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Dr. Teresa Chan (00:00):
Okay, MacPFD Spark listeners, I am back and giving you a special glimpse into a local rounds that was just so amazing that we couldn't not share it with the world in more than one format. Some of you may have already seen this online, or watched it live, but the Department of Medicine recently hosted on Zoom a Chair's Rounds that focused on the topic of anti-Black racism in healthcare. And the idea behind this was to actually highlight some stories and bring us towards action. The title of the rounds was called "From Stories to Action" addressing anti-Black racism in healthcare, and it featured a number of really amazing speakers. And thanks so much, first of all, to Doctors Crowther and Anand for sponsoring these rounds.

Dr. Teresa Chan (00:49):
And then thank you so much, especially to Dr. Madeleine Verhovsek, who actually put all the rounds together with the colleagues that you're gonna hear from, and actually starts off the presentation and frames her journey through all of this as someone who takes care of sickle cell patients. She then introduces three amazing speakers that I would like to thank for also allowing us to syndicate this through other means. Dr. Ameil Joseph from the School of Social Work. Doctor-to-be Sarah Adjekum, who is studying and doing her PhD right now here at McMaster, and she's just a phenomenal young scholar on the rise. And Mr. Lyndon George, who is involved very much in a lot of the local and provincial politics that actually helps drive all of our healthcare, and is also a patient advocate for one of the hospitals here in town.

Dr. Teresa Chan (01:43):
And so each one of them shares with us their stories, and actually puts into a frame of mind how we could move towards actually changing things, and taking action to be more anti-racist in today's healthcare system. So I just can't say enough good things about these rounds and I'm really excited to share them with you. Hopefully, they will open up your ears and bring new information to you. But if you wanna also use your eyes, you can check out the full video which is available on the McMaster Department of Medicine YouTube channel, and you can link to it from our website, macpfd.ca in the video archive. Alright, so listen in now for this episode.

Dr. Mark Crowther (02:29):
Morning, everyone. Mark Crowther from the Chair of the Department of Medicine's office. We're presenting today on anti-Black racism in medicine. I'm going to hand over the presentation to Dr. Verhovsek who will be running the show today, and each of the speakers will introduce themselves during the course of the talk. And without further ado, I'll turn it over.

Dr. Sonia Anand (02:50):
I'm Dr. Sonia Anand, and as many of you know, I'm the Associate Chair of Equity and Diversity within the department. And Dr. Verhovsek has been playing a very active role within that group, both on our advisory committee and on the Faculty of Health Sciences, Equity, Diversity, and Inclusion Advisory Committee. And Madeleine came up with this idea, I believe, a couple of months ago, and really has spearheaded putting together these rounds, and I think they're very timely for many reasons. Hopefully we will all be enlightened as to the role we play in the system of anti-Black racism, and learn what we could do to change things. So, Madeleine, without further discussion from me, I hand it to you.

Dr. Madeleine Verhovsek (03:36):
Thank you very much, Sonia, and thank you everyone who is logged in for the rounds early on this Thursday morning. I'd like to start with an Indigenous land acknowledgement. So we acknowledge that McMaster University sits on the traditional territories of the Mississaugas and the Haudenosaunee Nations, and within the lands protected by the Dish With One Spoon Wampum agreement. This is a treaty between the Anishinaabe, Mississaugas and Haudenosaunee that bound them to share the territory and protect the land. Subsequent Indigenous nations and peoples, Europeans, and all newcomers have been invited into this treaty in the spirit of peace, friendship, and respect. The dish or sometimes it's called a bowl, represents what is now Southern Ontario, from the Great Lakes to Quebec, and from Lake Simcoe into the US. All who live in this region eat out of the dish, all of us that share this territory, with only one spoon. That means we have to share the responsibility of ensuring the dish is never empty, which includes taking care of the land and the creatures we share it with. Importantly, there are no knives at the table, representing that we must keep the peace.

Dr. Madeleine Verhovsek (04:45):
The dish is graphically represented by the Wampum pictured at the top. So as we kick off this very important discussion of a topic that's quite different in many ways than much of what we usually discuss at Medical Grand Rounds, it is with the knowledge of what's been happening in the culture around us and across the world in these past unusual months. In late May, George Floyd died in a tragic event in the United States, kicking off worldwide protests and reckoning about what it means to be racist and anti-racist. In our medical world, this has also been highlighted by the challenges with the COVID pandemic. The New England Journal of Medicine, one of our premiere medical journals, has taken a particular focus on racial disparities, both in health and in academia. But we can't become too complacent here in Canada. For many years, we have thought of this as an American problem, but as this discussion continues, we increasingly hear from our Black friends and colleagues that this is in fact a constant struggle for them also.

Dr. Madeleine Verhovsek (05:56):
And when we come back to COVID, we have some scant evidence, primarily from Toronto that not only is COVID predominantly affecting racialized populations in the United States, but also in Canada. So with these statistics from Toronto, where 83% of people affected by COVID are Black or

other racialized groups, with 21% of reported cases affecting Black people, despite the fact they only make up 9% of the city's overall population in Toronto. And why don't we have better data? Because in fact, unlike in the United States where race-based data is routinely collected in most jurisdictions, this is something that has been problematic in Canada, and it has only recently begun to enter both the public health and healthcare discussion. Now, I would be remiss in this discussion if I didn't mention the very recent events, and if I didn't mention the fact that today's topic, while we're focused on anti-Black racism out of necessity of trying to compartmentalize the topic for a very short period of time, these disparities are affecting our Indigenous brothers and sisters as well, with this very recent media report about this unfortunate situation where a young woman encountered racial slurs just before dying in a Quebec hospital.

Dr. Madeleine Verhovsek (07:13):
So, here I am, a White hematologist, leading a rounds about anti-Black racism in healthcare, and you may be wondering, "What on earth?" I'm not a scholar in critical race theory, and I don't have the personal lived experience of racism that many of our panel members and webinar attendees can and will tell us about. I have, however, been working with and providing care to individuals living with sickle cell disease for the past 12 or more years, and it's provided me with an important inside look at the intersection of racism and healthcare. So very briefly, sickle cell disease is an inherited disorder of hemoglobin in which deoxygenated red blood cells form a sickle shape, leading to chronic anemia as well as a multitude of acute and chronic complications. The hallmark of sickle cell disease is the vaso-occlusive pain crisis, in which the bone marrow acutely becomes ischemic causing severe pain. While the inflammation can sometimes be seen outwardly in young infants with sickle cell disease, in older children and adults, there's no physical exam maneuver or diagnostic tests to confirm a pain crisis.

Dr. Madeleine Verhovsek (08:20):
As healthcare professionals, we just need to trust the patient's description of their pain and help to provide analgesic relief. While sickle cell can occur in individuals of any race, it's historically most prevalent in malaria-endemic areas and across the African diaspora. So in North America, the sickle cell community is mostly comprised of members of Black and other racialized communities. When I did my training in Boston, I saw first-hand the numerous barriers to care for patients with sickle cell disease, these included what's highlighted in this very unfortunate diagram. They were often coming out with frequent visits, there were maybe clinicians who may not have had the knowledge that they needed, and sometimes the patients didn't know how to advocate for themselves. There's a stigma as well associated with sickle cell disease, and there's this problematic invisible pain that happens along with this need for opioid treatment that ends up resulting in attention where there's some perception of addiction.

Dr. Madeleine Verhovsek (09:19):
And lastly, and not overly talked about enough is the racism that's underlying this, both in terms of individual and a systemic level. When I returned to Canada, I noticed that my patients were in fact encountering the identical issues the patients I saw in Boston were experiencing. So they were dealing with these sometimes enormous health challenges, and furthermore, they were needing to deal with these health challenges uphill while dealing with health inequities and with system barriers. This has increasingly been something that I've been interested in trying to educate myself, trying to ally myself with individuals who are Black and racialized who are doing this work. And it's really on behalf of my patients. So during all of this renewed interest in this topic, I've been very heartened to see prominent discussions happening, including this paper entitled "Diagnosing and

Treating Systemic Racism" from the New England Journal of Medicine, and I've highlighted in the bottom left corner, "Can the medical profession use the tools in its armamentarium to address this deep-rooted disease?"

Dr. Madeleine Verhovsek (10:25):
So again, New England Journal, Boston, United States, but it's not just United States, it's right here, it's right here in Canada, it's right here in Hamilton. And while we do a lot of things well, in healthcare and in Canada, we always wanna be striving for improvement. And so this is a feature from the Hamilton Spectator that included stories from both Lyndon George who's on our panel today and from Dr. Bernice Downey, who's on Faculty of Health Sciences, sharing their stories, and so that's why today we call this stories and changing it From Stories to Action. I've also been hurting to see statements from senior leadership at McMaster in our institution, these are two letters from Dr. Paul O'Byrne and Dr. Parveen Wasi. So, today we're gonna talk more about this, and again, moving from statements to action. And I'm gonna leave my comments off with this, all of us who are logged on today are at a different point in our journey with these kinds of ideas and discussions, when we may not be aware of a lot of the stories and experiences, we may be in this fear zone where we're striving to be comfortable for only wanting to talk to people who look and think like me.

Dr. Madeleine Verhovsek (11:40):
Hopefully, from there we move into the learning zone where we're really open to hearing these experiences, stories, and proposed solutions, and furthermore, into the growth zone. So, thanks all for listening to my little intro. And without any further delay, I would love to introduce Dr. Ameil Joseph. Dr. Joseph is an Associate Professor in the McMaster School of Social Work. He has an extensive experience in leadership, teaching, researching, writing, supervising, advocating, training, consulting, and working in the community, on matters of race, racism, racialization, mental health, disability studies and colonialism. He is also a registered social worker with over a decade of community practice experience with marginalized populations, as well as in executive leadership in the not-for-profit sector. Dr. Joseph is widely respected in the community for ethical leadership and expertise on matters of equity, oppression, marginalization, and social justice. Thank you so much for joining us this morning, Ameil, and please share with us your wisdom.

Dr. Ameil Joseph (12:51):
Morning. That was a great introduction. Thanks for joining us today. I thought best to help with this panel by situating some of the concepts that people use a lot, but aren't always clear about what they're talking about, and where. I think there's an appreciation that racism in healthcare in Canada is a pervasive issue, it is a topic that has found its way into the public media, into conversations around policymaking quite widely. I think how we talk about it and what we talk about shifts and changes. Today, I wanna talk a little bit about our responsibility to address racism, and what we mean by racism at individual, systemic, and structural levels in healthcare. I think there is some confusion about what we are talking about and where it exists and how we understand it, and with the proliferation really of misinformation in our world today, I think we should begin by being very clear about this.

Dr. Ameil Joseph (14:00):
When we're talking about race, we're talking about this idea that there's a classification of human beings into physically, biologically, and genetically distinct groups, and what's tied to that is this idea of unchangingness, that we can recognize these differences via phenotypic distinctions, and that

there's an implication, meanings attached to this about mental and moral behavior, as well as other things baked in around ideas and capacities, all tied to race or origin, and that this in some sort of way provide some sort of a satisfactory account of these differences and behaviors. If we acknowledge that as race, that's what we're talking about, and that it has been crafted and constituted socially and politically and historically. Racism is taking those ideas and baking them into how we think about these matters in policy and practice and law. So race is a socially, politically, historically established contract that we can critique, but we also have to recognize that inter-generationally, we now live these realities, that they're material, and they have lived consequences in our world today.

Dr. Ameil Joseph (15:15):
When we're talking about racialization, we're thinking about that process. It's the process of the historical, the social, the political constructing, the making of the constituting of racial identities and meanings. There are some theorists who we talk about what that means, racialization, this process for how it impacts the forming of our understandings of us and each other, how we have crafted and cast borders, separated people based on some of these ideas, how we've framed knowledge itself in policy and practice and law that have reconstituted these meanings in reality that materialize them. So we can talk about things like labor being racialized, as employment now being racialized, education and professions are racialized. We've internalized a lot of these meanings because we live them, they've become material, and we can think about racialization as, "How do we rationalize disproportionate things like criminalization, and substance use, and employment, or lack of employment, and education?" Is it systemic? Is it historical?

Dr. Ameil Joseph (16:21):
Are we socialized to internalize these ideas that perpetuate these hierarchies? When we talk about, in healthcare specifically, the process of racialization and racism have produced health inequities across health areas. And Sheryl Nestel covered some ground with this in the Colour Coded Health Care report she notes several social pathways to health inequities. What I notice in these is how often marginalization and oppression are mapped onto Black and Indigenous and people of color, usually in terms of lack, which is also a problem. There's also the issue of the healthy immigrant effect, and really it was a way to counter the discourse that suggests that there are uniform differences among people, and the challenge was that, well, people who are coming to more privileged countries should be doing better, and what we see is people come in healthy and things deteriorate over time, mostly from racialized countries in the global south.

Dr. Ameil Joseph (17:29):
The key point here is that even when we account for migration and socio-economic status, race is a significant determinant of health, what outcomes are affected, well, we see differences all over the place, cardiovascular disease, cancers. When we think about and how we think about occupational and environmental illnesses, and diabetes and mental health, HIV and AIDS, even in intimate partner violence, and how we think about domestic abuse, where those events and occurrences arise and how and how we think about them, and other health conditions and outcomes. So at the level of service delivery, we know there are racial inequities, not only in access to care, but also in life expectancy and mortality and morbidity, health status, disease, prevalence and incidents, the utilization of services, the clinical outcomes, the process of care.

Dr. Ameil Joseph (18:27):
We can think about it in the adequacy of pain management, how we think about advanced directives and do-not-resuscitate orders, the end-of-life care. And in all these situations, there's a number of Canadian physicians that believe that they are immune to these kinds of racial bias. In general, researchers found that residents were willing to admit that prejudice existed, but deny that it was a factor in their own clinical encounters with patients. I can talk about some of this for probably months. Canada has its own unique histories of race, racism and racialization and colonialism, that we often do not acknowledge in the dominant ways we talk about history. We rarely talk about residential schools in Canada, or how South African politicians came to Canada in the 1940s to learn from our racism in the Indian Act, how to use status cards in the reserve system in apartheid in South Africa. It would take several weeks for me to talk about Chinese head taxes and Japanese interment, and turned-away ships of South Asian and Jewish people, of chattel slavery and Black settlements erased and how those histories frame civil and social relations in healthcare, in policy and practice and law.

Dr. Ameil Joseph (19:45):
And these ideas took hold many years ago and have been divorced from their original projects, yet continue to operate with similar outcomes. I think we need to think clearly about how they operate within professions, disciplines, practices, policy, and law, and how we think about capacities and criminality and threat and burden, and risk in racialized ways. So in order to appreciate the consequences of racialization and how racism persist, we have to appreciate all of these technologies, the kind of things that we acknowledge at the individual level, the bigot, the bias, the prejudice, but also the things that aren't motivated from those places that are already inside of policy and practice and law, that carry these racialized ideas of race institutionally or systemically, and then also realizing that we haven't been trained to attend to a lot of these things in how we do what we do, and that's the structural way to think about racism.

Dr. Madeleine Verhovsek (20:55):
Thank you very much for framing all of that for us, Ameil. We can come back to many of these topics as we leave some time at the end for questions and discussion. So next, I'd like to introduce Sarah Adjekum, who is a social worker who has worked with populations with mental health, disabilities and experiences of trauma. She completed her Master's of Social Work at McMaster University, and has been committed to connecting her passion for social justice with her research interests. She has worked as an educator in post-secondary institutions focusing on issues of social justice, anti-oppression and social work. She is currently working on her PhD in Health and Society with attention to refugee experiences of mental health and displacement trauma. Thank you very much, Sarah.

Sarah Adjekum (21:44):
Thanks so much for that introduction, Madeleine. And I wanna thank Ameil as well for going in such depth about race and racialization. So today's conversation I'm gonna be talking in a lot more depth about some of the narratives and how they underpin healthcare, and I do wanna note that Madeleine mentioned the importance of focusing on both anti-Indigeneity and anti-Blackness, in part because of the severe consequences that it has had for these populations, and also because they're definitely underpinned and supported by the exact same systems, as is evident in the case of Joyce Echaquan. The three themes that I'm gonna be focusing on are professionalization, compliance and control, and race, and I'm focusing on these in part because they permeate all aspects of healthcare, so we've all bumped up against professionalization, race, and some aspects of control.

And also because they're pretty good markers for the macro, meso, and micro-interactions where these narratives take place.

Sarah Adjekum (22:37):
We define professionalization as the process through which an occupation develops the characteristics of a profession. And all of us are probably members of a professional body. Myself, I'm a member of the Ontario College of Social Workers and Social Service Workers, and there are some pretty practical reasons why we do this. Obviously, they advocate for our pay and our work standardization, they protect us from liability issues, and they protect the public from abuse and malpractice. But there's also the very practical reason of some level of authority so that we can do our work unencumbered. And when we think of authority, it does invite us to think a little bit about the kind of power that we have access to through professionalization. That power can be seen in three main ways. We can see this through culture, so access to specialized knowledge, jargon, which is exclusive language. We can also see this through credibility, so this is the prestige that we have access to, and that credibility can be signalled to us through our pay, also our expertise.

Sarah Adjekum (23:34):
And then finally, there is exclusion. And exclusion is possible through the scarcity of our membership, not everyone can be a healthcare professional, of course, and also stringent regulations and qualifications to have access to the field. Now, again, these all arise for practical reasons, but it's also really important for us to think about the histories that are connected to that power, especially when we look at exclusivity and the ways that race and gender were bound up into that. A very recent example that brings us to bear is what happened at Queen's University. We know in 1918, Queen's University banned Black applicants and expelled the six Black students that they had in the medical program. Part of their justification for this was the fact that the American Medical Association had a stringent ranking system, and we know that when Queen's moved to ban Black students, the ranking of the university went from a C ranking to a B ranking, so there was a clear incentive for them to do this.

Sarah Adjekum (24:35):
This wasn't unique to Queen's University, we know that this happened to medical educational facilities all across the country and of course, all across North America. But what's really important to note here is the ways in which that culture that was fostered between 1918 and 1965 when they did informally allow Black students to return, how that culture might still exist. There are lots of conversations about the lack of Black medical students and the lack of Black healthcare professionals, and a lot of this conversation has focused on recruitment and the fact that maybe these students aren't interested in pursuing a career in healthcare. But what's not talked about often enough is that very salient history and the ways that culture and beliefs might still permeate those institutions.

Sarah Adjekum (25:19):
The other thing that I wanna touch on is that of compliance and control. In the field of healthcare, compliance and control often refers to the ability of patients to comply and adhere to specific medical advice. So, often if you are that patient who's not following the advice of medical professionals, you are referred to as the difficult patient. And I think all of us have had encounters where we are immediately flagged to the idea that this person might be a problem, or not somebody that we want to work with. There might be instances where the idea of the difficult patient has

value. I'm thinking of nurses and staff would sometimes deal with belligerent, violent, abusive, and demeaning patients. But it is important to remember that this label is often used quite liberally.

Sarah Adjekum (26:00):
So we use it sometimes for patients that we simply don't like, patients that are asking too many questions, who are distrustful, patients who are resistant to the recommendations that have been provided, or patients who are unable to fulfill their end of the obligation of taking care of themselves, being on time for appointments, following medical advice like strict diets. Now, the reason why it's important to call into question this idea of the difficult patient is because it is absolutely stigmatizing. As I mentioned earlier, it creates this red flag for healthcare professionals where their interactions of that patient are now kind of tainted, and they are on guard and on edge and just distrustful of the interactions they're gonna have with this person. The other reason why though is, because it absolutely obscures the legitimate reasons why a patient might feel distrustful when they're interacting with medical professionals.

Sarah Adjekum (26:48):
So that might be present or past experiences of racism that they've had themselves personally, or the members in their community have reported. That might be the ways in which that race and gender and class all interact in that patient care provider interaction. So we know, for example, that racialized people are more likely to be framed as being difficult, even when they have legitimate questions and concerns about their healthcare. And this also interacts with what Dr. Joseph mentioned about the ways in which criminality permeates all aspects of that patient interaction. So, Black and Indigenous people, because of the perceived criminality associated with their skin tone and their race are already bumping up against these assumptions in that interaction. And finally, you can also see this in interactions with immigrants.

Sarah Adjekum (27:35):
So people who maybe speak English as a second language where they're assumed to be incompetent, or not able to manage their healthcare because they don't have full grasp of the language, or the idea that because they're coming from a place where healthcare systems are believed to be substandard to Canada's, they should be appreciative and not as challenging when they're accessing healthcare here. So this is, I guess, an article that came out more recently that has brought a lot of attention to the way that medical bias has an impact on patient care. So the article goes into depth talking about the fact that between 1992 and 2015, across 1.8 million births, they found that Black babies who already have really high mortality rates, found that that mortality rate dropped when they were being cared for by Black doctors, as opposed to the interactions they had with White doctors. And it's been held as a really good example of the kinds of impacts that medical biases have, particularly when we're looking at mortality.

Sarah Adjekum (28:31):
Obviously the study was done in the United States, and I think the question that's often asked are, "Do we have these same problems here in Canada? And what is the impact of these biases that we're talking about today?" So as Madeleine mentioned, in Canada we absolutely have these problems, and the very recent story of Joyce Echaquan is an important example of that. For those of you who might not be aware, Joyce Echaquan recently passed away. She had entered a hospital in Montreal for stomach-related pain. And in her final moments, she recorded her interactions with nurses as she was dying, who were saying terrible racist abusive things to her. The unfortunate thing is that we know that stories like Joyce's are not unique. Unfortunately, these are things that happen

all the time. The only difference, however, is that they're often not recorded or live-streamed. This brings me back to one of the most salient narratives. And I know that Dr. Joseph covered this in a lot of detail, but I wanna double-back and talk about it a little bit more.

Sarah Adjekum (29:31):
So the idea of race as a narrative still continues to have a lot of impact on patients accessing healthcare. These are ideas of race as a truly biological construct, and we see this when we look at the pain of Black patients. The assumption that Black patients are faking their pain, or they're seeking medication, and that they have a tendency towards addiction, that or the idea that Black patients don't experience pain the same way that White patients do, and how this has allowed their pain to be minimized. We also see this when we look at the idea of race as a cultural construct, so assumptions about certain people's cultures as being better or more deserving of attention than others. A great example of this is with the lack of respect and recognition towards Indigeneity and Indigenous beliefs around healthcare. In either case, if you're a healthcare professional and you have these assumptions about race, it's going to result in a failure on your part to empathize with the populations that you're working with.

Sarah Adjekum (30:27):
So I had some solutions since we've talked a lot about the problems that have arisen in healthcare. One of the places to start is by looking at professionalization itself and the ways in which anti-racism is looked at. Right now, I think there is still quite a bit of tension around whether we can call out racism without it being a liability to the way that we're perceived in the public. And it's very important to note that when the risk is much higher, when the risk is people's lives, that absolutely means that we have to be initiating and having these conversations. Another thing to consider is believing patient stories. I think Madeleine touched on this as well, when she was talking about the experiences of patients with sickle cell disease. Patients who are experiencing healthcare discrimination are not unique, they're definitely hearing these stories and they're experiencing them themselves.

Sarah Adjekum (31:12):
We also need doctors and healthcare professionals who are abreast of some of the issues that are taking place in communities. If you do live a life relatively insulated from interactions of racialized Indigenous, Black people, you do have to ask yourself how well-versed and how familiar you're going to be with the issues these populations are dealing with, and how you can attend to those issues in healthcare. And finally, there needs to absolutely be a commitment to anti-racism in practice. Healthcare does not exist in the vacuum, the issues that we're seeing in the community, whether it's regards to housing, employment, or even the political atmosphere which we know does cause a lot of stress for racialized people. All of these things absolutely need to be attended to. Thank you.

Dr. Madeleine Verhovsek (31:54):
Wonderful. Thank you so much, Sarah. As our last formal presentation, before our time for questions and discussion, we have Lyndon George. He is a Constituency Assistant to the leader of the Ontario NDP, an experienced government and stakeholder relations specialist, community organizer and health equity advocate. Whether it's organizing local discussions with Hamilton's healthcare union leaders, or publicly calling for race-based data collection in healthcare, Lyndon is passionate and vocal about addressing health inequities and anti-Black racism. As a board member of Hamilton Urban Core and a patient advisor at Hamilton Health Sciences, he is a Black man encouraging folks to have the uncomfortable conversation on race and health. Thank you, Lyndon.

Lyndon George (32:43):
Thank you, Dr. Verhovsek, and it's a pleasure to be with everyone here today. I wanna build on what you've heard from Dr. Joseph and from Sarah as well, and the health inequity in our community. You've had an opportunity to hear a little bit about my story, and I wanna try to delve into those issues here today in the short period of time that we have. And so, the topics that we're gonna be looking at here are racial and ethnic disparities in healthcare, looking at those from a Hamilton perspective, having the uncomfortable conversation, what it means to talk about race in healthcare when you see unconscious bias taking place, the need for new standards in patient care, our ability to look at our healthcare system and hold it accountable in ways that we know that we can, and then finally, leadership and representation, abilities in our healthcare institutions, in our universities, in our healthcare clinics and in government to start to look at ways that we can try and change the discourse for the better.

Lyndon George (33:40):
And so, I wanna talk to you about a case that happened in 2017, and the reason why I wanna talk to you about it is because when I was going through my healthcare experience, I started to think about a young man named Yosif Al-Hasnawi, a young man who media reported him as being a Good Samaritan, an individual here in Hamilton who when he was leaving his mosque saw an individual being... A senior being accosted in the community and decided to intervene and he was fatally shot. And what happened after that was something that I think that we as a community need to talk about, and there's linkages between the ways in which individuals who feel implicit bias and unconscious bias in a healthcare system, they can relate to, and I often believe that when you live it, you know it. And so, when I saw this article about the Good Samaritan being shot, I thought to myself, how is it that an individual who was wounded had to profess to paramedics with regards to his injuries and was being told, "No, you're faking it."?

Lyndon George (34:37):
And there's a quote here that I think is really important, and it's on the right, it says, "The investigation came after bystanders claimed paramedics told Al-Hasnawi he was faking his injuries and that he'd been shot by a pellet gun." And so there was a discrepancy at the scene as to whether or not it was a real handgun, and whether or not he had really been shot. But I want you to think for a moment here, if your brother, or your sister, or your father had been injured while doing something, to try and stand up in his community, and had to then profess that he was shot, and being told, "No, you're faking it." I think when you hear those words in public, it can be very demoralizing for individuals, especially Black, Indigenous communities to have to profess often about those issues only to be told, "No, it's not true." And this is happening. And so it's really important that we talk about this conversation. These two individuals, the paramedics have been charged with failing to provide the necessities of life and it is before the courts, but it's important for us to have this conversation.

Lyndon George (35:35):
There's a quote here by Dr. Tiffani Johnson from the US, a pediatric emergency care physician, and it talks about the disparities and the inequities in our healthcare system, and it talks about the reality of that different populations need different resources, and I think that's something that we need to talk about and have a conversation on as a community. Too often we are left not wanting to have that uncomfortable conversation around where there are different communities that have... That lack the kind of services. We know in the US, we see that often. Dr. Verhovsek talked a little bit

about that in her presentation, but it's happening here, and if we're not recognizing the pressures on our system, we then can't fix it. And so if we want equality in our healthcare system, which I believe everyone does, we need to start to be able to look at it from a lens of, "Where are we starting from?" And that's why I chose that particular quote.

Lyndon George (36:24):
We're talking about the uncomfortable conversation. Why did paramedics so easily dismiss his pain? Why did it take 38 minutes for paramedics to transfer him to hospital? We know in Downtown Hamilton for example, that there is a Level 1 trauma centre in our Downtown core. Paramedics didn't take him there. These are critical questions we have to ask as a community if we are going to improve care, and we need to start having it not after a trial, but before. We need to look at these in ways that we can start to say, "What happened? What did we know? When did we know it? And how are we going to respond to it?" Because there are lessons to be learned, and too often it is racialized communities who are trying to have these conversations, but we need allies at the table. One of the things that really troubled me was that in the community here in Hamilton, we knew that there was an issue with code zeros, and if you've had an opportunity... If you're not familiar with what the code zero is, it means that there aren't ambulances available to respond in the community.

Lyndon George (37:23):
And so, when you're from a racialized community and you're recognizing these pressures and the difficulties in our healthcare system, you become much more aware of how you have to sometimes elevate your voice, and to Sarah's point, sometimes be labeled around as being difficult and seeing a change in the care that you receive. And so, the media did report on the plummeting morale, increased absenteeism for Hamilton paramedics, but it wasn't also talking about what that directly means for particular communities. And so when you look at the timeline and the months leading up, there's an important conversation that we have to look at the pressures in our healthcare system, whether it's in our ER, whether it's for our paramedics, whether it's on our frontline community care, and how that disproportionately impact racialized, Indigenous seniors and many others in our communities. It's an important conversation that we all need to start to engage in. So what's the action plan? I have two statements here, on the left... We talked...

Lyndon George (38:20):
Dr. Verhovsek mentioned earlier about, right now during the moment of... And George Floyd and these discussions, there are these moments in which organizations want to come out and say the right things. And on the left, an important statement by a healthcare provider in our community at HHS, put out a key statement, and I wanna thank them for doing that because often times remaining silent isn't an option, and you need to speak up when these things are happening. But on the right, you also have a statement and a letter from Alliance for Healthier Communities, and in that letter they're writing to the Premier asking for race-based data collection. And there's a critical difference here of, what communities of color are saying is, "We need the data in order to inform and to direct the care that we need," and then there's the statement. And we need to move past the statement if we are really going to make change possible.

Lyndon George (39:10):
And so that's why I wanted to show that here today, as a patient advisor in our community, those are often what I'm saying here at the table, is that we got to start to do the work, the heavy-lifting that needs to be done shouldn't only be done by racialized voices in the room, but need to be done by those at the highest level of our organizations, all the way down to our frontline healthcare

workers. So leadership and representation, and the urgency of now. These are critical moments. We talk a little bit around what that means at this critical time around issues and around the passing of George Floyd, but we need to know that communities of colors are stepping up and want to see more than just words. And so we need to start to listen. And so some of that is around providing tasks force and direction and saying, "What are we going to do in our organizations?"

Lyndon George (39:56):
And I would tell you today, there are individuals there who are ready and willing and have already been doing the work, and you need to elevate those voices, you need to start to roll up the sleeves and start to say, "What is happening here and what are we going to do about it?" And so these are critical issues. And so, I just wanna thank Dr. Verhovsek and everyone else for allowing me this opportunity to be here today, but I also want us to keep that conversation going. Talk to someone you know who may not look like you, sound like you, and ask them about their experiences, and the next time you are in your ER, or you're at a doctor's office and you're looking around, have that uncomfortable conversation with yourself to understand what that means and what that care might mean for them. Thank you.

Dr. Madeleine Verhovsek (40:34):
Thank you so, so much, Lyndon, Ameil, Sarah, for sharing your wisdom and your experiences and for opening up these uncomfortable conversations. We've had some good feedback and questions coming through on the Q&A, so these last 15 minutes that we have now, I'd like to start engaging in some of these. We have the first question. "Can you please speak to how institutions can advance their commitment to anti-Black racism? For example, prioritizing funding of Black researchers to conduct studies that impact their communities and redistributing opportunities for leadership to enable Black individuals to hold positions that enable them to direct work on anti-racism." Thank you. Maybe Ameil or Sarah, if you would like to provide your perspective on that question.

Dr. Ameil Joseph (41:25):
I can start, then maybe Sarah can jump in, if you like. It's not that we have to start from scratch. You can look at a number of examples where people have waited strategically, they're thinking about individual levels of contact points of care, and what's happening in policy or lack of policy, and then some of the historical context. There's examples, the Canadian Public Health Association put out a statement, but then went beyond the statement, they acknowledged health inequities, and then talked about responding as an association, professed commitments to how they're gonna think about change at individual and systemic levels. They talked about calls for other agencies and organizations to respond in levels of education, so training and research, and then service provision.

Dr. Ameil Joseph (42:18):
They also then link their interventions and their calls to what they're asking in terms of government and resources to address some of these issues that have been consistently overlooked. And they're not alone, there's the Canadian Association of Midwives, the College of Family Physicians of Canada have also named some of these things in systemic ways and built working groups to respond. There's been social accountability working groups, groups that specifically attend to anti-Indigenous racism, colonial remnants and anti-Black racism. So there are more than a few examples that already exist where we don't have to recreate the wheel to intervene. Lyndon's point is key, that you can't do it without having the knowledge, the expertise, the lived experience of people who live and work and breathe and experience these things.

Sarah Adjekum (43:14):
I'm just gonna add to that, because I think Ameil's answer is spot-on. We don't need to reinvent the wheel, but I think what is important is to ensure that whatever changes are being made are designed to dismantle and challenge that long-term history that has existed in these spaces for so long. It is not unusual, I think, for folks to be focusing on things like recruitment and diversity, but we also have to think about what kind of space we're inviting these people into and whether it's safe or amenable for them to stay there. So if you're improving recruitment for racialized people, but there is still a culture of hostility or contempt, that is not a long-term solution, it's not a viable solution. And I think also really obscuring... Un-obscuring some of the ways in which healthcare works, many people who are interested in participating in healthcare and being a part of the system do still see it as a White institution, they do still see it as having that history. And so there does need to be perhaps a little bit more effort to shine light on the contributions of racialized healthcare professionals as well, and the contributions they are already making in this field.

Dr. Sonia Anand (44:15):
And Madeleine, if I could add in one point. Last year we had Camara Phyllis Jones from... The Past-President of the American Public Health Association, and she enlightened us all about the levels and the structure of racism with structural racism, individualized racism, and personalized racism. And although many initiatives are focused on unconscious bias training to change individuals within a system, there are many other examples of systemic change or structural change being most effective. So the whole Harvard Business Review in September is devoted to why unconscious bias training doesn't work, or diversity training doesn't work. And organizations such as Coca-Cola have been successful in bringing more Black members into the highest levels of leadership, and the way it happened is the CEO of Coca-Cola himself was directly involved in a diversity committee and met with that committee on a regular basis. So not creating a committee and say, "You guys go talk about discrimination," but being directly involved in it, change things. So that's what we need at the highest level, structural change will occur.

Dr. Ameil Joseph (45:33):
That's such an important point, and in response to the question about what we do differently, I think we have to acknowledge the traditional ways that are also part of the problem of systemic racism. Traditional responses are often the most simplistic interventions, having a training that conceptualizes the problem as individual, unconscious bias, where there's no evidence of a training affecting unconscious at all. And the other one is cultural competency, that we can learn about cultural groups or differences in these fixed homogenized essentialized ways, and that somehow reverses racism, rather than actually reconstituting it and selling it back to people. The third is the race-based data conversation. Well, you can collect it, but so long as you're not re-constituting that idea of race that is baked in with ideas of lack and difference and inferiority, and not for the analysis of racism and how we reproduce inequities, some of those things are part of the problem. And the establishing of committees by organizations that aren't relying on the expertise of lived experience of Black, Indigenous, and people of color, those are the four primary ways that systemic racism is reproduced in the redress that we need to counter as well.

Dr. Madeleine Verhovsek (46:58):
Thank you for that rich discussion on that topic. I think Dr. Crowther might have a question, or a point.

Dr. Mark Crowther (47:05):
Thanks, Madeleine. I'm just going through the Q&A and there's a whole bunch of questions here about the approach within the Department of Medicine, and I wonder if maybe Sonia could just comment on some of the stuff that she's led in the department that would address many of these issues, I think that would address many of the questions that are being raised.

Dr. Sonia Anand (47:19):
Yeah, I think within the Department of Medicine, and Madeleine's part of this, Will Harper has been involved, we've really tried to focus on structural change as a way to increase transparency in how things are done, and increase accountability. So just to give you an example, in terms of our selection committee procedures to bring on new faculty members or new leaders in the department, there are a few different steps. One is to increase, as much as we can, a diversity in the candidate pool applying for these positions. So, advertise, advertise, advertise, but go beyond that, seek out groups that we know are under-represented in our department. We do not have any Black faculty members or any Indigenous faculty members in the Department of Medicine, so we know we need to do better.

Dr. Sonia Anand (48:10):
The second part, though, is to try and standardize the selection process so that we minimize bias in our decision-making, recognizing that unconscious bias training isn't enough. So even though I am aware of my biases, I still may choose somebody because of other reasons, that's where Will Harper has come up with some very innovative ways to try and test if we can minimize bias by increasing the diversity of the members on our selection committee. And think about selection committees you may have participated in, if you walk in the room, often they're homogeneous. So now we're trying to diversify as much as we can, not just women, but people of color, people who have declared their sexual orientation and wanna participate, people based on their geography in the city, St. Joe's versus Hamilton Health Sciences. So diversifying the selection criteria and committee, and also having standardized committee questions and try to be as quantitative as possible.

Dr. Sonia Anand (49:09):
And I also would say, again, to the point of the leader of the department being invested in making change is crucial. So I could be Equity Diversity lead, but kind of pushed off to the side. But I have Mark Crowther beside me supporting and discussing initiatives and making these decisions together, and then speaking to our department at large, and that's really crucial, otherwise, equity and diversity initiatives can become a tick box and leaders can think we've finished doing the job when really no change has been made.

Dr. Madeleine Verhovsek (49:46):
Thank you both, Dr. Crowther and Dr. Anand for contextualizing it for our department. I'm gonna move back over to the Q&A box, the next question here, and I'm hoping maybe Lyndon, you might be able to comment and I can help from the healthcare professional side, "Do you find that there is a more significant disparity in diagnosis and care for Black patients when treatment depends only on the patient's account?" And I don't mean to put you on the spot, Lyndon, but I know that you've been very open with your own personal story, and I'm wondering what your perspective might be on that question.

Lyndon George (50:17):
Yeah, I think, for me, what I'm looking for when I'm receiving treatment is whether or not this individual is acknowledging what I'm describing, whether or not they are linking the story, my healthcare history, and taking that deep-dive to take the moment to talk to me. In the presentation I talked about these pressures, it exasperates the problem in our healthcare system when these pressures are happening because then doctors don't have that opportunity, and you start to see this unconscious bias play out so much more when you don't see someone who looks like you on the other end. And so there's this lack of relatability sometimes of trying to say, "Are you hearing me? Are you seeing me? Because I'm trying my best to connect with you on a human level," and sometimes you just... There is that doubt and you start to see the lack of communication, the lack of engagement, and Sarah really touched upon that well in her presentation, and so that's usually what I get from my experience when I walk into a room or if I'm trying to explain myself.

Dr. Madeleine Verhovsek (51:13):
I won't take up too much more time with it, but thinking back to the example that I had kicked off with of sickle cell disease, it really does end up playing out in that way where it's kind of an invisible problem that someone is presenting with, and where different intercepting aspects of the patient's identity may lead to discrimination or judgments about how reliable they are. And I'm actually going to dovetail that question into the next one, which is Dr. Amber's question, "How do we better address the intersection of opioid use in racialized patients who are struggling with chronic disease? These patients are often deemed to be addicted or drug-seeking, but rather need intensive pain management as part of their plan of care." Does anybody want to add any thoughts for that particular scenario?

Sarah Adjekum (52:01):
I wanna just respond quickly. There was a study that came out just this past year about how risk assessment was done for Black patients who have chronic pain or pain issues. And what was really interesting was they found that even though very often these patients didn't have any prior history of misuse, their profile against the profile of White patients, they were still deemed more likely to be at risk for addictions. And so I think what's really important there is, again... I don't wanna use the term "Bias" because I do think it's worth mentioning that this is racism, whether it's realized or not.

Sarah Adjekum (52:33):
And there needs to be some kind of controls in place, whether that's in the form of training or in the form of acknowledging that this is a history, this is a long-term history of Black racialized people whose experiences of pain are minimized, ignored, or diverted in favor of avoiding opioid addiction and/or opioid misuse. That is unacceptable. I think we do need to start at the point of listening to the stories of patients, starting with the point that they're not likely going to be telling lies. Where are their actual data and statistics to support where this misuse's happening and where this abuse is happening, and why is it that these racialized populations are experiencing the brunt of these very targeted risk assessments?

Dr. Madeleine Verhovsek (53:16):
Thank you, Sarah. I'd like to acknowledge just in the chat box, Dr. Suzanne Archie from Psychiatry has provided some information about an initiative that she and Dr. Abubaker Khalifa are working on. Looking to organize a town hall involving medical learners, so that would include residents and medical students looking to address the unmet needs for Black and racialized students. And she's provided her email address there for anyone who would be interested in reaching out. And Dr.

Anand had mentioned there aren't any Black faculty. I was just speaking with Dr. Khalifa, who I guess is adjunct faculty, so to his and my awareness, he is the only Black faculty member and he's very passionate about this topic, so we look forward to him being more prominently involved in these discussions going forward.

Dr. Madeleine Verhovsek (54:01):
So, perhaps with our last two minutes, we'll tackle this last question here. And we're gonna record the remaining questions that we didn't get to and try as much as we can to get back to the individual people who are asking the questions. Such a rich discussion and in the confines of a 60-minute discussion, we've just cracked the surface. So this last question, "We've been gathering data for time and been numbered since slavery. How do we ensure the data is owned and used for and by us?" This is from Tina Garrett, and I'm wondering if Ameil, you would like to comment.

Dr. Ameil Joseph (54:38):
I think that is... There's a number of issues that people have been raising for years about the misuse of data to reproduce the kind of ideas about race in our thinking, in our policymaking, and that is racism. That would be using ideas of difference and ordering people in terms of lack or threat or burden, and re-carrying these ideas forward into decision-making processes. That would be the misuse of data. But when we talk about data, we're talking about... Well, some of us are, methodologically speaking, about experiential data, about qualitative data, about how people know and where they know from. These can be inter-generationally known via trauma and discrimination that people have experienced. That is a site of knowledge that can be transformative. It can help people understand better how to transform systems and services.

Dr. Ameil Joseph (55:40):
So sometimes the race-based data conversation turns into quantitative analytics that reproduce racism systemically. And some of the asks are then, well, we're asking for a different kind of set of social relations around data itself. We know for a fact that for many years, a lot of this data has been collected and it has resulted in policy change, that it hasn't been wielded for these advocacy efforts that have been promised. But rather, we have to think about the ownership, who collects it, who has access to it, how we disclose, how we disseminate, these are ethical problems and ethical issues that need to be informed by and guided by and led by, in this case we're talking about anti-Black racism, by people who are Black.

Dr. Sonia Anand (56:27):
And I would just add that there are so many parallels with the research work I do with Indigenous peoples and communities. And we've had a complete transformation to things being community-led now. So the community needs to say, "We want this," and then with great care, we can do analyses and the community always reminds us, "Don't compare us to White Caucasians because it will always show that we're worse off and we have worse health outcomes, etcetera." So most recently, at their suggestion, we compare communities to each other and we show which communities have strengths and resilience and have strategies to overcome issues that will help other communities do the same. So I think being guided by the community is crucial. So research should be done, but it should be community-led and community-desired.

Dr. Madeleine Verhovsek (57:19):
Thank you very much, Dr. Anand. Dr. Crowther, would you like to wrap us up?

Dr. Mark Crowther (57:24):
Thanks, Madeleine, and thanks, Sonia, and thanks to our speakers for a great set of rounds. This has been extremely informative and helpful. We peaked at just over 260 people online, which is an immense number of people who are informed and the discussion in both the question and answer, and the comments has been really very valuable. So I'd like to thank our speakers for taking the time to present today for... Dr. Verhovsek and Dr. Anand for organizing this. And also to all of the people who attended, who listened attentively right till the very end, thanks very much for your attention, thanks for speaking and thanks for informing us about this critically important issue. We will have Chair's Grand Rounds again in a month, and I invite you to watch the hospital Grand Rounds which will run each week at this time slot. Thanks very much, everyone.

Dr. Teresa Chan (58:04):
Alright. Thank you very much for listening to that very important series of talks. I know it's a little longer than we usually have it, but I think that with each of the segments it was definitely a different voice and different vantage point that really highlighted the need for us all to think about how we can engage in better advocacy for our students, for our patients, and for the betterment of healthcare. So thanks again for tuning in to this special edition of MacPFD Spark, and we'll be back next week with another episode of our routine programming.