Centre universitaire de santé McGill | McGill University Health Centre

Executive Summary

Report of the Committee for Action on Inclusion, Diversity and Equity of the Board of Directors of the McGill University Health Centre September 2022

CONTEXT

Increasing global awareness of incidents and issues related to equity, diversity and inclusion (EDI) has inspired many public- and private-sector organizations to examine their policies and procedures. On June 19, 2020, the president and executive director of the McGill University Health Centre (MUHC), Dr. Pierre Gfeller, published a message stating: *"The existence of racism and all forms of prejudice in 2020 is disturbing, upsetting and wrong* (…) and *"the Board of Directors will have a serious discussion on what is needed to embed the principles of equity, diversity and inclusion within all aspects of our institutions, and on the deeds required to shape the future we would want for ourselves and our children."* Shortly thereafter, the Board of Directors of the MUHC called upon two members, Dr. Anita Brown Johnson and Ms. Seeta Ramdass, to co-chair a committee and gain insights into the situation within the MUHC community. The co-chairs populated this committee with a diverse membership and named it the Committee for Action on Inclusion, Diversity and Equity (C-AIDE). It began its work immediately, despite challenges associated with the COVID-19 pandemic.

PURPOSE OF THE STUDY

The initiative sought to gather sociocultural and demographic data to provide a portrait of the institution's workforce (MUHC and RI-MUHC) and to document its perspectives and lived experiences vis-à-vis EDI within the institution. The penultimate goal was to gather evidence-based data that could inform community-inspired recommendations, which would be presented to the Board, the ultimate goal being that of seeing the institution be as welcoming, safe, and inclusive as it could be through the integration of recommendations into an institution-wide action plan.

METHODS

C-AIDE used a mixed method to gather data: (a) two anonymized online surveys were developed and circulated electronically to the MUHC's and RI-MUHC workforce, including MUHC volunteers; (b) semi-structured interviews, focus group discussions and written responses to questions were the main source of qualitative data.

RESULTS, LIMITATIONS AND PRINCIPAL FINDINGS

The MUHC and RI-MUHC together (including learners and volunteers) represent a workforce of over 16,000 people. The calls for survey participants resulted in completion by 712 individuals at the MUHC and 228 individuals at the RI-MUHC, which is fewer than anticipated but can be explained by workforce fatigue and shortages, infection prevention and control and other measures related to the COVID-19 pandemic, and unequal access to computer and or email access across the institution.

Surveys

a) Seven out of ten respondents self-identified as women (MUHC and RI-MUHC);
b) The majority of respondents were between 31-65 years of age MUHC and RI-MUHC);
c) 6.1% of MUHC and 4.9% of RI-MUHC respondents self-identified as having a disability.
d) 1.1% of MUHC and 0.9% of RI-MUHC respondents self-identified as Indigenous peoples, namely First Nations, Inuit and Métis.
e) Two out of five survey respondents self-identified as a member of an ethnic minority group (MUHC and RI-MUHC);
f) 7.2% of MUHC and 9.3% of the RI-MUHC respondents self-identified as a sexual orientation and/or gender identity minority / 2SLGBTQIA+[1];
g) Top two origins with which the study population MUHC and RI-MUHC) self-identified were Other North American origins (ex.: Québécois, Acadian, Canadian, American), followed by Southern European origins (ex.: Greek, Italian, Maltese, Spanish). Within the MUHC study population, Caribbean origins (ex.: Antiguan, Bahamian, West Indian, Haitian) ranked third, whereas within the RI-MUHC survey participants, Caribbean origins ranked 14th. RI-MUHC survey respondents list the nations of the United Kingdom (England, Northern Ireland, Scotland and Wales), Channel Islands, and Ireland as third origin.
h) 12.4% of MUHC versus 13.3% of RI-MUHC survey participants selected two ethnic origins.
i) Survey respondents who self-identified as visible minorities were more likely to report working issues involving bias and/or discrimination, micro-aggressions or overt racism;
j) The majority of survey respondents indicated that they were concerned about the impact of racism, anti-blackness, and/or xenophobia at the MUHC and/or RI-MUHC, either personally and/or collectively.

Semi-structured interviews, focus group discussions and written responses

Participants shared a variety of incidents that they either experienced themselves or witnessed within the MUHC and/or the RI-MUHC. They also shared their perspectives and ideas.

Themes

Ten dominant themes emerged in the assessments and these appear below in no particular order:

Theme 1. Acknowledgement of Systemic Biases and Racism by the Institution: Study participants reported their own experiences and/or observations of incidents of racism and various forms of discrimination at the institution, including the lack of racial diversity in leadership and management positions throughout the organizational hierarchy. Some participants called for the MUHC leadership to acknowledge the existence of systemic biases and racism in the institution.

Theme 2. Experiences of Isms and Phobias: Participants shared a variety of experiences of isms and phobias that they encountered themselves or witnessed within the institution, including but not limited to xenophobia; anti-Asian, anti-Black and anti-Indigenous racism; gender and gender-identity bias, sexism, sexual harassment, cis-heterosexism, homophobia, and transphobia; ageism, ableism, islamophobia, linguism, etc.

Theme 3. Workforce Diversity: Participants cited underrepresentation of diversity in staff, leadership and management positions. For many, representation matters at all levels of the institution. Participants noted that due to homogenous groups and underrepresentation of diversity in upper-level management positions, it is impossible for a visible minority to obtain a certain career goal. Respondents observed that visible minorities are present mostly in lower-level positions such as cleaners, janitors, and very few reach the upper echelons of administration. They also raised concerns about barriers to the advancement of women, and of those who are not "French Canadians" to higher-level positions.

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[1] "Sexual orientation and gender identity minorities (2SLGBTQIA+)" refers to people whose sexual orientation is other than heterosexual/straight and/or people whose gender identity does not align with the sex assigned at birth. 2SLGBTQIA+ stands for Lesbian, Gay, Bisexual, Transgender, Two-Spirit, Queer or Questioning, Intersex, Asexual or other.

Theme 4. Human Resources**:** Participants cited their concerns about hiring practices, pay inequality and inequity at the MUHC, including wage disparity between male and female employees. Participants also pointed out the inherent bias in the hiring and selection process for committees and management positions.

Theme 5. Leadership and Management**:** Survey respondents and qualitative assessment participants expressed concerns and ideas related to management and leadership, sharing situations and discriminatory incidents involving supervisors/managers. Some described being treated disrespectfully, verbally assaulted, harassed and humiliated by supervisors and senior members at the institution. Verbal attacks on staff members due to having a different ethnic background were described in both assessments. Participants also shared that the current hierarchy and power dynamic at the MUHC and RI-MUHC are impeding constructive and safe discussion around bias and discrimination.

Theme 6. Patients and Quality of Care: Participants cited how some healthcare professionals displayed biased treatment towards patients of visible ethnicity, also emphasizing the inappropriate and derogatory style of communication towards these patients. Participants were concerned about all healthcare personnel having an understanding of their patient populations' needs, cultural, religious, and spiritual beliefs, and what barriers patients face when seeking care.

Theme 7. Education, Teaching and Training. Participants identified the need for anti-racism training, cultural safety and sensitivity training, conscious and unconscious bias training, conflict resolution and de-escalation training for all employees and physicians at all levels, with tailored sessions for specific areas such as patient-facing staff, and training senior leaders on inclusive leadership.

Theme 8. Trainees and Students: Trainees and students are missing from the survey respondents and are under-represented in the qualitative assessment. It was extremely challenging to get the trust of any trainee or student to talk to C-AIDE about their experiences at the MUHC and/or RI-MUHC as they expressed their concerns and fears of repercussions and damage to their young careers.

Theme 9. EDI Opportunities: Participants see many EDI opportunities and advocate for long-term strategies and a culture change at the MUHC/RI-MUHC in regard to EDI. Comments ranged from actions to take to have more sociocultural diversity representation in hiring and promotion practices to displays of artwork, portraits, and/or other iconography representing the diverse population of Quebec to concerns over language and archaic system with implicit bias in the institution. Also mentioned were positive comments and suggestions, such as performing an organizational culture assessment to update MUHC values to be more inclusive, representing MUHC's diversity in publications and communications material, and highlighting success stories. Two suggestions related to organizational structures were advanced, namely a way to report incidents of bias or discrimination safely, anonymously and without the fear of repercussions and an EDI office or designated EDI person to consult on issues of EDI, to support the coordination of EDI activities and ensure that policies and procedures follow EDI principles and best practices.

Theme 10. Positive Experiences: Despite the findings related to biases and discriminatory treatment, it is worth underscoring that survey and qualitative assessment participants shared positive and non-discriminatory experiences with C-AIDE. One of the most common elements shared among the positive experiences was how the professional, collaborative relationships within one's immediate team contributes to the overall work culture/ environment and sense of well-being. Participants also expressed their shared desire to help patients in any way they can.

RECOMMENDATIONS

The study's findings point to the following evidence-based, community-inspired recommendations, which C-AIDE respectfully puts forward. They represent a starting point for investments in EDI at the MUHC and the RI-MUHC, which would help ensure these institutions are world leaders in EDI with regard to their workforce and patients, and experts in socioculturally inclusive, responsive, equitable health care, social services, education, and research.

1. **Provide Education and Training in EDI:** Make diversity, unconscious bias and cultural safety training mandatory for all existing staff, physicians, learners, as well as new hires.

2. **Develop EDI Policies and Procedures Across all Spheres of the MUHC and RI-MUHC:** from cultural representation in hiring and advancement of personnel of visible minorities, marginalized backgrounds, or underrepresented communities to research and communications.

3. **Create a Safe and Anonymized Reporting System:** this is to address issues of discrimination, racism and biases of all forms.

4. **Establish an EDI Office/Officer:** this is to oversee the training and education in EDI at all levels of the MUHC and RI-MUHC, to ensure that institutional policies and procedures reflect EDI principles, to be the keeper of tools and resources about EDI, and to act as an advisory/consulting service on issues pertaining to EDI and anti-racism.

5. **Acknowledge Indigenous peoples:** acknowledge those who have lived and worked on this land historically and presently by including a land recognition statement on the MUHC Web site, using the physical spaces to reflect Indigenous peoples, and adopting Joyce's Principle.

6. **Reinforce Cultural Safety, Equity in Access, Continuity, Quality and Safety of Services:** this includes socioculturally safe and sensitive mental health and addiction services; more natural and holistic cultural healers/helpers, Inuit caregivers and psychosocial workers; and more community services for families.

7. **Improve Accessibility and Accommodations for Those with Disabilities:** this should include close captioning of online public meetings, sign language (ASL), optimal wheelchair access to all services throughout the institution, including bathrooms, imaging equipment, signage, accessible videoconferencing services, LSQ (Langue des signes du Québec), and oral interpreters, etc.

8. **Collect Sociocultural Data about the Patients Served and the Institutional Workforce:** this should include implementation of processes to document key performance indicators regarding EDI and continuous review of outcomes.

9. **Integrate EDI Commitment, Values and Initiatives into the MUHC Strategic Plan:** this will support leadership in EDI across the institution.

10. **Advocate for an Indigenous-led review of the "*Sensibilisation aux réalités autochtones*" training with Ministry of Health and Social Services (MSSS.**