interviews in languages other than English. Three interviews were submitted and have been included in our data set.

An 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 (see Appendix B). A community-based organization studying immigrant health care service gaps was invited to provide input on the interview script in order that the project might help meet the community's information needs and assist the organization's advocacy endeavours. With all individual study participants, it was stressed that their responses would remain anonymous and that participants had the right to withdraw from the study at any point. Consent to participate in the study and to have the interview audio-taped was obtained through written consent forms as well as verbal communication. Following the interview, participants were provided with a feedback sheet detailing how they would be provided with the results of the study. Procedures and materials used in the study were approved by the research ethics boards at Wilfrid Laurier University and McMaster University. Upon completion, the interviews were transcribed and analyzed using open coding and constant comparative methods. All proper names and other identifiers were converted to pseudonyms or removed. Data analysis resulted in the identification of key thematic areas, with each theme being further organized into salient subcategories.

During the study, concerns were raised by the researchers about our ability to outreach to the most marginalized members of the immigrant and refugee community in the absence of participant referrals and interpreter services. The investigators' prior experience working with community-based research initiatives suggested an increasing prevalence of distrust among social service agencies in forming partnerships and sharing data. This may be due to the depletion of funding dollars available for community-based research and services. Also observed was an increasing difficulty in accessing immigrant social networks. Research fatigue, or perhaps an increased suspicion of mainstream research, appeared to be a barrier to participation in our research study. The challenges posed by recruitment for our study suggest the ongoing significance of researchers' investing time in forming trust-building relationships with community members as well as adequate resource allocation to remove barriers to study participation for community members experiencing extreme marginalization in terms of language, age, class and other factors.

Our observations regarding participant recruitment received some confirmation from communication that took place at five meetings attended by the researchers between June and December 2010. These meetings involved discussion of the findings of health-focused research studies involving immigrant communities across Ontario. At these meetings, attended by academics, community-based researchers, study participants and general community members,

repeated expressions of resistance toward research were articulated by members of the immigrant community. In one instance, a palpable level of frustration was expressed by a research participant with regard to projects that have continued to generate similar results and recommendations “since the 1960s,” but which have not been acted upon at the policy and service levels. Another statement was made by a member of the immigrant community who suggested that it was time for researchers to turn their focus away from studying immigrants, who feel as if they are being treated like “symptoms to be cured,” and turn their attention toward “issues in mainstream society” such as why service systems are failing to follow through with recommendations to implement effective programs and what factors prevent Canadian society from embracing the social inclusion of immigrant newcomers. In addition to impatience with a lack of social change, these expressions of frustration and a general malaise or lack of trust with research initiatives focusing exclusively on immigrant communities provided additional nuance to the challenges we observed with participant recruitment outlined above. We will follow up with research participants on these concerns as we engage in the process of sharing the research findings with all participants and community partners through distributing the written report and hosting an open community forum.

## **RESULTS**

### **LITERATURE REVIEW: DISCRIMINATION & THE HEALTH OF NEWCOMERS**

Current evidence is generally derived from two methodological approaches, each addressing particular questions, pathways and areas of importance that the other cannot (Krieger & Sidney, 1998). Large-scale surveys and statistical analyses assist in demonstrating whether discrimination is indeed associated with particular health outcomes, the strength of such associations and related spatial and temporal patterns of vulnerability. Alternatively, qualitative approaches are essential for understanding the experiences of racialized groups and the needs of diverse newcomer populations. They also inform the development of culturally meaningful and accessible health policies and interventions, and reveal or humanize upstream, systemic discriminatory practices.

The Canadian literature documenting the lived experiences of discrimination and related consequences for health care access and service utilization patterns is slim relative to American and British literatures. This is true with respect to understanding how discriminatory practices impact the quality of different types of care (e.g. reproductive, mental health, cardiovascular, etc) received across various settings (e.g. hospitals, community health centres, etc), and in regards to determining or measuring “embodied” impacts or biological expressions of discrimination (Krieger, 2000). One notable exception would be documented experiences of discrimination against Aboriginals within Canadian health care settings. These works demonstrate how assumptions about Aboriginal people and culture shape patient/provider encounters and quality of care received. For instance, the stereotype that violence and substance abuse is an inherent attribute of Aboriginal culture, and therefore a causal factor for illness, can result in patients’ concerns being dismissed, misdiagnoses, over-pathologization, denial of care, poor patient/provider relationships and a reluctance to access health services due to fear of stigmatization and mistreatment (see Fiske & Browne, 2006; Browne, 2007; Tang & Browne, 2008).

Broader absences in the literature with respect to health impacts from discrimination are due, in part, to the lack or inadequacy of indicators of discrimination within provincial and national health surveys (Hyman, 2009; Kobayashi et al., 2008). However, using data from the Longitudinal Survey of Immigrants to Canada, DeMaio & Kemp (in press) note that visible minorities and immigrants who have experienced discrimination are most likely to report declines in self-assessed health and mental health relative to other newcomers. Furthermore, the balance of scattered literatures regarding discrimination and the health of newcomers in Canada touches upon mental health impacts, perceptions of discrimination, differences in perception and coping responses and debates around providing “non-discriminatory” care. These themes are further explored below.

### ***Discrimination and Mental Health***

Research examining discrimination’s impact upon mental health provides notable exception to the dearth of research investigating the effects of discrimination upon newcomers to Canada. Studies of Southeast Asian refugees (Noh et al., 1999) and Korean immigrants (Noh & Kaspar, 2003) reveal positive relationships between perceived discrimination and depression. Another study of Southeast Asian refugees suggests that strong ethnic identity enhances symptoms of distress associated with discriminatory encounters (Beiser & Hou, 2006). This contrasts with findings from the US on African Americans demonstrating that strong ethnic identity mitigates stresses of discrimination, including depressive affects (Branscombe et al., 1999). Concomitantly, immigrant and refugee women have been found to be at significantly higher risk for symptoms of post-partum depression (Stewart et al., 2008), yet the need remains for further investigating whether, and how, racial and gendered forms of discrimination impact reproductive experiences, health outcomes and service utilization patterns (Ahmed et al., 2008). Caxaj and Berman (2010) observe that the most common concerns facing newcomer youth in their study relate to experiences of racialization in the media, school, neighbourhood and other public settings. The discriminatory encounters experienced by youth at both individual and systemic levels inhibit their sense of belonging in Canadian society. Sense of belonging and the networks in which youth socialize and seek support are integral to general health and well-being, positive self-esteem and identity formation (Fantino & Colak, 2001; Salehi, 2010).

### ***Perceived Experiences of Discrimination***

Evidence suggests that the majority of discriminatory encounters in Canada today are generally subtle, elusive or systemic relative to traditionally overt forms (e.g. verbal and physical abuse). Subtle forms of discrimination include being excluded, dismissed and/or treated rudely or unfairly, which can, at times, be more difficult for victims to detect, evaluate and process (Beiser et al., 2001; Magoon, 2005; Noh et al., 2007). It is hypothesized that uncertainty as to whether differential treatment stems from personal attributes/inadequacies or prejudicial attitudes invokes additional stress and confusion for victims when determining how to respond appropriately (Wang, 1997; Noh et al., 2007).

Documented encounters of perceived discrimination within health care and social service settings range from incidents of insensitive, unfriendly or ignorant treatment from providers, to racial slurs, stereotyping and receipt of inferior care (Wang, 1997; Women’s Health in Women’s Hands, 2003; Johnson et al., 2004; Access Alliance, 2005; Magoon, 2005; Stewart et al., 2008; Wahoush, 2009). A study of young women of colour in Toronto found one in five experienced racism within the health care system (Women’s Health in Women’s Hands, 2003). Similarly, a

study which focused on the experiences of South Asian immigrant women and their health care providers in Vancouver revealed significant disjunctures between accounts. While the women referenced multiple instances of discriminatory treatment, providers themselves asserted that differences in treatment for newcomer clients merely reflected the need for providing culturally “appropriate” care (Johnson et al., 2004). Others have argued that the stereotyping assumptions of mental health care providers can skew observations and assessments, potentially resulting in inaccurate diagnoses (Kafele, 2004; Guilfoyle et al., 2008). As research from outside of Canada has demonstrated, the socio-environmental contexts of newcomer populations (including pre and post migratory experiences and potential trauma) are often inadequately considered, resulting in over-pathologizing otherwise “normal” reactions to psychologically stressful situations (Rousseau, 1995; Fantino & Colak, 2001). Likewise, failing to acknowledge the effects of systemic racism on an individual can result in pathologizing coping responses, while neglecting the need for ameliorating structural injustices (Krieger, 2000; Karlsen & Nazroo, 2002).

In an unpublished dissertation, Wang (1997) explores the experiences of Chinese immigrant women utilizing a health care system in Halifax. These women claimed physicians dismissed their competence and individual health values and made them feel like children expected to follow orders. This undermined patient/provider relationships, and consequently resulted in many of the women avoiding future care. Similar sentiments were echoed in a study of refugee mothers in Hamilton, Ontario who perceived racial discrimination as a barrier to accessing health care for their children (Wahoush, 2009). Mothers referred to negative attitudes and experiences of being ignored by health care practitioners. Prolonged periods of waiting in emergency rooms were also perceived as evidence of racism. Wahoush (2009) suggests that if time had been taken to explain that delays in emergency rooms are the norm, then this could have helped prevent such instances from being interpreted as discriminatory. Regardless of whether instances of discrimination are “real” or “perceived,” negative experiences can discourage individuals from seeking health care and contribute to feelings of isolation and despair (Beiser et al., 2001; Johnson et al., 2004; Magoon, 2005).

Others have explored discrimination against newcomer women accessing maternity care in hospital settings. Immigrant Muslim women living in St. John’s, Newfoundland claimed health care professionals’ lack of knowledge and discriminatory attitudes resulted in insensitive and inappropriate care (Reitmanova & Gustafson, 2008). These women reported instances of health care providers becoming frustrated or angry when asked to acknowledge or respect religious or cultural beliefs and needs (e.g. preference for female providers, need for privacy and remaining clothed). Some were subjected to insults and stereotypes that left them feeling embarrassed and ashamed. These findings are in line with a previous study of hospital birthing experiences among South Asian, Vietnamese and First Nations’ women (Spitzer, 2004). Spitzer (2004) likewise documented racist views held by some nursing staff, including candid statements regarding the “low pain threshold,” “tendency for substance abuse,” “peculiar body odours” and “inadequate mother-infant bonding” of particular ethno-cultural groups. This study notably exposes broader systemic and institutional factors shaping practitioners’ attitudes and behaviours. For example, health care reform and cutbacks, stemming from Canada’s new economy of care, resulted in increased workloads, staff and supply shortages and patient complaints, which compelled nurses to avoid patients deemed as problematic and costly in terms of time and energy investments. Overwhelmingly these patients were visible minorities presumed to be challenging due to linguistic and cultural barriers (Spitzer, 2004).

Similarly, a study examining barriers to health care for refugees in Canada found that some health providers are unwilling to accept refugees as patients, even when seeking new clients, as they are perceived as challenging due to complex health needs, linguistic barriers and/or complicated insurance coverage schemes that can delay payment for services delivered (McKeary & Newbold, 2010). These are examples of how prevailing institutional values (e.g. neo-liberalism, efficiency, objectivity, technocracy, etc) produce perhaps unintentional, yet nevertheless differential, impacts which may appear as discriminatory and inequitable.

### ***Differences in Perception & Response***

Existing research demonstrates variances in the propensity and willingness of newcomer groups to *perceive* acts of discrimination (Dion & Kawakami, 1996; Beiser et al, 2001; Moghaddam et al., 2002; Noh & Kaspar, 2003). For example, over the course of 30 years, surveys administered to ethnic groups in Toronto consistently yielded that visible racial minorities perceive greater discriminatory treatment than white ethnic minorities (Breton, 1990; Dion & Kawakami, 1996). These studies explored perceived discrimination within employment settings with some attention given to day-to-day social settings. Focus was not placed upon experiences in health care and social service settings specifically. Additionally, survey participants were distinguished by ethnic background and visible/non-visible minority status, and therefore other potential factors of importance, including migratory history or newcomer status, were unexplored. Thus, variations in perception across minority groups remains poorly understood.

Nevertheless, some other attempts have been made to untangle determinants of perception and response. A study of Southeast Asian refugees in Canada (Beiser et al., 2001) showed that loyalty to heritage culture, receiving education in Canada and extensive use of Canadian media were all associated with increased likelihood of perceived discrimination. However, conflicting associations were demonstrated with respect to context and community size. For instance, Chinese immigrants living in ethnically dense neighbourhoods were likely to perceive discrimination, while ethnic enclosure was a protective factor for Vietnamese and Laotian populations.

Similar to, and likely associated with observed variations in propensity to perceive discrimination, is the range of coping strategies employed by individuals and cultural groups. Direct or active coping responses include confrontation or disclosure to authorities or the media, while passive responses include minimizing, ignoring, accepting, or privately confiding in another (Noh & Kaspar, 2003). A seminal study of African American women showed that passive responses to discrimination were associated with elevated blood pressure (Krieger, 1990). A later study of female Indian immigrants in Montreal also found avoidant coping styles to be associated with higher blood pressure and negative psychological symptoms (e.g. anger, anxiety, depression) (Moghaddam et al., 2002). The relationship between passive coping and depression is further supported in a study of Korean adults in Toronto (Noh & Kaspar, 2003).

In contrast, others have argued forbearance or less confrontational modes of coping is health protective. For example, forbearance amongst a sample of Southeast Asian refugees minimized stress and depression, particularly for individuals with strong ethnic identities and values (Noh et al., 1999). Some theorize that tactics of forbearance or self-reliance over confrontation is a better use of time and energy and preserves self-esteem (Ruggiero & Taylor, 1997; Wang, 1997). Noh and colleagues (1999) initially suggested that some individuals evade conflict in adherence to cultural norms. However, their later work leans towards more “social-

contextual” explanations (Noh & Kaspar, 2003). That is, differences in coping strategies may be indicative of available personal and social resources. When sufficient resources (e.g. language proficiency, financial security, awareness of rights and supports, etc) are in place, minorities of diverse backgrounds are more likely to confront discrimination. Indeed, one’s perceived power or positionality has been shown to factor in when assessing the risks of how to respond to an unjust encounter within health-related patient/provider relationships (Wang, 19997) and in the job market (Beiser et al., 2001)

### ***“Non-Discriminatory” Health Care & Service Provision***

Cultural theories of health emphasize the role of beliefs and values in determining how health and illness are perceived, experienced and communicated, in addition to explaining wide-ranging variations in help-seeking behaviour (Kafele, 2004; Gesler & Kearns, 2002). Health care systems and service delivery in Canada are recognized as generally homogenous, reflecting hegemonic, westernized perceptions, values and priorities, despite increasingly diverse user populations and needs (Noel, 1996; Mulvihill et al., 2001; Fenta et al., 2006).

A commonly cited barrier to health care amongst racialized minority groups in Canada is inadequate cultural competency and respect for alternative health values and practices (Noel, 1996; Wang, 1997; Oxman-Martinez et al., 2001; Kafele, 2004; Spitzer, 2004; Fenta et al., 2006; Reitmanova & Gustafson, 2008; Carrasco et al., 2009; Newbold, 2009). Cultural differences can inhibit meaningful therapeutic client/practitioner relationships, preventing individuals from seeking out care or following advice. Deteriorating health status can result from culturally inaccessible services and unaddressed problems. Nevertheless, studies on caregiver attitudes and implications for race-based differences in care remain very rare (Guilfoyle et al., 2008).

Consequently, calls for culturally competent and sensitive care have been on the rise (Carillo et al., 1999; Oxman-Martinez et al., 2001; Betancourt et al., 2003). The intent 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 quality, non-discriminatory care (Magoon, 2005; Guilfoyle et al., 2008; Reitmanova & Gustafson, 2008). Strategies identified in Canadian and other literatures include sensitivity training in understanding migratory and settlement experiences and power dynamics involved with patient/provider relationships. This is in addition to hiring professionals who share clients’ languages and ethnic backgrounds, developing interpretation services and peer support programs, integrating with traditional healers and medicine and ensuring linguistically accessible education materials (Brach & Fraser, 2000; Betancourt et al., 2003; Kafele, 2004; Carrasco et al., 2009). Nevertheless, there remains need for examining whether theoretically prescribed adaptations ultimately improve client/practitioner relationships and reduce disparities in health outcomes and access (Brach & Fraser, 2000; Spitzer, 2004).

Critics also caution against treating “culture” as a discrete and static variable, as this perpetuates existing stereotypes (Carillo et al., 1999; Johnson et al., 2004; Reitmanova & Gustafson, 2008). Conclusions stemming from research on discrimination within Canadian health care settings have emphasized that cultural beliefs, values and individual health status cannot be divorced from either unique social, political and economic contexts or institutionalized power dynamics and related inequalities (Noel, 1996; Reitmanova & Gustafson, 2008; Fiske & Browne, 2006). There remains need for better understanding the ways in which the individualized behaviours of health care providers *and* broader systemic factors (e.g. health policies, economic systems, etc) distinctly and interactively influence racialized disparities and

health outcomes. Attempts to ameliorate the impacts of discrimination upon health must be multi-scaled. That is, both practitioner oriented and systemically oriented initiatives (e.g. community development, equitable partnerships, participatory planning and research, etc) are required. Likewise, scale and context must be considered when evaluating interventions and embodied experiences of discrimination.

## KEY INFORMANT INTERVIEWS

Key informant interviews revealed the degree and magnitude of systemic barriers within the health care system, including interpretation/language, cultural competency, health care coverage, isolation, poverty and transportation in terms of health care and availability of services (McKeary and Newbold 2010). Despite widespread acceptance that discrimination is a key determinant of health, and recent arguments for measures to counter racism being incorporated into Canada's Population Health framework (Oxman-Martinez *et al.* 2001; Hyman 2009), issues of health and discrimination were *not* directly raised by key informants. However, interviews revealed instances where providers did not accept new patients based on language ability or insurance, suggesting that other, institutionalized forms of discrimination exist within the system which may lead to marginalization and poor health outcomes as providers avoid more problematic or time-consuming patients. The lack of primary care providers is also a reflection of the unwillingness of providers to accept new patients, particularly when language and insurance are issues. The added time and expense of working with such clients become an additional drain on physician resources (Newbold and Willinsky, 2009). As such, physicians, even if seeking new clients, may decline refugees, including those with pressing health needs:

*Even family physician, that... are accepting new patients. But when you call them they say: 'No, they will accept them if they speak English.' The meaning is 'no'. You know? This is barrier. Big, big challenge. [Especially] if we have a person who really need to have a family physician...a woman with a pregnancy or some other issue. (#503)*

*... there's times when there's nobody receiving new clients in the inner city at all and so it's just a challenge. (#505)*

These quotes hint at instances of institutional and systemic discrimination, and also reflect results by Ramsey and Turner (1993) who noted that GPs expressed concerns over language difficulties leading to extended consultations when dealing with refugees with limited English abilities. While not overt discrimination (as compared to, for example, verbal or physical abuse), the results are counter to the expectation of the equitable delivery of health care, and the refusal of patients impacts the quality and effectiveness of care received across various settings and points of delivery (e.g. hospitals, community health centres), leading to inferior or inadequate care (Johnson *et al.* 2004; Magoon 2005; Access Alliance 2005; Stewart *et al.* 2008; Wahoush 2007).

Beyond the health care environment, discrimination, racism and racialization were, however, raised by key informants, although it was not immediately or directly tied to health care access and use. Instead, they reflect systemic outcomes or reflections of the broader Canadian society, which have likely become particularly attuned during the recession and when resources are scarce:

*Then there were growing, growing insensitivities and challenges and resistance and racism towards people who were not white, not-English speaking, not Canadian-born, in general. And to people coming from African countries specifically. (#505)*

Skin colour, dress, language, or religion were all observed to trigger incidences of discrimination, racism and/or racialization within the broader community:

*Similarly with the Somali community as well, where there's great judgment on the large number of children in the family. I remember there was some comments, even from one of the local politicians offices who we were asking for some assistance around a particularly challenging experience that one of the people in the community were having. And they said, "Well, for God's sakes they have 11 kids and they're pregnant, like what the hell is going on?" So, imposing, their own moral perspective on 2.5 children and a house and a garage and a car and all that kind of stuff on other people. Making an assumption about ability and morality and all of those kind of things. (#505)*

Refugees may bear the brunt of racism given their vulnerability within society and potentially precarious settlement within Canada:

*The issue of racism is huge for refugees, experiencing challenges as they go around. 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. (#504)*

While not immediately related to health care, incidents of discrimination or racism have been noted to impact personal health and well-being, leading to poorer health outcomes.

## **INTERVIEWS WITH NEWCOMERS**

Of the 26 immigrant newcomer interviewed, five were male and 21 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. When asked "do you consider yourself a member of a visible minority group?" 18 replied affirmatively, with one replying "I don't know...If I say my background, people automatically put me in the category, otherwise, no" (11). Two participants qualified the term "visible minority" by using the words "racialized" and "accent" to describe themselves. One used the term "audible minority" instead of visible minority to describe herself. Five participants had entered Canada as refugees, and six participants had not received citizenship status but indicated a desire to become Canadian citizens. The duration of time spent living in Canada ranged from 3 years to 22 years. 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 participants replied they had personally experienced discrimination at least one time when interacting with a health care practitioner or clinic staff in Canada. A similar proportion of participants who self-identified as non-visible minorities reported discrimination as

those who self-identified as visible minorities. Participants also mentioned anecdotal instances of discrimination told to them by other immigrant newcomers. Identified instances of discrimination ranged in severity from overt forms (e.g. verbal abuse) to more subtle forms (e.g. rudeness). Of the participants reporting a discriminatory incident, 9 had deemed the issue serious enough to report it to a higher authority, including filing a formal complaint. The majority of participants reporting discrimination stated that they would not seek repeated contact with the particular health care provider or, in some cases, had chosen not to access the health care system at all since the incident's occurrence.

The complexity of defining, identifying and describing experiences of perceived discrimination surfaced several times over the course of the research project. The researchers noted the indeterminacies associated with the term "discrimination" and the various intersecting forms of discrimination. Although the subject under study was articulated to participants as "perceptions" or "experiences" of "racial discrimination" or "unfair treatment," several participants explained that they were uncomfortable with the relative and subjective criteria upon which judgments of discrimination were based. Participants appeared less comfortable with the term "racism" than "discrimination," perhaps because the word carries more gravity, as does suggesting that a health care provider is "racist." One participant said, "Racism does exist, it's real. But you cannot identify it in people's faces" (16). Another said that determining if a situation was discriminatory was "tricky" (8). Some wished to know how health care providers behaved toward other patients, as their own interactions with health care providers typically occurred on a one-to-one basis. Challenges with linking behaviours (e.g., abruptness) to discriminatory attitudes were likewise expressed by participants, particularly when interactions with health care providers were limited in terms of time and frequency. Most participants expressed satisfaction with long-term relationships established with family physicians, and all participants indicated they had at least one positive experience with a health care practitioner. Negative incidents, by contrast, were usually isolated events so that participants found it difficult to decipher what might be discrimination or simply the personality characteristics of the health care provider. In addition, most participants interpreted discrimination through reference to specific factors that might identify them as not being Canadian born, thereby limiting experiences of discrimination primarily to personal identifiers, such as accent, rather than race, gender, class, education, sexual orientation or other potential areas of identity-based discrimination. In the absence of a consensual understanding of discrimination and its more subtle and/or intersecting forms, it is conjectured that participants were likely to underreport the prevalence of discrimination.

Although the term "discrimination" remained loose and undefined, considerable consensus emerged in terms of how participants identified and described the types of discrimination they had experienced. There was also a great deal of consensus in terms of how participants responded to interpersonal discrimination. In addition to recounting interpersonal incidents, most participants also used the term "discrimination" to refer to policy barriers or systemic inequities within the Canadian health care system that impacted themselves and other immigrant newcomers differentially from Canadian-born patients. Discrimination related to systemic issues was distinguished from interpersonal forms of discrimination in data analysis and coded as a separate category, although uncertainty was expressed by a few participants regarding whether the perceived discrimination they experienced was caused by systemic or interpersonal factors, or both. When asked about barriers to using health services, participants recommended several ways in which current policies, programs and practices that were considered negative

could be changed to better accommodate immigrant newcomers. They also suggested that services received positively could be enhanced through expansion and increased governmental support. Data analysis produced the following major thematic areas, each explained in further detail below: (1) types of interpersonal discrimination; (2) responses to interpersonal discrimination; (3) systemic discrimination; and (4) recommendations for clinical practice and system improvement.

### *Types of Interpersonal Discrimination*

Reports of discrimination were associated with being refused medical services on the basis of immigrant or refugee status. Participants reported being refused as new patients for a family practice. One participant named 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 “felt so miserable” because of the “serious discrimination against immigrants” she had experienced. Lianne also explained how she felt her family physician had “ignored” significant mental health concerns of a family member, leading to acute crisis and seeking emergency care:

*Because of [the family doctor], maybe [my husband] got this crisis. We went there, because [the doctor] didn’t do anything. That’s why. Because we went there, he saw my husband. He could protect him, but he didn’t do anything, just anti-depressant. ... I don’t know how I can complain about him, 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 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. We are not in the, we are not in the, good hands.*

Many participants felt doctors viewed immigrant patients as a hassle, too time-consuming or exceptionally demanding. Another participant named Emily explained how as a community advocate she had confronted family doctors who refused to take government-sponsored refugees as patients. Refugees, whose health expenses are covered by federal rather than provincial health insurance, experienced “exclusion just because of different coverage.” Emily felt she had to tell 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, was seeking 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.” She subsequently filed a complaint with the Ontario Human Rights Commission.

In addition to facing barriers to being taken on as a patient, participants who had family doctors reported difficulties in booking appointments over the phone to see their doctor. Gail stated, “[it is] very hard to get an appointment to see the doctor, the secretary acts as gate keeper and is not friendly.” James 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 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. Emily reported, however, that the prior hostility of the receptionist had made her reluctant to seek health care services and continued to deter her from going to the doctor for her own health care needs. Another participant named Nadia told a story involving two hospital nurses who had used a tone of voice that was "quite stern and seemed angry" when Nadia 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" (25, 10, 7, 14). Two participants explained how they had experienced "positive discrimination" after making known their education level or professional credentials with a health care provider, or after indicating members of their immediate family were health care professionals (8, 14, 7).

In addition to encountering accent discrimination when speaking English, many participants felt that language ability was a major barrier to accessing health care as well as a source of discriminatory behaviour on the part of health care providers. Several participants felt that doctors did not show enough patience with people who speak very little or no English. They felt this lack of accommodation compromises the clear communication required for proper diagnosis and treatment. One participant named Patricia, who would take a dictionary with her on doctor's visits because she could not access an interpreter, said, "How do they ensure they are treating the patient or giving the same quality of care?" She explained how she viewed health care providers who took no measures to mitigate language issues as lacking professional responsibility "because they took an oath to take care of human beings, not only those who speak English." It was suggested repeatedly that many doctors do not use interpreters because of added time costs and the financial expense. Knowing this, patients who cannot afford to hire for themselves a trained interpreter to go to the doctor with them might then rely on family members, often their children, to translate conversations (13). Using child interpreters was considered a serious problem by several participants. One participant, Danielle, who often acted as an interpreter for her parents, recounted a mix of emotions when she was expected to tell her father he had "terminal, stage four lung cancer." She said, "I just didn't think it was fair that a family member should have to say this. You know, for my dad to hear it from me. It felt like my dad wasn't being treated like a person."

Using family members as interpreters was an often cited issue in a large set of potential problems associated with language barriers. It was also mentioned that a lack of patience in communication could result in the patient not giving or receiving adequate information. Maria felt that doctors "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." Issues involving complex medical terminology, mental health issues or issues of a sensitive or sexual nature might not get addressed (13). Pain or other symptoms might

be disregarded, due to language or cultural barriers, resulting in mistreatment. Jack explained how his complaints of pain were ignored by doctors and paramedics until he presented at the hospital emergency with acute appendicitis. The director of the hospital later phoned to apologize to Jack, who told the director he would not pursue a malpractice suit. In addition to feeling that they cannot be heard, a non-English speaker may nod as if they understand because they “don’t want to bother the doctor” (12). Danielle explains how patients who seek health services when English is not their first language also experience stress:

*because then the patient, they’re left with kind of unknown questions. And they don’t know what to do, and, yeah, it would for sure impact the care on both sides. Just 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.*

Compounding the risk of miscommunication and inappropriate medical care, as one participant pointed out, is the deterioration of English fluency under stress. In those moments, an ESL speaker might think, “Oh my god, I’m getting crazy” (6). Experiencing such distress, a person might repeat the wrong expression, know they are being misunderstood and feel unable to correct the communication problem (6). 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” (15). One participant who acted as a cultural interpreter recalled an instance when the doctor “left the room in two minutes.” The interpreter decided to follow the doctor and said to him, “you need to listen.” The doctor came back and sat down with the patient, then prescribed a new medication. Although the medication did not prevent the patient from having a stroke two months later, the interpreter felt it had “helped to prevent a bigger stroke” and posed the question “what if no other person advocated for them?” (17).

Closely related to language discrimination were various forms of cultural discrimination described by participants. These ranged from more subtle forms, such as the doctor’s style of communication being experienced as “abrupt” and “aloof,” to more extreme forms leading to possible misinterpretation and improper judgments (22, 24). Lianne described how she felt in response to perceiving more subtle signs of discrimination: “Service providers’ behaviours are so cold and distant. You feel yourself as far as, as I said before, you feel yourself so loser and miserable. You lose your, your respect yourself, and you feel yourself silly. Because they behave like that, unfortunately.” Participants also related stories that suggested how “ignorance” on the part of health care providers could lead to serious misjudgments, differential treatment and traumatic experiences for immigrant patients (7). Kate, for instance, explained how she had been taken to a hospital emergency department following an unexpected 38-hour airplane flight. She had an “anxiety issue with planes” and had “almost fainted” prior to being picked up by the ambulance. Once in emergency, she explained the situation to the intake nurse and said she was feeling better. However, the nurse kept her isolated in a small room, “alone in the dark” for three hours during which “nobody come, nobody talks to me.” This made her feel “threatened.” Kate felt the intake nurse did not know “how to interpret immigrants,” but also expressed self-doubt: “perhaps I didn’t give her the right answers.” Kate was accompanied by a friend, also an immigrant, who spoke English fluently, but who was no more successful in communicating with

the nurse. Kate explained, “even when language is not a barrier, [the nurse] was not able to interpret the messages we gave her, not able to understand in a correct way.” Kate felt like she had been “treated like a psychologically disturbed person” until the doctor arrived. Then she “made some jokes with doctors and nurses so they were convinced I’m an okay person.” Another participant, Jessica, who doesn’t have any family members living in Canada, reported going to an emergency department when she experienced extreme grief after learning that her mother had died. She explained to the doctor that she needed to talk to somebody, but had been unable to access mental health services in the community. She was admitted to the hospital by the doctor, who then “wouldn’t let me go.” Jessica felt the experience was “terrifying” and that the doctor misunderstood “how immigrants vocalize distress.” She felt models of support lying outside a “Western dominated” crisis and recovery model were simply not available. The inability of Canadian doctors to acknowledge the culturally specific nature of the treatment models—particularly ones that rely “heavily” on prescription medication—was perceived by Jessica as a source of discrimination and feelings of disempowerment.

Not understanding cultural differences, for some participants, was not equated with discrimination (5). One participant said she had repeatedly encountered views such as “all third world women lived in slums” which she attributed to “not really racism, but it’s just racial ignorance” (9). One participant, however, stated unequivocally that “Ignorance is a type of racism” (18). Participants expressed concern that cultural ignorance might lead to improper care for refugees from war torn countries or immigrants experiencing post-traumatic stress disorder (9, 10, 13). One participant explained how the doctor’s lack of knowledge about the 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 (14). 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” (9). Participants indicated that they might go to a physician for a routine checkup or physical, but would neither be invited to address more complex issues nor have the opportunity to discuss anything personal. Participants expressed uncertainty whether a doctor’s lack of interest in them signaled the doctor’s personal judgment against them or a broader systemic issue regarding work overload and lack of time allotted to patient care. Several participants felt that doctors, including family physicians, did not respect alternative styles of communication. One stated, I “felt rushed, not listened to ... felt like I was a burden” (25).

Another participant felt her interactions with a gynecologist were “culturally awkward, insensitive” because the doctor had “imposed his own values” (14). One participant noted that “women in a multicultural society” with diverse “religions, beliefs, and cultures” may require being examined by a female doctor. It was suggested that male family doctors would need to understand this and provide a referral; otherwise, gynecological exams and routine Pap tests, in particular, would be “hard on [the women] or avoided” (13). Another participant talked about Canadian doctors being “scared” when caring for African-born patients who had undergone female genital mutilation. The participant 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 (10). Another female participant said that hospital procedures surrounding childbirth were not explained to her in advance, and the obstetrician was “sometimes quite aggressive, other times sarcastic about my questions.” She felt 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” (11). Some participants suggested that a doctor’s lack of exposure to people from other cultures might make the doctors uncomfortable and less friendly. One participant was pleased with her family doctor who “made an effort to pronounce my name properly” (17), while another participant 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. She felt it was “depersonalizing” when health care providers “don’t want to make an effort to say [my name]” (9). Another participant 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” (26). In some cases, cultural ignorance or insensitivity on the part of health care providers was seen as having harmful psychological or emotional effects. Several participants suggested a person’s self-worth or self-esteem could be impacted when a health care provider’s behaviour or attitude reflected hurtful cultural or racial stereotypes. One participant named Mary described feeling “vulnerable” and threatened by a nurse’s response to her. 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 ‘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.”

Further examples of stereotyping were related to discrimination against a person’s country of origin. For example, one female participant who had been a victim of familial violence in her country of birth was asked by a doctor, “Isn’t that normal in your country?” (9). Another participant said that doctors she met had “assumed there is no health care in Egypt” (11). A participant named 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.” Another participant named 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.” He sensed some health care providers think “maybe because they’re black... they may have, they may be more open to certain types of disease” (16). 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.” He 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 or shaped by North American culture, particularly the media, or possibly by the type of training doctors received. Mark voiced similar experiences with 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” (16). Another participant named Anne felt that her interactions with health care providers had left her feeling “almost apologetic and embarrassed about not only my Polish identity but also my queer identity.” When she was being examined by a doctor, she was asked

about the tattoos on her back: “Upon hearing that one of them was from the Czech Republic he sighed, made a disgusted face and said something along the lines of ‘that’s no good.’ He then went on to tell me about the dangers of using any needles in dirty tattoo parlours in dirty countries” (2). One participant commented that stereotypical judgments made her feel like health care providers were “not even seeing a human being” (9). Another participant said subtle negative associations referring to his “background” made him feel that “even though a citizen, you’re still an outsider” (21). The ways in which participants chose to act in response to feeling discriminated against by health care providers are discussed in the next section.

### *Responses to Interpersonal Discrimination*

Feeling intimidated or threatened by the attitudes or judgments expressed by health care providers led some participants to simply avoid seeking out health care services at all (2, 6, 11, 25). One participant stated, “I avoid my doctor as much as possible” (12). Other participants felt that going to see a doctor was pointless, except in cases of medical emergency when they would typically use a urgent care facility (15, 22). 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. However, several participants expressed difficulty with finding a family doctor who was taking patients in the communities where they lived, and many were unable to find doctors who shared their cultural background. Many participants felt that seeing a family physician who spoke their language and/or shared their culture was beneficial to their health and the quality of care they received (7). They felt a shared background fosters good communication and mutual understanding, while also providing “continuity of care” (19). 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.*

As Anne mentions, she had to travel greater distances to access services that she found supported her self-identity and health care needs. Other participants reported facing similar lack of services available within their own communities (9, 13). Consequently, they were either travelling to Toronto for health services or seeking health care in another country, which might include returning to country where they had previously lived or going to the United States (3, 10, 18, 19). Another option that several participants mentioned was seeking alternative health care services from homeopathic, naturopathic or traditional Chinese medical practitioners (3, 12, 13, 17, 18). 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 focuses mostly on physical symptoms (17, 20). However, those who had sought alternative services or services outside Canada said they were expensive and recognized that few people could afford to pay for them. 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 (13, 15, 17, 20).

Many participants also described ways in which they felt "self-advocacy" was necessary in the Canadian health care system (26). One participant named Nadia explained how living in Canada for five years made her "feel confident to address issues." 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." She asked one receptionist, "Why are you angry with me most of the time?" The receptionist responded that she was "not angry, just busy." Nadia concluded, "When the issue is addressed directly, they get more polite and more friendly." 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 specialist who eventually treated her that it "should have been taken care of" sooner. After her doctor's office had not sent a referral to a specialist and then multiple appointments with specialists had been rescheduled, Amanda decided to "be my own advocate" and asked for a referral to a specialist who shared her cultural background. She had decided to approach her health by informing herself of her options, "asking for those referrals" with her family doctor, getting a copy of the referral and booking appointments herself. Other participants had enlisted friends or family members to advocate for them with health care providers. In one instance, a hospitalized participant had been given the wrong medication by a nurse, but a friend had been there to draw the nurse's attention to the problem (9). Three participants said they had negative experiences in health care settings because when they first arrived in Canada they didn't know their "rights" (7, 10, 15). Maria who had endured an unexpected five-hour wait at a specialist's appointment in Toronto and wished to make a phone call home to Waterloo was denied access to a telephone by the receptionist. She said, "I started to cry and couldn't breathe." She felt the receptionist had cast suspicion on her reasons for making the call and "was calling me a liar." When the hospital manager was asked to speak with Maria, she felt the manager was "very rude. He protect employees. He just nod the head, thinks I'm overreacting." Maria reflected, "I don't fight. Maybe if I was a Canadian, then they would apologize. I don't have English, so nervous, I didn't advocate, I didn't do the right thing... If I know my rights, they treat me a different way. I'm not supposed to know my rights." Since that time, Maria decided she would advocate for herself as well as have "friends talk for me when it's too complicated." Several other participants stated that they had at various times taken on an advocacy role for friends, family members and clients who were using health care services.

Variation in participants' responses suggested that the impact of discrimination or "racial ignorance" on the part of health care providers could carry greater or lesser degrees of harm in terms of impacting the patients' self-esteem, the patients' desire to access care and/or the provision of quality health care (9). Generally speaking, discrimination, ranging from ignorance to outright abuse, was seen as negatively impacting interpersonal communication and influencing the health care provider's assumptions and behaviours, thereby undermining the provider's capacity to make a proper assessment. However, a few participants commented on how the discrimination they encountered from receptionists or clinic staff contrasted with the doctor's behaviour, which they felt overall was positive (14, 17, 19). Although clinic staff, particularly those who book appointments, may act as an obstacle or deterrent to accessing care, it was felt those encounters did not impact the quality of care provided by health care professionals. Two participants felt that immigrant newcomer perceptions of doctors were overly negative, sometimes formed without adequate information, perhaps influenced by duress or feelings of

isolation or bitterness related to living a new country, and did not accurately reflect the general treatment offered by Canadian health care providers (14, 23). Janna suggested that the behaviour of one doctor, if perceived as discriminatory, should not be generalized to all doctors or used as the basis to assess the whole Canadian health care system, as that would be to use similar logic upon which stereotypical judgments themselves are based:

*The same thing would happen anywhere. ... I have this perception that everywhere you will find bad people and good people, and that will include people in the health care system. Some will discriminate, or could discriminate, perhaps because of their own experience as well. When people have stereotype, it comes from somewhere. And sometimes stereotypes are to some degree, or part of them, are accurate. Or one, let's say one out of a hundred is accurate, that will be enough for some to make a stereotype. Could be they've met a hundred people, one of them made a mistake, that's it.*

Another participant said she felt the health care system had improved since she first came to Canada fifteen years ago: "I'm really happy that things have changed...if I look at the overall picture, they were very, most of them anyway, were very, were out there to help you" (9). Other participants mentioned cases where 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 (17, 9). 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" (17). Some health care providers were also viewed as being aware and openly critical of systemic barriers faced by immigrant newcomers.

### *Systemic Discrimination*

Several participants pointed to gaps in the Canadian health care system by making reference to their experiences of superior health care services in other countries. Many stated that using Canadian health care felt like going through an "assembly line" or a "factory system" (1, 3, 6, 21, 22). One participant named Alex stated that it was "the breakdown point" in his settlement experience. Alex felt the information that had been provided to him by the government before immigrating to Canada had not reflected the reality of how the system functions: "what I experienced for the first time was that they spend so less time with you, and they make a decision which might and will have a huge impact for your health." He felt that immigrants were being "deceived" about the quality of the health care system before arriving in Canada. Another participant explained further how many newcomers respond to their first encounter with Canadian health care:

*My point of view is that a new immigrant coming here, there is the attitude that everything will be free sponsored by government. They don't have a clear picture of the health care from documentation, information from Citizenship and Immigration Canada. There should be information about waiting for a family doctor, what options if you need services, waiting in emergency three to six hours. You need to mention things clearly so people don't have a flowery idea in their minds. People are disappointed. I've talked to community members who had the perception that everything related to health—from checkup to medication is covered by government. (8)*

Some participants praised universal Canadian health coverage but also explained how they were able to access prescription medications and dental care for lesser or no cost in other countries (19). One participant said she experienced “shock” when she first encountered the Canadian health system: “one of my expectations coming to Canada, the First World, was a little bit of improvement [but] the health system had no dental care, how it could be?” (13). Another participant explained that the first time she filled a prescription at the pharmacy, the cost was over fifty dollars. She was “surprised at how expensive the medication, what if I had a health condition?” (8). One participant with diabetes said “medication is so expensive, not many people can afford it” (19). She suggested that it would be cheaper for the government to provide drug coverage for people with critical diseases than for people to forgo taking their medication and end up using the health system “for the rest of their life as damaged people” (19).

Paying for dental care and medication was considered an added stressor for immigrant newcomers who may already be struggling with unemployment, language barriers and poverty. Several participants pointed out that immigrants and refugees face multiple sources of discrimination, not just when seeking health care. One participant stated, “new immigrants are discriminated against at the time they land.” While many immigrants are admitted on a point system that counts their education and credentials “back in their country...here [credentials are] not more than a piece of paper” (8). Community-based services that provide assistance to newcomers with employment and housing and other related issues were therefore viewed as part of a larger system of community-wide health and well-being. Ensuring health-related services, such as help with applying for drug coverage through Ontario Works (8), are accessible to immigrants and refugees means both supporting existing community services and expanding the number of languages in which such services are made available.

The underuse of cultural interpreter services within the health care system combined with a lack of cultural diversity among health care professionals was also viewed as a clear barrier preventing immigrants and refugees from equitable access to quality health care services. Perhaps less obvious issues noted by participants were a lack of family doctors and extended wait times. These issues were mentioned repeatedly as impacting on immigrant newcomers’ use of health care services. Although many participants understood that wait times and a lack of doctors would have detrimental impacts on all users of the health care system, they pointed out that treating everyone equally when, in fact, immigrant newcomers have particular and different needs was equivalent to treating immigrants unfairly or in a discriminatory way (16). One participant was unable to get a family doctor or repeat access to a doctor who “knows me” (20). Another felt she was unable to get a referral and tests she required because she did not have a trusting relationship with a doctor: “doctor didn’t want to refer to a specialist. It made me feel I did not deserve to be spent money on, or not worth getting the best services” (26). Many participants also expressed concern about the effect of wait times on newcomer children and on non-English speaking adults who may not understand or be fully prepared for waiting extended periods to see a doctor. One refugee participant felt that “waiting in doctor’s room is torture” (10). With newcomers, even those who speak English, the brevity of appointments was perceived as creating a systemic barrier against culturally sensitive and effective doctor-patient communication. Many felt that the “one issue per appointment” could simply not address the complex, socially embedded health concerns of immigrant newcomers and refugees (1). Some participants added that mental health services were inadequate, culturally inappropriate or “broken,” and this might bear down disproportionately hard on immigrant newcomers who might

be affected by post-traumatic stress disorder, post-partum depression or other mental health issues, such as stress and depression (13).

Participants also emphasized the “nervous” stress they experienced after they arrived in Canada and were required to wait three months before receiving health care coverage (3, 20, 24). Kate said, “first three months, you’re living in this trauma.” Many participants explained they simply could not afford to purchase private coverage during this time. Trying to stay healthy added to already heightened anxiety. Kate’s husband would repeat “don’t get ill,” and she would tell the children “don’t break your bones.” One participant named Mark explained how the current health care system too often fails to provide health care professionals with training that would create a greater awareness of the particular situation of immigrant newcomers. When important surrounding elements impacting on immigrant newcomers are not understood, when assumptions are made because there is a lack of time for discussion, then it becomes far more difficult to ensure positive health results. Mark explains how the reality of being an immigrant newcomer carries with it health impacts that can be ignored by doctors:

*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.*

A health care system that overlooks the stresses associated with living in a new country cannot fully equip health care providers to address the needs of newcomer patients.

Mark and another participant named Lisa described additional stress they experienced with the “round of tests” required for them to attain landed residency status. Although both were already living in Canada with work or student visas, they felt like they were being placed under scrutiny as if the Canadian government was going to turn down their application because they might represent a “risk” to the general population or a potential burden on the health care system. Lisa explained that she found the medical exams “anxiety provoking—what if I don’t pass the test?” She described the process as “super invasive, [I had to] put my body up for approval.” Mark described his experience as “disarming” and “not feeling welcomed” as a result of being subjected to extensive medical exams. Mark explained how it felt as if the doctor was “looking for something.” He then explained, “the system tends to be prejudiced” depending on a person’s country of origin. He mentioned that one of his doctors encouraged him to write a letter because “my doctor himself was questioning why immigration was asking for all these supplementary tests” and had pointed out to Mark that “there is an abuse here.” A final systemic issue identified by participants was a lack of mechanisms to report discrimination so that it felt like their concerns could be addressed safely and effectively. Mary described how “cultural sensitivity is not enough...there needs to be accountability.” Doctors are “in charge, treating vulnerable populations who know nothing...If doctor or nurse know well that they won’t be held accountable, why would they follow through?” Another participant explained how even when

service users know their rights and make complaints, the system protects health care providers and employed staff. Although several participants felt that improvements to systemic discrimination have been made in recent years, they still ended up in situations that are “empowering the system rather than the client” (8).

### *Recommendations for Clinical Practice and System Improvement*

It was felt that many of perceived sources of discrimination could be addressed through improved clinical training and system change. Some instances of miscommunication and misunderstanding could be avoided if newcomers were provided with clear and realistic information on how to navigate the health care system as well as other social services. Most participants reported that they learned about using the health care system from informal networks, such as family contacts or friends. Three participants indicated that they used the Internet as a source of information (3, 22, 26). It was felt that immigrant newcomers should receive better assistance connecting to family doctors. Newcomers could also be better informed about accessing health care services for annual checkups, requesting referrals and expected wait times. One participant stated, “People need to be prepared and provided with resources for support. An accurate picture would really benefit, save people from a lot of anxiety and frustration” (8). It was felt that this information, to be effective, should be translated and made available in many languages (26). The information could also make explicit the rights of service users and how they can report incidents when they feel they have been mistreated by health care providers or the health care system.

There was also agreement that immediate health coverage should be provided to newcomers who have already been subject to health examinations. The three-month gap in eligibility for health care service (OHIP) was viewed as compounding the stressors associated with settlement and immigration. One participant suggested that, at minimum, emergency care could be provided for all newcomers during the three-month waiting period (3). Participants also questioned the need for extensive medical exams prior to qualifying for landed immigrant status (16, 20). Another recommendation was to provide advocacy options for individuals who feel their concerns are not being heard. Support for services that assist immigrant newcomers with navigating the health care system as well as more coordination in services, particularly between health care and mental health services, were also suggested by several participants.

In terms of clinical settings, it was recommended that the system could allot extra time per appointment for health care providers to speak with newcomer patients, particularly those who have difficulty conversing in English or require cultural interpretation. It was felt more cultural interpreters need to be trained, and interpreter services needed to be properly funded. A number of participants emphasized that when doctors and nurses are not provided with the time, services and training that would help them listen to patients’ needs, then health issues are not treated in an efficient and appropriate way, eventually leading to an increased burden on the system. Providing health care professionals with training on how “to be able to listen and to understand” patients with accents and how to use cultural interpreters properly was seen as a necessity (18, 25). Several participants also referred to “cultural sensitivity” or “cultural competency” training, but explained how competency did not mean health care providers should be experts on every culture. Rather, health care professionals required support and monitoring so that they would treat people’s differences with respect and sensitivity. Being more “aware of other cultures” was defined as not making assumptions, but listening more carefully, asking questions and viewing the “client as expert” (25, 9).

It was felt avoiding perceptions of interpersonal discrimination would require not only fostering cultural sensitivity among health care providers, but also creating a better understanding of the various conditions in which immigrant newcomers find themselves after they arrive Canada. When immigrant newcomers are visiting health care professionals, their fragile or vulnerable status might contribute to greater anxiety around communication and heightened sensitivity to gesture and tone. It was felt that clear communication also entails patience and a caring attitude. One participant felt doctors should be monitored not only in terms of their medical expertise and qualifications, but also in terms of how they speak with and relate to patients. She stated, “style is a qualification skill,” and endorsed a “humanistic way” of communicating with patients (10). Participants explained that medical school and professional development curricula need to be more comprehensive in terms of considering wider determinants of health, and how these might impact health-related contexts and concerns of immigrant newcomers. It was felt that educating health care professionals about the key issues and barriers faced by immigrant newcomers and refugees would help improve care and reduce instances of miscommunication leading to stress and perceptions of discrimination. It was also felt that it would benefit immigrant newcomers if it were made easier for primary health care providers to receive and pass on information about available community and social services, such as ones that help individuals get drug coverage or provide cultural interpreter and counseling services.

Many participants recommended that more supports on a systemic level be put in place for what currently works within the health care system. This would include increased funding for holistic approaches to health care and mental health services, health prevention/promotion programs, community-based health centres and family health teams. It was felt there needed to be more family doctors and specialists, especially within smaller communities outside the greater Toronto area. This would also shorten wait times, which were repeatedly associated with increased stress among the participants. It was also felt that funding for innovation in health services, such as providing gynecological screening clinics for women from specific ethno-cultural groups or coverage for alternative health care services, such as acupuncture, would improve immigrant newcomers’ experiences with the health care system. Several participants associated satisfaction with the care received from family doctor because their doctor was also an immigrant and/or shared their cultural background. It was felt that quality of care was related to building a trusting relationship with their primary health care provider so they felt their concerns would be heard. Consequently, they could feel their doctor’s assessment was unbiased and could be trusted and that they could access important treatment and tests that might be denied by a provider who didn’t know them, thereby reducing the potential for feeling misjudged or unfairly treated. Many participants emphasized that removing systemic barriers and discriminatory processes in order to facilitate the licensing of foreign trained health care professionals would have significant benefits by both addressing the doctor shortage and generating more cultural and linguistic diversity among health care providers.

It was expressed that on a system-wide level health care providers should be held accountable for discriminatory practices, such as refusing immigrant newcomers and refugees as patients. It was likewise felt that clinic and hospital staff, particularly those who provide reception services, should receive cultural sensitivity training because their behaviours, when perceived as discriminatory, “reflect on the doctor” and can act an obstacle to care (21). It was suggested that training could assist staff with maintaining professionalism while being more welcoming with patients who were not Canadian-born and may need more explanation about

clinical and system protocols. Finally, it was felt that some health care services and institutions such as hospitals were ignoring changing needs within the community by not engaging immigrant newcomers in dialogue or by not participating on multisectoral policymaking bodies, such as local immigration partnership councils. It was felt mutual learning and mutually beneficial ideas for improving health care services would arise from genuine public consultation as well as better coordination between the health care system and community-based immigration and settlement services.

### *Study Limitations and Future Research Considerations*

Recruitment for this study invited immigrant newcomers to share their experiences and perceptions of the health care system; however, there is a possibility that participants self-selected because they may have experienced discrimination or felt they had other issues with the health care system that required communication. Consequently, a broader, representative survey is required to gauge the extent of discrimination in health care setting. 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. The profile of the study participants was therefore a limitation in that discriminatory incidents and effects may actually be more severe and frequent than the examples described above. However, the participants also contributed to strengthening certain aspects of this research project. For example, several participants worked in health care or in 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 several health care and service providers who were themselves immigrants or refugees provided rich analyses of discrimination in health care services. Participants shared professional perspectives and a sophisticated consideration of systemic barriers, while also bringing many of their clients' perspectives into the discussion.

Interviewing people who had lived in Canada longer and who had several experiences with the health care system also contributed to nuanced accounts of discrimination. However, there was some indication that perceptions of discrimination in health care provision may diminish over time. 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. Similarly, a more focused survey of newer immigrants, older immigrants, immigrants living in poverty, LGBT immigrants, children and adolescents, or non-English speakers might have produced different results in terms of perceptions of discrimination. Also, the researchers agree with a point raised by study participants that the particular vulnerability and health care needs of survivors of war, torture and organized violence may exacerbate both the incidence and effects of their experiences with discrimination within health care and other related services. It is therefore an especially pressing issue that should be addressed by taking immediate measures to ameliorate services as well as addressing the need for further research.

Although a less pressing concern, future research could also be conducted on the dilemma surrounding how perceptions of discrimination in health services are distinguished in terms of interpersonal dynamics and/or systemic factors. Greater consensus could be formed around what constitutes discrimination by exploring relationships between particular behaviours, attitudes guiding the behaviours, and perceptions of what the behaviours mean to others.

Interviews addressing perceptions of discrimination with health care providers might serve to illuminate this grey area, as would comparing the responses of immigrant newcomers and health care providers to a set of case examples. The various types of discrimination reported by participants suggest complex intersections between newcomer status and discrimination based on race, gender, ethnicity, religion, type or thickness of accent, spoken language and sexual orientation. Some types of discrimination would be generalizable to the Canadian-born population or to Aboriginal peoples. Comparing immigrant newcomer experiences of health care services with other populations would help to identify how the particular realities of being a New Canadian may influence perceptions of discrimination. Understanding the discrimination encountered specifically by immigrant newcomers and refugees requires making further connections between the particular differences concentrated in newcomer populations (e.g. diverse cultures, races, accents and languages) that our study participants clearly linked to discriminatory experiences and what each of these differences signify to both newcomer service users and health care providers. More specificity of this kind in the research would strengthen capacity to speak openly about and address immigrant newcomers' experiences with discriminatory health care and other settlement and integration challenges. Additionally, the role played by doctors and other health care providers as allies to immigrant newcomers and refugees was not explored in this study, but merits further exploration. Finally, we provided an account in the "methodology" section above of community-based, participatory research approach used in this study in order to underscore the importance for current and future researchers working on immigrant newcomers issues to establish respectful relationships with study participants by including them in meaningful ways at every stage of the research project.

## CONCLUSIONS

Existing knowledge of the role of discrimination in health care outcomes among New Canadians is limited. In addition to a review of relevant literature, this study presents data from 14 interviews with health and social service providers who work with newcomers and 26 interviews undertaken with newcomers of diverse ethnic or racial minority backgrounds. Well over half of the newcomers interviewed reported that they had experienced discrimination at least once when interacting with health care providers or clinic staff. This report documents several types of interpersonal and systemic discrimination encountered by newcomers, their responses to discrimination and what they feel should be done to improve clinical practices and policies related to immigration and health care that have negative impacts on immigrants and refugees.

The role played by health care providers as allies and advocates as opposed to perpetrators of oppression emerged as a theme warranting further investigation. It is important to acknowledge, as did several study participants, that some health care providers may not be themselves discriminating against newcomers, but rather be functioning as part of a system that constructs discriminatory barriers to care. One such barrier is the Interim Federal Health Program for refugees which is fraught with payment difficulties. 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. Likewise, standard emergency rooms procedures may involve extended wait times and patient isolation; while they may continue to be experienced negatively by service users, their appearance as being discriminatory could be mitigated with clear, effective interpersonal communication. Situations and actions such as these can appear

discriminatory when health care providers do not have discriminatory intentions, especially when the circumstances are not properly explained or understood. Avoiding such situations requires rethinking and ameliorating the education, cultural interpreter services and supports made available to health care providers so that they can communicate the rationale behind their actions to immigrant newcomers and refugees in a way that minimizes the potential for miscommunication and misjudgment.

While this report has moved to address some of the gaps around immigrant minority perceptions of discrimination in health services, the area remains complex and continues to demand additional analysis, including with respect to different newcomer classes and how they compare and contrast with each other and with more established minority groups across Canadian communities. In addition, there is a strong need to continue to acknowledge, document and address the unique stressors facing refugee survivors of war and torture and other vulnerable sub-populations as their vulnerability to health impacts from discrimination is often compounded by socioeconomic marginalization, isolation and/or mistreatment based on gender, age, disability and other factors. Veteran as well as new researchers should be cognizant of a growing frustration within immigrant newcomer communities with respect to research being undertaken with little to no productive results being seen and felt at the community and individual level. Researchers need to be active in ensuring their results are communicated in effective and multiple ways to foster timely implementation. This should include employing community-based participatory research approaches, sharing research initiatives and results with the community and disseminating research to various institutional and policymaking authorities.

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 constraining 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. Future consideration should also focus on various ways 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.

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