WE CARE FOR EVERYONE - BUT WHO ARE WE?

A Survey of the Diversity of the Medical Staff at Vancouver Coastal Health

Final Report

Prepared by the Meaningful Metrics Working Group, under the guidance of the VCH Physician Diversity, Equity and Inclusion Steering Committee, a partnership between the Medical Staff Associations and VCH, Physician Engagement

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EXECUTIVE SUMMARY

A noticeable lack of women physicians applying for leadership roles within Vancouver Coastal Health (VCH) triggered a series of actions culminating in the creation of this report based on a diversity survey of all medical staff at VCH in the fall of 2020. Four key qualitative themes emerged from this work:

1. A lack of diversity in medical leadership, particularly senior medical leadership, exists.

2. There is a culture that appears to lack diversity tolerance, where implicit bias is not corrected and that does not support inclusion of all people.

3. There is a lack of support, including structures and policies, for medical staff around significant life events such as illness in self or a family member, pregnancy, crisis, and other needs.

4. Generally, there is strong support for the efforts being made by the institution to address shortcomings in diversity, equity and inclusion (DEI) and hope that these efforts will continue and grow. However, there are those who believe that DEI initiatives are not necessary at VCH because there are no perceived issues, they are viewed as an invasion of privacy, and in some cases considered harmful

The key recommendations from the Meaningful Metrics Working Group, and VCH Physician DEI Steering Committee are:

1. That VCH continues to make meaningful efforts to address DEI within the medical staff and continues to support this work with resources and funding.

2. That VCH recognize the importance of robust and accurate data to guide DEI efforts and strengthens DEI data collection and analysis capacity.

3. That VCH use data to benchmark, assess and monitor DEI efforts within the medical staff and organization at large.

4. That particular emphasis be placed on using DEI data to monitor the search and selection process for medical leaders, including candidates for leadership positions, as well as the search and selection committee.

5. That DEI data collection tools be built and applied uniformly to all medical staff. Specifically, collection of DEI data at the time of privileging, as this will capture all medical staff on a two-year cycle.

6. That VCH develop agreed upon metrics and key performance indicators (KPI) based upon the collected DEI data and that DEI-related KPI are made a component of leadership appointment, re-appointment, and performance assessment.

7. That DEI training be made readily available and accessible for all new and existing VCH staff, medical staff, and leaders with regularly offered refresher courses and a DEI lens be applied to all VCH leadership courses and other training required for reappointment and professional development.

Background and Impetus for a Diversity Survey

An appreciative inquiry (AI) in 2018/2019 was the first action taken to address the lack of women applying for leadership roles. The affirmative topic selected to guide the direction of the AI was "Meaningful leadership experiences and opportunities for women physicians: women and men physicians participating together and equally in strong leadership roles at Vancouver Coastal Health."

The AI discussions highlighted women physicians' experiences, the implications of unconscious bias and the barriers for women physicians based on how medical leadership work is structured. Participants repeatedly emphasized the need for clear physician talent management processes. This included the importance and need for succession planning. There was a strong emphasis on the importance of establishing meaningful metrics. Metrics are vital to enable comparison, track progress, and enable data-driven decision-making.

The VCH Board reviewed the AI report in September of 2019 and implemented the action plan recommended by the AI[1]. The Board agreed with the formation of a Physician Diversity, Equity and Inclusion (DEI) committee to address the recommendations of the report and to support the DEI vision of the organization. **A critical first step in this journey was to collect diversity data on its medical staff, something that had never been done at VCH.** To lead this effort, the Meaningful Metrics Working Group, reporting directly to the Physician DEI Committee, was created.

While the initial report focused on gender diversity, it was acknowledged by the presenters that other aspects of diversity of the medical staff should be explored. Without appropriate data, it is not possible to describe the diversity of the medical staff or highlight improvements and progress over time.

1. Using All Our Talents: Meaningful Leadership Opportunities for Women Physicians at Vancouver Coastal Health (VCH). Published by Vancouver Physician Staff Association, Facility Engagement Team; July, 2019. https://ourvancouvermsa.ca/wp-content/uploads/2019/07/Using-All-Our-Talents_Final-Report-1.pdf

A diversity survey was carefully designed and then disseminated to medical staff in 2020. This report highlights findings gathered from the survey and is the first of its kind to be carried out at VCH and one of the first medical staff diversity surveys in Canada.

This first survey has several limitations, but still provides an important and valuable account of the DEI landscape at VCH. In future we hope for greater response rates and broader coverage of the organization. Regardless, the data collected coupled with our commitment to continue to advocate for improved data collection methods are vital to addressing these issues within our organization. We will continue to work to learn more about our medical staff, because ***you cannot change what you do not know***.

A more complete picture of the challenges faced by medical staff with respect to DEI may be formed by considering this report alongside the reports generated through thematic analysis of focus groups and other discussions over the last few years: Women Physicians Experiences during COVID-19[2], Enhancing Inclusion for Physicians of Colour at VCH[3], and the VCH Physician Debrief Session Report & Recommendations[4].

Methods

The DEI Meaningful Metrics Working Group collaboratively developed a voluntary diversity survey that was distributed to medical staff in fall 2020. The survey was accessible from September 28 to October 26, 2020 and contained both closed and open-ended questions.

Of the 3,114 medical staff at VCH at the time, responses were obtained from 469 (15%). The majority (75%) of responses came from Vancouver Acute and from physicians (90%). It is likely that our survey suffers from sampling error due to the lower than desired response rate. However, rich data was obtained from the qualitative analysis to identify our four key themes.

The range of diversity metrics collected include:

- Category of medical staff (physician, dentist, midwife, nurse practitioner)
- Community of Care (Vancouver Acute, Vancouver Community, Coastal, Richmond)
- Age
- Gender identity

[2] I may be essential but someone has to look after my kids": women physicians and COVID-19. Smith, J., Abouzaid, L., Masuhara, J., Noormohamed, S., Remo, N., Straatman, L. Canadian Journal of Public Health. 2022 Feb;113 (1):107-116. https://pubmed.ncbi.nlm.nih.gov/34919212 /

[3] Enhancing inclusion for physicians of colour at Vancouver Coastal Health. Oct. 29, 2021. Submitted by Aliya Jamal and Zenobia Jamal, Zenev and Associates, Diversity and Inclusion Consultants.

[4] Vancouver Coastal Health Physician Debrief Session Report & Recommendations. Dec. 2021. Submitted by Amil Reddy, Amil Reddy Consulting.

- Sexual orientation
- Race/ethnicity
- Identification as First Nations, Métis or Inuk/Inuit
- Identification as a visible minority
- Ability to speak a language other than English
- Completion of medical training inside or outside of Canada
- Presence of a disability
- Family status/responsibility for dependents
- Spiritual, religious, faith background

Respondents were also asked if they held leadership roles and, if so, if they were paid, unpaid, or both.

Finally, there was an open-ended question where respondents were invited to share anything they wanted VCH to know about their experiences with diversity, equity and inclusion.

Results

Detailed results of the metrics collected are presented throughout the report. Even with the limitations of the survey we see an organization where the medical staff has rich diversity with respect to gender, sexuality, race, faith background, training experiences and languages spoken. However, the medical staff does not fully reflect the composition of the communities served and there seem to be unrealized opportunities to leverage diversity to strengthen the organization. Such examples include a lack of BIPOC medical staff, a noticeable near absence of Indigenous medical staff, and a preponderance of white males in paid leadership roles.

INTRODUCTION

Diversity in Health Care in 2021

Diversity, equity and inclusion in health care is a topic that is increasingly being discussed. Notably, the president of the Institute for Healthcare Improvement recently called for adoption of "advancing health equity" as part of the quintuple aim of health-care improvement along with improving population health, enhancing patient experience, reducing costs and addressing burnout in the health-care workforce[5]. The events of 2020 and the COVID-19 pandemic have laid bare the inequities that exist at all levels of the health-care system, including within medical staff. There is ample evidence that racialized and other marginalized individuals experience inequities when accessing the Canadian health-care system and that health-care providers from their communities can mitigate some of these systemic effects[6,7,8,9]. At VCH we did not have information on the composition and diversity of the medical staff.

Diversity refers to our understanding that every person is unique and recognizes individual differences including gender and gender identity, ethnicity and race, religion and belief, nationality, sexual orientation, disability, age, and social class. Individuals differ in many ways that may not always be obvious or visible and there are intersections between those differences.

When it comes to physicians and descriptions of diversity, most of the information available is concerned with gender diversity and age. Gender parity in Canadian medical schools was achieved in 1995[10] and the gender composition of the current practicing physician group is rapidly reflecting this change.

Many institutions collect information on the age and gender of their employees but there is little information about the other areas of diversity including gender identity, race and ethnicity, sexual orientation, disabilities, and religious/spiritual beliefs. Multiple studies have demonstrated that it is important that the composition of those in the health-care system

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[5] Nundy, S, L. A. Cooper, K.S. Mate. The Quintuple Aim for Healthcare Improvement: A new imperative to advance health equity. JAMA. 327(6):521-522 (2022)

[6] Street Jr, R. L., K. J. O'Malley, L. A. Cooper, P. Haidet, Understanding concordance in patient-physician relationships: Personal and ethnic dimensions of shared identity. Ann. Fam. Med. 6, 198–205 (2008).

[7] J. Malhotra et al., Impact of patient-provider race, ethnicity, and gender concordance on cancer screening: Findings from medical expenditure panel survey. Cancer Epidemiol. Biomarkers Prev. 26, 1804–1811 (2017).

[8] Greenwood, B. N., R. R. Hardeman, L. Huang, A. Sojourner. Physician–patient racial concordance and disparities in birthing mortality for newborns. Proceedings of the National Academy of Sciences, 117 (35) 21194-21200 (2020)

[9] Komaromy M, K. Grumbach, M. Drake et al. The role of Black and Hispanic physicians in providing health care for underserved populations. NEJM;334:1305-1310 (1996)

[10] Canadian Medical Association. Addressing gender equity and diversity in Canada's medical profession: A review (Rep.). 2018 doi:https://www.cma.ca/sites/default/files/pdf/Ethics/report-2018-equity-diversity-medicine-e.pdf

reflects the composition of the society it serves. This is one facet in trying to achieve culturally appropriate health care.

Diversity, Equity and Inclusion at Vancouver Coastal Health

In response to a noticeable lack of women physicians present in and applying for leadership roles within VCH, an appreciative inquiry (AI) was conducted in 2018/2019. The affirmative topic selected to guide the direction of the AI was "Meaningful leadership experiences and opportunities for women physicians: women and men physicians participating together and equally in strong leadership roles at Vancouver Coastal Health." The purpose was to share the leadership experiences of women physicians and consider a future where women and men physicians in all their diversity participate together and equally in strong leadership roles at VCH[11,12].

It is important to acknowledge that while the initial inquiry was focused on women physicians in leadership, the action plan was intended to support continuing discussion and address diversity, equity, and inclusion. The action plan was also meant to be part of a much larger, organization-wide VCH strategy of diversity, equity, and inclusion in the workforce[13]. **Prior to the inquiry it was determined that women physicians, despite composing 43 per cent of the practicing physicians at VCH, only occupied 18 per cent of the paid medical leadership roles and this ratio had been stable for several years.** This reflects the situation in medicine and medical leadership in Canada in general where women are underrepresented[14,15].

The AI discussions highlighted women physicians' experiences, the implications of unconscious bias and the barriers for women physicians in job structures and expectations. The need for clear processes for physician talent management and succession planning were repeatedly requested by participants as was the importance of meaningful metrics to establish a benchmark for comparison, to track progress over time, to influence decision-making and, ultimately, to inform and inspire change.

The AI report was brought to the VCH Board in September of 2019 for review. In the presentation to the Board, it was acknowledged that, while the initial report focused on gender diversity, other aspects of diversity of the medical staff should be explored. This work is underpinned by the value statements adopted by VCH: We care for everyone. We are always

[11] Using All Our Talents. Meaningful Leadership Opportunities for Women Physicians at Vancouver Coastal Health (VCH). VMDAS (2019) https://ourvancouvermsa.ca/wp-content/uploads/2019/07/Using-All-Our-Talents_Final-Report-1.pdf

[12] Abouzaid, L., A Brown, L Filiatrault, N Remo, L Straatman. Taking action toward gender diversity and equity in medical leadership. cjplvol7number1.pdf (2020)

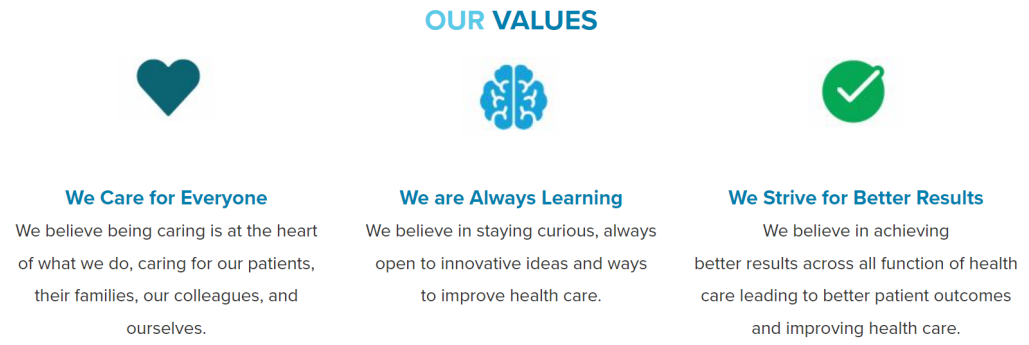
[13] https://one.vch.ca/working-here/diversity-equity-and-inclusionAccessed March 15, 2021

[14] Canadian Journal of Physician Leadership. Medical Leadership: Striving for Equity (Part 1 of 2). (2018). 5(1). https://cjpl.ca/assets/cjplvol5num1.pdf

[15] Canadian Journal of Physician Leadership. Medical Leadership: Striving for Equity (Part 2 of 2). (2018). 5(2). https://cjpl.ca/assets/cjplvol5num2.pdf

learning. We strive for better results (Figure 1). Only with appropriate metrics does it become possible to describe who we are currently or highlight improvements and progress over time.

Figure 1: VCH Values



The Board supported the formation of a physician diversity, equity and inclusion committee as a structure to implement the action plan laid out in the report and to support the DEI vision of the organization. In 2019 the committee was established, and three working groups were formed (Figure 2). Development and implementation of the medical staff diversity survey was the primary objective of the committee's Meaningful Metrics Working Group.

Figure 2: Structure of the DEI Committee and Working Groups

Survey Development Process (Brief)

The Meaningful Metrics Working Group (MMWG) was tasked with conducting an anonymized survey of medical staff with co-operation from the VCH Physician Engagement office. This survey was initiated to describe the diversity of the medical staff (physicians, nurse practitioners, dentists, and midwives) of VCH. The plan to collect anonymized data through a survey was considered to be faster to implement and more likely to provide contemporaneous guidance for planning DEI activities than collection of diversity metrics through the credentialing process. Data collected through the credentialing office would likely be high quality and capture a greater proportion of the medical staff compared to a voluntary survey

but the need for extensive stakeholder review and discussion would have led to implementation delay.

The survey was developed through an iterative process after review of the literature and the Canadian Employment Equity Act. Under the Employment Equity Act, the government is required to strive to meet levels of representation within estimated workforce availability for four employment equity designated groups: women, Indigenous peoples, persons with disabilities, and members of visible minorities[16]. VCH chose to add a fifth designated group: sexual gender diversity (LGBTQIA2S+ - Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual, Two Spirit, and analogous). Therefore, the survey questions were developed to describe the medical staff in terms of these defined facets of diversity.

After review of multiple standard questions from publicly available surveys including the University of British Columbia (UBC) Equity and Inclusion Survey, Canadian Institute of Health Improvement (CIHI)[17], Colour of Poverty Disaggregated Data Collection Survey Tool (Ontario), City of Vancouver Talk Vancouver Survey, and Doctors of BC DEI survey demographic section, survey questions were developed that incorporated standard definitions from Canadian sources.

In order to be able to compare survey data, questions around age, occupation (e.g., physician, nurse practitioner) and community of care (i.e., the community in which one practiced) were also included.

When collecting data, there are some benefits to using predetermined categories, like those developed by other groups for comparison. There are, however, challenges in finding ways to best describe people. Terminology at any time may be fluid and what is considered most appropriate at the time of the survey will likely evolve. In addition, there may be disagreement on preferred terminology and individuals may choose to use different terms to describe themselves. These options, for example the choice to self-describe, were provided to the questions where applicable and every question was accompanied by an option to "prefer not to say."

For a detailed account of survey development that includes how question domains were chosen and details of preambles, phrasing, and choice of responses, please refer to Appendix B.

Survey Media Campaign

The survey was shared with every member of the medical staff at VCH via multiple platforms including the Regional Emergency Operations Centre (EOC) newsletter, direct email from Medical Staff Association (MSA) presidents to all members, social media notices, and emails

[16] https://www.canada.ca/en/government/publicservice/wellness-inclusion-diversity-public-service/diversity-inclusion-public-service/employment-equity-annual-reports/employment-equity-public-service-canada-2017-2018.html Accessed March 14, 2021

[17] https://www.cihi.ca/sites/default/files/document/defining-stratifiers-measuring-health-inequalities-2018-en-web.pdf

from medical senior leadership. A reminder message was also sent to all medical staff two weeks after the first email. The survey ran for a total of four weeks. It launched on Monday September 28, 2020 and was initially scheduled to close on Monday, October 19, 2020. However, a one-week extension (to Monday, October 26) was added to allow additional medical staff to complete the survey.

Figure 3: VCH Medical Staff Diversity Survey Ad Campaign Poster

Data Collection

The survey was accessible to participants online through the SurveyMonkey platform on a voluntary basis. Participants were asked to consent online to participating. They could withdraw at any time prior to the completion of the online survey by simply abandoning it. Participants could also skip any question(s) that they did not wish to answer. Each question presented participants with the option to answer “Prefer not to say.”

Risks to Survey Participants

There were no anticipated risks to the participants. If a participant felt uncomfortable with a question, she/he/they could answer “prefer not to say,” skip that question, or withdraw from the survey. However, as with the nature of any survey that gathers sensitive information, the questions could elicit an emotional response. If the participant had an emotional response or

found that some questions or aspects of the survey triggered distress, they were directed to the VCH Employee and Family Assistance Program (EFAP) service for assistance.

Data Storage

Participant privacy and anonymity was protected throughout this initiative. Electronic data (survey results) were stored within a password-protected Excel file and all documentation was kept strictly confidential. No specific comments could be attributed to any individual. Data collected in support of this project will be retained for a period of seven years following the completion of the survey. Only de-identified aggregate data was shared.

Data Access and Analysis

Only the VCH data analysts (maximum four analysts working in the Physician Relations & Compensation Department) have access to the raw survey data. They de-identified data to ensure anonymity. Information from the online survey was summarized, in anonymous aggregate format, before being disseminated or presented to the DEI Committee members, medical staff, MSA members, VCH People, VCH Board of Directors, and others.

When the number of respondents were less than 5 we suppressed or, if possible, aggregated responses to preserve respondent anonymity.

Free text comments were analyzed thematically by two Physician Relations & Compensation Department staff at VCH, who first independently familiarized themselves with the data and constructed themes, and then compared and finalized the themes.

OVERALL RESULTS

The results of VCH's first medical staff diversity survey provide limited, but important, information on the composition of our medical staff workforce.

Four hundred and sixty-nine (469) or 15 per cent of medical staff took time to respond to the survey. While information was collected across all VCH Communities of Care (CoC), 75 per cent of respondents were from Vancouver Acute (VA) and Vancouver Community (VC) leaving response rates for other CoCs too low to analyze in detail. Nearly 90 per cent of respondents were physicians.

We compared the respondent results for gender, age, and profession, to that of all medical staff credentialed at VCH (broader population) to assess if there were any key differences.

Future efforts to collect diversity metrics will benefit from efforts to increase the proportion of medical staff individuals who contribute their data. In this way the data that are collected will have less sampling error and be more representative of the medical staff body. For voluntary surveys this means initiatives to increase survey response rates will be important. Coupling data collection with processes that are uniformly applied to medical staff, such as reappointment, would help reduce sampling bias in the results.

DETAILED RESULTS: QUANTITATIVE ANALYSIS

Comparative Description of Medical Staff through Credentialing and Privileging System

Based on VCH's credentialing and privileging system (CACTUS) data, there were over 3,100 medical staff across the health authority in 2020. VCH is made up of three Communities of Care (CoCs), these include Vancouver (Acute and Community), Coastal (Central Coast, North Shore, Powell River, Sea to Sky Corridor, Sunshine Coast, Bella Bella, Bella Coola), and Richmond. The breakdown of medical staff by discipline and CoC is as shown in Table 1.

Table 1: VCH Practitioners by Practice Types and Community of Care in 2020

	Physicians	Nurse Practitioners	Midwives	Dentists and Maxillofacial Surgeons	Grand Total
Vancouver Acute	1,863	70		32	1,965
Vancouver Community	423	47		1	471
Coastal	899	39	23	22	983
Richmond	466	24	11	2	503
Grand Total	**2,932**	**96**	**34**	**52**	**3,114**

Survey Response Rate by Practitioner

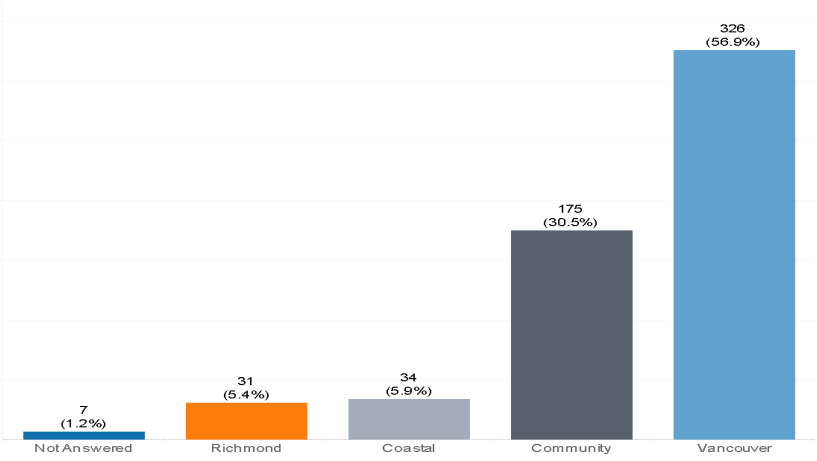
The medical staff diversity survey had a total response rate of 15 per cent (469 of 3114). Just over eighty-eight per cent (88.7%) of the respondents were physicians, seven per cent were nurse practitioners and one per cent were dentists. A small number of midwives responded to the survey, but their response rate was too low to be shown in Figure 4. However, their responses are included in subsequent figures and tables as those are not identifiable on the basis of profession. Nearly three per cent of respondents did not provide a practice profession (Figure 4).

Figure 4: Response Rate by Practitioner

Survey Response Rate by CoC

A breakdown of respondents by CoC is provided in Figure 5. The largest representation of respondents was from Vancouver Acute at 57 per cent followed by Vancouver Community (which includes long-term care) at 30.5 per cent. These areas represent where the highest number of medical staff work within VCH. Responses from both the Coastal and Richmond CoC were significantly lower by comparison, a factor that made it challenging to provide any sub-analysis for these groups.

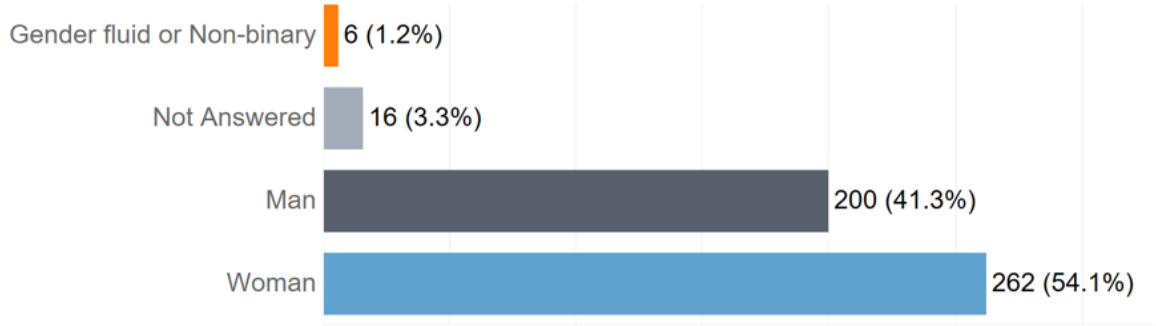
Figure 5: Respondents by CoC



Gender Identification

When asked about gender identity, 54 per cent of respondents identified as women, 41 per cent identified as men, three per cent did not answer, and one per cent identified as gender fluid or non-binary (Figure 6). The data on those who identified as transgender was too small to report.

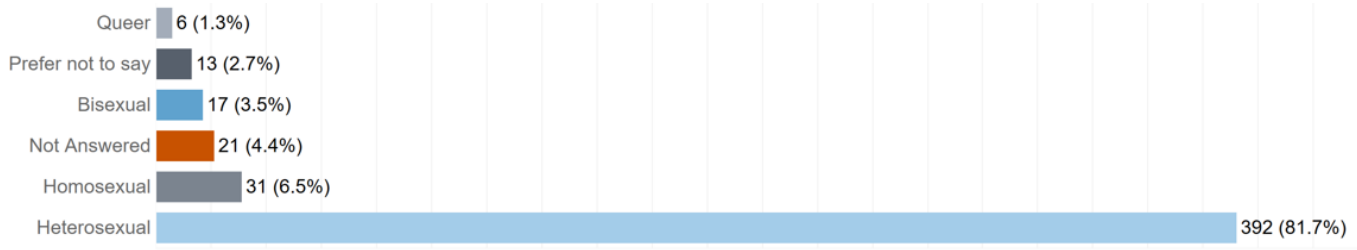
Figure 6: Gender Identification



Sexual Orientation

Survey participants indicated their sexual orientation as heterosexual (81.7%), homosexual (6.5%), and bisexual (3.5%). Less than five respondents preferred to self-describe, which is unreportable. (Figure 7).

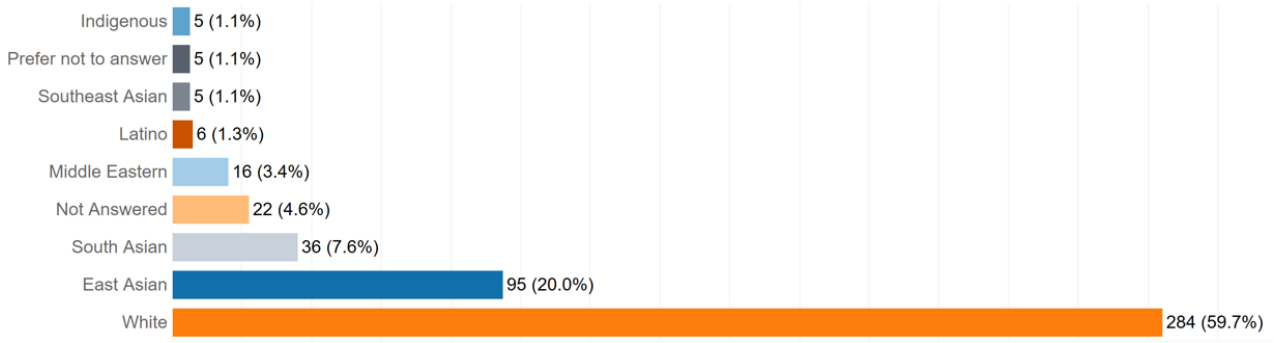
Figure 7: Sexual Orientation



Race

Four hundred seventy four (474) participants identified which race category best described them (Figure 8). The survey was constructed so that it was possible to select multiple answers to this question. The three largest race categories chosen by participants were White (59.7%), East Asian (20%), and South Asian (7.6%). Several categories were identified by respondents; only those with 5 or more respondents are being reported on.

Figure 8: Identification of Race



Indigenous Identification

Nearly ninety-four (94) per cent responded 'no' when asked if they identified as First Nations, Métis and/or Inuk/Inuit. One per cent responded 'yes'; however, the individual categories were too small to be able to report on (Figure 9).

Figure 9: First Nations, Métis and/or Inuk/Inuit Respondents

Identification as a Visible Minority

Approximately one-third (32.1%) of respondents identified as a visible minority (Figure 10). Figure 11 provides a breakdown of which race group respondents selected, whether they identified as a visible minority or not. Data on several race groups were not included due to the small number of respondents.

Figure 10: Identifying as a Visible Minority

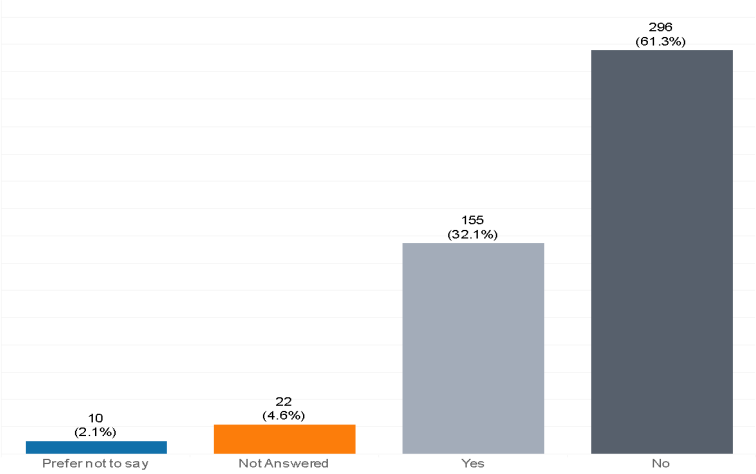
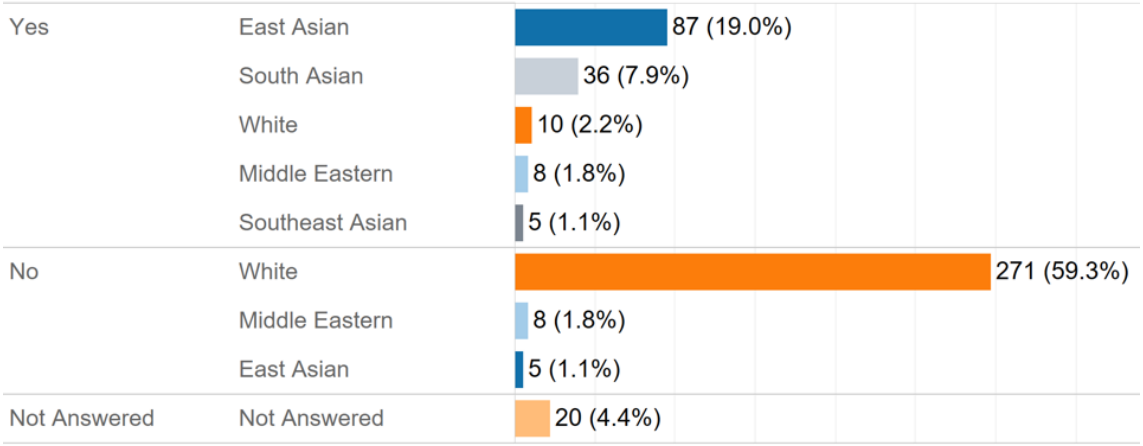


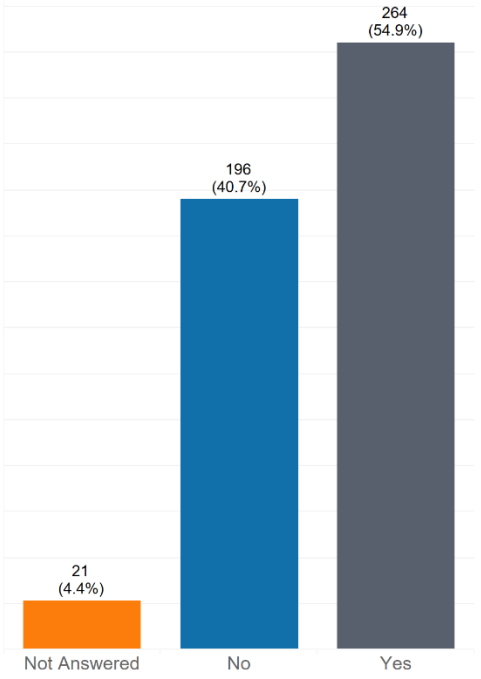
Figure 11: Visible Minority and Race Responses



Languages Spoken other than English

The medical staff who responded to this survey indicated a rich language skill set. Over 50 per cent of respondents reported speaking a language other than English. The most frequently reported languages were French, Cantonese, Mandarin, Spanish and Punjabi; however, there were many other languages identified, some of which were not included in the report due to the small number of respondents in those categories (Figure 12).

Figure 12: Languages Spoken other than English



French, and other languages	91	37.9%
Cantonese, and other languages	32	13.3%
Mandarin, and other languages	30	12.5%
Other Languages (N < 3)	24	10.0%
Not Answered or Prefer not to say	22	9.2%
Spanish, and other languages	12	5.0%
Punjabi, and other languages	10	4.2%
Hindi, and other languages	8	3.3%
German, and other languages	6	2.5%
Arabic, and other languages	5	2.1%

Medical Training Outside of Canada

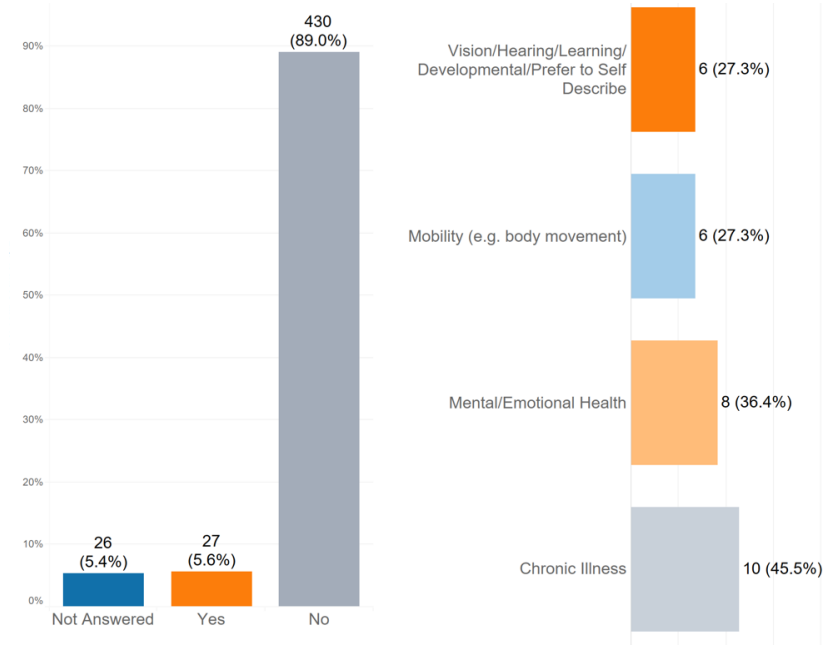
Most respondents (77.7%) obtained their medical training in Canada; almost 17 per cent reported completing their medical training outside of Canada (Figure 13).

Figure 13: Training Outside of Canada

Disability

While 89 per cent responded that they did not have a disability, 5.6 per cent of respondents reported that they did and a nearly equal number, 5.4 per cent, did not answer (Figure 14). Of those who identified having a disability, individual categories were reported where 5 or more participants responded, otherwise data were aggregated.

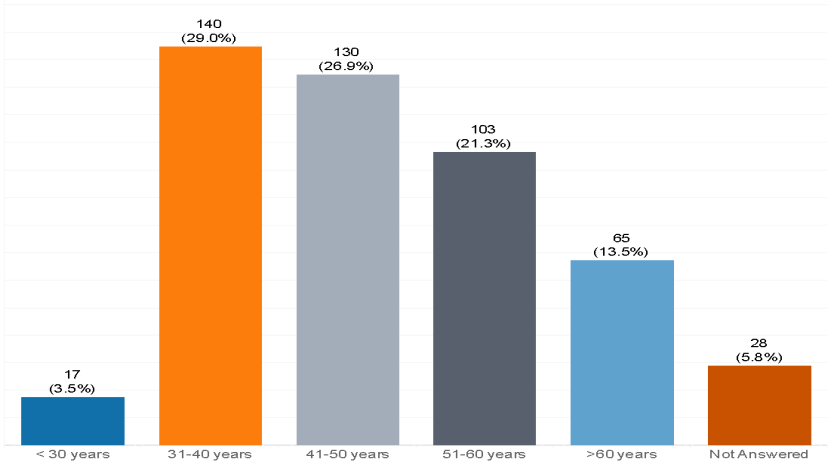
Figure 14: Disability



Age

The two most selected age categories were 31-40 years (29%) and 41-50 years (26.9%) (Figure 15). One third of respondents reported that they were 51 years of age or older (21.3 per cent were 51-60 years, 13.5 per cent over 60 years).

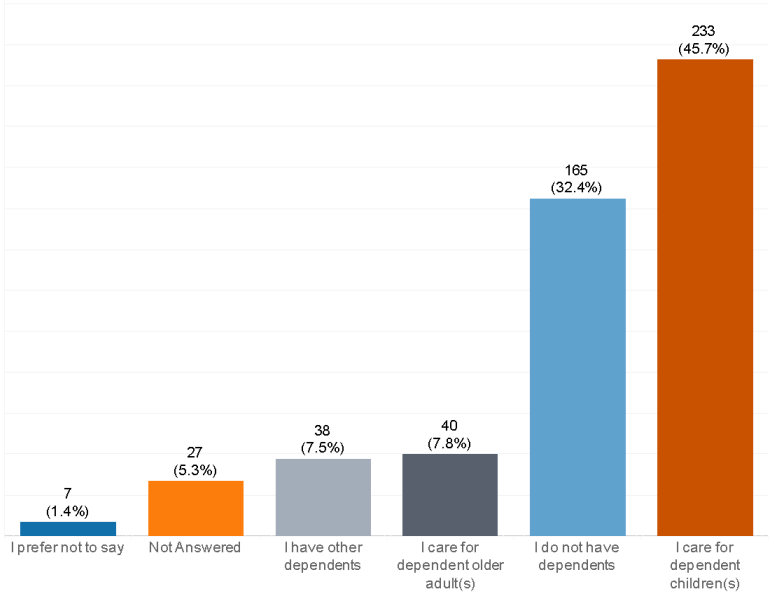
Figure 15: Age



Family Status

The split between respondents with and without dependents was 60 per cent to 32 per cent, respectively. The largest group of dependents was children at nearly 46 per cent; however, almost eight per cent of medical staff indicated caring for dependent older adults and 7 per cent had other dependents (Figure 16).

Figure 16: Family Status



Spiritual, Religious, Faith Background

There was a broad array of spiritual and religious backgrounds reported; those with less than 5 respondents were not included (Table 2). Just over one quarter (26.3%) of respondents stated they do not have a spirituality/religion/faith affiliation and approximately six per cent preferred

not to say. Of those who did ascribe to a faith, the majority, approximately 25 per cent, identified Christianity, 15.4 per cent reported atheism and the rest were spread out among a number of different options.

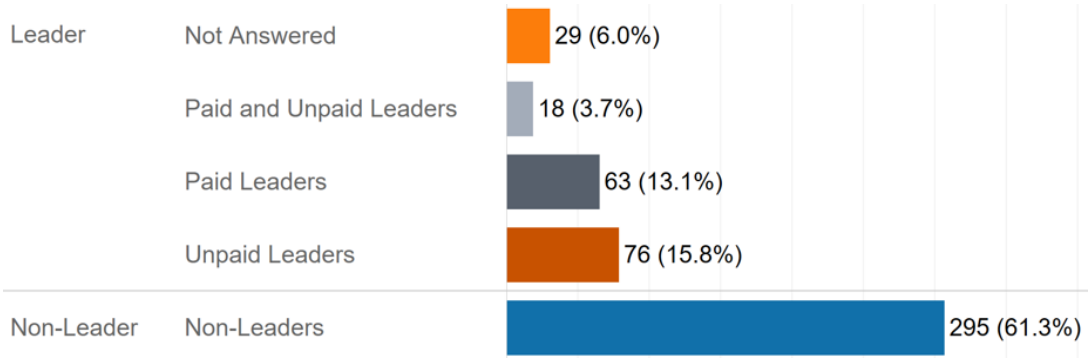
Table 2: Spiritual, Religious, Faith Background

No spirituality/religion/faith affiliation	130 (26.3%)
Christian	127 (26.1%)
Atheism	76 (15.4%)
Not Answered	29 (5.9%)
Prefer not to answer	29 (5.9%)
Judaism	20 (4.0%)
Buddhism	16 (3.2%)
Islam	16 (3.2%)
Prefer to Self Describe	11 (2.2%)
Sikhism	11 (2.2%)
Hinduism	10 (2.0%)
Spiritual	10 (2.0%)
Do not know	8 (1.6%)

Leadership

Participants were asked to identify whether they were in a leadership position and if the position was remunerated. Sixty-one (61) per cent of the medical staff who responded indicated they were not in a leadership role. Of the identified leaders who answered the questions about payment, 16 per cent reported holding unpaid positions, 13 per cent held paid positions and 3.7 per cent held both paid and unpaid positions (Figure 17). Over 90 per cent of these respondents were physicians; approximately five per cent were nurse practitioners.

Figure 17: Paid and Unpaid Leadership Roles



Of the total paid leader respondents, 47.6 per cent were men and 50.8 per cent were women. The breakdown for unpaid leader respondents was similar with 44.7 per cent men and 52.6 per cent women. For those respondents with both paid and unpaid leadership roles the split was 55.6 per cent men and 44.4 per cent women.

When compared to the actual gender ratio in VCH medical leadership, the survey data reflected here greatly overestimates the proportion of women in leadership roles, which was closer to 28

per cent for overall medical leadership roles and 24 per cent of senior medical leadership roles at VCH in an informal review of leadership and gender in June 2021.

Other factors related to leader respondents:

- Leader respondents were 81.5 per cent heterosexual, 7.6 per cent homosexual and 4.5 per cent bisexual.
- One-third of leader respondents reported being 41-50 years of age; nearly 30 per cent were 51-60 years of age; and 14 per cent were over 60 years of age.
- Over 70 per cent of leader respondents were White, followed by approximately 16 per cent East Asian and six per cent South Asian.
- Just over 80 per cent completed their medical training in Canada.
- Ninety-three (93) per cent of leader respondents reported that they have no disabilities.

DETAILED RESULTS: QUALITATIVE ANALYSIS

The final question of the diversity survey was open-ended to allow respondents to provide any comments and suggestions related to diversity, equity and inclusion at VCH. Comments included in this section were provided by survey respondents and could trigger a strong emotional response in individuals.

Over 140 medical staff responded to the question and over 12 pages of free text were gathered. Four overarching themes were identified:

1. A lack of diversity and opportunities in medical leadership, particularly senior medical leadership.

2. A culture that appears to lack diversity tolerance, where implicit bias is not corrected and that does not support inclusion of all people.

3. Support for medical staff around significant life events such as illness in self or a family member, pregnancy, crisis, or other need for leave or support is lacking.

4. Strong support for the efforts being made by the institution to address shortcomings in DEI and hope that these efforts will continue and grow; but also, concerns and skepticism about the need for DEI initiatives.

Theme One: A Lack of Diversity in Medical Leadership

The predominant theme within the qualitative data collected was related to leadership at VCH. Specifically, the lack of diversity within medical leadership, particularly senior leadership, within the health authority. Medical staff commented that the under-representation of women,

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"BIPOC are lightly scattered within very white upper echelons of the health authority and medical institutional structures. I have not met or experienced a supervisor who reflected my demographic as a physician women of colour. The female leads were generally white and they were usually under the leadership of white males"

"It does concern me that senior medical staff are largely male and white. I do sometimes feel that my comments as a woman and visible minority in leadership settings are not taken with the same degree of consideration. There is very little active reaching out to obtain input from women and minorities in group settings. I don't think this is done on purpose, but is part of the unconscious bias that affects all of us. We need to be more aware."

"More diversity needed on physician side. Still very male dominated and mostly Caucasians. Not reflective of current trends seen in recent residency or fellowship graduation classes. Unaware if VCH is actively doing anything about increasing the diversity and promoting inclusion."

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people of colour and other minority groups did not reflect the demographics of the clients served nor the makeup of the medical staff body itself and is something that is badly in need of attention. Comments were also made that there is a lack of visible effort in acknowledging and addressing the lack of diversity in leadership by VCH and tokenism is evident.

Lack of inclusion and opportunities to progress into leadership roles emerged as a sub-theme under leadership. Many respondents commented that there is a general lack of opportunity for growth and advancement into senior positions. It was felt that some of this was tied to leadership term limits not being enforced; however, there were also several references to people feeling unwelcome to pursue such roles.

"I don't think I would ever feel welcome or included at any leadership table in Vancouver. Even as a physician I feel like an outsider—never mind a leadership position. All of my clinics/hospitals have white male leaders."

"There should be terms for leadership positions. One person cannot be a head of the division for life. There is no growth opportunity for others if the heads of the divisions are appointed and never change."

"I have been respectfully excluded from opportunities within my department in many years at VCH. I've been told I cannot be as good as some other clinicians because I'm different."

Barriers such as those related to an 'old boys club' culture were identified, which some perceived as so significant that trying to break through was considered futile. There was also frustration that existing medical staff leadership deliberately ignore and/or undermine diversity

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"Racial bias is huge and should be addressed. Please also recognize that gender bias contributes to work climate. The section head of my department outright denied there being an "old boys club" climate after blatantly demonstrating nepotism towards a male friend of his."

"I feel like the VCH group is like an "old boys club", who only lets in the females that they know and like. For people who have trained externally, I feel like the opportunities for engagement and participation are limited."

"Specific individuals who are very damaging to DEI initiatives need to have some sort of repercussions for their actions. Just because they have been around for a long time and occupy senior roles is not an excuse."

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efforts by hand picking or shoulder tapping individuals for roles; some felt that there should be consequences for this type of behaviour.

Comments also illustrated that one of the barriers to participating in medical leadership was related to the structure and compensation of leadership roles themselves. Respondents shared that leadership work is either poorly compensated, or not compensated at all. This results in those who take on leadership roles and activities having to do the work on top of their clinical work during either off-hours, days off, or weekends. Leadership work that must occur during clinical hours results in a financial disincentive as paid work is replaced with unpaid work. The resulting financial hit means that less people can or will come forward to apply for these roles. Some felt that if leadership work/time is not appropriately valued and compensated, people will continue to be discouraged from coming forward.

"Still do not feel supported when trying to build systems which recognize this model of long days is not necessarily what works in many families. In particular women, but not exclusively. This also impedes women going into leadership roles."

The structure of leadership roles was described as outdated and based on the traditional family model of men (husbands and fathers) working long hours while the women (wives and mothers) are at home looking after the family and household. This model does not lend itself to inclusion of others and is also problematic for those who are in these roles and looking for work/life balance and reducing burnout.

"As a female physician who works part time, I am able to contribute to my Dept. through various committee and leadership roles. However I do so often on unpaid days off work. This allows me to participate in home life and childcare and also to the nonclinical roles in my Department. However, I am often poorly or not at all compensated for this and if I didn't have the home responsibilities to do that day, I would have just picked up a paid day of work. Like many of my colleagues do."

Several suggestions were made by survey respondents to address the leadership issues identified (Table 3). The most frequently cited recommendations were to create more leadership opportunities for those interested, make leadership roles more accessible to equally skilled and qualified women, people of colour and other minority groups in the organization and support those in leadership roles. It was felt that this could be achieved by addressing current outdated leadership structures and introducing fair, transparent, consistent, and unbiased search, selection and hiring practices. One respondent expressed that the lack of visibly out and proud leaders made it more difficult for others, junior medical staff in particular,

to feel comfortable to do so and that seeing this type of representation would have personally helped them along the way. This respondent felt that modeling this type of behaviour was something they could think and act upon themselves.

Table 3: Summary of Theme 1 – Leadership

Themes	Comments	Suggestions
Lack of diversity in leadership	- Lack of diversity/under representation, especially in senior level roles - Leadership does not reflect Vancouver demographics and clients served - Need more diversity and representation of specifically: women, people of colour/minorities, Indigenous peoples - Lack of visible effort in addressing diversity in leadership by VCH; tokenism is evident	- Make leadership positions more accessible to women, IBPOC and other underrepresented groups - Prioritize the Truth and Reconciliation Commission recommendations of hiring Indigenous nurses, midwives, physicians, and dentists at all levels including leadership levels - Affirmative action - Acknowledge the additional load women have to carry and build supports - Create leadership support teams - Cultural safety and respectful workplace training and communication - Create blind hiring practices and require mandatory unconscious/implicit bias training - Carefully assess the pipeline; set targets
Lack of leadership opportunities	- Lack of opportunities for positions and growth - Feeling unwelcome to apply - 'Old boys club' exists - No consequences for those who deliberately ignore/undermine DEI efforts and practices	- Communicate and abide by term limits - Mentorship, sponsorship, and succession planning - Tie accountability for DEI measures to leadership roles - Train leaders in how to model inclusive behaviour to make environment more welcoming
Poor compensation and structure for leadership roles	- Poor or no compensation for non-clinical, administrative and leadership work means a financial hit and less people come forward - Time not valued or paid appropriately - Work is done on off hours/days off - Model is outdated and impedes broader participation	- Improve compensation - Pay for current unpaid leadership positions - Review leadership roles and requirements with DEI lens

Theme Two: A Culture That Lacks Diversity Tolerance & Inclusion

Many respondents used the open-ended question to provide comments and observations about the culture at VCH. Themes related to lack of diversity within the medical staff, diversity intolerance and lack of inclusion at VCH stood out.

Uncorrected bias was seen as the biggest contributing factor to diversity intolerance/lack of diversity. Respondents shared personal as well as witnessed accounts of racism and discrimination at VCH that involved colleagues, staff, learners, patients and families.

> "*There is a considerable amount of diversity intolerance in the VCH system. I attribute this to unconscious bias and it needs to be remedied through education."*

In particular, respondents identified the risk to patients from various diversity profiles, specifically, patients who were Black, Indigenous, did not speak English, and 2SLGBTQI+ who were labeled difficult, making them the target of racism and poorer health care.

> *"There is significant racism on the ward I work on. Black and Indigenous clients are often labelled by staff as 'non-compliant' or difficult. The make-up of the staff is not reflective of our clientele nor are their linguistic abilities (lack of Mandarin and Cantonese speakers) and those who don't speak English are sometimes treated disrespectfully."*

> *"Diversity, equity and inclusion should not be the goal, anti-racism needs to be the goal of any institution including VCH. We cannot just add in Indigenous or other racialized people into the mix and not change anything about the inherently white supremacist and colonial power structure of medicine and medical health organizations."*

Many spoke of the need for transparent and effective processes to address discrimination. Respondents advocated for training and education, such as cultural safety training, unconscious/implicit bias training, etc., to help medical staff better understand how to care for marginalized populations safely and appropriately.

Several suggestions to improve diversity were made, ranging from more representative promotional materials, to finding respectful ways to celebrate non-dominant cultures, to improving hiring practices. It was identified that support for greater diversity starts at the top and VCH as an organization should state clearly that this is a priority. There was also recognition that the lack of diversity in medicine went much deeper than organizational hiring practices. It was recommended that Health Authorities partner with faculties of medicine to increase access to undergraduate medical education to people from racialized and other under

represented groups. *"This Includes increased financial support and mentoring at the secondary and undergraduate level - the pool of applicants becomes progressively less diverse at each stage of the process."*

Collection of diversity data was also recommended by respondents as a way to highlight the issue and demonstrate progress over time.

"I think VCH could be more 'out' with its support of LGBTQ2S peoples."

"We need to do better. There are many common myths about certain cultural groups that determine how people are treated when accessing our healthcare service, usually in a negative way. In addition, many clients experiencing mental health and/or substance use concerns do not have equitable access to healthcare or are treated in a negative manner."

Lack of inclusion at VCH was also identified as an issue. Some spoke about personally not feeling included at VCH because they had studied outside BC or moved to Vancouver from another city or outside of Canada. The sentiment of not feeling welcome was expressed more than once. Others felt they were not included because they were not from the majority group within their department or division.

Inclusion related to how medical staff are treated by VCH as an organization was also raised; non-physician medical staff felt that opportunities to participate in training, for example, and influencing the organization were more inclusive of physicians than nurse practitioners and midwives.

"I trained outside of UBC (but still in Canada) and have been working in Vancouver since 2010. Despite this, I feel like the VCH group is like an "old boys club," who only lets in the females that they know and like. For people who have trained externally, I feel like the opportunities for engagement and participation are limited."

"This is the first time I've received messaging directed to medical staff that is inclusive of midwives, dentists, and NPs. We are constantly forgotten. Worst of all is there are many emails with funding or training opportunities addressed to medical staff but are really only inclusive of physicians and should go to the physician society exclusively."

To create a more inclusive environment for patients, clients, and medical staff alike respondents suggested visible support from the organization (e.g., policies and procedures, promotional material, changes to Cerner). Other suggestions to promote inclusion were

training and education, fair and transparent opportunities and selection processes for filling positions and committees.

"When putting out promotional material or posters for things like hand hygiene, it is nice to see photos of all the faces of VCH."

Table 4: Summary of Theme 2 - Culture and Inclusion

Themes	Comments	Suggestions
Lack of diversity	- Lack of diversity in medical staff - Organization should reflect the population - Make DEI a priority - Raise awareness/show commitment to this work	- Address lack of diversity through affirmative action or other measures - Provide cultural sensitivity and safety training - Improve and make hiring practices transparent - Work with UBC to increase access to medical education for racialized people - Systemic change to address power structure - Recognize and respectfully celebrate cultures
Discrimination and lack of tolerance	- Micro-aggressions/racism exists at all levels - Significant perceived diversity intolerance - IBPOC clients labeled "non-compliant" or "difficult" by staff - Need greater emphasis and equal access for patients who are Indigenous and First Nations, transgender, experiencing mental health and/or substance use concerns, have visual or hearing impairments, and more	- Assess existing policies and processes with the lens of DEI and make necessary changes - Make it clear that discrimination of any kind is not tolerated at VCH, state it publicly - Believe victims; take discrimination seriously - Provide training and education (mandatory if necessary) online and through interactive workshops to address myths and stereotypes, promote cultural safety, assess implicit bias, and provide appropriate care to marginalized populations - Seek input from marginalized groups when creating training and policies
Lack of inclusion	- VCH is not very welcoming to people from outside Vancouver/trained elsewhere - VCH is not collaborative or inclusive, 'old boys club' - Perception of less opportunities for non-physician medical staff	- Find ways to improve inclusion and shift "unwelcoming culture" but not by alienating others - Consider staff input and communicate decision-making transparently

Themes	Comments	Suggestions
	- Lack of visible support of underrepresented groups (e.g., LGBTQ2S+ people)	- Provide training/education programs on how to create safe, supportive, and inclusive environments - Include broader representation in promotional material - Create policies around inclusion and enforce them (e.g., calling transgender people by their preferred name, addressing gender options in Cerner (currently very gender binary))
Collect data	- No reporting available on diversity of leadership, medical staff and/or patients	- Make diversity questions optional part of credentialing and/or the VCH engagement survey - Collect patient diversity data - Report on diversity data collected publicly

Theme Three: Lack of Structures to Support Medical Staff

The third theme centred on how the structures and environment at VCH do not support all medical staff. Many respondents shared difficult personal experiences or witnessed accounts where colleagues struggled, in which they felt that the organization had let them down. Examples include during illness, pregnancy, or dealing with crises within their families, and struggles related to childcare accessibility.

Inconsistent and unfair leave policies, difficulties in finding coverage, loss of opportunities and a general lack of understanding and empathy during difficult personal times were all reported by respondents, leaving some feeling like they were being punished for needing to be away or

"I have been entirely unsupported [during a] terrifying journey and this has had a severely negative impact on my life and work - VCH is not supporting the various challenges that are faced by its members – personal, family related, pregnancy - It has improved with the current Director but the decades of toxicity and lack of support for long term employees/staff has occurred."

"VCH has always had a non-collaborate approach that feels non-inclusive to even the non-minorities in the world, so I believe this attitude - that comes from the very top and trickles down everywhere - will be an impediment to attract a diverse staff…I feel the attitude, so I can only imagine how a minority member of a society might feel in the same setting."

"I hope this survey and other steps can truly assist with the vision of "One VCH" and "People First", as I believe that some have seen these strategies as words only and limited action."

work differently. Lack of psychological safety and "basic human compassion," along with bullying were identified as significant issues. Many expressed frustration that they did not know where to turn when faced with these issues and wanted to see real action from the organization to better support them.

Summary of Theme 3: Lack of Supportive Structures

Themes	Comments	Suggestions
Unsupportive and unsafe work environment	- Need more understanding and compassion from leaders and the organization - Work environment is toxic/psychologically unsafe - Bullying is a significant issue - No accessible childcare - Lack of support, unfair and inconsistent polices around maternity/parental and other types of leaves - Unsure who/where to go to when issues arise; no safe way to report issues	- Provide training/education programs on how to create safe, supportive, and inclusive environments - More support for parents, pregnant women, those with or recovering from illness, those with mobility issues, etc. - Clear, consistent, and fair policies around leaves - Psychological safety training (for leaders and med staff) - Provide childcare options, with extended hours - Empower work teams to have conversations and come up with local solutions to work-related issues - Small focus group discussions to explore further - Less surveys, more action - Clearly identify resources to support victims and safe channels to report bullying, unfair practices, discrimination, etc.

Theme Four: Thoughts on VCH DEI Efforts

The final theme that emerged from the open-ended question centred on support for DEI efforts being taken on by VCH and physician partners; however, there were also several respondents who questioned the need for DEI initiatives, particularly if they take attention away from other important health care system issues.

"Be wary of this rabbit hole of generating issues and ignoring the hospital mission of patient care."

"I hope the emphasis on these issues doesn't lead us down the path of what we are seeing in US Universities and US society in general. Perhaps you'd like to reassure staff that this isn't leading to a drive for forced re-education programs"

There were comments that respondents themselves had never experienced or witnessed any concerns around bias. Some felt that their areas of work were diverse enough and that VCH was already doing well in this regard.

"I have not perceived any barriers to diversity, equity and inclusion at VGH."

"Have not noted any bias from VCH."

"I think my department does this very well to be honest."

"Seems fine! Lots of minority leaders in my department, feels equitable and just."

Others were weary that inclusion of DEI factors in hiring and promotion would undermine efforts to hire medical staff on the basis of their qualifications and merit and may even take opportunities away from those who deserve them most.

There were suggestions that DEI matters are private and that being asked for information in this way was offensive; conversely, others suggested that these questions should become a mandatory requirement as part of the credentialing and privileging process.

"What's the meaning of this questionnaire I think these are info bites that should strictly remain personal and protected…"

"Diversity is key but not at the expense of qualification. UBC is moving aggressively for diversity with sacrifice for excellence at times."

"Grant tenure and CRCs are no-longer available to me, meaning my race (lack of minority status) excludes me from the main academic funding sources."

"You should be employed based upon your skill not your colour, not your religion, not your ethnicity, not your sexual orientation. The ability to do your job is paramount - hiring based on preferential need for the token minority representative is blatant discrimination against those who are more qualified and should not be tolerated in this 21st century."

"As a visible minority, I am a bit uncomfortable with the emphasis being suddenly placed on diversity, equity, and inclusion - are we striking the right balance between EDI and choosing the best people for the organization, regardless of race, gender, etc.?"

"Having this survey as a standalone item, versus combining with other essential interactions, just adds to the burden of people for whom this is a daily thing... the "diversity tax". Instead make these questions an OPTIONAL part of e.g. credentialing or the Health Authority engagement survey.

"I don't have any qualms about ensuring that everyone is treated equally. However, history has repeatedly shown that such "progressive" agendas such as "diversity" are not applied equally, and are Trojan horses to push specific agendas. There is a great risk of alienating people who would normally have been prepared to work towards advancing an inclusive VCH environment, but will be less likely to do so if they are being constantly hectored for being racist, sexist, transphobic and homophobic."

By way of acknowledgement, encouragement or simply 'thanks,' respondents shared their support for this important work and moving it forward, beyond a survey, to action.

"Diversity makes us stronger and better able to care for our population. I strongly support equity and inclusion practices and policies."

"Pleased to see increased awareness of and engagement in these important issues.

" "I was very relieved to see DEI move ahead and have found it excellent."

"I am appreciative of the fact that you have this initiative. Bravo but long overdue."

"Just to add my strong support for the process to strengthen our collective pursuit ....."

"Great that you are doing this work! Thank you!"

DISCUSSION AND RECOMMENDATIONS

This was the first diversity survey of medical staff undertaken within VCH. Measuring diversity and inclusion is an important step institutions can take to describe the current landscape, encourage conversations, benchmark, imagine change, and measure the impacts of programs designed to improve equity and inclusion.

This survey had sampling challenges and a response rate that is too low to provide an accurate description of the medical staff; however, it does provide a glimpse into the diversity that our institution, patients, and community could benefit from. In addition, the comments shared by medical staff provide a powerful voice that calls to us to continue to strengthen our current efforts with respect to DEI within VCH. Based on the survey findings and growing awareness of best practices in DEI, the Meaningful Metrics Working Group has developed a number of recommendations for consideration of VCH leadership.

Recommendation 1: That VCH continues to make meaningful efforts to address DEI within the medical staff and continues to support this work with resources and funding.

Efforts to address gaps in DEI were favourably viewed by survey respondents with several noting that these efforts felt long overdue. Leadership work in DEI should be viewed comparatively to leadership work in other areas in the health authority, compensated to the same degree and ascribed the same importance. All too commonly across industries, those who work in DEI are uncompensated, disproportionately made up of underrepresented groups and in some cases those who work in DEI experience adverse effects on their career trajectory[18].

Recommendation 2: That VCH recognizes the importance of robust and accurate data to guide DEI efforts and that VCH strengthens its DEI data collection and analysis capacity.

Interventions that will increase sampling will strengthen efforts to describe the diversity of our medical staff and help provide data that can be used to benchmark and monitor efforts.

Collection of accurate data that reflects the demographics of the medical staff will remain difficult as long as voluntary tools are the primary method used. We recommend that diversity questions are included in the privileging process, which is mandatory for medical staff on a two-year cycle.

Recommendation 3: That VCH use data to monitor, benchmark and assess efforts to improve DEI within the medical staff and organization at large.

Data should be tracked longitudinally to monitor progress and improvement. Periodic climate surveys can support quantitative data reporting to monitor shifting attitudes and experiences around themes such as diversity and opportunities in leadership and inclusion.

[18] https://hbr.org/2016/03/women-and-minorities-are-penalized-for-promoting-diversity

Exit interviews with departing staff that include questions on the themes of diversity, equity and inclusion can also provide important information regarding culture and climate.

Recommendation 4: That particular emphasis be placed on using DEI data to monitor the search and selection process for medical leaders, including candidates for leadership positions as well as search and selection committees.

The search and selection process for medical leadership positions should include transparency in the posting and requirements for the role, a diverse selection committee and the use of rubrics to evaluate candidates. A DEI-oriented observer should be present to help guide the committee through the use of bias interrupter tools and make sure an inclusive process is followed. VCH should adopt a guideline for recruitment of medical staff and medical leadership positions. One example of such a guideline is the UBC Faculty of Medicine Guide to Faculty Recruitment[19].

Recommendation 5: Build DEI data collection tools that can be applied uniformly to medical staff. We recommend collection of DEI data at the time of privileging as this will capture all medical staff on a two-year cycle.

This recommendation addresses the difficulty in achieving a high response rate to voluntary diversity surveys, especially those that must be administered multiple times in order to achieve a longitudinal understanding of the medical staff. Concerns related to data privacy should be addressed through robust governance and systems to handle sensitive data. BC's Office of the Human Rights Commissioner has released a report discussing these issues with respect to the collection of diversity data by the province that contains a framework that could be applied by VCH[20].

Recommendation 6: That VCH develop agreed upon metrics and key performance indicators (KPI) based upon the collected DEI data and that DEI-related KPI are made a component of leadership appointment, re-appointment, and performance assessment (e.g., department and division heads).

These metrics would need to be tailored to the level of leadership but could include items such as:

- diversity of decision-making and overseeing groups such as the Executive Medical Group and the Health Authority Medical Advisory Committee (HAMAC), among others
- presence of mentorship and sponsorship structures, particularly programs for members of underrepresented groups

[19] FoM_Guide_Faculty_Recruitment.pdf (ubc.ca)
[20] Disaggregated demographic data collection in British Columbia: The grandmother perspective - BC's Office of the Human Rights Commissioner (bchumanrights.ca)

- transparency in hiring and promotion with use of scoring rubrics and tools to interrupt implicit bias
- transparency in remuneration for leadership roles
- developing and instituting DEI memorandums of understanding governing expected behaviour and plans within departments or divisions

Recommendation 7: That DEI training be made readily available and accessible for all new and existing VCH staff, medical staff, and leaders with regularly offered refresher courses and a DEI lens be applied to all VCH leadership courses and other training required for reappointment and professional development.

STATEMENT OF APPRECIATION AND FUNDING SOURCE

This work was made possible through Physician Engagement Funding. The Meaningful Metrics Working Group would like to thank the Vancouver Physician Staff Association, Physician Compensation and Relations at VCH, and the Board of Directors at VCH for their support of the DEI Initiative and, of course, our fellow members of the VCH Physician Diversity, Equity and Inclusion Committee.

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ADDITIONAL READING

https://www.canada.ca/en/government/publicservice/wellness-inclusion-diversity-public-service/diversity-inclusion-public-service/employment-equity-annual-reports/employment-equity-public-service-canada-2017-2018.html Accessed March 14, 2021

https://one.vch.ca/working-here/diversity-equity-and-inclusion Accessed March 15, 2021

https://cjpl.ca/assets/cjplvol7number1.pdf

https://www.cihi.ca/sites/default/files/document/defining-stratifiers-measuring-health-inequalities-2018-en-web.pdf

https://www.cma.ca/sites/default/files/pdf/Ethics/report-2018-equity-diversity-medicine-e.pdf

APPENDIX A - DIVERSITY SURVEY IN FULL

THIS SURVEY IS INTENDED FOR VCH MEDICAL STAFF ONLY - NURSE PRACTITIONERS, MIDWIVES, PHYSICIANS and DENTISTS

1. Completing the survey will take between 5 to 10 minutes.

Purpose: This survey aims to explore the diversity profile of medical staff, establish a baseline, and inform future policies, practices and interventions to improve diversity, equity and inclusion at VCH.

Risks/Benefits: Answering personal questions about yourself may cause you distress. You do not need to answer questions that you are not comfortable answering.

If you feel upset after completing the survey, or find that some questions or aspects of the survey have triggered distress, you may reach out to the VCH Employee & Family Assistance Program (EFAP) service for assistance. Contact information will be available at the end of the survey.

Anonymity and Confidentiality: All information received will be anonymous and no personal identifiable information is being collected. If the collective results are too small that reporting them could potentially reveal an individual's identity, the data will be added to a larger group in order to prevent identification.

Voluntary and Withdrawal from the Study: Taking part in this survey is voluntary. You may skip a question(s), answer "prefer not to say" or withdraw at any time without giving a reason by simply abandoning the survey with no negative consequences to you.

How results will be used: Results will be shared in an anonymous aggregate form with physicians and VCH leadership and may be used for scholarly purposes and be presented at professional conferences, and/or published in a professional journal.

2. Are you a:

Nurse practitioner
Midwife
Physician
Dentist

3. Where do you work? (select all that apply)

Vancouver Acute (VGH/UBCH/GF Strong)
Richmond
Sunshine Coast/Sea-to-Sky
North Shore
Vancouver Community/Long Term Care

Community private practice

4. What gender do you identify with? (select all that apply)

Woman
Man
Non-binary
Gender fluid
Prefer not to say
Prefer to self-describe:

5. Do you identify as transgender?

Yes
No
Prefer not to say

6. How do you identify your sexuality/sexual orientation? (select all that apply)

Heterosexual
Homosexual
Bisexual
Prefer not to say
Prefer to self-describe:

7. We know that people of different races do not have significantly different genetics. But our race still has important consequences, including how we are treated by different individuals and institutions. Which race category best describes you? Check all that apply:

Black (African, Afro-Caribbean, African Canadian descent)
East Asian (Chinese, Korean, Japanese, Taiwanese descent, other East Asian descent)
Southeast Asian (Filipino, Vietnamese, Cambodian, Thai, Indonesian, other Southeast Asian descent)
Indigenous (First Nations, Métis, Inuk/Inuit)*
Latino (Latin American, Hispanic descent)
Middle Eastern (Arab, Persian, West Asian descent – e.g. Afghan, Egyptian, Iranian, Lebanese, Turkish, Kurdish)
South Asian (South Asian descent - e.g., East Indian, Pakistani, Bangladeshi, Sri Lankan, Indo-Caribbean)
White (European descent)
Do not know
Prefer not to answer
Another race category:

8. Do you identify as First Nations, Métis and/or Inuk/Inuit?

Yes
No
Prefer not to answer

If yes, select all that apply:

First Nations
Métis
Inuk/Inuit
Prefer not to answer

9. Do you identify as a visible minority?

Yes
No
Prefer not to say

10. Do you speak a language other than English?

Yes
No
Prefer not to say
If yes, please specify which languages:

11. Did you do your medical training outside of Canada?

Yes
No
Not applicable
Prefer not to say

12. Do you have a disability? Disability is defined as a long-term physical, mental, emotional/psychiatric or learning disability, which may result in a person experiencing disadvantage or encountering barriers to employment, public appointment or other opportunities for full participation in society.

Yes
No

If yes (pick all that apply):

Hearing
Vision
Mental/Emotional Health
Mobility (e.g., body movement)

Speech
Learning
Chronic Illness
Developmental
Drug and/or Alcohol Dependence
Prefer not to answer
Do not know
Prefer to self-describe:

13. What is your age?

< 30 years
31-40 years
41-50 years
51-60 years
>60 years

14. Which best describes your family status?

I care for dependent child/children
I care for dependent older adult(s)
I have other dependents
I do not have dependents
I prefer not to say

15. What, if any, is your spiritual/religious/faith background? (select all that apply)

American indigenous/native spirituality
Atheism
Buddhism
Christian – not included elsewhere
Confucianism
Hinduism
Islam
Jainism
Judaism
Orthodox Christian
Protestantism
Rastafarianism
Roman Catholicism
Shamanism/Aminism
Sikhism
Zoroastrianism

No spirituality/religion/faith affiliation
Prefer not to answer
Do not know
Prefer to self-describe:

16. Do you hold a paid leadership position at VCH? (any compensation qualifies as paid)

Yes
No
Prefer not to say

17. Do you hold an unpaid leadership position at VCH?

Yes
No
Prefer not to say

18. Do you have any comments or suggestions related to diversity, equity and inclusion at VCH?

APPENDIX B

SURVEY DEVELOPMENT - How and why questions were chosen

The survey was developed through an iterative process after a review of the literature and the Canadian Employment Equity Act. Under the Employment Equity Act, the government is required to strive to meet levels of representation within estimated workforce availability for four employment equity designated groups: women, Indigenous peoples, persons with disabilities, and members of visible minorities[21].

VCH chose to add a fifth designated group: sexual gender diversity (LGBTQIA2S+ - Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual, Two Spirit, and analogous). Therefore, our survey questions were developed to describe the medical staff in terms of these defined facets of diversity.

After a review of multiple standard questions from publicly available surveys including the University of British Columbia (UBC) Equity and Inclusion Survey, Canadian Institute of Health Improvement (CIHI)[22], Colour of Poverty Disaggregated Data Collection Survey Tool (Ontario), City of Vancouver Talk Vancouver Survey and Doctors of BC DEI survey demographic section, survey questions were developed that incorporated standard definitions from Canadian sources.

In order to be able to compare survey data, questions around age, occupation (e.g., physician, nurse practitioner) and community of care (i.e., the community in which one practiced) were also included.

Medical Staff

The medical staff of VCH consists of physicians, nurse practitioners, midwives, and dentists. Each survey participant was asked to select one of these categories.

Community of Care

Vancouver Coastal Health consists of many communities of care (geographic areas) and a single practitioner may work in more than one community of care. In order to report anonymized data, some of the smaller communities of care were grouped together geographically.

Age

Age was asked in 10-year brackets except where all ages less than 30 years or greater than 60 years were grouped together into two bracket categories. Age was one of the categories

[21] https://www.canada.ca/en/government/publicservice/wellness-inclusion-diversity-public-service/diversity-inclusion-public-service/employment-equity-annual-reports/employment-equity-public-service-canada-2017-2018.html Accessed March 14, 2021

[22] https://www.cihi.ca/sites/default/files/document/defining-stratifiers-measuring-health-inequalities-2018-en-web.pdf

routinely collected by VCH at the time of credentialing and could be used to compare survey respondents to the general medical staff body.

Gender Identity

We began with definitions of sex and gender because they are often incorrectly used interchangeably.

The British Columbia Law Institute reminds us that the correct use of commonly understood language is essential. It assists us in framing issues properly, keeps the discussion respectful, and helps identify areas where improper use of terms and concepts is impacting policy rationales and choices.

For the purposes of this survey, gender minority refers to a person whose gender identity or self-expression differs from conventional expectations of masculinity or femininity. This includes people who self-identify as trans, transgender, gender-fluid, or an analogous term. This was the same language utilized on the Doctors of BC and UBC surveys already completed.

Sexual Orientation

There is no information about the sexual orientation of physicians currently in the literature. The American Medical Association is currently conducting a voluntary survey of its members so it "will be better equipped to meet the specific needs – and better reflect the makeup – of the nation's increasingly diverse physician community."

Ethnicity

The terms "race" and "ethnicity" are often used interchangeably or as a single, conflated construct — "race/ethnicity." Race and ethnicity in health research are commonly used as proxies for one another. Race is a social construct used to categorize people based on perceived physical differences (e.g., skin colour, facial features). There is no scientifically accepted evidence of a biological basis for the identification and classification of discrete racial groups. Ethnicity is a multi-dimensional concept referring to cultural group membership; it may be connected to language, religious affiliation, or nationality, among other characteristics.

The Canadian Institute for Health Information's (CIHI) proposed race-based data standard is adapted from the Ontario Anti-Racism Directorate's race data standards and is consistent with The Upstream Lab's recommendations on collecting data on race[23]. The standard should be accompanied by a distinctions-based Indigenous identity question (at minimum), along with community engagement and/or data governance agreements.

Organizations interested in monitoring and addressing inequalities that may stem from racism and bias can consider collecting race-based data. However, if the interest is in tailoring services or initiatives to improve care (e.g., anticipating language service needs), then ethnicity-related

[23] https://www.cihi.ca/sites/default/files/document/proposed-standard-for-race-based-data-en.pdf

concepts (e.g., language) may be more relevant. It may also be useful to collect race-based and ethnicity data on providers, to understand the diversity of the workforce. Collecting and using both race-based and ethnicity data together can support the responsiveness of health-care systems to the diverse needs of patients.

The preamble to questions on race and ethnicity attempted to capture some of the complexity of these constructs: “We know that people of different races do not have significantly different genetics. But our race still has important consequences, including how we are treated by different individuals and institutions. For the purpose of this survey, this self-identification is intended to capture your ancestry which may be different from one's birthplace, citizenship, or language. If you are of mixed descent, please indicate this by checking off all that apply. If your self-identification (or parts of it) does not appear in this list, please specify under ‘Prefer to self-identify as…’.”

Also, when utilizing CIHI reporting standards with respect to Indigenous status, it is common to see categories such as First Nations, Inuit and Métis within race-based or ethnicity data collection standards. There may be some commonalities between these concepts, such as experiences of racism and cultural belonging; however, First Nations, Inuit and Métis are constitutionally recognized sovereign nations with inherent rights to self-determination. Although the term “Indigenous peoples in Canada” often refers to First Nations, Inuit and Métis peoples, these categories may not reflect the preferred community or nation-specific labels.

Identification as a Visible Minority

In the federal Employment Equity Act, visible minorities are defined as “persons, other than aboriginal peoples, who are non-Caucasian in race or non-white in colour.”

This question recognizes that belonging to a visible minority still has social implications and we wanted our concept of visible minorities to reflect the reality of racism and its impact. The term “visible minority” or “person of colour” does not in itself identify a uniform group and, as such, is problematic and therefore we needed to ask other supplementary questions, using the Canadian census language about how one further self-identifies to be able to identify distinctions within the broader concept of “visible minorities.”

Language Spoken

Medical staff were asked if they spoke any language other than English. Medical staff with multilingual capability reflect the wide community we serve. This question is also asked at the time of credentialing.

Medical School or Residency Outside of Canada

While there is little literature on whether medical school or residency was done outside of Canada, there was one study that examined the intersecting roles of gender, ethnicity, and professional status in shaping the experiences of internationally educated health professionals

in Canada[24,25]. The study utilized semi-structured qualitative interviews with internationally trained physicians who came to Canada between 2005 and 2015 with the intention to practice their profession. Physicians rarely reported instances of discrimination in communication with patients or nurses but were concerned about instances of discrimination within their own professional group. This differed from nurse-reported discrimination by patients and their families as well as racialization by physicians, management, and other nurses. The article reflected on the role that gender and professional status play in shaping the experiences of ethnic discrimination of internationally educated health professionals.

Disability

This study defined disability as a long-term physical, mental, emotional/psychiatric or learning disability, which may result in a person experiencing disadvantage or encountering barriers to employment, public appointment, or other opportunities for full participation in society. If answered in the affirmative, participants were asked to further define according to predetermined categories or to self-describe.

Additional Questions not Specific to Designated Group Categorization

In addition to the questions that directly answer the diversity of the five designated groups, other aspects that define an individual's diversity were developed to include religion or spiritual belief system.

Religion

There are no documented studies that have asked the religious or spiritual beliefs of physicians in Canada. There have been some studies that have asked about medical student or physician perceptions and intentions toward medical assistance in dying that have also reported on religious beliefs of the respondents in relation to the question asked[26]. There are, however, numerous articles about the interplay of religion, spirituality and beliefs in physician and patient interactions[27].

Family Dependent Status

[24] Neiterman E, Bourgeault IL. The shield of professional status: Comparing internationally educated nurses' and international medical graduates' experiences of discrimination. Health (London). 2015 Nov;19(6):615-34. doi: 10.1177/1363459314567788. Epub 2015 Jan 26. PMID: 25627697

[25] Campbell-Page RM, Tepper J, Klei AG, et al. Foreign-trained medical professionals: Wanted or not? A case study of Canada. J Glob Health. 2013;3(2):020304. doi:10.7189/jogh.03.020304

[26] Robinson KA, Cheng MR, Hansen PD, Gray RJ. Religious and Spiritual Beliefs of Physicians. Journal of Religious Health. 2017 Feb;56(1):205-225. doi: 10.1007/s10943-016-0233-8. PMID: 27071796.

[27] Falconer, J., Couture, F., Demir, K.K. et al. Perceptions and intentions toward medical assistance in dying among Canadian medical students. BMC Med Ethics 20, 22 (2019). https://doi.org/10.1186/s12910-019-0356-z

Despite their increased participation in the Canadian workforce, women still act as the primary caregivers of both children and the elderly in the home. It is assumed that women will be the main caregivers (in heterosexual couples) not because of their sex (biology), but because caregiving is seen as part of their role as the female parent (socially defined in an assumed heterosexual couple), and because of a culturally constructed association between femininity and nurturing. The uneven burden of caregiving in Canada has economic and health-outcome repercussions for women, including contributing to the gender-wage gap. In addition, policies that overlook the role of men as primary caregivers and nurturers perpetuate gender stereotypes that are harmful to men as well as women.

Research has demonstrated that women take on more caregiving responsibilities than men even when this is a deterrent to their career advancement as physicians[28]. Recent focus groups on the experience of women physicians with COVID-19 from our own institution confirmed this[29].

Leadership

How an institution's leadership reflects diversity is a recognized measure of equity and inclusion. Within VCH there was only data on paid leadership positions that could be further stratified to gender, age, and community of care. Other aspects of diversity in leadership positions are unknown. Women may be over represented in unpaid, unofficial, or untitled leadership and administrative tasks and this has been described to be a key equity indicator that has been overlooked.

General Comments/Suggestions to Support Diversity in the Medical Staff

Participants were given an opportunity at the end of the survey to add comments or suggestions. All posts would be considered confidential and any information that could potentially identify the commenter was anonymized prior to analysis.

Areas of Diversity that were Intentionally Left Unasked

Income Level/Educational Attainment

While we are aware that there are several drivers of health equity as defined by the Canadian Institute for Health Improvement (CIHI) that include income and educational attainment, we did not ask specific questions of these. Compared to the general population, most medical staff would be in the higher income quartiles. We do know that there is data on the gender disparity in income amongst physicians but there is no data on income with respect to other intersections of diversity. In addition, with respect to educational attainment, almost all staff

[28] What's Holding Women in Medicine Back from Leadership. Mangurian, C., E Linos, U Sarkar, C Rodriguez, R Jasi. Harvard Business Review 2018.

[29] I may be essential but someone has to look after my kids": women physicians and COVID-19. Smith, J., Abouzaid, L., Masuhara, J., Noormohamed, S., Remo, N., Straatman, L. Canadian Journal of Public Health. 2022 Feb;113 (1):107-116. https://pubmed.ncbi.nlm.nih.gov/34919212

would be in the higher quintile of having a post-secondary school completion above a bachelor's degree, with an exception for some midwifery staff who can practice after attaining a Bachelor of Midwifery, and therefore this would not be a valuable measurement of diversity.

Recent data on the socioeconomic characteristics of Canadian medical students demonstrated that they had a higher socioeconomic status than the general population as indicated by level of their parental education (29 per cent of respondents' parents had a master's or doctoral degree, compared to 6.6 per cent of Canadians aged 45–64), parental occupation (59.7 per cent of respondents' parents were high-level managers or professionals, compared to 19.2 per cent of Canadians aged 45–64), and parental/family income (62.9 per cent of respondents grew up in households with income >$100,000/year, compared to 32.4 per cent of Canadians)[30].

One of the interesting questions we could have looked at is parental status of our physicians and understanding if there is a difference in those who did not start at a higher socioeconomic status and if there is any intersection with other areas. Data from Statistics Canada does identify that it is difficult to escape from the income quintile of your parents.

The final survey questions were presented to institutional experts from the Legal and Privacy departments.

[30] Khan, R., Apramian, T., Kang, J.H. et al. Demographic and socioeconomic characteristics of Canadian medical students: a cross-sectional study. BMC Med Educ 20, 151 (2020). https://doi.org/10.1186/s12909-020-02056-x