FORWARD

The Final Report of the Committee for Action on Inclusion, Diversity and Equity

November 11, 2022

Dear members of the MUHC community,

I am pleased to share today the final report of the Committee for Action on Inclusion, Diversity and Equity (C-AIDE) in both English and French, as required by law.

Let us recall that on September 23, 2022, the co-chairs of C-AIDE—Ms. Seeta Ramdass and Dr. Anita Brown-Johnson—presented highlights of the committee's study results and ten recommendations during the public meeting of the Board of Directors of the McGill University Health Centre (MUHC). That day, the Board also adopted the recommendations. Since then, an executive summary of the report has been available online in English, French, Inuktitut and Cree.

The report delves into the many facets of equity, diversity and inclusion and includes lived experiences at the MUHC and/or Research Institute of the MUHC (RI-MUHC). Some statements and incidents found within it are troubling.

It took courage for our patients, volunteers, healthcare professionals and support staff to share their experiences. It now requires humility to effect positive change because the issues raised are not unique to the MUHC and RI-MUHC, or to the healthcare system. In fact, the report's emergent themes raise important questions that we, individually, collectively as an organization and more broadly as a society cannot ignore. We do not profess to have all the answers, which is why we are presently working on an action plan in response to the concerns raised by C-AIDE's report.

I want to take this opportunity to express gratitude to those whose voices bring the pages of this report to life. I also want to thank once again the members of C-AIDE for completing this mandate despite COVID-19-related challenges. The MUHC community is rich in diversity owing to the population it serves, its workforce and volunteers.

The value of respecting each other and learning from and with each other should be our ultimate goal. Let us work together so that we come to appreciate the diversity that will contribute to a healthy workplace and equitable and inclusive healthcare services.

Pierre Gfeller, MD, CM, MBA
President and Executive Director, MUHC
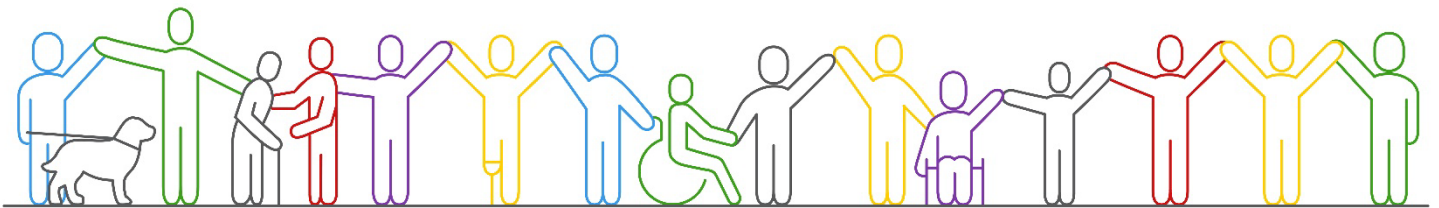
FINAL REPORT

Committee for Action on Inclusion, Diversity and Equity (C-AIDE), Board of Directors of the MUHC

Results of Survey & Qualitative Assessments of EDI Perspectives within the MUHC Community and Recommendations

September 23, 2022

ACKNOWLEDGEMENTS

On behalf of C-AIDE, we — the Committee's co-chairs—wish to acknowledge the courage and tenacity of the respondents who participated in this study, particularly those who shared lived experiences. We wish to underscore that despite the nature of the challenges brought forward, participants expressed their appreciation for the MUHC and its mission, and for the opportunity to work with dedicated, multidisciplinary colleagues who are committed to excellence in patient care.

C-AIDE's membership represented a broad range of lived experiences, views and perspectives. This nurtured a fertile space for attentive, non-judgmental listening and hearing of sensitive stories. The diversity of disciplines, cultural and gender identity, sexual orientation, age, physical ability, religion, race, intersectionality and expertise in matters of equity, diversity and inclusion (EDI) helped inform C-AIDE's recommendations. We thank each of them for their respective contribution, much in the same way that we thank the independent research consultant who was responsible for helping to collect and subsequently to analyse the data.

We also want to acknowledge and thank the Chairman of the Board of Directors of the MUHC, Mr. Peter Kruyt, for entrusting this unprecedented initiative to us, which has ultimately led to this report. We are humbled by what we have learnt by listening, hearing, and documenting the perspectives and experiences shared by the MUHC's most valuable asset — its people—, and those of its raison d'être—its patients.

It is our hope that this report will inform the MUHC's EDI action plan and support the embedding of EDI principles and values at every level of the organization for the benefit of its patients, workforce and partners.

We are proud to have had the opportunity to be a small part of the organization's future success and confident that MUHC leadership has the institutional will and courage to make bold changes.

Dr. Anita Brown-Johnson, C-AIDE Co-Chair
Chief of Family Medicine, MUHC
Member of the Board of Directors, MUHC (designated by Regional Department of General Medicine)

Ms. Seeta Ramdass, C-AIDE Co-Chair
Member of the Board of Directors of the MUHC (designated by the Central Users' Committee)

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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 institution, 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:

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.

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.

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.

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.

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

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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.

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.

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.

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.

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.

9. EDI Opportunities: Participants see many EDI opportunities and advocate for long-term strategies and a culture change at the MUHC/RI-MUHC with 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.

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).**

1. INTRODUCTION

In September 2020, following a call to action by Board Chairman, Peter Kruyt, and President and Executive Director, Dr. Pierre Gfeller, the Board of Directors of the MUHC formed the Committee for Action on Inclusion, Diversity and Equity (C-AIDE). It then entrusted two co-chairs (Board members Dr. Anita Brown-Johnson and Ms. Seeta Ramdass) to populate a committee and fulfill the mandate the membership had agreed upon (see page 9 and 10, tables 2 and 3). This report presents the findings and recommendations of C-AIDE following two years of work. The authors wish to underscore that the government directives brought on by the COVID-19 pandemic caused delays to this important initiative and had a tangible impact on participation, as expressed in the section on limitations. Nevertheless, the findings and recommendations confirm that a tremendous amount of good was accomplished.

In consulting stakeholders, C-AIDE 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.

In 2021, C-AIDE felt strongly that it had sufficient empirical data to submit six preliminary recommendations. The Board of Directors adopted the first five recommendations, as noted below:

Table 1 – Preliminary Recommendations

1. Appoint EDI Resolution Officer (An Independent Ombudsperson-like Authority Serving MUHC Workforce who would be in a position to maintain impartiality).
2. Implement Mandatory Implicit Bias and Cultural Safety Training for all MUHC Stakeholders (across all departments and at all levels of the organization, including on hiring/search committees):
   a) Educational Campaign to Raise Awareness of EDI values and healthcare inequities
   b) Tools and Resources to Facilitate Acquisition of Desired Attitudes and Behaviours
   c) Sociocultural Consultation and Interpretation Services available across the MUHC
   d) Engagement of Human Resources, Communications and Legal Affairs Directorate and the Education Directorate for execution success
3. Include Closed Captioning at all public meetings and events, technology permitting
4. Adopt Joyce's Principle
5. Integrate EDI Commitment / Values / Initiatives into MUHC Strategic Plan
6. Include Land Acknowledgement Statement on MUHC Web site and public facing events

This final report builds on the above.

2. BACKGROUND AND OBJECTIVES

The general level of awareness of racism and all forms of discrimination is at an all-time high around the world. The COVID-19 pandemic and the high-profile murder of George Floyd, a Black man, by a White police officer in 2020, further highlighted sociocultural disparities that confront marginalized and minority communities, rapidly expanding the Black Lives Matter movement and amplifying awareness of racism and social injustices. The results of the Canadian Truth and Reconciliation Commission of Canada Calls to Action in 2015 set a precedent in our country's efforts to acknowledge and address issues of racism, marginalization and multiple levels of sociocultural inequities faced by Indigenous communities. Further to this, the Government of Canada acknowledged systemic anti-Black racism in its Anti-Racism Strategy 2021-2022, as did the report of the UN Working Group of Experts on People of African Descent on its mission to Canada.

The deaths of Akeem Scott (a young black man whose family believe that racial profiling by a Montreal hospital played a role in his death; see references), Mireille Ndjomouo (a Black Quebec mother who posted a video of herself pleading to be transferred from a Montreal hospital where she did not feel safe' see references) and the high-profile death of Joyce Echaquan (an Indigenous mother who posted a video of her being insulted by hospital staff) have raised the alarms of socioculturally harmful practices within the healthcare system in Quebec.

The above events and increasing global awareness of systemic sociocultural inequities inspired many public- and private-sector organizations to examine their policies and procedures in the context of equity, diversity and inclusion (EDI). Thanks to the MUHC's commitment to excellence and innovation in patient care, research, education and technology assessment, as well as its recognition that EDI is a collective responsibility, the MUHC and RI-MUHC embraced this undertaking.

Table 2 – Mandate

i.	Engage with a broad range of stakeholders within the MUHC community (communicate, listen, hear) who, by expressing their views, sharing ideas and proposing solutions, will help identify the metrics needed to provide an accurate picture of the current reality of EDI within the MUHC, and the optimal methodology to collect the data;
ii.	Identify all initiatives under way in the MUHC and across its network, as well as their level of success, and gaps for the entire work force, trainees, patients, families and visitors;
iii.	Analyse and ensure informal and formal alignment, as may be appropriate, with other initiatives, including but not limited to McGill University and its community, the Government of Quebec and Government of Canada;
iv.	Recommend immediate changes and/or initiatives that have been road-tested and can be implemented on a fast-track basis in the short term, with particular emphasis on work force, trainee and patient programmes.
v.	Provide a progress report to the Board of Directors in fall 2020.

Table 3 – Committee*

Ms. Seeta Ramdass (co-chair)	Dr. Anita Brown-Johnson (co-chair)	Ms. Judith Horrell (administrator)
Ms. Patricia Noël	Ms. Kate Marr-Laing	Ms. Claudiane Poisson
Ms. Samira Sakhia	Mr. Fabien Pernet	Ms. Marie Serdynska
Mr. Damien Chalaud	Ms. Sonia Rea	Mr. Diego Herrera
Dr. Saleem Razack	Dr. Samir Shaheen-Hussain	Dr. Laurie Plotnick
Ms. Stéfanie Brisson	Ms. Carole Dupéré	Dr. Vincent Lacroix
Ms. Diane States	Ms. Lisa Rosati	Dr. Rislaine Benkelfat

*Note: Members assumed various advisory and/or other work and report-related functions. Some were present for the duration of the mandate while others for a shorter period.

Once the committee was fully formed, the C-AIDE co-chairs sent the first of many messages to the MUHC community, highlighting that helping the MUHC to be its best self is a shared responsibility and confirming that its objectives were to hear from, listen to, and connect with the full spectrum of stakeholder groups associated with the MUHC, from patients and their family members to healthcare professionals and personnel, academics, trainees, and partners, etc. It would also catalogue existing initiatives, review literature, as well as collect and analyze data. It understood that it would need to engage in difficult conversations, sensitize the community to topics of collective interest, and spark individual and institutional reflection on different matters affecting how the MUHC's teams deliver care, conduct research, teach, train, and work together.

Since that time, C-AIDE promoted EDI-related learning/training opportunities, encouraged awareness of the principles of EDI, and participated in a number of outreach activities, as well as engaged with a broad range of stakeholders through surveys, focus groups, one-on-one interviews and written questions. The results of these consultations (hereinafter "the study") form the main thrust of this report.

3. STUDY METHODS

The C-AIDE EDI study employed a mixed method design where both quantitative and qualitative information and data were collected. Quantitative data were collected through two anonymized surveys using a web-based platform and qualitative data were collected through semi-structured interviews, focus group discussions and written responses to interview questions. Participants were asked to share their experience(s) of discrimination, biases and racism at the MUHC and or RI-MUHC (workforce and patient population) and provide suggestions/ideas for improvements. A literature review to explore certain questions and leading practices was also carried out, though these were not exhaustive given time and resource constraints.

Study Population: The study population involved clinicians, non-clinicians, researchers, and trainees/learners, volunteers, and patients of the RI-MUHC and MUHC community. The qualitative assessment through semi-structured interviews, focus group discussion or a written response to seven interview questions consisted of clinicians, non-clinicians, researchers, trainees/students, volunteers, patients, and care givers of the MUHC community.

Questionnaire Development: The survey questions were developed in accordance with a variety of organizational EDI surveys, patient satisfaction surveys and quality assessment surveys, as well as reviewed by the diverse multidisciplinary members of C-AIDE [See table 3, page 10]

Survey Resources: Various models and templates were consulted in order to develop the survey used by the Committee to collect data. Sources include the World Health Organization, Statistics Canada data products related to the Government of Canada's census, and the McGill University Health Centre's own Sociocultural Consultation and Interpretation Services. These questions were vetted and adjusted, as recommended by the Committee.

MUHC and RI-MUHC surveys were divided into three sections, comprising 22 and 24 questions respectively. Each contained three open-ended questions while two closed-ended questions offered the option of leaving comments via a write-in-field. Section 1 represented self-identifying demographic questions such as age range and ethnic origin. Bias- and/or discrimination-related questions were covered in Section 2. Survey respondents had the opportunity to voice their opinions on EDI throughout the MUHC and RI-MUHC in section 3. Question 13 in the MUHC questionnaire was split into three separate questions in the RI-MUHC questionnaire. Question 7 ('What is your mother tongue') and Question 8 ('What language do you use the most in your day-to-day dealings at work') were added on March 23, 2021 to the MUHC questionnaire, a month after the release of the MUHC EDI survey. The RI-MUHC questionnaire included both questions from the start. Both anonymous surveys were available in English and French.

The questions for semi-structured interviews and focus group discussions were developed by the co-chairs of C-AIDE in consultation and with input from the independent research consultant. In order to compare and contrast responses, questions were consistent between both qualitative assessment methods. It was up to participants to decide if they wanted to provide responses in English or French. The option of providing a written response to the interview questions was offered due to time constraints, availability issues of C-AIDE members and participants, pandemic-related scheduling challenges and a desire to make the participation accessible and inclusive to participants with motor and/or sensory challenges.

Data Collection: The C-AIDE co-chairs and the president and executive director of the MUHC, Dr. Pierre Gfeller, circulated calls for participation in the C-AIDE EDI survey to potential survey participants via e-mail and the MUHC's intranet. A total of 10,636 potential participants within the MUHC community and 2,784 potential participants within the RI-MUHC received the information on multiple occasions. Some participants may be included in both lists, given that they practice medicine at the MUHC and conduct research at the RI-MUHC, though it is unlikely that duplicate participants would complete both surveys. E-mails for potential participants were obtained through the MUHC IS/IT system while human resources at the RI-MUHC managed the circulation to potential candidates. The sampling method

applied for this anonymous web-based survey was a non-probability sampling (convenience sample) due to the convenient access to e-mail addresses of the MUHC and RI-MUHC study populations.

Both surveys used Alchemer as the data collection tool. An MUHC employee in the Quality, Performance, Evaluation, and Ethics department programmed the survey. Survey participants had the option to skip any question they did not feel comfortable answering. The initial data collection time period for the MUHC was February 23 to March 30, 2021 and for the RI-MUHC it was March 30 to April 26, 2021. For the MUHC, C-AIDE decided to extend the collection period until April 30, 2021. However, the survey collection submission option remained active until the end of July 2021. Thus, survey responses were collected between February 23 to July 18, 2021 for the MUHC and March 30 to July 7, 2021 for RI-MUHC. For both surveys, 99% of responses were submitted in the initial data collection period.

Participants were identified via the MUHC-wide calls for taking part in C-AIDE's focus groups and contacted by e-mail either to set up the interview, the focus group discussion or to provide a written response to the interview questions. The RI-MUHC published a call for participants as well, which provided for a sample of researchers, managers and staff. Zoom video-conferencing was used for qualitative data collection. Zoom provides the "ability to securely record and store sessions without recourse to third-party software" (Archibald et al., 2019, p. 2). The independent research consultant and one of C-AIDE's co-chairs conducted semi-structured interviews and focus group discussions between March 1, and May 14, 2022. Informed consent forms, signed by participants, were obtained prior to the interview, the focus group or before the submission of a written response from every participant. Participants were asked for permission to audio-record or video-record the interview and group discussions. If participants indicated they did not permit either, the interviewers took detailed notes and no recordings were made.

Participants were asked seven questions. Prior to a Zoom call or a written response query, participants received an email with demographic questions. Socio-demographic information was captured in seven questions about age, native tongue, Indigenous peoples, visible minority and/or ethnic background, 2SLGBTQIA+ communities, sensory and/or motor challenges, and the role/relationship with MUHC/RI-MUHC. Participants had the option to skip questions.

The interview questions were the following:

- The participant's understanding of equity, diversity, and inclusion;
- The participant's description of the culture/environment at MUHC and/or RI-MUHC;
- EDI-related challenges/conflicts the participant experienced at MUHC and/or RI-MUHC;
- Which EDI topics are most important to the participant; and
- Anything of EDI relevance the participant felt important to share with C-AIDE.

Focus group discussions comprised two to four participants and included both visible minorities and non-visible minorities from various sectors, departments and sites within the MUHC and RI-MUHC, including patients, caregivers, administrative staff, advisors/planners, allied health professionals, trainees/students, nurses, physicians, researchers, and managers. Ideally, focus groups should comprise a homogeneous group, in this case participants based on their workplace role. One focus group discussion was heterogeneous due to availability issues.

Interviews and focus groups discussions, which lasted 30 to 90 minutes, were recorded. Closed captioning was applied to retrieve a first draft of a transcript for every conversation. The live transcription texts from each Zoom call were re-evaluated by listening to the recording, verifying and correcting errors. Zoom only has the capability to transcribe in English. A French translator transcribed French responses manually. Interview respondents and focus group participants were de-identified to prevent their identities from being revealed and to prevent others from linking them to their responses.

Due to the qualitative nature of the interviews, focus group discussions and written responses, results from this report cannot be extrapolated to a broader audience beyond the MUHC and RI-MUHC. The findings may be considered

indicative. The sample of participants was generated through an opt-in process and based on those who had access to MUHC and RI-MUHC intranet and e-mails. Consequently, while participants cannot be said to be representative of the entire MUHC and/or RI-MUHC community, their shared lived experiences provide experientially informative and valuable insight into their realities vis-à-vis EDI.

Data Analysis: Descriptive statistical analysis of closed-ended survey questions was conducted in R (*Version: 2021.09.0 Build 351*). If a variable missed < 15 data points, the missing data was excluded from analysis and visualizations. Pearson's chi-square test of independence was applied for categorical data to assess differences between groups. For the three open-ended survey questions and two write-in-text-field options, inductive coding was applied via MAXQDA Analytics Pro (*Version: 2022*). For question No. 15, deductive coding was used due to predetermined themes. Inductive coding was used to analyze interview transcripts, focus group discussion transcripts and written responses via MAXQDA Analytics Pro (*Version: 2022*).

Grounded theory was applied to the qualitative part of this study. "Grounded theory provides a set of guidelines and a flexible yet rigorous process from which to develop empirical theory" (Hennink et al., 2019, p. 704). "It offers an implicit inductive approach" with "explicit deductive strategies" (Hennink et al., 2019, p. 704). An inductive, or 'bottom-up' coding process was chosen to get a sense and an understanding of the predominant themes within the entire dataset (open-ended survey questions, semi-structured interviews, focus group discussions, and written response to the interview questions). This form of analysis allows for a rich description of the entire data, for derivatives of "codes, concepts, and theory" from the data, and for the development of research questions during the coding process (Braun & Clarke, 2006; Hennink et al., 2019). Additionally, the coding process does not constrict emerging themes to "a pre-existing coding frame or the researcher's analytic preconceptions" (Nowell et al., 2017, p. 8). Inductive coding was used to "capture the emic perspective of study participants more directly from the data" (Hennink et al., 2019, p. 752). MAXQDA's creative coding option was applied to create a code hierarchy and sort codes into 'parent codes' and 'sub codes' to create a 'code tree'. In order to create a visual overview between the connections within specific identified categories/themes, MAXQDA's MAXMaps was used to aid the understanding of emerging theories (MAXQDA, 2021).

4. SURVEY RESULTS

A total of 712 complete (or partially complete) survey responses were recorded for the MUHC survey with a response rate of 6.7%. A total of 228 complete (or partially complete) survey responses were recorded for the RI-MUHC survey with a response rate of 8.2%. Survey participants had the option to skip any question they did not feel comfortable answering, hence the partially complete responses.

Table 4 – Number of survey participants and response rate (%) for MUHC and RI-MUHC

	Population	No. of survey participants	Response rate (%)
MUHC	10,636	712	6.7%
RI-MUHC	2,784	228	8.2%

Demographics

Age range: Of the 712 MUHC survey respondents, 40.1% (n=284) are between 46 to 65 years old, 38.7% (n=274) are between 31 to 45 years old, 15.7% (n=111) are between 18 to 30 years old, and 4.2% (n=30) indicate they are over 66 years of age. Of the 228 RI-MUHC survey respondents, 43.4% (n=98) are between 46 to 65 years old, 35.4% (n=80) are between 31 to 45 years old, 15.9% (n=36) are between 18 to 30 years old, and 5.3% (n=12) indicate they are over 66 years of age.

Persons with a motor and/or sensory challenge: Survey participants were provided with a definition of 'persons with disabilities'[2]. For the MUHC, 6.1% (n=43) and for the RI-MUHC 4.9% (n=11) of respondents self-identify as having a disability.

Ethnic minority group and ethnic origin: Of the 712 MUHC respondents, 42.6% (n=300) self-identify as a member of an ethnic minority group[3]. Of the 228 RI-MUHC respondents, 42.5% (n=96) self-identify as a member of an ethnic minority group. Thus, two out of five survey respondents self-identify as a member of an ethnic minority group at the MUHC and/or RI-MUHC. For both surveys, Other North American origins (ex.: Québécois, Acadian, Canadian, American) (RI-MUHC: 26.3%, n=75, MUHC: 25.9%, n=226) followed by Southern European origins (ex.: Greek, Italian, Maltese, Spanish) (RI-MUHC: 11.2%, n=32, MUHC: 11.1% n=97) are the ethnic origins one-third of each study population self-identifies with the most. Within the MUHC study population, Caribbean origins (ex.: Antiguan, Bahamian, West Indian, Haitian) is third (9.2%, n=80), whereas within the RI-MUHC survey participants Caribbean origins ranks 14th (2.8%, n=8). RI-MUHC survey respondents list nations of the United Kingdom, the Channel Islands and Ireland as third origin (8.1%, n=23). Survey participants had the option to select multiple choices for ethnic origin. 82.6% (n=584) of MUHC survey participants versus 80.5% (n=182) of RI-MUHC selected one ethnic origin, 12.4% (n=88) of MUHC versus 13.3% (n=30) of RI-MUHC survey participants selected two ethnic origins. Five are the most ethnic origins survey participants select from the MUHC and/or RI-MUHC community.

Indigenous peoples: For the MUHC, 1.1% (n=8) and for the RI-MUHC 0.9% (n=2) respondents self-identify as 'Indigenous peoples' namely First Nations, Inuit and Métis.

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[2]"Persons with disabilities" refers to people with a long-term, persistent or recurring physical, mental, sensory, psychiatric or learning impairment and who consider themselves disadvantaged in employment or other situations because of that impairment and the functional limitations it causes, or believe that an employer might consider them disadvantaged. Persons with disabilities also include those who have been or should be accommodated in their current job because of their functional limitations (e.g., by means of technical aids, changes to equipment or other working arrangements).

[3] "Ethnic minorities" refers to people of a particular race or nationality living in a country or area where most people are of a different race or nationality.

Visible minority: Of the 712 MUHC respondents, 32.3% (n=227) self-identify as a racialized person/visible minority[4]. Of the 228 RI-MUHC respondents, 27.4% (n=62) self-identify as a racialized person/visible minority.

2SLGBTQIA+ community: 7.2% (n=51) of the MUHC and 9.3% (n=21) of the RI-MUHC survey respondents self-identify as a sexual orientation and/or gender identity minority/ 2SLGBTQIA+[5].

Gender at birth: 77.0% (n=545) of MUHC and 69.0% (n=156) of RI-MUHC survey participants indicate they were female at birth. 21.8% (n= 154) of the MUHC and 30.1% (n=68) of the RI-MUHC survey participants indicate they were male at birth.

Current identity: For the MUHC, 75.8% (n=537) of survey respondents currently self-identify as a woman, 21.8% (n=154) as a man, 0.1% (n=1) as intersex, 0.4% (n=3) as non-binary, and 0.3% (n=2) as Two-Spirit. For the RI-MUHC, 68.6% (n=155) of survey respondents currently self-identify as a woman and 30.1% (n=68) as a man. Thus, for both institutions, seven out of ten survey respondents self-identify as a woman.

Native tongue: For the MUHC survey, the native/mother tongue question was added a month after the start of data collection. After the removal of the 402 missing values for MUHC data, 34.5% (n=107) list French as their native tongue followed by 31.6% (n= 98) for another language and 28.7% (n=89) for English. Since the MUHC data set has 56.5% of missing data for the native/mother tongue variable, the results need to be interpreted with significant caution due to this limitation. At the RI-MUHC, 38.1% (n=86) of survey respondents list English as their native tongue, followed by another language with 33.6% (n=76) and French with 23.0% (n=52).

Language used for day-to-day dealings at work: For the MUHC survey, this question was added a month after the start of data collection. After the removal of the 403 missing values for MUHC data, 56.6% (n=175) list using a combination of English and French in day-to-day dealings at work followed by 33.3% (n=103) for English and by 10.0% (n=31) for French. At the RI-MUHC, 68.0% (n=153) of survey participants indicate using English in day-to-day dealings at work, followed by a combination of English and French with 30.7% (n=69) and 1.3% (n=3) for French. For both institutions, survey participants indicate using French the least. Since the MUHC data set has 56.6% of missing data for the language used at work, the results need to be viewed with caution due to this limitation.

Table 5 – MUHC and RI-MUHC Demographics

	MUHC		RI-MUHC	
	Responses (n)	Percentage (%)	Responses (n)	Percentage (%)
Age range				
18 to 30 years	111	15.7	36	15.9
31 to 45 years	274	38.7	80	35.4
46 to 65 years	284	40.1	98	43.4
66 years of age or older	30	4.2	12	5.3
Prefer not to answer	9	1.3	0	0
Persons with a motor and/or sensory challenge				
Yes	43	6.1	11	4.9
No	649	92.1	212	94.2

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[4] "Racialized Persons/visible minorities" refers to persons of colour (excl. Indigenous peoples) who are non-Caucasian in race or non-white in colour.
[5] "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 at birth. 2SLGBTQIA+ stands for Lesbian, Gay, Bisexual, Transgender, Two-Spirit, and Queer or Questioning, Intersex, Asexual or other.

Another category (listed as 'Other')	5	0.7	1	0.4
Prefer not to answer	8	1.1	1	0.4
Indigenous peoples				
Yes	8	1.1	2	0.9
_No_	674	96.1	222	98.7
Another group (listed as 'Other')	13	1.9	1	0.4
Prefer not to answer	6	0.9	0	0
Visible minority				
Yes	227	32.3	62	27.4
_No_	459	65.4	162	71.7
Another group (listed as 'Other')	8	1.1	1	0.4
Prefer not to answer	8	1.1	1	0.4
Ethnic Minority				
Yes	300	42.6	96	42.5
_No_	384	54.5	124	54.9
Another group (listed as 'Other')	8	1.1	2	0.9
Prefer not to answer	12	1.7	4	1.8
Ethnic Origin				
Other North American origins (ex.: Québécois, Acadian, Canadian, American)	226	25.9	75	26.3
Southern European origins (ex.: Greek, Italian, Maltese, Spanish)	97	11.1	32	11.2
Caribbean origins (ex.: Antiguan, Bahamian, West Indian, Haitian)	80	9.2	8	2.8
British Isles origins (ex.: English, Channel Islander, Scottish, Cornish, Welsh, Irish)	74	8.5	23	8.1
East and Southeast Asian origins (ex.: Chinese, Japanese, Filipino, Korean)	70	8	19	6.7
Latin, Central and South American origins (ex.: Argentinian, Colombian, Mexican)	32	3.7	19	6.7
2SLGBTQIA+ community				
Yes	51	7.2	21	9.3
_No_	635	89.9	203	90.2
Prefer not to answer	20	2.8	1	0.4
Sex at birth				
Female	545	77.0	156	69.0
Male	154	21.8	68	30.1
Prefer not to answer	9	1.3	2	0.9
Current gender				
Woman	537	75.8	155	68.6
Man	154	21.8	68	30.1
Intersex	1	0.1	0	0
Non-binary	3	0.4	0	0
Two-spirit	2	0.3	0	0
Other	0	0	1	0.4
Prefer not to answer	11	1.6	2	0.9

Note: Native tongue and language used for day-to-day dealings at work were not added to the table due to high percentage of missing values in the MUHC dataset.

Bias- and/or Discrimination-related Survey Results

Each survey included questions for participants to address bias- and/or discrimination-related issues and concerns at the MUHC/RI-MUHC. Survey respondents had the option to express their concerns with bias- and/or discrimination-related issues through seven questions at the MUHC and through nine questions at the RI-MUHC. Survey questions inquired about the following issues:
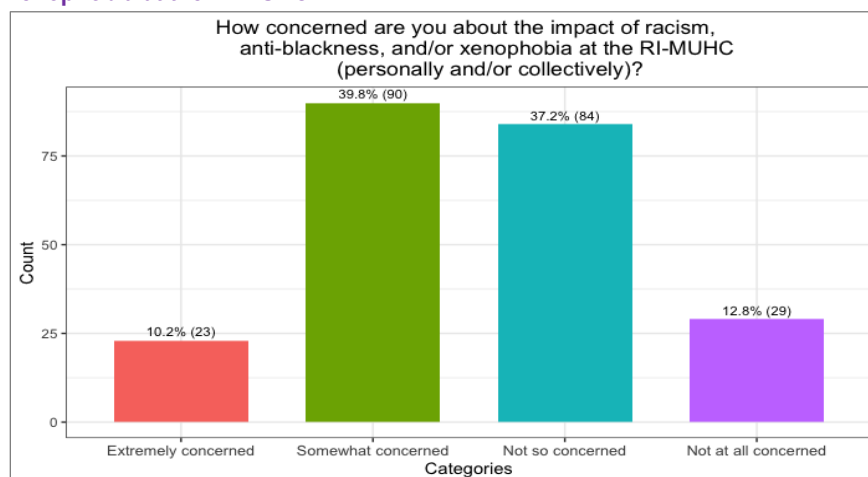
- Impact of racism, anti-blackness, and/or xenophobia (Q12)
- Impact of sexual orientation, gender identity, disability, or socio-ethno-cultural group on respondents personally at the MUHC/RI-MUHC (MUHC -Q13; RI-MUHC Q13a-c)
- Bias- and/or discrimination-related issues faced at the MUHC and/or RI-MUHC (Q14)
- Working issues at MUHC and/or at RI-MUHC involving bias and/or discrimination, micro-aggressions or overt racism (Q15)
- Conversations about bias and/or discrimination (Q16)
- Confidence in leadership to create an inclusive workplace (Q17)
- Addressing any form of bias and/or discrimination with provided categories of people (Q18)

Impact of racism, anti-Blackness, and/or xenophobia at the RI-MUHC and/or MUHC (Q12): Survey participants were asked how concerned they are about the impact of racism, anti-blackness, and/or xenophobia at the MUHC and/or RI-MUHC. More than five out of ten or 55.7% of MUHC survey respondents and 50.0% of RI-MUHC survey respondents indicate to be extremely concerned or somewhat concerned about the impact of racism, anti-blackness, and/or xenophobia at the MUHC and/or RI-MUHC. Thus, one out of two or the majority of survey respondents are concerned about the impact of racism, anti-blackness, and/or xenophobia at the MUHC and/or RI-MUHC, either personally and/or collectively.

Figure 1 – Distribution of survey participants who are concerned about the impact of racism, anti-blackness, and/or xenophobia at the MUHC.
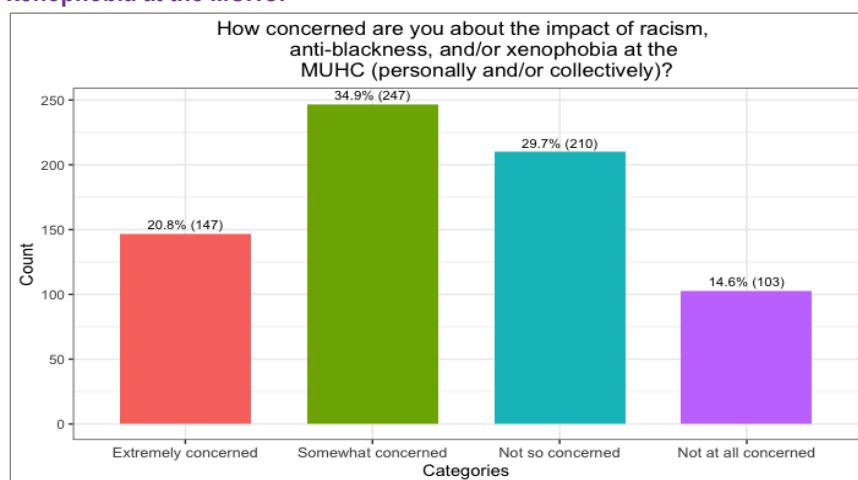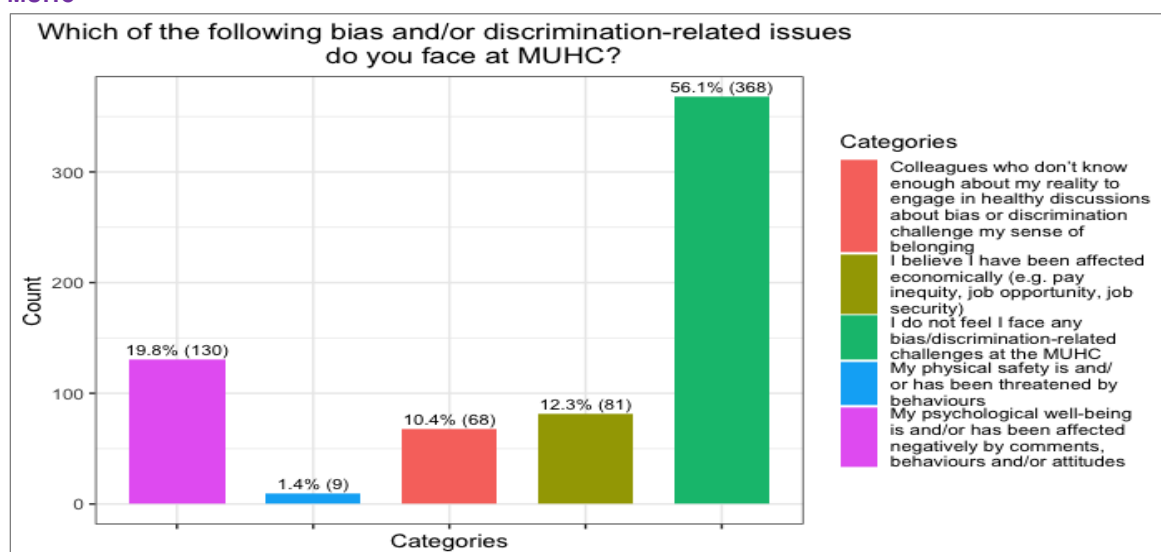
Figure 2 – Distribution of survey participants who are concerned about the impact of racism, anti-blackness, and/or xenophobia at the RI-MUHC.


Impact of sexual orientation, gender identity, disability, or socio-ethno-cultural group on them personally at the MUHC and/or RI-MUHC (MUHC -Q13; RI-MUHC Q13a-c)P: Survey participants were asked how concerned they are about the impact of sexual orientation, gender identity, disability, or socio-ethno-cultural group on them personally at the MUHC and/or RI-MUHC. For the MUHC, two out of five or 39.5% survey respondents are extremely or somewhat concerned about the impact of sexual orientation, gender identity, disability, or socio-ethno-cultural group on them personally in the workplace (combined extremely and somewhat concerned data). For the RI-MUHC, 24.8% survey respondents are concerned about the impact of sexual orientation and/or gender identity on them personally in the workplace, 17.3% survey respondents are concerned about the impact of disability on them personally and 32.3% survey respondents are concerned about the impact of socio-ethno-cultural group on them personally at MUHC and/or RI-MUHC. For all three, the extremely and somewhat concerned answer options were combined.

Bias- and/or discrimination-related issue survey participants are facing at the MUHC and/or RI-MUHC (Q14): MUHC and RI-MUHC survey participants were given various options to express bias and/or discrimination they are facing at the MUHC and/or RI-MUHC. 19.8% of MUHC and 11.5% of RI-MUHC respondents report that their psychological well-being is and/or has been affected negatively by comments, behaviours and/or attitudes. 1.4% of MUHC and 0% of RI-MUHC of respondents report that their physical safety is and/or has been threatened by behaviours. 10.4% of MUHC and 8.7% of RI-MUHC respondents report that colleagues, who don't know enough about their reality to engage in healthy discussions about bias or discrimination, challenge their sense of belonging. 12.3% of MUHC and 10.6% of RI-MUHC respondents report that they believe they have been affected economically (e.g., pay inequity, job opportunity, job security). Thus, 56.1% (n=368) of MUHC and 69.3% (n=151) of RI-MUHC respondents do not feel that they face any bias- and/or discrimination-related challenges at work, but 43.9% (two out of five) of MUHC and 30.8% (one out of three) of RI-MUHC respondents report that they have faced bias- and/or discrimination-related issues at work.
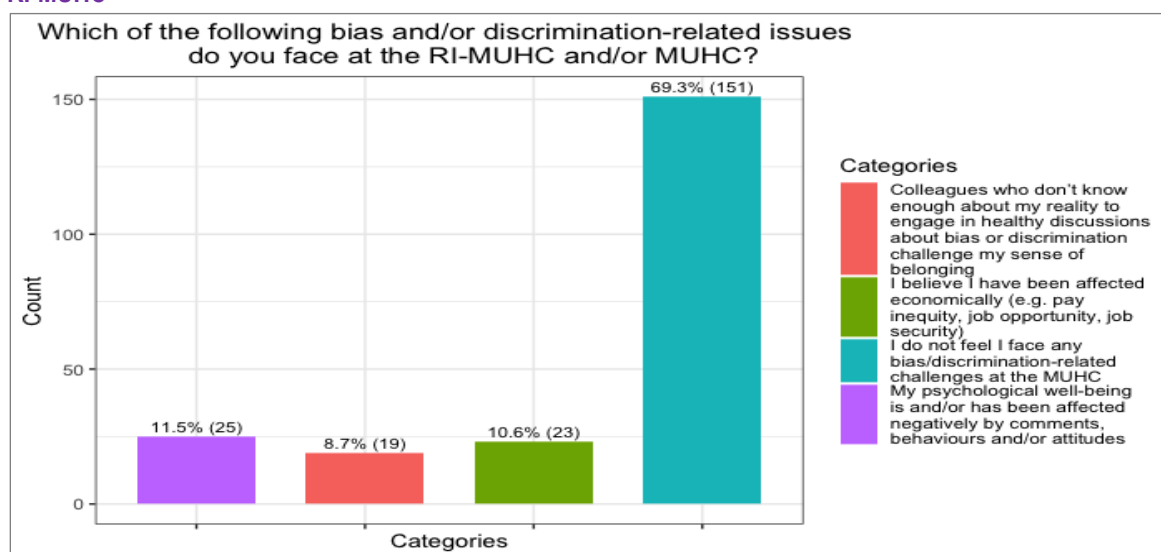
Additionally, both surveys asked the question 'Which of the following bias- and/or discrimination-related issues do you face at the MUHC and/or RI-MUHC' had a fillable text field in order to list 'Other (please specify)'. 6.9% of MUHC and 3.2% of RI-MUHC respondents left a comment under the 'Other (please specify)'.

For both surveys, it was noted that multiple selection options, such as select all that apply, were not provided. Survey respondents indicated they would have liked the option to select more than one of the provided responses under the 'Which of the following bias- and/or discrimination-related issues do you face at the MUHC and/or RI-MUHC' question. One survey respondent indicated "I believe that each of these answers play a major role...so I would have liked to been able to answer more than one." Another respondent wrote « *Il faudrait pouvoir cocher plus d'une réponse* » (Translation: "You should be able to choose more than one answer").

Working issues at the MUHC and/or RI-MUHC involving bias and/or discrimination, micro-aggressions or overt racism (Q15): Survey participants were asked if they ever have had any working issues at the MUHC and/or RI-MUHC involving bias and/or discrimination, micro-aggressions or overt racism (with members of the RI-MUHC and/or with members of the MUHC, with research participants, patients, family members, visitors, volunteers). Two out of five or 42.8% of MUHC respondents report having had working issues involving bias and/or discrimination whereas 22.8% of RI-MUHC survey respondents report having had working issues at the RI-MUHC involving bias and/or discrimination.

Figure 5 – *(MUHC)* **Distribution of survey participants who indicated having working issues involving bias and/or discrimination, micro-aggressions or overt racism at MUHC**
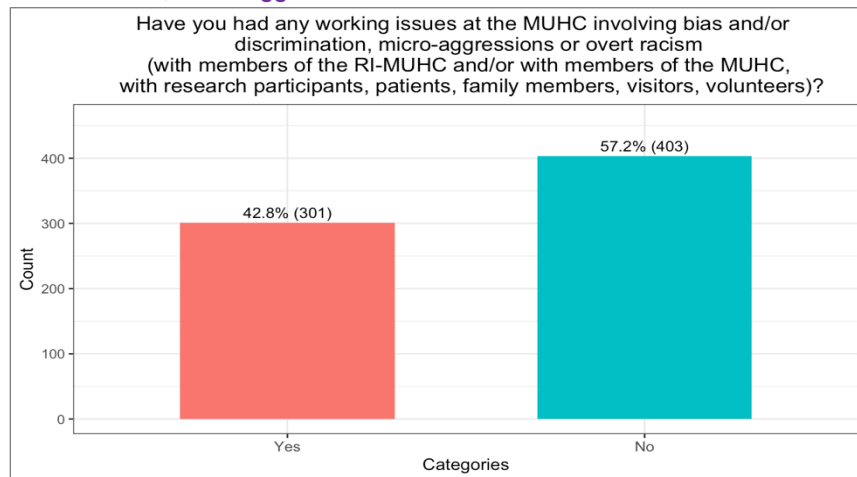
Figure 6 – *(RI-MUHC)* **Distribution of survey participants who indicated having working issues involving bias and/or discrimination, micro-aggressions or overt racism at RI-MUHC**
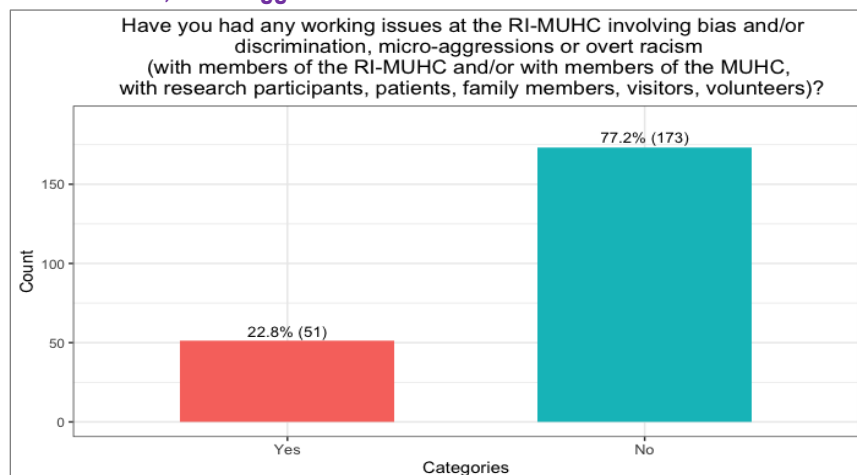

Conversation about bias and/or discrimination (Q16): When asked if they ever had any workplace conversation(s) about bias and/or discrimination. 44.0% of MUHC and 39.5% of RI-MUHC respondents answered yes.

Confidence in leadership to create an inclusive workplace (Q17): When asked about their confidence in leadership to create an inclusive workplace. 84.7% of MUHC and 94.3% of RI-MUHC respondents are extremely, very or somewhat confident that the MUHC leadership can create an inclusive workspace.

Figure 7 – *(MUHC)*: Distribution of survey participants who indicated their confidence in leadership to create an inclusive workplace at MUHC
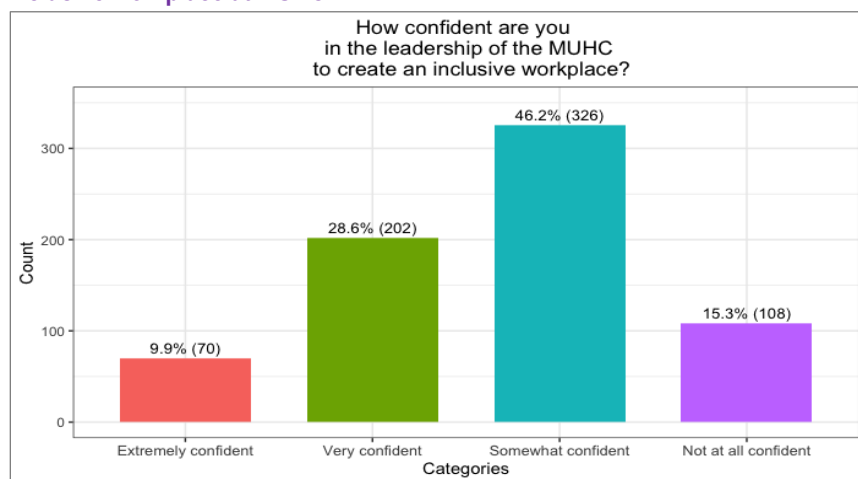
Figure 8: *(RI-MUHC)* Distribution of survey participants who indicated their confidence in leadership to create an inclusive workplace at MUHC
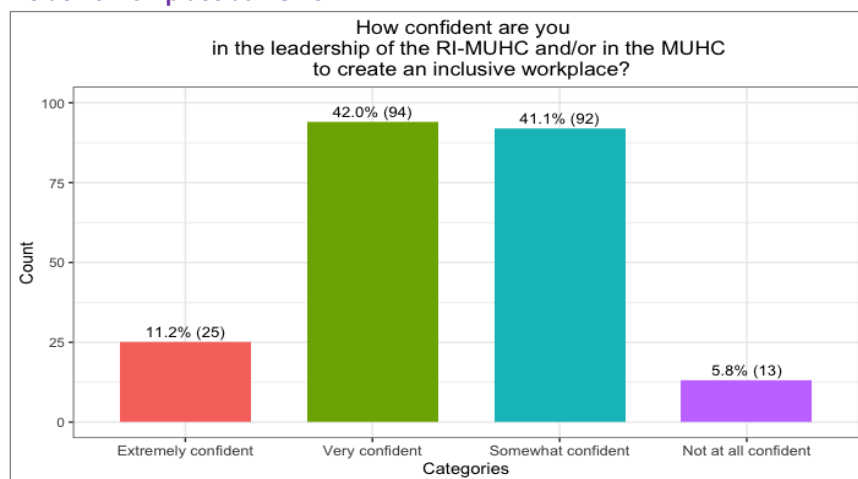
Addressing any form of bias and/or discrimination with provided categories of people (Q18): Survey participants were asked the question "How safe do you or would you feel addressing any form of bias and/or discrimination with the following categories of people at the MUHC?"

MUHC respondents report feeling safe addressing any form of bias and/or discrimination with immediate team members and among peers (Teams: 48.1%, Peers: 52.4% – totally safe and very safe combined). However, 39.4% (two out of five) of respondents report feeling unsure and/or not safe addressing any form of bias and/or discrimination with patients, research participants, family members, and visitors. Further, 31.3% of respondents report being unsure and/ or not safe addressing any form of bias and/or discrimination with senior management (administration, clinical, research, education). 43.2% of respondents also feel unsafe and/or unsure when addressing any form of bias and/or discrimination with any staff or MUHC/RI-MUHC vendor/supplier and 46.9% of respondents also feel unsafe and/or are unsure when addressing any form of bias and/or discrimination with board members. Overall, MUHC survey participants report feeling less safe addressing bias and/or discrimination issues with anyone at the institution compared to the RI-MUHC survey respondents.
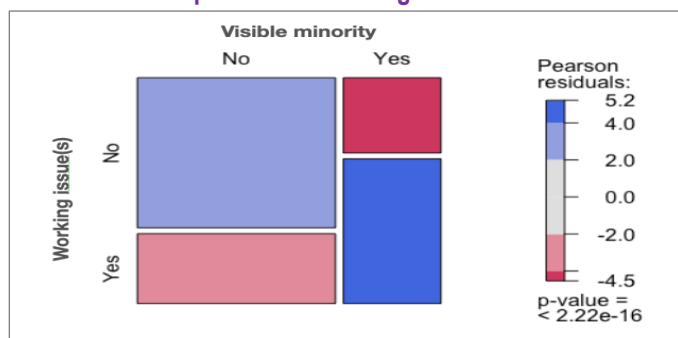
RI-MUHC respondents report feeling safe addressing any form of bias and/or discrimination with immediate team members and among peers (Teams: 59.8%, Peers: 60.7% – totally safe and very safe combined). 21% of respondents report being unsure and/ or not safe addressing any form of bias and/or discrimination with senior management (administration, clinical, research, education). 32.1% of respondents also feel unsafe and/or unsure when addressing any form of bias and/or discrimination with board members. 17.5% of respondents report feeling unsure and/ or not safe addressing any form of bias and/or discrimination with patients, research participants, family members, visitors. However, 34.1% of survey participants report having no interaction with patients, research participants, family members, and/or visitors (not applicable).

Disaggregated Results by Visible Minority Status Involving Bias and/or Discrimination, Micro-aggressions or Overt Racism and Experience of Bias and/or Discrimination-related Issues

MUHC: Visible minority status and working issues at the MUHC and/or RI-MUHC involving bias and/or discrimination, micro-aggressions or overt racism (Q15): The relationship between self-identified visible minority status and experience of workplace issues at the MUHC involving bias and/or discrimination, micro-aggressions or overt racism (Q15) was examined. The question 'Is experience of bias- and/or discrimination-related work issues independent of visible minority status?' was explored using Pearson's chi-squared test with Yates' continuity correction to examine the relationship between self-reported visible minority status and the experience of workplace issues at the MUHC involving bias and/or discrimination. The relationship between these variables is statistically significant, X^2 (1, N = 682) = 69.948, p < 0.01.

Experience of bias- and/or discrimination-related workplace issues is not independent of visible minority status in the MUHC survey data set. Survey respondents who self-identify as visible minorities are more likely to report workplace issues involving bias and/or discrimination, micro-aggressions or overt racism (with members of the MUHC and/or with patients, research participants, family members, visitors, volunteers) whereas survey respondents who did not identify as a visible minority are less likely to report workplace issues involving bias and/or discrimination, micro-aggressions or overt racism (with members of the MUHC and/or with patients, research participants, family members, visitors, volunteers). Therefore, visible minorities are more likely to report workplace issues related to bias and/or discrimination compared to non-visible minorities (39% vs. 19.2%) in the MUHC survey data set.

Figure 9: **Residual Plot for Pearson's chi-squared test to examine the relation between self-reported visible minority status and the experience of working issues at the MUHC involving bias and/or discrimination.**

Positive residuals are in blue. Positive values in cells specify an attraction (positive association) between the corresponding row and column variables. Thus, the blue color indicates that the observed value is higher than the expected value if the data were random. Negative residuals are in red. This implies repulsion (negative association) between the corresponding row and column variables. Thus, the red color specifies that the observed value is lower than the expected value if the data were random.

RI-MUHC: Visible minority status and working issues at the MUHC and/or RI-MUHC involving bias and/or discrimination, micro-aggressions or overt racism (Q15): The relationship between self-identified visible minority status and experience of working issues at the RI-MUHC involving bias and/or discrimination, micro-aggressions or overt racism (Q15) was examined. This relationship is not statistically significant in the RI-MUHC survey data set. Therefore, experience of bias and/or discrimination related to work issues are independent of visible minority status at the RI-MUHC.

MUHC: Experience of bias and/or discrimination related issues and visible minority status (Q12): Additionally, the relationship between self-identified visible minority status and any experience of bias and/or discrimination at the MUHC (Q12) was examined. The question 'Is experience of bias and/or discrimination related issues independent of visible minority status at the MUHC' was of interest to C-AIDE. A Pearson's chi-squared test with Yates' continuity correction was performed to examine the relationship between self-reported visible minority status and any experience of bias and/or discrimination-related challenges at the MUHC. The relationship between these variables is statistically significant, X^2 (3, N = 627) = 99.014, p < 0.01. Experience of bias and/or discrimination-related challenges is not independent of visible minority status at the MUHC.

Self-reported visible minorities at the MUHC are less likely to report that "I do not feel I face any bias/discrimination-related challenges at the MUHC" (1) than non-visible minorities, and are more likely to report "Colleagues, who don't know enough about my reality to engage in healthy discussions about bias or discrimination, challenge my sense of belonging" (3), and "My psychological well-being is and/or has been affected negatively by comments, behaviours and/or attitudes" (4). Respondents, who do not identify as visible minority, are more likely to report, "I do not feel I face any bias/discrimination-related challenges at the MUHC" (1).'

Figure 10: Residual Plot for Pearson's chi-squared test to examine the relation between self-reported visible minority status and bias/discrimination-related challenges at the MUHC.
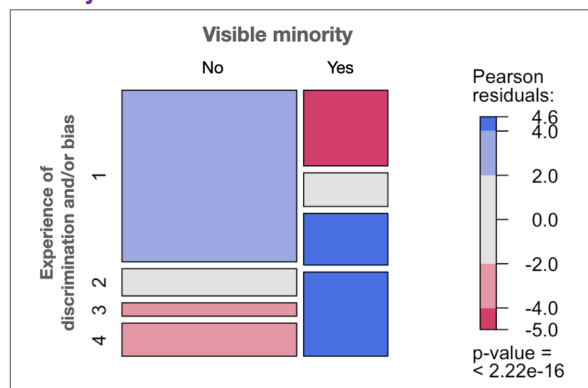

Positive residuals are in blue. Positive values in cells specify an attraction (positive association) between the corresponding row and column variables. Thus, the blue color indicates that the observed value is higher than the expected value if the data were random. Negative residuals are in red. This implies repulsion (negative association) between the corresponding row and column variables. Thus, the red color specifies that the observed value is lower than the expected value if the data were random.

Legend for residual plot for y-axis:
1 = "I do not feel I face any bias/discrimination-related challenges at the MUHC"
2 = "I believe I have been affected economically (e.g. pay inequity, job opportunity, job security)"
3 = "Colleagues who don't know enough about my reality to engage in healthy discussions about bias or discrimination challenge my sense of belonging"
4 = "My psychological well-being is and/or has been affected negatively by comments, behaviours and/or attitudes"

RI-MUHC: Experience of bias and/or discrimination related issues and visible minority status: The relationship between self-identified visible minority status and any experience of bias and/or discrimination at the RI-MUHC (Q12) was examined. This relationship is not statistically significant in the RI-MUHC data set. Therefore, experience of bias and/or discrimination related issues are independent of visible minority status in the RI-MUHC dataset.

MUHC: Visible minority status and confidence in leadership to create an inclusive workplace (Q17): Additionally, the relationship between self-identified visible minority status and confidence in leadership to create an inclusive workplace was examined. The question 'Is confidence in leadership to create an inclusive workplace independent of visible minority status at the MUHC' was of interest to C-AIDE. A Pearson's chi-squared test with Yates' continuity correction was performed to examine the relationship between self-reported visible minority status and any confidence in leadership to create an inclusive workplace at the MUHC.

The relationship between these variables is statistically significant, X^2 (3, N = 684) = 40.075, p < 0.01. Confidence in leadership to create an inclusive workplace at the MUHC is not independent of visible minority status at the MUHC. Self-reported visible minorities at the MUHC are less likely to report that they have confidence in the MUHC leadership to create an inclusive workplace than non-visible minorities.

Figure 11: Residual Plot for Pearson's chi-squared test to examine the relation between self-reported visible minority status and confidence in leadership to create an inclusive workplace at the MUHC.
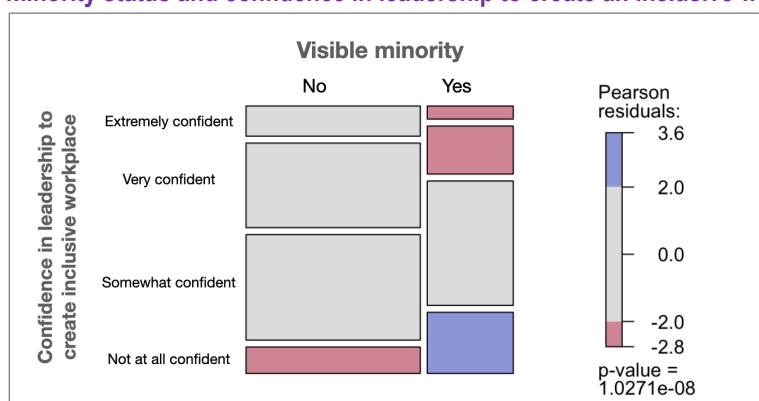
Positive residuals are in blue. Positive values in cells specify an attraction (positive association) between the corresponding row and column variables. Thus, the blue color indicates that the observed value is higher than the expected value if the data were random. Negative residuals are in red. This implies a repulsion (negative association) between the corresponding row and column variables. Thus, the red color specifies that the observed value is lower than the expected value if the data were random.

RI-MUHC: Visible minority status and confidence in leadership to create an inclusive workplace (Q17): The relationship between self-identified visible minority status and confidence in leadership to create an inclusive workplace at the RI-MUHC (Q17) was examined. This relationship is not statistically significant in the RI-MUHC survey data set. Therefore, confidence in leadership to create an inclusive workplace at the RI-MUHC is independent of visible minority status in the RI-MUHC survey data set.

Results for Open-ended Questions

Survey respondents had the option to express their concerns and provide ideas and solutions through three open-ended questions and one multiple-choice question to choose three predefined EDI priorities. The survey questions inquired about the following ideas and solutions:

- Sharing ideas on listed thematic categories (e.g., human resources, patient care) to accomplish the most good and be the most inclusive (Q19)
- To choose three or four pre-listed EDI priorities for MUHC and the RI-MUHC (Q20)
- What do you need from the MUHC and/or RI-MUHC to succeed professionally? (Q21)
- Ideas and suggestions on short-term EDI actions (Q22)

In general, in both surveys, multiple survey respondents used the open-ended questions to leave additional comments regardless of the question. Due to the phenomenon of respondents using the opportunity to provide comments not necessarily related to the question, C-AIDE opted to report emerging themes from open-ended questions and qualitative data together. Emerging themes for both assessments are reported together in section 6: Emergent Themes.

MUHC: Share ideas on listed thematic categories (Q19-write in text field): Keeping in mind the MUHC's mission and the diverse population it serves and employs, survey participants were asked 'What EDI initiatives or ways to integrate EDI into practices should the MUHC and/or RI-MUHC consider adding and/or enhancing to accomplish the most good and be the most inclusive?'. Participants were encouraged to shared ideas on the following themes: (A) Patient Care, (B) Research, (C) Teaching & Training, (D) Human Resources, (E) Communications, (F) Physical Facilities, (G) Resources for Teams, (H) Evaluation of Health Technologies, and (I) Partnerships and Relationships

A total of 351 or 49.3% respondents provided feedback and ideas for the listed themes. 'No comments' or '_Ne sais pas_' responses amounted to12, leaving 339 valid survey responses for analysis (n=339, or 47.6%). The question only had one fillable text field. Themes were listed in the question and survey respondents had no option to choose a category. This caused some confusion and a number of respondents indicated uncertainty on how to answer question 19.

In general, respondents mixed issues and ideas. Some only listed letters, for example A, C, D, but did not specify or provide any more details. Some opted to provide only a comment for one theme while others listed a comment for every theme. Written text responses were coded manually to assign listed themes from the survey question (deductive coding/concept-driven coding). Some responses had to be assigned to multiple themes due to various themes being listed under one or more examples. In addition to the listed themes, the following two codes emerged during analysis: 'Management and Leadership', 'All of the listed themes', and 'No issues or not sure'. The majority of responses addressed ideas and issues for (1) Human Resources, (42.2%), (2) Teaching & Training (41.3%), and (3) Patient Care (26.0%). Evaluation of Health Technologies (5.3%) received the least number of suggestions for listed themes. The inductive emerging theme 'Management and Leadership' received 15.3% of the number of responses per theme.

Question 19 - MUHC: Percentage of survey respondents commenting per theme/category

Theme/Category	Percentage
D: Human Resources	42.2%
C: Teaching & Training	41.3%
A: Patient Care	26.0%
E: Communications	22.1%
G: Resources for Teams	18.9%
Management & Leadership	15.3%
I: Partnerships and Relationships	10.6%
F: Physical Facilities	7.7%
B: Research	5.9%
H: Evaluation of Health Technologies	5.3%
No issues/ No experience of discrimination/	4.4%
All of the listed themes	2.7%

Percentage (%) of survey respondents commenting per theme
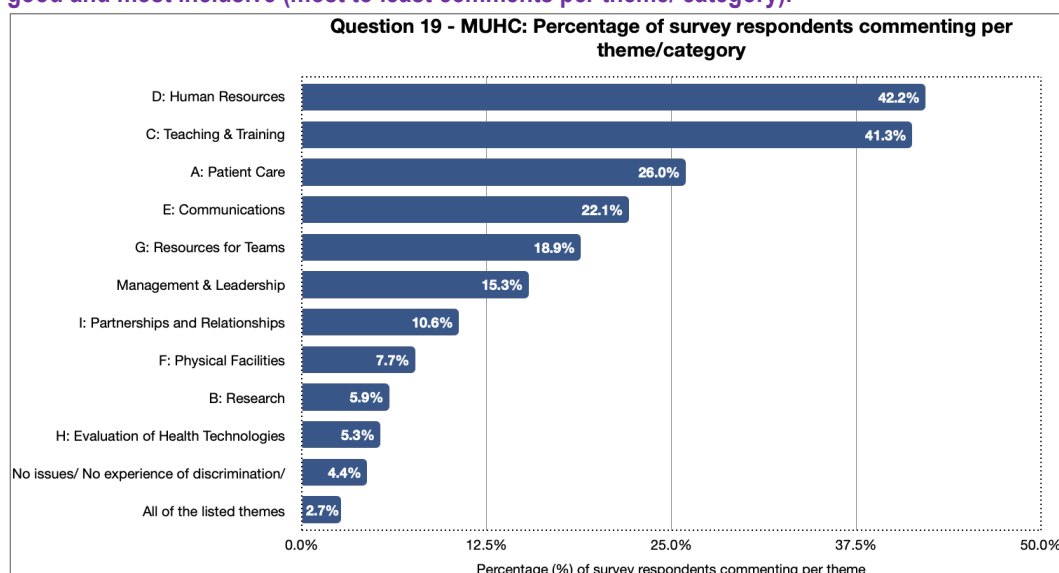
Disaggregated results by self-reported visible minority status by themes for MUHC (Q19): Coded segments were also analyzed by self-reported visible/marginalized minority status. 'Is there a difference between the number of coded segments per theme by self-reported visible minority status and non-visible minority status?' Coded segments by self-reported visible minority status and non-visible minority status by themes do not differ. The difference is not statistically significant (p-value < 0.15).

RI-MUHC: Share ideas on listed thematic categories (Q19-write in text field): For the RI-MUHC, a total of 101 or 44.3% of respondents provided feedback and ideas for the listed themes. Within the written responses, 'NA' or 'no comments' responses were 5, leaving 96 valid survey responses for deductive analysis (n=96, or 42.1%). In addition to the listed themes, the following three codes emerged during the analysis of 'Management and Leadership', and 'All of the listed themes'. The majority of responses addressed ideas and issues for (1) Human Resources, (49.0%), (2) Teaching & Training (47.9%), and (3) Resources for Teams (22.9%). Evaluation of Health Technologies (4.2%) received the least number of suggestions. The inductive emerging theme 'Management and Leadership' received 19.8% of the number of survey responses per theme.

Disaggregated results by self-reported visible minority status by themes for RI-MUHC (Q19): Coded segments were also analyzed by self-reported visible/marginalized minority status. 'Is there a difference between the number of coded segments per theme by self-reported visible minority status and non-visible minority status?' Coded segments by self-reported visible minority status and non-visible minority status by themes do not differ. The difference is not statistically significant (p-value < 0.3).

Figure 13: RI-MUHC-Percentage of survey respondents commenting per category on ideas to accomplish the most good and most inclusive (most to least comments per theme/ category).
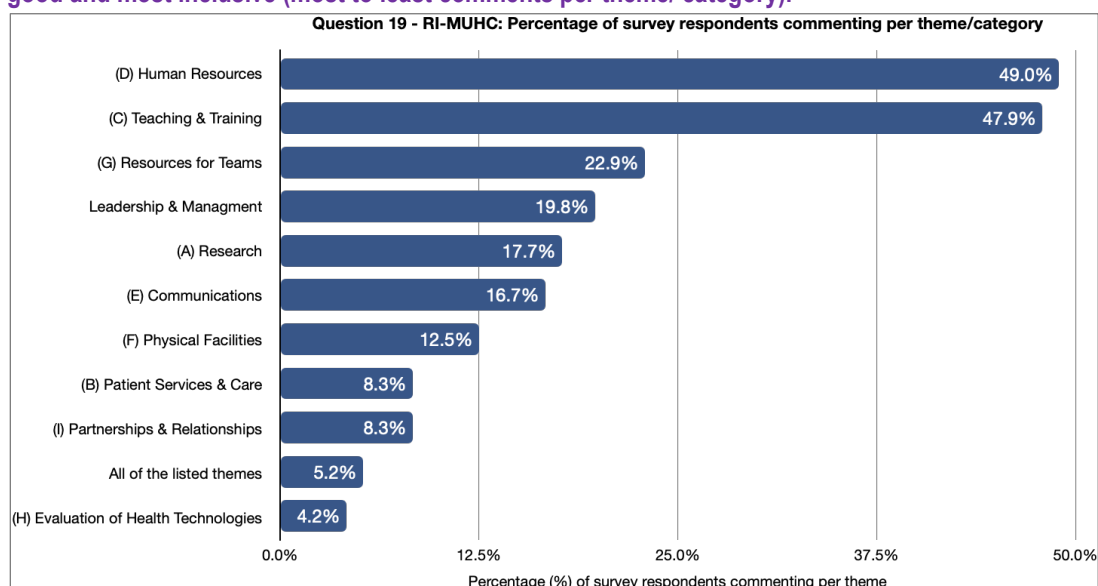

Question 19 - RI-MUHC: Percentage of survey respondents commenting per theme/category

Category	Percentage
(D) Human Resources	49.0%
(C) Teaching & Training	47.9%
(G) Resources for Teams	22.9%
Leadership & Managment	19.8%
(A) Research	17.7%
(E) Communications	16.7%
(F) Physical Facilities	12.5%
(B) Patient Services & Care	8.3%
(I) Partnerships & Relationships	8.3%
All of the listed themes	5.2%
(H) Evaluation of Health Technologies	4.2%

Percentage (%) of survey respondents commenting per theme

Four EDI priorities (Q20): Survey participants were asked what four EDI priorities the MUHC and/or RI-MUHC should be prioritizing. The top four priorities for both the MUHC and RI-MUHC are appear below in table 6.

Table 6 –Top four EDI priorities for MUHC and RI-MUHC survey respondents

|	RI-MUHC		MUHC	
Top 4 Priorities	**Rank**	**(%)**	**Rank**	**(%)**
Make diversity, unconscious bias and cultural safety training mandatory for all existing staff and physicians, as well as new hires (Training)	1	18.6%	1	18.0%
Develop a programme to increase awareness of and celebrate diversity (Program)	3	12.2%	2	11.5%
Train and make available EDI advisors and mentors (Mentor)	4	10.9%	3	11.2%
Improve accessibility and accommodations for those with disabilities (Disability)	2	12.8%	4	10.9%

5. SEMI-STRUCTURED INTERVIEWS AND FOCUS GROUPS RESULTS

Demographics of Participants

C-AIDE interacted with 34 participants through semi-structured interviews, focus group discussions and written responses from the MUHC/RI-MUHC community. Participants' ages ranged from 23 to 83 years. 35.3% listed English, 29.4% listed French, 2.9% listed English and French, and 23.5% listed another language as their native tongue. Roles of participants included patients and caregivers, volunteers, nurses, administrative employees, trainees/students, clinical managers, and physicians. No participant (0%) self-declared as being Indigenous. 61.8% indicated to be a visible minority and/or having an ethnic background. 12.1% self-identified as a member of the 2SLGBTQIA+ community. 17.6% self-identified as a person who lives with a sensory and/or with motor challenge(s).

Equity: 'What is your understanding of equity?'

Equity and equality are similar sounding terms, but the implementation of equality versus that of equity leads to completely different outcomes for marginalized and visible minority groups. "Equality means each individual or group of people is given the same resources or opportunities. Equity recognizes that each person has different circumstances and allocates the exact resources and opportunities needed to reach an equal outcome" (George Washington University, 2020). To connect a simple visual to the two different terms, equality is that everyone gets a ladder to access fruit (Ex.: an apple). Even with equal distribution of the same ladder to every person, the reach of the apple may remain unequal, for example due to height difference of people. However, when one provides a longer ladder for a smaller individual, notably the specific resource a person needs to access the apple, and then we see an equitable solution in action (George Washington University, 2020). Thus, equity allows us to address imbalances in a social system.
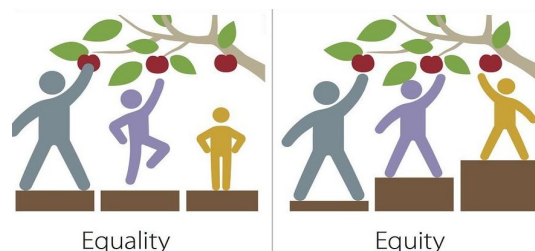
Equality   Equity

Participants were asked about their understanding of equity. No definition or previous explanation were provided to participants. Each participant provided a response to this question. 52.9% of participants had an adequate understanding of what equity is. The majority of participants conveyed that equitable treatment ensures that everyone gets the support they need to succeed. However, 47.1% of participants did not recognize (or describe) that equity needs additional resources and opportunities for people to reach an equal outcome.

For example, participants who recognized the need of addressing the imbalance and providing additional resources and opportunities for people to reach the same outcome described equity as follows:

> "My understanding of equity is to adjust or customize the application of something (like resources, services, etc.) that is relevant to meet the needs of an individual to reach an equal outcome" (Participant identity anonymized)

> « Que tous soient traités équitablement, donc que tous puissent bénéficier des mêmes chances de réussite au sens large, nonobstant leurs caractéristiques biologiques et/ou sociales. Ce qui implique de compenser les manques en tant que système : éduquer le système afin d'éviter les jugements négatifs et favoriser l'auto-

questionnement et l'entraide, fournir aux employés dans le besoin le soutien nécessaire sans en limiter la forme (la bonne solution pour la bonne personne), avoir un processus de dotation exempt de préjugés et axé sur l'adaptation du système à la personne ». (Translation: *"That all are treated equally, i.e., that all have the same chances of success in the broadest sense, notwithstanding their biological and/or social characteristics. This implies compensating for shortcomings as a system: educating the system to avoid negative judgements and to encourage self-questioning and self-help, providing employees in need with the necessary support without limiting the form (the right solution for the right person), having a staffing process free of prejudice and focused on adapting the system to the person"*) (Participant identity anonymized).

"Equity involves offering different levels of support to reduce disparities in opportunities and achieve fairness in outcomes among a multitude of communities. It involves recognizing that each individual experiences different circumstances and allocating the necessary access to resources, opportunity and advancement to reach an equal outcome. It also recognizes that these disparities among communities and individuals are embedded in historical and present-day injustices and obstacles" (Participant identity anonymized).
Participant *(identity anonymized)* even provided specific examples for different groups of the MUHC community:

"Patients: equal access to care, treatment, likelihood of referral to specialist, prioritization for procedures, access to hospitalization, to rehab, to out-patient services, etc."
"Trainees: access to the same training opportunities, e.g., opportunities for funding, invitations to conferences, mentorship, accommodations, etc."

"Staff: equal access to job accommodations, career advancement opportunities, mentorship, equal pay and benefits, etc."

This participant summed the statement up with *"[c]orrecting inequities could require targeted measures be put in place to re-[e]quilibrate. E.g., preferential funding/scholarship of under-represented minorities"*.

In contrast, participants who either did not know the difference between equity and equality, or did not want to address that inequality exists, or indicated that it is not enough to address equality in order to achieve equal outcomes for different groups of people, described 'equity' as follows:

"To me equity means that with equal competency and skills, everyone has […] has equal chances. It means that no one is favoured because of sex, gender, race, etc. I believe this is the foundation of any structure or society, which will lead to diversity and eventually inclusion. I believe that favouring a group of individuals in the name of equity is in complete opposition to the concept of equity" (Participant identity anonymized).

Other participants did not recognize that each person starts out from different circumstances and that additional resources and opportunities need to be allocated for people to reach an equal outcome. These individuals mostly described equality as follows:

"That things are equal, no one is treated differently because of race, gender, sexuality, economic status, disability etc. Everyone has the same opportunities. People are rewarded or penalized in the same manner for the same action". "Well, my understanding of equity is that everybody should be treated equally and not […] discrimination according to age or anything else" (Participant identity anonymized).

Additionally, most of the participants who described equality also mentioned fairness and fair process, but did not mention or recognize that additional steps are needed for it to be equity.

> *"My understanding of equity is that fairness plays a part in the way patients are treated, as well as the way the employees of the MUHC are maintained and compensated". « C'est le fait de traiter toutes personnes de façon juste ». (Translation: "It is about treating all people fairly".)* (Participant identity anonymized).

Understanding the difference between equality and equity is important for society. In the context of the MUHC/RI-MUHC community, understanding the difference between health equality and health equity is even more important to ensure the allocation of healthcare, research and human resources to meet the MUHC/RI-MUHC community members where they are. Inherent to the start of a conversation is that everybody understands that "[t]he routes to achieving equity will not be accomplished through treating everyone equally. It will be achieved by treating everyone justly according to their circumstances." (Race Matters Institute & Paula Dressler, 2014).

Diversity: 'What is your understanding of diversity?'

Focus group and interview participants were asked about their understanding of diversity. As with the equity question, participants were not provided with an example or a definition beforehand. The purpose of this question was to get an insight of how MUHC/RI-MUHC community members view diversity and what associations they make in reference to the term. Each participant provided a response. Participants discussed diversity under a couple of different thematic topics. The majority of the topics were in terms of the fabric of our society (32.3%), the MUHC/RI-MUHC workforce and its diversity (17.6%), in relation to coexisting and being welcome(d) (5.8%), in the context of leadership (5.8%), people's strength (2.9%), that diversity has visible and invisible (hidden) factors/elements (2.9%), and that diversity requires continued investment (2.9%).

Firstly, one common factor among all participants is the tendency to categorize people, intentionally or unintentionally when explaining what diversity meant for them. For example, participants listed visible elements such as gender, race, having a visible disability, age, skin color, religion etc., into which people may be categorized. However, participants also mentioned categorizations such as education, ethnicity, nationality, origin, sexual orientation, job title, family situation, etc., which are often not visible or obvious from one person to the next. Only a small proportion of interview participants acknowledged that there are both visible and invisible (hidden) elements to diversity (2.9%).

For example, one participant described the different attributes/ elements as follows:

> *"My understanding of diversity is the complex social composition of society according to different demographics (e.g., race, religion, ethnicity, nationality, language, gender, economic status, sexuality) [and], physical attributes (weight, height, skin color, other physical features, etc.), [and] disability, values, culture, etc.)"* (Participant identity anonymized).

Secondly, the majority of participants explain their understanding of diversity in relation to 'fabric of our society' (32.3%). 'Fabric of society' is often used as a metaphor for social composition (as in the quote above) or the framework of the social world the person is living in. It relates to the different connections and (inter) relationships we form with one another. The fabric is seen as a common thread of society, thus making everyone part of society as a whole. Since everyone is part of the fabric, interview and focus group participants reflected and discussed diversity in relation to the diverse populations of Canada and Quebec. One participant suggested that the institution should be "aiming to have a body of patients, trainees and staff at the MUHC that reflects the make-up of the Canadian population" when asked about diversity.

Participant (identity anonymized) related to diversity in the following light:

> *"Diversity is having people [with] different social and, […], socio-economic ethnic backgrounds, different genders, different sexual orientations, […] But for example, the Inuit having, […] men, women, transgender, indigenous, […], kind of representative of the fabric of the society we are living in".*

Thirdly, participants also talked about the diversity of the workforce/ staff in general, but also in relation to the MUHC (17.6%). As with the quote relating to the diverse population of Canada, it is important for MUHC/RI-MUHC community members that this diverse make-up of the Canadian and the Quebec population is also reflected within its workforce. It is essential:

> *"[…] to have a space that reflects the population. And so, whether that is in the physicians, whether that is in the leadership, whether that is in the patient population. How do we ensure that we reflect, […] the beauty of Canada and Quebec in all levels of our hospital?"* (Participant identity anonymized).

Additionally, a participant emphasized that having an *"[…] understanding of diversity is having a workforce/community that does not have all the same type of person, and has a mix of opinions, cultures, races, backgrounds, etc."* (Participant identity anonymized). Thus, it is essential for MUHC/RI-MUHC community members that the institution and its workforce reflect the community it is serving.

Last, but not least, participants described and saw diversity as an asset versus a liability. They acknowledged that encountering colleagues and patients who are different from themselves might be uncomfortable at times, but also recognized that these interactions are part of everyday life. Further, despite one's worldview, it is important to recognize that *"there are people and communities around the world who have very diverse ways of seeing and being in the world"* (Participant identity anonymized).

One participant alluded to the beauty of diversity as follows:

> *"Diversity is, […] I think […] appreciating [and] seeing different ethnicities, different orientation, different ages, people with disabilities, people without disabilities, being welcomed in the same environment. So, all, even ways which you can't even describe are welcomed and no one is essentially excluded […], because, creating a safe space that everyone can coexist, all the different types of […] people can coexist, [that is] diversity"* (Participant identity anonymized).

Therefore, diversity can be a rich asset and should be respected, as noted another participant:

> *« La diversité est synonyme de choses différentes qui sont mises ensemble. Par exemple, il y a plusieurs opinions dans un groupe, plusieurs personnes de cultures différentes sur la planète, les apparences physiques sont souvent toutes différentes et uniques et c'est la même chose pour les langues. Pour moi la diversité peut être riche et devrait être respectés en premier ».* (Translation: *"Diversity is about different things being put together. For example, there are many opinions in a group, many people from different cultures on the planet, physical appearances are often all different and unique and the same goes for languages. For me diversity can be rich and should be respected first")* (Participant identity anonymized).

Inclusion: 'What is your understanding of inclusion?'

Focus group and interview participants were asked about their understanding of inclusion. No definition or explanation was provided to participants prior to the interviews or discussions. The purpose of this question was to get an insight of how MUHC/RI-MUHC community members view inclusion and what associations they make in reference to the term. Each participant provided a response. Participants discussed inclusion in a variety of settings, such as the workplace or society, and in relation to visible and non-visible attributes/features such as age, race, sex, gender identity etc. The aforementioned examples of features are often attributed to the exclusion of people from participation due to racism, biases and discrimination. Thus, inclusion was attributed mainly to the rise of feeling of being included and/or welcomed as a person.

73.5% of participants expressed that inclusion for them needs to have the 'feeling of being included' and/or the 'feeling of being welcomed'. The majority of the participants used the word 'feeling' in connection with their description and understanding of inclusion. In contrast to the description of equity and diversity, inclusion involved emotions and feelings. For example, one interview partner described the understanding of inclusion as:

> *"All individuals within a group would feel equally part and important and valued within that group. And so there, that would also mean, […] that there would be no element of exclusion, that there is no one who would feel outside of the group in any way"* (Participant identity anonymized).

Another interview partner referred to inclusion as:

> *"That feeling of belonging. […] you can have a diverse group of people. But the […] vibe of that group, the vibe of each individual person, the way they feel within your organization, it doesn't mean anything without inclusion, right? It can be diverse, but not inclusive. So, the idea of […] feeling valued and feeling […] that sense of belonging"* (Participant identity anonymized).

Yet another participant described it as follows:

> *"Inclusion refers to the concept of belonging; of welcoming and of feeling welcomed, heard and seen; of feeling assured that one will be treated equitably, regardless of one's (for example) race, ethnicity, Indigeneity, socioeconomic class, sexuality, sex, gender identity, ability or religion; of feeling agency to participate actively in the activity/process/institution regardless of one diverse background"* (Participant identity anonymized).

For a majority of participants, inclusion comprises two components: 1) making an effort to adapt and accept differences (mostly in a system) and 2) the rise of the feeling of acceptance on the side of the person ('feeling welcomed and included'), who is judged as being different for this group or in society (in general). Participants provided instances of the intention and the effort to adapt the system for differences (Ex.: making buildings accessible for people with sensory and motor challenges, providing interpretation and translation services for allophone community members and adjusting to the needs of an aging population).

Participant (identity anonymized) explained that:

> *"[i]t could mean storing items that are frequently used by someone using a wheelchair at a height he can reach. It could mean providing materials in text form at a meeting for someone who cannot hear". Inclusion consists of the effort of "[m]aking everyone feel respected, valued and supported" by providing all means necessary for the individual to "have equal opportunity to participate and be genuinely heard and understood".*

One important aspect of the conversation on inclusion was about the fact that not only should people with diverse backgrounds feel included and welcomed, but that minority groups should be respected and have an equal voice in any of the ongoing conversations. In order for a system to be truly inclusive, opinions and advice of all, including minorities, need to be integrated in the decision-making process. One interview participant expressed the concern:

> *"that these people and these diverse backgrounds are included in conversations, and not just included in the sense that they have a seat at the table. But that they have an equal voice so that they […] are part of [the] decision-making process. They are part of change, […] and that's just not, it is not a figure, it's not just 'Oh, now we have someone with a visible, like a disability that we include them. That looks great!"* (Participant identity anonymized).

The above comment addresses tokenism, which may be defined as doing something only to show that you are following rules or doing what is expected or seen to be fair, and not because you really believe it is the right thing to do. (https://dictionary.cambridge.org/dictionary/english/tokenism). It is therefore imperative for all members of the community to be represented, for minority members to have the opportunity to voice their concerns and suggestions, and for all to be listened to and heard to create an inclusive system. By embracing the differences, this system becomes accessible for everyone.

6.   EMERGENT THEMES

Participants shared a variety of incidents that they either experienced themselves or witnessed within the MUHC and/or RI-MUHC. Emergent themes from open-ended questions, survey responses and qualitative assessment of interviews, focus group discussions and written responses to interview questions overlap for the preponderance of the shared topics and stories. The surveys missed the voices of patients/caregivers and possibly trainees/students. However, the qualitative assessment included these two groups and participants took the opportunity to share experiences and concerns related to their needs and ideas. The following section provides an overview and quotes from emergent themes, which appear below in no particular order.

1. Acknowledgement of Systemic Biases and Racism by the Institution:

Participants shared a number of experiences involving racism, discrimination and biases that they encountered themselves or witnessed within the MUHC and/or the RI-MUHC. The reporting of racism, discrimination, and biases were present in both assessment types. A majority of the shared experiences and observations may be classified as racism and to the wider extent as systemic racism. *"Systemic discrimination can be described as patterns of behaviour, policies or practices that are part of the structures of an organization, and which create or perpetuate disadvantage for racialized persons"* (Ontario Human Rights Commission, n.d.). Systemic racism is also *"characterized by a dominant racial hierarchy"* (Zambrana & Williams, 2022, p. 164). Any form of racial discrimination can emanate from individual behaviour and through unintended and unconscious consequences of a discriminatory system resulting in systemic discrimination (Ontario Human Rights Commission, n.d.). Thus, an *"interlocking and reciprocal relationship between the individual, institutional and structural levels"* function together as a whole system and represent *"a system of racism"* (Canadian Race Relations Foundation, n.d.). Survey respondents, interview and focus group participants highlighted:

- **Lack of racial diversity in leadership and management positions throughout the organizational hierarchy**

  "They love to talk about the diversity and there are a lot of Black people but guess where the Black people are? On the ground floor. All of the securities are Black. All of everyone else aren't Black, which is okay. But that's not the hierarchy of diversity that we need" (Participant identity anonymized).

  "I think part of [the] challenge is that I don't see, […] I feel like in certain groups, it's always just like homogeneous, […] you kind of know, and certain committees who will sit in that committee. You kind of know in higher leadership positions […], you kind of know the person or the type of person they are looking for. And I don't feel […] me […] identifying as a minority, I don't feel […] I am included in that" (Participant identity anonymized).

  « Plus de diversité culturelle dans la gestion » (Translation: "*More cultural diversity in management")* (Participant identity anonymized).

  "Making a deliberate and sustained effort to increase representation of members [of] under-represented communities at upper administrative echelons" (Participant identity anonymized).

  "Representation matters at all levels not just hiring visible minority housekeeping and leaving only the cream-so to speak- at the upper echelons who actually wield the power to change" (Participant identity anonymized). *"I need the white leadership to explicitly acknowledge that implicit bias exists in our institution, and that it can result in white people being favoured in advancement, more likely to be praised/rewarded, put in places of power"* (Participant identity anonymized).

- **Lack of diversity in staff and representation of the make-up of the Canadian and Quebec population**

"Ideally, aiming to have a body of patients, trainees and staff at the MUHC that reflects the make-up of the Canadian population" (Participant identity anonymized).

"*How do we ensure that we reflect, […] the beauty of Canada and Quebec in all levels of our hospital?"* (Participant identity anonymized).

« *Plus de visibilité des minorités* ». (Translation: "More visibility of minorities") (Participant identity anonymized).

"*As an academic institution the MUHC appears to favor individuals with higher socio-economic backgrounds. There is a lack of Indigenous representation and other visible minorities"* (Participant identity anonymized).

- **The call to acknowledge that systemic racism exists within the MUHC**

"It should start with the MSS[S] recognizing systemic racism as well as the first step, I think that would be kind of a really important step" (Participant identity anonymized).

« *Reconnaître le racisme systémique* » (Translation: "*Acknowledging systemic racism*") (Participant identity anonymized).

"*Acknowledgement of the systemic racism that exists within the [MUHC]"* (Participant identity anonymized). "*What I hear from people that are on the ground […], for example, […] and […] this is anecdotal evidence, is, that there is systemic racism, that is there at the MUHC as it is in a lot of other places"* (Participant identity anonymized).

"Well first there has to be an admission that systemic racism exists. Without that we have Premier Legault saying that NOT allowing a White man to be appointed as the Commissioner for Anti-Racism is racist. This retarded mentally (sic) is the same flawed leadership that's pervasive throughout all of Quebec's institutions and solidifies the erroneous notion that White (males) are the ones being racially profiled. This also smacks of patriarchy not ally-ship, basically "we know" what's important for BIPOC and the disadvantaged" (Participant identity anonymized).

2. Experiences of Isms and Phobias

Participants shared a variety of experiences of isms and phobias that they encountered themselves or witnessed within the MUHC and/or the RI-MUHC. Please note the isms and phobias that follow are listed in alphabetical order. Participants also shared a number of incidents and expressed ideas and suggestions. While it is impossible to share all the examples gathered, the following section provides scenarios of the type of isms and phobias shared with C-AIDE. Where possible, details of the lived experiences have been included to promote awareness of the nature of the issue at the MUHC and/or RI-MUHC, generate acknowledgment and understanding of the impact of these lived-experiences on minorities, other staff members and on patients/care takers, and include the participants' suggestions and ideas that they wanted to inform C-AIDE's policy recommendations for the MUHC Board of Directors. To protect the anonymity and trust of the participants, C-AIDE could not present in this report some of the explicit incidents and comments shared by participants.

- **Ableism and Ageism**

Ableism and ageism are two isms that survey respondents and qualitative assessment participants highlighted. Ableism is "*simply defined as prejudice and discrimination toward individuals because they are classified as disabled – regardless of whether their impairments are physical or mental, visible or invisible*" (Nario-Redmond, 2020, p. 6). Ageism, on the other hand, "*refers to the stereotypes (how we think), prejudice (how we feel) and discrimination (how we act) towards others or oneself based on age*" (World Health Organization, 2021). Of the qualitative assessment participants, 23.5% mentioned ableism and 20.6% mentioned ageism. Ableism and ageism were also mentioned in the survey under questions 15, 19 and 21. Both topics were discussed often together or after each other. Experiences shared include incidents personally encountered or witnessed within the MUHC and/or RI-MUHC. The three major concerns are a) accessibility of physical and virtual spaces for people with sensory and/or motor challenges, b) mistreatment of employees and patients with sensory and/or motor challenges (conscious or unconscious) and c) ableism and ageism biases in recruitment and hiring at the MUHC.

First, employees and patients expressed concerns and reported issues concerning the accessibility of buildings for people in wheelchairs, people who are deaf and/or hearing impaired, and people who are blind or visually impaired. The lack of usage of American Sign Language (ASL) for the Web site and for in-person interpreters was also mentioned during the discussions. For example, one participant shared the following concerns with C-AIDE:

> *"Challenges? It's the accessibility that is terrible for people in wheelchairs. And also for a person that's deaf and hearing impaired. It's not good at all. If you look at [the MUHC] website, there's nothing pertaining to a person that's deaf. There's no ASL which I think it should be incorporated on the website, because deaf people [not all of them can] read […]. And a lot of people don't realize that. And even when you go in person, and you need an ASL interpreter. It's difficult for some people […]. And the accessibility […] for wheelchairs, we shouldn't have to travel around the hospital to different floors just to use a bathroom because our wheelchair can't get into all bathrooms. This is a new hospital that was built and it doesn't make sense to me. Why are you getting people [that are] walking to do something for somebody in a wheelchair? Where are you getting people that hear to do something for people [that are] deaf? I don't understand that logic because a person that's deafening (sic) and hearing impaired it's not the same as a person that hears. You need to go to the source. It's the same thing for people [that are] blind. You need to go to the source. My concern was, there was a code silver called back, I think it was last summer. […]. And […] I was really concerned because I wanted to know what happens to the person that's hearing impaired or deaf. How do they know? How can they go to safety? How are they [singled] out? Because if it's announced over the PA system, we are not hearing it. We don't understand what's being said on the PA system. And if you're gonna put it on a screen, the deaf person can't read it. So, what's done? What's being done? How do you get people in a wheelchair out safely, […] and a blind person? What's being done […] for this?"* (Participant identity anonymized).

A general call to "*improve accessibility of MNH, MGH and Lachine sites for people with disabilities*" was echoed by another participant. Disappointment in the newly constructed MUHC Glen site building was expressed. It was suggested to go beyond the standards in terms of accessibility for people with disabilities to correct the poor physical environment:

> *« Il faut aller au-delà des normes en termes d'accessibilité pour les gens en situation de handicap. Pour un nouvel hôpital [qu'est] le Glen, nous entendons souvent qu'il n'est pas du tout accessible. Inclure l'avis des gens qui le vivent à tous les jours afin d'être plus accessible. La cafétéria n'a pas de micro-onde au Glen. Ceci est difficile à expliquer pour les gens qui viennent pour un rendez-vous et ne pourrons pas*

réchauffer leur nourriture. Ou pour les familles qui veulent réchauffer leurs bouteilles/nourriture pour leurs enfants. Cela crée une disparité pour ses gens ». (Translation: "*We need to go beyond the standards in terms of accessibility for people with disabilities. For a new hospital like the Glen, we often hear that it is not accessible at all. Include the opinion of the people who live it every day in order to be more accessible. The cafeteria does not have a microwave at the Glen. This is difficult to explain to people who come for an appointment and will not be able to heat up their food or for families who want to heat up their bottles/food for their children. This creates a disparity for these people"*) (Participant identity anonymized).

Secondly, participants addressed the treatment of employees and patients with sensory and/or motor challenges. The shared experiences involved conscious or unconscious bias from healthcare personnel and/or work colleagues and supervisors/managers. One participant shared with C-AIDE that almost every time the person has an appointment at the MUHC, the person does everything in the person's power beforehand to inform healthcare personnel about the person's need of assistance due to the use of a motorized wheelchair. Motorized wheelchairs are wider as compared to a standard manual wheelchair used in the hospital. Therefore, one of the major issues the participant encounters at the MUHC is how to get to appointments on different floors and in various buildings. The person also shared how difficult this situation can get when healthcare personnel has been informed of the need of the patient in advance, but is surprised and taken aback when the patient shows up in a motorized wheelchair.

> "*For an example, if you are going to a [specialist], you know you tell them I'm in a wheelchair, I'm gonna need help, and they tell you 'Yeah don't worry about it'. And then, when you reach the appointment it's like 'Oh, well, you should have told us'. BUT I DID!!!*" (Participant identity anonymized).

The participant also emphasized that a solution healthcare personnel suggest frequently is to transfer to a manual hospital wheelchair. This is not the best or practical solution for the person's health and autonomy. Another participant shared concerns regarding observations made at the MUHC on how aging and people with physical and intellectual disabilities are treated. The person expressed concerns as follows:

> "*[…] I work in X department, and often witness […] patients, when they come to the emergency for example, being rushed or neglected because of their age, frailty, the complexity of their medical condition and fears their discharge will be delayed because of loss of autonomy. There is discrimination against people who are expected to take up beds, time etc. compared to younger people with single diagnoses and no social complications. The same applies to people with physical and intellectual disabilities and mental illness, homeless people, people with unpleasant characters, and anyone else whose life situation is precarious for whatever reason*" (Participant identity anonymized).

Other participants also expressed concerns regarding the treatment of older patients at the MUHC. One reported that they had witnessed on multiple occasions that seniors were not informed about changes in their care plan, surgical procedures or transportation to other wards or facilities.

> *« Combien de patients j'ai vu faire un séjour à l'hôpital ignorant complètement l'orientation [du] plan de soin... découvrir que tu vas en opération quand le transport arrive! Découvrir qu'il[s] sont transférés dans un autre [CH (centre hospitalier] quand l'ambulance arrive !!! Pourquoi ces personnes (patients) ne sont pas informé[e]s? Parce qu'ils sont des aînés? Ça ne vaut pas la peine de leur expliquer? Oui, nos patients aînés eux aussi vivent des injustices. Souvent, ils sont « overlooked » et pas informés. Je ne pense PAS qu'ils bénéficient d'inclusion. Et certains MD manquent de courtoisie, il y a un minimum de grandes lignes qu'il faut communiquer aux patients aînés, car nos aînés ne sont pas tous incapable de communiquer ou de comprendre »* (Translation:

"How many patients have I seen go to hospital completely unaware of the direction of the care plan... find out you are going into surgery when the transport arrives! Find out they are being transferred to another ward when the ambulance arrives! Why aren't these people (patients) informed? Because they are seniors? Isn't it worth explaining to them? Yes, our elderly patients also experience injustice. Often they are overlooked and not informed. I do NOT think they benefit from inclusion. And some MD's lack courtesy, there is a minimum outline that needs to be communicated to senior patients, as not all of our seniors are unable to communicate or understand") (Participant identity anonymized).

Thirdly, examples were shared regarding ageism and the biases in recruitment and hiring process for the MUHC. Participants voiced concerns about practices and biases as to the exclusion of people with motor- and/or sensory challenge(s) and excluding older applicants.

A participant (identity anonymized) stated:

"*In most organizations, diversity is narrowly defined as gender, skin colour, and national/ethnic origin. Ageism and ableism remain commonplace, with little effort made to facilitate the early steps of the application process for people with sensory or mobility issues, and with the date of birth or date of graduation from university often used as a means to exclude older applicants as overqualified".*

Another participant shared the person's experience on the hiring process and additional administrative actions needed to establish the person's needs for the workplace. The person shared that, as per the MUHC mandate, a medical exam by a physician is required. The participant explained that they were "subjected to every possible prejudice and inappropriate comment" regarding the person's health and disability. A participant (identity anonymized) stated that during the medical examination the following comments were made:

o « *nier le fait que j'ai un handicap […] et me faire volontairement mal pendant l'examen physique »,* (Translation: *"denying that I have a disability [..] and deliberately hurting me during the physical examination");*
o « *me dire que je suis grosse et que je devrais lire le livre « SOS, j'ai toujours faim »,* (Translation: *"telling me that I am fat and that I should read the book 'SOS, I am always hungry'");*
o « *que je suis trop souvent malade et que je vais manquer trop de jours de travail »* (Translation: *"that I am sick too often and will miss too many days of work");*
o « *prétendre que je veux entrer au CUSM juste pour pouvoir me mettre en arrêt maladie après 2 ans »* (Translation: *"claiming that I want to go to the MUHC just so I can go on sick leave after two years");*
o « *et finir par me dire [qu'elle/qu'il] va recommander que mon contrat soit annulé parce que je n'aurais pas dû être embauchée selon [elle/il] ».* (Translation: "*and end up telling me that [the person is] going to recommend that my contract be cancelled because [the person] thinks I shouldn't have been hired").*

The participant emphasized that this experience was *"truly one of the worst experiences of* [the person's life]. If the individual hadn't already started working at the MUHC and found that this was not at all the opinion of the manager and the MUHC HR contact, the participant would have refused the job and complained. Additionally, the participant stated « *Comment parle-t-on aux patients si on traite nos collègues de la sorte? »* (Translation: "*How do we talk to patients if we treat our colleagues this way?")*

- **Anti-Asian Racism**

Anti-Asian racism was another ism survey respondents and qualitative assessment participants reported on. *"In Canada, anti-Asian racism refers to historical and ongoing discrimination, negative stereotyping, and injustice experienced by peoples of Asian heritage, based on others' assumptions about their ethnicity and nationality. Peoples of Asian heritage are subjected to specific overt and subtle racist tropes and stereotypes at individual and systemic levels, which lead to their ongoing social, economic, political and cultural marginalization, disadvantage and unequal treatment"* (Government of Canada, 2022). For example, at the beginning of the COVID-19 pandemic, police-reported hate crimes against East and Southeast Asians in Canada jumped by 301 percent (2019: 67; 2020: 269) (Wang & Moreau, 2022, p. 14). Thus, survey, interview and focus group discussion participants expressed their concern with regard to incidences of anti-Asian racism at the MUHC and/or the RI-MUHC. Participants shared concerns regarding negative stereotyping of people with Asian heritage, overt and subtle racist comments by individual members of the MUHC community, incidence of cross-race effect, and the need of the institution to acknowledge that anti-Asian racism exists within the MUHC/RI-MUHC. Reported incidents of anti-Asian racism involve patients, as well as MUHC employees.

For the qualitative assessment, 2.9% participants shared lived experiences of anti-Asian racism. Issues and incidents regarding anti-Asian racism were also raised in survey responses. Survey participants expressed their concerns under questions 14, 15 and 22. The following quotes are examples of anti-Asian racism shared with C-AIDE:

> "[A]cknowledge that Asians also get discriminated against (currently a lot of the discourse is focused on Black and Indigenous populations, and rightfully they should receive a lot of attention)" (Participant identity anonymized).

> "[P]atients using inappropriate words/terms associated to my Chinese heritage (mostly unconsciously)". (Participant identity anonymized).

> "Witnessed [department] and HR manager making judgements on candidates […] after interview based on racial stereotypes (e.g., 'You can see [the person] is very Asian- very black and white [thinking], will have difficulty dealing with ambiguity' and 'I once had a manager who was Chinese - he was very much a perfectionist, this candidate will be the same, will overwork, it is in 'their culture')" (Participant identity anonymized).

> "There was once that I heard a […] nurse at the [department] say to another […] nurse '[name], open your eyes, you're not Chinese!' There were more than 4 nurses sitting in the charting area, who all heard what [the person] said; however, they were all laughing and giggling, and no one stopped [the person]. I was surprised to find a group of employees at MUHC could be this racist and shameless" (Participant identity anonymized).

> « Depuis la pandémie, il y a eu une augmentation de sentiments anti-asiatiques qu'on a pu observée dans les nouvelles. On entend par-ci et par-là le virus chinois, c'est absurde d'entendre des préjugés de cette nature. Le CUSM reste silencieux sur cet enjeu. Pourtant, c'est une belle occasion pour les gestionnaires de sensibiliser tout le personnel du CUSM sur ce sujet ». (Translation: *"Since the pandemic, there has been an increase in anti-Asian sentiment in the news. You hear the Chinese virus here and there, it's absurd to hear prejudice of this nature. The MUHC remains silent on this issue. Yet this is a great opportunity for managers to raise awareness of this issue among all MUHC staff"*) (Participant identity anonymized).

"I was on a specific unit. I had my ID on, but I was […] really coming as more [of] a family member. But […] I came after work, I had my bag on and my ID and this person […] walks towards me, and says, 'oh, goodbye', and gives me a name. And I am like 'No, I'm not this person'! […] Clearly, this person didn't realize that like: NOT all Asians look the same. […] I'm my own self, […] […] maybe you have someone, […]. [Or] maybe it was the mask that was a mistake. But as soon as I said, 'I'm not, no, like you have the wrong person'. I think [the person] didn't know how to respond and kind of said like 'Oh, Ok!', and then left. And clearly [the person…] thought I was someone part of [the person's] team, and [the person] was very polite and nice, and saying bye to me, at the end of the day. But you know "Not all Asians look the same!!!") (Participant identity anonymized).

- **Anti-Black Racism**

Anti-Black racism was another ism survey respondents and qualitative assessment participants stated. Anti-Black racism, as first expressed by Dr. Akua Benjamin in Canada and defined by the Black Health Alliance, is "*policies and practices rooted in Canadian institutions such as, education, health care, and justice that mirror and reinforce beliefs, attitudes, prejudice, stereotyping and/or discrimination towards people of Black-African descent.*" This definition aims to highlight *"the unique nature of systemic racism on Black-Canadians and the history, as well as experiences of slavery and colonization of people of Black-African descent in Canada"* (Black Health Alliance, n.d.).

In total, 8.8% of qualitative assessment participants shared experiences of anti-Black racism at the MUHC and/or RI-MUHC. Survey participants shared experiences and observations of anti-Black racism throughout the survey questions. Anti-Black racism incidents shared with C-AIDE involved patients, family members, co-workers and supervisors/ managers. The following quotes are examples of shared lived experiences and observations by participants:

"I was called the N word and struck by my manager [multiple] times. HR did not discipline my manager nor did HR take any initiatives to provide me with a safe working environment to protect me from harm so the abusive behaviour of my manager persisted, and the HR agents got promoted" (Participant identity anonymized).

"Co-workers maki[n]g fun of Black people" (Participant identity anonymized).

"[I] and another racialized colleague were told by a manager that us not taking our breaks to keep up with the work made us [the person's] little slaves" (Participant identity anonymized).

"I observed on several [occasions] the head security guard […], speak very condescending towards [the person's] staff, who were disproportionately Black (Haitian), both male and female. [The person] spoke to them in a way that I would imagine a security guard in a prison would speak to the [inmates]. I would often discuss with the security staff afterwards how I thought [the person's] behaviour was inappropriate. I wish I had had the opportunity to address this with [the person's] supervisor" (Participant identity anonymized).

"When [the person] came upstairs before [the person] spoke, 'where's the ID?', 'Where is [your] ID?'. So, I looked, and said, 'Well, here are all my things. Here's my name, here's my face, there's everything, you can ask [my co-worker]'. Then [the person] asked [my co-worker] 'Does he work for you?'. When [the person] was doing this, everyone is now looking because the one black guy is being followed by a security guard. So, it is so expected. You know what I mean? And I am now so ashamed, and everyone is looking. Everyone is looking, everyone […] is looking, 'Why is the security here? Like what's happening?'. Why is he following [the person]?" (Participant identity anonymized).

Evidence leads C-AIDE to determine that anti-Black racism is present within the MUHC community. Based on the emergent literature in Canada, the reality of Afro-Canadian and Caribbean populations is not recognized, understood or addressed, and even less is known about the health of Black populations in Quebec. As the heart-wrenching, highly publicized assaults on Black individuals in the USA, Toronto and Montreal, coupled with the eye-opening healthcare inequities observed during the COVID-19 pandemic, including among seniors and healthcare workers in long-term-care centres, have demonstrated, inequity and racism are disease equivalents in terms of impact, and contribute to complexity and poor health outcomes. Despite progress and societal reform, racism lingers, contributing to higher rates of chronic diseases and mistrust, leading to over-representation of Blacks in the in-patient setting and under-representation in the outpatient setting. Further, the historical lack of participation of the Black population in research studies has created knowledge gaps in best practices.

As Nobel laureate, the late Toni Morrison once asked, "What motivates the human condition to construct others? Why do others make us afraid?" Perhaps one malleable piece of the puzzle may be ignorance stemming from lack of formal or informal education pertaining to matters of race, racism, social determinants of health, and the powerful impacts on the lives of Black, Indigenous, other people of color and other equity seeking groups. This should not be surprising, given the historical exclusion of large periods of Black Canadian history from elementary, secondary and post-secondary curricula. This has resulted in a lack of understanding of historical adversities such as slavery, segregation and other race-based exclusion from health, educational, social and economic resources in the socioeconomic disparities observed across North America today, including at the MUHC, RI-MUHC and elsewhere in Quebec's healthcare system. However, there is an unseen benefit. Education, empathy and humility are key. Through ongoing debate of systemic racism within our communities and its commitment for EDI, it is the MUHC's obligation to not only raise awareness of inequities and racism in healthcare, but also to implement measures to stop the erosion of Black history in Canada stemming from anti-Black racism, be it unconscious, overt, covert or systemic.

- **Anti-Indigenous Racism**

Anti-Indigenous racism was another ism about which survey respondents and qualitative assessment participants expressed their concerns. *"Anti-indigenous racism or indigenous specific racism is the ongoing race- based discrimination, negative stereotyping, and injustice experienced by Indigenous peoples within Canada. It includes ideas and practices that establish, maintain and perpetuate power imbalances, systemic barriers, and inequitable outcomes that stem from the legacy of colonial policies and practices in Canada"* (Government of Ontario, 2022; Loppie et al., 2020; Wabano Centre for Aboriginal Health in Partnership with the Ottawa Aboriginal Coalition, 2022, p. 6). The video documenting mistreatment and death of Joyce Echaquan, an Indigenous woman and mother of seven, caused a national outcry and calls for political leaders in Quebec to acknowledge the presence of systemic racism in the province.

Initially, a few members of the Indigenous community expressed interest in participating in the focus groups, but after reflection they indicated that given the emergent developments around Truth and Reconciliation issues, what they perceived as another act of systemic tokenism, and their concerns that western paradigms of research did not respect their culture, they chose not to engage in the EDI study. In the end, 1.1% of survey respondents and 0% of qualitative assessment participants self-identify as Indigenous.

The majority of shared incidents are observations made by participants who addressed 1) the treatment and quality of care that Indigenous patients receive at the MUHC, 2) the lack of Indigenous representation within MUHC staff, and 3) the wish and need to include a land recognition statement on the MUHC Web site and in the physical spaces of the hospitals.

For the qualitative assessment, 32.3% participants mentioned issues and observations. Issues and incidents regarding the treatment and care that Indigenous patients are receiving were also raised in survey responses. Survey participants expressed their concerns under questions 15, 19 and 22. The majority of shared concerns and experiences addressed treatment of Indigenous people and the quality-of-care Indigenous patients receive at the MUHC. For example, one participant shared the treatment of an Indigenous woman during labour:

"And [I will] name one to kind of go with the theme of Indigenous maternal health. We […] had a patient that came […] in labour. She was brought in by an ambulance. She was homeless, and had been drinking. And there was a lot of judgment that she received, and I would say that the care […] that she had during […] her labour was really, really subpar to what another person would have received. And that's really disappointing; I was very shocked by that, and when I took over, […], I kind of was appalled by the things that weren't done for this woman. And I think there's a lot of lessons to be learned by that example. Definitely there's a need for our staff to be trained in trauma informed care" (Participant identity anonymized).

Another participant related concerns regarding the quality of care that Indigenous patients receive, and the lack of understanding of traditional healing, which incorporates health practices, approaches, knowledge and beliefs of Indigenous wellness.

"We care for a huge population of Indigenous people from [...] any age group, from the children, from paediatrics, like we serve [the] population up North, and even [with] adults, where we have a huge population in our trauma center, yet I don't think […] we apply the same principles of how we care for any trauma patient to that population. And yes, we have translators. We have people who accompany them, but […] I don't feel like we include them in conversations. Like they are there to help us kind of achieve our needs. But I'm not sure we really understand what the patient wants and how they see their health experience. […] I think it's to serve us as professionals. But I'm not sure how well it serves the patient. Even […] the way [how] we care for that population. I'm not sure we truly understand their culture, their belief system, how they see health episode[s]. I think there's a lot of, […] you generalize all: 'they are here again, for of course it's related to this issue'. […] We just categorize them as the same, they always come because they [got] into an accident, of course, and it's related to this, of course. So, I think we just generalize" (Participant identity anonymized).

Another participant noted:

« Des soins donnés à des patientes/familles autochtones qui ne sont pas culturellement sécuritaires, des commentaires discriminatoires, une approche non adaptée ». (Translation: *"Care given to Indigenous patients/families that is not culturally safe, discriminatory comments, inappropriate approach")* (Participant identity anonymized).

Yet another participant not only conveyed concerns regarding the quality of care and treatment of indigenous patients, but also the inequitable approach regarding translation and interpretation services, the absence of additional food options available, the absence of a holistic approach, as well as the need to realize the impact of an unfamiliar environment on Indigenous patients.

"When it comes to patients, there's definitely improvements to be made in my opinion. Not only in our attitude towards our patients, […], we need to learn a lesson about how we treat each other in the workplace, and how we treat our patients. Because in some cases that's different, unfortunately, and as an institution like in general, there's definitely some barriers that can be removed when it comes to equity. For example, with the indigenous population: […] They come to give birth often. I

work in the birthing center and they are in a completely unfamiliar environment. Some of them have never been to the city before, have never been to Montreal. They speak a different language. […] It is such a huge culture shock […and] to [come] alone as well. Some people will have an escort come, but only later and it's only one person. There are just so many challenges in that situation, and I don't think that's being addressed enough. They don't eat the food that they are not used to eating. They don't have their families with them. They don't speak the language often. So there's just a multitude of challenges that we are not addressing and that's something that we can learn from them actually because in, I don't want to speak for them, but there's the idea that there's not only physical health but there's mental, emotional, and spiritual health that need to be addressed in order to have a holistic understanding of […] our well-being, and that's a cue that we can take from them in multiple instances. But to keep going with the same example: If we were to address some of these emotional needs, having a more of a home setting, being more accommodating to family members and helping, […], increase the number of escorts or people that can come down South to be with them in this moment, being appreciative, and maybe incorporating, […] some of their traditional medicines that are used in different instances, will help ultimately with their physical health. If those other things are being respected and appreciated about them. So yeah, that there's definitely room for improvement" (Participant identity anonymized).

Other participants talked about Indigenous patients, their connection to the land and made suggestions on how the hospital and the hospital space needs to evaluate current policies and practices to welcome and accommodate Indigenous people more. One person acknowledged that in order to change the system it might be helpful to try to see solutions that are kind of out of the box a little bit. For example, the person explained the following with regards to space for living plants in the hospital:

"If the rule says, 'You're not allowed to have a plant in a space', how can we instead of just saying right away: Let's not put plants because we're not allowed to do it! Let's think about it! How can we […] go around that? Is there a way? Is there something we need to change? [Are] there things around that […] can be done more than putting a false plant [in the hospital corridor]? So […] kind of things like that […] taking a step back to look at the policies in place, and see […] how those can be kind of modified, so that we accommodate different […] cultures and their beliefs so that they feel safe in the hospital and that they feel that it's their hospital [too]. I think that's super important". (Participant identity anonymized).

Another participant suggested allocating space for a smudge room for Indigenous patients and caregivers and encouraged the MUHC to strengthen collaboration with the Indigenous Health Centre of Tioak_te (IHCT) (Participant identity anonymized).

Participants also shared observations regarding discriminatory comments and micro-aggressions made towards indigenous patients.

« *Malheureusement beaucoup de préjugés, notamment face aux individus/familles de communautés autochtones* ». (Translation: *"Unfortunately there is a lot of prejudice, especially towards individuals/families from Indigenous communities"*) (Participant identity anonymized).

"I've noticed when some people work with Indigenous patients, they sometimes approach them in a manner which comes of[f] as 'belittling' (in my opinion)" (Participant identity anonymized).

One micro-aggression shared is the following:

"My [MUHC staff person's job category] called Indigenous people a bunch of drunks at a work meeting and said that's why our department would not be providing care to this group. The person was very vengeful so I didn't report [the person], as I didn't have a method to do so safely. I have heard clinicians making negative comments about Indigenous people coming for surgery related to their behaviour when they arrive in Montreal" (Participant identity anonymized).

Participants also addressed the lack of representation of Indigenous people within the MUHC staff and the need to hire Indigenous community members. For example:

"I tried to have an Indigenous person hired on a research project but because of specific hiring guidelines/educational requirements it was not feasible" (Participant identity anonymized).

"We need to hire more Indigenous people. I think that [is…] in a lot of the reports as well and I think there's a lot of buzz around that as well. It's not so easy to do. But, […] to make all the efforts, put all the extra efforts to do [it] that would be great and recognize that and celebrate that, if we're able to do [so]" (Participant identity anonymized).

Lastly, participants mentioned the wish and need to include a land recognition statement on the MUHC website and in the physical spaces. Acknowledging the land is to express gratitude to those who reside on this land and to honour the Indigenous peoples who have lived and worked on this land historically and presently.

"We at the MUHC, we […] say a lot of things. We say what […our…] values are, […], Dr. Gfeller, I think in September sent out a memo about the […] Indigenous situation with Joyce Echaquan and then […] there is nothing a lot more that I see happening. […] What made me think about it was that I was looking for: […] What is the land that MUHC sits on? Now we have many sites, but what is […] the Indigenous land that we […] sit on, and that. And I looked on our website! And it wasn't appearing there! But I thought well for […] such an organization that really has a huge population [which] is our Indigenous community, why is that not there?" (Participant identity anonymized).

"So, it's basically that, […], and that's the case for a lot of the different hospitals if you go to Sick Kids in Toronto or the Ottawa General, they would have a land acknowledgement statement at the entrance of their hospital. Or on their website, both. Saying that we recognize that we are on the land of and on Mohawk territory, [unseeded]. And I think that […] would be […] very powerful if we could do that. I know those are just words but they are very important words […]. And I'm not sure why it hasn't been done because I know that there's a lot of interest […] on the part of […] high level management to […] work with Indigenous people and so I don't understand why […] this piece hasn't been done yet" (Participant identity anonymized).

- **Gender Bias and Discrimination (Cis-heterosexism)**

Gender-based discrimination and biases were also listed and shared with C-AIDE during both assessment types. Gender bias is the tendency to favour one gender over another (Rothchild, 2014). The most prominent form of gender bias is the act of preferring men over women (and boys over girls) and usually results in negative ramifications for women (Cook, 2016; Rothchild, 2014). Gender bias can involve unconscious or implicit bias and takes place when an individual (consciously or unconsciously) attributes certain characteristics and stereotypes to a person or a group of people. The ascribed attributes and behaviours influence how this individual engages and understands the other person or group.

Survey respondents and interview participants provided reports of sexism (or sexual harassment), which is an overt manifestation of gender bias and discrimination based on a person's sex. Please find quotes and examples in a section titled '2SLGBTQIA+ and Gender Diverse Population(s)'.

For the qualitative assessment, 11.8% of participants mentioned incidents and observations related to gender bias and discrimination. Survey participants reported incidents and observations and expressed their concerns under questions 14, 15, 19, and 22.

Survey respondents and qualitative assessment participants reported gender biases and discriminations, such as differential treatment due to a person's gender (mostly due to being a woman), perceived stereotypes within healthcare professions (such as a nurse 'has to be' female and a physician 'has to be' male), gendered power dynamics (such as not being able to voice concerns and ideas due to male dominated discussions), inequity in promotion and compensation, and the inequity in power dynamics and hierarchical structure of the organization. One consistent shared concern was that women reported facing barriers that prevent them from reaching upper-level roles in management and leadership due to male dominated discussions and positions. The following quotes are examples of shared incidents and microaggressions directed towards women at the MUHC:

> "*Listen little girl...*" *and* "*I don't know why they keep hiring more women to be in charge here*" *(*Participant identity anonymized).

> « *Quelques occasions seulement, différence de traitement en lien avec mon genre* » (Translation: *"On a few occasions only, different treatment related to my gender"*) (Participant identity anonymized).

> *"This is what has been said about me to a colleague: 'I will do everything in my power to make sure that that uppity (insert slur) is run out of here. She should know her place"* (Participant identity anonymized).

> "*Just being a woman, you are sometimes treated differently*" (Participant identity anonymized).

> *"And status […] in the organization, I feel like whenever I'm in a room for an interdisciplinary forum, where there are physicians who are male and they dominate the conversations and also make decisions. Everything has to be, […] related to this male physician speaking because either he has been louder or they react louder, so we don't want to cause trouble. We don't want to cause, […], we don't want this physician to react to us. […] if I just look at male and female, […] even that, I feel […], it's not equal. […], I don't have an equal voice, because […] their status, […] decisions are made surrounding their priorities, and I'm not and find […] other professionals can voice their priorities. But in the end, all the decisions are made by them so there's really sometimes no point. And then […] it's like people saying 'Oh, well there's no point in […] saying anything because he's male'. This person can get away with a lot of other things that if a female person would have said and done would not have, and would be frowned upon. And because of male, even if it doesn't make sense what they are saying, they just seem to have an advantage over decision-making, position, power, [and] influence. So, I think, just from that itself, it is not equal"* (Participant identity anonymized).

> *"I am white, cis, and straight. Things are pretty easy for me. The only aspect of my identity that I sometimes feel prevents me from 'thriving' is that I am a woman. I am so fortunate to have many wonderful female colleagues and supportive male colleagues, but there are nonetheless challenging moments. For example, when collaborating with my male colleague in patient care, patients will call me his assistant, his student, or the nurse, while he is Dr. So-and-So (neither of us are nurses or*

physicians. It is also bothersome that using 'nurse' and 'physician' insinuates a gendered power dynamic). With certain male colleagues, being called 'frustrated' or being perceived as aggressive if I mirror their communication style, which is often necessary to get a word in. Having these same colleagues mostly address other men, thank other men, or take no acknowledge that an idea came from a woman" (Participant identity anonymized).

"On occasion, in the distant past, patients have mistakenly assumed that I am a nurse (as opposed to an MD)" (Participant identity anonymized).

« J'ai une collègue feminine qui a été écartée de certains processus de recrutement parce qu`[elle avait prévue un congé de maternité]. Je trouve cela complètement aberrant. Cela ne devrait pas se produire. ... Laissez la place aux femmes et ne pas les limiter dans leur carrière parce qu'elles sont en train de construire leur famille ». (Translation: *"I have a female colleague who was passed over for some recruitment processes because she had planned maternity leave. I find this completely aberrant. This should not happen. ... Make room for women and don't limit them in their careers because they are building their families")* (Participant identity anonymized).

"*Due to my position in the hierarchy, and being a younger wom[a]n, my opinions are not valued as much as my manager, for example, despite having more qualifications and experience in certain fields"* (Participant identity anonymized).

"*Equality between female/male employees (salary) and secretaries/nurses/doctors (respect)"* (Participant identity anonymized).

« S'assurer que les femmes et les hommes sont traités égaux » (Translation: *"Ensure that women and men are treated equally")* (Participant identity anonymized).

"*Fair pay for female-dominated positions would also be good, we are grossly underpaid in the […] department"* (Participant identity anonymized).

"*The [position title] must stand for the rights of female [M]uslim hijabs or the MUHC is participating in the gender and religious exclusion of many. You can certainly cover your face now, and we must represent the public we serve with the diversity we accept at the hospital. The [name of the department] must not support a department head when it is recognized that their leadership has been the cause of the exodus of a disproportionate number of women over men as in the [name of the] department"* (Participant identity anonymized).

- **2SLGBTQIA+ and Gender Diverse Population(s)**

Survey respondents reported situations of homophobia, transphobia and other forms of phobia against 2SLGBTQIA+ (two-spirit, lesbian, gay, bisexual, transgender, queer or questioning, intersex, asexual and other) and related mistrust by employees and patients. Homophobia is defined as the irrational aversion to, or fear or hatred of gay, lesbian or bisexual people and communities, or to behaviours stereotyped as homosexual (Ontario Human Rights Commission, 2022a). Biphobia is fear, hatred, discomfort, or mistrust, specifically of people who are bisexual. Similarly, transphobia is fear, hatred, discomfort with, or mistrust of people who are transgender, genderqueer, or do not follow traditional gender norms (Planned Parenthood, 2022).

Survey participants reported incidents and observations and expressed their concerns under questions 14, 15, 19, and 21, notably of not being able to be open with colleagues regarding a person's orientation, inappropriate and homophobic comments made by co-workers, the mistrust of the 2SLGBTQ+ community in the healthcare systems, and the necessity of EDI training for gender diverse populations. Please find that information under the section titled 'Theme 7. Education, Teaching and Training'.

The following are examples of incidents, microaggressions and concerns related to 2SLGBTQIA+ at the MUHC and/or RI-MUHC:

« *J'ai vu des gens [sévèrement discriminés qui faisaient] partie du LGBTQ+* » (Translation: *"I have seen people severely discriminated against who were LGBTQ+")* (Participant identity anonymized).

"*From personal experience there have been times where multiple coworkers are together in the department making 'jokes' about individuals who are LGBT+, without knowing that there are others in the room listening who may be LGBT+ as well. This [is] deeply disturbing"* (Participant identity anonymized)

"*I do not feel as though I can be honest about who I am with my coworkers in my department after hearing the jokes and comments they have made*" (Participant identity anonymized).

"I want to be able to not be afraid of telling people I'm trans and not having to hide it. I wish there were more mental health resources to help deal with this as well as more trained professionals and mention of diversity" (Participant identity anonymized).

"I want to highlight that relationship building with the trans and gender diverse community should not be overlooked. I have interacted with several trans patients who have extreme mistrust for the healthcare system. Their point of view is essential" (Participant identity anonymized).

- **Sexism**

Survey respondents and interview participants provided reports of sexism (or sexual harassment), which is an overt manifestation of gender bias and discrimination based on a person's sex. Employees and patients also reported prejudice or discrimination based on sex, mostly against women.

For the qualitative assessment, 5.8% of participants mentioned incidents and observations related to sexism. Survey participants reported incidents and observations and expressed their concerns under questions 14, 15, 19, 21, and 22. The following quotes are examples of shared incidents and microaggressions reported by (mostly) female employees at the MUHC:

"Inappropriate sexual/sexist remarks by a supervisor MD" (Participant identity anonymized).

«*Des commentaires de nature sexiste à mon égard mais aussi des commentaires sexistes et racistes à l'égard de patient* » (Translation: "*Comments of a sexist nature directed at me, but also sexist and racist comments directed at patients")* (Participant identity anonymized).

« *Microaggressions à connotations sexuelles verbales* » (Translation: "verbal sexual microaggressions") (Participant identity anonymized).

"*Sexually suggestive* [comments]" (Participant identity anonymized).

« *Harcelée sexuellement* » (Translation: "sexually harassed") (Participant identity anonymized).

« *Mon chef de division est sexiste contre les femmes […] microaggressions en cours contre les femmes de ma division* » (Translation: "*my division manager is sexist against women […] ongoing micro-aggressions against women in my division*") (Participant identity anonymized).

"*Sexism has been omitted from the survey and is very much systemic at the MUHC!!*" (Participant identity anonymized).

"*Other than myself, I witnessed many other situations occurring to colleagues related to their ethnic background, religion or allegations of sexual harassment or verbal abuse*" (Participant identity anonymized).

The following quotes are examples of shared incidents and micro-aggressions reported by female patients at the MUHC:

"*With a follow-up with a [specialty] doctor, when he asked my sexual history, I replied that I was not active. He was flustered and made an inappropriate sexual comment that I was 'aging like a fine wine'. And then he commented that he should not have said that as a Catholic*" (Participant identity anonymized).

"*An instance with a female gynecologist: when I was asked about my sexual history and the number of partners, I stated that the history was null and partners zero. She angrily interrogated me as if I was lying and then chastised me that sex was perfectly fine and that I should take off my clothes and get on the examining table so she could see for herself if I was lying. Why should I allow a doctor to touch and examine me with that attitude? Again, I felt uncomfortable on the basis of my marital/relationship status (no partner or family/friend with me at the appointment to protect and deter doctors from talking to me the way they did), my gender (because she was demeaning and scolding me as a female and not respecting my choice), and being a visible minority (because again none of my Caucasian sexually inactive friends never had such an experience with their doctors). This was a very intimidating experience because I froze when the doctor was harshly /bitterly speaking to me. Part of my (sic) wants to comply because I was afraid of her, but also, I didn't want to waste this appointment. She looked at me scornfully as if I was dirty and yet she demanded that I take off my clothes. For a first gynecological experience (or even if it was not a first) and even if I was sexually active at the time, she was intimidating and used her authority to mishandle patient care*" (Participant identity anonymized).

- **Religious Discriminations such as Islamophobia**

Survey respondents and qualitative assessment participants shared concerns regarding religious discriminations such as Islamophobia. Religion includes the practices, beliefs and observances that are part of a faith or religion (Ontario Human Rights Commission, 2022b). Islamophobia is the fear, prejudice and hatred of Muslims or non-Muslim individuals that leads to provocation, hostility and intolerance by means of threatening, harassment, abuse, incitement and intimidation of Muslims and non-Muslims, both in the online and offline world. Motivated by institutional, ideological, political and religious hostility that transcends into structural and cultural racism which targets the symbols and markers of a being a Muslim (Awan & Zempi, 2020, p. 2).

The majority of concerns and addressed incidents were in relation to Islamophobia. Other forms of religious discrimination were also mentioned, but without specifications in terms of the religion or faith. Shared concerns

involved religious beliefs and faiths not being respected, unequal rules and regulations for religious and faith-based holidays, patients refusing to be treated by a hijab-wearing physician, and reactions and experiences in relation to Bill 21 and a related Canadian Medical Association Journal (CMAJ) opinion paper published in December 2021. The CMAJ opinion paper was retracted.

For the qualitative assessment, 5.8% of participants talked about religious discrimination. Survey participants reported incidents and expressed their concerns under question 14, question 15, question 21, and under question 22.

The following quotes are examples of shared incidents and concerns related to religious discrimination at the MUHC:

> "*Patients need to be informed that we are a multi-racial, inclusive society at the MUHC and will not tolerate any racist comments or choices i.e.: refusing to see a physician who wears a hijab*" (Participant identity anonymized).

> "*And so I was involved with an initiative where we collected stories […] with regards to Islamophobia just in the context of this letter. And people were sharing stories like, 'Yes, my hijab was pulled off in an MUHC elevator'. And I was like shocked*" (Participant identity anonymized).

> "*As long as the province keeps working against us, we will not be an inclusive society. Barring women who wear a hijab from working in some professions and cracking down on Anglophones sends the signal that Quebec is for dyed-in-the-wool Québécois*" (Participant identity anonymized).

> "*Make rules and regulations regarding approving vacation being standardized for everyone. Many times, some of us on the team are given a difficult time to take time off for vacation or religious holidays, while others on the team have no problems being approved for their vacation whatsoever. This is truly unfair, especially when there is a religious holiday involved. I am an ethnic minority and have been given a hard time for a day off regarding a religious holiday, while other employees with different religions are given a free pass. This has happened often by management and is extremely unfair and discriminatory. The same issue for vacation. I don't feel there is equity or inclusion all around and is causing many people great stress and anxiety and I feel like I have nowhere to turn to*" (Participant identity anonymized).

> "*Respect people['s] religious beliefs and their attire. To grant or make allowance for special cultural or religious events*" (Participant identity anonymized).

> « *Ne pas fêter --Noël-- permettre une flexibilité accrue pour les congés fériés pour tenir compte de la diversité* » (Translation: [For those who are] "*not celebrating – Christmas - allow more flexibility for public holidays to accommodate diversity*" (Participant identity anonymized).

> "*My faith in Jesus Christ not honoured and respected*" (Participant identity anonymized).

3. Workforce Diversity

Participants emphasized that representation matters. Diversity in staff, management and leadership position or the lack of it was listed as a key issue for EDI in survey responses and by interviewees. 32.4% of qualitative assessment participants addressed this topic. Participants for the MUHC and RI-MUHC cited the lack of diversity in staff, leadership and management positions. For many participants, representation matters at all levels of the institution.

"With whatever initiatives that are undertaken at the MUHC in the spirit of fostering inclusion, it is critical to note that diversity is having a seat at the table, inclusion is having a voice, and belonging is having that voice be heard. Right now, I feel as though the individuals in positions of power are disproportionately [unrepresentative] of the people they employ" (Participant identity anonymized).

People criticized that visible minorities are hired mostly for lower-level positions such as cleaners, janitors, or security guards.

"I *want to be able to see diversity in management positions not just when I'm looking at who is emptying garbage cans or mopping the floor"* (Participant identity anonymized).

"Representation matters at all levels, not just hiring visible minority housekeeping and leaving only the cream so to speak at the upper echelons who actually wield the power to change" (Participant identity anonymized).

To one participant, the lack of diversity in leadership and management positions was blatant:

"For the most part, most of senior leadership across the MUHC, both on the upper management and the departmental level, is mostly white, heterosexual, and increasingly more francophone. These are people who have never felt discrimination the way that many of us have. As a result, any issues that we have are just not comprehensible to them and all the talk surrounding this topic seems like just paying lip service so that the MUHC upper management can claim to be doing well with regard to this issue. So, rather than simply continuing with the same rhetoric, my advice would be to do something more concrete to actually BE more inclusive and less discriminatory. The lack of diversity is all around us while we work, whether it be subtle or more overt. One example that struck me recently, walking down the long corridors at the [MGH] on the 6th floor from the parking structure to Livingston Hall, I noticed all the portraits of white people plastered all over the walls. Even the more contemporary advertising campaigns for the foundation are mostly with white clinicians. While I doubt this was done consciously, it just goes to show how the mentality of the administration of the MUHC is mostly white-centric, whether consciously or subconsciously" (Participant identity anonymized).

Another participant expressed concerns about not being able to convey EDI difficulties with the management team or other colleagues:

« De plus, il faut des mécanismes clairs dès l'embauche quant à la diversité et l'inclusion (personnellement, je ne me suis jamais senti assez en confiance pour aborder mes difficultés avec l'équipe de gestion et mes collègues) » (Translation: *"In addition, there needs to be clear mechanisms in place at the time of hiring regarding diversity and inclusion (personally, I have never felt confident enough to discuss my difficulties with the management team and my colleagues)"* (Participant identity anonymized).

Participants also pointed out the inherent bias in the hiring and selection process for committees and management positions. Participants noted that due to homogenous groups and the lack of representation of diversity in the upper-level management positions, it is impossible for a visible minority to obtain a certain career goal. For example, one participant explained the following:

"I think part of [the] challenge is that I don't see, like […] in certain groups, it's always just […] homogeneous, […] you kind of know, [on] certain committees who will sit in that committee. You kind of know in higher leadership positions if I may say, you kind of know the person or the type of person they're looking for, and I don't feel like, me, like identifying as a minority, I don't feel like I'm included in that and I don't see myself in that. And I don't want to, like I feel like it gives it, doesn't even interest me anymore, because I feel like 'Okay, well, in this group of people it's always the same time type of people in it', and they don't see it as a problem

it seems like, and I won't get an equal chance in obtaining a career goal, let's say that I want" (Participant identity anonymized).

Other participants voiced the same issue of homogeneity among managers as follows:

The "Human Resources [team]: this is a very homogenous team, who hire people in senior positions with the same "background". There is not enough diversity in their hiring practices" (Participant identity anonymized). *"Participative management is frowned upon and the management team is striking in terms of its homogeneity of backgrounds and work experience. Dissent is quickly silenced and reprimanded to quickly remind employees of their status and rank in the hierarchy. The top-down autocratic leadership style creates a psychologically unsafe environment, breeding and fostering a lack of appreciation, frustration and disengagement"* (Participant identity anonymized).

"Why are there no indigenous people in leadership roles?" (Participant identity anonymized).

Yet another participant expressed the biases present in the hiring process for manager positions as follows:

"The hiring for management is flawed and biased. Each time an employee seeks an opportunity they're interviewed by the same people. You speak of proficiency in English and French however hiring practices for management positions are heavily awarded to Francophone individuals who do not even know how to speak one word of English. This is appalling and quite frankly outright against the mission of bilingualism and inclusivity. The MUHC should have an independent body when hiring managers to avoid biases and personal preferences. Managers often show preferential treatment to those they would like to see in the position for example an assistant nurse manager or a [n]urse manager position that is filled by someone who doesn't know the institution and is not proficient in the English language" (Participant identity anonymized).

One participant pointed out that if a person is not French Canadian, no matter how hard a person works to reach a certain career goal, it is very unlikely for the person to be successful.

« Pour une meilleur[e] gestion de la diversité: Il faut former les gestionnaires et cadres supérieurs, et renforcer le concept, car il sera difficile de transmettre aux employés que notre organisation voit et accepte la richesse qu'est la diversité quand certains adoptent une attitude envers les employés qui disent le contraire. Ex. : si tu n'es pas Canadien français tu ne va[s] pas progresser dans ta carrière ou que tes efforts et ta bonne performance ne seront pas récompensés ou valorisés. Il faut aussi améliorer les connaissances des employés aussi ». (Translation: *"For a better management of diversity: We need to train managers and executives, and reinforce the concept, because it will be difficult to transmit to employees that our organization sees and accepts the richness that is diversity when some adopt an attitude towards employees that says the opposite. Ex.: if you are not French Canadian you will not progress in your career or your efforts and good performance will not be rewarded or valued. It is also necessary to improve the knowledge of employees as well")* (Participant identity anonymized).

One person even pointed out that "lack of diversity amongst directors and senior management shows a lack of support for EDI" by the MUHC. A RI-MUHC survey respondent noted that for the person:

"The biggest mistake the RI is making is by having the same people hire the same leaders who are taking EDI workshops and then trying to guide others when they have no idea what cultural, amongst other, challenges they face like writing something simple as their expertise section. It really is a pity. Diversity starts at the top" (Participant identity anonymized).

One can conclude from the comments above and below that participants at MUHC and RI-MUHC are calling for leadership and management positions to be representative of the patient population the MUHC serves.

> *"The MUHC should recruit more socio-ethno-culturally diverse employees across all disciplines and in all staffing categories and levels of governance in the organization, including senior administration to reflect the population it serves"* (Participant identity anonymized).

One suggestion from multiple participants was that the MUHC and the RI-MUHC boards represent the population. Participants are calling for an "[a]ctive outreach to improve diversity.

> *« Aborder la thématique avec les gestionnaires et ne pas bloquer l'accès aux minorités dans des postes de cadres ou autres pour que ça soit représentatif de la population... c'est à dire une expression de la diversité tant prônée »* (Translation: "*Tackle the issue with managers and do not block access to minorities in managerial and other positions so that it is representative of the population... i.e. an expression of the much-valued diversity"*) (Participant identity anonymized).

Another participant stipulated to *"have your leadership a bit more diverse, like not a bit, actually diverse. And have different people in certain positions"* (Participant identity anonymized).

Participants had the following suggestions regarding diverse representation:

- "Support women in developing into leaders at the MUHC. The executives should look like the front line: overwhelmingly female" (Participant identity anonymized).
- *« Augmenter le nombre de personnes en position de pouvoir (médecins chefs, directeurs de départements) issues des minorités visible ».* (Translation: *"Increase the number of people in positions of power (chief physicians, department heads) from visible minorities"* (Participant identity anonymized).
- *"Aligning EDI considerations into all governance activities, for example - board composition, committee composition, task force composition, etc. This is not to say that everything needs to include everybody but rather thought should be given to the relevant diversity needed to address the particular mandates at hand/population served while respecting competencies needed"* (Participant identity anonymized).
- Have *"cultural representation in hiring practices, that is, hire more people from socioculturally […] diverse backgrounds in more leadership/management roles not just in the lower ranking positions. Hire people who also have mobility and accessibility challenges and give them leadership/management roles. This practice of culturally inclusive recruitment will ensure the staff reflects the diversity of the patients they serve"* (Participant identity anonymized).
- *"More diversity of staff in leadership roles representative of the floor staff. It can be intimidating to report racism to a […] white person as they may not have a clear perspective on the issue"* (Participant identity anonymized).
- *"We also need to do more to hire more people in leadership positions who are in EDI groups — the bias is so inherent that even people with good intentions don't realize their biases — it is better to have people at the table who are part of those groups"* (Participant identity anonymized).
- *"We need to hire more people and embrace diversity. We need to be proud of our diversity and the fact that we are diverse. We need to show others how diversity can make our organization and mission even better"* (Participant identity anonymized).
- *"Making sure RI employees and researchers represent truly the Canadian population diversity. This means hiring more people that are not Caucasian (more First Nations... Asians... etc.)"* (Participant identity anonymized).

Finally yet importantly, one participant wanted the MUHC management and leadership team to contemplate the following: *"So, if your committees contain biases and prejudices within, how is it representatives of patients' rights, and further, how are such discriminatory behaviours handled, and how does this infect other areas of your corporate culture and the health-care providers' ambition to serve patients?"* (Participant identity anonymized).

4. Human Resources

Human resources (HR) is a dominant topic amongst participants. For example, under question 19, which asked for ideas and solutions for various sectors such as patient care, training and teaching, human resources and other listed categories, HR is the top concern. Of the MUHC survey respondents who added a comment under question 19, 42.2% referenced HR. Of the RI-MUHC survey respondents, the percentage was 49.0. For the qualitative assessment, 47.0% of participants mentioned issues, concerns and ideas related to HR. The most talked about topics in interviews and focus group discussions were diversity in staff (63.4%), conflict resolution (9.8%), and being understaffed (7.3%). Lack of diversity in leadership and management and lack of diversity in staff and representation were the top concerns discussed in relation to HR in both assessment types. For details on these two themes, please go to the section titled 'About Diversity in Staff, Management and Leadership'.

- **Current Hiring Practices and Promotion Opportunities**

  Participants expressed concern regarding current hiring practices at the MUHC. The hiring process was described as being biased and favouring specific groups over other qualified candidates. For example, Participant (identity anonymized) mentioned:

  > *"Better hiring process. It seems that all new [hires] are mostly French Québécois. This makes me wonder how fairly the hiring process truly is. Is it so realistic to believe that all the qualified people that are getting jobs at the MUHC are only the French Québécois? That no one else other than French Québécois are qualified? I have known plenty of people applying for jobs at the MUHC that were more than qualified, but because they did not have a typical French Québécois last name, they barely got a second interview, let alone a first one. I am an ethnic minority and have noticed that many of the new French Québécois hired do not speak a word of English (and this is an English hospital!). How is that fair considering that when I got hired, I went through a rigorous interview process in both French and English? Very unfair and discriminatory hiring practices".*

  One of the most pointed out issues is the reference to sorting potential candidates according to their (last) names. As in the quote above, multiple participants mentioned the biased and preferential practice of sorting applications by typical French Québécois names, as well as lack of presence of HR in the interview process.

  > « *S'assurer que les candidats sont évalués par [HR] et le département sans référence à la provenance ou à la tonalité du nom* » (Translation: "*Ensure that candidates are assessed by HR and the department without reference to the origin or tone of the name". (*Participant identity anonymized).

  > « *Aussi, lors des entrevues pour des postes de cadres les ressources humaines doivent montrer une présence non seulement physique, mais aussi assurer une surveillance réelle de [ce]qui se passe et que les règles ont bien été respecté dans tout processus de sélection du candidat, afin d'éviter que des préjudices soient subis par des candidats susceptibles [d'être victimes]*». (Translation: "*Also, when interviewing for management positions, human resources must show not only a physical presence, but also ensure actual monitoring of what is happening and that the rules have been respected in any candidate selection process, in order to avoid prejudice to candidates who may be victims*") (Participant identity anonymized).

  However, participants were not only worried with the hiring practices but also with the promotion process. Participants described that there are major challenges and difficulties in being promoted. Participants described being overlooked, and never being promoted. For example, Participant (identity anonymized) shared "[n]ever be[ing] promoted despite having a university degree". Another participant described

functioning as an interim for a position but not being eligible for the position once it became vacant for permanency.

> *"More specifically, if evaluating the retention trends at the MUHC… I have been a victim of this, and know of other peers who (sic) have been primary individuals in [instances] where, they will work on a replacement basis for a specific position, and when the position becomes vacant for permanency, they are deemed ineligible due to specifications about academics. However, no honour or respect for the work that has been achieved, or openness to reconsider the requirements of the position. I believe the MUHC must consider working on respecting individuals for the work and devotion done, and not simply promote individuals to fulfill a job with no recognition when it matters most. Academic discrimination is an ongoing challenge, and not [comforted by HR, and management's self-serving community that has not respect for the ethicality of such decisions"* (Participant identity anonymized).

Another participant shared the following experience:

> *"Need to be seen and heard. A few years ago, I applied for a supervisor position in a department that I worked for 12 years. I did my job well. Also won a nursing award. But I did not even get called for an interview. Sad. The whole department now is in shambles. 99% of the staff has left"* (Participant identity anonymized).

In general, issues with regards to hiring processes and promotions were mainly associated with statements such as *"[s]eeing hiring decisions, promotion decisions where it is always similar types of people who are considered"* (Participant identity anonymized). Thus, in order to ensure an equitable hiring and promotion process, participants suggested reviewing the current processes, practices and policies and to enact a (new) policy that is applicable for all. Participants suggested that a more transparent HR process is needed in order to address the lack of diversity in staff and leadership, and the biased hiring and promotion practices present at the MUHC/RI-MUHC *("[u]ne transparence dans le processus de recrutement")*(Participant identity anonymized). An overlapping proposal from participants in both assessments is the integration of EDI in the hiring, onboarding and promotion processes.

One participant (identity anonymized) suggested the following regarding the aforementioned (last) name bias: *"CVs sent to hiring managers should not include the names of the candidates - studies show this removes bias"* while another encouraged feedback and follow-up if a person does not get a promotion. « *Favoriser (ou même obliger?) le feedback lorsqu'une personne n'obtient pas une promotion* » (Translation: *"Encourage (or even require?) feedback when a person does not get a promotion".* Yet another participant recommended reviewing the organization's data:

> « *Analyser différentes données dans l'organisation en termes de promotion (genre, minorité ethnique), recrutement et autres décisions d'emploi en fonction de divers éléments de la diversité pour avoir une vue d'ensemble de l'organisation et pistes d'amélioration* » (Translation: *"Analyse different data in the organization in terms of promotion (gender, ethnic minority), recruitment and other employment decisions according to various elements of diversity to get an overview of the organization and avenues for improvement")* (Participant identity anonymized).

Another participant suggested having a fixed salary range before starting to interview candidates: *"Opportunities [whether] it is job positions, salary... to be equalized. Salary could be fixed before employers meet the candidate"* (Participant identity anonymized). Another went a step further and suggested active and continuous relationship-building with high school and university students from diverse communities:

"I suspect this is already in place, but ensuring through hiring practices that MUHC employees are as diverse as the people we serve. Lack of diversity in healthcare professions starts before being hired at the MUHC. The MUHC should engage with high school, CEGEP and university students from diverse communities to encourage an interest in health professions and recruit future employees" (Participant identity anonymized).

- **Salaries, Pay Inequality and Pay Inequity**

Another topic addressed under HR is salaries, pay inequality and pay inequity at the MUHC/RI-MUHC. The main concern raised was pay inequalities and the call for addressing the wage disparity between male and female employees. Participants are asking for "*[e]quality between female/male employees (salary)"*, for *"[b]etter pay for women-dominated professions"* and for pay to be matched to the private sector salaries (« *équité salariale comme au privé* »). One female employee expressed her concerns and explained her situation as follows:

> *"Directors and leadership need to do regular assessments of their departments, programs to ensure that there are no salary discrepancies or other unfair practices. For example, my salary is lower than a male who was recently hired (whose position is to support mine and is below me in the org [anization] chart). He also has an assigned office. I have been waiting for an office for almost 3 years and still don't have a phone extension. How does this happen? The program director is probably unaware of this due to diffusion of responsibilities for space/salaries but, ultimately, he should be getting involved to ensure this doesn't happen"* (Participant identity anonymized).

Besides the unequal pay between female and male employees, participants in both categories of assessments raised the issue of payment according to qualification, experiences and expertise, for example:

> « *Je m'attends que les tâches soient diversifiées et payées en fonction de leurs difficultés. Ça serait tellement intéressant d'être récompensé en fonction de l'expertise offerte et ne pas automatiquement par les années vécues au CUSM* ». (Translation: *"I expect the tasks to be diversified and paid according to their difficulties. It would be so interesting to be rewarded according to the expertise offered and not automatically by the years spent at the MUHC")* (Participant identity anonymized).

> « *Appliquer l'équité salariale: prendre en considération mon expertise, mes diplômes et me rémunérer à ma juste valeur. J'ai dû me battre pour avoir une augmentation de salaire qui était très inférieure pour un poste de manager ayant une maîtrise avec 19 ans d'expérience dans la recherche* ». (Translation: "*Applying pay equity: taking into account my expertise, my qualifications and paying me what I am worth. I had to fight for a salary increase that was much lower for a manager with a master's degree and 19 years of experience in research"*) (Participant identity anonymized).

Pay equity, especially when it comes to foreign-educated MUHC/RI-MUHC employees, was addressed in both assessment types as well. The discussion around pay inequities, unrecognized education and experience was detailed through the lenses of newcomers to Québec. Recruiting a qualified and highly educated workforce from other countries has been the main strategy for Canada's population and economic growth for the past decade. For example, 49.9% of recent immigrants had at least a bachelor's degree in 2016 (Hou et al., 2019, p. 12). The MUHC and RI-MUHC are home to employees who either graduated from a university outside of Canada and/or bring tremendous international work experience with them. However, participants expressed their disappointment when being hired by the MUHC/ RI-MUHC and told that their international work experience did not count and that it was not taken into account when it came to their compensation.

One participant expressed personal letdown as follows: *"But like doing 10 years as an engineer in any other country or a doctor or a surgeon […] and coming here and getting a junior job as zero experience is […] totally not inclusive. […] It's not diversity sensitive and it's against all means of inclusion"* (Participant identity anonymized).

Other participants conveyed the issue as follows:

*« Ressources humaines : Reconnaître l'expérience de travail passée et les diplômes effectués à l'extérieur du pays au moment de l'embauche et du salaire ». (*Translation*: "Human resources: Recognize past work experience and diplomas obtained outside the country at the time of hiring and salary")* (Participant identity anonymized).

"Do not treat professionals with previous experiences in another country (that validated their diplomas in Canada) as entry-level professionals. This is absolutely frustrating" (Participant identity anonymized).

*"I need my previous experience in the field (more than 11 years in another country) to be recognized by HR" (*Participant identity anonymized).

5. Leadership and Management

Survey respondents and qualitative assessment participants expressed concerns and ideas related to management and leadership. The survey covered management and leadership topics under questions 15, 19, 21, and 22. For example, under question 19, 15.3% of survey respondents who left a comment addressed the topic of management and leadership. As for focus groups, 52.9% of qualitative assessment participants talked about issues with direct supervisors and managers (53.4% of the coded segments), unequal assignment of duties (13.3%), issues with conflict resolution (13.3%), (more) training and especially EDI training for management and leadership (6.7%), shift assignment (6.7%), and miscommunication (6.7%).

Participants shared situations and discriminatory incidents involving supervisors/managers. They described being treated disrespectfully, being verbally assaulted, harassed and humiliated by supervisors and senior members at the MUHC. Verbal attacks on staff members due to having a different ethnic background were described in both assessments. For example, one visible minority described the following experience:

"I was personally [attacked] by a more senior individual based on my ethnic background and despite [bringing] the situation up, there were no consequences and the upper was 'instructed to cover it up'. Until this day, I still feel that I was harassed and aggressed, and no justice was done" (Participant identity anonymized).

Another person cited that duties are not assigned equally and that some employees are given humiliating tasks and shared the following:

« Certaines t[â]ches sont réservées [à] certaines personnes dont je fais partie, beaucoup de pression et de parole humiliante, des cris (..) « Ne pas se sentir étiqueter. Tout ce qu'on fait sembl[e] être perçu négativement malgré tout. Être traité avec respect lorsqu'on a une remarque [à] te faire au lieu de se faire crier devant tout le monde. Tout ce que tu fais est dramatisé. Des critiques dans ton dos avec les collègues, l'isolement ou encore te fait faire des tâches humiliantes ». (Translation: "Certain tasks are reserved for certain people, of whom I am one, a lot of pressure and humiliating words, shouting". Not feeling labelled. Everything you do seems to be perceived negatively despite everything. Be treated with respect when someone makes a comment to you instead of being shouted at in front of everyone. Everything you do is dramatized. Criticism

behind your back with colleagues, isolation or even making you do humiliating tasks") (Participant identity anonymized).

While the assigned humiliating tasks that can be equated with discriminatory and racist practices that led to the person's feeling of being labelled cannot be detailed herein, as it would reveal the participant's department, the participant still had the following to add:

> *« Je ne sais pas mais j'aime beaucoup le CUSM et je veux juste me sentir [à] ma place. Chaque jour je sens que je ne ferai jamais assez (malgré mes efforts) devant certaines personnes et cela me fait beaucoup de peine ».* (Translation: *"I don't know but I really like the MUHC and I just want to feel like I belong. Every day I feel like I'll never do enough (despite my best efforts) by certain people and that makes me very sad").*

The above quote was not unique. Other participants related comparable discriminatory behaviour by managers. One participant for example cited similar concerns regarding the distribution of work assignments. The person listed that *"[m]anagement has to be fair and distribute work equally and not push the employees to the point where they dislike their job".* Yet another visible minority participant simply asked *"[t]o be treated equally as my peers, in relation to work assignments"* (Participant identity anonymized).

One common element among all the shared stories describing discriminatory or even racist behaviours by senior members of the MUHC workforce was the lack of showing respect. The majority of participants in both assessments conveyed that they simply wanted to be respected and valued by co-workers, management and leadership. One participant described an incident in which the person was asked to train a new employee. However, the person expressed unease about providing the training, citing being out of depth in the particular case. The participant related the concern to the supervisor *"and the supervisor told me if I did not give the training that they would fire me. But I did not feel I can give it. … Like I said, […] Respect us. There are simple things that you can do"* (Participant identity anonymized).

Another participant described a scenario in which the person tried to raise awareness and encourage a committee to evaluate a discussed topic from another point of view. However, the senior members of the committee were not pleased with the person's action and the participant described the failure of being respected by senior leadership of the MUHC as follows:

> *"And the respect, you don't always get the respect. You don't get the respect. Is it because of your disability? Is it because of your skin colour? Is it because of what? And if you don't agree with them, it's a problem! And is it because what? I don't agree with what you said? I don't! I have a right to disagree. But they feel you have to agree with them. You are not allowed to have your own mind. You have to be a follower. And if you don't follow, you get treated with no form of respect at all. If you speak out, you're treated with [disrespect], it's even worse"* (Participant identity anonymized).

Being respected as a person was an overarching theme that was brought up by 82.4% of qualitative assessment participants and 12.8% of survey participants under question 21. Participants want leadership and management to create a work environment that encourages employees to respect each other's cultural differences. No one group of people wants to be treated differently. There is a desire for basic courtesy, politeness and respect at all levels of the institution and for all employees and workers to be valued and respected.

Participants also shared that the current hierarchy and power dynamic at the MUHC and the RI-MUHC are impeding constructive and safe discussion around bias and discrimination. For example, participants expressed the need that all managers should be approachable and available. Additionally, 38.5% of the MUHC survey participants reported that they are confident in the leadership of the MUHC and/or RI-MUHC to create an inclusive workplace. When asked about how they felt addressing any form of bias or discrimination with senior management, department directors, direct

supervisors, managers, or clinicians, one third of survey respondents indicated to be unsure or that they do not feel safe to bring up any topic related to biases and/or discrimination. One participant expressed the feeling of being excluded actively from communication with upper management/ administration as follows:

> *"The top-down approach creates multiple loopholes, tribalism, difficulty addressing challenging situations in a timely manner, and perpetuates biases and disparities. One cannot address the lack of inclusiveness, if s/he is already excluded/blocked from communicating to the next level of management/administration in an open way"* (Participant identity anonymized).

Addressing the mistrust in management and leadership along with the hierarchy and power dynamics at the MUHC are essential to have a safe space for discussions. One participant called on the MUHC management and leadership team to *"act on organizational culture to make it safer to discuss issues around bias. Addressing power dynamics due to hierarchies will also be essential. It will be difficult to act on one source of power dynamics while not addressing others"* (Participant identity anonymized). Yet another participant has the following suggestion when it comes to racist and discriminatory actions by managers: *« gestion proactive des gestionnaires lorsque des paroles ou gestes se produisent pour démontrer ce qui n'est pas acceptable pour permettre un changement de culture »* (Translation: *"proactive management of managers when words or actions occur to demonstrate what is not acceptable to enable a culture change")* (Participant identity anonymized).

The lack of diversity among leaders and managers is another topic that dominated the discourse of the management and leadership theme in both assessment types. Please find details under the section titled 'About Diversity in Staff, Management and Leadership'.

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.

6. Patients and Quality of Care

Another theme that emerged in both assessment groups is patients and the quality-of-care patients are receiving at MUHC sites. Under question 19, in the MUHC survey responses, patient care was the third ranked topic. Out of the MUHC survey respondents who left a comment under question 19, 26.0% addressed patient care. For the RI-MUHC, only 8.3% of the respondents left comments addressing patient services and care. In the qualitative assessment, 29.4% of participants addressed the theme of quality-of-care patients are receiving at the MUHC and 55.9% of participants talked about patients in general.

The five top-listed concerns and suggestions relate to (1) Education and access to appropriate resources, (2) use of language, treatment and communication with patients, (3) access to services and continuity of care, (4) access to interpretation and translation services, (5) minority patient populations (e.g., gender diverse patients, etc.).

First, education and access to appropriate resources was often talked about in relation to patients and the quality-of-care patients receive at the MUHC. Participants were concerned how healthcare personnel is interacting with patients overall, but also with specific groups of patients. For example, one participant expressed the need to respect every individual and has the following suggestions for training: *"There should be on the ground training to staff about how to treat each other and patients with the proper respect so that BIPOC individuals feel safe working and being treated at the MUHC, as well as LGBTQ+ individuals"* (Participant identity anonymized).

Another participant explained the necessity for staff members to listen to patients' concerns and suggested to train all staff members to interact with all patient groups accordingly. *« Soins aux patients: former le personnel à écouter les patients. Pour les rejoindre dans leurs préoccupations ».* (Translation: *"Patient care: train staff to listen so as to connect to their concerns")* (Participant identity anonymized).

Additionally, participants shared the necessity that all healthcare personnel at the MUHC need to have an understanding of their patient populations, needs, cultural, religious, and spiritual beliefs, and what barriers patients face when seeking care. One participant noted:

> *"Trainings on diversity and anti-oppression competence should be mandatory for at least all clinical and patient-facing staff. It is not acceptable that many clinicians and learners do not know anything about First Nations understandings of wellness, what particular needs non-binary and trans patients have (outside of gender-related care), or the realities faced by non-white non-men, both as patients and professionals, in the healthcare system"* (Participant identity anonymized).

Participants also requested access to education and resources for patients with different ethnicities. For example, one participant explained that the majority of case studies presented in textbooks or in case descriptions are usually white heterosexual patients when it concerns skin disease. However, not only people with white skin have skin diseases. One participant asked for training and resources as follows: *« Des ressources approprier pour traiter des conditions chez les différentes ethnies. (Exemple, des documents sur les conditions de la peau chez les personnes de couleurs) »* (Translation: *"Appropriate resources to address conditions in different ethnicities. (Example, documents on skin conditions in people of colour)"* (Participant identity anonymized). Another participant expressed concerns regarding how training material is presented and perpetuates certain stereotypes. Whereas in 2019, 39.7% of new HIV infections were in gay, bisexual and other men who have sex with men followed by 28.3% of cases being "attributed to heterosexual contact" and 21.5% of new cases "among people who inject drugs" (Haddad et al., 2021, p. 77), the participant stated:

> *"(…) Always in the vignette, it is a gay man who has HIV. Never is it a gay man who has a cold. And so, then […], you have trained medical professionals who associate being gay and HIV and that is wrong. Right? […] And so, […] how do we ensure that when we do any sort of training or any sort of endeavour that we don't further perpetuate stereotypes?"* (Participant identity anonymized).

Hence, for participants it is not only about the education and access to resources, but the resourcing of appropriated and population-representative teaching materials. Additionally, participants want to get an understanding of how EDI looks like with patient care. For example, one participant asked *"what are the [EDI] standards in caring to ensure it is inclusive?"* (Participant identity anonymized). Many suggestions regarding types and formats of trainings were also made. Please find more details on education and resources in section titled 'Theme 7. Education, Teaching, and Training'.

Secondly, participants related concerns and provided examples for the treatment of patients by healthcare personnel. Participants did not only mention how some healthcare providers displayed biased treatment of patients due to their visible ethnicity, but also emphasized the inappropriate and derogatory style of communication. Stereotyping can affect how healthcare providers treat a patient and it may not only lead to biases in the treatment plan but also be harmful for the patient.

For example, one participant shared how a colleague felt uneasy in providing care to a visible minority patient and rushed through the examination of the individual in order to get the person out of the office. The person explained the situation as follows:

"I had a very concrete example of a conflict that I had with a co-worker who had been, […] assessing a patient who was […] of the same race, [XX] race as myself, and [the co-worker] made some very derogatory comments about the patient. And you know the smell of [the patient's] clothes and […] how [the co-worker] wanted the patient just to hurry up and get out of the [colleague's] office, so that you know that the smell was overwhelming for [the colleague]" (Participant identity anonymized).

A conflict resulted from the above-described situation, which presents an excellent example of how patients who are visible minorities can be treated by healthcare personnel and how this can affect the quality of care they receive, as well as working relationships amongst professionals. Survey participants described witnessing similar incidents that used unappreciated language with a patient or overhearing inappropriate and harmful stereotypic comments such as:

"Inappropriate jokes made by MDs, clinicians, others. If they speak like this, how do they understand their minority patients?" (Participant identity anonymized).

"Hearing assumptions made about patients and families of different backgrounds during case discussions" (Participant identity anonymized).

"Hearing clinical leaders make incorrect, inappropriate stereotypic comments about patients" (Participant identity anonymized).

"Overhearing racist comments from staff about patients" (Participant identity anonymized).

Another participant described the process of stereotyping the person's family experienced at the MUHC as follows:

"A [type of specialty/physician] racially and ethnically stereotyped that my father was a high-risk patient and should get better control of his diet because he concluded that [name of ethnicity] from [country] eat too much fried foods, too much flour, oil and sugar. The doctor jumped to a conclusion where my father was from by looking at me, since it is not evident that my father may be from an [name of ethnicity] background, and also asked us what the origin of our name. The origin of our name, nor my physical features, nor that of my father's were indicative of his low sodium, low fat diet that he has been on for over 30 years. Also, the doctor overly focused and racially accused my father's health was a diet problem instead of inquiring what […] my father's diet [was]" (Participant identity anonymized).

Thirdly, participants were also concerned about the access to services and continuity of care at the MUHC. Some participants acknowledged the harmful effect of stereotyping and how related biases, either conscious or unconscious, influence care, or to be more specific access to care. One person shared doubts about the inclusivity of the MUHC and how the person's own biases play into interactions and care provided to patients:

"I feel […] ultimately we care for people, like patients and their families and I don't think we're inclusive at all. And also […] I have done it myself, even […] I have assumed that if I cared for this family it's like that or I make it [like that], or because they are less interactive, [less] engage[d], then maybe I would not offer the same services because they have not asked, or I would not ask certain questions. So, I think, […] ultimately […], for our patients and our family members, I feel like we need to do more […]. We […] care for a multicultural society" (Participant identity anonymized).

One participant alluded to the issue of the MUHC being viewed as a research-driven institution while at the same time disregarding the needs of patients on the primary care level.

"You know the patient should be the center of the reason for our existence as an institution. And yet, […] at public board meetings we hear that […] the MUHC is a research driven institution, and it's not a patient-driven institution, which in part is true. But I think these two identities have to be put into some perspective, in that the MUHC provides health care, not only at a tertiary level, but also very much at a primary level as well. It has the whole spectrum, whether it wants to or not, and it has to come into some acceptance that it is, it needs to provide all levels of care and, and ensure continuity of care for the patients. You know there's no patient at the MUHC or […], I should say they said, […] there are very few patients at the MUHC that are only treated by one super specialty. […] Most patients […] need a family doctor, and […] this needs to be […] [acknowledged] within the institution [and] that equity, diversity and inclusion […] also plays a role there as well" (Participant identity anonymized).

The person went on to discuss the issue of not having access to a family doctor and the matter of continuity of care.

"The continuity of care, I mean it's a complex institution, the MUHC, and quite often, I don't know […] percentage wise. But it's, you know, one at times is too many, is that patients because they are going through many different specialties, […] and they go home, […] and unfortunately, the communication between the specialties and the community is a real challenge at times. […] There are a lot of patients [who] go home and […] they have no family doctor. They become their own case managers. […] So they do not have the support and they are expected to deal with their medications. […] One specialist changing the medications of another one because they somehow prescribed something and the patient is lost often in this. And so, […] one of the challenges trying to convince the institution [is that] it has to provide resources for continuity of care" (Participant identity anonymized).

Fourth, access to interpretation and translation services was listed as an issue to provide the best quality of care for patients. 11.8% of qualitative assessment participants listed limited or no access to translation and interpretation services as an impediment. One participant said that they *"(…) had encounters with patients where it was difficult to find a non-family member interpreter to discuss their medical status"* (Participant identity anonymized).

Another participant related the unavailability of translation services to not being equitable or inclusive:

"Equity and inclusion: It is also my experience that language barriers get in the way of delivering excellent care and that more could be done to facilitate this. For one, we do not have access to a reliably accessible translation service to translate to any of the languages we frequently encounter (mandarin, Cantonese, Punjabi, Arabic, Spanish, Italian, Greek, etc), and not all staff/clinical trainees speak French, which is understandably an expectation of Francophone patients" (Participant identity anonymized).

Participant (identity anonymized) suggested employing more translators instead of volunteers. *"Rather than having volunteers, create more and permanent positions for interpreters to allow for more efficient and increased services for patient communications & appointments, liaising with community, etc."*

Another participant commented on the current system and how it fails to meet healthcare providers' and patients' needs. *"Enhance access to translation resources. The current system makes getting a *PRN translator highly unlikely while arranging one in advance requires a byzantine, cumbersome process that fails more often than not"* (Participant identity anonymized). *A PRN translator (a practicing registered nurse who possesses a second language and can provide interpretation)

Another participant suggested having a *"readily accessible translation service. One hospital I worked at in the United States had a phone service for translators with expertise in medical translation"* (Participant identity anonymized).

The notion of easily accessible resources was also expressed through common phrases for various languages representative of the MUHC patient population.

> *"In terms of patient care there should be an easily accessible document with common terms/questions in various languages in order to better serve our diverse patient population. Do you have pain? Do you need to use the bathroom? Can you show me where you have a problem? (Closed-ended questions)"* (Participant identity anonymized).

Fifth, participants also addressed the treatment of minority populations by healthcare providers. For example, participants are calling for the recognition of the diversity of patients and their needs. It is essential for the MUHC to recognize that *"[t]he patient population is reflecting the changes in society and we should be able to address them with compassion and most importantly respect"* (Participant identity anonymized). Thus, it is inevitable to continuously "[t]reat each patient as an individual and [for example] try to observe [the person's] belief systems, and incorporate in the healing process" (Participant identity anonymized).

Participants were also extremely concerned with the unacknowledged need for the MUHC to improve the care and update the MUHC policy to reflect the gender diverse patient population. Participants pointed out that the intake form only allows male or female to be selected. No guidance or official policy on how to interact with gender-diverse patients has been provided by the institution. Participants described this issue as follows:

> *"Significant improvements could be done for our gender-diverse patients. Many staff members seem uncomfortable working with this population. I have seen staff members refer to trans patients by an incorrect name or pronoun. I have seen staff mock patient's appearance, dress, voice, etc., although never to a patient's face. This needs to be addressed for all MUHC staff, including administrative and clinical staff. Allowing for easier changes of name/gender marker on hospital card/OACIS would be one way to make sure trans and gender-diverse patients are addressed correctly no matter where they are in the hospital. Improving intake forms at all clinics for patients to provide their names and pronouns. Offering more than "M/F on intake forms" (…). Specifically, I would like to see an MUHC policy about the treatment of trans people. As a member of the clinical staff I want it to be made explicit how we are to treat patients when their stated gender or gender presentation or name is different than on their documentation. For example, when a patient whose name and gender on file is different than how they identify themselves presents to my department for a service I want there to be a consensus about how to identify them. And for there to be a policy about how we address or identify patients who have not yet had a legal name change. I am not aware about any way for me to know that they are using a different name than their legal name or that they identify as a different gender"* (Identity anonymized).

Additionally, participants also pointed out that the information provided to gender-diverse patients is not appropriate because the pamphlets assume heteronormativity.

> *« Arrêter l'hétéronormativité (présumer que nos patients, clients et employé(e)s sont hétérosexuels). Ceci mène souvent à des notions erronées sur les relations et la sexualité. Les documents que nous remettons à nos patients assument qu'ils sont hétérosexuels et simplifient les choses au niveau binaire. Pas tous les hommes ont des pénis, pas toutes les femmes ont des vagins, pas toutes les personnes s'engagent dans des rapports sexuels pénis dans vagin. Il faut être plus inclusif dans nos termes, nos notions et descriptions ». (*Translation: "Stop heteronormativity (assuming our patients, clients and staff are heterosexual). This often leads to misguided notions about relationships and sexuality. The material we give to our patients assumes they are heterosexual and simplifies things to a binary level. Not all men have penises, not all women have vaginas, not all people engage in penis-in-vagina sex. We need to be more inclusive in our terms, notions and descriptions")* (Participant identity anonymized).

"In the end the MUHC is a hospital that cares for the population of the Greater Montreal Area. Thus, "patient care is vital. No one asks to be sick. Patients should be treated with care and respect" (Identity anonymized). For the purposes of clarification, it should be noted that the MUHC's catchment area also includes two other major regions of the province, namely Region 17 (Nunavik) and Region 18 (Terres-Cries-de-la-Baie-James).

7. Education, Teaching and Training

Another theme that emerged amongst both assessment groups is education, teaching and training. For example, under question 19, which asked survey participants to list ideas and solutions for various provided topics, teaching and training was the second most addressed idea after human resources. 41.3% of MUHC survey participants and 47.9% of those from the RI-MUHC who shared a comment under question 19 left a remark with regard to education, teaching, and training. For the qualitative assessment, which includes the semi-structured interviews, focus group discussions and written responses, 41.2% of participants mentioned ideas, issues and concerns regarding education, teaching, and training.

The top concern for survey participants is access to training for all MUHC employees at all levels. In general, survey respondents proposed making training and education accessible for all MUHC employees (from janitor to senior leadership) with tailored sessions for specific areas such as patient-facing staff. EDI, as mandatory training session(s) with different modules as part of the onboarding process for everybody, was also proposed. Access to patient teaching materials and to continuous EDI education and related training throughout the year were cited as examples that would permit continued investment in the MUHC community. Survey participants also noted that not all employees have access to the Intranet. Thus, in order to be inclusive and to make sure announcements reach all employees, patients, etc., reviewing current methods of distribution of information regarding effectiveness and reach were suggested. Survey participants listed a variety of types and formats of training.

Below are examples suggested by participants:
- Mandatory anti-racism and cultural safety training for all MUHC staff (clinical and non-clinical)
- Anti-Black racism
- Anti-Indigenous racism
- Biases and how to improve patient care
- Culturally safe care: more training for staff to deal with patients or family members of different ethnic backgrounds
- Conflict resolution and communications training: teach people how to actively respond to racist/ sexist/LGBTQ-phobic statements
- Conscious and unconscious bias training: interactive discussions that make one question one's own judgement and challenge what you know. (Why does one judge an ethnic group a certain way? What appears obvious for some is not so for another. It is not because someone has an accent that the person is less competent or intelligent).
- Communication skills courses
- Diversity training
- English and French courses for all employees/staff
- Gender norms and 2SLGBTQ+
- Impact of injustice and systems on minorities information
- Micro-aggression training
- Relationship and partnership training and resources
- Soft skills course
- Structured discussions: the idea would be to have structured discussions with well-informed facilitators to bring forth the assumptions and misunderstandings which lurk in all of our lives
- Team building exercises
- Training for senior leadership: mandatory training for all managers and directors on EDI

One participant stressed the following:

"The No. 1 mandate is to train/coach our senior leaders on how to be inclusive leaders. Their performance should be evaluated on this dimension as well. This is 2021. The 70s and 80s are long gone and so are the restrictive and dehumanizing leadership practices of a long-gone era. Time to modernize and refresh our leadership practices to empower employees and recognize the value of their talents and to support them with their professional aspirations. Time to reconnect with purpose and rehumanize the MUHC work environment (…) Also, actually teach MDs about what constitutes inappropriate behaviour, systemic racism, harmful cognitive biases" (Participant identity anonymized).

Another participant proposed to review what other countries are doing and how the MUHC could learn from their approaches:

« En tant que gestionnaire, je crois qu'il serait intéressant et constructif d'avoir des formations générales sur les habitudes et différences de la réalité[...] du travail dans les autres principaux pays d'où les travaill[e]urs de minorités visibles que nous employons ont travaillés afin de nous aider à mieux comprendre l'adaptation et les mesures à mettre en place afin de faciliter l'intégration. Ceci serait applicable pour les non-minorités visibles provenant de l'étranger également d'ailleurs ». (Translation: *"As a manager, I believe it would be interesting and constructive to have general training on the habits and differences of the work realities in other major countries where the visible minority workers we employ have worked in order to help us better understand the adaptation and measures to be put in place to facilitate integration. This would be applicable to non-visible minorities from abroad as well")* (Participant identity anonymized).

In addition to the above listed recommendation, RI-MUHC survey respondents made additional propositions concerning the unique needs of researchers at the Institute. Participants listed anti-oppression training, competence training, EDI in grant applications training, EDI and research participants, EDI and being a manager/ supervisor (as a researcher), and the establishment of a mentorship program. For example, one respondent made the following suggestion:

"I would suggest mandating anti-oppression training for all senior staff and PIs. Often PIs are completely ignorant of their position of influence over other members of the community, not least their trainees and staff! And this kind of reality check can be really helpful in terms of giving individuals the tools to do some meaningful self-examination". (Participant identity anonymized).

In both the MUHC and RI-MUHC surveys, participants conveyed the need for an institutional strategy, for mandatory education and training sessions on EDI topics to be continuous and for the need to acknowledge how harmful the denial of institutional racism is on marginalized groups:

"In all these kinds of situations I will intervene, stop inappropriate or incorrect comments, try to educate but perhaps if there was an organizational strategy across the institution it would make much more of a difference. And much of this comes from lack of knowledge and/or lack of lived experience. The more representation, regular discussion and accountability the more likely these things will improve" (Participant identity anonymized).

"There should be more than one lecture about EDI for trainees and staff. The amount of time allocated to teaching about EDI and why it matters is not sufficient" (Participant identity anonymized).

« Session d'information / formation obligatoire pour encourager la prise de conscience, incluant exemples concrets à l'IR-CUSM. Tel qu'exemplifié par l'attitude officielle de notre gouvernement envers le racisme institutionnel, une des formes de discrimination les plus pernicieuses est celle où une personne croit

honnêtement ne pas être raciste ou discriminatoire dans son comportement et n'est pas consciente d'un manque de sensibilité potentiel envers certains groupes ». (Translation: *"Mandatory information/training session to encourage awareness, including concrete examples at the RI-MUHC. As exemplified by our government's official attitude towards institutional racism, one of the most pernicious forms of discrimination is when a person honestly believes not to be racist or discriminatory vis-a-vis behaviour and is unaware of a potential insensitivity towards certain groups"*) (Participant identity anonymized).

"Training on how to react promptly and appropriately when we see racist incidents or hear racist comments in the workplace, including with peers, visitors and family members" (Participant identity anonymized).

Secondly, survey participants also listed various formats for training. Workshops, seminars, online tools and modules, small group sessions, and role model training were suggested. For example, one participant suggested role modelling in small groups to prevent neglect of patients and dismissal of their needs. An interview participant relayed similar information regarding role-plays, highlighting the belief that awareness exercises, role-plays and increased exposure to persons not in an acute crisis situation could be helpful. Another respondent relayed the following regarding small group training sessions with real life scenario-based examples:

"Small-group training on impact of race and culture on relationships with patients, co-workers, etc. as part of onboarding activities. This training should be constructed of different modules to address the different contexts in which the knowledge is to be applied. It should be practically oriented and scenario-based rather than theoretical. Should promote discussion among participants and include concrete tips for inclusive and equitable practice" (Participant identity anonymized).

Thirdly, survey and qualitative assessment participants voiced their concerns regarding the need for detailed and continuous training relating to Indigenous peoples. Participants asked for educational training and material on history of Indigenous peoples, such as:

*"As an immigrant, I am not as aware of the history of Indigenous populations and the challenges that they faced and are still facing. Seminars and training sessions to raise cultural awareness for immigrants and other interested MUHC members may be helpful to improve patient care and inclusiveness for patients and MUHC personnel". (*Participant identity anonymized).

Another participant advised that any course related to cultural sensitivity and the history of Indigenous people needs to be taught by Indigenous peoples. The person conveyed the urgent need for it by leaving their comment in capital letters:

*"PLEASE MAKE A CULTURAL SENSITIVITY COURSE MANDATORY FOR ALL STAFF!! PLEASE ENSURE SUCH A COURSE IS GIVEN BY INDIGENOUS PEOPLES AND MINORITY ETHNIC GROUPS" (*Participant identity anonymized).

Additionally, participants in both assessments recommended education on Indigenous people's holistic understanding of physical, emotional, mental, and spiritual wellness. One participant explained that *"[i]t is not acceptable that many clinicians and learners do not know anything about First Nations understanding of wellness"* (Participant identity anonymized). Another participant emphasized that the training and understanding of Indigenous wellness also needs to include teachings on the history of residential schools in Canada and education on trauma informed care.

"Definitely, there's a need for our staff to be trained in trauma informed care. [… it is essential for] understanding the realities of Indigenous people. What they went through. What these scars are from having been through residential schools, and the general distrust that they have for the medical system, and having

to rely on the medical system, anyways, to […] come in through those doors, when so much trauma has been [endured] by them and their ancestors. Something that there isn't an understanding of in general. And so, I think that's kind of an emerging field, trauma informed care. But just kind of understanding different reactions people can have […] that are sometimes physical as well, and visceral. You know that that can really impact the health, their health. And so, I think that can be really, really powerful, just in terms of educating staff. And it goes kind of in line with […] You never know what the person on the other end of this phone is going to, right? So, it's just basic empathy" (Participant identity anonymized).

Another participant even suggested what learning modules on Indigenous health could look like and recommended reviewing what other provinces are doing:

"Mandatory learning modules on Indigenous health, including a section on resources within the QC health system (ex. Ullivik). Modules like these are the norm in other provinces. Various health boards in BC have well-established modules that could be looked to for inspiration". (Participant identity anonymized).

Voices of Indigenous people are missing from the qualitative assessment, and it is essential to include Indigenous representation in all stages of the development of any educational modules and resources on Indigenous history and understanding of wellness, etc.

Fourth, survey and qualitative assessment participants voiced their concerns regarding the need for detailed and regular training on gender diverse (patient) populations. Participants asked what particular needs do non-binary and trans patients have (outside of gender-related care) in order to provide safe care. It was stated that as of March 2021, the MUHC had not provided any form of training on how to care for gender diverse patients. One participant stated: *"We currently don't have LGBTQ+ affirming care for patients; no training exists on using the right pronouns, etc."* (Participant identity anonymized).

Other participants shared the following concerns regarding patients with gender reassignments and/or a patient's sexual history, and the urgent need to educate the staff on gender diverse populations and culturally safe care:

"And even like when someone comes in with a gender reassignment, let's say, if you have a patient who has a gender reassignment, or they've gone through the process, I think it's, it's kind of made to feel like, oh, it's something taboo to talk about it, or even like we don't even know what, what is the like? What do we have to do? What do we need to be mindful of? Are there certain things that we [need] to be aware of, to assess? Like I don't even think that's being taught, and maybe it's not a MUHC problem. Maybe it's a wider problem too, but, but the fact that, like we, it's kind of like we don't, or what we talk about [it] in the groups and I don't know, it feels like we are not as open in discussion when we see something that's out of the norm" (Participant identity anonymized).

"The health care providers should ask questions and clarify questions. They should be culturally sensitive as part of their bedside manners to treat people with respect if a patient' sexual history is against the norm of society. Patients are not coming in to be judged or to have the staff's attention diverted to the patient's personal conduct that has nothing to do with the hospital visit. Maybe a social worker should be assigned to represent that patient's concerns since some staff do not deem the patient to be worthy of respect or being credible about expressing their symptoms. And the staff should be trained in respect to address all cultural sensitivities" (Participant identity anonymized).

In general, participants conveyed the need for the creation, establishment, and continuous adaptation of educational sessions, materials and resources to provide culturally safe and adequate care for all patients at the MUHC. One educator relayed the following information:

"At present I am an educator and wish I had more resources for teaching cultural sensitivity, that type of thing to nurses. I'm happy there is an e-learning now for aboriginal people, but I think more is needed. I think we could do better, but I'm not quite sure where to start, especially because I know we need to include diverse voices about what they need. I think we could do better for gender inclusivity, aboriginal inclusivity, etc." (Participant identity anonymized).

Another patient participant suggested providing real life examples of biased and discriminatory treatment of patients by staff to demonstrate how the lack of empathy by healthcare personnel is impacting the care patients are receiving:

"It just shouldn't happen and again I think that the people, the staff, should be educated and given examples of these stories about people, because I'm sure that they probably are sympathetic a lot, but they just don't think about it, you know they just let something out, and they, they have no idea they have no empathy". (Participant identity anonymized).

"*Diversity in my medical practice regards above all trying to understand the social, cultural and linguistic roots of my patients and their effect on their health care. If I don't know and understand them, it means seeking to learn about them"* (Participant identity anonymized).

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.

One participant highlighted:

"Yes, I think that there is a lot of fear. And I think just even that is something to note! […] The fact that you are saying trainees are difficult to reach speaks to either their lack of connectedness to the institution, which is unfortunate because I think trainees see the most patients […]. But also, the lack of safety and inclusion they experience in the institution. And if they feel that then patients feel that" (Participant identity anonymized).

Another participant also conveyed that students *"have a lot of issues, trust issues because they don't know if these things will come back to haunt [their] career"* (Participant identity anonymized). Trainees/students also expressed not feeling included. One person described their feeling of isolation at the MUHC/ RI-MUHC:

"But just like with anything new or an awkward technological age […with] machines […], everything is cold. It's literally cold. It's cold. It's very cold and it's very sad and it's very unfortunate that such a beautiful building like this can feel like this. Even among the professors themselves it's cold. Among the trainees, it's even worse" (Participant identity anonymized).

Additionally, for the RI-MUHC, it was suggested to establish a student wing or have a student representative on the current EDI committee. *"The EDI committee at the RI-MUHC is very broad and mainly employees. It would be great to have a student wing of the EDI committee for the students at the RI-MUHC, for the minority and international students at RI-MUHC"* (Participant identity anonymized).

Following up with a representative sample of trainees/students to evaluate their needs and the current climate for trainees/students at the MUHC and RI-MUHC is highly recommended. The fact that trainees/students should describe their training environment as being extremely cold and isolated should also be considered in the context of the fact that

many of them are international students and within the context of the current pandemic and associated layers of social isolation.

9. EDI Opportunities

Survey participants and qualitative assessment participants did not only share personal experiences and observations, but they also had suggestions on how the MUHC could be improved in regard to equity, diversity and inclusion. Survey participants are advocating for long-term strategies and solutions and a culture change at the MUHC/RI-MUHC. When asked about ideas and short-term actions in regards to the MUHC, the majority of survey participants who left comments highlighted the current organizational culture. Comments ranged from the depiction and displays of art works and portraits representing the diverse population of Quebec and concerns over language to an archaic system with implicit bias in the institution. Also mentioned were positive comments and suggestions such as to perform an organization culture assessment to update MUHC values.

Other suggested EDI opportunities were the incorporation of EDI, anti-oppression training and anti-isms, such as anti-Black racism and anti-Indigenous racism, into the MUHC's strategic plan, reviewing statistics on current employees and new hires, MUHC-wide and departmental surveys, representing MUHC's diversity in publications and communications material, showcasing success stories and performing a general evaluation of the organizational structure, as expressed by the following participants:

« Je ne pense pas qu'il y a beaucoup d'actions à court terme à prendre. Pour que le CUSM soit aussi inclusif que possible, des stratégies long-terme sont nécessaires, ce qui demande un changement de culture dans certains cas ». (Translation: "*I don't think there are many short-term actions to take. For the MUHC to be as inclusive as possible, long-term strategies are needed, which requires a change of culture in some cases")* (Partici*pant identity anonymized).

"(…) Perhaps some investigative work is in order. For instance, when looking at who filled a certain position, instead of looking at the outcome ("who got the position"), why not look at the opportunity ("Number of applicants, what criteria were considered, were the criteria met, etc."). Interview applicants, and interview managers. Remunerate them as needed. Declaring inequality of outcome without investigative data provides an incomplete picture that will lead to, at best, imperfect solutions, and at worst inadequate ones". (Participant identity anonymized).

"Increased diversity in news publications. Include more diverse news and stories across the MUHC. We typically see the same people in the MUHC news. With approximately 12,000 employees surely there is more to discuss than a few researchers and physicians" (Participant identity anonymized).

"To promote these values, it needs to become a true value and not just words. The behaviours need to be encouraged, modeled and taught throughout all levels of the institution" (Participant identity anonymized).

« Que le CUSM s'engage dans la reconnaissance de l'existence du racisme systémique ou du moins qu'il reconnaisse que cela peut prendre part dans ses établissements, mais qu'il condamne cela et qu'il comprenne que cela puisse être extrêmement dangereux pour les patients » (Translation: "*That the MUHC engage in the recognition of the existence of systemic racism, or at least acknowledge that it can take place in its institutions, but condemn it and understand that it can be extremely dangerous for patients*") (Participant identity anonymized).
« Voir [au] sein de l'organisation les problématique[s] que les employés soulèvent, donner la voix aux personnes qui subissent en silence des injustices. [Pour] être honnête, le [MUHC] est l'employeur le plus [inclusif] que je connaisse. Mais la gestion basée sur la sanction et la culture de la peur est en train de changer cela. On ne peut même plus parler car les échos se retrouve dans les bureaux de gestionnaire et on finit d'une façon ou une autre avec une réprimande » (Translation: "*Seeing the issues that employees raise within the organisation, giving a*

voice to people who silently suffer injustice. To be honest the MUHC is the most inclusive employer I know. But the management based on punishment and the culture of fear is changing that. We can't even speak out anymore because the echoes end up in the manager's office and one way or another we end up with a reprimand")
(Participant identity anonymized).

In addition to the above listed opportunities, MUHC and RI-MUHC survey participants provided an array of suggestions for events and programs, including a mentorship program and/or a buddy program, a celebration of diversity via social and informal events, the establishment of annual EDI activities, regular EDI 'Lunch & Learn' sessions, a wellness program, the establishment of a safe and non-judgmental space to ask questions and have discussions, the establishment of support groups and clubs (e.g. book club, music club), special cultural activities to learn more about a specific ethnic group, and the display of arts from all diverse groups of Canada/ Quebec. Participants want to celebrate the diversity the MUHC and the RI-MUHC has to offer.

- **Establishment of a Safe Reporting System**

Survey participants and qualitative assessment participants did not only share personal experiences and observations, but they also had suggestions on how the MUHC could be improved vis-à-vis EDI. One of the suggestions raised by survey respondents and interview/focus group participants was the establishment of a safe reporting system. Most of the participants cited that they do not know how or where they can report incidents of bias and discrimination safely and without the fear of repercussions. Some patients were aware of the ombudsman's office. However, some patient participants reported perceiving that the ombudsman supports the institution's point of view and not that of patients. There was no difference between visible and non-visible minorities with regard to expressing the need to have a safe reporting system for employees.

A cross-section of the myriad comments shared is found below:

"Create methods where we can report concerns without personal repercussions" (Participant identity anonymized).

« Il serait intéressant d'avoir une ressource dédiée à l'intégration en milieu de travail qui pourrait assurer le suivi de l'employé et assurer que celui-ci ne subisse pas de représailles ou autres conséquences en lien avec la divulgation de ce genre d'information. » (Translation: *"It would be interesting to have a resource dedicated to integration in the workplace that could follow up on the employee and ensure that he/she does not suffer retaliation or other consequences for disclosing this kind of information"* (Participant identity anonymized).

"Ways to safely signal observations of discrimination made by our superiors; there were times when this would happen and I had no way to safely share the information, as there would be personal repercussions if I reported the person" (Participant identity anonymized).

"A system of reporting is needed- before it's reported to the HR. Litigation is not always an option. Recipients need to be protected". (Participant identity anonymized).

"Method of escalating issues related to EDI that does not require communicating to immediate superiors (perhaps a dedicated HR service?)" (Participant identity anonymized).

"Better open-door policy to Human Resources to file a complaint and not be scared to lose your job when you do so" (Participant identity anonymized).

"Create an EDI hotline to report related issues" (Participant identity anonymized).

"Allow employees to make anonymous reports to an EDI officer or to meet with the ability to stay anonymous" (Participant identity anonymized).

"Create methods where we can report concerns without personal repercussions – [A] [MUHC staff position] called Indigenous people 'a bunch of drunks' at a work meeting and said that's why our department would not be providing care to this group. [The staff person] was very vengeful so I didn't report [them], as I didn't have a method to do so safely" (Participant identity anonymized).

"Insist on more accountability from supervisors and managers. At the moment, they have too much power over the people in their departments. As an employee, I feel like the RI is too far away to protect me, the manager does exactly as they please. We don't have a union, where exactly do RI employees go when they are treated unfairly?" (Participant identity anonymized).

"Take complaints relating to discrimination, harassment, and other abuses of power seriously" (Participant identity anonymized).

"A listening ear, acknowledgement of concerns and inclusion where necessary" (Participant identity anonymized).

« *Un service d'écoute pour tous ceux qui ont besoin de soutien en matière d'ÉDI* » (Translation: *"A listening service for all those who need support in relation to EDI"*) (Participant identity anonymized).

« *De l'écoute pour ceux qui signale un problème* ». (Translation: *"An ear for those who report a problem"*) (Participant identity anonymized).

"I am hoping that we can have a reporting hotline/email address with a transparent, online dashboard that shows recorded issues. For issues related to equity, diversity and inclusion, but also other issues that arise in the hospital. In a quick but comprehensive way, to ensure issues get reported" (Participant identity anonymized).

"We should have an anonymous reporting system, where it is easy to quickly send reports, then the reports can be investigated and reported in an open forum" (Participant identity anonymized).

"Also, some kind of info line we could call and speak to someone and get advice if something happens" (Participant identity anonymized).

"Maybe a hotline or email address to anonymously report, these reports are monitored. A[n] online dashboard exists to show people that a report was made and under what category, thus ensuring transparency. Transparency can ensure that people are motivated to report as they can see that they were heard" (Participant identity anonymized).

"The QI agents, as neutral and trusted outsiders to EACH clinic / service / department, could be charged with collecting such data or be the "first responders / triaging agents" directing personnel to appropriate resources" (Participant identity anonymized).

"How should the reporting system for that work?": "That's the big question right there. You need somebody that's not staffed by the hospital. That they can feel confident [in] going to. The ombudsman, they are supposed to be neutral but […], I don't think highly of the ombudsman's department. They are there just because they have to be there […]. But they have to have somebody that's maybe even off site from hospital to be able to

say, 'Look I have this problem', and the person has to know [that they] can go to them [and that] it is a safe space. That's what it comes out to, a safe space. And if the person finds out that they are being paid by the hospital, I think they hold back in speaking to them" (Participant identity anonymized).

"Provide patients and families a secure space to voice their experiences and integrate better mechanisms for 1) resolving these situations and 2) addressing the undercurrent (ex: departmental bias, training needed, etc.). Could be integrated into existing patients' committees, ombudsman" (Participant identity anonymized).

"I need an objective ombudsman that I could go to with concerns about psychological haras[s]ment. I cannot go to my supervisor, boss or HR since they are all part of the problem. There is no one here who can help me or be on my side - and I'm currently a [X] student, I know how proper mediation should be done - which leaves me vulnerable, and having to hire an outside lawyer to protect myself" (Participant identity anonymized).

- **Establishment of an EDI Office or Having a Designated EDI Person**

Another suggestion participants brought up is the establishment of an EDI office or having a designated EDI person at the MUHC and RI-MUHC. There was no difference between visible and non-visible minorities with regard to expressing the wish to have a designated EDI person or office. The following selected comments reflect this wish:

"Establish a dedicated EDI office" (Participant identity anonymized).

"Anonymous reporting: allow employees to make anonymous reports to an EDI officer or to meet with the ability to stay anonymous" (Participant identity anonymized).

"I need an office where complaints can be handled" (Participant identity anonymized).

"A dedicated EDI Office that would include representation from Indigenous, Black and other equity seeking groups is needed to address the significant amount of work that will be required in an ongoing manner" (Participant identity anonymized).

"Having an EDI officer to make sure that all policies and procedures at the MUHC follow EDI principles and to provide education would go a long way" (Participant identity anonymized).

« Créer un bureau affilié [à l']ombudsman qui peut faire le suivi sur les micro-aggressions » (Translation: *"Create an affiliate office of the ombudsman that can follow up on microaggressions"*) (Participant identity anonymized).

"Establish an MUHC EDI Office, under which initiatives to address anti-Indigenous and anti-Black racism and that of other equity seeking groups are housed/managed" (Participant identity anonymized).

"Create an ombudsman's office for Indigenous persons" (Participant identity anonymized).

« Ressources pour les équipes (besoin de quelqu'un de neutre pour aider à régler des différends entre patients/équipes de santé ou personnel de bureau ou autre personnel ou entre 2 employés et des directeurs/trices ou superviseur(e)s si problèmes car j'ai déjà eu des commentaires concernant le fait que notre union n'était pas toujours efficace. » (Translation: *"Team resources (need someone neutral to help*

settle disputes between patients/health teams or office staff or other staff or between 2 staff and managers or supervisors if problems as I have already had comments about our union not always being effective") (Participant identity anonymized).

"I need an establishment with trained advisors for [] help, support, or guidance when needed" (Participant identity anonymized).

« Il faut créer une adresse courriel confidentielle pour le EDI pour recevoir des plaintes d'employés qui se sentent lésés à ce sujet. Et assigner une personne compétente pour analyser les situations et trouver des solutions. (comme l'ombudsman) ». (Translation: *"Create a confidential email address for the EDI to receive complaints from employees who feel aggrieved about it. And assign a competent person to analyse the situations and find solutions. (like the ombudsman)".*) (Participant identity anonymized).

"I would like to have someone outside of the management structure to report and/or discuss issues that present themselves around EDI, with the option to keep it anonymous or not made aware to HR/management" (Participant identity anonymized).

"Definitely a safe place to talk openly without fear of prejudice or bias" (Participant identity anonymized).

« Création d'un bureau de l'inclusivité » (Translation: *"Creation of an Inclusiveness Office"*) (Participant identity anonymized).

« Miser sur l'expertise existante au CUSM mais qui manque de ressources : Bureau EDI? Voir les programmes et bureaux existants : Bureau partenariat patient, Services de consultation socioculturelle et d'interprétariat, soins centrés sur la personne au Children... Les programmes existent déjà mais les ressources sont insuffisantes pour mener un réel changement organisationnel from the top to the bottom, from the bottom to the top » (Translation: Build on existing expertise at the MUHC but that lack resources: EDI Office? see existing programs and offices: Patient Partnership Office, Socio-cultural Consultation and Interpretation Services, Person-centred Care at Children's... Programs already exist, but there are not enough resources to lead a real organisational change" (Participant identity anonymized).

"Have a central office that could have rarely needed but important adaptation devices for people with disabilities" (Participant identity anonymized).

"Given their positions they don't have a union, (MAUT/McGill Association of University Teachers is an association, not a union) either ombudsman. For example, creating a dedicated office would be a solution" (Participant identity anonymized).

"Train and make available EDI advisors and mentors to all MUHC sites" (Participant identity anonymized).

*« Créer un poste pour une personne ressource spécialisée dans la médiation et dans la formation du personnel de recherche et administratif aux questions EDI. Cette personne serait en charge de mettre en place des formations obligatoires sur les questions de diversité, équité et inclusion (biais implicites, microagressions, prise en charge des personnes issues de minorités au niveau clinique, etc.) Que la charge ne repose pas uniquement sur des personnes sur la base de leur volontariat. Pour que la politique EDI soit menée sur la continuité et ait un impact, un poste doit être créé ». (*Translation: *"Create a position for a resource person specialised in mediation and training of research and administrative staff on EDI issues. This person would be responsible for implementing mandatory training on diversity, equity and inclusion issues (implicit bias, microaggressions, dealing with minorities at clinical level, etc.). That the*

burden is not placed solely on individuals on a voluntary basis. For the EDI policy to be carried out on a continuous basis and have an impact, a position must be created") (Participant identity anonymized).
"When people make reports, the RI could follow up with them to ensure that issues are resolved. Right now, too many people feel that nothing ever happens; they need the jobs, so they suffer in silence" (Participant identity anonymized).

"*Create an ombudsman or similar 3rd party group where complaints can be officially taken and rigorously investigated, such as the system used in the government (both my siblings work in government and are shocked that there is no person higher than HR for me to take complaints of abuse to)"* (Participant identity anonymized).

"*A committee within the MUHC RI that handles complaints and harassment"* (Participant identity anonymized).

"People don't want to be branded as a racist. I suggest there should be an anonymous helpline for people to ask questions or advise about situations. Peers tell me stories and I just say "contact HR" but that's too much trouble and the problem festers" (Participant identity anonymized).

"EDI resources should be provided by RI-MUHC, FMHS, and McGill University" (Participant identity anonymized).

10. Positive Experiences

While the biases and discriminatory behaviour and treatment listed in this report may be disheartening, it is worth underscoring that participants shared positive and non-discriminatory experiences with C-AIDE and highlighted that they are confident that leadership will create an inclusive environment. For example, 35.3% of qualitative assessment participants shared at least one heart-warming interaction relating to their work (with patients and/or teams) at the MUHC. One of the most common elements shared was team environment and how the positive, collaborative relationships within one's immediate team contributes to their overall work culture/ environment. Participants expressed their gratitude and experiences while acknowledging the need for improvements as follows:

"Of course, I can only speak to my experience in my department. But I would say that […] as an employee, as a worker at the MUHC, I would say that my unit is very inclusive, it's very diverse, and we have equal opportunities. So, I am very happy with what is being done at that level. But it's interesting, […] [that], once upon a time something that was so obvious now, wasn't even considered as a priority then. So, what are […] we not seeing? That are issues that you know that aren't visible? But from what I can see as an employee, I'm very satisfied with like the work culture" (Participant identity anonymized).

"Yes, I am very comfortable coming to the MUHC, coming to work, I like what I do. I like the team that I am with. […] and I like the environment. I'm very comfortable". "When I walk […] into the Glen, it's like I am at home" (Participant identity anonymized).

"People are very nice, incredible expertise, hugely dedicated and some wonderful teamwork. It is an excellent place to work. In the area of EDI there is some improvement that could be made" (Participant identity anonymized).
"And I come to work, to work, but I also come to work, to be able to work together with people. Whether you are a colleague or manager, or supervisor, or even a doctor, nurses, we all come to work to work together as a team and I do believe in such a work, team effort" (Participant identity anonymized).

"I work in a team that is very inclusive and very respectful. So, my direct team is […], I would say very amazing in that way" (Participant identity anonymized).

"So far, I have had the utmost respect and trust for the MUHC community, whether for my personal needs, or the care that my family has received. I have witnessed diversity in its staff, from the professionals to all other service providers and caregivers. I have not witnessed anyone being turned away, for reasons involving non-inclusion" (Participant identity anonymized).

In general, participants also shared that everything they do is for the patients and expressed their desire to help patients in any way they can, as follows:

"I like being able to help the patients. That's really like what coming to work is all about, for the patients" (Participant identity anonymized).

"I work for the patients who are waiting for me, I know that they are in my hands" (Participant identity anonymized).

"Ultimately we care for people like patients and their families" (Participant identity anonymized).

« Cependant c'est un endroit qui a sa dose de rumeurs aussi. Même si certains départements ne s'aiment pas et ou, ont mauvaise réputation, on va faire notre part et un peu plus si c'est pour aider un patient. En échange de faire sa part, de faire partie de l'équipe et de mettre de côté son égo, on peut gagner du professionnalisme et de l'entraide ». (Translation: However, it's a place that has its share of rumours too. Even if some departments don't like each other or have a bad reputation, you will do your bit and a bit more if it is to help a patient. In exchange for doing your part, being part of the team and putting your ego aside, you can gain professionalism and mutual support") (Participant identity anonymized).

7. DISCUSSION

Prior Initiatives and Current Observations

Before C-AIDE was set up, after the murder of George Floyd by a police officer shocked people around the world and sparked public demonstrations, public- and private-sector institutions began to examine or re-examine their policies and practices of inclusion and commit to anti-racist practices within the Canadian community, including CPS, UHN, Sick Kids, Black North Initiative, to name but a few in Canada. *(*1) At the MUHC, Sociocultural Consultation and Interpretation Services (SCIS) posted a statement on the MUHC portal entitled "Black Lives Matter at the MUHC" acknowledging the existence of racism in the healthcare system with relevance for the MUHC. SCIS proposed offering "Unlearning Racism" workshops for healthcare workers. These workshops/webinars were offered in 2021, raising awareness and encouraging collective action to create an Anti-Racism Strategy with focused education. *Unpacking Racism: Tools for Healthcare Workers Summary (*2).

Other initiatives undertaken by SCIS included Indigenous History, Health and Culture workshops/webinars, held over a period of 5 years starting in 2015, following the *Calls to Action* from *The Truth and Reconciliation Commission,* launching a pilot in collaboration with Northern and Native Pediatric Health. Proposed recommendations were made in *Indigenous History, Health and Culture Reflecting Indigenous Worldviews at the MUHC: The Way Forward (3), promoting Indigenous friendly initiatives.*

In 2014, the MUHC (SCIS and Quality and Risk), after participating in the development of Health Equity Standards with HPH International Migrant Friendly Task Force, then pilot tested those standards with other participant organizations. (4) In 2018, members of the TF and others spoke at a two-day *Health Equity Symposium: Embedding Health Equity into Policy, Practice and Participation, October 11 and 12 2017* hosted by SCIS-MUHC and ACCESSS, a provincial lobby group representing health needs of diverse ethnocultural communities. The goals of these initiatives were to encourage the adoption of Health Equity policies and practices at The MUHC (5). Some specialized services/speakers who presented at the symposium were/are involved in equity-based initiatives, but in order for equitable access to become routine throughout the MUHC, RI-MUHC and elsewhere, a public commitment to equity-based policy and practice is required, (6) accompanied by detailed action plan(s), in line with the C-AIDE recommendations to update existing and develop new inclusive policies. These plans should encompass concrete processes and structures that encourage participation in equity practices (data collection, measurement, education, budgets, community outreach and partnerships, etc.,) and incentives to mark progress. Examples would include budgets for diversity recruitment, translations, language interpretation and equity-based initiatives involving under-represented communities with annual measures to identify progress, gaps and causes.

As racism has been identified as being prevalent in workplace arenas, including healthcare settings, anti-racism practices with an anonymous reporting system for professionals and personnel would be beneficial. In the C-AIDE Report, patients were not surveyed due to COVID restrictions but they could benefit from a similar process. Clear guidelines are recommended in outlining the parameters of a racism reporting initiative for successful outcomes. It would be helpful to involve a Social Justice (a fair route to equality) practicing entity to carry out this work. Additionally, a restorative justice (RJ) mediation approach to resolving issues. RJ is associated with the legal system but it shows increasing positive impacts over time in academic and other settings (7), demonstrating adaptability for the workplace. Independent management would build trust and protect confidentiality. In that regard, C-AIDE carried out an abridged literature review on safe reporting systems, findings of which follow here:

- **Safe Reporting Systems**

    Relevant articles identified present key considerations for safe reporting system design to support an organizations' commitment to EDI principles. Recommendations made throughout the literature aim to reduce barriers to reporting for healthcare personnel and ensure fair and equitable responses to filed reports.

Main barriers to reporting: The literature identifies key barriers healthcare personnel face in reporting incidents of discrimination and harassment. These include inability to identify an incident of harassment or discrimination, unfamiliarity with the reporting process, and fears of retaliation or having concerns dismissed or ignored (Dobbin & Kalev, 2020; Fenwick et al., 2022; Hostetter & Klein, 2021; Huang et al., 2022; Jenner et al., 2022; LeSage, 2019; Ontario Human Rights Commission, 2008; Vargas et al., 2022; Zeidan et al., 2022). Further concerns that personnel are hesitant to file a report due to inaccessible or unclear reporting procedures are also prominent in the literature (Fenwick et al., 2022; Huang et al., 2022; Jenner et al., 2022; LeSage, 2019; Odes et al., 2022).

Throughout the literature, one finds recommendations to reduce barriers to reporting. These recommendations address:

- Education and training on reporting procedures;
- Reporting system design, and;
- Institutional response to filed reports.

Education and training: There is broad consensus in the literature that education and training must accompany the implementation of a reporting system (Dobbin & Kalev, 2020; Hostetter & Klein, 2021; Huang et al., 2022; Jenner et al., 2022; LeSage, 2019; Ontario Human Rights Commission, 2008; Zeidan et al., 2022). Recommendations include ensuring all employees know the definition of discrimination and harassment and can identify behaviour that warrants reporting (Hostetter & Klein, 2021; Jenner et al., 2022; Ontario Human Rights Commission, 2008; Zeidan et al., 2022). It is also widely recommended that training ensure all personnel know how to report an incident and what will happen during the reporting process (Jenner et al., 2022; LeSage, 2019; Zeidan et al., 2022). In a review of nurse-reported incidents of workplace violence, Huang et al. (2022) find that familiarity with the reporting process may help diminish fears of retaliation or other perceived negative consequences from reporting (Huang et al., 2022).

Reporting system design - anonymous reporting: There is mixed support in the literature for anonymous reporting systems. Such reporting systems are widely acknowledged to address the concern of retaliation (Hostetter & Klein, 2021; LeSage, 2019; Zeidan et al., 2022). However, anonymity may restrict how an institution can respond to a report (Dobbin & Kalev, 2020; LeSage, 2019; Zeidan et al., 2022). Zeidan et al. (2022) identify concerns among personnel that anonymous reporting may lead to abuse of the reporting system and inaccurate accusations. LeSage (2019) further proposes that the potential misuse of an anonymous system may fail to normalize or increase comfort with the reporting process. There is no consensus in the literature regarding whether an anonymous reporting system can be used to pursue fair and equitable formal investigations. Hostetter and Klein (2021) recommend instead that information collected from anonymous reports be used to identify areas of concern within an institution, which may warrant increased oversight or targeted training and education programs. The Ontario Human Rights Commission (2008) also recommends that institutions proactively respond to areas of concern even without formal complaints having been filed. While Dobbin et al. (2020) suggests that anonymous reporting cannot allow for identification of trends in perpetrator behaviour, as perpetrator identification may not be possible, they did not consider the merits of other information that may be collected, such as the department in which the incident occurred or the nature of the incident. This information may be used to inform institutional responses to discrimination and harassment (Hostetter & Klein, 2021; LeSage, 2019).

Reporting system design - various reporting options: There is evidence in the literature that providing a variety of reporting systems may encourage higher rates of reporting incidents of discrimination and harassment (Dobbin & Kalev, 2020; Fenwick et al., 2022; Schneider et al., 2016; Vargas et al., 2022; Zeidan et al., 2022). There is strong support for a system design where both informal and formal reporting options are available to personnel (Dobbin & Kalev, 2020; Vargas et al., 2022; Zeidan et al., 2022). Informal reporting systems may

include the option of remaining anonymous, and may trigger mediation or dispute resolution procedures without necessarily leading to further disciplinary action through a formal investigation. To encourage reporting, studies show that variety in reporting methods is important (Dobbin & Kalev, 2020; Fenwick et al., 2022; Schneider et al., 2016). Methods may include options to report through an online platform, through a telephone hotline, or in-person (Schneider et al., 2016).

Consultation: There is evidence in the literature that access to consultation for personnel considering filing a report may help build comfort and familiarity with the reporting process and decrease fear of retaliation (MacCurtain et al., 2018; Zeidan et al., 2022). A consultation process allows a reporting party to discuss an incident with a trusted advisor or designated support person before filing a report (MacCurtain et al., 2018; Zeidan et al., 2022). This consultation can provide information to the reporting party on their options for both formal and informal complaint resolution procedures (MacCurtain et al., 2018; Zeidan et al., 2022). There is mixed support in the literature as to whether this consultation should be carried out by a member of the organization or an independent third party (LeSage 2019, Jenner et al., 2022; Zeidan et al., 2022.).

Institutional response to filed reports: An institutional response to a filed report can have an important impact on the comfort of personnel with the reporting system. A study by Fenwick et al. (2022) which identifies expert recommendations for reporting system design argues that institutions must take all complaints seriously and provide logistical support for the reporting party in order to promote a culture within the institution where violation of EDI principles is not tolerated. Huang et al. (2022) and Fenwick et al. (2022) stress the importance of institutional follow-up with the reporting party regarding a report's outcome, whether resolved through formal or informal means. Follow-up on reports and completed investigations may identify or reduce retaliatory action and provide feedback to the institution on employee satisfaction with the reporting process (Fenwick et al., 2022; Huang et al., 2022).

Limitations: The literature on safe reporting systems has a primary focus on instances of sexual harassment and gender discrimination. Further research is required to assess reporting system use for other forms of harassment and discrimination.

Community Engagement and Consultations

Throughout the execution of its mandate, C-AIDE conducted formal and informal consultations with a diverse group of (internal and external) experts in equity, diversity, inclusion, anti-racism and indigeneity, locally and nationally, to draw upon leading practices to help inform the work of this committee. The committee also shared educational opportunities with the MUHC community, through webinars, panel discussions and workshops - the latter forum being restricted during the CoVid-19 pandemic. Among the experts consulted were: Dr. Upton Allen, Professor of Pediatrics and Chief of Infectious Diseases at SickKids, University of Toronto; Dr. Kwame McKenzie, CEO, Wellesley Institute; the Health Committee Co-Chairs of the Black North Initiative - an organization committed to removing barriers negatively affecting the lives of Black Canadians; McGill Faculty of Medicine and Health Sciences Social Accountability and Engagement Office/SACE; Wabano Center for Aboriginal Health; Mr. Sipi of Flamand, Vice-Chief of Manawan; Hear Entendre Quebec; and Colors of COVID. Internal consultations were held with three unions representing MUHC's workforce, the Council of Nurses, MUHC Partnerships Office, nurse managers, and the Council of Physicians, Dentists and Pharmacists of the Montreal Children's Hospital, among others. In addition, MUHC leadership supported the participation of C-AIDE co-chairs and other members in local, national and/or international conferences focusing on the development and translation of leading practices in EDI, anti-Black and anti-Indigenous racism.

Throughout its mandate, C-AIDE received requests for consultations from Quebec healthcare institutions and collaborated to varying degrees in the development/design of approaches to evaluate the status of EDI in such organizations as the Teresa Dellar Palliative Care Residence. C-AIDE co-chairs and other members served as advisors, collaborators and/or reviewers of community-driven EDI research projects and initiatives at the McGill Faculty

of Medicine and Health Sciences (e.g., implementation of Black Candidate Application Pathway and/or Provostial delegate on academic hiring committees), at the University of Montreal, and of national initiatives in health education and EDI (e.g., Black Health Education Collaborative, Canadian Conference on Medical Education 2022 Subcommittee on Anti-Black Racism and Health, and Association of Faculties of Medicine of Canada).

C-AIDE wishes to shine a light on various positive achievements:

- The leadership of the Sociocultural Consultation and Interpretation Service of the Montreal Children's Hospital for over 30 years;
- C-AIDE Ad-hoc member and award-winning author of "*Fighting for a Hand to Hold: Confronting Medical Colonialism Against Indigenous Children in Canada*", Dr. Samir Shaheen-Hussain whose advocacy campaign to enable critically ill Indigenous children to be accompanied by their parents during air ambulance transfers from Northern communities to the MUHC is a prime example of how to make a life-changing impact
- Inclusion of Indigenous representation on Outpatient Subcommittee (Glen site);
- The Culturally-Safe Indigenous Birth in High Risk Obstetrics project being implemented this year at the MUHC Birthing Centre, including Inuit-led cultural safety training;
- Translation of MUHC Patient Brochure into Inuktitut, Cree and Mohawk languages;
- Collaboration between MUHC and Indigenous Health Center of Tiohtia:ke (IHCT), including a new project being planned in collaboration with the MUHC Department of Family Medicine and Queen Elizabeth Urgent Care Clinic, entitled "Establishing culturally safe walk-in medical services for urban Aboriginal people in Montreal";
- The project entitled "Towards Cultural Safety: Understanding MUHC professionals' beliefs, attitudes, knowledge around care for Indigenous patients", which includes rapid assessments of the status of cultural safety of MUHC professionals to inform the adaptation of cultural safety training to the specific needs identified within the MUHC community, in close collaboration with Indigenous communities and under the umbrella of the MUHC Partnerships Office;
- An initiative to sensitize clinical teams to diversity in gender identities;
- Other initiatives led by the Nursing department;
- The MUHC Distance Learning Continuing Education Program for interdisciplinary healthcare professionals residing in/serving Indigenous communities;
- Joint initiatives with the McGill Faculty of Medicine and Health Sciences and Faculty of Dental Medicine and Health Sciences in the implementation of the respective Action Plans to Address Anti-Black Racism;
- Creation of EDI committees at the MNH site and the RI-MUHC; and
- The diverse composition of the MUHC Board of Directors - all of whom underwent unconscious bias training during the early stages of C-AIDE's mandate, its timely adoption of five of C-AIDE's (six) preliminary recommendations in 2021, and bold leadership in commissioning this study.

Indigenous Voices and Perspectives

Recognizing the vast expanse of geographic regions from which MUHC patients hail and the value of community partnerships, C-AIDE invested efforts to include and to learn the perspectives/insights of community partners, including members and allies of Indigenous communities. Despite COVID-19 pandemic and other trauma-induced challenges to participation in the second/qualitative phase of this study, C-AIDE received input from Indigenous scholars and allies and was informed by the previous community-driven needs analysis and recommendations produced by the Indigenous Health Center of Tiohtia:ke. Among its main recommendations, the IHCT called for the implementation of a holistic approach to healthcare anchored in four main pillars to facilitate access to quality care and services for 35,000 First Nations, Metis and Inuit residents in Montreal, with attention to the diversity of languages, origins and cultural practices to help mitigate the impact of social determinants of health. These include (1) mandatory cultural safety training for all healthcare professionals; (2) Indigenous navigators to accompany Indigenous patients throughout each stage of their care trajectories; (3) creation of departments of Indigenous Health within healthcare institutions, to support the delivery

of culturally safe care throughout the healthcare network, including culturally sensitive adaptation of physical spaces, including smudge room; and (4) establishment of holistic/comprehensive Indigenous healthcare centers including primary care and mental health services.

C-AIDE acknowledges having heard serious concerns expressed by Indigenous communities and allies, seeking suspension of MUHC's promotion of the MSSS-mandated cultural sensitivity training "*Sensibilisation aux réalités autochtones*" modules, pending consultation with the MSSS to adapt it under the direction of Indigenous knowledge keepers and scholars to halt harmful impacts. MUHC healthcare professionals, trainees and researchers voiced similar concerns during the quantitative and/or qualitative phases of this study. Three letters documenting these concerns were shared with C-AIDE.

As an example, the following extract from one letter highlights specific concerns of the Cultural Safety Committee of the Council of Physicians, Dentists and Pharmacists for Region 18 – Eeyou Istchee, the Cree territories of James Bay, which relies on the MUHC for tertiary care services:

1. *"By definition, all training on cultural safety for Indigenous users of the health system should be led by Indigenous communities owned by them, and follow an agenda determined by their needs. The MSSS modules do not meet this basic standard.*
2. *Cree colleagues who were deemed to have been consulted on the development of the modules expressed several concerns about them, but their input was ignored. Their approval of the final modules was not sought.*
3. *At a minimum, it is most appropriate for the MUHC to consult the Nations it serves in its RUISSS on which cultural safety trainings they consider relevant for their particular realities, including but not limited to, the Kanien'kehá:ka, Anishinaabek, Cree, and Inuit Nations. Many communities have trainings they are able to offer. The government of Quebec is not in any way a recognised authority on systemic racism, cultural safety, or Indigenous realities.*
4. *The MSSS modules do not address in any depth the calls to action in healthcare from the Truth and Reconciliation Commission, the health-related recommendations of the Viens Commission, or Joyce's Principle, all of which we believe are fundamental components of knowledge and orientation for any health worker in Quebec.*
5. *The MSSS modules do not centre on the lived experiences in healthcare of Indigenous people in Quebec, nor do they address the particular dynamics of navigating cultural safety within care-based relationships, where power plays a very particular role."*

The above concerns were echoed by the outcry of Indigenous voices, including patients, caregivers, scholars, elders, physicians and interdisciplinary allies within the MUHC and RI-MUHC and wider community, including views such as:
"I found it disrespectful to not address Joyce's death, systemic racism or Joyce's Principle. The training barely touches on healthcare or healthcare history. It was also alarming how little Indigenous experts were consulted. It is time to listen."

Professor Faiz Ahmad Khan, clinician-scientist at the RI-MUHC and a respirologist at the MUHC and Inuulitsivik & Tulattavik Health Centre stated:

"I am concerned that the MSSS "Indigenous awareness" training may actually counteract progress being made on addressing anti-Indigenous racism in the Faculty of Medicine and at the MUHC.

1 - The majority of the content is delivered by non-Indigenous people, many of whom are academics. This reflects a mind frame in which non-Indigenous voices are considered better suited-more "expert"- to speak about Indigenous people than Indigenous people themselves. Moreover, it transmits the message that Indigenous peoples are to be studied in order to be understood. It is particularly disturbing that the history is told from a purely settler perspective and by non-Indigenous academics, rather than by Indigenous historians.

It is not surprising that history is whitewashed, with deliberate acts of violence, including those involving spread of disease and non-consenting experiments left out.

2 - The violence and unsafety that Indigenous people experience over and over again when seeking healthcare in Quebec is not mentioned even once. No mention of the Viens commission. No mention of Joyce Echaquan and the coroner's report on her death. No mention of racism. No mention of the TRC. By completely ignoring these issues, the makers of this training are actively working against the demands of Indigenous people to address these problems directly. I am frankly appalled by these omissions.

3 - It would be naive to consider the brief video portion where Indigenous people provide advice about how to interact with them, as demonstration that Indigenous people were provided a platform and voice in the video. It is likely that it was non-Indigenous people curating the questions, and not directly asking about racism and violence and how to address them.

4 - Supporting this type of video is also inconsistent with the following recommendation submitted to the Dean of the FMHS, by a committee struck to make recommendations on how to strengthen social accountability in the school of medicine: Ensure that Indigenous-created and led cultural safety training specific to the populations we serve is mandatory for all members of the School involved in clinical work and research. Offer support to Indigenous communities that are in the process of developing such training."

Among other concerns expressed by Indigenous people and allies, including MUHC clinicians and researchers, were that this type of training will cause more harm than good; that non-First Nations or non-Indigenous people are not qualified to give training/teaching of Indigenous peoples' realities; that important historical facts were erased/omitted, the absence of any reference to the late Mrs. Joyce Echaquan's experience with racism at the hands of a nurse at Centre hospitalier de Lanaudière, Joliette, Quebec shortly before her death; no reference of smallpox and disease brought by Europeans to Indigenous peoples in Canada; no mention of the disappearances of Indigenous children within the Quebec medical system; and no comment on the unethical medical experiments performed on children in residential schools; and no discussion of the OCAP (ownership, control, access, and possession) principles - a cornerstone of modern research with Indigenous persons and communities.

C-AIDE first shared similar concerns expressed by MUHC health professionals and Indigenous communities, including Indigenous elders, with the Board of directors and MUHC Partnerships Office last spring. During this study, survey participants mentioned the importance of "trauma-informed care" and advocated for cultural safety trainings to be led by Indigenous people. C-AIDE renews its call for the MUHC to cease promotion of the controversial "*Sensibilisation aux réalités autochtones*" training program at the MUHC, pending consultation with the MSSS and subsequent revisions informed by the experiences and leadership of Indigenous patients, colleagues or partners, to prevent further harm. C-AIDE also calls for the MUHC to adopt a land acknowledgement statement developed by a committee of Indigenous scholars and lived expertise.

About Diversity in Staff, Management and Leadership

In terms of diverse representation in management by being included and heard, many spoke about not feeling safe, appreciated or confident in traditional processes. As one participant describes: *Inclusion is having a voice, and belonging is having a voice be heard. These statements and comments indicate situations of epistemic injustice when someone is given less credence than they deserve (Miranda Fricker) (8) This occurs when a speaker's explanations are considered less credible (testimonial injustice) and/or there are differences in interpretations of collective or individual experiences, corporate versus community, that put minority voices at a disadvantage in being acknowledged or having concerns meaningfully addressed (Hermeneutical Injustice). (8)*

Credibility factors apply in the workplace where knowers or knowledge keepers in the hierarchical chain bring their own distinct perspectives on their lived experiences pertaining to work that do not correspond to the structural norm and belief systems of those who have more power in the chain. While anyone can experience epistemic injustice, marginalized groups that are negatively stereotyped and underrepresented in positions of power are especially likely to be treated as lacking knowledge when they possess valuable information, and can be left out of opportunities to gain knowledge and share the knowledge they possess. Special efforts are required to keep all staff persons/professionals, students and others (knowledge keepers) engaged and contributing their perspectives in safe spaces that will lead to shifts in integrative organizational practices. Please see section 12 for references.

Leading Practices and Other Resources

C-AIDE compiled a significant number of publications and other resources regarding leading practices, topics related to EDI, plans of other institutions, etc. These resources are consolidated in an Excel document with links for eventual integration on an electronic platform available to all.

8. LIMITATIONS AND STRENGTHS

Historical Events to Consider

It is important to consider major historical events that happened either before or during the data collection process for the work undertaken by C-AIDE, notably:

1) Bill 21, "An Act respecting the laicity of the State" was adopted on June 16, 2019 (An Act Respecting the Laicity of the State, 2019). Bill 21 restricts wearing and displaying visible religious imagery, such as crosses, hijabs, turbans and yarmulkes, in the public service.

2) On March 11, 2020, the World Health Organization (WHO), declared the novel coronavirus (COVID-19) outbreak a global pandemic (World Health Organization, 2020). All of the data collection for C-AIDE's work took place during the pandemic. Semi-structured interviews and focus group discussions were held during the sixth wave of the COVID-19 pandemic in Québec.

3) On September 28, 2020 Joyce Echaquan, an Indigenous woman and mother of seven, died shortly after recording a video of hospital staff insulting her as she lay helpless and in distress in the Centre hospitalier de Lanaudière in Saint-Charles-Borromée, Quebec. Ms. Echaquan's death caused a national outcry and calls for political leaders in Quebec to acknowledge the presence of systemic racism in the province.

4) The survey was e-mailed to the MUHC community in March 2021 approximately 10 months after police officers in the USA killed George Floyd on May 25, 2020, drawing attention and an international outcry (T*he New York Times*, 2022).

5) Qualitative interviews and focus group discussions took place in March and April 2022 after the publicized discovery of unmarked graves of Indigenous children at former residential schools in Canada, which was announced on May 27, 2021 (Dickson & Watson, 2021).

6) Bill 96, "An Act respecting French, the official and common language of Québec" was announced on October 21, 2021 and adopted on May 24, 2022 (An Act Respecting French, the Official and Common Language of Québec, 2022).

Limitations for Open-ended Questions for Surveys and Qualitative Assessment

1) (Some) survey participants used the open-ended questions to leave comments, no matter the question in both surveys.

2) Short answers without explanation or details: Survey participants wrote very brief comments without any explanation or providing any details, context in relation to the issue, concern, or idea (e.g., sexism).

3) 'Vague, non-contextual responses: Some survey participants avoided giving a definite answer or position by skimming the surface of an issue or concern, but providing no further details or explanation.

4) Number of details can lead to identification of participant and other parties involved. Survey respondents and interview participants provide scenario(s) and other relevant details (such as proper names and institutional positions or titles) related to the concern or issue, which can lead to the identification of the participant and other individuals. In order to protect the anonymity of participants, some details cannot be shared.

5) Participants had the opportunity to provide written responses to the seven interview questions via e-mail. Follow-up questions were handled via e-mail and some e-mails may have been left unanswered by participants.

6) In-person recruitment was not possible. Due to the ongoing pandemic, the continuous infectious disease prevention measures in place at the MUHC sites, and the fact that some MUHC employees do not have an MUHC e-mail address and/or do not have access to the MUHC Intranet, potential participants may have not been aware of the C-AIDE EDI initiative and may have been missed, which represents a significant limitation.

7) Due to the use of a Web-based survey and electronic recruitment for participants in this project, electronic/digital literacy may have been an issue for potential participants.

8) Patients' voices are missing in the survey data. The survey focused on the MUHC workforce with employees and physicians receiving e-mails. Memos and Intranet messages were sent out multiple times. While C-AIDE wanted to reach patients and volunteers, the pandemic and available resources resulted in this desire being set aside. It therefore represents a limitation despite a number of patients' voices being captured in focus group discussions.

9) Indigenous voices are missing from the qualitative assessment (focus groups and interviews) though, with respect to the survey, 1.1% of MUHC survey respondents identified as Indigenous/Metis/Inuit, while 0.9% for the RI-MUHC. Additionally, Indigenous voices of the Indigenous Health Centre of Tiohtia:ke (IHCT) and others contributed through their prior community-driven needs assessment and recommendations and on-going discussions, respectively. This is elaborated in a separate section of this report above entitled: Indigenous Voices and Perspectives.

10) Trainee/student voices are present, but are limited in terms of quantity and further discussions with trainees/students are therefore needed.

11) Other important issues (topics) may have been missed or overlooked due to the nature of the qualitative approach used and other challenges.

12) The coding and analysis of qualitative data is time-consuming and the observations and interpretation of data may be subjective.

13) With respect to the survey data, a conclusive statement regarding the representativeness of the studied sample cannot be made as MUHC Human Resources does not have adequate sociodemographic information on 43% of the MUHC workforce. However, the sample is of practical significance since the respondents comprise people from various sectors, disciplines and stakeholder roles across the institutions. Additionally, some members of the MUHC also hold positions at the RI-MUHC.

Strengths

1) The qualitative approach allows for the capture of a diversity of experiences, perceptions, and incidences of equity, diversity, and inclusions (or the lack of it) at the MUHC/RI-MUHC.

2) The qualitative data obtained on lived experiences are very powerful and can be more compelling than quantitative data. Stories and direct quotes derived from the qualitative assessment may make it easier for people to understand the findings.

3) Qualitative data allow for the identification of trends (themes) by looking for statements (quotes), which are similar and/or identical between participants. Open-ended questions in the survey and interview results allowed for the identification of overlapping trends (themes) by two different assessment types.

4) Issues and concerns shared with C-AIDE allowed for detailed and in-depth examination.

5) Interviews were not restricted to the prepared seven questions, which allowed the interviewers to redirect questions and ask for more details in real time (only if participants wanted to share more information).

6) Interviews and focus group discussions allowed the capture of emotions (non-verbal clues).

7) The qualitative assessment approach allows for the exploration of sensitive topics.

8) The qualitative assessment approach gives voices to participants.

9) The anonymous Web-based survey provided respondents the opportunity and a safe forum in which to voice opinions and raise issues, which may have been missed or ignored in the past.

10) The capturing of participants' demographics data provides a potential snapshot of the MUHC's workforce and a baseline from which the MUHC's Human Resources directorate can conduct additional assessments.

11) The data analysis and participant engagement in focus group, interviews and feedback was conducted by an experienced, independent researcher with Masters degrees in bioethics and public health who has a solid understanding of Tri-council Policy Research Ethics, data gathering, analysis and reporting and an unwavering professional commitment to research ethics. The researcher had no role, knowledge of, or position with the MUHC, thus ensuring no institutional bias, conflicts of interest or interference.

12) Participants had the opportunity to self-identify with respect to the various demographics indicated, such as gender identity, cultural identity etc.

13) Participants had the right to decline any questions or topics as they wished.

Findings

1) Are useful in testing current policies for their relevance, accuracy, timelines, effectiveness, and either updating and/or developing new policies.

2) Aid in long-term planning for continuous investment in EDI at the MUHC and RI-MUHC.

3) Fill an existing data gap by giving voices to a variety of participants who are often left out and by providing details and in-depth insights into sensitive topics related to EDI at the MUHC and RI-MUHC.

4) Have the potential to inform the exploration of additional areas of EDI to get a more in-depth understanding of challenges and opportunities.

5) Have the potential to establish and promote new initiatives at the MUHC and RI-MUHC.

6) Help to improve and revise existing care and services (e.g., safe reporting system for employees and patients) so everyone feels welcomed, valued and respected.

7) Should be viewed as a starting point to invest in EDI at the MUHC and RI-MUHC with a purview to establishing them as world leaders in EDI with respect to their collective work force and patients, and as experts in socioculturally inclusive, responsive, equitable health care, social services and research.

Challenges

1) Given the sensitive nature of this institutional study on equity, diversity and inclusion, many very delicate subjects were raised and there were very difficult conversations about issues of racism, sexism, ableism, ageism, linguism, xenophobia etc.

2) Study participants expressed concerns about potential repercussions but, by guaranteeing them a safe space where their anonymity would be preserved, they shared their experiences and provided very emotionally charged and sensitive feedback.

3) The survey used colonial terminology in certain instances. Terminology, especially as it pertains to Indigenous and other colonized populations, can be offensive, sensitive and very challenging to navigate. As the domain of cultural safety and sensitivity is developing, it is important to be socio-culturally safe in the use of language, methodology, evaluation and interpretation of data in all spheres of research, in fact, in all disciplines.

4) The committee faced a number of challenges related to apprehension in promoting the surveys and focus groups amongst their colleagues; the ongoing effects of the COVID-19 pandemic-imposed demands on schedules and constraints that created additional hurdles in accessing potential participants (workforce and patients); and an attempt to acquire sensitive information during the process that was averted.

9.   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).**

10. CONCLUSION

The alignment of C-AIDE's preliminary and final recommendations speaks to the commonality and credibility of the experiences shared by a broad range of MUHC stakeholders during the quantitative and qualitative assessment phases of this study. The findings offer clear evidence that the MUHC leadership's "Call to Action" two years ago was justified. The results of this study and participants' shared lived experiences are not intended to point fingers. Rather, the report is about acknowledging the existence of various attitudes of racism, bias, discrimination and xenophobia throughout the MUHC and RI-MUHC and proposing solutions to make the institutions more inclusive, equitable and socioculturally diverse for the benefit of both the patients served and the workforce.

Having been entrusted with the immense privilege of listening to, hearing, and learning about the lived experiences of a broad range of MUHC stakeholders, many of whom feel unseen or unheard, C-AIDE cannot unsee what we have seen, nor can we unhear what we have heard. As the late Maya Angelou once said: "Do your best until you know better. Then when you know better, do better." The MUHC's leadership is correct. We can — and must — do better. The overall combined level of (somewhat, very or extreme) confidence in the MUHC (84.7%) and RI-MUHC (94.3%) leadership's ability to create an inclusive work environment, together with the deep appreciation for the passion and commitment of MUHC's clinical teams to deliver excellent patient care, as expressed by a majority of study participants, speak well to the readiness of MUHC stakeholders to confront these challenges collaboratively. To this end, C-AIDE looks forward to the adoption and rapid implementation of this study's evidence-based, community-inspired recommendations by the Board of Directors and Senior Management of the MUHC to optimize the health and well-being of *all* MUHC stakeholders, by championing best practices in equity, diversity, inclusion and indigeneity.

Prior to the completion of this report, an unknown source leaked a working draft to a media outlet. The ensuing coverage was unfortunate, as the report was incomplete and not final. This in turn resulted in an increase in MUHC voices contacting C-AIDE and / or the C-AIDE co-chairs with more reports of various forms of discrimination and racism they have encountered.

The study may have ended and the report written, but the issues continue, as does the important need for action on inclusion, diversity and equity. A bold step forward has been made with this report and there is every reason to believe that the courage already exhibited by the Board of Directors of the MUHC and MUHC Management will translate into leading practices in EDI at every level of the institution.

11. GLOSSARY OF TERMINOLOGY

"**Ethnic minorities**" refers to people of a particular race or nationality living in a country or area where most people are of a different race or nationality.

"**Ethnic origin**" refers to the ethnic or cultural origins of the person's ancestors. An ancestor is usually more distant than a grandparent (Statistics Canada, 2021b).

"**Gender**" refers to an individual's personal and social identity as a man, woman or non-binary person (a person who is not exclusively a man or a woman). A person's gender may differ from their sex at birth, and from what is indicated on their current identification or legal documents such as their birth certificate, passport or driver's licence. A person's gender may change over time (Statistics Canada, 2021d).

"**Indigenous**" or Indigenous people or Indigenous group refers to whether the person is First Nations (North American Indian), Métis and/or Inuk (Inuit) any related identities (Statistics Canada, 2021a). Indigenous people identify as being descended from the Original Peoples of what is currently known as Canada (Government of Ontario, 2022).

"**Mother tongue or native tongue**" refers to the first language learned at home in childhood and still understood by the person at the time the data was collected. A person has two mother tongues (or native tongues) if the two languages were learned at the same time and are still understood by the person (Statistics Canada, 2021e).

"**Persons with disabilities**" refers to people with a long-term, persistent or recurring physical, mental, sensory, psychiatric or learning impairment and who consider themselves disadvantaged in employment or other situations because of that impairment and the functional limitations it causes, or believe that an employer might consider them disadvantaged. Persons with disabilities also include those who have been or should be accommodated in their current job because of their functional limitations (e.g., by means of technical aids, changes to equipment or other working arrangements) (Human Resources and Skills Development Canada, 2013).

"**Racialized Persons/visible minorities**" refers to persons of colour (excl. Indigenous peoples) who are non-Caucasian in race or non-white in colour (Statistics Canada, 2021c).

"**Sex at birth**" refers to sex assigned at birth. Sex at birth is typically assigned based on a person's reproductive system and other physical characteristics (Statistics Canada, 2021f).

"**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 they were assigned at birth. 2SLGBTQIA+ stands for Two Spirit, Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, Intersex, Asexual, and other.

"**Tokenism**"**:** doing something to show that you are following the rules or doing what is expected or seen to be fair, but not because you believe it is the right thing to do (https://dictionary.cambridge.org/dictionary/english/tokenism)

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