ASSOCIATION MÉDICALE CANADIENNE | CANADIAN MEDICAL ASSOCIATION

CMA POLICY

CMA DRAFT POLICY
EQUITY AND DIVERSITY IN MEDICINE

See also Backgrounder to CMA Policy Equity and Diversity in Medicine

A. RATIONALE

The objective of this policy is to identify a set of guiding principles and commitments to promote equity and diversity in medicine. It supports the view that improving circumstances and opportunities for physicians and learners is essential in creating a more equitable and sustainable culture and practice of medicine. Equity refers to the treatment of people in a way that recognizes and accommodates their differences and to the situation in which all members of society have similar chances to become socially active, politically influential, and economically productive. Equity in the medical profession relates to the opportunities of any given person, with their own identity, culture, and characteristics, to create and sustain a career as, or receive care from, a medical professional without discrimination, harassment, or any other cultural or characteristic-related negative bias or barrier.

Diversity refers to differences between people as manifested in their interactions with others in practice, learning, and societal contexts. Diversity includes those (observable and non-observable) characteristics which are constructed – and sometimes chosen – by individuals, groups, and societies to identify themselves (e.g., age, culture, language, gender, sexuality, health, cognitive abilities, socio-economic status) in different contexts and which may describe them in relation to others in those contexts. While identity informs perspectives and approaches, it does not mean that these will be the same for all people who share specific characteristics.

As part of equity and diversity frameworks, inclusion is sometimes articulated to refer to strategies used to increase an individual's ability to contribute fully and effectively to organisational structures and processes. Inclusion strategies are specific organisational practices for structurally including individuals from diverse backgrounds in an equitable manner in decision-making processes. Thus, in this policy, inclusion is positioned at the nexus of the overarching principles—equity and diversity.

Attention to equity and diversity by individuals, institutions, and governments aims to remove the structural barriers that individuals face, based on their unique characteristics, that prevent them from using the full range of their skills and competencies in training and practice environments and redress the negative impact this has on their lives and the communities where they live and work. The current professional landscape in medicine features widespread examples of these barriers. Differential access to opportunity, institutionalized and systematized over time, privileges some communities over others. Training and practice environments are too often experienced as unsafe spaces for those learning and working within them and often unrepresentative of the communities served. The professional and learning culture of medicine does not adequately solicit and incorporate diverse perspectives or provide leadership opportunities to those perspectives.

Individual protection from bias and discrimination is a fundamental right of all Canadians. Yet bias and discrimination at the individual and systemic levels continues to create barriers to the advancement, health, and livelihood of those entering the medical profession and those practicing medicine. This is not sustainable if we seek to treat all individuals fairly, to enhance patient care, and to support physician health and wellness. A clear set of principles and commitments to improving equity and diversity demonstrates that we hold ourselves accountable to recognizing and challenging behaviours, practice, and conditions that hinder equity and diversity and promoting behaviours, practice, and conditions that will achieve these goals.

A more equitable and diverse medical profession is achieved when the communities it serves are reflected in its membership. It is achieved when all physicians have a fair opportunity to cultivate and demonstrate their capabilities and strengths, and to influence decision making processes that impact them and their patients. It is further achieved when the professional and learning culture of medicine welcomes and cultivates the diverse perspectives within them.

A more equitable and diverse medical profession reduces bias and discrimination. This improves the satisfaction with, and health outcomes of, those receiving care from physicians as well as the health and wellness of physicians themselves. Indeed, evidence indicates that when this is achieved physicians experience greater career satisfaction and sense of solidarity with the profession while patients experience improved care and a more responsive and adaptable health care system.

Scope of policy

This policy aims to provide guidance to physicians in all areas of their professional life, with particular attention to the training and practice environments. This guidance is consistent with each physician's ethical and professional obligations. Physicians should be aware of the federal and provincial laws in the jurisdiction in which they practise, the standards and expectations outlined by their respective regulatory authority, as well as the policies and procedures of the setting(s) in which they practise.

B. GUIDING PRINCIPLES

Achieving equity in medicine

Equity refers to the treatment of people that recognizes and accommodates their differences. To ensure equity exists in the medical profession, we must recognize that structural inequities exist in our training and practice environments that privilege some at the expense of others, and so we must deliberate commitments to reduce these barriers and biases, and put in place measures that make recruitment, retention, and advancement opportunities more accessible, desirable, and achievable to all those entering and already within the profession. To achieve this goal, we must apply existing evidence-based strategies that are shown to be effective and must support applied research into the mechanisms of and dynamic processes that lead to the inequities that have been identified within our training and practice environments.

Valuing and fostering a culture of diversity

Diversity refers to differences between people as manifested in their interactions with others in practice, learning, and societal contexts. The influence of culturally-embedded bias leads to individuals and groups being excluded from opportunities to participate in these contexts because of their differences or, if included, often not able to use the full range of their skills and competencies. The barriers to diversity in medicine are broad and systemic, and transcend geography, specialty, and age. As with improving equity, the benefits of a medical profession that is more diverse and respectful of that diversity include improved patient care, system adaptation, and physician health and wellness. To encourage these outcomes the medical profession must become increasingly diverse by striving to create, foster, and retain a community of physicians and learners that reflects the diversity of the communities they serve and is receptive and responsive to the evolving (physical, emotional, cultural, and socioeconomic) needs of the patient populations.

Promoting a just professional and learning culture

Physicians value learning and understand that it reflects, and is informed by, the professional culture of medicine. A professional and learning culture is one of shared respect, shared meaning, shared knowledge, shared opportunity, and the experience of learning together. Critical to creating and sustaining this culture is the availability of an environment that is physically and psychologically safe by being free from bias, discrimination, and harassment. For the culture of medicine to meet this standard, physicians must promote and foster training and practice environments where diverse and unique perspectives — across generations, cultures, and abilities — are solicited, heard, and appreciated, and are cultivated through formal and informal mentorships, and in leaders across all levels of training, practice, and health system delivery.

Fostering solidarity and accountability within the profession

Solidarity involves recognition of others, our commonality, shared vulnerabilities or goals, and interdependence. It is enacted through collective action and aims. To show solidarity with others in our profession means making a personal commitment to recognizing others as our

equals, to cultivating respectful, open, and transparent dialogue and relationships, and to role modelling this behaviour. Solidarity enables each of us to support our colleagues in meeting their individual and collective responsibilities and accountabilities to their patients, to their colleagues, and to the health care system and society. Being accountable to these goals and to each other means taking action to ensure the principles that guide the medical profession are followed, responding justly and decisively when they are not, and continually searching for ways to improve the profession through practice-based learning and experience.

C. RECOMMENDATIONS

To accomplish equity and diversity in medicine, organizational and institutional changes will be required across many facets of operation and culture including leadership, education, data gathering/analysis, and continuous improvement through feedback and evaluation of policies and programs.

The CMA recommends that:

1) Medical organizations and institutions, as well as individuals, take leadership in achieving greater equity and diversity, recognizing the role everyone plays in shaping training and practice culture through the implicit and explicit ways in which they communicate core values through language and action, and by challenging systemic and structural factors that perpetuate inequities

2) Medical organizations and institutions prioritize defining and elevating the discussion of equity and diversity, both internally and in collaboration with stakeholders, and to provide the appropriate platforms, resources, and training necessary to do so.

3) Organizations, institutions, and individuals who conduct or support research take a leadership role in addressing the need for data related to equity and diversity through calls for research and the allocation of financial support to researchers in this area.

Organizations, institutions, and individuals should practice and promote cultural competence and cultural humility. Humility is key to developing collaborative and respectful relationships with historically under-represented groups.

4) Medical organizations and institutions review their data practices (collection, analysis, and communication) to ensure:
   i) Data regarding the representation of historically under-represented groups is being systematically collected and analyzed;
   ii) Under-represented groups are meaningfully engaged through the co-development of data practices
   iii) Information collected is used to review and inform internal policy and practice with the aim of reducing or eliminating system-level drivers of inequity;

iv) Findings relating to these data are made accessible to the greatest extent possible while respecting under-represented groups' interests.

5) Medical organizations and institutions recognise the need to question and co-create policies and processes that apply to them, and the individuals therein, in an accountable and transparent manner. Of note, the following require attention:

i) Review all workforce and educational policies, procedures, and processes to consider their impact on equity, diversity, and health and wellness. Areas of consideration include (but are not limited to) recruitment, promotion, pay, leave of absence, parental leave, resources and support, and working/learning conditions and accommodations.
ii) Ensure safe, appropriate, and effective avenues exist for victims of discrimination, harassment, or abuse in training and practice environments to report these events outside of their supervisory/promotional chain. Those experiencing these events should be able to seek counselling in a safe manner without the fear of negative consequences.
iii) Examine whether hiring procedures, especially for leadership and executive positions, perpetuate inequities for any marginalized group.
iv) Create and appropriately fund equity and diversity Chairs, Committees, or Offices with a mandate to investigate and address issues in equity and diversity.

Further institutional/organizational recommendations:

1) Institutions/Organizations should create administrative emphasis on equity and diversity which includes:

i) Creating awareness of available resources and advancing use of these resources.
ii) Studying organizational environments and frameworks to identify institutional or other barriers that privilege people from the same group (or conversely, unfairly disadvantage people from other groups, particularly those with historically less power).
iii) Providing training on implicit bias, allyship, and cultural competence and humility.
iv) Iterative evaluation, using components such as comprehensive workforce surveys, to determine the impact of programs/policies and promote long-term transformation towards equity.
v) Creating transparency in reporting current status and revaluating effectiveness of initiatives implemented to address disparities.
vi) Recruitment of organizational leaders to be champions for systemic change.
vii) Support the availability of mentors for historically under-represented groups through recruitment and salary support.
viii) Recognize that full potential of human capital is an essential driver of innovation and health system development.

2) Leadership, faculty, and any staff involved in recruitment, hiring, or promotions should support equity and diversity at their workplace by:

   i) Requesting and participating in training to better understand approaches and strategies to improving equity and increasing diversity.
   ii) Requesting and participating in allyship training that highlights the roles and responsibilities of all members of the community with emphasis on self-awareness, cultural humility, and sensitivity to intersectionalities.
   iii) Considering the adoption of explicit criteria that promote qualified candidates from historically under-represented groups in selection processes.

Further educational recommendations:

1) Educational curriculum should seek to advance equity and diversity in medicine by:

   i) Establishing effective programs that espouse cultural competence and humility practices and develop valid measurement tools for assessing provision of appropriate cultural care.
   ii) Requiring that all instructors have competencies including critical self-reflection, non-discriminatory and non-stereotyping communication, awareness of intersectionality, and a capacity to reflect with students on the social or cultural context of various encounters (including colleagues and patients) in a manner that promotes cultural competence and humility.
   iii) Supporting the availability of mentors for historically under-represented groups through recruitment and salary support.
   iv) Providing training programs, from undergrad onwards, that include awareness and education around stereotypes (gender and otherwise), intersectionalities, and the value of diversity in improving outcomes.

2) Educational institutions should address equity and diversity in recruitment for medical education through:

   i) Considering subscribing to a holistic process of defining pools for medical training interviews – pools should include members of communities that face barriers to access.
   ii) Consider developing learning communities (such as undergraduate pipelines) to promote community engagement as well as comprehensive academic and social integration.

Approved by the CMA Board of Directors _____
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