

# The Time Is Now for the Canadian Rheumatology Community To Lead the Way in Equity, Diversity and Inclusion!

By Nicole Johnson, MD, FRCPC

The year 2020 was the beginning of the COVID-19 pandemic, but also the beginning of a new consciousness of the ongoing oppression of Black people in society. The inhumane and violent death of George Floyd was captured on video and became viral on social media. There was an immediate response globally to acknowledge and address the injustices experienced by Black individuals. Our own Canadian Rheumatology Association (CRA) leadership addressed our membership with a President's message<sup>1</sup> followed by a call for volunteers to form a Task Force on diversity and inclusion.

The Equity, Diversity, and Inclusion Task Force was established in August 2020, and consists of Drs. Tooba Ali, Maysoon Eldoma, Aurore Fifi-Mah, Natasha Gakhal, Nicole Johnson (Chair), Ambreen Khan, Manisha Mulgund, Trudy Taylor and our invaluable CRA coordinator, Kevin Baijnauth.

Our volunteers on the Task Force are avid advocates of the equity, diversity and inclusion (EDI) initiative and wish to guide the CRA to become a leader as an inclusive and innovative Canadian subspecialty organization. Quotes from some of our members are as follows: "I identify as an Afro-Caribbean woman with a multicultural upbringing, being born on a French island where diversity is the norm. After moving to Canada, I struggled with the lack of diversity in leadership roles. Becoming a member of the EDI Task Force Committee is a unique opportunity to provide guidance and inform the important changes necessary to implement EDI pillars in the CRA," says Dr. Aurore Fifi-Mah. "I am passionate about EDI in all spaces and am excited to see it being embraced in an explicit and thoughtful way by the CRA. I want to be a part of that, both to help shape the values that guide the operation of our organization and for personal growth and education," says Dr. Trudy Taylor.

Our focus to date has been identifying key diversity and inclusion priorities for the CRA Board. One of these priorities entailed defining Equity, Diversity and Inclusion (EDI) as it pertains to the CRA organization.<sup>2</sup> It was important to the Task Force members that the CRA efforts for EDI were not limited to racial differences, but to encompass all equity-deserving groups. These additional groups include, but are not exclusive to, age, gender, sexual orientation, religion and varied abilities. As with many organizations with a strong commitment in EDI, we strive to move beyond a



statement on equity to having our day-to-day operations reflect the principles of EDI.<sup>3,4</sup>

The next steps will be to establish, in conjunction with the CRA board, organizational values that will incorporate EDI concepts. These values will be central to all functions and decisions of the CRA and will be an integral force behind the priorities of the organization as the CRA works with its membership, staff and stakeholders. In addition, through the newly established links to other CRA committees, for example the Communications, Education, Human Resources and Annual Scientific Meeting Planning Committees, the Task Force hopes to highlight EDI across the organization. An early example of these efforts was a well-received session on EDI in the LEAP (CRA leadership) program.

Our future aspirations include seeing opportunities to enhance EDI skills in our CRA members through awareness, education, and policies which will ultimately influence our daily activities in advocacy, leadership, sponsorship and justice for equity-deserving populations. The time is now to make changes in our healthcare systems. Racism, be it individual, interpersonal, institutional or systemic in nature, is a social determinant of health.<sup>5</sup> We can no longer turn a blind eye to this reality. The year 2021 has shown us the devastating impact of COVID-19 on various populations in Canada, including our rheumatology patients, and highlighted health inequalities across the country.<sup>5</sup> In addition, the recent discovery of unmarked graves of Indigenous children in Canada has brought increased awareness of the effects of systemic racism and its long-term impact on the mental and physical health of the generations of survivors of residential schools and their families, some of whom are our neighbours, colleagues, and patients. We need to take

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responsibility for the lasting intergenerational impact of residential schools in Canada,<sup>6</sup> by addressing health inequalities as health providers. These inequities leave us with a renewed commitment to take responsibility as colleagues, educators, rheumatology providers, researchers and global citizens to be part of the change towards health equality and justice for all. As a rheumatology community, we would like to be at the forefront of this transformation, and we welcome new members to the Task Force to be part of the change.

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# Bridging the Gap: Learning Spanish To Better Help My Patients

By Nancy Keesal, MD, FRCPC

I've always been a lover of languages. I was born in Montreal, and I attended a Jewish elementary school and high school and learned French, English, Hebrew and Yiddish, not to mention sign language as I had two grandparents who were deaf-mutes. That being said, when I moved to Toronto for my residency, facing the multiculturalism of the city was daunting, and I soon came to see that translation was a fundamental and often frustrating part of medical practice. No matter how good your translator is, you know you are never getting the full story, and that your patient is not getting the best of you because of it.

When I started in private practice as a rheumatologist, I spent part of my time in an area of Toronto dominated by Portuguese and Spanish patients. Every second patient required a translator, and it was time-consuming and tiring, so I signed myself up for a Spanish class. I have been seeing patients without a translator for years now. It has even helped me learn some Portuguese, not enough to not require a translator, but enough to know when I am not being translated well. It is frightening to realize how often the information we share or the questions we ask our patients are incorrectly conveyed.

Because of my Spanish, I decided to travel to one of the poorest parts of Guatemala with a non-governmental organization (NGO) and offered my services there. The "clinic"

was crude, and we barely had any medical supplies. It was publicized through the village that a "bone doctor" was in town. I snuck in a lot of Depo-Medrol in my suitcase (I found out that to bring it in legally would require the mayor of the town writing a letter on my behalf and 10 pages of paperwork, so I hid it in my luggage). I listened to many stories and gave a lot of cortisone injections that week. I had to ignore the patient with a breast mass I saw, because she had no money for medical care, and the lice on a newborn, passed on to her by the only midwife in the village. There was nothing to do because they can't wash all their clothes with clean water.

There are so many barriers to equity; so many cultural differences that lead to separation instead of celebration. At the core of relationships within medicine is the ability to communicate with ones' patients. Language, at the very least for me, helps me to cross the first fundamental barrier at least with some of my patients. Language has brought a richness and joy to my life and has helped me expand my world, and now I am trying to teach that to my children.

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