JOHN RENNISON THE HAMILTON SPECTATOR

Lyndon George says systemic racism affected the care for chest pains and shortness of breath he received at Hamilton General's emergency department. He'd suffered a pulmonary embolism.

When race is a barrier to care in the emergency room

Lyndon George says being Black factored into the inadequate care he received at Hamilton General

Teviah **Moro**

It wouldn't be as simple as going to Hamilton General and asking for attention.

That went through Lyndon George's mind when he headed there with shortness of breath and chest pain.

As a Black man, he'd have to take extra measures.

"I even put on a better coat that day to walk into the ER because I wanted to be taken seriously," recalls George, 39.

He experienced racial bias at a Canadian hospital 12 years earlier.

At 27, George suffered from blood clots in his legs. Then, a heart attack sent him by ambulance to an Ottawa hospital.

Despite his condition, staff wanted to send him home. A doctor also asked him not once but twice if he'd taken illicit drugs. The answer both times was no. He was shocked.

"And for a moment, I thought, 'Will that get me the care that I need if I say something that's not true?' and you should never have to be in that position in order to get the care that you need."

A decade later in Hamilton, his trip to the General left him with much to be desired — despite the coat.

After sitting in pain for nearly eight hours, George felt staff weren't taking his symptoms seriously.

"There was never a series of probing questions."

So George went into "complete self-advocacy mode" to combat what he felt was an unwillingness to acknowledge he could be in serious medical distress.

He was eventually sent for a chest X-ray, diagnosed with pneumonia and prescribed antibiotics.

But there was no "deep dive" into his symptoms or admittance overnight for care.

George worried something more than pneumonia ailed him given his cases of deep-vein thrombosis — the blood clotting — and that heart attack.

When he went home, the pain worsened and his breathing became more shallow. So he returned to the General's ER that same night.

With little response from the triage nurse in the empty waiting room, George says his mother advocated on his behalf. It was only then that the nurse called him for an echocardiogram.

But as time lurched on, and with no offers of oxygen or a wheelchair — a signal of empathy from staff — George says he left in pain and frustration over a "you can wait" attitude from staff.

That morning, he wrote the

RACE continued on A8

hospital to complain about a lack of attention for Black patients and their health concerns.

'Trying to be heard'

Three weeks later, George still felt terrible. This time, he tried St. Joseph's Hospital.

There, staff took the time to do that "deep dive" — a CT scan and a d-dimer test, which detects clotting in blood.

It showed his chest was "full of blood clots." He'd suffered a pulmonary embolism.

He ended up spending four days in the hospital. That was in June 2019.

A year later, George credits the ER doctor who took the time to listen to him for saving his life.

So why were his experiences at the two Hamilton hospitals so different?

The critique isn't to suggest there aren't good health-care workers at the General, operated by Hamilton Health Sciences, or that they didn't want to treat him, George emphasizes.

He recognizes the trauma centre has unique pressures, including long ER wait times.

But those factors coupled with systemic racism pushed "someone who looked to be a healthy Black man" out the door.

During his visits, there was no specific reference to race, but as a Black man who'd experienced racism before, the testimonials of members of his community who'd also run into barriers, and the research he'd read, George felt it was at play.

"Unconscious bias plays out because of these inequities in our health-care system time and time again."

Hamilton Health Sciences CEO Rob MacIsaac says George's experience indicates the organization has work to do when it comes to systemic racism.

"I think the concerns that he's annunciating absolutely affirm our resolve to continue on down this road of doing better relative to equity, diversity and inclusion," MacIsaac said.

"From my perspective, I'm committed to taking a very aggressive approach to reviewing our policies, procedures, practices using this lens of anti-Black racism. I think that his advocacy is helpful."

Moments of reckoning

When George first shared his hospital experiences with The Spectator, the tragic death of Yosif Al-Hasnawi in 2017 weighed on him.

After being shot, the 19-year-old immigrant from Iraq lay on the Main Street East sidewalk writhing in pain. It took paramedics 38 minutes to transport him to hospital, where he was pronounced dead.

Two paramedics — Christopher Marchant and Steve Snively — were charged with failing to provide the necessaries of life. Their trial is scheduled for Nov. 24.

There was a connection with Al-Hasnawi — that "feeling of trying to be heard." A systemic problem in health care was at play, thought George, a constituency assistant to MPP Andrea Horwath.

Then, a few weeks later, COVID-19 changed the world.

The pandemic exposed deep societal gulfs, hitting racialized groups disproportionately hard in the United States.

Then the violent death of George Floyd — who had coronavirus — while in Minneapolis police custody thrust anti-Black racism in law enforcement into the global spotlight.

None of this — the health inequities and lethal police violence trading on race — originated with these galvanizing times.

But Black communities are seizing them, to "hold the system accountable," including health-care institutions, Lyndon George says.

"Doctors have empathy, sympathy and understanding. They do, but there's that management component that needs to understand how critical this is to influencing that care, and I think that that's lacking."

'Ripple in a pond'

Over the phone, Bernice Downey paints a self-portrait:

"I have dark skin and black hair, and I wear traditional jewelry, so you could look at me and say, 'I think that's an Indigenous woman.'"

The McMaster University professor says her appearance factored into how a medical resident treated her at a local walk-in clinic an early weekend morning two and a half years ago.

She'd gone in with a bladder infection.

"I was wearing sweatpants and probably didn't have makeup on, maybe combed my hair, but I was asked a very rude question, and it had a sexual overtone about what I may have or may have not been doing the night before."

In a nutshell, he'd asked her if she'd had a one-night stand. She was shocked.

"His responses were unprofessional and racist," said Downey, who's the Indigenous health lead at McMaster's Faculty of Health Sciences.

But for some patients, this is par for the course.

"If you're Indigenous or a person of colour, that is part of your reality in the health-care system, and for some, more than others."

Downey and Lyndon George alike speak of how their racialized peers "strategize" to receive care, "navigate" the system, or "self-triage" by relying on friends and family when the normal points of access are closed to them.

And like George, she notes the obstacles to care thrown up by systemic racism are nothing new.

Consider Brian Sinclair, a 45-year-old Indigenous man who died of a bladder infection in 2008 after staff in a Winnipeg emergency room left him to languish for 34 hours.

Downey also points out the more recent CBC report of an Indigenous woman "shopping around" at hospitals and health centres in Edmonton before, on a seventh visit, a doctor finally tells her she's had a stroke.

Just last week, B.C.'s health minister announced an investigation into allegations of health-care workers playing a game that involved guessing the blood-alcohol level of Indigenous patients.

"It's a ripple in the pond," she says about these horrid cases. "You realize that it's pervasive, that it's at the system's level. People try to make it as an individual incident, but it's so much larger than that."

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Power imbalance

Dr. Madeleine Verhovsek, an expert in sickle-cell disease at McMaster, says she will call ERs ahead of patient visits to ensure adequate care.

In particular, her young Black male patients' requests for care and medication are much more likely to be disregarded unless someone else validates their health concerns, she says.

"Basically, it's now to the point where we tell them, 'No, don't just go to the emergency department out of the blue. Call us first, let us know that you're going, so that we can call ahead and vouch for you.'"

A hereditary condition, sickle-cell disease can cause blood flow to clog. This leads to degenerating tissue, resulting in painful episodes. It presents in Black people at higher rates.

Studies in U.S. medical journals have pointed to a disturbing prevalence of health-care professionals or trainees who subscribe to the false belief that Black people feel less pain than white people.

Verhovsek says racialized patients tell her they feel as though their pain isn't taken as seriously as white people's. But the power imbalance that exists between patients and health-care providers can be stifling.

"When you're coming vulnerable in pain, the health-care team really does have power over you. You have to be kind of deferring to them. You can't be perceived as being confrontational or trying to argue."

Diverse voices

Lyndon George says race-based, socioeconomic data could help shed light on disparities and lead to meaningful change.

Specifically, George, who's a patient adviser at Hamilton General, wants hospitals to conduct surveys asking patients if they experience racial bias in care.

"Diverse voices need to be elevated so that their voices can shape our health-care system for the better."

HHS CEO Rob MacIsaac says he's open to asking patients about racial bias.

"I think that should be something that is considered going forward as we consider and apply this lens of anti-Black racism to reviewing our policies, procedures, practices."

Having a say in studies is crucial, says Bernice Downey, a medical anthropologist and nurse by training.

For decades, Indigenous people were "researched to death," but not always about what they thought was important, she says.

"Often university academics would go away, take the information, write a fancy report, and they'd never see them again."

But in recent years, Indigenous people have "reclaimed their right to research," Downey says, citing seminal health care-related reports, including one focused on Hamilton.

There's much to address, not just racist attitudes of health-care workers, but also the direction of policy-makers in shaping institutions, Downey notes.

And hundreds of years of colonialism; the Indian Act, residential schools, the '60s Scoop, intergenerational trauma, tainted water on reservations, outsize levels of poverty, missing and murdered Indigenous women and girls, rupture from tradition and land.

It all requires a holistic approach, leading to culturally safe experiences for everyone, Downey says.

"Everything is interdependent. It's like a domino effect. If you're out of balance in your emotional or the physical realm, it's going to affect your mental realm and your spiritual realm."

MacIsaac says it will take time to erase systemic racism in health care.

"I think we at Hamilton Health Sciences have been on this road for some time in trying to respond to these kinds of concerns and address them, but we know that our work isn't finished and there's still more to do."

George says the discussion gains traction among senior administrators after years of advocacy.

"It is Black and Indigenous health-care professionals who have raised the alarm," he said. "That is why it's happening."

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