ALBERTA PHYSICIAN DIVERSITY CENSUS

Diversity, Equity & Equality among Alberta Physicians

BACKGROUND

Data on the diversity of Alberta physicians is limited. Not only do we not know the proportion of physicians by gender identity, disability status, sexual orientation, or racial identity, we don't know how the experiences of physicians differ by these characteristics.

This lack of data limits development and evaluation of equity, diversity & inclusion initiatives.

QUESTIONS

WHO?

What are the demographics of Alberta physicians?
Who is represented in the medical workforce, and who is missing?

WHERE?

Are there representation gaps in rural or urban settings? In academia? In leadership?

HOW?

How do physicians experience work?
Do experiences differ between groups?

WHAT WE ALREADY KNOW & WHAT WE DON'T

ABOUT THE CANADIAN PHYSICIAN WORKFORCE

61% of Alberta physicians are **male**.

39% of Alberta physicians are **female**.

The prevalence of transgender, gender diverse, or non-binary physicians **is not collected.**

Canadian Institute for Health Information

70% of Canadian physicians are **white**.

2% of Canadian physicians are **Black**.

<1% of Canadian physicians are **Indigenous**.

Statistics Canada

The diversity of physicians in academic and leadership positions is not known.

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CONTENT WARNING

Some of the content of this report is offensive and describes racism, anti-Indigenous racism, sexual assault, homophobia, and transphobia. Reading these comments will be upsetting, especially for readers with these identities. Please consider skipping pages 2, 7, 9 and 10 if you are concerned.

These comments were not isolated to one or two respondents, but represent a subset of participants. The comments were voluntarily contributed by Alberta physicians.

We included quotations from Alberta physicians to demonstrate the scale of these harmful attitudes in our provincial workforce. We consulted with stakeholders with these identities about the balance of harm and potential benefit from including these views, but others may disagree with our decision.

If you need support, please call your provincial physician health program or workplace support program. In Alberta, we are fortunate to have the Physician and Family Support Program (1-877-767-4637) and the Employee and Family Assistance Program (1-800-268-5211).

WHAT WE DID

Invited all practicing Alberta physicians to complete an electronic survey in September 2020.

Asked about demographics, work characteristics, leadership roles, academic roles, experiences of harassment & discrimination, perceptions of gender equity, perceptions of racial equity, and measured anti-Indigenous bias.

Analyzed data by demographic groups with an intersectional lens.

University of Calgary REB20-1139

WHAT WE LEARNED

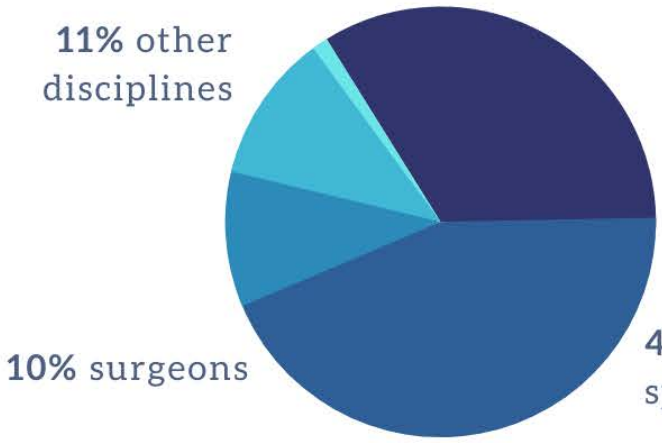
WHO WORKS IN ALBERTA?

9.3% or 1,087 of the 11,688 Alberta physicians completed the census.

WORK CHARACTERISTICS OF PARTICIPANTS

60%

Most participants were affiliated with a University.



PRACTICE LOCATION

68% metropolitan
11% urban
5% large rural
7% rural
2% remote
8% not listed

What is your gender identity?

"Normal man - not sure what the other bullshit terms mean"

"I identify best as 'genderqueer' and I am not open about my gender identity at work"

Do you consider yourself a minority?

"Non-victim, logical realist"

"Older white males are discriminated against in today's society, a change from previous generations"

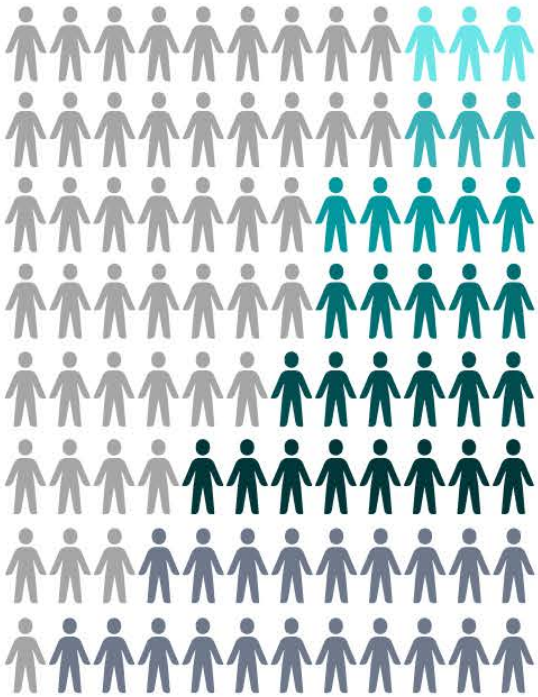
"Being a white South African, you are seen as an apartheid racist - this survey and the world has gone crazy. We all have struggles, deal with it, that is life"

"I am a white passing, religious minority"

WHO IS MISSING?

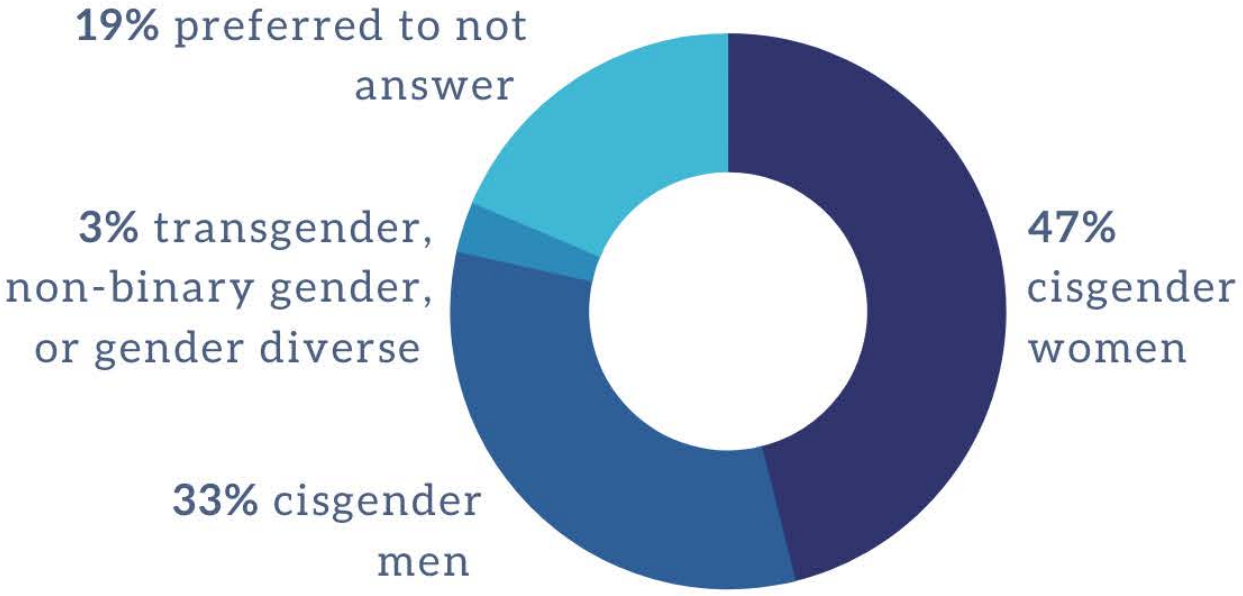
Indigenous physicians are underrepresented relative to their proportion among the general public in Alberta.

RACIAL IDENTITY



*Multiple responses were permitted.

GENDER IDENTITY



*Multiple responses were permitted.

HIDDEN IDENTITY

More than half of transgender, gender diverse & non-binary physicians had not shared their true gender identity at work.

INTERSECTIONAL IDENTITIES

OVERLAPPING DISADVANTAGE

Intersectionality refers to the way identities intersect to produce relative advantage or advantage.
For example, Black women have different experiences than white women and Black men.

28% white cisgender women

14% BIPOC cisgender women

17% white cisgender men

13% BIPOC cisgender men

3% transgender, non-binary gender, or gender diverse

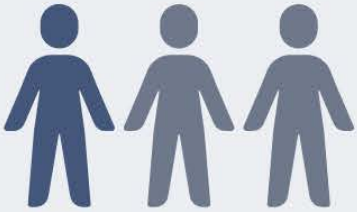
22% preferred to not answer

***BIPOC** refers to Black, Indigenous and People of Colour, a heterogenous group with diverse lived experiences that we grouped together to avoid identification of people in categories with small numbers.

OTHER FORMS OF DIVERSITY

<5%

of Albertan physicians were members of the **LGBTQ2S+ community.**

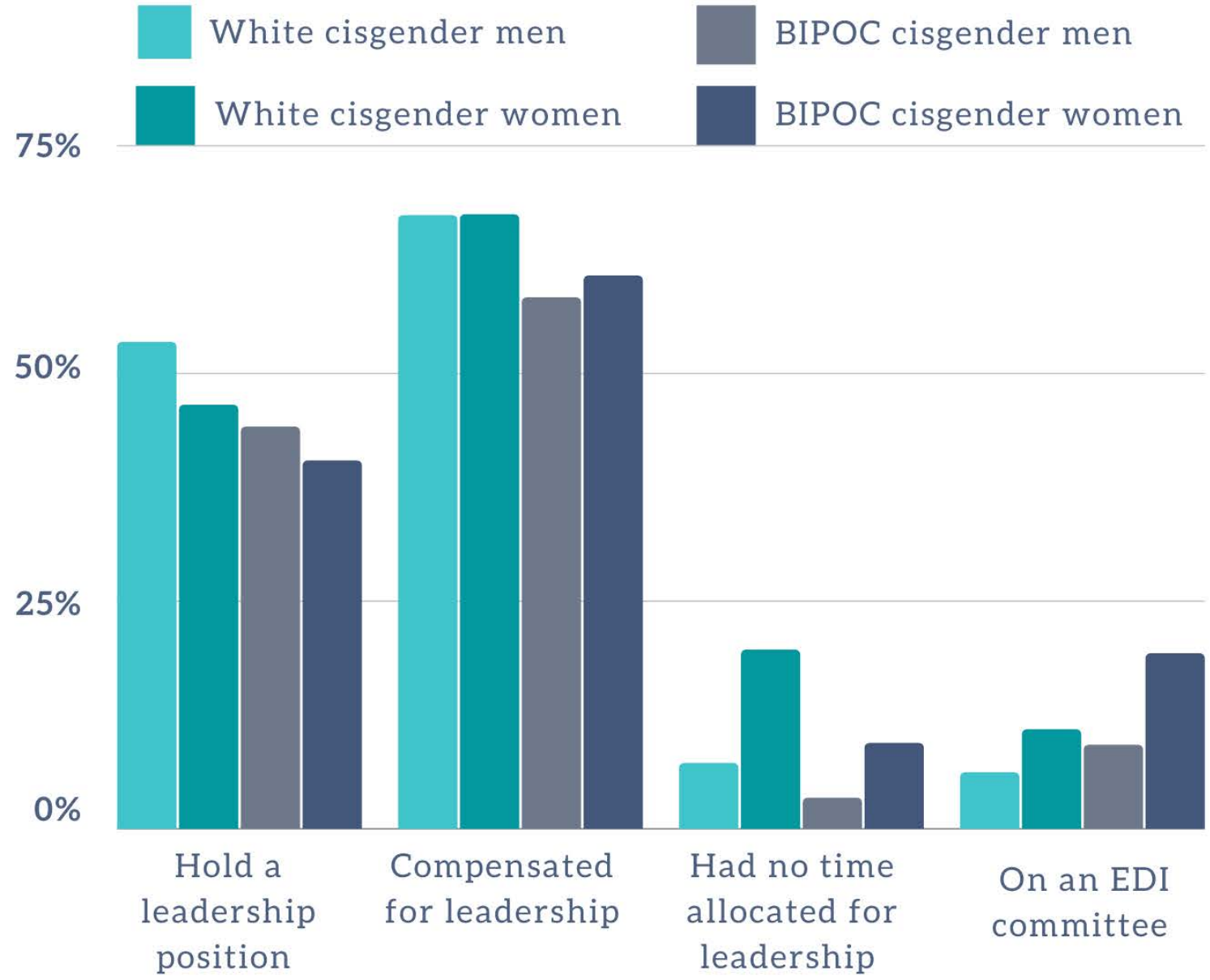


1 in 3

had an other **ability** or **disability**, of which 9% had a mental illness.

WHAT WE LEARNED

WHERE DO THEY WORK: LEADERSHIP



BIPOC physicians

held fewer leadership positions & were less often compensated for their leadership work than white physicians.

Cisgender women physicians

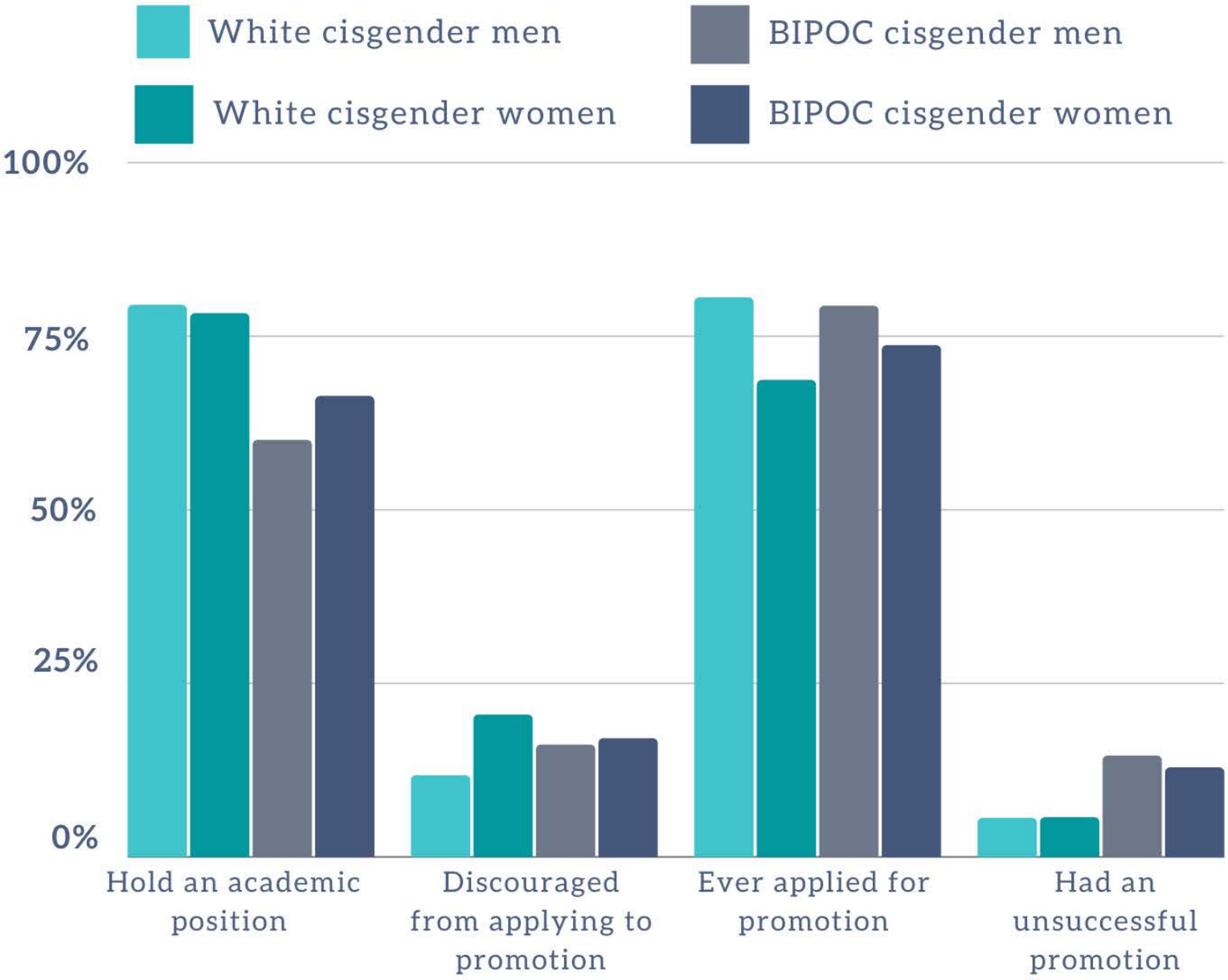
held fewer leadership positions, were less often compensated for their leadership work, and more often had no time allocated for their roles than cisgender men physicians.

BIPOC cisgender women

held the fewest leadership positions & most often served on EDI committees.

WHAT WE LEARNED

WHERE DO THEY WORK: ACADEMIA



BIPOC physicians

held fewer academic positions & were less often successful in their promotion application than white physicians.

Cisgender women physicians

were more often discouraged from applying for promotion and less often applied for promotion than cisgender men physicians.

"We have been subjected to biases which our white colleagues deny ever exist, and shut us down if try raising the issue"

BIPOC physician

"We need to oppose 'social justice' and other harmful manifestations of the critical race theory... I wanted to let you know that your hateful ideology will never win"

white physician

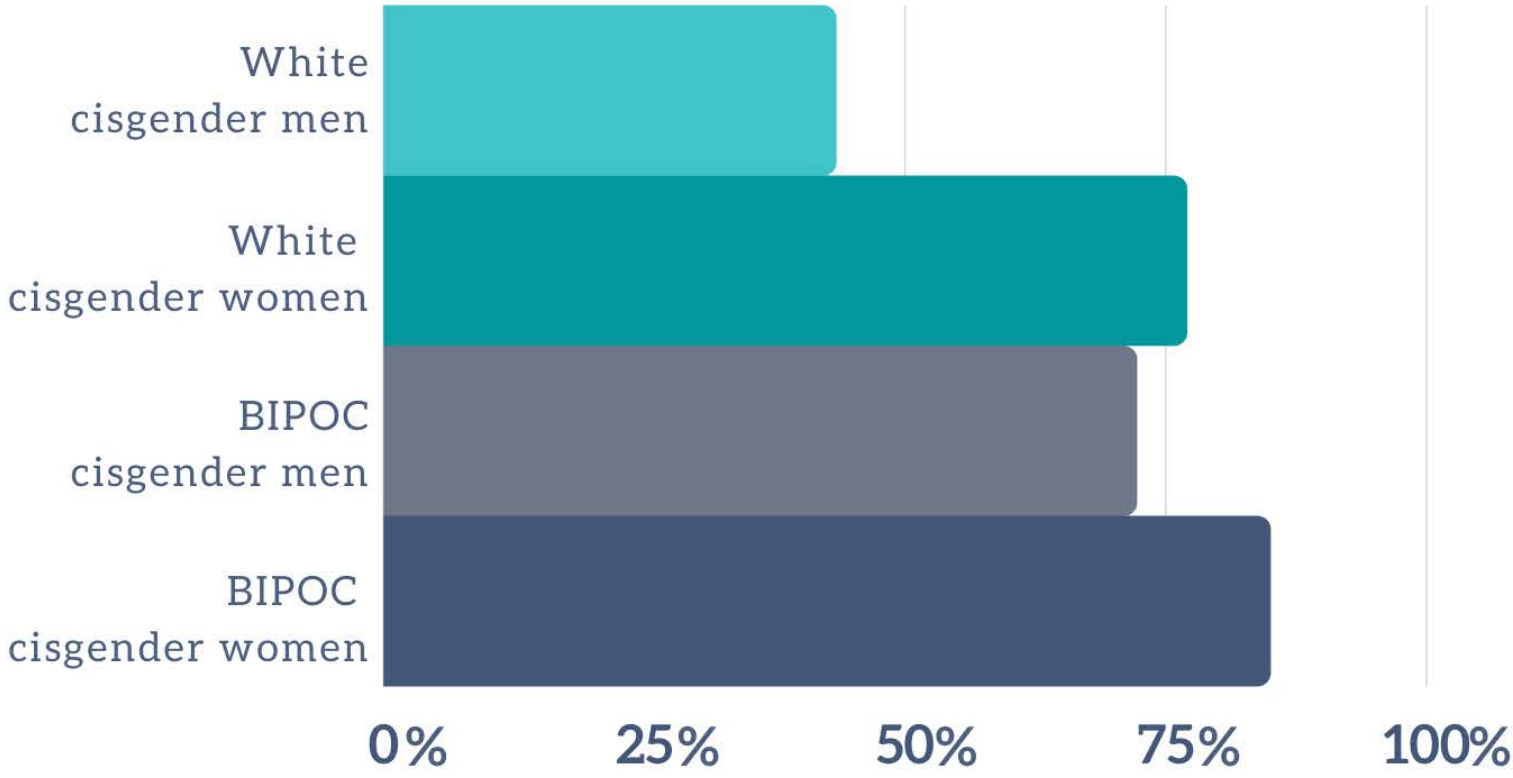
"If we consider just one race, the human race, we'd all be better off"

white cisgender man physician

"Some physicians who are lazy try to use the RACE card so that their inadequacies are not able to be used against them"

white cisgender man physician

WHAT WE LEARNED
HARASSMENT & DISCRIMINATION



DIFFERENT EXPERIENCES

70% of physicians had experienced harassment or discrimination at work and this differed by identity.

Nearly twice as many BIPOC cisgender women had experienced workplace harassment and discrimination compared to white cisgender men.

HARASSMENT REPORTING

1 in 3

of Alberta physicians **did not know where to report** workplace harassment & discrimination, including **over 50% of BIPOC cisgender women.**

24% had reported workplace harassment & discrimination.

26% were satisfied with the outcome of reporting, most often due to **lack of outcome** and **retaliation.**

"I have been hearing racist remarks since I was a medical student, and I'm exhausted"

Indigenous cisgender woman physician

"The way other physicians and nursing staff treat Indigenous patients is scary. They are not healthcare providers, they are a group of criminals working in a hospital"

BIPOC cisgender woman physician

"Our Indigenous patients very commonly play the race card and treat white healthcare workers in a very racist manner"

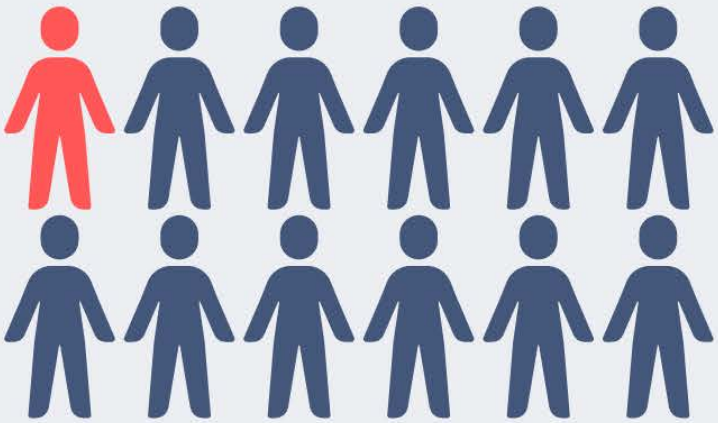
white cisgender man physician

"Because I have white skin, I am guilty of residential schools, slavery, and I am to be punished by having less chance to get a leadership position"

white cisgender woman physician

WHAT WE LEARNED
ANTI-INDIGENOUS BIAS

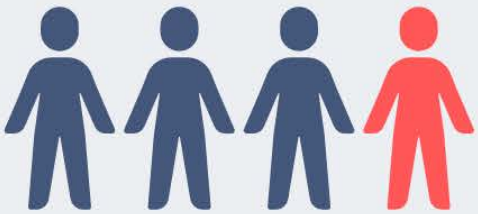
EXPLICIT ANTI-INDIGENOUS BIAS



1 in 12

Alberta physicians **felt cold toward Indigenous people.**

25% Alberta physicians **preferred white people to Indigenous people.**



IMPLICIT ANTI-INDIGENOUS BIAS

Overall, Albertan physicians had **moderate implicit preference for European faces.**

LESS BIAS

Younger physicians
Academically affiliated
Working in remote settings.

STRONGER BIAS

Older physicians
Not academically affiliated.
In large rural and urban settings.

RECOMMENDATIONS

MEASUREMENT

1. Update questions about sex and gender identity.

Current registration data does not reflect the true diversity of the workforce and reinforces false binary understanding of sex and gender.

Sex and gender identity should be collected separately, using contemporary, sensitive wording.

Physicians should have the option to conceal their sex or gender identity from public dissemination.

2. Co-ordinate data collection on physician identity.

Data collection allows monitoring for trends and identification of gaps in representation.

These data should include the diversity of physicians in leadership and academic roles and should include compensation data.

These data should be reported publicly to ensure accountability.

3. Monitor the demographics of physicians and patients involved in complaints.

Patients from marginalized group have greater prevalence of adverse events and are more likely to experience discrimination from healthcare providers, but it is not know if these groups are similarly overrepresented amongst complainants.

Relative underrepresenation may hint at inaccessibility in the complaint process.

4. Adopt evidence-based methods for addressing diversity gaps.

Data collection allows monitoring for trends and identification of gaps in representation.

These data should be reported publicly to ensure accountability.

RECOMMENDATIONS

LEADERSHIP

1. Adopt evidence-based strategies to reduce homogeneity in leadership.

Successful strategies, including mentorship dyads, quotas, and opt-in selection, can be used to diversify leadership.

Selection criteria should include a demonstrated understanding of EDI concepts, evaluated by people with lived experience or expertise.

2. Standardize compensation and resources for leadership positions.

Identify and universally apply criteria for leadership appointments that will receive time and financial compensation.

Monitor resource allocation disparities for physicians from marginalized demographics.

ACADEMIA

1. Adopt evidence-based strategies to reduce disparities in promotion.

Opt-in promotion selection, group promotion mentorship, and pre-specified and transparent criteria for promotion reduce disparities in other settings.

RECOMMENDATIONS

HARASSMENT & DISCRIMINATION

1. Address evidence-based barriers to reporting harassment & discrimination in Alberta.

Knowledge of how to report harassment & discrimination and satisfaction with current reporting is low.

Participants identified lack of supportive leadership, low literacy for recognizing racism and other forms of discrimination, lack of anonymity, retaliation and lack of perceived effect of reporting as key barriers.

Physicians require an anonymous mechanism to report harassment that covers the spectrum of harassment and discrimination seen in practice, from microaggressions to assault. This mechanism should focus on remediation for perpetrators and protection for complainants.

2. Provide training for leaders in accepting reports of harassment.

The majority of physicians who had reported harassment were not satisfied with the outcome of reporting. Many of the written comments spoke to perceived dismissal or lack of sensitivity by the leader that they had reported to.

3. Adopt a "just culture" approach to addressing harassment & discrimination.

A "just culture" approach centres that physicians are people who do their best but make mistakes. This approach reduces defensiveness and creates space for growth, learning, and structural change.

4. Tie remediation of harassment & discrimination to physician work.

Participating in an inclusive, culturally safe workplace is a core competency of physicians, and should be treated as such. Demonstration of remediation for complaints of harassment and discrimination are a prerequisite for treating patients.

RECOMMENDATIONS

ANTI-INDIGENOUS BIAS

1. Acknowledge the presence of interpersonal anti-Indigenous bias among Albertan physicians.

Albertan physicians must take ownership for their role in the racism, colonialism, and oppression of Indigenous people and communities.

This racism leads to worse health outcomes, including death, for Indigenous patients.

The explicit, anti-Indigenous bias expressed by Albertan physicians must be confronted by senior leadership, which starts by acknowledging its existence.