



SASKATCHEWAN
HUMAN RIGHTS
COMMISSION

**The Case for a Restorative Response to Perceptions
of Systemic Inequity at the University of
Saskatchewan College of Medicine: A Systemic
Investigation Summary Report**

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1. Chief Commissioner's Message

For nearly a century, many of Saskatchewan's physicians and other medical professionals have been educated at, or received training through, the College of Medicine at the University of Saskatchewan and its predecessor, the School of Medical Sciences. In addition to its educational mission, the College conducts critical medical research, and is fully embedded in our province's health care system. The College has contributed greatly to the well-being of all Saskatchewan citizens.

In 2020, a group of physicians provided a contrasting view, sharing their concerns about racism and inequity in the medical profession, and in Saskatchewan's medical education system, with the College of Medicine at the University of Saskatchewan.

In turn, the University of Saskatchewan College of Medicine began to address these concerns. Their efforts included initiating a conversation with the Saskatchewan Human Rights Commission. The Commission encouraged the College of Medicine to work closely with students and physicians and hear what they had to say.

At the College's invitation, the Commission initiated an independent, systemic investigation and stakeholder engagement process. Addressing inequity and discrimination is part of the Commission's legislated mandate, as described in *The Saskatchewan Human Rights Code, 2018*.

This report, as a summary of that open and constructive process, is one step in a larger systemic effort. The Commission is committed to collaborating with stakeholder groups through multiparty discussion to respond to, address, and remove inequity and systemic barriers experienced by students, faculty, and staff in the College of Medicine and, in turn, positively affect the wider health care system in our province. In effect, this report represents an opportunity to advance medical education in a way that ultimately benefits the people of Saskatchewan.



Barry Wilcox, K.C.
Interim Chief Commissioner

2. Introduction

In 2020, in the aftermath of the murder of George Floyd, and against the backdrop of the first year of the COVID-19 pandemic, the world's attention was firmly fixed on racial inequity – not just in justice systems, but across all of society. In the profession of medicine and across health care systems, the concerns of Black Canadians were prominently discussed. In Saskatchewan, the College of Medicine at the University of Saskatchewan was prompted to action by concerns raised by its students, alumni, faculty, and staff.

Part of the College of Medicine's response was to engage in a dialogue with the Saskatchewan Human Rights Commission about human rights and the College's responsibilities under *The Saskatchewan Human Rights Code, 2018* (the Code).

As a result of these discussions, the College of Medicine invited the Commission to begin an independent and collaborative systemic advocacy process, aimed at affirming the College of Medicine's interest as an equitable learning organization, free from discrimination. That process, undertaken November 2021-April 2022, culminated in this report.

While the genesis of this initiative is in the specific concerns regarding racism, a systemic evaluation of discrimination necessarily invites an intersectional approach, considering the possibility of other inequities and systemic barriers caused by sexism, ageism, and ableism.

This report provides a summary of issues surrounding discrimination at the College of Medicine. It does not seek to exhaustively document incidents of discrimination or mistreatment, but rather to gather and synthesize the concerns raised by students, staff, faculty, and others.

The Commission considers this work to be the beginning of a process of improvement. Further collective efforts are required to achieve the goal of eliminating systemic discrimination.

The Saskatchewan Human Rights Commission

The Saskatchewan Human Rights Commission is mandated to forward the principle that every person is free and equal in dignity and rights without regard to religion, creed, marital status, family status, sex, gender identity, sexual orientation, disability, age, colour, ancestry, nationality, place of origin, race or perceived race, or receipt of public assistance. The Code prohibits discrimination based on these personal characteristics. Discrimination in specific areas of social life, including in education and employment, which contravenes the Code, is illegal. The Saskatchewan Human Rights Commission is required to respond to individual as well as systemic complaints of discrimination.

What is systemic advocacy?

Discrimination is any unfair action, policy, or practice that puts a person or group at a disadvantage by treating them differently from others, or by applying the same rule to everyone, resulting in a person or group being unjustly denied opportunities or receiving

fewer benefits in what are often called the social areas of life (e.g., education, employment, housing).

Discrimination can flow from prejudice, negative stereotypes, or a failure to consider the needs of others. Sometimes discrimination is deliberate and direct – such as the use of racial slurs, or refusals to employ someone because of their race – but it can also be indirect or unintentional.

The Commission uses systemic advocacy, including multi-party dialogue, to address discrimination and inequity, including differential treatment, policies, rules, or actions that unfairly disadvantage an identifiable group. In short, systemic advocacy addresses systemic discrimination.

Systemic Advocacy through Systemic Investigation

A systemic approach enables the Commission to work collaboratively with stakeholders. The Commission has successfully used systemic advocacy to address inequity and inequality that affects individuals and groups by considering the systems which, sometimes by design, and sometimes unintentionally, create barriers or disadvantages. Through its Equity Programs, the Commission also has the capacity to approve measures that can address disadvantages experienced by identifiable groups.

The Commission’s systemic investigations seek to examine systems to uncover subtle or hidden processes (policies, procedures, and practices – both official and informal) that may be contributing to unfair disparities and discrimination. Once problematic processes are identified, they can be reviewed and revised as required to eliminate and remedy inequity and other barriers. Such an examination also highlights any existing positive processes and notes past and current successes.

Context for this Systemic Initiative

In 2020, Black medical students at the University of Saskatchewan authored “9 Calls to Action” with specific recommendations for addressing structural racism and making the College of Medicine a more equitable learning environment. Other Black medical students and Black physicians across Canada were also speaking out about their experiences.

On August 5, 2020, the Royal College of Physicians and Surgeons of Canada published an online letter by Dr. Adebola Obayan entitled “My Experience with Racial Discrimination in Residency,” wherein he described incidents of racism and mistreatment during his period of medical residency in Saskatchewan.¹

On September 1, 2020, a group of 19 Black and visible minority physicians affiliated with the University of Saskatchewan College of Medicine, motivated in part by Dr. Obayan’s

¹ Royal College of Physicians and Surgeons of Canada, “404 – Broken Link Explanation,” August 10, 2020, accessed December 5, 2022, <https://newsroom.royalcollege.ca/404-error-broken-link-explanation/>. This letter was published only briefly, and the royal college subsequently stated that it “is not in a position to investigate anybody’s allegations, and we therefore removed the letter.”

experiences, wrote another letter demanding changes at the College of Medicine and investigations into allegations of past discrimination and mistreatment.

As part of its response to the students and physicians, the College of Medicine initiated a conversation with the Saskatchewan Human Rights Commission, which, ultimately, led to this systemic initiative.

At the same time, the University of Saskatchewan joined with universities and colleges across the country in October 2020 to discuss anti-Black racism in higher education. This led to the creation of the Scarborough Charter – a framework of principles, actions and commitments aimed at redressing anti-Black racism and supporting Black inclusion.² This effort builds on other initiatives over the past decade, including: Inclusive Excellence Principles by Universities Canada, 2017; Report on Equity, Diversity, and Inclusion by Universities Canada, 2019; Principles on Indigenous Education by Universities Canada, 2015; and the Statement on Equity, Diversity and Inclusion by Colleges and Institutes Canada, 2021.

The Association of Faculties of Medicine of Canada also began a project to improve the culture of academic medicine. A new organization, the National Consortium for Indigenous Medical Education was established in 2021, with a mission to lead reforms that update the education of physicians to ensure Indigenous Peoples have access to culturally safe medical care.

More broadly, for physicians, gaining a better understand of racial discrimination in their areas of practice is consistent with their professional obligations, including “respect for persons,” “justice,” and “inquiry and reflection” as described in the CMA Code of Ethics and Professionalism. For instance, a physician is called to “recognize that social determinants of health, the environment, and other fundamental considerations that extend beyond medical practice and health systems are important factors that affect the health of the patient and of populations.”³

The College of Medicine at the University of Saskatchewan

The College of Medicine at the University of Saskatchewan is the province’s only medical school. It is a complex organization, unique within Saskatchewan. It serves as a primary provider of physicians and physical therapists to the province.⁴

The College of Medicine sits at the intersection of the University of Saskatchewan and the Saskatchewan Health Authority. It furthermore has connections with various professional regulatory bodies and associations, such as the College of Physicians and Surgeons of Saskatchewan. Through its undergraduate and post-graduate medical programs, the College of Medicine places medical students and residents into more than 20 clinical sites

² For more, see: <https://www.utsc.utoronto.ca/principal/scarborough-charter>.

³ Canadian Medical Association, *CMA Code of Ethics and Professionalism*, December 8, 2018, accessed December 5, 2022, <https://www.cma.ca/cma-code-ethics-and-professionalism>.

⁴ University of Saskatchewan College of Medicine, *The Value of Saskatchewan’s Medical School: A fully delivering USask College of Medicine provides incredible value to our province*, 2022.

across the province. At any given time, the College of Medicine oversees the education of more than 400 medical students and a further 450 resident doctors. As well, the School of Rehabilitation Science is housed within the college, with 120 Master of Physical Therapy students.

However, the College of Medicine is not just a medical school. The College also provides education to more than 900 students in biomedical undergraduate programs and is home to 220 Master of Science and PhD students.

To do all this, the College employs about 500 administrative staff, as well as 150 full-time faculty members. A further 1,850 contracted medical faculty appointees provide teaching, research, and academic leadership.

Over the past twenty years, the College of Medicine, like medical schools across the country, has undergone many changes. This has included explicit acknowledgment of the need for “social accountability” and more deliberate efforts at fostering equity, diversity, and inclusion. For the College of Medicine, this also included major internal changes in response to issues of accreditation.⁵

Within the last two decades, the College of Medicine’s undergraduate medical education program has twice been put “on probation” by the national Committee on Accreditation of Canadian Medical Schools. However, significant restructuring was achieved in response to this and, in 2018, the College of Medicine received “top marks,” meaning that it will not host another visit from the accreditation group until 2025.

Guiding the College of Medicine is its Strategic Plan 2017-2025. The plan articulates a number of strategic directions that are aligned with the pursuit of equity, diversity, and inclusion, as well as anti-racism. Many of the Strategic Directions already contain commitments that relate to the substance of the Commission’s systemic initiative, such as the Indigenous Health Strategic Direction, which includes a commitment to “foster transformative learning experiences to ensure curriculum and practices are delivered in a culturally safe way.”

In 2020, the College of Medicine Policy and Procedure Guidelines were updated to mandate the consideration of EDI factors when developing new policies or reviewing old policies. The College of Medicine also adheres to University of Saskatchewan policies, including the Equity, Diversity, and Inclusion policy, strategy and action plan.

Over the past few years, the College of Medicine has also made investments in anti-racism and EDI through new positions and hires. As well, there are other initiatives underway at the College of Medicine, such as the three-year Anti-Racist Transformation in Medical Education program run by the Icahn School of Medicine at Mount Sinai.⁶

Finally, the Office of Student Affairs has been empowered as a confidential destination for medical student concerns, and similar confidential student support offices exist within

⁵ *Ibid.*

⁶ Leona Hess *et al.*, “Addressing and Undoing Racism and Bias in the Medical School Learning and Work Environment,” *Academic Medicine* 95, no. 12 (2020): S44-S50. Also see: <https://icahn.mssm.edu/education/medical/anti-racist-transformation>.

the college and university for medical residency, physical therapy, population health and biomedical science learners.

Impact of Discrimination

Not all discrimination is blatant or readily apparent. In some cases, “low-level” incidents of discrimination can take the form of “microaggressions.” Racial microaggressions, for example, are “brief and commonplace daily verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults toward people of color”.⁷ These types of incidents may accumulate and cause psychological and emotional harm, especially when combined with other forms of discrimination.

Intersectionality

Individuals and groups are more than any single personal characteristic they possess (e.g., race or perceived race). Every person’s identity is influenced by the culmination – or intersection – of several personal characteristics or identities (e.g., age, gender, disability). This is the idea of “intersectionality.”⁸ In turn, an individual or group may experience discrimination based on the intersection of prohibited grounds such as sex (“sexism”), disability (“ableism”), or age (“ageism”). From a human rights perspective, intersectionality provides a more fulsome understanding of “stereotyping, prejudice, discrimination, and social oppression” toward people based on their sex/gender, ability/disability, or age.⁹

On “race” and discrimination

The idea of “race” as a social and cultural concept has deeply influenced the function of societies. There have been many pseudoscientific attempts to define and validate “race,” and racial differences, and to subdivide humanity into distinct groups according to common, and often superficial, physical traits. Such efforts have been tied to the rise of modernity and a worldwide political economy.¹⁰

Moreover, the “selection of these particular human features for purposes of racial signification is always and necessarily a social and historical process.”¹¹ The concept of race continues to be a powerful force; its power derives entirely from its social and political construction, not in biological truth.

7 Derald Wing Sue *et al.*, “Racial Microaggressions in Everyday Life: Implications for Clinical Practice,” *American Psychologist* 62, no. 4 (2007): 271.

8 Kimberlé Crenshaw, “Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Anti-discrimination Doctrine, Feminist Theory and Antiracist Politics,” *University of Chicago Legal Forum* 1989, no. 1 (1989): 139-167.

9 Annette Bogart *et al.*, “Ableism Special Issue Introduction,” *Journal of Social Issues* 75, no. 3 (2019): 650-664; and: Sara Mills, *Language and Sexism*, (Cambridge: Cambridge University Press, 2008).

10 Howard Winant, “Race and Race Theory,” *Annual Review of Sociology* 26, no. 1 (2000): 172.

11 Howard Winant, “Race and racism: Towards a global future,” *Ethnic and Racial Studies* 29, no. 5 (2006): 999.

Over the last century, scientists and scholars closely examining the idea of race have concluded that the use of race as a biological classification is an inaccurate and misleading way to account for human genetic variation.¹² Today, many scientists call for an end to the use of race terminology in human biological and genetic research, even where its use is seemingly benign.¹³

Despite its lack of scientific basis, the concept fuels “racial essentialism” – the incorrect belief that “individuals of the same racial category are biogenetically similar; and that different races are fundamentally different”¹⁴ (e.g., all persons of a particular racial group act the same way: “all x are lazy/smart”). Racial essentialism can cause people to perceive members of other racial groups as less worthy. Indeed, research shows that holding racial-essentialist beliefs correlates to “dehumanization of and heightened discrimination against racial outgroups and is actually a causal factor in increased racial prejudice.”¹⁵ Acts motivated by racial prejudice, whether intentional or not, are commonly referred to as “racism” and “racial discrimination.” Many societies struggle with individual, structural, and systemic racism, where the ideas of racial essentialism permeate culture and institutions.

Racism causes actual harm to individuals and groups. In addition to physical and emotional harms, the impact of lost educational, employment, and social opportunities creates long-lasting and ongoing harm across generations. In all its forms and consequences, racism is detrimental to the well-being and success of society.

Medical education is necessarily concerned with biology, genetics, and differences among populations of human beings. Terminology rooted in race-based ideology and racial essentialism has proliferated through medical curriculum and into medical practice, and consequently racial essentialism may also be present in physician training and needs to be uprooted.¹⁶

To be clear, racial essentialism has no objective basis in genetics or biology. Indeed, after many years of research, the United Nations Educational, Scientific and Cultural Organization declared definitively that:

Any theory which involves the claim that racial or ethnic groups are inherently superior or inferior, thus implying that some would be entitled to dominate or eliminate others, presumed to be inferior, or which bases value judgments on racial differentiation, has no scientific foundation and is contrary to the moral and ethical principles of humanity.¹⁷

Human rights in Canada, and internationally, reject the concepts of race and racial essentialism as fundamental truths about humanity. Instead, the world community

¹² Jessica Cerdeña *et al.*, “From race-based to race-conscious medicine: how anti-racist uprisings call us to act,” *Lancet* 396, no. 10258 (2020): 1125.

¹³ Michael Yudell *et al.*, “Taking race out of human genetics,” *Science* 351, no. 6273 (2016): 564.

¹⁴ Jennifer Tsai, “How Should Educators and Publishers Eliminate Racial Essentialism,” *AMA Journal of Ethics* 24, no. 3 (2022): 201.

¹⁵ *Ibid.*

¹⁶ *Ibid.*, 202-206.

¹⁷ UNESCO, “Declaration on Race and Racial Prejudice 1978,” UNESCO General Conference, 27 November 1978, Article 2(1).

recognizes the inherent dignity and equal rights of all members of the human family.¹⁸

Despite the scientific assurances that race does not exist, the social and political power of the concept of race continues to impact people and societies. As such, there is a need for social and legal prohibition of racism and racist actions. Human rights laws prohibit discrimination on the basis of race, meaning that race is a personal characteristic that cannot be used to treat another person inequitably (also referred to as a prohibited ground).

Race, as a social and political construction, is operationalized through the process of “racialization,” wherein different races are established “as real, different and unequal in ways that matter to economic, political and social life.”¹⁹ People within society can then be described as “racialized.” All people are racialized through this process, including “white” people. As the term racialized retains the implicit acknowledgement that race is a social and political construct, it may be preferred to terms such as “visible minority” or “racial minority.”²⁰ In this report, these terms are used to describe persons who experience racism.

Eliminating Discrimination in the Workplace and in Education

Different approaches have been developed to address and eliminate discrimination in the social areas of life. The prohibition on racial discrimination in employment in *The Saskatchewan Human Rights Code, 2018*, for example, is one such approach. A legislated prohibition on discrimination, by itself and without social and workplace engagement, cannot fully remedy the accumulated negative impacts of racism on groups of people.

Organizations and employers frequently adopt and implement practices and methods to reduce and remedy discrimination systemically. These approaches, each with their merits and limitations, such as Equity, Diversity and Inclusion (EDI)²¹, anti-oppression, and anti-racism programs. Another approach known as “employment or education equity,” is designed to prevent, reduce, or eliminate disadvantages that people experience based on characteristics protected by human rights legislation, such as race, sex, and disability.²² Many of the core concepts of employment equity in Canada were laid out in the *Report of the Commission on Equality in Employment*²³ in 1984. The Saskatchewan Human Rights Commission has established a formal employment equity program for employers (See Appendix 3).

18 See: United Nations General Assembly, “Universal Declaration of Human Rights (1948),” General Assembly Resolution 217A.

19 OHRC, *Under Suspicion: Research and consultation report on racial profiling in Ontario*, 15.

20 For this reason, the Ontario Human Rights Commission has used the term “racialized” in their report *Under suspicion: Research and consultation report on racial profiling in Ontario*, 2017.

21 Equity, Diversity, and Inclusion (EDI) programs (also called Diversity, Equity, and Inclusion (DEI) programs), are sets of practices and policies that seek to address and remedy historical exclusions from a workforce. EDI programs employ a broad range of techniques, but sometimes include preferential hiring based on specific prohibited grounds (e.g., disability, Indigenous identity, and gender). While preferential hiring practices typically contravene human rights legislation, they are permissible when implemented in accordance with specific terms.

22 See: Sections 55 and 56 of *The Saskatchewan Human Rights Code, 2018*.

23 Rosalia Abella, 1984, *Report of the Commission on Equality in Employment*.

Working to eliminate discrimination and create more equitable workplaces requires uncovering and addressing root causes. This requires information. Most universities have limited demographic data about the composition of the classrooms, the statistics that point to successes of students (and student population groups), and the real numbers of visible minority students dropping or stopping out.

It is clear that Canada has a diversity problem in medicine, which is compounded by the fact that we simply don't collect good data. Our best estimates in medical school programs suggest that some groups—East and South Asians—are overrepresented relative to their population and that Black and Indigenous people remain woefully underrepresented.²⁴

Understanding the intrinsic equality and value of all human beings is fundamental. Lack of such awareness impedes academic success, the transition from student to physician, the valuing/devaluing of physicians, and, ultimately, the lives and well-being of physicians and patients alike.

Racial Discrimination in Health Care in Canada and Saskatchewan:

Selected Incidents

- On May 21, 2020, Samwel Uko, a 20-year-old Black Canadian, sought emergency care for a mental health issue at the Regina General Hospital. He was removed from the hospital, without being triaged or receiving care, and was later found dead in Wascana Lake.²⁵
- On September 28, 2020, Joyce Echaquan, a 37-year-old Atikamekw woman, died in the Centre hospitalier de Lanaudière in Saint-Charles-Borromée, Quebec, having been subjected to verbal abuse. Racism and prejudice were contributing factors in her death.²⁶
- In July 2017, the Saskatchewan Health Authority offered an apology after an independent report described the experiences of Indigenous women who were coerced into tubal ligation procedures within the Saskatoon Health Region.²⁷

24 Arundhati Dhara, "Our complicit role in systemic racism," *Canadian Family Physician* 66, no. 8 (2020): 596-597.

25 For recommendations relating to this incident see: Saskatchewan Coroners Service, "Extract from Jury Report respecting the death of Samwel Taban Uko," Saskatchewan Coroners Service, June 3, 2002.

26 Géhane Kame, "Investigation Report: concerning the death of Joyce Echaquan," Bureau de coroner du Québec, 2020.

27 Yvonne Boyer and Judith Bartlett, "External Review: Tubal Ligation in the Saskatoon Health Region: The Lived Experience of Aboriginal Women," 2017.

- On September 20, 2008, Brian Sinclair, a 45-year-old Indigenous man from the Fort Alexander First Nation, died at the Health Sciences Centre Emergency Department in Winnipeg, Manitoba, having waited for 34-hours without assessment or treatment.²⁸
- Inquests were launched into the deaths of Mr. Uko, Ms. Echaquan, and Brian Sinclair, and each of the subsequent official reports found racism to be a factor in their deaths.²⁹
- The 2015 report of the Truth and Reconciliation Commission of Canada and the 2019 report of the National Inquiry into Missing and Murdered Indigenous Women and Girls have further documented anti-Indigenous discrimination within Canada’s healthcare systems.³⁰
- The Truth and Reconciliation Calls to Action specifically ask medical and nursing schools to provide training in intercultural competency, confliction resolution, human rights, and anti-racism.³¹

3. The College of Medicine Systemic Initiative

For this systemic initiative, the Commission began by gathering information regarding racial discrimination in the health sector. This included reviewing recent academic research and reports from Canadian jurisdictions. A list of consulted works is appended to this report.

As a stakeholder-based process, the systemic investigation required conversations with students and faculty – both medical and non-medical – as well as staff, recent graduates, alumni and other external stakeholders (see Appendix 2, list of stakeholder affiliations). The daily experiences for people associated with the College vary considerably, including between medical students and non-medical students, resident learners and non-medical post-graduates, and faculty and staff of all types. The personal background of every person varies considerably too by gender, race, religion, ability, and place of origin. It was important to seek to capture as many diverse types of experiences as possible, within the constraints of the initiative.

Beginning in November 2021, more than 50 conversations with stakeholders occurred, in both one-on-one and in small group settings. These were conducted via remote videoconference. Each conversation lasted 1.5 hours and took the form of a free-flowing discussion based around a common set of questions. In some cases, where needed, further follow-up discussions occurred. Those interviewed included persons with specific or unique

²⁸ Timothy J. Preston, “Inquest Report for Brian Lloyd Sinclair,” 2014.

²⁹ See: Saskatchewan Coroners Service 2002, Kame 2020, and Preston 2014.

³⁰ See *Reclaiming Power and Place: the Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls*.

³¹ See Call to Action #24 in: Truth and Reconciliation Commission of Canada. 2015. *Truth and Reconciliation Commission of Canada: Calls to Action*. Winnipeg: Truth and Reconciliation Commission of Canada.

expertise, as well as those charged with representing student or professional bodies. The interviews were recorded, transcribed, and analyzed for themes and trends.

At the same time, the Commission also collected and reviewed documents provided by the College, members of the College community, and other stakeholders. This included statistical information, information on mistreatment reporting, and a recent college survey. We also reviewed college policies, strategic documents, and publicly available information.

As well, the Commission used an open online survey to gather information from persons connected to the College of Medicine. Forty-four people chose to provide information about their experiences and observations via the survey.

Finally, some stakeholders also engaged the Commission in dialogue via email. During this correspondence, stakeholders provided personal information about their experiences at the College of Medicine and in the medical profession.

Participants were assured of confidentiality throughout the process. As such, most remarks noted throughout this section of the report do not identify the originator.

Stakeholder Experiences and Views

Participants provided rich qualitative data, including detailed information about direct personal experience. While individual experiences varied considerably, there were areas of significant overlap and agreement. On several topics, themes emerged from the discussion where different stakeholders recounted similar experiences. These themes are distilled into topics below and include issues relating to Anti-Black and Anti-Indigenous racism, as well as other forms of racial discrimination, gender bias, and ableism.

In general, the incidents most often discussed had affected stakeholders' personal sense of trust and safety within the College of Medicine or with the profession of medicine.

It was not the aim of this initiative to conduct a formal investigation into specific allegations. However, it is important to note that, in several cases, the allegations relayed were specific enough that they could have potentially sustained formal human rights complaints in accordance with the requirements of *The Saskatchewan Human Rights Code, 2018*. These types of experiences tended to appear in situations where there already existed mistrust, miscommunication, absence of communication, and missed opportunities to resolve disputes earlier or lack of confidence in complaint-resolution processes.

While most of the negative experiences stakeholders related would not, in and of themselves, likely rise to the level of a human rights complaint, they could still constitute violations of the College of Medicine harassment policies. At the very least, stakeholders reported experiences that contributed to negative work and learning environments and reduced productivity.

Finally, some people also reported having no notable negative experiences.

The selection of quotations throughout this section of the report were selected from interviews or from survey comments to highlight aspects of the common themes. They were provided by stakeholders on a confidential basis. Often, the particular sentiment or point expressed was repeated by more than one participant.

Racial discrimination

Individual students, faculty, and staff provided the Commission with personal stories that described instances of racial discrimination, ranging from offensive comments to overt acts of discrimination that negatively impacted their academics or ability to study and/or work. People who reported experiencing discrimination often described a series of incidents – not just one occurrence. In some cases, these experiences were described as “microaggressions,” which primarily took the form of direct, verbal remarks. Black, Indigenous, and other students, faculty, and staff who experienced multiple instances of microaggressions or other discrimination were more likely to describe racism as pervasive institutional phenomena.

For me, as a student, I’ve had multiple encounters. Whether it’s someone making a joke about a person of color, or someone saying things to me directly about my skin color or my ethnicity. I often times feel silenced.

Honestly, like it was a pretty small incident, but it had been repeating over and over ... making weird comments about my skin tone.

Several people described instances in the past when faculty used outdated or derogatory terminology, such as “Orientals,” as well as racist slurs, including the “n” word. Several other people described faculty-led discussions of race and racism which were handled poorly, and included the use of racial slurs, which led to discomfort and distress.

In some of these instances, students felt unable to respond freely or to leave. In other cases, faculty did not respond positively to student feedback. Following these incidents, students reported feeling distress. These incidents also had lasting impacts on their professional careers.

I was initially interested in the general field that [this physician] was in, but I intentionally did not seek out that elective opportunity for fear of having [them] as a potential preceptor.³² So, I avoided that. Maybe in a perfect world I would have wanted to do that elective, but I completely cut that off because I don’t want to deal with that.

The College of Medicine UGME Office of Student Affairs (OSA) Mistreatment Report for 2020-2021 identified 3 cases where students reported being subjected to racially or ethnically offensive remarks/names. There were no reports of being denied opportunities for training based on race or ethnicity. As such, for 2020-2021, mistreatment related to race amounted to approximately 5% of the total mistreatment reported.³³ However, in discussion with the Commission, some students described incidents they said had not been previously reported, formally or informally.

³² A “preceptor” is an experienced medical practitioner who provides supervision during clinical practice and facilitates the application of theory to practice for students and staff learners. <https://www.dal.ca/faculty/health/practice-education/for-students/what-is-a-preceptor-.html>

³³ Office of Student Affairs, “Mistreatment Report 2020-2021,” 12.

The College of Medicine has a policy on professionalism, in compliance with its accreditation requirements, that aims to ensure its learning environment is conducive to the ongoing development of appropriate professional behaviors in its medical students, faculty, and staff. Significant lapses of professionalism may constitute sufficient grounds for removal from the program, regardless of performance in other aspects of the curriculum. Some students reported that they felt the obligations of professionalism prevented them from responding to situations honestly, from voicing disagreement, or from making complaints about matters which they found discriminatory. Students reported that the fear of getting a “professionalism strike” against them was much worse than other academic failings.

The threat of getting a professionalism strike against you is a constant threat at the back of your mind.

In the course of their career, faculty can also find it difficult to advocate on their own behalf and experience similar professionalism pressures as students. Some racialized faculty and staff have felt alone and misunderstood when trying to call attention to bias or discriminatory practices.

Some stakeholders felt that they were subjected to excessive scrutiny and criticism because of their race. For students, some reported experiences where some preceptors were more critical of students of colour. In some situations, the students described this treatment as stark and obvious, while in others they said it was subtle.

I do believe that if I made one mistake, I'll be dragged with it. I have to be perfect all the time. And that's how we survive. That's what others have told me in this college: don't make a mistake! Don't fail anything. You have to be perfect. Just look and see the difference in promotion decisions and you'll see that it's a lot of brown people and a lot of black people who repeat.

Students wanted staff and faculty to have a better understanding of race issues and to avoid making inappropriate comments and committing other microaggressions.

I'm a respectful student. I know how to have a dialogue with you. I'm open to dialogue and conversation, but when you shoot me down because you don't have the courage to have difficult conversations about race, about sex, about religion, then I think you're just hiding under the covers of your authority.

For some students, especially those born or raised in another country, the cultural mores and customs of the western profession of medicine were sometimes difficult to navigate. Students wished for the practice of medicine to be more universally accepting of diverse cultural behaviours and approaches.

You just get that feeling of not belonging in that environment and just standing out and feeling more like a minority and not being understood in terms of like where you come from ... It is isolating, not feeling like I belong, not feeling I am understood.

In my case it's mostly a case of different standards being applied to other students, and different standards being applied to international students ... Other students aren't expected to be as proficient, or as composed, or as good at giving seminars as we are as internationals. We are held to a higher standard and if we don't meet that standard, then we are scrutinized heavily.

Some stakeholders reported observing racist attitudes and actions across the health care system in Saskatchewan.

[1] have witnessed colleagues make discriminatory comments about patients (colleagues with teaching appointments).

Specific experiences of discrimination were also described as resulting from overlapping (intersectional) prejudices and biases, including race, gender, place of origin, and disability.

In my years working as a medical student and then as a practicing physician in Saskatchewan, I have experienced and witnessed discrimination. I have experienced and observed discrimination towards women in the medical field and towards Indigenous patients in the emergency department.

Gender discrimination

The College of Medicine UGME Office of Student Affairs (OSA) Mistreatment Report for 2020-2021 identified four incidents where students alleged being subjected to offensive sexist remarks/names. There were no reports of receiving lower evaluations/grades based on gender.³⁴ Several students described a situation involving sexual harassment from an instructor. Students agreed that college administration took swift and appropriate action in that case.

In conversations with the Commission, some students reported hearing sexist jokes or comments from faculty. Female students reported additional hurdles to success in certain specializations.

Male surgeons telling female students interested in surgery: "Don't expect your male colleagues to pick up your slack when you have kids and go down to part time." Being told surgery "isn't good for women."

While the number of female students has increased steadily over time, many people had the impression that gender parity had not yet been reached in faculty and senior leadership.

In my experience, female population was 50% in undergrad, and 50% in grad school. It still looked to me like 50% in postdoc. But then you get to faculty and it was like 10%. And the dirty little secret is that hasn't changed much in 50 years.

34 *Ibid.*

Some women reported seeing significant improvement in the treatment of women within the profession of medicine over the duration of their careers. Some stakeholders pointed out that there were a large number of female faculty and college staff.

However, some women students, staff, and faculty reported the continued existence of negative gender stereotypes. Specific obstacles to career success were attitudes regarding childrearing and policies regarding maternity and parental leave. Several women also reported difficulties in being treated respectfully in leadership roles. One described regular apprehension about “being labelled a bitch” when being decisive.

Gender Identity & Sexual Orientation

While issues of gender identity and sexual orientation were not the primary area of inquiry, during the discussions a number of people self-identified as lesbian or gay. Some participants were unsatisfied with the LGBTQ content in the medical undergraduate curriculum.

I am frustrated that our queer education takes the shape of two lectures in the first year, and then just a couple of things that pop up along the way. Like this case in our OSCE: “Wow, it turns out this student is gay. Wow, they must have a mood disorder” – that sort of thing.

The participants suggested that these issues had been identified, and that efforts to improve them were underway.

Other participants noted that perceptions about sexual orientation had changed over time in Saskatchewan and across the country, and they no longer considered their sexual orientation to be a significant factor in their experiences at the College of Medicine.

Ableism

We heard from some people who felt discriminated against due to disability. Students reported feeling that the profession of medicine was not very welcoming to people with disabilities, and that accommodations for disabilities were frowned upon and difficult to obtain in some environments. In some cases, students would not report having a disability because of fears of discrimination. Some staff also reported experiencing discrimination due to disability.

I have experienced discrimination, including [being questioned] whether the requested accommodations were necessary, [and] extreme slowness in getting accommodations in place.

Some people called for the greater visibility of issues of disabilities, alongside that of racial and gender issues, including in curriculum and standardized patients.

The College of Medicine doesn’t address anything to do with disabilities or people with disabilities. We talk about race and marginalized groups by gender, but not this.

Diversity

Generally, people believed that the most recent student cohorts were broadly representative of the racial and gender diversity of Saskatchewan.

Many people pointed to the Indigenous Admissions Pathway as a successful program. Some students spoke of the need for a similar dedicated admissions stream for students who self-identify as having African, Caribbean, Black Nova Scotian, and multi-racial Black heritage.

We also want to have a Black medical students stream. It's not either or. It's not Indigenous versus Black. It is these are two ethnic minority groups who face racial discrimination, economic discrimination, and different things. These are two groups that should be addressed in parallel pursuits of total inclusivity.

However, it was often mentioned that there were too few Black, Indigenous, or other persons of colour among staff and faculty or holding leadership positions.

I think it's really important to have more black doctors and more visible minority doctors in to give lectures all the way from our first year through fourth year training.

As well, some people also commented on the lack of women at the senior leadership level. While this varies over time, only about a third of Department/Provincial Heads were women. With the addition of the Vice-Dean Indigenous Health position, the Dean's Executive was also composed of one-third women.

Over the past few years, the number of EDI committees has expanded across departments in the College of Medicine. These activities were generally applauded. In some cases, people reported these committees to be doing particularly good work that has resulted in improvements in the hiring process and in the overall culture of the department. Nevertheless, people indicated that further work was required.

We're all doing this off the corner of our desk, so you know we're making progress slowly, but we're committed to it ... it's an iterative process as we all learn about EDI.

Some stakeholders suggested that the importance of EDI efforts needed to be acknowledged as formal work, and compensated as such.

Stakeholders also reported that it was important to have institutional support for and encouragement of peer networks or groups. Institutional support was requested for small local groups, like the Black Medical Students Association, but also to facilitate connections to provincial or national organizations, like the Canadian Black Scientists Network.

Several stakeholders discussed that a medical student was likely to belong to a privileged socio-economic class – often as the child of a physician – regardless of their gender or ethnic background. Attracting people to the study of medicine from diverse socio-economic backgrounds of all types has proven difficult.

Complaint Processes

In 2016, the College of Medicine revamped its discrimination policies and procedures. Currently, students have a range of reporting mistreatment options, including class and rotation evaluations, the University's Office of Discrimination, Harassment and Prevention, the anonymous ConfidenceLine, and online mistreatment report forms. Students and learners may also contact their Program Director or their program office, access central University of Saskatchewan wellness resources, and (for graduate students) the College of Graduate and Postdoctoral Studies. Students and learners working with clinical partners (including the Saskatchewan Health Authority) may also access reporting and complaint processes of those agencies. OSA provides students services, including mistreatment reporting, to UGME and Physical Therapy students. Medical professionals may seek assistance from employee supports through the College of Medicine, University of Saskatchewan, Saskatchewan Health Authority, the Saskatchewan Medical Association, and other professional bodies.

There are ways for students to report issues anonymously, but in many cases, anonymity may limit the ability to fully address the issue. Currently, there is no system in place to allow for follow-up communication with students making anonymous reports. Complaint processes are similar, but the specifics vary depending on the organization receiving the complaint. For UGME student complaints, for instance, are initially handled by the OSA.

Some students reported using the system and being satisfied with the outcome. However, other students noted that there were limitations to the current system.

I have heard there are multiple situations instances in clinical scenarios where overt discrimination has occurred. And these students have submitted reports – but there has been no follow-up and these students continue to be paired with these preceptors. And there is really no consequence for any of these preceptors.

Incident and mistreatment reporting can also be problematic for people who could potentially be identified, even within the larger College of Medicine population, because of unique and identifying characteristics (e.g., a disability, religious apparel, etc.).

Students continued to have concerns about the power differential between faculty and students.

The power dynamic that exists between a student and a preceptor is huge. We're obviously trying to become like them, and we're trying to respect them, we're trying to be nice to them, and all of this. You know, it's really hard to talk back, or make those concerns heard through the preceptor, without feeling like there's going to be negative repercussions.

We shouldn't be fearful of the consequences of, you know, reporting what happens to us. That makes us feel unsafe and discriminated against.

On the other hand, faculty suggested that medical students are often unaware of the amount of power they have. Some stakeholders suggested that faculty can experience unwarranted difficulties because of student complaints.

Many students commented that the outcomes of complaints were often unknown, and they had no sense, overall, if the process was working.

We generally have no idea what kind of like consequences the other person is going to face ... There's not that much to look forward to for an outcome, because all of that side is completely unclear. And then you have to go through your own obstacles to even get to reporting it in the first place.

There is no way for the student to know the outcome of their complaint. It is confidentially handled between administration and the preceptor. Whereas, for the student, their experience is often very public, in front of their peers. So there is a mismatch here.

For some stakeholders, it was also essential to increase the penalties for discriminatory behaviour.

Statistical information about complaint reporting and outcomes is not readily available across the University of Saskatchewan. But specific programs may have transparency processes, such as the OSA who have begun providing aggregate information on complaint outcomes. Staff suggested they are still pursuing ways to provide better information back to students about the disposition of complaints.

According to the 2020-2021 OSA Mistreatment Report, one-in-five medical students experience mistreatment of some type, but only a small number report the mistreatment.³⁵ A minority of the reported mistreatment experienced by students was related to race or gender. However, based on discussions with students, there is reason to believe that some incidents involving race and gender go unreported.³⁶

There was general agreement among participants that the largest issue with the complaint process was a reluctance to make, or proceed with, formal complaints. Students provided two explanations for this:

1. The time and effort required to pursue a complaint (as medical students are primarily focused on academic success).

There is a reluctance to go forward with reporting and seeing a complaint through because we are all busy. At the end of the day, a complaint takes a lot of time and commitment, and it is easy to rationalize brushing it off and moving on. The effort that is required is sometimes too high.

2. Concerns about the impact on their future career.

³⁵ Office of Student Affairs, *Mistreatment Report 2020-2021*, 12.

³⁶ *Ibid.*

The power dynamic – the differential between the preceptor or doctor and student – is huge. It is really hard to make your concerns known to the preceptor without fearing negative repercussions.

Students also articulated some doubt as to the independence or fairness of the complaint process, with some students feeling administration would tend to play favourites.

Research

For many students and faculty, conducting original research is an essential requirement for career success. As well, research and innovation are a priority for the College of Medicine. Some faculty reported the awarding of research opportunities was unfair:

There is discrimination in the following: rewarding of start-up funds; transparency regarding money available from Graduate studies for researchers; and research mentorship is not equal for people of color as compared to whites.

Others, however, reports improvements in the fairness of research funding over time.

One faculty reported that the requirements for EDI considerations in Tri-Council funding applications could have a beneficial impact on all research activities.

The granting agencies more and more are asking us what we're going to do on EDI, and SSHRC in particular asks for a detailed training plan ... and I think that is a good push for us.

Still, there were reports from some students who felt discriminated against during their research by others at the College of Medicine. In these situations, the students sought to minimize the impact of discrimination by taking extra efforts to involve White colleagues in their work.

If we need anything, we actually ask [our White colleague] to ask him because it usually goes smoother.

Culture

Personal prejudices and biases are often shaped through broad societal processes. Such prejudices and biases are manifested in action or comments that include harassment and discrimination. Biases also influence the development of policies, procedures, and workplace practices. The aggregate outcome can work to sustain the existent cultural preferences to the exclusion of other people. Altogether, these cultural factors can generate and sustain significant inequitable outcomes.

Many stakeholders discussed a variety of concerns about the prevalence of prejudices and biases, often unconscious, among students, staff, and faculty at the College of Medicine and throughout the practice of medicine and healthcare system. Many people recommended education, such as anti-racism and anti-bias training, as a key remedy for these systemic forces.

Right now, we're learning about Indigenous people in our final year. The learning is through online modules that we have to complete. There's sixteen assignments that we have to do. There's no face-to-face discussions. There's no elders coming in to talk to us. It feels like something we're just checking off to do. And then that's it. And it would have been really useful to have this information – in a meaningful way – much earlier on in our education.

It was clear in speaking to staff that the work environments, and sense of safety, differed from department-to-department.

Whether someone feels safe enough in a group to bring up issues relating to EDI, and I have realized that I haven't felt safe to bring it up.

Some staff described different ways that the work culture itself is creating barriers to making improvements in the College of Medicine.

It would be really nice if senior leadership in particular could feel comfortable turning a mirror on themselves, you know, and really unpacking what they are, who they are, what bias they bring, and how they've contributed to the culture that we have.

Making Change

The recent College of Medicine Equity, Diversity, and Inclusion Survey³⁷ showed that the senior leadership perceived the College of Medicine to be broadly safe, fair, and inclusive. However, some survey respondents had notably lower perceptions, especially undergraduate students and those who identified as Indigenous, racialized, or with a disability.

It's interesting to see that the administrative leaders – their sense of belonging, their sense of perception of success, their perception of whether they're included in decision making – they're way happier with those things than staff and students and others.

One participant suggested these results indicate that senior leaders should consult widely and proceed carefully when managing change.

Some participants discussed the burden of fostering change often fell primarily to marginalized and disempowered people.

I've heard a lot of accounts of students who are from discriminated-against or marginalized backgrounds that they are the ones who have to put in the extra work to make things better. And then that takes away from things like studying or working on other skills that students with more privileged. You have the choice of working on EDI stuff or you can do really well on exams or in clinical.

³⁷ USask College of Medicine, *College of Medicine Equity, Diversity, and Inclusion Survey: College-Level Report, March 2022*. See: <https://medicine.usask.ca/about-us/edi.php#EDISurvey>

Furthermore, there was concern that leading or participating in EDI efforts was not fully acknowledged as worthwhile and important work.

Data and Reporting

The University of Saskatchewan and the College of Medicine captures information about students, staff, and faculty through a variety of data-collection processes. Currently, most demographic data about race or disability is self-declared, and detailed demographic information is limited.

Stakeholders reported that there is a need to improve the existing set of demographic data about students, staff, and faculty in order to make the information more meaningful and useful.

The other very important thing is the data collection. If we don't have information about how many Black students, or other people of color and indigenous students, are applying, how many are getting in, and what the retention and graduation looks like, then we won't be able to see those gaps in our College of Medicine. How then are we able to allocate our attention and initiatives towards that issue?

The College of Medicine has undertaken a number of initiatives that involve the collection of demographic information and provide some statistics about the makeup of the college.

In 2019, the college conducted a survey of faculty and academic leadership. The self-reported diversity demographic results suggest a fairly diverse faculty – but not one that fully mirrors the diversity of the broader Saskatchewan population (see Appendix 3 for more on Saskatchewan's population diversity). The faculty sample who completed the survey possessed the following characteristics: 4.6% Indigenous, 3.1% experienced disability, 24.9% visible minority/racialized, and 43.7% women. For academic leadership who completed the survey – a much smaller population – the results showed less diversity: 21.7% visible minority/racialized persons, and 39.1% women. At the time, there were no self-identified Indigenous persons or people experiencing disability.

Similar rates of diversity were captured by the College of Medicine's 2021 Equity, Diversity, and Inclusion Survey.³⁸ This survey sought to measure how respectful and safe survey participants found the culture in the College of Medicine to be. The results, especially the open-ended feedback comments, echo what participants stated as part of this systemic initiative:

Although the overall findings speak to an environment which is experienced positively by most, results also revealed that these experiences vary based on demographic differences. In particular, it was found that respondents who identified as Indigenous, racialized, immigrant, or having a disability had

³⁸ USask College of Medicine, *College of Medicine Equity, Diversity, and Inclusion Survey: College-Level Report*, March 2022.

less positive ratings as compared to their counterparts. Undergraduate MD students were also found to have the lowest ratings as compared to all other roles within the College of Medicine.³⁹

The College of Medicine also provided an internal report which analyzed the academic outcomes of medical residents who experienced academic difficulty over a ten-year period (2011-2021). This report included a comparison of the outcomes of International Medical Graduates (IMGs) with that of Canadian Medical Graduates. Currently, IMGs account for about a quarter of all resident learners at the College of Medicine (120 IMGs out of 487 total residents). However, the report does not provide any information on ethnicity or race of residents – again reflecting the absence of demographic details in data. This report showed that IMGs were the majority of those residents who experienced difficulty. In 78% of the cases, interventions lead to the successful completion of residency. For IMGs, the intervention success rate was 79%. However, the intervention success rate for female residents was only 67%. Ultimately, about 14 residents were unsuccessful during the 2011-2021 period.⁴⁰

A College of Medicine Diversity and Inclusion Working Group (DIWG) was formed in 2017 with a membership that includes faculty, senior leadership, and administrative staff. The DIWG Annual Report for 2018-2019 lays out specific and actionable goals, and details some specific recent achievements, including adding diversity and inclusion questions to the job

interview process.⁴¹ There is no more recent annual report of this working group and further work may remain ongoing.

Other Voices

While the themes described above are accurate reflections of what we heard from most people, it is useful to note that the College of Medicine is not homogenous. There are a diversity of experiences and opinions about the College of Medicine, and a few people expressed skepticism about this project and indicated that no further equity efforts were required:

- Please no additional mandatory equality training.
- I have been overlooked and bypassed numerous times due to my demographic of white male. The pendulum has swung and created another problem of discrimination.

On the other hand, others expressed doubts that the College of Medicine was capable of improvement on race and equity issues. Some members of the College of Medicine community related experiences that had eroded their trust in the current leadership and in the processes intended to facilitate redress, asserting that “racism is endemic in the system.”

³⁹ *Ibid.*, 30.

⁴⁰ USask College of Medicine, *Residents in Difficulty: Summary Report*, April 2022.

⁴¹ USask College of Medicine, *2018–19 Diversity and Inclusion Working Group Annual Report*.

4. Legal Analysis

The Commission's Authority

Pursuant to section 24 of *The Saskatchewan Human Rights Code, 2018*, the Commission has legal authority and legislated mandate to address systemic discrimination: “The commission shall promote and pursue measures to prevent and address systemic patterns of discrimination.”

The College of Medicine's Duty to Students

As a part of the University of Saskatchewan, the College of Medicine is subject to *The University of Saskatchewan Act, 1995*, SS 1995, c U-6.1, and all university bylaws, regulations, policies, and procedures. The College of Medicine must follow and uphold academic policies of the University Council, and the non-academic policies of the University Senate and Board of Governors. The non-academic policies include (but are not limited to) the Duty to Accommodate,⁴² Equity, Diversity, and Inclusion,⁴³ Discrimination and Harassment Prevention,⁴⁴ Violence Prevention,⁴⁵ Sexual Assault Prevention,⁴⁶ and Health and Safety.⁴⁷

These policies protect students and medical residents during activities inside and outside the classroom. It is the duty of the College of Medicine and its representatives to carry out their responsibilities and comply with the policies.

For medical students, the UGME Mistreatment, Discrimination & Harassment webpage illustrates the various avenues for UGME students to consider, the relevant forms, and procedures for reporting mistreatment.⁴⁸ Similar webpages exist for PGME learners, Master of Physical Therapy (MPT) students, and graduate students generally. The College of Medicine has created a reporting structure charts⁴⁹ to make it clearer for students to understand where to make complaints. Most of the complaints are to go through the Office

42 USask Board of Governors, *Duty to Accommodate Policy*, available at: <https://policies.usask.ca/policies/student-affairs-and-activities/duty-to-accommodate.php>

43 USask Board of Governors and University Council, *Equity, Diversity and Inclusion Policy*, available at: <https://policies.usask.ca/policies/equity/equity-diversity-inclusion.php>

44 USask Board of Governors, *Discrimination and Harassment Prevention Policy*, available at: <https://policies.usask.ca/policies/health-safety-and-environment/discrimination-and-harassment-prevention.php>

45 USask Board of Governors, *Violence Prevention Policy*, available at: <https://policies.usask.ca/policies/health-safety-and-environment/violence-prevention-policy.php>

46 USask Board of Governors, *Sexual Assault Prevention Policy*, available at: <https://policies.usask.ca/policies/health-safety-and-environment/Sexual%20Assault%20Prevention%20.php>

47 USask Board of Governors, *Health and Safety Policy*, available at: <https://policies.usask.ca/policies/health-safety-and-environment/health-and-safety.php>

48 USask, UGME Mistreatment, *Discrimination & Harassment, Procedures and Guidelines*, available at: <https://medicine.usask.ca/policies/mistreatment-discrimination-harassment.php#relatedForms>

49 USask College of Medicine, *Chart for Students Reporting Discrimination, Harassment and Mistreatment*, available at: <https://medicine.usask.ca/documents/policies/ugme/ReportingStructureDiscrimination.pdf>

of Student of Affairs⁵⁰ or Discrimination and Harassment Prevention Services.⁵¹ Reports can be made anonymously; but in those cases, the receiving body will be unable to follow up with the complainant.

The College of Medicine is also required to comply with the Code as it relates to students, patients, and employees.

The Dual Role of Postgraduate Medical Learners

Students in the College of Medicine Undergraduate Medical Education (UGME) program attain their medical doctor degree by successfully completing two years of primarily lecture-based studies, called pre-clerkship, followed by two years of primarily clinic-based training, called clerkship. In the final year of UGME, most students apply for medical residency in a specific medical field, referred to as a Post-Graduate Medical Education (PGME). When they become medical residents in the PGME program in Saskatchewan, they have a dual role as both university students and as employees of the University of Saskatchewan.

Most resident positions are paid for by the Ministry of Health. Article 1.1 of their Collective Agreement notes that medical residents complete rotations in facilities operated by the Saskatchewan Health Authority and cannot be bound by the Collective Agreement.⁵²

This dual role can sometimes lead to confusion, which may be apparent when seeking to inquire about student and employee rights or to make a complaint regarding workplace safety, harassment, mistreatment, or discrimination. Students may find it difficult to navigate the reporting landscape because of the various parties involved: the College, the Office of Student Affairs, the university, the Health Authority, the preceptor, the supervising resident, or the Resident's Association. Residents in PGME are advised in the Collective Agreement to report to the Discrimination and Harassment Prevention Services, as they are considered employees of the university.

Legal Test for Discrimination

As mentioned, the College of Medicine is required to comply with *The Saskatchewan Human Rights Code, 2018*. All learners and employees may bring complaints forward to the Saskatchewan Human Rights Commission when they think the College has violated the Code.

For a complaint of discrimination to be successful, complainants are required to show: 1) that they have a characteristic protected from discrimination under the Code; 2) that they experienced an adverse treatment with respect to the service; and 3) that the protected

⁵⁰ USask College of Medicine, Office of Student Affairs, Reporting an Incident, available at: https://cm.maxient.com/reportingform.php?UnivofSaskatchewan&layout_id=3.

⁵¹ USask, Discrimination and Harassment Prevention Services, Reporting an Incident, available at: <https://wellness.usask.ca/safety/discrimination-harassment.php#Reportinganincident>

⁵² University of Saskatchewan and Resident Doctors of Saskatchewan, Collective Agreement (2018-2022), <http://www.residentdoctorssk.ca/contract/current-collective-agreement>.

characteristic was a factor in the adverse treatment. Once a *prima facie* case has been established on these three factors, the burden shifts to the respondent to justify the conduct or practice, within the framework available under human rights statutes. If it cannot be justified, discrimination will be found to occur.⁵³ It does not matter whether a respondent intended to discriminate against the complainant; the focus is on the effect of the respondent's actions.⁵⁴

While there are few human rights decisions involving medical schools based on race, gender or age discrimination, there have been cases involving disability that provide a way to examine the complexities of a human rights complaint in a medical school setting. Given the dual status of some students and employees, questions may arise how to accommodate a learner in work and academic settings.

The following jurisprudence will provide insight.

Discrimination in Medical Schools

There are several cases in Canadian human rights jurisprudence regarding discrimination in medical school settings. In particular, two cases involving the University of British Columbia Faculty of Medicine and one from the University of Saskatchewan College of Medicine. In these cases, medical colleges failed to fully understand what disability is and the duty to accommodate for disability.

Dunkley v UBC and Providence Health Care involves a dermatology resident who was denied a requested accommodation for her disability, which was deafness.⁵⁵ The University of British Columbia (UBC) said it was unable to provide interpreter services, which they estimated to be cost-prohibitive. Dr. Dunkley filed a complaint with the British Columbia Human Rights Tribunal (BCHRT) under services and employment. Dr. Dunkley was placed on leave and ultimately dismissed from the residency program and the employment of the hospital. The BCHRT and BC Supreme Court held that Dr. Dunkley met her obligation to cooperate in the accommodation process and that UBC did not sufficiently demonstrate that the cost of accommodation would amount to undue hardship.

The BCHRT found that UBC's cost estimates were unreliable and inflated, as they did not fully explore funding arrangements, or options, such as hiring an interpreter on staff rather than paying for contracted interpreters. UBC had initially advised Dr. Dunkley that the student office for Access & Diversity would address her accommodation request, then later said that the post-graduate medical education program would handle it. The BCHRT rejected UBC's argument that Dr. Dunkley was not eligible for accommodation services from Access and Diversity because she was not technically a student and said that UBC has the authority to designate Dr. Dunkley as a student entitled to seek accommodation.

53 *Moore v British Columbia (Education)*, 2012 SCC 61 at para 33, [2012] 3 SCR 360 [Moore] at para 33.

54 *Ontario Human Rights Commission v Simpsons-Sears*, *supra* at paras 13-14.

55 *Dunkley v UBC and Providence Health Care*, 2015 BCHRT 100, *aff'd* 2016 BCSC 1383.

The BCHRT determined that both UBC and the hospital have a duty to reasonably accommodate its residents to avoid an adverse impact because of a disability, and that they failed to do so. They were ordered to reinstate Dr. Dunkley and pay damages for eight months of lost earnings, expenses, and \$35,000 for injury to dignity.

University of British Columbia v Kelly, 2013 BCHRT 32, aff'd 2016 BCCA 271, details an earlier instance of UBC failing to accommodate a medical resident in family medicine. When Dr. Kelly asked for accommodation of his attention deficient hyperactivity disorder (ADHD) and learning disability, UBC denied his physician-suggested accommodations, and he was dismissed from the program. Dr. Kelly successfully complained against UBC to the BCHRT under services and employment. The Tribunal found that UBC discriminated against him based on learning disabilities and mental disabilities and did not prove a *bona fide* reasonable justification or operational requirement. It said that UBC should not have acted on impressionistic beliefs that particular accommodations could not be implemented without checking.

The Tribunal ordered Dr. Kelly's reinstatement, damages for lost earnings (\$385,194) and injury to dignity (\$75,000). UBC sought judicial review and the chambers judge reduced the award for loss of dignity. UBC appealed that decision, and Dr. Kelly cross-appealed the reduction in award. The cross appeal was allowed, and the Court of Appeal found that the BCHRT correctly analyzed the *prima facie* discrimination and could make an award outside the range of past awards for loss of dignity due to Dr. Kelly's unique position.

The above cases underscore that residents are both employees and post-graduate students with academic requirements to fulfill. Due to this dual role, the individual resident seeking accommodations cannot be viewed as strictly an employee or a student – a joint and collaborative approach is required. For instance, the Tribunal in *Dunkley* stated that UBC could have simply designated Dunkley as a student entitled to receive accommodation through the Access & Diversity Office, because the determination of who is a student is within the control of UBC. That way, she would have had access to experienced disability advisors and a budget for accommodation, which could have been augmented from other funding sources.

By contrast, the Tribunal in *Kelly* found that UBC and specifically the PGME program did not meet its duty to reasonably accommodate Dr. Kelly as it took an overly broad and rigid view of the accommodations and could have consulted with Dr. Kelly on the proposed accommodations before ruling them out.

The University of Saskatchewan appeared in Saskatchewan court in a case involving the accommodation of a medical resident with a mental disability in *Haghir v University Appeal Board*, 2019 SKCA 13, 54 Admin LR (6th) 24. Despite Dr. Haghir's accommodations and appeals being dealt with primarily as a student matter, it did not preclude the PGME program from its duty to accommodate the resident in an employment capacity, to the point of undue hardship. The Court speaks to this joint responsibility:

[80] Sections 13 and 16 of the *Human Rights Code* apply to Dr. Haghir, who is not only a student at the College of Medicine, but a resident doctor, and, therefore, an employee. The portions of those sections relevant to this appeal read as follows:

13(1) Every person and every class of persons shall enjoy the right to education in any school, college, university or other institution or place of learning, vocational training or apprenticeship without discrimination on the basis of a prohibited ground other than age.

...

16(1) No employer shall refuse to employ or continue to employ or otherwise discriminate against any person or class of persons with respect to employment, or any term of employment, on the basis of a prohibited ground.

...

[84] Human rights legislation requires an employer to make “every possible accommodation short of undue hardship”: *VIA Rail* at para 129; *Central Alberta Dairy Pool v Alberta (Human Rights Commission)*, 1990 CanLII 76 (SCC), [1990] 2 SCR 489 at 520; *BCGSEU* at para 55. Thus, the duty to accommodate is an ongoing one to the point of undue hardship.

The Saskatchewan Court of Appeal allowed Dr. Haghir’s appeal and remitted it back to the Appeal Board, concluding:

In my view, the Appeal Board’s decision was not reasonable as it did not consider the law of accommodation and overlooked relevant evidence. Its reasons were thus not justifiable, transparent or intelligible and its decision was unreasonable.

Courts have set a high threshold for satisfying the duty to accommodate. There are many options for accommodation in academic and professional settings. It may require creative thinking and collaboration to determine appropriate accommodation. While an employee is not entitled to perfect or their preferred accommodation, the duty on the employer to accommodate extends to the point of undue hardship. This means that some hardship is expected. Undue hardship is generally defined as an unbearable financial cost or a considerable disruption to business, or an interference with the rights of others. The size of the employer’s operation may be taken into account, as well as safety considerations and the nature of the employment contract.

The above examples are illustrative of the obligations and responsibilities regarding the protection of human rights in school and work settings. For the College of Medicine, therefore, accommodating medical students and residents is a unique situation that may, at some points, require the collaboration and cooperation of the Access & Equity office, the College UGME or PGME program, and the Health Authority.

5.9 Issues to be Addressed

Based on the views and experiences of stakeholders, and the information received, 9 key issues to be addressed were identified as requiring the further involvement of the Commission, the College of Medicine, and key stakeholders:

1. Implement a College-level EDI action plan linked to Research and Evaluation
2. Ensure education equity by supporting student diversity
3. Review and update curriculum and assessment mechanisms to eliminate discriminatory elements
4. Improve the student complaint process
5. Address uneven diversity in faculty and leadership positions
6. Pursue constructive relationships with Black, Indigenous, and other physicians
7. Strengthen work culture, building trust and pursuing employee satisfaction
8. Implement demographic data collection and data stewardship
9. Communicate the College's Policy and Practice on Racism and other forms of discrimination

Further explanation and context needed to fully address the issue is provided below:

Implement a College-level EDI action plan linked to Research and Evaluation

- Refine and study the delivery of EDI, anti-bias education, and cultural competency education for students, faculty, staff, and leadership.
- Introduce the concepts of unconscious bias, the social construct of race, and systemic discrimination through connections to the existing medical education curriculum and professional development programs. For faculty and staff, offer a tiered and structured approach to meet people where they are at, while grounded in the context of the College and the work of the participants. Note that training

programs can provide theoretical foundations but may not lead to improved behaviours on their own,⁵⁶ and, as such, should be pursued in tandem with other efforts.

- Address the perceived lack of Indigenous cultural competency and confidence among management and senior leadership and expand the number of employees with experience working with Indigenous communities and cultural issues.
- Integrate the efforts of Departmental and College-level EDI Committees to ensure a unified, cohesive approach, and to promote social accountability.

Ensure education equity by supporting student diversity

- Periodically review admissions criteria and processes, including the use of the MCAT, in order to reduce bias and cultivate a balanced and representative student body.
- Consider expanding the positions available through the Indigenous Pathways Admission program, which is currently 10% of UGME admissions (whereas approximately 17% of the general population in Saskatchewan is Indigenous). As well, consider redefining the program eligibility to more specifically reflect the diversity of First Nations and Métis peoples who have historic links to the Saskatchewan area.
- Consider creating further mentorship opportunities for Black and other racialized students.

Review and update curriculum and assessment mechanisms to eliminate discriminatory elements

- Curriculum should be regularly reviewed with the participation of students. Such a review should seek to remove harmful stereotypes and to increase the diversity represented in books, videos, diagrams, and presentations. Standardized patients⁵⁷ should also be diverse.
- Implement measures for, and promote the practice of, fairness in evaluation, by adopting objective indicators for assessment, wherever possible.

Improve the student complaint process

- Acknowledge and address the reluctance of students to report their concerns and make formal complaints, ensuring that retaliation, or the fear of retaliation, is mitigated.

⁵⁶ Elizabeth Levy Paluck, *et al.*, “Prejudice Reduction: Progress and Challenges,” *Annual Review of Psychology* (2021) 72:1, 533-560.

⁵⁷ A “standardized patient” is a lay person who has been trained to present symptoms, characteristics, and case history, in order to facilitate a training experience for medical students.

- Pursue complaints in a confidential manner, including informal complaint resolution.
- Provide fulsome, transparent, and public reporting on complaint outcomes, and make this information readily available online.
- Provide detailed information about possible outcomes for mistreatment complaints, describing the limitations of such processes and explaining remedies available through the criminal justice and/or human rights system.

Address uneven diversity in faculty and leadership positions

- Implement employment equity strategies that include long-term recruitment and retention techniques.

Pursue constructive relationships with Black, Indigenous, and other physicians

- For some physicians, past experiences have reduced their level of trust with the College of Medicine. Further outreach is required. More work should be done to support Black, Indigenous, and other racialized physicians in pursuing or advancing careers as faculty members.

Strengthen work culture, building trust and pursuing employee satisfaction

- An evaluation of the employee complaint process should be done to assess its responsiveness.
- 360-degree reviews (or similar assessment practices) can be used to more accurately locate and detail employee concerns.

Implement demographic data collection and data stewardship

- Expand student and employee demographic data collection and reporting, with demographic transparency to the department level.

Communicate the College's Policy and Practice on Racism and other forms of discrimination

- Ongoing communication regarding College initiatives and policies regarding discrimination is required to establish clear expectations.
- Opportunities should be expanded for students, staff, and faculty to express their concerns about racism and other discrimination, and to be heard by College and campus leadership.

Addressing these 9 Issues

Addressing the 9 issues raised in this report will require further collaboration among all the stakeholders at the College of Medicine.

Over the past year, the College of Medicine has proceeded with several initiatives that relate to the issues raised in this report. For instance, the College has now created and staffed a new Vice-Dean Indigenous Health & Wellness position, and work on EDI and anti-racism issues has been ongoing. Members of the College have been active in the Anti-Racist Transformation in Medical Education project, and are now moving forward to phase 3, which includes building a larger Guiding Coalition within the College. At the Office of Student Affairs there have also been changes to the complaint process. A student-led committee on mistreatment will also contribute to improvements in how student interact with the mistreatment reporting process. Finally, new options are being implemented to accommodate students' religious needs.

At the same time, the work of this initiative has been done against the backdrop of the COVID pandemic and additional stresses on the province's medical system. The College of Medicine will have to address these issues at the same time as dealing with increasing 'burnout' among the medical professions.

The Commission is prepared to facilitate further discussions within the College of Medicine, or otherwise assist. In past systemic initiatives, the Commission has established working groups with members from different stakeholders and facilitated consensus-based solutions and improvements to issues. The detailed structure of each of these multi-party processes are unique and respond to the circumstances of the stakeholders. For the College of Medicine, for instance, responding to this report may include the pursuit of new academic research.

Regardless of the format, making significant progress on the issues to be addressed will take time and the dedication of College of Medicine resources.

6. Conclusion

This report has distilled the experiences, perceptions, and opinions of individuals, organizations, and stakeholder groups with specialized insight into the operations of the College of Medicine. The issues raised are, in several cases, matters of human rights, including inequity and discrimination. These issues are also systemic in nature – they affect more than one individual, they effect population cohorts, including cohorts based on personal characteristics (i.e., prohibited grounds, as per *The Saskatchewan Human Rights Code, 2018*).

With systemic initiatives, the Commission's practice is to identify issues to be addressed. These issues to be addressed are not recommendations. The Commission intends to continue its work with the College of Medicine, and identified stakeholders, in a collaborative and cooperative manner. This restorative justice approach recognizes the need

for all involved to participate in, and take ownership of, outcomes that ensure human rights, and the equality of all persons, are promoted and protected.

As an academic institution, the College of Medicine is well-situated to study, understand and, ultimately, resolve many of the issues identified in this report. The College of Medicine is also uniquely placed to conduct and support research into its activities, including the issues of racism, sexism, ageism, and ableism. These concerns are germane to, and with long-term implications for, the practice of medicine for persons studying and serving in the field of medicine in Saskatchewan and elsewhere around the world.

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8. Appendices

Appendix 1: *The Saskatchewan Human Rights Code, 2018* (excerpts)

Duties of commission

24 The commission shall:

...

(h) promote and pursue measures to prevent and address systemic patterns of discrimination;

...

Programs, approved or ordered by commission

55(1) On the application of any person or on its own initiative, the commission may approve or order any program to be undertaken by any person if the program is designed to prevent disadvantages that are likely to be suffered by, or to eliminate or reduce disadvantages that are suffered by, any group of individuals when those disadvantages would be or are based on or related to the race, creed, religion, colour, sex, gender identity, sexual orientation, family status, marital status, disability, age, nationality, ancestry or place of origin of members of that group, or the receipt of public assistance by members of that group, by improving opportunities respecting services, facilities, accommodation, employment or education in relation to that group or the receipt of public assistance by members of that group.

(2) At any time before or after the commission approves a program, or a program is ordered by the commission or the court, the commission may:

(a) make inquiries concerning the program;

(b) vary the program;

(c) impose conditions on the program; or

(d) withdraw approval of the program as the commission thinks fit.

(3) Nothing done in accordance with a program approved pursuant to this section is a violation of the provisions of this Act. 2018, c S-24.2, s.55.

...

Reasonable and justifiable measures

56(1) Subject to subsection (2), it is not a contravention of this Act for a person to adopt or implement a reasonable and justifiable measure:

(a) that is designed to prevent disadvantages that are likely to be suffered by, or to eliminate or reduce disadvantages that are suffered by, any group of individuals if those disadvantages would be or are based on or related to one or more prohibited grounds; and

(b) that achieves or is reasonably likely to achieve that objective.

Appendix 2: List of Participant Affiliations

College Leadership
College Administration
School of Rehabilitative Science
Division of Social Accountability
Department Faculty (including Biochemistry, Microbiology & Immunology, Psychiatry, Surgery, and others)
UGME Program Office
PGME Program Office
Regina Campus
Office of Student Affairs
Student Medical Society of Saskatchewan (SMSS)
UGME Students
PGME Learners
Graduate Students
Saskatchewan Medical Association (SMA)
Resident Doctors of Saskatchewan (RDos)
External Physicians

Appendix 3: Reflecting Saskatchewan’s Diverse Population

Efforts aimed at reducing systemic discrimination often look to data and statistics to help determine progress. One such indicator is how representative an organization is of the community it serves.

Every workplace should pursue a representative workforce across the range of jobs and roles within its operation. It is not sufficient to meet equity targets through the employment of equity group members in entry level positions only. Over time, the recruitment, retention, and promotion of employees within an organization should reflect the true picture of diversity in our society.

Under Section 55 of the Code, the Commission offers employment and education equity programs. These programs are designed to prevent, reduce, or eliminate disadvantages experienced by groups of individuals because of a prohibited ground of discrimination.

The four equity groups are approved by the Saskatchewan Human Rights Commission are:

- Persons reporting an Indigenous identity;
- Members of a visible minority group;
- Individuals reporting a disability; and
- Women in underrepresented occupations.

Saskatchewan Human Rights Commission equity target recommendations are derived from Canadian census data, the Canadian Survey on Disability, and the Labour Force Survey.

While some 2021 Census data is available, the full information needed to update the equity targets has not yet been released.

New Commission equity target recommendations are expected to be available in 2023.

2016 Saskatchewan Human Rights Commission Equity Targets	
Equity Group:	Target:
Indigenous Peoples	
Provincial	14.0%
Prince Albert CA	35.0%
Members of a Visible Minority Group	
Provincial	10.6%
Regina/Saskatoon	16.8%
Persons with Disabilities	22.2%
Women in Underrepresented Occupations	47.0%

(Saskatchewan Human Rights Commission: <https://saskatchewanhumanrights.ca/education-resources/equity-programs/employment-equity-targets/>)



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