Federation of Medical Women of Canada | Fédération des femmes médecins du Canada

Spring 2021

The Voice

of Women in Medicine

FMWC PRESIDENT'S LETTER

Spring Newsletter 2021

By Dr. Charissa Particelli, National President

Let me start by acknowledging the land and ancestral, traditional and unceded territory of the Coast Salish people. Namely the xʷməθkwəy̓əm (Musqueam), Skwxwú7mesh (Squamish), and sel̓íl̓witulh (Tsleil-waututh) Nations of whom I am an uninvited guest and am grateful to live, work, and play.

Here at the Federation of Medical Women of Canada we are in momentum. The voices and momentum of a journey that began with a small group of women who have changed history year after year and has continued to grow and inspire change decade after decade. As you read through our Voice edition, let us celebrate the power and grace of our organization looking to our ancestors for wisdom and forward for what is possible and yet to come.

Inspiring our vision of women in medical leadership, "femtoring" at all stages of career is vital. We are all called to carry on this tradition of the Federation and I encourage you to see the opportunities around you for creating runways to leadership and pathways for yours and others' success. I choose the word "femtoring" because this is a powerful word. It reminds me that language matters and it reminds me of the femtoring I have received through women in the Federation. I invite you to explore the references on femtorship and please stay tuned as we develop strategic plans and runways for women's leadership in academics and politics.

Throughout these pages you will see the many ways our members are breaking the glass ceiling and impacting others in meaningful ways. We received dozens of award nominations this year! An accolade to the fact that so many incredible female physicians and learners are in our midst. The last year we experienced the devastation of a pandemic, racism, economic losses and also the power of collective voices in speaking out on Black Lives Matter, Anti-Indigenous Racism in Healthcare, the

importance of Equity, Diversity and Inclusion in all areas of society.

In these times when we see the devastation of the opioid crisis taking the lives of people of every generation, often the poorest and most marginalized, we can choose to see hope with new therapies and dedicated practitioners. We can experience the hope of a new mother who gets to remission from her substance use disorder because she was resilient and a practitioner cared. I would like to share my gratitude with the frontline teams I have the privilege to work with. Again, I call for a National Action Plan for the Fentanyl Crisis.

The COVID pandemic has resulted in profound challenges for everyone. With innumerable lives lost, trauma and mental health are taking a toil. As frontline staff are facing fatigue, burn out, and struggling with our own trauma amidst this pandemic, my hope is that we can find resilience with connection in one another. The vaccine may bring hope but giving love and connection will bring more. Do we "budge" in line as my daughter says? By "budge" I mean a "me first, or my type first", or do we inspire compassion and care for others in this pandemic, looking at equity, science and our global health.

The poor will be impacted for much longer than those with resources. The COVID-19 pandemic has simply worsened the gender-based discrimination experienced by women and girls locally and globally. This expands to all domains including, but not limited to sexualized violence, food insecurity, education, and the impacts of climate change. Let us leave no one behind.

With conflict, challenge, and ethical dilemmas we learn from one another. We can walk in another's shoes, and seek to understand first. As a child in the Yukon many years ago I recall being asked, "have you walked in your friend's moccassins?" Sometimes I had not. As humans we can.

Thank you FMWC for the power of connection, action, and amplification. Gratitude for each and every one of you.

PRESIDENT'S REPORT ON

IBM 2021 Highlights

By Dr. Charissa Patricelli, National President

On February 6, 2021, your FMWC Board of Directors held its annual Interim Board Meeting (IBM). With a fantastic attendance at our virtual meeting, we discussed the needs of the Federation in serving its members as we move toward our 100th anniversary. As part of our commitment to the advancement of all women in the medical profession, we want to take a couple of initiatives to better our organization for our members past, present, and future.

First, we will be forming a working group to work with our indigenous colleagues to explore how we can forward the goals of the Truth and Reconciliation Commission within our own organization and work to combat systemic racism in our profession. Second, we will be forming a working group to examine the definitions of our membership to ensure we are not discriminating, excluding potential members, or failing to be a welcome place for all women. Discussion around the process for advocacy requests was an important part of the IBM. Exciting updates were presented from all the Advocacy groups with incredible work happening in each of the Committees; Women's Cardiovascular and Cerebrovascular Health, HPV and Pap Campaign, Gender Based Violence and Family Violence, and Women's Peace and Security have all been active with incredible work over the last year. Webinars over the last several months and upcoming as well as the celebration of International Women's Day were highlighted. We listened to inspiring reports from our Branches and our International MWIA reps! The Vancouver Branch was inspired to put forth a request to Honour our National, Provincial and Territorial Public Health Officers. This letter of honour went out during the week of International Women's Day and the first Canadian Women Physician's Day and is posted on our website. Other highlights include the work of our Communications Committee in our newsletter with a new feature beginning with this issue on Equity, Diversity and Inclusion as well as outreach for more blog posts. There was also a great deal of work done by our awards committee with an incredible number of award nominations this year!

The upcoming year will be one of expanding our reach and continuing our partnerships. We will be applying to join the United Nations Department of Communications Civil Society Division. This will open up a number of opportunities for our members to participate in UN-sponsored activities. We also hope to welcome the Medical Women International Association (MWIA) North America Regional Meeting as part of our own AGM this fall.

Substantive Resolutions passed:

- **(#2021-IBM-02) Resolved** the FMWC to create a working group on truth and reconciliation with IPAC to determine our role as an organization in decolonizing and fighting anti-indigenous racism in healthcare.
- **(#2021-IBM-03) Resolved** the FMWC to apply for membership in the UN Civil Society Unit of the Department of Global Communications by the end of February 2021 for the purpose of increased opportunities for our members in the global community.
- **(#2021-IBM-04) Resolved** the FMWC to create a working group to look at the membership criteria of the FMWC for the next Board meeting as an opportunity to explore our mission regarding gender.
- **(#2021-IBM-15) Resolved** the Executive explore a process for rapid response for advocacy requests from membership.
- **(#2021-IBM-16) Resolved** the proposal to create a branch in St. John's, Newfoundland and Labrador, be approved.

The Board is made up of an amazing collection of new and returning members, who bring an incredible dynamic energy to the federation. Thank you to the FMWC 2020-2021 Board for the engagement and courageous leadership!

Medical Women of Canada Foundation Update

Medical Women of Canada Foundation

By Dr. Shajia Khan, Chair; and Dr. Charmaine Roye, Treasurer
Medical Women of Canada Foundation

The Medical Women of Canada Foundation is a registered charity incorporated in 2015, per Canadian Revenue Agency (CRA) guidelines to separate the charitable goals from the advocacy role of the Federation of Medical Women of Canada.

The Medical Women of Canada Foundation (MWCF) manages and administers the Maude Abbott Scholarship Fund (MASF) and the Maude Abbott Research Fund (MARF).

The Awards Committee of the Foundation receives and reviews applications for the awards and recommends the successful applicants to the board of the Foundation which makes the final decision.

The Maude Abbott Scholarship Fund provides educational grants for deserving female medical students. It was started in 1939 as a loan fund and named after Dr. Maude Abbott who was the founding member of the FMWC. Over the years the fund accumulated sufficient income from investments and donations to change it to a scholarship fund. The number of awards depends on the annual investment income and the donations received in each fiscal year. The 2020 recipient was Milan Sivapragasam, McGill University Faculty of Medicine.

The Maude Abbott Research Fund was set up as an incentive for practicing female physician members to get involved in clinical research in women's health. As evidenced by the excellent applications received every year, it has generated a great deal of interest. The number of awards is limited by the annual investment income and donations received each fiscal year. The 2020 recipient was Dr. Jennifer McCall, PGY2, Queen's University School of Medicine, for her project "The imposter syndrome in female surgeons."

Applications for both awards are available on the awards tab of the FMWC website. Applications for 2021 are now closed and

the successful recipients will be decided shortly. Applications for 2022 are now open.

Fundraising for the awards is our challenge! There are active fundraising events at each FMWC annual meeting, however, since we did not meet in person, the past year was a missed opportunity. We are counting on your direct donations through the DONATE section of the FMWC website and by cheque addressed to the MWCF, c/o the FMWC National Office. Donations to the Foundation are tax deductible and a charitable receipt will be sent to you.

As part of your financial planning please consider a legacy donation to MWCF.

Contact information for ideas for fundraising and other communication: mwcfdn@gmail.com.

Canadian Rape Kits Resources and Fact Sheet

Written by:

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Edited and Reviewed by the Women, Peace, and Security Committee:

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Dr. Patricia Warshawski *– Member, WPS Committee*

Dr. Shelley Ross *– Member, WPS Committee; Past Secretary-General MWIA*

Dr. Edith Guilbert *– Member, WPS Committee, SOGC representative*

Dr. Beverly Johnson *– Member, WPS Committee*

Dr. Anne Niec *– Member, WPS Committee, MWIA National Coordinator*

Dr. Karen Breeck *– Member, WPS Committee*

In 2014, approximately 553,000 Canadian women self-reported sexual assaults (Statistics Canada, 2014). However, this number does not include the vast majority of unreported sexual assaults against women each year. During times of crisis, including the COVID-19 pandemic, an increase in interpersonal violence including those against women has been demonstrated (Peterman et al., 2020). Healthcare professionals have a duty to promote the well-being and to provide timely support and the highest quality of care to address the individual health needs of all women,

especially survivors of sexual assault and/or interpersonal violence (Ontario Hospital Association, 2010).

Best Practices

Due to lack of exposure during training, many Canadian healthcare professionals may be unaware of the resources and guidelines that exist for the treatment of sexual assault and interpersonal violence survivors. It is our belief that all healthcare workers, regardless of responsibility, should be familiar with the fundamentals of sexual assault treatment and resources. A sexual assault treatment requires a holistic and multidisciplinary approach that meets the survivor's medical, legal, and psychosocial needs. The Ontario Hospital Association and The Ontario Network of Sexual Assault/Domestic Violence Treatment Centres (SA/DVTC) have developed standardized Guidelines to guarantee the existence of consistent provincial hospital care. The government of Quebec also developed guidelines regarding sexual assault treatment and resources (Des, Et, & Lignes, n.d.). A network of *Centres d'aide et de lutte contre les agressions à caractère sexuel* is widely available across the province ("RQCALACS," n.d.). These standards can be adapted to help inform other Canadian healthcare professionals of their responsibilities and the public of what they may expect if they are unable to access a SA/DVTC (Ontario Hospital Association, 2010).

Access Gap

The Ontario Hospital Association as well as the government of Quebec identify that institutions treating people who have been sexually assaulted should have sexual assault evidence kits (SAEKs) available onsite. However, there have been numerous media-driven articles exposing the lack of accessibility and availability of SAEKs, in both Ontario and Quebec (Fauteux, 2020a, 2020b). One such article, is a Change.org petition by Gabrielle Doyon Hanson to Canada's Minister of the Department of Women and Gender Equality (Doyon Hanson, n.d.).

It is the responsibility of healthcare providers to be informed on how they can provide the best care to their patients including accessing SAEKs and other community resources. The Government of Canada has created two national virtual platforms; *The Sexual Misconduct Support Resources Search Tool and Respect in the CAF Mobile App* geographically list centres across Canada and indicate if SAEKs can be administered at said locations on request (Government of Canada, 2020).

Psychosocial Supports

The Sexual Misconduct Support Resources Tool includes extensive information on each centre including languages spoken and available psychosocial supports (Government of Canada, 2020). This tool can be used by healthcare providers to help connect their patients with resources in their locality and can also be used by survivors to locate psychosocial resources. Provincially, there exists other such resources. The Ontario Coalition of Rape Crisis Centres also contains a geographic breakdown of sexual assault centres that provide free counselling and information on sexual violence for survivors (Ontario Coalition of Rape Crisis Centres, n.d.).

As Gabrielle Doyon Hanson said "[SAEKs] are part of our right to healthcare. Quality rape kits should and must be available to everyone…."(Doyon Hanson, n.d.).

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HPV Prevention Week Update

Dr. Vivien Brown, HPV Prevention Week Committee Chair

In keeping with the goal of the FMWC to promote women's health and influence health care policies for women and the general population, the FMWC founded HPV Prevention Week in 2015. In the five years since we began, our activities have grown from a small reception on Parliament Hill, to a day of one-on-one meetings with Members of Parliament and Senators, to a week of national webinars. In addition, we have launched a series of year-round activities to engage physicians in encouraging preventative measures with their patients. We hope to support our community of health care providers both in practice and the advocacy sectors as we make Canada the second country in the world to eliminate cervical cancer (Australia has declared it will be the first).

HPV Prevention Week was held October 5 to 9th, 2020. The pandemic forced a change of tact for us. Instead of organizing another Parliament Hill or any in-person event, we held a week-long series of virtual lunch and learn webinars with some of Canada's leaders in HPV prevention and elimination. We had an average of 50 live participants per day and the presentations were recorded, uploaded to YouTube, and linked through our website fmwc.ca/hpv-prevention-week, where they have attracted another average of 100 unique views per session.

Additionally, we partnered with the SOGC and Merck Pharmaceuticals on a national communications campaign which saw us co-produce a PSA for: the canadavshpv.ca website, a press release, an op-ed, and media interviews. Across all platforms combined we reached over 5 million Canadians.

Cancer Won't Wait Initiative:

Under the direction of myself and Dr. Christine Palmay and made possible by a grant from Merck, the FMWC is producing a series of newsletters directed at medical practitioners and care providers to emphasize best practices in HPV prevention. These newsletters are also promoting upcoming webinars. Registration is available on the FMWC website and has been promoted through the website, our eblasts, social media, as well as by Merck reps. As of this writing, 283 professionals have subscribed. If you wish to join this movement, sign up here.

FMWC Invitation

Cancer won't wait

Help Prevent HPV and Cervical Cancer Now

Dear Colleagues

Hello to all, I hope you are well during this unprecedented time.

My name is Dr. Vivien Brown and I am a Past President of the FMWC, the Federation of Medical Women of Canada.

Our organization, which has been around for 96 years, has the mandate to support women physicians and to promote women's health. It was created in 1924, when Dr. Maud Abbott and her colleagues faced discrimination as women physicians and started the organization for mentorship and leadership. The FMWC, in recent times, has been advocating for HPV prevention and supporting the use of HPV vaccination.

In 2017, we lobbied on Parliament Hill, and with all party support, Canada announced the creation of a week to promote HPV education and prevention. I am honoured to now be the Chair of HPV week, celebrated annually during the first week of October. We were the first country in the world to promote education nationally through a dedicated week of advocacy and education.

The FMWC, under my guidance and with the collaboration of Dr. Christine Palmay, an award winner in women's health, has now started a new project, an initiative particularly pertinent at this time named:

CANCER WON'T WAIT

Help Prevent Cervical Cancer and Certain HPV-Related Cancers Now

The initiative follows the World Health Organization's call for Global Elimination of Cervical Cancer (2018). Many organizations have joined this call to action, including the NIH (National Institutes of Health), National Cancer Institute, the CPAC (Canadian Partnership Against Cancer), and FIGO (International Association of Gynecology and Obstetrics).

Our project is to encourage you and your clinic, as well as various stakeholders, to join with us to identify actions within your clinic and community that is appropriate for your patients to increase awareness around HPV disease. By joining our movement, we will share bi-monthly newsletters, containing educational materials, as well as information about what others are doing in their environments to increase awareness for us all. Your clinic may put up posters or add something to your EMRs to remind you about HPV. Other clinics may choose to do something else. Regardless, I believe that by collaborating and sharing information, we create a momentum that is positive, hopeful and impactful as we move forward in our goal to prevent certain HPV-related cancers. I am hoping you will join this project and work with us.

As an African wise saying eloquently summarizes:

"If you want to go fast, go alone, but if you want to go far, go together"

By collaborating, sharing knowledge and skills, we can strive to eliminate certain HPV-related cancers. Such an immense accomplishment is within reach, but only if we reach far and together.

To join the movement, click here.

We look forward to hearing from you.

Disclosure: FMWC has received financial support from Merck Canada for the publication of the newsletters and has helped to engage HCPs and stakeholders to participate in the initiative called "Cancer won't wait-help prevent HPV and Cervical Cancer". All content of newsletters will be developed by solely FMWC.

HPV Prevention Centre of Excellence:

The HPV Prevention Week committee is establishing a Centre of Excellence for HPV Prevention where a leading researcher or practitioner presents on the latest research. The first session was held on January 22, 2021, with Dr. Monique Bertrand as the presenter. The session was recorded and is available for viewing on the HPV Prevention page of the FMWC website. Our next meeting is March 12th with Dr. Marla Shapiro presenting on vaccine hesitancy. If you're interested in joining, email our national office at fmwcmain@fmwc.ca.

Retirement savings: *What's a physician's magic number?*

How do you figure out how much you need to save for retirement? Here are the assumptions typically used when generating projections in a retirement plan.

1. Rate of return. This is the percentage you expect your investments to grow by on average every year. Considering long-term historical averages and recent sustained low interest rates, you might use 4% to 5% as the expected long-term rate of return for a balanced portfolio (60% equity, 40% fixed income). Generally, it's better to project longer-term returns on the conservative side so that you're not left in a shortfall position.

2. Savings pattern. Investment growth is one thing, but you'll also likely keep saving throughout your career. Part of your projection should include your expected savings over time and how much those savings will grow based on your expected rate of return.

3. Government pensions. When you retire, you may be eligible for Old Age Security (OAS) and the Canada Pension Plan (CPP). If you live in Quebec, you may be eligible for the Quebec Pension Plan. At age 65, the maximum CPP and OAS payments are about $14,100 and $7,400 per year, respectively.[1] You can estimate how these amounts might grow based on your personal circumstances and inflation assumptions.

4. Inflation. An inflation rate of 2% annually is a good place to start. Just remember that over the long term, the actual inflation number could vary.

5. Life expectancy. Because some people live much longer than the average life expectancy, it may make sense to create a plan that assumes your life expectancy is around 95 years old.

6. Withdrawal rate. Assuming you live to 95, your investment portfolio would need to last 30 years (age 65 to 95). A typical annual withdrawal rate is 4%. Any changes to the withdrawals taken in retirement will need to be factored into the assumptions, and your plan updated accordingly. This may include withdrawals for vacations, home repairs, gifts to beneficiaries, and so on.

Financial plans need regular checkups

You can estimate your own "magic number" for retirement savings using assumptions like the ones above, but you may need to refine or adjust them over time. If your retirement plan hasn't been reviewed recently or you've experienced major changes because of the disruptions of 2020, check in with your MD Advisor* to see whether you need to make any changes.

MD Financial Management

* MD Advisor refers to an MD Management Limited Financial Consultant or Investment Advisor (in Quebec), or an MD Private Investment Counsel Portfolio Manager.

[1] Based on data provided by the Government of Canada as of November 1, 2020.
https://www.canada.ca/en/services/benefits/publicpensions/cpp/payment-amounts.html
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MD Financial Management provides financial products and services, the MD Family of Funds and investment counselling services through the MD Group of Companies. For a detailed list of these companies, visit md.ca.

How Did We Get Here and Where Do We Start?

An introduction into actively engaging in antiracist pedagogy and praxis

"But race is the child of racism not the father. And the process of naming "the people" has never been a matter of genealogy and physiognomy so much as one of hierarchy. Difference in hue and hair is old. But the belief in the pre-eminence of hue and hair the notion that these factors can correctly organize a society and that they signify deeper attributes, which are indelible- this is the new idea at the heart of these new people who have been brought up hopelessly, tragically, deceitfully, to believe that they are white."
(Coates, p.7)

By Dr. Farha Shariff

I am a second-generation South Asian Canadian. I am a daughter to both Suni and Shia Muslim immigrant parents who arrived here in Canada in the early1960s on educational scholarships offered by the University of Alberta. As the daughter of educators, teaching is in my blood; as a woman of colour, I have been living and studying race and racism my entire life. My lived experiences with racism not only allows me access to a physical and psychosocial understanding of racism, my doctoral research is also grounded in antiracism and specifically informs my pedagogy.[1] I have the lived cultural, historical, religious, gendered and academic expertise in antiracism and the legacies of colonialism. Far too often antiracist initiatives and training sessions are offered and led by White folx[2] and while some of these folx may have the academic expertise, they cannot speak to lived experiences of the impacts of race and racism.

For those of you who are beginning your journey into what it means to be

1. I use the term ***pedagogy*** to describe the method and practice of teaching, especially as an academic subject or theoretical concept. ***Praxis*** is defined as an accepted practice or custom, or an idea translated into action, or something in reality rather than something in theory. Another way to think of praxis is the practical application of any branch of learning while **practice** is repetition of an activity to improve skill with the eventual goal of achieving mastery.
2. I use *folx* intentionally as it is a more inclusive, gender-neutral term, and specifically centers the inclusion of marginalized groups including people of color (POCs) and trans people.

an anti-racist practitioner, it is important to understand that being an antiracist ally is not a set of guidelines and strategies, a tool kit, if you will. It is a way of seeing the world in a different way. Step one would be to understand the theoretical framework needed for this kind of work.

Critical social justice theory (CSJT) helps us to move beyond our opinions (layperson) and into a more informed knowledge through critical thinking and a commitment to scholarly research. CSJT interrogates the political and ideological aspects of where knowledge comes from and who validates it and who says it's true. Through an examination of the historical contexts of current social processes and institutions we can examine the processes of socialization and its relationship to social stratification. CSTJ also centers the inquiry on the inequitable distribution of power and resources among social groups by calling into question the idea that objectivity is desirable or even possible. The term theorists use to describe this way of thinking about knowledge is that *knowledge is socially constructed*. When we refer to knowledge as being socially constructed, we mean that knowledge is reflective of the values and interests of those **who** produce it (Banks, 1996). This concept captures the understanding that all knowledge and all means of knowing are connected to a social context.

Critical race theory (CRT), was born out of legal studies and then further developed in education scholarship, as a framework that also centers experiential knowledge, challenges dominant ideology, and mobilizes interdisciplinary and intersectional methodology in order to examine structural and institutional inequality. CRT seeks to name, locate, analyze, and transform those structural and cultural aspects of society that maintain the subordination and marginalization of People of Color. CRT offers a language for physicians and physicians-in-training to make sense of the causes and consequences of race and racism by examining inequity and critically interrogating power structures. Finally, CSJT and CRT equips learners with the ability to recognize and articulate racism in medicine and presents us with an important strategy for addressing gaps in current medical education. In light of very real situations of racism in medicine, medical education should teach through a CSJT and CRT lens so that physicians in training are better prepared to discuss and treat racial inequities, in and outside of the clinic.

On your journey to becoming an antiracist practitioner you will need to

be informed in critical race theory and critical social justice theory and be keenly interested in using the most current research and theory as your roadmap. Begin by engaging in courageous conversations about race and culture and the impacts of learning on learners and patients. Look to Black, Indigenous and racialized authors and academics of colour, who speak from lived experience and theoretical experience before looking to the folx who are the most widely published.[3] (Think about who's sitting at the table in publishing houses.)

I often use the metaphor of a pair of glasses; the frames of the glasses are the social groups to which we belong (Sensoy & DiAngelo, 2017). These social groups constitute the macro level norms that we are all taught at birth. Another way of thinking about it would be the groups we are born into constitute part of this frame: gender, class, ability, religion, and nationality. These macro level norms are then organized into binaries which means for every social group, there is an opposite group. Oftentimes, we can't learn what a group is without learning what a group is not. Therefore, the frames of our glasses are the big picture ideas about social groups. We all rely on shared understandings about these social groups because we received messages collectively about them from our culture. The frameworks we use to make sense of race, class, or gender are taken for granted and often and seem invisible to us.

The lenses or the prescription, that fits the frame then constitutes the individual or micro perspective. These are our unique experiences that make us one of a kind and include birth order, family, and our personality. Yet no one is simply an individual. We need to consider that we are all members of multiple social groupings and the widely circulating social messages about those groupings. To better understand our personal cultural glasses, we then have to explore the interplay or relationships between our frames and our lenses. A primary challenge of developing critical social justice fluency is to understand the relationships between ourselves as individuals and the social groups that we belong to. This is called to understand our *positionality*. From a critical social justice framework, when we use words such as men, women, heterosexual, middle class, and so on, we are speaking about specific social group experiences and histories.

3. Some of the authors that are influencing my work right now include (but are not limited to) the works of Drs. Ibram X. Kendi, Ijeoma Oluo, Loretta J.Ross, Audre Lorde, Marie Battiste, Carl James, Gyatri Spivak, Edward Said, Homi Bhabha, Stuart J. Hall, Bettina Love, bell hooks, among many others.

If we are resisting the very idea of having to identify ourselves in terms of positionality, for example, to consider social categories like our race or gender, this provides a glimpse into our collective socialization. In Western Society, we are socialized to prioritize ourselves as individuals. But, it is important to remember that even though we are individuals, we are also and perhaps more fundamentally, members of our social groups.

By understanding our positionality, we are able to decenter ourselves and understand that statements like "White privilege" are not claims being made about us as individuals, but rather the *patterns among social groups* that are long-standing, measurable, and well-documented. We have been taught that social group memberships such as race, class, and gender do not and should not matter, and thus be minimized and denied. It is important to recognize that the memberships in these social groups ***do matter*** and have fundamental, impactful, and often disastrous consequences for Black, Indigenous and Peoples of Colour. This is why the problematic colour blind approach of only "seeing people" and not seeing colour is in fact, racist. When we only see people and we don't recognize the social group membership of race and class and gender (and so on) have systemic and oppressive impacts on the lives of racialized folx.

There is a fundamental flaw with the simple metaphor of social positionality as a pair of glasses; such that the antiracist practitioner must appreciate that these lenses are not to be removed. In order to see clearly the lenses become a necessity to carry out our role as physicians to the fullest extent possible. It's about our humanity. It's part of our daily work. It is who we are.

When we can begin to see more clearly, we can then start by asking questions like, "who is leading this work? Is this person/organization representative of the populations they serve and seek to represent? Keeping in mind that, all institutions and sectors in Alberta as far reaching as schools, hospitals, media, financial and judicial systems and as far reaching into our government, are predominantly staffed by White folx, with White folx with White administration and leadership.

This is what we call systemic, institutional racism; it is so deeply rooted that we don't see it at the surface.

By being able to understand our cultural classes, positionality asserts that knowledge is dependent upon a complex web of cultural values, beliefs,

experiences, and social positions. This recognition of where we stand in relation to others in society shapes what we can see and understand about the world. The knowledge we create is influenced by our experiences within various social, economic, and political systems. Essentially, who we are as knowers is intimately connected to our group socialization including gender, race, class, and sexuality (Banks, 1996). **How we know what we know is connected to who we are and where we stand.**

Begin by exploring what you know about equity. Exploring statements like, "everyone should be treated equally," seems to be a phrase that most, if not all practitioners would agree with. Explore questions such as: What are basic human rights? Have we already achieved them? If not, why? How do we go about achieving them if we can agree on what they are and why they haven't been achieved? From whose perspective is something fair and equitable? Might something be fair for one person while actually having an unfair outcome for another? What does respect actually mean in practice (Sensoy & DiAngelo, 2017)?

Some say it is important to treat others the way we would like to be treated, but the definition of equality itself is our first challenge.

Even though there is discussion of the disparate health outcomes patient populations face in current medical curricula, these discussions provide a superficial discussion of health inequities instead of interrogating and critiquing the social, historic, and racial and institutional legacies that fundamentally generate, sustain and perpetuate these disparities and marginalize Black, Indigenous and Peoples of Color. Multicultural curricula often sustain stereotypes of marginalized peoples and go as far as citing behavioral and lifestyle choices as likely causes of health disparities (Carrillo et al., 1999, Gee & Ford, 2011).

This focus further pathologizes patient populations thereby omitting any discussion of the systemic forces that create the inequitable educational disparities and environments. Even implicit bias curricula, which in effect, encourages increased understanding and awareness of personal prejudices, this pedagogy fails to consider the structural inequities that generate pervasive bias (Tsai, Crawford-Roberts, 2017). In fact, implicit bias training can and often does normalize bias and fails to examine power differentials that enable

individuals and institutions to systematically enact prejudice.

Race continues to be understood as a biologic variable, whereby a significant number of practitioners continue to understand race as an innate characteristic. This is problematic for a multitude of reasons but primarily because race is a power construct of collected or merged differences that has very real social, educational, physical, emotional, and psychosocial consequences with no inherent phenotypical or biological validity (Kendi, 2019).

In order to understand what antiracism is we have to understand what racism is and what it is not. We don't have social inequalities because of race. We have social inequalities that are justified by race. The simple truth is that race is a system. It's like oxygen, like an atmosphere. It flows everywhere in our society and infects everybody it touches.

It protects power and privilege.

Another key concept to grasp would be the concept of intersectionality[4] (Crenshaw, 1991), which cannot be left out of conversations about antiracism. We cannot separate conversations about economic class from racism. Antiracist practitioners will learn how deeply unjust systems affect people and their communities in unique ways but also understand the intersections of injustice. Understanding intersectionality allows physicians to dialogue around a set of questions that will lead them to a better sense of their patients' full selves, challenges, the grace and the beauty that is needed to juggle multiple identities seamlessly, and how medicine and health care perpetuate injustice. In fact, key questions to consider when evaluating information, research or policy work include: From whose perspective is this written? Who's making the policy/decision? Who does the policy/decision impact (the most)? Whose perspectives are missing? Are said people sitting at the table making the policy/decision? Who's racial perspective is reflected in the ideas? Which racial groups may be invested? Which racial groups may be invested in challenging it?

4. We cannot have a conversation about race, without understanding the concept of intersectionality. The concept of intersectionality recognizes that people can be privileged in some ways and definitely not privileged in others. There are many different types of privilege, not just skin-color privilege, that impact the way people can move through the world or are discriminated against. These are all things you are born into, not things you earned, that afford you opportunities that others may not have.

My day-to-day engagement with students, administrators, medical practitioners and community members across disciplines involves reflecting upon what it means to teach, live and contribute towards more equitable communities and workplaces. It involves considering how social, cultural, political, spiritual, psychological, and ideologies shape practitioners' identifications and implicit biases. It also informs how these forces and tensions can make teaching dynamic, challenging, intellectually engaging, and rewarding.

As antiracist practitioners, we must never be silent. *Ever*. We understand that our positions as teachers, leaders, practitioners, and policymakers are roles that come with a great deal of power and privilege. We have the ability to leave the spaces that we inhabit better places to co-exist.

Race
Racism
Racist
Whiteness
White supremacy
Prejudice
Bias
Stereotype
Discrimination
Reverse racism
Oppression
Colourblind
Individualism
Dominant group
Minority group
Antiracist education
Multicultural education
Defund the police

These words floating around conversations have profound meaning and are probably among the most misunderstood concepts with regards to antiracist pedagogy, praxis and practice. As the words *antiracist* and *equity* have become dangerously trendy and practitioners need to pause and grapple with what they *truly* mean. It is important that practitioners and administrators have a shared understanding of what antiracism in medicine looks like, that we have an understanding of what it is not, and that we embrace the understanding that antiracist work is never completely finished, nor does it always look the same. **Practitioners can learn how to begin to think about antiracist work in medicine in ways that are holistic and practical because it is not enough to be "not a racist" anymore.** We have come to a moment where there is no neutrality. Being neutral upholds the status quo. The status quo, wherein the state of healthcare, education, and justice are systemically racist.

Part of the hard work of antiracism is the constant self reflexion and coming to terms that we are constantly moving in and out of

moments where we may be acting racist. Acknowledging this doesn't mean we are a forever racist. It just means that we all have the capacity to be racist. This constant reflexion and awareness will fluctuate given the day and situation, context and audience, and all of this is dependent on our positionality. Meaning - it's not a fixed identity (for most).

To be antiracist is to admit we are being racist, a confession of sorts, to constantly be aware of our biases, to believe there's nothing dangerous about a specific group, to question what policies are behind so many disproportionate numbers of racialized folx being affected by COVID-19 or how many Black and Indigenous peoples are being killed at the hands of police?

We have arrived at a moment where neutrality is not enough. The work of antiracism is slow, sustained, hard work. What does this work look like beyond the current momentum, in two years from now? In ten years from now?

> *I am no longer accepting things I cannot change, I am changing the things I cannot accept.*
>
> – Angela Davis

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Why Should We Care That Zero Women Candidates Ran for CMA President?

By Dr. Kim Kelly
Region II Representative

It's Alberta's turn to vote for the president-elect of the Canadian Medical Association (CMA). Every year CMA members from the designated province or territory determine the nominee for confirmation at General Council. Due to the alphabetical rotation, this opportunity will not recur in Alberta for twelve years. Realistically speaking, a physician leader might consider running once, maybe twice, over their medical career. Despite having many talented women physician leaders in Alberta, none chose to run. This is a lost opportunity for women, for the medical profession, and for organizations and associations which claim that they are committed to equity, diversity and inclusion. I write this piece from my perspective as a white cisgender straight settler and first-generation mid-career woman physician. I am early in my journey of learning and unlearning.

There is certainly cause for celebration that this year's nominees included two Indigenous physicians, one of whom also identifies as two-spirit. In over 150 years of CMA history, there has never been an Indigenous president. There continues to be underrepresentation of Indigenous physician leaders across Canada. I would like to acknowledge the significance and courage of a candidate who is Indigenous and non-binary, two oppressed groups in Canada, putting his name forward.

The fact remains that zero women[1] put their names forward in an association, namely the Alberta Medical Association (AMA), of over 14,000 members. Zero nominees from an equity-seeking group, approaching 50% of membership, is indicative of a biased process at play. To positively affect systemic change and address "isms" like racism, sexism, and ableism, we must call-out these inequities when we see them. Otherwise, these processes stay the same, another year passes, and medical associations and organizations keep issues like the lack of women applicants, the gender pay gap, the underrepresentation of women at all levels of leadership, and gender

1. Throughout this piece I have used the term "women" with an intention of inclusion of all individuals who identify as a woman. I acknowledge that language has its limitations and continues to evolve.

harassment on the backburner. The concept of intersectionality ("Why Intersectionality Matters Even More in 2020," 2020), a term coined by Kimberlé Crenshaw in 1989, recognizes that people can be privileged in some ways and not in others. This concept must be considered when examining why women did not apply. Simply explained, categories like race, sexual orientation, and gender can combine and compound oppression and this is why intersectionality is a key factor to consider when exploring the current situation leading to zero women candidates.

The CMA's nomination process occurred over a short four-week timeframe from October 29, 2020 to November 26, 2020 which coincided with Alberta's second wave of COVID-19. Research has shown the inequity of increased childcare duties for women during COVID-19 further likely also compounded the lack of women applicants (Power, 2020). We also know there are significant differences between women and men when applying for jobs; wherein, a Hewlett Packard internal report indicated that women only apply for jobs if they think they can meet 100% of the requirements while men apply if they meet 60% (Sandberg, 2013). Nagwan Al-Guneid, a political expert, states that on average a woman needs to be asked seven times before she agrees to run for political office (McKeon, 2020). Another barrier for women trying to advance in leadership is that women receive less mentorship and sponsorship than men (Travis et al., 2013). By applying a gender "lens" to the CMA's nomination process, as described above, we are able to identify that this process was inequitable for women.

How was this obvious gender gap missed? It could be the product of an absence of diverse leadership at the decision-making table. It could be that someone spoke up but their voice was not heard and/or was dismissed or marginalized. It could be that someone saw the obvious gap but did not feel safe to speak up because of a lack of inclusion or feared retaliation. These are hypotheses but I have experienced all of these scenarios at leadership tables.

What steps could the CMA, and other organizations, take to address this lack of intersectional representation?

To assess this situation with a retrospective eye and then consider what we can do to avoid this

scenario again in the future I propose the following:

Step 1 Ask why women, an equity-seeking group, are missing from the pool of applicants? Are there other equity-seeking groups missing? In our decision-making, we must train ourselves to use a diversity "lens", an inclusion "lens", and an intersectionality "lens" with the intent of identifying possible barriers and inequitable processes for individuals applying.

Step 2 Plan to reactively halt the process, midstream, if the recruitment pool does not meet minimum diversity standards and extend the call-out. This is not unusual and extensions to job postings frequently occur within the private sector. Intentional outreach can occur through targeted advertising to groups with memberships that are absent from the recruitment pool. In this case, the Federation of Medical Women in Canada, Canadian Women in Medicine, and the Edmonton Women in Health Network are some examples of groups that can be leveraged to help ensure their members are informed of opportunities.

Step 3 Review the nomination and electoral process to identify bias and inequity. Once identified, actions to address bias and inequity need to be resourced over the short and long-term. This should occur well in advance of the next nomination period.

Step 4 is to operationalize policy. The CMA, like many medical organizations, has good intentions in addressing EDI and anti-racist action. Policy is important but without creating, implementing, measuring, and funding an action plan, the status quo will continue. An organization will risk accusations of being a performative ally if their policies do not align with their practices and with their allocation of resources ("Beware Performative Allyship," 2021).

I now return to why we should care that zero women candidates put their names forward in this election. If no one speaks up when women are absent from the recruitment or selection pool, inequity will continue unchecked and unchallenged. EDI, intersectionality, and anti-racism action will remain as topics we simply discuss but never make any action to remedy. Women will continue to be excluded and underrepresented at all levels of medical leadership as they have been for over a century. As bleakly stated in the recent Globe and Mail article "…women continue to be outnumbered, outranked and out-earned by men not just at the very top, but on the way to the

top and in the middle" (Doolittle & Wang, 2021). If nothing changes, it will take 108 years to close the global gender gap (Myklebust, 2019).

My values have compelled me to act. I have spoken up about this issue on social media, conducted interviews of the candidates about EDI, communicated my concerns with the CMA's CEO and Board Chair, co-authored an advocacy letter with Canadian Women in Medicine, organized an "All Candidates Forum" to help educate voters, applied to sit on CMA's nominating committee, and written this article. I voted and encouraged others to vote. I continue to contribute to culture change by leading the Equity in Medicine national team and as the elected Alberta representative for Equal Voice Canada. I share these actions to show a range of advocacy and activism that may appeal to you. For me, they provide a sense of hope that change is possible.

Many have indicated that the issue of zero women candidates does not bother them. They have responded that they would not have voted for a woman because women have already served in this role. I remind the reader that the issue I have tackled here is the necessity of a diverse recruitment pool rather than who you vote for, which is associated with different biases and barriers. The blanket statement, "women have already served in this role" does not consider intersectionality and assumes that all women are the same. We know, for example, that the barriers faced by racialized women physicians are more pronounced than those for white women. When one considers the race demographics for past CMA women presidents nine out of ten were white. We know that 90% white women is an overrepresentation when considering the race demographics of women physicians. We must have the courage to examine why some groups are overrepresented in medicine while others are underrepresented. As Ibram X. Kendi writes, "when racist policies resound, denials that those policies are racist also follow" (Kendi, 2019, p. 9).

In conclusion, we have inherited unfair systems and it is up to each of us to dismantle them and rebuild. Zero women applicants for any medical position is no longer acceptable. The absence of women candidates for the CMA president-elect role is an obvious gap that was somehow missed. Women, and others from equity-seeking groups, have been missed for generations. It is our individual responsibility

to grow our competencies in EDI and antiracist action to enable us to see the gaps, biases, and inequity. We all have power and can choose to use that power to speak up, call out, call in, support others, and engage in uncomfortable conversations. These conversations are necessary to move change forward and the more we have them, the more they will become normalized. Starting today, we can choose to sit with our discomfort when it arises, reflect upon it, and realize that it signals that we are making progress.

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Founder, Equity in Medicine

Founder, Edmonton Women in Health Networking

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CAREER ADVANCEMENT AND LEADERSHIP OPPORTUNITIES FOR WOMEN IN MEDICINE:

Ten Actions to Defeat the Stall

Dr. Clover Hemans
Past-President

The Corridors of power are firmly buttressed by the pillars of patriarchy—this includes medicine.

It is 2021. Despite that fact that in 2017, more women enrolled in medical school than men (50.7% vs 49.8%), the numbers certainly do not equal gender equity success. The pandemic certainly has not helped. The purpose of this commentary piece is to explore this phenomenon. What can we do about this? What is the hold up?

The message I would like to convey is this. There is no better time than NOW to build coalitions and reach out to peers and allies from all realms to blast through the obstacles preventing ALL women from achieving their full potential. This should be done using an intersectional lens (Cole, 2019).

Although I have utilized non-medical references early in this article, I do so to point to the ubiquitous power imbalance that the patriarchy imbues in all segments of society---academic, corporate, justice/social welfare, and most definitely medicine. We must resist the inclination to decline talking about uncomfortable issues such as patriarchy, priviledge and discrimination based on gender, race, and other intersectional factors. Priviledge is the "unearned advantage of an unequal, invisible system." (Patriarchy, n.d.)

Patriarchy is defined as:

> *a social system in which power is held by men, through cultural norms and customs that favour men and withhold opportunities from women.*

This describes our current society. Furthermore, men benefit/have privilege from being male whether they want to or not, even when they are not being actively sexist. An example of this was seen in research using identical, fake resumes with names modified to influence race and gender stereotypes. Men were deemed more hire-able and women more likeable. Black and Hispanic contenders were rated less competent and less hire-able than White and Asian sounding candidates (Flood, 2020).

The corporate non-medical world has also measured the effect that chauvinistic "Bro" power imbalance has on women and success. The Globe & Mail published a series of articles on women and corporate

leadership which is certainly worth reading (Doolittle, 2021). One such article is entitled "*Out-earned, Outumbered, Outranked*". In this article, Robin Doolittle and Chen Wang provide an excellent synopsis of the experiences from women across the globe, across occupations, and across income levels; with the usual rare exceptions for those very few who have managed to climb to the top. This quote from the article sums it up:

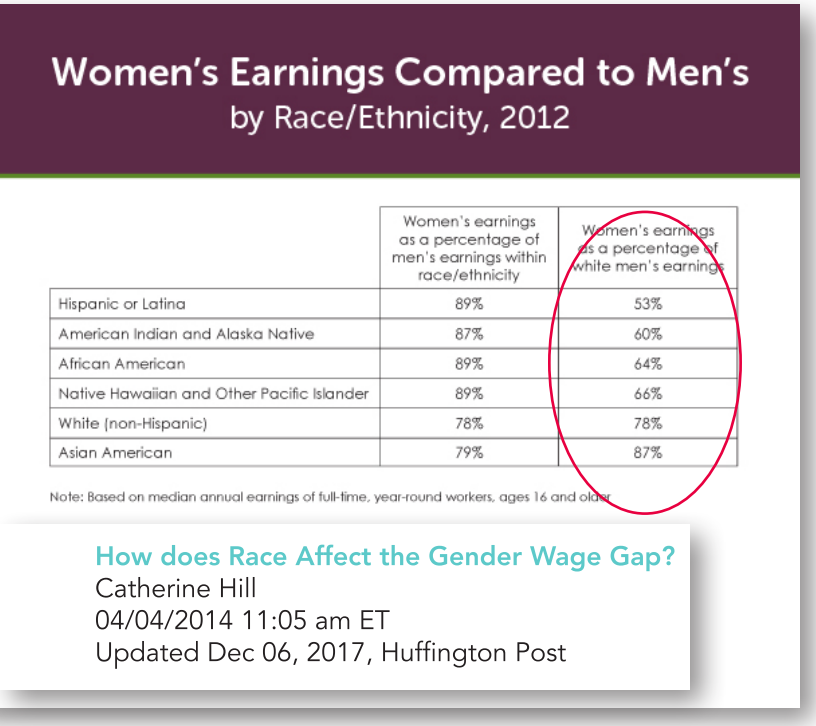
> *No matter the strata, no matter the pay cheque, no matter the number of letters after a person's name on their business card, women are encountering backlash for having children, they're being passed over for promotion or the most desirable assignments, they're being excluded from networking opportunities, they're being sexually harassed, they're being paid less, and they're being labelled difficult for complaining about any of it. Of course, there are exceptions. This isn't true everywhere, but the broad trend is plain to see.*

Women in medicine are not exempt and in fact, suffer from the addition of the pandemic's childcare and household complication. Childcare and the "second shift" (Hochschild, 2012) of household duties are still largely considered a women's problem. Many women have had to make significant changes to their work and their work output, by decreasing attention to academic papers and research. These have stalled significantly and with that goes opportunities for promotion, increased pay, increased power, and prestige. These decreased academic pursuits have not nearly been as affected to same extent during the pandemic on men. This past year with its associated pandemic work adjustments will affect long-term academic promotion.

Canada and most of the world already has a paucity of women in the highest levels of academic leadership. For example, throughout Canada, there are only 4 deans of medicine and from that small sample, only one is a woman of colour. The pandemic has worsened opportunities for women in leadership in the near future.

In the area of gender, the gender pay gap and opportunities for senior leadership, women lag markedly behind. In Canada, it is more difficult to determine gender and race in leadership because we simply do not measure this metric. Fortunately, 2020 was the year that the gender pay gap was measured in Ontario by the OMA (Ontario Medical Association, 2020) and nationally in a paper by Cohen and Kiran (Cohen, 2020). Data from the US, where it is easier to obtain race-related information

indicates that although women make less that men of their own race—between 11-22%, when compared to White males, BIPOC women made considerably less (reference here please).



Women's Earnings Compared to Men's
by Race/Ethnicity, 2012

	Women's earnings as a percentage of men's earnings within race/ethnicity	Women's earnings as a percentage of white men's earnings
Hispanic or Latina	89%	53%
American Indian and Alaska Native	87%	60%
African American	89%	64%
Native Hawaiian and Other Pacific Islander	89%	66%
White (non-Hispanic)	78%	78%
Asian American	79%	87%

Note: Based on median annual earnings of full-time, year-round workers, ages 16 and older.

How does Race Affect the Gender Wage Gap?
Catherine Hill
04/04/2014 11:05 am ET
Updated Dec 06, 2017, Huffington Post

There have been a number of papers debunking the myth that the gender pay gap is secondary to women not working hard enough or long enough as compared to their male peers. Uncovered by Cohen and Tiran were systemic biases— again based on deep-seated patriarchal, socialized norms

Dr. Shannon Ruzycki, a Canadian Internist and researcher has written on gender disparities in medicine. A 2019 paper revealed a generational divide:

> **Senior men perceived gender equity to be achieved in the DOM (Department of Medicine) and used numerical equality as evidence of lack of bias against women physicians. Senior men did not recognize barriers to a career in medicine that women physicians might face, such as parenthood, second-shift responsibilities, and sexual harassment. In contrast, junior men, junior women, and senior women physicians perceived gender inequities in medicine that disadvantaged women physicians. These 3 groups had increased awareness of the range of challenges faced by women physicians and the consequences of these challenges on career progression. Further, junior women and male physicians shared concerns about the effect of parenthood on career progression** (Shannon, 2019).

A proposed fix to these "generational challenges" was to wait until the old guard was "dead or retired" (Ruzucki et al, 2019, p.8). This solution is acquiescent and assumes that the displayed behaviours and attitudes which have long been supported, will simply go away. History, passive

socialization, and the status quo has shown that this strategy does not always work. Power is firmly clasped in the hands of senior male leaders. They have performed and mentored their style of leadership. They successfully made it to the top. It will require active strategies to un-see and un-learn this patriarchal and discriminative style.

So, what will it take? We know talking about it alone does not change behaviour. Appealing to emotions alone does not change overall behaviours. We need actions that beget movement.

Pebbles coming together to make stones while rolling downhill, gathering momentum and power is a great analogy. A few important steps that impact change are outlined below.

Measuring and reporting of gender and race in leadership roles for remuneration for example, is a definite start. According to both business management and improvement science, "You can't improve what you don't measure" (Drucker, P). Dr. Gigi Osler, former CMA president, put it this way, "you measure what you treasure." How do you know if you have improved, if you do not measure where you were at the start? Reporting indicates that you value transparency, then further holds you accountable for improvement… or not.

Recognizing that socialization of our children starts early, starts with all of us, and contributes to perpetuating gender stereotypes and intersectional biases. How do we ensure that children feel comfortable in multiple roles without the pressure of being boxed into gendered expectations? All children should feel comfortable caring for babies, building things, and experimenting with cooking and playing house. Children should not be subject to what I refer to as "pink pointing"—where they are led by adult assumptions and biases (both implicit and explicit) to subject matter learning that pushes them into gender-stereotypical jobs or post-secondary careers. The "second shift" at home should not come with a pink ribbon.

Mentorship, sponsorship, allyship, and fostering need to be stressed as positives for building a better society for everyone. Exclusion from networking is a real issue when it means 'going out for drinks with the boys' after work. The second shift, childcare, and family care are less valued in this scenario and sends the message that success means less family time and less home-life balance.

Women should feel very comfortable amplifying and elevating the competencies of other women when they see jobs that align with skillsets of other women.

This is important as women have less formal and informal networking opportunities to sponsor or tap them on the shoulder. Additionally, seek the beneficence of male allies. We need them.

Seek to build a coalition of equity-minded, future-forward, feminist thinkers of all genders. Be inclusive, open minded, and curious. When you meet those folk who do not see the barriers that prevent women from reaching their full potential, actively listen in an effort to understand what they believe. Seek to build on common ground. Use your skills of persuasion to help them see the gifts that are lost to the world when women are prevented from reaching their full potential.

We must put women at every table where decisions are made. To do this, here is my call to action which can be achieved over the next 12 months.

We must forge ahead with:

1. Putting women (especially BIPOC women) on search committees because representation makes a difference in selection. This helps to rebalance gender and hopefully other inequities in the longer term (Duke, 2017).
2. Demanding transparency in job descriptions and remuneration
3. Asserting that all staff be on-boarded with a minimum standard of implicit bias training and awareness to try to alleviate the un-awareness excuses/responses to some of the more blatantly misogynistic, racist, affronts and sexual discrimination.
4. Pressing ahead for fair and equitable compensation --The gender Pay gap is real and is not explained by hours of work, and has long-term consequences for livelihood, respect and promotion. Let us put women on governance and search committees in medical education and on surgical specialties. Governance work is crucial to organizational direction and guidance. Fact: when specialties become "feminized" they become fiscally devalued (Pelley, 2020).
5. Continuing the fight against "Pink Pointing" where women are pointed toward specialties more "suitable" for their gender, are penalized when applying to areas such as surgical specialties, and are as viewed as "less" if their working life interfere with their role as a mother (Dossa, 2018) (Cuddy, 2004).
6. Measuring and reporting data around the lack of women as clinical chiefs of departments, corporate division heads, and equally paid leaders in every clinical/administrative medical setting. Lack of transparency leads to old,

comfortable, non-diverse leadership—otherwise known as "organizational preferential-ism." (Allen U. , 2020).

7. Learning to leverage informal networks --there is a vast and unplumbed depth to these types of informal networks. Make friends with writers and journalists. Become comfortable with writing yourself so that you can share your own insights and experiences. Join organizations/committees that appreciate, nurture, elevate, and amplify women and their work. Some examples include: The Federation of Medical Women of Canada, Ontario Medical Association's OMA Women, CWIM, and Women in Medicine and The Raft©

8. Continuing to build and support formal mentorship, allyship, and nurturing relationships that support excellence and skill acquisition for women in leadership e.g., "Executive Presence" (Allen T. , 2019). If you do not know what this is, it is time to find out. An example of this type of networking can be found in *The Raft*. Founded by Dr. Mamta Gautam, a lauded and respected icon of skilled excellence in leadership, this is an online leadership program for experienced and new leaders.

9. Advocating for a deliberate rebalance of roles/positions where women are currently unfairly absent. Data has indicated that waiting for voluntary steps to rebalance gender inequities and power do not work (Trichur, 2021). Exposing privilege and patriarchy should debunk the myth of meritocracy. Find allies from everywhere to assist with this.

10. Becoming social media savvy. This mode of communication has been a boon for widespread connectivity. Leverage this tool for increased awareness of the "cement" ceiling. A glass ceiling implies one can see what is on the inside...much of what is behind, is opaque. The advantage of an enlarged digital footprint and outreach means women can lend support to the sisterhood across the globe, even when the borders are closed. Measuring the effectiveness of these tools to see which work most effectively is vital. A clear pipeline to success can be determined if we report what is working with actions and data. One of the utilities of the digital world is the ease of measurement. Information and influence is power.

There are a number of suggestions in the list above. I urge you to choose at least one or two that resonate with you. If we all commit to trying at least one suggestion over the next 4 weeks, we can accomplish a great deal.

Again, I reiterate that there is still no better time than NOW to build coalitions and reach out to peers and allies from all realms with the aim of blasting through obstacles preventing ALL women from achieving their full potential. These actions have boundless power when rendered through an intersectional lens.

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LGBTQ2S+ HEALTH:

Development of an E-Module and the Importance of Using Respectful Language

Dr. Casey Hicks
and Dr. Haleema Jaffer

Lesbian, gay, bisexual, transgender, queer, Two-Spirit, and other (LGBTQ2S+) people experience stigma, discrimination, pathologization, and erasure in healthcare settings, resulting in adverse health outcomes and the avoidance of Western health care services (Stinchcombe et al., 2018; Clark et al., 2017). Sexual and gender minority physicians also experience stigma and discrimination during training and in the workplace leading to "a culture of invisibility" where they may need to conceal or are unable to honour their identities, negatively impacting their health and wellbeing (Zelin et al., 2020). Though many health professional organizations recognize the need for medical learners to develop specific competencies related to LGBTQ2S+ health, medical education programs often lack comprehensive approaches to LGBTQ2S+ health education (AAMC, 2014; Weicker and Zhang, 2016).

As medical students at the University of British Columbia, CH and HJ worked with the curriculum sexuality theme lead and UBC's Medical Education and Technology team to develop Foundational Concepts for LGBTQ2S+ Health, an online learning module (e-module) on LGBTQ2S+ health and health equity (Hicks et al., 2019). They welcome the invitation to introduce this module, discuss the importance of using respectful language, and highlight important equity concepts in this issue of The Voice. HJ is a second-generation South Asian settler and PGY2 UBC Family Medicine resident currently working on the territories of the Musqueam, Squamish, and Tsleil-Waututh Nations. CH is a queer, white settler and PGY1 UBC Family Medicine resident currently working on the territories of the Stz'uminus, Stó:lo, and Kwantlen Nations. They are extremely grateful for funding through UBC's Teaching and Learning Enhancement Fund which enabled them to work with queer, trans, and Two-Spirit people to develop a series of personal account video interviews featured in the e-module. The four-part, 2.5 hour e-module has been integrated into the fourth year of the

UBC MD Undergraduate Program curriculum. HJ, CH, and co-residents Drs. Mona Maleki and Emily Ower have also facilitated workshop sessions for family medicine residents on the module's content. The e-module aims to teach learners how to engage and communicate with LGTBQ2S+ people in a respectful way, recognize health inequities and structural violence, and provide gender-affirming health care.

An important aspect of providing care to LGBTQ2S+ people includes using affirming language. Affirming language avoids assumptions about a person's body or gender and means using neutral terminology until you are able to ask individuals what specific terminology they would like you to use (Stroumsa et al., 2018). Using affirming language shows people that you respect them and is one way to help create more welcoming environments for people who often feel unwelcome or have had prior negative experiences in healthcare settings (Greene et al., 2019). **On a fundamental level, people are who they say they are**. This means referring to people by the name they would like to be called and using the pronouns that they would like you to use. Often, we assume that people use the name that is on their identification documentation and assume their pronouns based on their gender presentation or the gender on their documentation. This is not always correct, so it is important to ask people specifically. Refrain from using honorifics (e.g. Mr, Ms, Mrs.) until you have confirmed how they would like to be addressed. In clinical settings, it can also be helpful to ask people what terminology they use when referring to their body parts as some parts of the body are particularly gendered. Some people may prefer using, for example, the words monthly bleeding instead of period/menses or genitals instead of penis or vagina (Trans Care BC, n.d.).

For some healthcare providers, the words people use to describe their genders and sexualities will be unfamiliar so specific learning is necessary. We also all make mistakes when it comes to people's names and pronouns. If you do make a mistake, remember to apologize, correct yourself, and then move on. Commit to not making the same mistake again. To learn more, the Trans Care BC website has several resources including handouts and online learning modules on using affirming language (Trans Care BC, n.d.)

While language is an important way to signal to your patients that they can be open with you about gender and sexuality,

providing affirming care to LGTBQ2S+ people also involves understanding structural violence. Structural violence is the "systems of meaning and control" that advantage some people while disadvantaging others (Spade, 2015, p.5). When looking at health disparities among LGBTQ2S+ people, we must remind ourselves that being, for example, queer or trans, is not inherently bad for your health. Rather, it is being subjected to colonialism, homophobia, transphobia, racism, and other forms of discrimination, harassment, and violence that impacts health outcomes (McGibbon, 2012). Structural violence is more pervasive than the biases and prejudices that impact how we treat each other on an interpersonal level. These structures are embedded deeply in our institutions, laws, and policies, and subsequently create large-scale differences in the ways people move through their lives. This includes determining who has access to housing, physical public spaces, community resources, and Western healthcare services. The differences in how people are affected by the intentional high-level design of our socio-political environment creates health disparities (McGibbon, 2012).

Many LGBTQ2S+ people experience synergistic forms of violence ("Kimberlé Crenshaw on Intersectionality," 2017). To illustrate this, we can consider how the ongoing genocidal efforts of the Canadian state are based in heteropatriarchal and binary understandings of gender (Hunt, 2016; National Inquiry Into Missing and Murdered Indigenous Women and Girls, 2019). Among Indigenous peoples, the imposition and enforcement of gender-related norms such as heteropatriarchal marriage and binary gender expressions have disrupted traditional understandings and roles of people with diverse genders and sexualities (Hunt, 2016). The resurgence of these traditions is important, as is providing respectful and affirming care to Two-Spirit and Indigenous people of diverse genders and sexualities (Hunt, 2016). Important terms and concepts to help learners understand systems of violence, like heteropatriarchy and the gender binary, are explored throughout the module, and Part 3 asks learners to consider possible avenues of advocacy and accountability (Hicks et al. 2019).

Using appropriate language when working with LGBTQ2S+ people is one aspect of providing respectful and affirming care. While it is critical to communicating with and about patients, we must also learn about and

address the systemic factors that influence health and wellbeing, resulting in health inequities. Our understanding and actions must be guided by the knowledge and experiences of LGBTQ2S+ people.

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Mentorship is More Than Papers Published

By Dr. Dalia Karol
National Resident Represntative

As a resident physician, my junior trainees often inquire of me how to become involved in leadership, advocacy, quality improvement, or in pursuit of a particular specialty. To all such inquiries my answer focuses on an invaluable tool – mentorship.

My junior trainees, and all of us, are well served by securing effective mentors. In securing an outstanding mentor to advance one's goals I have never advocated a specific gender for that mentor. Rather, it is the skills, lessons, and support that mentors provide that are essential. It is for this reason that I was concerned that a published paper would suggest that women in academics "reap more benefits when mentored by males rather than equally impactful females" (Al Shebli et al, 2020, p.6). While I disagree with this conclusion for a multitude of reasons, it is noteworthy that such a conclusion favouring male mentors was reached primarily by the number of "papers published" with male mentors. I agree that papers published is essential in academia and in the advancement of new research; however, the value of outstanding mentorship is broader than the narrow issue of papers published. Indeed, a focus only on published articles does not do our mentors justice and fails to reflect the broader benefits of strong mentorship.

I want to illustrate this point about the broader role and benefits of mentorship by speaking about a personal mentor of mine, Dr. Elianna Saidenberg. Dr. Saidenberg was an esteemed hematologist at The Ottawa Hospital. Dr. Saidenberg and I were involved in a research project exploring residency education related to women and girls with bleeding disorders (Karol et al., 2019). Since Dr. Saidenberg was the last author of this project and I the first author, according to AlShebli et al's paper, we would be classified as a mentorship "dyad". I benefited greatly from this published project. I learned about the research process and where this was my first publication it opened the door to many other research opportunities. This published research paper led by Dr. Saidenberg certainly advanced the

medical literature in the field of women and girls with bleeding disorders. However, this published paper does not do justice to the huge impact of Dr. Saidenberg as a mentor.

Dr. Elianna Saidenberg was known to Ottawa medical students as a dedicated and devoted teacher who made herself available for mentorship, guidance, and supervision. Even while actively undergoing chemotherapy treatment, she would lecture to medical students, attend research meetings her students were presenting at, supervise research projects, and be available to support any student in need. Her lectures to medical students always included "coffee challenges" in which a medical student could answer a medical question by email but then have the opportunity to meet for coffee with Dr. Saidenberg. But, it wasn't just coffee. It was coffee that then evolved into more coffee, which evolved into important conversations about research, medicine, and life. Dr. Saidenberg prioritized her students' wellness and would engage from a personal perspective by offering help with work-life balance, essential research advice and guidance, and beyond that would even offer a home cooked meal. Her broad mentorship inculcated her mentees with sage advice, such as learning from one's academic librarians. This allowed me to learn how to effectively search the scientific literature, a skill that I will use for the rest of my career.

When my clinical responsibilities prevented me from going home to visit my family on holidays, Dr. Saidenberg invited both my boyfriend and I to join her family's holiday celebrations. Dr. Saidenberg's mentorship was indeed broad and multi-faceted. In all her dealings with mentees, she sought to impart key clinical, personal, and life tools. Clearly, the mentorship of Dr. Saidenberg was hugely impactful and was not limited to simply "a paper published".

While Dr. Saidenberg's passing in 2019 was devasting for me, and for all her mentees, her powerful and comprehensive approach to mentorship was truly life changing. The importance of mentorship is more than the sum of publications; effective and powerful mentorship can be a transformational personal and professional experience. It is fitting for the new FMWC newsletter section to devote to honouring and acknowledging our mentors. Mentors like Dr. Saidenberg, whose legacy in mentoring has been so impactful, are a shining beacon for broad and effective mentorships that truly benefit our profession.

This commentary piece will serve as an introduction to the newest section of The Voice FMWC newsletter that will feature outstanding women mentors. These outstanding women mentors are those individuals who have made a truly significant impact on the lives of their

mentees and also promote the mission statement of the FMWC. The submission form will be available in the upcoming months at fmwc.ca – stay tuned!

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"When I was a medical student at McMaster University, I was introduced to the Federation of Medical Women of Canada by Dr. May Cohen.

I was taken aback by the warm welcome we received and the support for us 'lowly' (as we saw ourselves) medical students by the inspirational and successful women present. Over the years I have had the pleasure of attending wonderful educational events that helped me grow both personally and professionally and to network with other like-minded women in my medical community. It is a gift I felt very strongly about passing on to the next generation of medical women. As I see the passion and keen intelligence in these young Women, I know that the profession will continue to be in good hands, and that the Federation will continue to grow."

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COVID-19 and the Impact on Gender Equity

Santanna Hernandez, BSW
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The pursuit of equality within the profession of medicine has been a long-fought battle by courageous women over the last century.[1] As academics have recognized the difference between equality and equity, there has been a shift in the goals desired from advocacy efforts by leaders.[2] Profound inequity continues to exist as exemplified by the recent review of media coverage of the COVID-19 pandemic. The purpose of this commentary is to highlight one of the recent articles that presents gender inequity in newspaper media coverage of the COVID-19 pandemic. Being cited as an expert source paves the way for individuals to pursue research and leadership opportunities. Within the study an expert was defined as someone who was asked to speak directly about SARS-Cov-2, coronavirus, disease, health or health systems. Gender-based inequities have worsened during the pandemic and there is growing evidence highlighting excluding female academics from leadership opportunities.[3] A cross-sectional study of the top 10 newspapers in the USA between April 1, 2020 and April 15, 2020 were analyzed wherein all names cited as experts were separated by gender based on the use of pronouns and identification on organizational websites. 2297 expert sources were gathered, 35.9% identified as women and 63.7% were men, with 95% confidence intervals. Consistent results were found in the 1738 unique experts per newspaper, 34.6% were women, and of the 1593 unique experts in all newspapers, 36.5% were women. Of articles with multiple experts referenced, 27.3% cited only men experts and 11.8% cited only women experts. Women were underrepresented as experts as Healthcare Workers and Professionals, Non-STEM Experts, Public Health Leaders, and STEM Scientists. This study documents that male academics outnumber women in COVID-19 newspaper reporting. In conclusion, the results of this descriptive cross-sectional study demonstrates the persistence of inequity that women continue to face in the context of academia. Currently there is no way to predict the long-term impacts the COVID-19 pandemic will have on the experience of women in the profession of medicine or the society at large. The

Federation of Medical Women of Canada's mission encompasses a commitment to the advancement and well-being of women in medicine and society. This research paper brings quantitative data to support the disparities woman are facing allowing evidence-based research to support future advocacy of the federation to ensure we are continuing to strive for equity.[4]

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