

# HORIZONS

THIS ISSUE: BIPOC

ISSUE 1 • 2021

*Presented in partnership with the Queen's FHS Equity, Diversity and Inclusion Office.*

## BIPOC

Lived Experiences  
in the  
Queen's Faculty  
of Health Sciences



Illustration: Amanda Toope



## Message from the Dean

It is a delight to congratulate the team who have put together this terrific edition of *Horizons* that includes so many challenging, personal reflections from our colleagues here at the Queen's Faculty of Health Sciences (FHS).

As a relatively new dean, I have tried to be outspoken in acknowledging that a profound obligation we have to our students and to society is to be fair and inclusive as we deliver health-professions education. We are experiencing a period of unprecedented awareness about systemic racism and other forms of oppression. There is no doubt that racism, sexism, and colonialism exist in many Canadian institutions. Many health-care systems and academic institutions are structured in a way that perpetuates these forces. I recognize the unearned privilege that I have received from deep-seated patterns of injustice, and I want to work with others on changing these structures.

The correct response to recognizing privilege is not denial or guilt; it's self-reflection and informed action. Our approach to addressing these matters must be more than notional. We need to meaningfully demonstrate our commitment to the principles of Equity, Diversity, and Inclusion (EDI) in our workplace as well as in our teaching, research, and care.

One of my first initiatives as dean was the formation of the Dean's Action Table on EDI. We have more than 160 volunteers working on issues that include outreach, admissions, curriculum, recruitment, retention, mentorship, professional development, research, and culture. The work of this table is more than an academic exercise. We intend to listen well, and we will act. We have also opened an Office of EDI with four staff members focused on supporting this work across the Faculty of Health Sciences.

Right now, our student population is not reflective of the diversity of Canada. Here in FHS, we must seek greater inclusion of Indigenous Peoples and Black Canadians. Though FHS has already made progress in this area through the introduction of Indigenous admissions processes and the acknowledgement of the ban on Black medical students and initiatives that ensued, there is more to be done. This requires attention to our structural biases so we can intentionally recruit and support more students and faculty from under-represented populations. We have more work to do on creating mentorships, adapting admission processes, and improving curricula. Queen's FHS could be a leader in teaching about cultural safety, anti-racism, and anti-colonialism in the delivery of care.

The work ahead is not easy. Addressing EDI is not a one-step journey. It involves cultural transformation and will require permanent attention, with iterations of evaluation and adaptation.

We will need to ask hard questions. And we'll need to listen well to people whose voices have been barely audible. We should be prepared to hear anger, hurt, and pain. When people who have experienced sexism, racism, and oppression share their stories, we must be prepared with mental-health supports, including Indigenous Elders who can offer their wisdom and healing circles.

Our collective success will require personal, organizational, and cultural humility. We will all need to study, to learn and unlearn about history and culture. We have an obligation to act on what we learn, with cycles of self-reflection, recognition, and informed action. Changing patterns of injustice is the goal. We will make mistakes. But we will also make friends and, ultimately, we will make an even stronger Faculty of Health Sciences at Queen's.

Please enjoy this wonderful collection of writing and art.

Dr. Jane Philpott  
Dean, Faculty of Health Sciences  
Queen's University

# It's Time to Shift. It's Time to Lead.

By Celina Caesar-Chavannes  
Senior Advisor, Equity, Diversity and Inclusion Initiative  
Queen's Faculty of Health Sciences

"Culture eats strategy for breakfast" was famously stated by educator and consultant Peter Drucker. It is a critical phrase in understanding why the best strategies fail and how the culture of an organization, or, more specifically, the toxic culture of an organization, can play a critical role in that failure.

As Queen's University embarks on a mission to redefine itself, increase campus diversity, and grow into a more open, inclusive, and equitable institution of higher learning, one has to heed Drucker's words and closely examine the culture of an institution that is largely white and has a history of anti-Black and oppressive formal policies.

And let us not kid ourselves. Changing the culture of organizations steeped in tradition, colonialism, and anti-Blackness is tough. To be honest, I was quite concerned about taking the position of senior advisor for the Equity, Diversity and Inclusion (EDI) initiative for the Faculty of Health Sciences. However, the "urgency of now" created a situation in which those fears were made irrelevant when weighed against the importance of leading change for the greater good.

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*Empathy is critical for making progress toward racial equity because it affects whether individuals or organizations take action, and what kind of action they take.*

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This is an important reminder for all of us — particularly those who support the changes we are about to embark on — to temper personal fears and feelings. Let's be clear. This work around cultural transformation is going to be tough. We cannot get "all in our feelings" every time we feel uncomfortable, are challenged in a way we have



Celina Caesar-Chavannes

never been challenged before, or are called out for things we should have known better. I don't expect you to go easy on me, and you should expect that I will not go easy on you. We, the like-minded, must remain committed to helping bring along those members of the Queen's community who may be slower to change.

Additionally, we must keep in mind that though this equity work is difficult sometimes, living through and experiencing oppression and racism is tougher ... always. Can you put yourself in the shoes of the learner, who paid their tuition, excited to begin a new chapter of their lives in university, only to experience threats to their safety? Can you put yourself in the shoes of a colleague that has been dismissed, looked over or thought less of, multiple times in their career, simply because of their race or gender? Can you put your own feelings aside to understand why this transformation is critically important, not just to individual students or other faculty and staff, but to the success of Queen's overall? Can you understand that when critics of equity work use phrases like "cancel culture" to disparage movements for change, it is laughable to those of us who have lived marginalization, because our culture has been cancelled from the consciousness of Canadians for centuries? Can you understand why we can no longer wait for equity and justice? And why it must be now?

If you answered yes to these questions, you are demonstrating the empathy that will contribute to necessary culture change at Queen's.

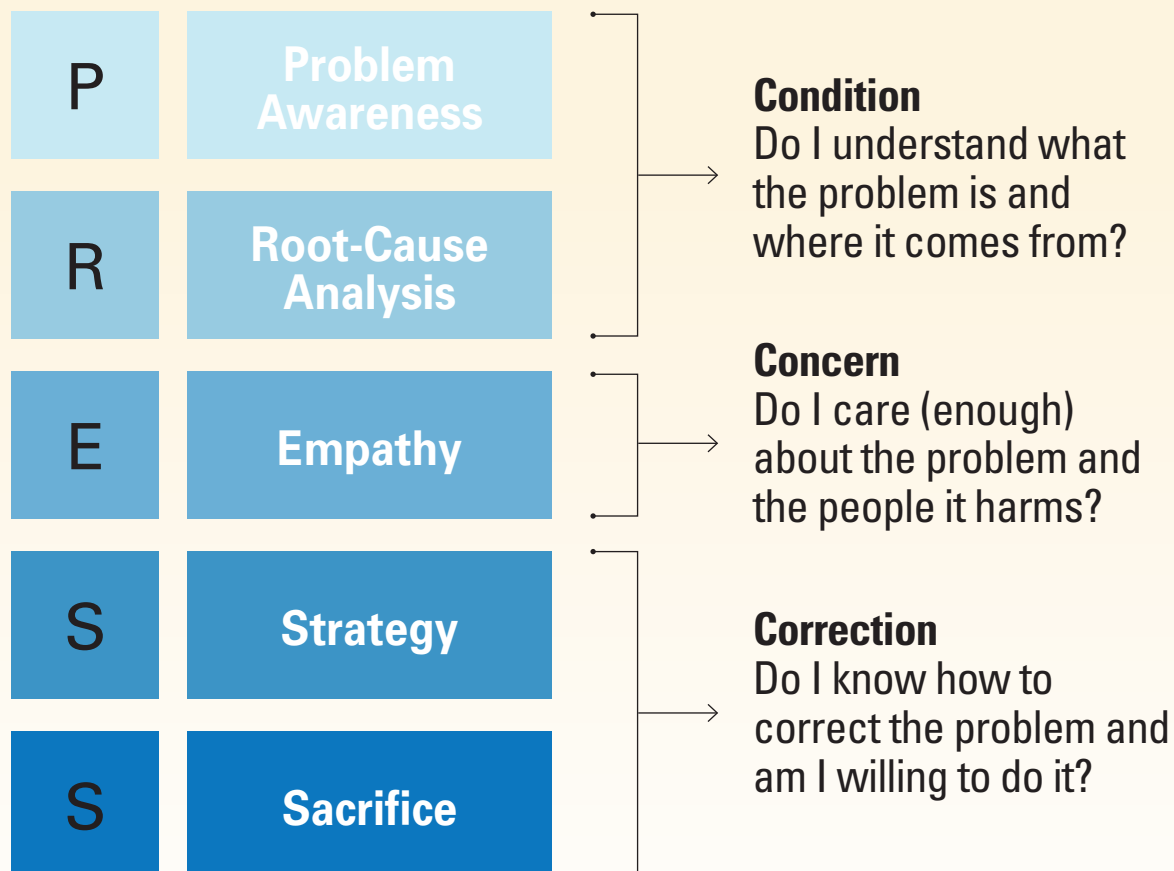
Robert Livingston (2020) posits that empathy is critical for making progress toward racial equity because it affects whether individuals or organizations take action, and what kind of action they take. He describes four ways to respond to racism that can be applied to other instances of inequity: “join in and add to the injury, ignore it and mind your own business, experience sympathy and bake cookies for the victim, or experience empathic outrage and take measures to promote equal justice.” What has been your reaction to inequity at Queen’s? What will your action be now?

Inevitably, there are those who will have answered no to some or all of the questions above. Culture change at Queen’s will require that they begin at a place that allows for the development of empathy. This process starts with problem awareness. As Livingston (2020) describes in his P.R.E.S.S. process for racial equity: once we understand the problem (P) and realize that there are historical roots (R) (ban on Black student in medical school) to our present-day racial challenges (low numbers of Black students attending Queen’s), we can then develop the

empathy (E) required to start to address the problem. With this in mind, we can then develop the strategy (S) to combat personal biases, disrupt informal cultural norms, and challenge formal institutional policies, all of which can or should ensure that leadership makes the sacrifices (S) to invest adequate time, finances, and resources to ensure success.

Does this sound achievable? I think so. I joined this team because I have faith in our ability to seize this leadership moment and make the changes at Queen’s that we and the world wish to see. We have the capacity, and we are more than capable. All we need to do is get it done.

*Celina Caesar-Chavannes is Senior Advisor, EDI initiative and adjunct lecturer at Queen’s University. Her forthcoming book, “Can you hear me now?” (Penguin Random House Canada), will be available on February 2, 2021. She is a former Member of Parliament for Whitby, Parliamentary Secretary to Prime Minister Justin Trudeau, and Parliamentary Secretary for International Development.*



*“How to Promote Racial Equity in the Workplace: A five-step plan” by Robert Livingston  
Harvard Business Review*

# Mentorship across the Shades of Grey

## The “Black” Mentee

By Aquila Akingbade, Student  
Queen’s School of Medicine

The word “mentor” arose from the character Mentor in Homer’s *Odyssey*, who aided the main character in the latter’s time of need. The importance of mentorship is undeniable: it allows for career exploration, professional development, effective goalsetting, and behaviour modelling.

For Black learners in medicine, however, there is an additional dimension: mentorship is empowering. We are afforded opportunities to explore how our predecessors navigated certain challenging situations, such as racism when patients assume you are a nursing student or the caretaker, with emphasis on the assumption and not the role. Almost every Black physician could regale you with tales of people — patients or otherwise — obstinately refusing to believe they are medical professionals. Imposter syndrome, experienced by almost everyone in medicine, is amplified in Black (and many BIPOC) students. As such, Black students often have different and additional needs compared to their peers.

As one of the five Black students comprising less than one per cent of the student body at Queen’s School of Medicine (~520 students), I think frequently about the dearth of Black medical learners. Black people comprise about four per cent of the Canadian population, with higher proportions in major metropolitan areas like Toronto, Montreal, Ottawa, and Calgary. Moving up the ladder, this disparity is even more apparent. In my two-and-a-half years thus far at Queen’s, I have only met three staff members and four residents who are Black. Granted that I have not completed a comprehensive search and inevitably there will be more, I doubt I will unearth significantly more Black medical professionals.



Illustrations: Amanda Toope

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*Knowing we have support and wisdom in the form of mentors is a source of comfort as we instigate change locally and nationally and navigate our early careers.*

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Personally, I have been blessed to have great mentors at different periods of my life. Amanda Khan, a current radiation oncology resident in Calgary, provided beneficial guidance during the medical school application process and introduced me to the field of radiation oncology. Angel Compton, my supervisor while I worked as a support worker, navigated life with creativity, grace, and finesse and taught me the importance of critically appraising problems from multiple viewpoints.

Currently, I, along with the four other founding members of the newly established Black Medical Student Association (BMSA), am part of the Black Student Mentorship Program at Queen's. Akin to a boat pulling into the solace of a harbour after stormy weather, our meetings involve laying down our burdens, shields, and worries with the group — incredible acts of vulnerability and trust. We leave each meeting enlivened and motivated due to the unrestrictive setting, mutual respect exemplified by all, and insightful discussions. Knowing we have support and wisdom in the form of mentors is a source of comfort as we instigate change locally and nationally and navigate our early careers.

An important part of mentorship is reciprocation and the concept of paying it forward. Although I am still a trainee, I use every opportunity presented to me to guide Black and minority students because I recognize there is a higher chance of them being under-resourced, having fewer connections, and having little to no visible representation in their career of interest.

It is important to note that I am not making a case against mentorship wherein members of the dyad are racially incongruent. I have benefitted from mentors of different races. However, it remains gender, race, and personal circumstances bear upon the mentor-mentee relationship.

I therefore call upon you, the reader, to consider mentoring a minority student, being cognizant to do so in a culturally appropriate manner. You might be surprised by how rewarding and insightful the process is.

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*Aquila Akingbade is a third-year medical student at Queen's School of Medicine and a member of the newly established QMed Black Medical Student Association (BMSA).*

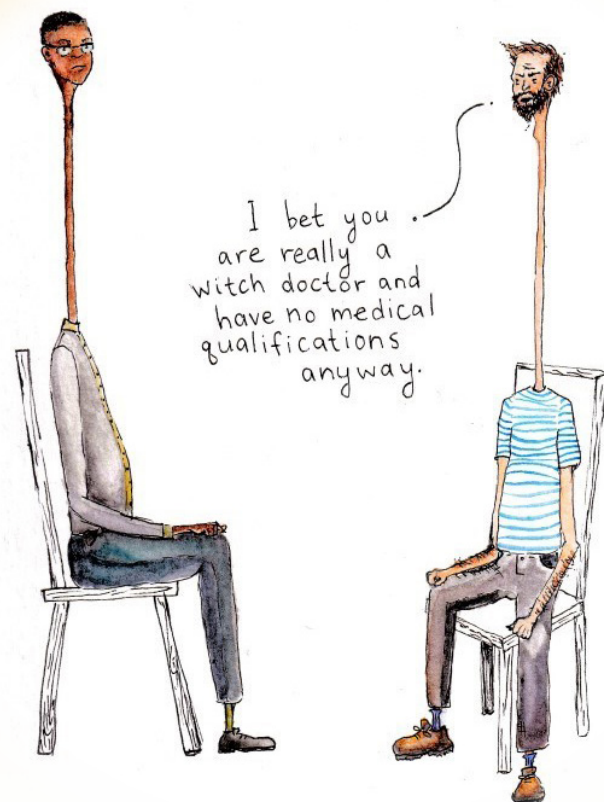
## The “Grey” Mentor

*By Dr. Oyedeji Ayonrinde, Associate Professor  
Queen's Departments of Psychiatry and Psychology*

Medicine is a heterogeneous profession with shared pillars across specialties — providing care with compassion, dignity, kindness, and respect regardless of our differences. As we train, we “apprentice,” learning our craft and modelling our practice around our teachers and preceptors — the bedside manners, the leadership in teams, the education of those less knowledgeable, and advocacy where needed.

The more specialized we become, the more divergent we find ourselves in the application of knowledge and some skills across different specialties.

For instance, the intricate skill differences between pathology, psychiatry, surgery, and cardiology — visual skills in recognizing aberrant patterns, empathy in exploring emotional distress, fine dexterity in carrying out procedures, and the capacity to monitor fine rhythms, to mention a few. We of course salute the amalgamated knowledge of our family physician colleagues who



engage a kaleidoscope of clinical scenarios daily across the full demographic spectrum in short bursts of time.

Clinicians of different demographic backgrounds are able to model across gender, sexuality, age, race, ethnicity, and faith differences to their preceptors. Likewise, the teacher is often equipped to provide clinical, professional, research, and pastoral support to aspiring colleagues, mentoring them along the way. However, mentoring the racial experience in clinical practice is a very different proposition; arguably a rare skill set often based on painful, extremely lonely, and vulnerable lived experience.

Here is an insight into some of the weekly experiences of a Black physician ... with a less-familiar African name.

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*... mentoring the racial experience in clinical practice is ... arguably a rare skill set often based on painful, extremely lonely, and vulnerable lived experience.*

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You turn up at a new job and someone welcomes you with the warmest smile: "You speak good English; we had been worried when we saw your name that we may not be able to understand you."

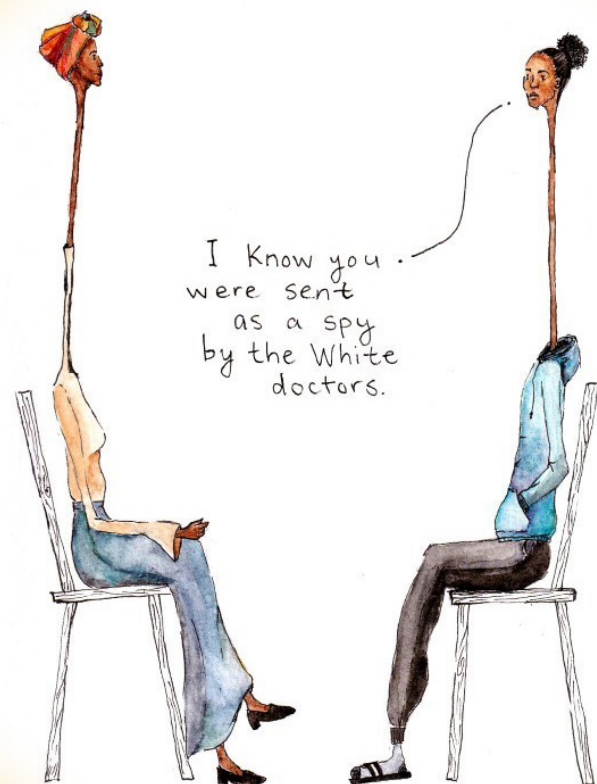
"So where are you from? ... No, I mean *from*? ... What I mean is where are you really, really from?"

"Doctor, do you have a shorter name we can use for you or an English name?"

In social conversation: "You really did well to become a doctor you know."

You are invited to review a patient on call who challenges that you cannot be a doctor: "People like you are either pimps, crack dealers, or gang members." (As ward staff mask a snigger.)

You visit a patient at home and he stands at the threshold of the door shouting: "I will never see a Black doctor ... go away ... go! ... go!" as he slams the door in your face.



A note is left by a patient stating "Canada should be kept for White people only. That's why we are here."

A two-minute phone message is left with edited ranting content littered with the "N-word" (29 times), reference to a "rope" ... "lynching" and the Black b@5t@rd doctor with black eyes and lips who should die.

A colleague suggests that perhaps you shouldn't see a client together so as not to damage their therapeutic relationship with the client.

A patient's family member turns to address your trainee, assuming the resident doctor is the senior physician.

You are beckoned by a co-attende at a faculty fundraising dinner to take an order for drinks — all attempts to turn up dressed as a suave-looking "Bond" character in a bowtie deflated into being treated as a butler.

The well-worn ID card or security pass that has had bonus scrutiny has been scuffed from being permanently on you under all conditions ... other than your pyjamas.

These are only a fraction of experiences of the Black physician in his natural professional habitat in the hospital or community, where he or she is equipped with a degree of professional status and, dare I say, “power” and identity. The scope of existence outside the physician role is too descriptively rich to write in this piece.

Where can Black medical students discuss their early-career racial experiences; experiences of feeling marginalized and stereotyped, and scarring racial trauma from some peers, professors, or patients? Who do Black medical students look to, to guide and model the additional professional cloak of being a competent and dignified Black physician? How many people really understand the loneliness and emotional exhaustion of being the “other?” How do you aspire to be and model yourself around clinicians you struggle to identify with? What emotional defences do you deploy in clinic, meetings, or theatre while still reeling from a cerebral explosion of racial slurs?

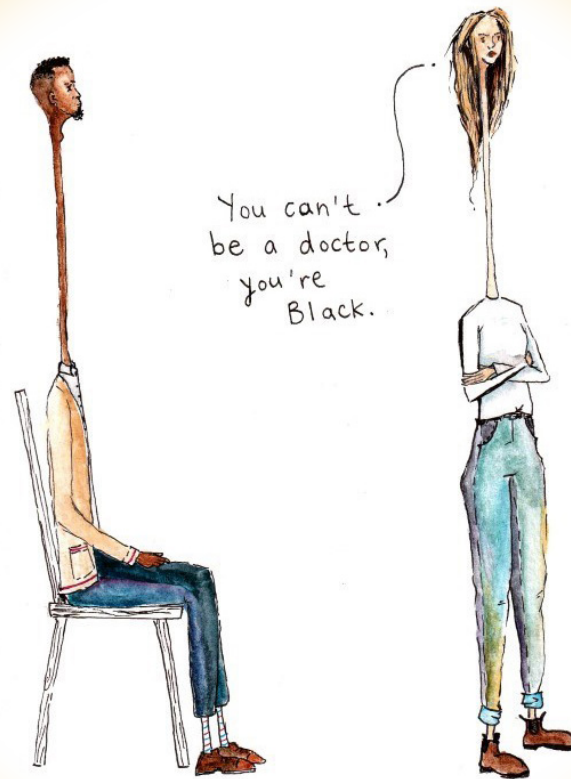
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## *Black medical students need every support available, mentoring their career growth wearing white coats on Black skin.*

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When Black medical students say they have never seen a Black surgeon, obstetrician, or pathologist, one’s heart sinks; surely, they deserve better. While impossible to mentor specific specialty career aspirations of all Black medical students, the response from the breadth and depth of Black physicians in Canada and internationally has been most inspiring. The emerging directory of potential specialty-specific co-mentors is rich in expertise and experience. We thank each of the volunteers for generously offering to complement the Faculty of Health Sciences’ resources and student needs when required.

Black medical students need every support available, mentoring their career growth wearing white coats on Black skin. As they navigate the stages of residency, fellowship, academic ranks, and consultant roles, they will, in all probability, need peers they can feel safe and



vulnerable with, share and feel understood by — the mentee gradually metamorphosing to becoming a mentor and supportive peer.

In the greying twilight of my medical career, one thing has remained constant: Black never stops being Black!

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*Dr. Oyedemi Ayonrinde is an associate professor in the departments of psychiatry and psychology at Queen’s University. He is the chair of the Commission on Black Medical Students and oversees the Queen’s Black Student Mentorship Program for Black medical students.*

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*Amanda Toope is an illustrator and ceramicist who completed her Honours Bachelor of Fine Arts at Lakehead University. Her past work has focused on how our surroundings affect our well-being, with a specific focus on living with depression and weight stigma. Amanda’s art critiques the ways in which social class directly affects one’s ability to access treatment. She hopes to build on her current body of work and develop a broader understanding of the field of health care.*



# Holistic Learning through Anishinaabe Reflections:

## Sharing Insights at Queen's University

*PhD nursing candidate Crystal Hardy and her co-supervisor, Dr. Mary Smith, an assistant professor, are members of First Nation communities in Ontario and are nurse practitioners. Here, they share their Anishinaabe (Ojibwe) insights that are highly meaningful to health care, education, research, methodology, and beyond.*

### Decolonizing Nursing Care in Canada: Recruitment and Retention of Indigenous Nursing Students

*By Crystal Hardy Zongwe Binesikwe*

*Decolonization is about shifting the way Indigenous people view themselves and the way non-Indigenous people view Indigenous people. This happens through restoring the Indigenous world views, culture, and traditional ways of knowing and being. (Indigenous Corporate Training Inc, 2017). The recruitment and retention of Indigenous nurses can assist in the decolonization of nursing care, particularly as it relates to nursing care provided to Indigenous patients. Indigenous nurses consistently draw on their inherited Indigenous knowledge when delivering nursing care to Indigenous patients (Bourque-Bearskin, Cameron, King, Weber-Pillwax, Stout, Voyageur, Reid, Bill & Martial, 2016). I hope my experiences as an Indigenous patient, nurse practitioner, and nursing student can provide insight into ways to improve nursing care for Indigenous people.*

Boozhoo! Crystal Hardy nindizhinikaaz. Zongwe Binesikwe nindizhinikaaz Anishinaabemowin. Makwa nindoodem. Binjiitiwaabik Zaagiing Anishinaabek niin nindoonjibaa Thunder Bay nindaa.

In my Anishinaabe culture, we introduce ourselves with our names, clan, and community to help establish where we are located within the world. I used Anishinaabemowin in my introduction, which translates to: Hello! I am Crystal Hardy. My Spirit name is Sounding Thunder Bird Woman. I am part of the Bear Clan. I am a member of Rocky Bay First Nation and I live in Thunder Bay.

As an Indigenous patient, I have felt more comfortable receiving care from an Indigenous nurse because I perceived a shared relational space, which is also a cornerstone of the nursing profession. My Anishinaabe culture also values relationality and the interconnectedness of all things. Perhaps the recruitment and retention of Indigenous nurses in the profession could promote safer health-care experiences for Indigenous patients.

The underrepresentation of Indigenous nurses can be related to those same historical and social factors that affect all Indigenous people in Canada. For Indigenous nursing students to complete a nursing program requires

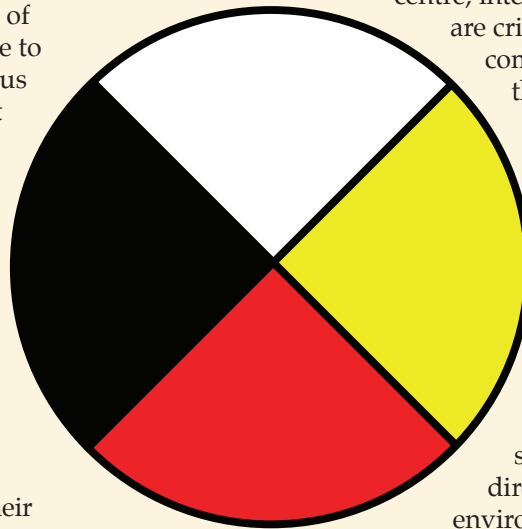
overcoming ongoing and numerous barriers including socio-economic and cultural realities, educational preparation, family obligations and availability of childcare, access to role models and mentors, and inclusion of culturally relevant content in nursing curricula (Wilson, McKinney & Rapata-Hanning, 2011). In my undergraduate nursing program, I had limited access to culturally safe support and mentorship. It was difficult to find positive representations of people like me in our content. “Western focus of curricular content often lacks relevance to the reality and worldview of Indigenous students, which is made more difficult when their learning styles are not accommodated in the delivery of the curriculum” (Wilson, McKinney & Rapata-Hanning, 2011, p.60).

Indigenous students are exposed to experiences of racial and discriminatory practices by faculty, staff, and their peers (Martin & Kipling, 2006), which results in isolation and barriers that contribute to attrition. It is not uncommon for Indigenous students to be the first in their family or community to embark on university-level study, and to lack essential role models to assist them in their education (Anonson, Desjarlais, Whiteman & Bird, 2008). Dropping out or needing to repeat courses may add to the burden of these students. Additional barriers compromising their success include the prioritization of family and community obligations over their study. Barriers are not only confined to the students’ personal circumstances (Wilson, McKinney & Rapata-Hanning, 2011).

Supportive and culturally safe learning environments grounded in Indigenous students’ cultural and learning needs promote retention in nursing programs (Kurtz, Mahara, Cash, Nyberg & Moller, 2017), including the use of mentorship circles, language and cultural supports, financial supports, and childcare) (Curtis & Reid, 2012). Strategies that have improved retention in nursing programs include affirming students’ identities; providing academic support; accessing Indigenous role models, mentors, and relevant clinical experiences; and having supportive teaching and learning environments with Indigenous content (Wilson, McKinney & Rapata-Hanning, 2011). I would have loved to see any of these strategies available during my undergraduate degree. There have been some improvements since then and, as

a PhD candidate, I have access to Indigenous role models and mentors, such as my co-supervisor, Dr. Mary Smith. In my PhD work, I have started to explore decolonizing the classroom setting.

If the focus on the student’s learning environment was re-imagined, Toulouse’s (2016) Holistic Model of an Indigenous Quality Learning Environment would be a valuable model to review as it posits the student in the centre, interacting with four key conditions that are critical to learning (the classroom, school, community, and globe), which is based on the medicine wheel teachings (Toulouse, 2016).



The medicine wheel is also known as the living teachings that demonstrate that everything is connected and sacred (Toulouse, 2016). Each domain reflects aspects of a human being that makes them whole. The east is the physical; the south, the emotional; the west, the intellectual; and the north, the spiritual. The medicine wheel has a direct relationship to holistic learning environments that value the physical (health), the emotional (social-emotional), the intellectual (citizenship), and the spiritual (creativity) (Toulouse, 2016).

Holistic Indigenous learning environments include the whole student surrounded by the classroom, school, community, and globe (Toulouse, 2016). The classroom is the space where an exchange of knowledge takes place and where the curriculum (mandated and hidden) provides a structure (Toulouse, 2016). The classroom can be viewed as the microcosm of society and has real outcomes for many groups of people (King, 2002). Indigenous inclusive classroom spaces recognize student voices as integral to the construction of active knowledge, and ensures that classroom activities are culturally relevant

and student learning is expressed in a variety of forms that honour diversity (Toulouse, 2016).

The classroom is connected to the school environment. Conditions that facilitate Indigenous inclusion in the school include leadership that is shared with teachers, students, and the community; supportive of students and their families; and is an open learning space where community members with diverse expertise work with students and staff (Toulouse, 2016). Community to

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me includes all beings (humans, plants, animals, seen, unseen) and interconnectedness among them. A quality learning environment that honours global perspectives includes having students understand and confront the conditions of unequal power and privilege; promotes Indigenous earth knowledge and sacred connection to the land; integrates the idea of education as a communal resource; and connects students across the globe (Toulouse, 2016). These recommendations may benefit non-Indigenous students as well.

Decolonization happens through restoring the Indigenous world views and shifting the way Indigenous people are viewed.

The recruitment and retention of Indigenous nurses can assist in the decolonization of nursing care in Canada. The retention of Indigenous nurses starts with recruitment. Supportive and safe learning environments grounded in the needs of Indigenous students may include the use of affirming students' identities; providing academic, cultural, and financial support; accessing Indigenous role models and mentors; and including Indigenous content in the curriculum. The medicine wheel can be used as a framework to position the student in the centre of connection to the classroom, school, community, and globe.

Decolonizing health care and education starts with making space for all ways of knowing and being, not just Indigenous. Re-imagining the way we provide nursing care for Indigenous people can come from remembering our traditional ways and teachings.

*Crystal Hardy Zongwe Binesikwe is a Two-Spirit Anishnawbekwe from the Bear Clan. She is a member of Biinjitiwabik Zaaging Anishnabek living in Thunder Bay, Ontario. Her storytelling is guided by Spirit and promotes creating safer spaces for Indigenous people through positive media representation. The focus of her PhD in nursing at Queen's University is decolonizing trauma work. She hosts a radio show called Zee's Place on CILU 102.7FM and a podcast called Under the Same Stars. Find her creative non-fiction published in Golden Brick Road's "Lighting the North" and "She's No Longer Silent" and in the upcoming release of The Great Canadian Woman's "She means Business."*



Crystal Hardy



Dr. Mary Smith

## Story as Methodology

*By Dr. Mary Smith*

In my mind, I think of the story as a methodology that is significant to teaching, research, and practice. As an assistant professor, I am tasked to teach and facilitate learning for very large groups of nursing students. Taking the time to listen to a student's story within a large group requires innovation and creativity.

I often reflect on the wisdom within the Anishinaabe sharing circle that offers a safe place for respectful listening to everyone's story. Where this was already difficult to do within very large classes, it has become even more strained during the current pandemic. Research has also been affected where developing trust and relationships critical to Indigenous protocols is challenged through online or teleconferencing methods.

From large classes to managing research projects and teams, it all makes for a hectic pace and it creates a great need for me to go home to Chimnissing, the area of the Beausoleil First Nation, where the waters soothe and console.

Mental health has been a priority throughout my many years of practice. Within the escalating tensions, frustrations, and tragedies mounting through the pandemic and crushing news of violence and racism across Turtle Island (North America), drawing inwards to find peace, love, and kindness becomes the highest priority and essential to overall health. Critical to well-being are the traditional ceremonies, the sacred medicines, the elders, and language. What keeps me going are the visionary leaders, fellow faculty, students,



and my family and friends who work together through their hearts to make a better world, bimaadiziwin — a good life and a peaceful way for our children. Support from and involvement with Indigenous events, programs, students, faculty, and leaders at Queen's University has additionally made the journey and transition as an assistant professor possible.

Learning requires self-reflection and courage to address systemic racism in all its forms. It entails a decolonizing shift to unpacking historical events surrounding the doctrine of discovery, treaties, and unceded territories, as well as addressing the legacy of the residential school system and the Sixties Scoop. I have noticed a difference between the uptake of cultural safety within nursing education in comparison to the western provinces. In this regard, during spring 2020, I was able to work with a team including Indigenous elders, faculty, and a student — a partnership made possible through the leadership of the Ontario Primary Health Care Nurse Practitioner Program. Together we created the report Maawanji'idiwag — Coming Together in a Good Way, where the concepts of cultural safety and humility were prioritized in mapping the nurse practitioner curriculum.

Although there is much work ahead, this was another critical step towards meeting the 2015 Truth and Reconciliation Commission of Canada's Calls to Action. Cultural safety resonates with me as lifesaving, just the same as a defibrillator or a dialysis machine. Racism and a lack of cultural safety results in catastrophic consequences for all of us. Education provides a means to learn cultural safety, but it takes time, unwavering support, and commitment.

I would like to conclude by asking you to contemplate the concepts of cultural humility and safety and to consider what they mean to you. Chi-miigwetch — many thanks!

*Dr. Mary Smith is an assistant professor in the Queen's School of Nursing. Her current research is funded through the Kidney Foundation of Canada and includes addressing chronic kidney disease for Indigenous people.*

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# Tokenism at the Queen's Faculty of Health Sciences



Dr. Nancy Tatham, Dr. James Makokis, Karhinéhtha' Cortney Clark, and Dr. Mala Joneja at an event offered through the Dr. M. Nancy Tatham & Donna Henderson Lectureship — a series of talks featuring scholars and experts from diverse backgrounds discussing inclusivity in health, with a particular focus on LGBTQ2S+ and Indigenous issues. As guest speaker, Dr. Makokis presented *Decolonizing Medicine: Creating an Inclusive Space for Transgender and Two-Spirit People*.

By Karhinéhtha' Cortney Clark  
Indigenous Access and Recruitment Coordinator  
Queen's FHS Equity, Diversity and Inclusion Office

Co-authored by MEDS 2022 Indigenous student lead  
(anonymous) and allied students (School of Medicine, FHS)

Tokenism can be defined as the practice of making only a perfunctory or symbolic effort to do a particular thing, especially by recruiting a small number of people from underrepresented groups in order to give the appearance of racial, gender, or cultural equality within a workforce.


The current number of self-identified Indigenous staff and faculty members at the Queen's Faculty of Health Sciences (FHS) is fewer than 10. This might be called tokenism or marginalization, or described in various ways that ultimately describe discrimination.

Having this select group of workers results in individuals being subjected to greater pressures to perform work that meets higher production standards, with higher quality and increased volume; and to behave in the expected, stereotypical manner. In my case, the presumed faculty Indigenous knowledge expert, often being disproportionately accessed for duties outside of my stated job responsibilities — leading to eventual burnout. The result of such an approach to diversity and inclusion is that the FHS's slate of employees maintains the appearance of inclusivity but members of the majority group remain overrepresented in the university, and thus little to no substantive progress toward greater inclusion of underrepresented groups has actually occurred.

As a Kanien'kéhaka Bear clan woman, (Mohawk, People of the Flint, member of Wahta Mohawk Territory), I have experienced such tokenism throughout my time here in several different roles across Queen's and the Faculty of Health Sciences.

I first started working at Queen's in 2015, advising on governing policies and processes that embody Indigenous ways of knowing with the purpose of fostering a diverse community in order to elevate and inform the institution. This included a portfolio of Indigenous student recruitment, as well as facilitating cultural, academic, and community support work. At the time, the Indigenous staff and students operated centrally from the Four Directions Indigenous Student Centre.

In 2017, I was embedded into the FHS to expand Indigenous student recruitment, retention, and supports. This endeavour has only grown with the arrival of Dean Jane Philpott in July 2020, and a renewed commitment to prioritize equity, diversity, and inclusion at FHS. Most notable is the inauguration of the Office of Equity, Diversity and Inclusion, alongside the creation of a series of working groups to propel recommendations from the



*Changemaking at a traditionally conservative institution like Queen's University is a lengthy, tedious process, but as a community of health professionals it is critical to be mindful and to take the time to listen to the less prominent voices in our communities, especially the next generation of health-care workers.*

Dean's Action Table across the faculty's three schools — medicine, nursing, and rehabilitation therapy. These recommendations will aim to illuminate the levels of inequities our underrepresented staff and students face, and will begin to remedy the current climate.

The end goal is to foster an environment where Indigenous students and other underrepresented learners can see themselves thriving.

The 2015 final report of the Truth and Reconciliation Commission of Canada outlines nine specific health calls-to-action, and my role is to bring these recommendations to fruition throughout the FHS. This legislation is an integral blueprint for supporting our Indigenous health professionals across Canada and increasing health outcomes for Indigenous communities.

"The effect of tokenism within the Faculty of Health Sciences extends beyond the staff and faculty to the students as well," says a Queen's MEDS 2022 Indigenous medical student who requested anonymity due to fear of institutional backlash.

"I feel that myself and other Indigenous students are often responsible for acting as the source of Indigenous knowledge and are primarily responsible for advocating for Indigenous integration within the faculty. One of the best examples of this is how the education and promotion of land acknowledgments within the School of Medicine has fallen predominantly on Indigenous students and allies. Despite the significant impacts of tokenization of students, where I see underrepresentation as being the most serious and apparent is in the separation of Indigenous content, medicinal or otherwise, from the general medical curriculum. Though Indigenous topics do make an appearance in the curriculum, they are often presented as separate from the rest of the curriculum instead of threaded and woven throughout lesson structures.

"Furthermore, it is unfortunate when critical learning opportunities — such as the KAIROS Blanket Exercise, which aims to educate participants on the longstanding effects of colonization — are dropped into the curriculum with inadequate time allocated to them and no preceding

contextual information. The inadequate teaching time and learning opportunities such as course add-ons demonstrate to the student body that FHS is not just tokenizing the Indigenous students and very few staff, but also Indigenous health education content.

"With improved consultation with our Indigenous community partners, integration of Indigenous cultural content (including traditional medicines and healing practices), and adequate student supports for underrepresented students, the Faculty of Health Sciences can begin to create the safe space to produce health-care professionals who value Indigenous knowledge holistically in life, and not be confined to a tool implemented in specific contexts or groups."

This work is personal for me, and I understand the need for this work. I want to use my lived experiences as a Kanien'kéhaka daughter, sister, friend, and mentor, and utilize this privileged role in higher education to help propel reconciliation through accessible and culturally safe health sciences teaching and learning.

Changemaking at a traditionally conservative institution like Queen's University is a lengthy, tedious process, but as a community of health professionals it is critical to be mindful and to take the time to listen to the less prominent voices in our communities, especially the next generation of health-care workers.

Our educators have an opportunity and duty to be cognizant of internal dialogues and unchecked biases. We have an opportunity to reflect on our student needs, and innovate our curriculum and learning environment to work towards becoming a leader in Indigenous health education.

As health specialists, we must come together to support our next generation, especially the most underrepresented populations, as we fervently continue this journey to unlearn, relearn, and continue to learn.

Nia:wen kowa for reading. (Thank you very much.)

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*Karhinétha' Cortney Clark is the Indigenous access and recruitment coordinator for Queen's FHS.*

# Helping Build Capacity through Partnership

## Mastercard Foundation Scholars Program and Queen's Graduate Program

Ethiopia's University of Gondar and Queen's University have partnered in a program that allows faculty leaders from the University of Gondar to enrol in various programs at Queen's. This 10-year initiative, launched in 2016, is in partnership with the Mastercard Foundation Scholars Program. The partnership's programs include a Master of Science degree in occupational therapy and a PhD in a range of disciplines (e.g. rehabilitation science, nursing, law, engineering, education, epidemiology) with a research dissertation focused on inclusive education, community-based rehabilitation, and other inclusion-specific issues facing people living with disabilities in Ethiopia or the continent of Africa.

It is important for the PhD fellows to maintain a connection to home during the four years of their program. The project supports a personal well-being/family connection trip home in addition to trips to and from the continent to conduct their research projects. Of the four years, two are spent in Canada and two in Ethiopia.

The project funds eight collaborative research projects between the partnering universities with a focus on inclusion for people with disabilities, inclusive education, and community-based rehabilitation practices.

We asked project co-manager Anushka Mzinganjira, an occupational therapist, to provide a perspective of her own lived experiences as a racialized woman managing a global health program.

### **Why is it important to have diverse representation of identities in the field of occupational therapy?**

It is a necessity to have diverse representation across all health-care groups, especially being situated in Kingston. We should reflect the population we are serving. Diverse identities allow those who are seeking services to be and feel represented. From a research and learning perspective,

having people that contribute different lenses and understandings of the world enables a profession to grow.

The field of occupational therapy has a critical role to play in achieving Sustainable Development Goals (SDGs). We require diverse perspectives to achieve these goals, starting from within the classroom through to practicing clinicians. Diverse lenses allow us to better serve our community.

### **What led you to work in the field of global health?**

As a first-generation Sri Lankan who was born in the Middle East and came to Canada at the age of six, I identify as a global citizen. Regardless of where you are born on the planet, access to health care is a human right. From a social justice point of view, it is important to build resources in places where access has not been easy or straight-forward. As an occupational therapy learner, I completed a northern study stream opportunity within Ontario that examined support afforded to Indigenous communities. Being exposed to the issues facing First Nations communities and seeing the lack of access to resources in our province was insightful regarding the work to be done in our own backyard.

I worked in mental health and addiction as an occupational therapist for many years and in 2013, I worked with the Toronto Addis Ababa Academic Collaboration (TAAAC) at Amanuel Hospital in Ethiopia, building capacity in occupational therapy skills. We also built awareness around the field of occupational therapy. Then an opportunity came up at Queen's through the Mastercard Foundation Program and it was fitting. This role has been instrumental in deepening my learning and engagement with increasing access to quality health care for all and those who are actively made most vulnerable in our societies.



Anushka Mzinganjira

### How do you use your own lived experiences and expertise in the field of global health to manage this program?

Growing up in a previously homogenous neighbourhood as a first-generation immigrant and as a racialized woman, in addition to living in a plethora of places across Ontario, all have contributed to my lived experiences. Some of these difficult experiences persist living in Kingston. My lived experiences certainly influence how I interact with strangers, neighbours, peers, and friends, but most particularly in my role as a manager. My lived experiences help me to navigate the nuances of the partnership with University of Gondar and the cultural differences between our institutions. Additionally, my lived experiences help me to manage relationships and engage with people with different experiences.

On our team, we have a diversity of staff. I treat them as people first. I acknowledge all of what they bring to the team and value their lived experiences because of how essential their specific contributions are when working with our fellow cohorts with distinct global experiences who are leaving and uprooting from their families and home country. It is very important to me that we create spaces and opportunities that enable everyone to enhance and broaden their experiences and perspectives. The way in which I look at the world and how I understand the entrenched delineation of social hierarchies has helped me navigate my job as well as the relationships that I have built and sustain.

### Can you speak about the importance of the program at Queen's and the value and innovation it brings to FHS?

The program is invaluable to Queen's and the Kingston community. The calibre of fellows who are faculty members at the University of Gondar who come to Queen's to build their skills and expertise are depositing much of themselves here. Principal Patrick Deane has a [vision around SDGs](#) and this program is an embodiment of that vision. The fellows' research aims to support broader goals of inclusion, as the program itself provides a global lens on equity and inclusion. We are situated to learn from our fellows, as much as they are learning from us. Hopefully, we can continue the partnership beyond the program's 10-year timeline.

It is very timely given the work that Queen's is trying to do in internationalization and EDI. Having these fellows present in FHS and Queen's University adds to the identities and perspectives present at Queen's. This will have a gainful impact on other students who share classrooms with the fellows.

In terms of innovation, the fellows add to the presence of international students at Queen's. The willingness of the School of Graduate Studies, the School of Rehabilitation

Therapy, and the other departments and schools that host our fellows to problem-solve and think creatively to work through challenges is pushing us as an institution to think in new ways. It requires the entirety of the Queen's community to provide the resources and have the willingness to engage to have the innovation we seek at this institution.

### What type of support is in place for the fellows as they navigate the completion of their degree at Queen's?

The Mastercard Foundation Scholars Program has requested that we have wrap-around support for fellows, not just limited to financial assistance. The project team, including the student and faculty liaison, is in place to provide frontline support for the fellows. PhD supervisors provide regular reports to our office outlining the fellows' progress. We provide orientation to supervisors and to fellows to support their experience. We aim to be present to support the fellows through emergencies and difficult times, while making sure they are also aware of and able to access the appropriate Queen's resources.

### Have you had any discussion about racism in Canada with the fellows?

We raise the issue of racism, directly and indirectly, during orientation. We also discuss the concept of "consent" and how it is tied to race. There are ethnic issues in Ethiopia, however racism takes on a slightly different form in our Canadian context. The management team has taken the time to meet with the fellows to discuss the Black Lives Matter movement, and we are committed to sustaining important dialogues as such in order to contribute to the required societal transformations both on and off campus. Many issues have arisen regarding racism in Kingston, and we are here to support the fellows in navigating those situations.

The fellows presented the Stephanie Nixon article "[The coin model of privilege and critical allyship: implications for health](#)" (*BMC Public Health* 2019) to the management team for discussion. We had meetings with the Queen's Human Rights and Equity Office to examine potential options on how to proceed with the team in addressing the learning gaps we have as a team in this area and our commitment to better understanding and supporting issues of equity, diversity, and inclusion.

Our hope is that the information provided at orientation can be useful to the fellows as they navigate the Kingston community and Canadian societal landscapes. It is our hope that the fellows feel safe within our community and are equipped with the knowledge and confidence to be able to approach us or various supports at Queen's when faced with challenging situations.

# Allyship, Belonging, and Community — The Path Forward

By Dr. Mala Joneja  
Associate Professor and Division Chair  
Queen's Division of Rheumatology

Imagine you have chosen to start a career as a health professional and you are attending the first day of classes. You are about to take your first step toward becoming a physician, nurse, or rehabilitation therapist, and you are standing outside the building where your class is going to be held. When you grab the metal handle to pull open the heavy door of the university building, you pause and wonder if the academic world waiting inside that door will accept you for who you are and allow you to thrive and succeed to your fullest potential.

This hesitation or question is not hypothetical. It's real for students who are BIPOC entering the traditional halls of health-professional schools. The Queen's Faculty of Health Sciences (FHS), home to three schools of health-professional education including medicine, nursing, and rehabilitation therapy, has embarked on a journey towards inclusion by examining its past, present, and future.

By acknowledging the history of exclusion in health-professional education and by envisioning an inclusive learning environment as a goal, the FHS has begun to take steps forward to promote allyship, belonging, and community.

As health-profession educators and students, we are bound together by our common humanity and common mission,

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*By acknowledging the history of exclusion in health-professional education and by envisioning an inclusive learning environment as a goal, the FHS has begun to take steps forward to promote allyship, belonging, and community.*

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Dr. Mala Joneja

yet it is well known that underrepresentation, bias, and discrimination are common experiences for students in the health-professional learning environment. Using allyship, belonging, and community as steps forward, the FHS is preparing to advance from the awareness of diversity issues to tangible positive actions, recognizing that there is a great deal of work to do. By becoming familiar with these concepts and their potential, educators

and learners can work together to improve the learning environment for BIPOC students who may be hesitating at the entryway to professional education.

An ally, in the realm of social justice, is a member of a privileged social group who commits to the struggle against oppression, and works in solidarity with those experiencing racism, bias, and discrimination. Allies

understand the structures of oppression, listen, and learn, and work toward societal transformation.<sup>1</sup> Allyship can be a strategy of practices in an organization to promote equity through personal support, sponsorship, and advocacy.<sup>2</sup> Becoming an ally means educating oneself and becoming aware, but it cannot stop there. Moving from awareness to action, such as speaking up, is essential for allyship.

The FHS is well-equipped to design and implement programs around allyship education, and can give faculty and students the tools needed to become active allies. The Dean's Action Table on Equity, Diversity and Inclusion has a working group dedicated to professional development that will advise and make recommendations to leaders and educators.

Belonging is the experience of being accepted, included, and valued by others.<sup>3</sup>

Uncertainty about belonging can contribute to isolation, diminished trust, emotional distress, and lessened effectiveness. In the case of health-professional students, a lack of belonging can lead to disillusionment, lack of retention, and unfulfilled academic potential.

Belonging in health-professional education, which is based on social and cultural models of education, is promoted (or reduced) at all points of the educational journey, from admissions to postgraduate opportunities. Belonging is also fostered in all activities in academia, from the small day-to-day interactions to the structural composition of administrative committees.

The key to promoting belonging is action at all points of health-professional education, and before action must come awareness. There is a wealth of student, faculty, and alumni experience that can be leveraged to learning about belonging.

The Dean's Action Table also has a working group dedicated to admissions, and one dedicated to culture and community, that will advise and make recommendations to leaders and educators.

As mentioned in his [Report on the Conversation](#), Principal Patrick Deane has emphasized that a key benefit from

attending Queen's University is becoming part of a community, and the university's size and geographical layout promote this.<sup>4</sup> Today's leaders aim to extend this feeling and notion of community to all who attend the Queen's FHS by promoting inclusion in all aspects of the learning environment.

There is work to be done; however, there exists a foundation ready for building, and this foundation

includes leaders who are willing to acknowledge the past and actively promote transformation, communities of allies in the student body and faculty, and a readiness for change.

Together, allyship, belonging, and community represent the steps forward on the path to inclusion in health-professions education.

Under Dean Jane Philpott's leadership, the Dean's Action Table on Equity, Diversity and Inclusion is bringing together leaders,

educators, and learners in the FHS to build a health-professional faculty where no one should pause before walking in the door.

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*Dr. Mala Joneja is an associate professor and the division chair for the Division of Rheumatology at Queen's University. Her interests in medical education include role modelling in postgraduate medical education, the hidden curriculum, professionalism, and transformative learning. Dr. Joneja is the Director, Diversity and Equity, at the Queen's School of Medicine.*

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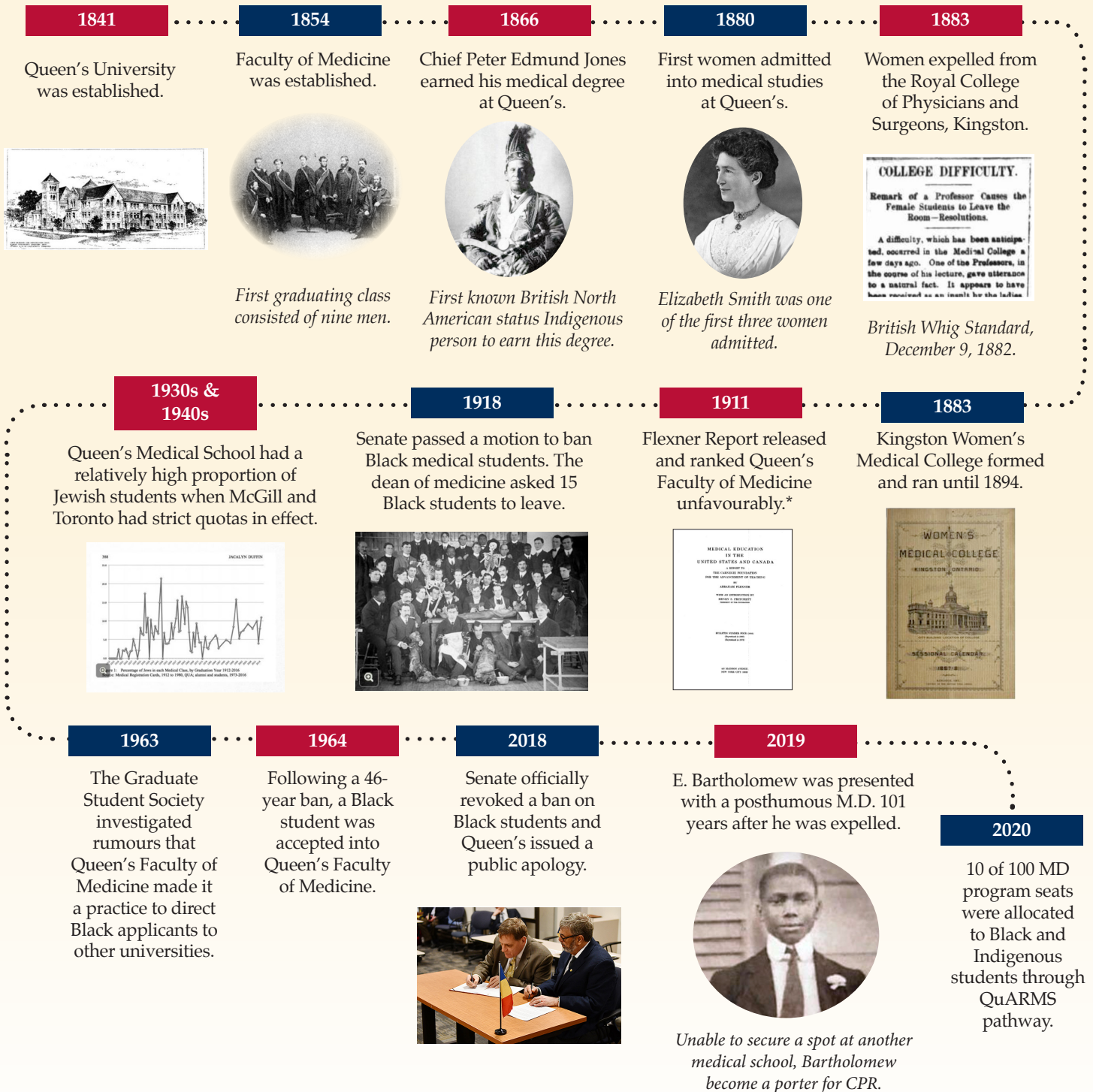
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3. Roberts, L. Belonging, Respectful Inclusion, and Diversity in Medical Education. *Academic Medicine* 2020; 95(5):661-664
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# Who Gets to be a Doctor?

While this history is specific to Queen's University, these examples are representative of broader trends in medical education across North America. At the beginning of the 20th Century, educational reforms created a profession that was almost exclusively made up of white, Protestant men from elite backgrounds. Medical admissions committees discriminated against students of colour, women, and religious minorities such as Jews and Catholics. Students of low socioeconomic status or those who came from rural or remote communities were also less likely to be admitted to medical school.

*Adapted from Dr. Jenna Healey's lecture, "Who Gets to be a Doctor?"*



\* Flexner Report released by the AMA's Council on Medical Education rated medical schools based on their standards of admission and graduation, quality of laboratory facilities, and clinical instruction. This report resulted in medical education across North America becoming more exclusive and the profession becoming less diverse. The report contained a chapter that indicated "there was little need to train Black physicians, other than a handful of 'hygienists' who would help to prevent outbreak of disease in Black communities." Queen's received an unfavourable report and was under great pressure to improve its ranking. Infographic courtesy Queen's FHS Equity, Diversity and Inclusion Office.



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