Jacey: [00:00:04] The purpose of this podcast is to explore the relationship between marginalization and access to health care. Since the emergence of a formal medical industry the imperialist alliance between science and medicine has created unequal access to medicine and health care through discrimination and the devaluing of certain people in their bodies. In the past the medicine was often practiced by witches and midwives but around the 13th century medicine started to become a professional line of work with legal and educational requirements that were not accessible to women or low-income people.

Jacey: [00:00:42] A woman could be charged with witchcraft for performing medicine or possessing medical tools. Women were persecuted and killed and these were mostly poor peasant women who were easy targets because of their gender and their class. This was the beginning of the medical field as we know it today.

Jacey: [00:01:01] Health is often seen as a requirement for people to be productive contributing members of society. However through the privatization of certain aspects of healthcare and the physical and social barriers that some people encounter healthcare is not equally accessible to all members of society the Canada Health Act is a piece of federal legislation that outlines the terms for publicly funded health care.

Jacey: [00:01:24] The primary objective of this legislation is to protect promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers. In other words a person in Canada should not encounter barriers to accessing healthcare regardless of their socioeconomic status geographical location their gender their race or ethnicity or any other potential barriers one may encounter. Despite the inclusive wording and the idea behind the Canada Health Act many Canadians have unmet healthcare needs which are directly related to geography and social demographics. This is referred to as the Social Determinants of Health which describes how social economic political and environmental factors influence health outcomes things like income social support employment gender and someone's ethnicity all have important effects on people's health. For example transgender people represent a Canadian population with a high rate of unmet healthcare needs. One study out of Toronto found that 21 percent of trans people in Ontario had avoided receiving medical care in an emergency because of concerns of discrimination from healthcare workers. The same study found that among

trans people who had sought emergency care 52 percent of them had experienced discrimination including insults and refusal of care according to research done in Canada. Trans individuals have experienced the following when accessing healthcare insulting and harassing language physical abuse insufficient care or complete refusal of care. Miss gendering and the minimizing of an individual's experiences as a trans person so trans people in Canada are subject to health discrimination despite the fact that the government of Canada requires each province and territory to provide universal medical care.

Jacey: [00:03:23] Someone's daily living conditions influence their health everything from whether or not you smoke to your sense of community belonging. Additionally some people have physical barriers to accessing healthcare such as people living in rural areas or time constraints. This all influences how easily someone can get to a clinic or to a doctor but another barrier to healthcare is a historical one. Western medicine was established through the violent exclusion and elimination of certain groups of people such as the witches of the past. But another example is Jane Marion Sims who is often recognized as the father of gynecology in the 1900. He performed surgical experiments on black slave women with no anesthesia or painkillers because he believed that black women did not feel pain. And frankly he likely did not care if they felt pain or not because slave women were seen as disposable just as many women of color are still regarded today. Unfortunately some things still happen today. There is a breadth of Social Research and the fact that black people are often refused pain medication or are given lower amounts of pain medication in relation to nonblack patients. So the exclusions of the past are still played today. I spoke with Irene Shankar about the feedback loop between exclusions of the past and today.

Irene: [00:04:48] My name is Irene Shankar. I am a sociologist, Associate Professor in the Department of Sociology and Anthropology at Mount Royal University.

Jacey: [00:04:59] Within Canada, how does marginalization within society influence marginalization within the healthcare system?

Irene: [00:05:06] Well I think you see similar trends. There's a lot of different groups who don't receive the similar amount of attention. So people who are residing in rural and like non-urban areas like remote rural areas. The other group that we see is

Indigenous people are continue to be excluded from… or do not receive the same level of treatment that we see non-Indigenous people getting. In terms of reproductive health, that's very uneven all over Canada. So some people some communities are getting better reproductive health than others. Some provinces cover let's say Plan B rate while other provinces still don't cover that so there's that discrepancy. We also find that younger women who come in to their doctors with health issues are less likely to be believed and they are not likely, they are less likely to be diagnosed or their concerns are taken less seriously than older population right.

Irene: [00:06:04] So, so, the young, younger women who are coming in, that means that their issues don't get diagnosed in time it may spread, it may get more serious. And also the suffering for a really long time because no one believes them. So I think that whole hysteria seems still to seems to be a piece for women. I think racialized immigrants because of translation issues, language barriers. We see some cases of men who are not getting preventive care because of gender and socialization where they're socialized not to take care of their health. Or we have this entire hyper-masculine culture where it's not very much you know very manly to go to the doctor and say I'm depressed or I need any care so there's that.

Irene: [00:06:56] I think the distribution… I mean I could I can go on and labeling all the different populations that are not getting the care that we need. But disproportionately it's not evenly spread out. Not all Canadians have equal access to healthcare and which is a violation of the Canada Health Act it's supposed to be equal access across the board.

Jacey: [00:07:15] And can you see a feedback loop between stereotypes and unmet healthcare needs? Just as you were talking I was thinking about how when women go in they're not believed because women have a stereotype of being irrational.

Irene: [00:07:30] Yeah definitely. And there's I think that's a huge issue right. And it works in a couple of places it works the way that you've said it in terms of the stereotypes preventing you from getting care. So in terms of the hysterical female right who it's all in their head kind of thing of this of course that stereotype plays into women especially young women not getting adequate care or being taken seriously in terms of their health care needs.

Irene: [00:07:53] But we also see it in terms of Indigenous people where some of the symptoms of heart attacks have been misinterpreted to be substance abuse or are just being high or drunk right, which is completely incorrect. Or there's also, like this happened to my mom where she after her operation for endometrial cancer and endometrial lining, they left her for hour without drugs because they thought she wouldn't be in pain because her face was too stoic and so like not, being a racialized women not being able to read her face, stereotypes do influence the kind of care you get.

Jacey: [00:08:36] That example your mom also makes me think of what we would talk about in your class about women, black women, slave women being the first recipients of gynecological surgery without any anesthesia and they were just assumed to be able to take the pain.

Irene: [00:08:53] Ya and the disposability of those bodies right. Not seeming to matter so and I think I mean first of all there was no consent. So these were experiments conducted on women who were enslaved and then done without any painkillers and complete disregard for black women's body.

Jacey: [00:09:23] So, marginalized individuals encounter barriers when trying to receive healthcare. They have worse health outcomes due to discrimination and they're forced to access health care through a system that was built on the violence against them. But are we seeing any improvement in the situation today?.

Irene: [00:09:36] Okay so in terms of practitioners we've seen a huge shift in terms of who is included. So for… I think when we look at historical documents since women were practicing overwhelmingly medicine obviously wasn't called medicine in its current conceptualization and that it was slowly but surely taken out of the domain of the women and in some cases where women were accused of witchcraft who were practicing medicine. And then for a very long time we've seen the domain being wholly focused… concentrated upon white males, at least in North America where they where the predominantly the ones who were getting entry into the medical schools and then graduating right, so that over the last few years maybe the last five to 10 years we've seen a huge shift and maybe even longer than that, where there's more women coming

into medicine and then we see a lot more women practicing to the point I think the latest stats was that 52 percent of the family physicians are women now. So, that that has changed in terms of gender. But when you look at the racial demographics that is still not quite equally distributed. So we see more along the lines of the South Asian like people who are of the ancestry South Asian ancestry, East Asian ancestry, black Canadians and Indigenous folks are still excluded from the domain of medicine. And so with the underrepresentation of those two groups especially in Canada. So we're seeing a lot of shifts but still a lot of exclusions are at play. But there's also the other kind of representation is the lack of representation. So in terms of this latest there was a recent study that came out and it talked about the lack of people of color in medical textbooks. So when we doing diagnosis for skin conditions the only pictures tend to be the white body. So even what people are learning in terms of being able to diagnose people provide good care tends to be very limited right. So if our somatic norm is the white male body and that's all we are designed to look all our treatment everything our education is centered upon that body and that everyone all gets left out.

Jacey: [00:12:11] Isaiah MacDonald helped shed some light on male dominance within the med school curriculum, but also on shifts within the curriculum and the changes that are happening today.

Isaiah: [00:12:21] My name’s Isaiah MacDonald, and I am a second year medical student at the University of Alberta.

Jacey: [00:12:26] So are there any big names that you learn about in the curriculum at med school?

Isaiah: [00:12:30] One of the big names that we hear about a lot is William Osler who is a Canadian physician from the early 1900s and he is credited for being the father of modern medicine and what we know med school to be now.

Jacey: [00:12:46] Do you think there's like certain kinds of people who get like the main credit?

Isaiah: [00:12:57] I'm sure that like most of the people that we're like we do here of our like white men in Europe and Canada and the United States. The head of the lab really

the main principal investigator like they're the ones probably getting credited and you know they are most often white men, a lot of times like the techs in the lab and like the research assistants and the lab managers tend to be more women and they're like the ones that are essential for like research but definitely aren't being remembered.

Jacey: [00:13:35] What I'm thinking about is sort of a feedback loop. Who is learned about in med school who are the kind of people that attend med school and are giving out health care. How that influences how people receive their healthcare. So just in terms of the example we were talking about before with trans patients there's been a lot of studies done out of Ontario where they find that trans patients have to do a lot of educating to their health care professionals and informing them of their needs so they're going in and having to do extra sort of emotional and mental labor and order to receive health care.

Isaiah: [00:14:08] We have specific learning objectives that are set for all of Canadian medical students each school during the accreditation is responsible for like meeting these learning objectives. Curriculum has really changed, the undergraduate medical education is really pushing for a lot of Indigenous and LGBT and addictions curriculum and they are really working on making sure that we are educated about underserved populations.

Jacey: [00:14:42] Can you see that as a positive feedback loop of like where people are noticing unmet needs and then pushing for it like a younger generation like influencing.

Isaiah: [00:14:51] So a lot of the curriculum changes are coming from students. it's students seeing a hole in our education and like pushing the faculty to change. So I'm part of a group called the Sexuality and Gender Advocacy Initiative and we are planning this conference called The Inclusive Health conference and we have it every year in early March and we get it accredited for these continuing medical education credits. We talk about unmet needs within the LGBT community in terms of healthcare and gear it towards physicians and nurses and other health care professionals. Although like members of the community are totally encouraged to come. For example, this year we're having a whole discussion on hormone replacement therapy, HRT. There's going to be a panel on LGBT family planning. Also we're having some midwives from Calgary come up who work with specifically queer families. Another panel is from a social

worker and they're going to be talking about LGBT needs within the new refugee population within Canada. Our keynote speaker is going to be talking about bisexuality and how it's always included in the LGBT acronym. However, it is like often minimalized and forgotten about and people like really don't talk about bi people.

Jacey: [00:16:19] As yourself as a queer person have you felt like there's a good amount of information about LGBTQ things within med school.

Isaiah: [00:16:27] I have no idea what it was like even 5/10 years ago. But like now I think there is like a significant amount of information on, like, within our LGBT curriculum. Some of our LGBT curriculum is like fantastic. For example, when we were going through our reproductive health and gynecology block we had we had a trans teenage patient come in. We're like very privileged to have these like patients come in and be so open so vulnerable like talk like so explicitly about their experience and stuff. Then we also have lectures that they come in and are like this is the LGBT accurate. What does it mean to be transgender? Like look I've seen it before. But clearly is like an effort being made.

Jacey: [00:17:22] I am hopeful that people like Isaiah can influence change. As a queer person who is helping to bring queer issues to the table, Isaiah is contributing to a shift in the institutional exclusions of the medical field. But despite these positive changes and improvements to health care today and in the future, the medical field was still built on the violence and discrimination of marginalized people. So is it even possible for the medical field to be an inclusive institution? Based on the inequalities throughout history, will there ever be equality within Western medicine?