Transcript: SPARK: Conversations LIVE | Creating Equitable and Inclusive Healthcare Systems for Children and Families

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Katharine: Welcome to SPARK: Conversations. Children's Healthcare Canada's monthly podcast series. SPARK: Conversations is one component of Children's Healthcare Canada's SPARK Knowledge Mobilization Program. And today we're excited to be joining you live from the stage at the annual conference. I'm Dr. Katharine Smart. And today I'm absolutely delighted to be speaking with Dr. Nell Weiman and Dr. JC Cowden. So welcome. I'm going to give you an introduction of both of these amazing guests.

Dr. Nel Wieman is a nationally recognized expert in Indigenous Health. She is the Acting Chief Medical Officer at the First Nations Health Authority in British Columbia, where she has worked since 2018. She is Anishinaabe (from Little Grand Rapids First Nation, Manitoba) and lives, works and plays on the unceded territory of the Coast Salish peoples – the səl̓ílwətaʔɬ (Tsleil-Waututh), Sḵwx̱wú7mesh (Squamish), and xʷməθkʷəy̓əm (Musqueam) Nations.

Dr. Wieman completed her medical degree and specialty training in psychiatry at McMaster University. She is Canada's first female Indigenous psychiatrist. Dr. Wieman has more than 20 years of clinical experience, working with Indigenous peoples in both rural/reserve and urban settings. Her previous roles include co-director in the Dalla Lana School of Public Health at the University of Toronto, and the National Network for Indigenous Mental Health Research. She has served as Deputy Chair of Health Canada's Research Ethics Board; President of the Indigenous Physicians Association of Canada from 2016-2022; CIHR's Governing Council; and as a director on many boards, including the Inspire Foundation and Pacific Blue Cross. As well, Nel has worked and taught in many academic settings, chaired national advisory groups within First Nations and Inuit Health Branch at Health Canada. All Nel's clinical, academic, research, and advocacy work has been focused on improving the health and mental health status of Indigenous peoples across Canada.

Dr. Wieman is one of the 6 Indigenous physician founders of the National Consortium on Indigenous Medical Education (NCIME). She has been appointed to the BC Provincial Task Team charged with ensuring the implementation of the recommendations arising from the “In Plain Sight" report.

Also joining us is Dr. JC Cowden. He is a Professor of Pediatrics at the University of Missouri-Kansas City and a general academic pediatrician at Children’s Mercy Kansas City, where he formerly served as Medical Director of the Office of Equity and Diversity and now serves as Health Equity Integration Project Leader. He is also Founder and Director of Children’s Mercy’s Culture and Language Coaching Program (CLCP), an innovative model for training bilingual health care providers seeking to reach a professional level of linguistic and cross-cultural proficiency.

Dr. Cowden’s research and quality improvement interests include health equity integration throughout hospital systems, provider-patient communication, models for culturally and linguistically appropriate care, and data collection for health equity surveillance.

So wow, these are two pretty incredible people joining us this morning. And today we're going to be talking about an extremely important topic and one that I think is really important to everyone in this room, which is health equity, and how to implement EDI principles into the child's health care setting. So hello Nel and JC and welcome to SPARK: Conversations and to the stage.

Nel: Good morning. Thanks for having us.

JC: Yeah, thank you so much. It’s great to be here.

Katharine: Thank you. So Nel I'm going to start with you. I want to, you know, have you kick us off in this conversation and tell us why EDI and anti-Indigenous racism are such important and current topics, especially for child health and child health providers in this room.

Nel: Great thank you Katharine. So, when we talk about the principles of EDI and anti-racism, I think it's so important for children's health because it has a direct, these factors have a direct impact on health outcomes for children, for youth, for adults and our elders in First Nations communities. And it's really, you know, that is a really glaring gap. One of the things we do here in British Columbia is we partner with the office of the Provincial Health Officer. And we, part of my office’s responsibility is to report on the state of, in this case, children's health of First Nations Children's Health and BC. And one of the things we found, and there is a report that is out there, it's called Sacred and Strong. This is a report specifically focused on First Nations, females. So all the way from birth to the elder years, there are chapters related to First Nations, female children's health, unfortunately, we don't have that specific report just deals with females. But what we see are these different gaps, disparities in gaps in health status or health outcomes. And racism, for example, is so important to address because it really impacts people's health. In one way, for example, that impacts people's ability to access the health care system. So one of the things when we talk about health care access is people have in their mind, well, is there a physician or a nurse practitioner available in communities? It's not just having that person, that healthcare person, or the bricks and mortar building; but it's whether or not people feel safe to

come forward and seek help. And children are really, in some ways, and even more. I don't like using the word vulnerable, but they're in vulnerable situations because of the issues around child protection and being taken into child protective custody. So it's not just that there isn't the people or a clinic in a building is about whether people in this case, parents, guardians, grandparents feel safe bringing their grandchild to seek care in the first place because of a fear of how they're going to be treated.

Katharine: Yeah, so, so important. And I think something as pediatricians that we think about a lot in our care and interactions with families. I'm curious Nel if you could speak to us a little bit about how you see the principles of EDI applying or adapting specifically around Indigenous children, youth and families? And what are principles that that makes sense? And what are things where we maybe need to be thinking slightly differently to make them relevant for Indigenous patients and families that we serve.

Nel: So I think for First Nations children, and I'm thinking all the way even before birth, until say they're, they're late. We define it First Nations Health Authority, a youth of the age between 15 to 29. But obviously, we look at children as well. And what we started to do, and this was even before I joined the organization, was to try to promote the concept of cultural safety, which really encapsulates the principles of EDI. And for those of you like, there is a lot of language issues. So for example, you know, when I was 100 years ago, when I was a medical student, And we started a campaign years ago when it's available on our First Nations Health Authority website called It Starts With Me. So even for grassroots health practitioners, in this case, those who work with young people, children and youth.

There is all sorts of information about how that can be achieved. And a related concept to that is cultural humility. So recognizing the power imbalances between healthcare providers and their patients, again, in this case, children and their families. Recognizing those power imbalances and really paying attention to that, and treating people in an equitable manner. A quick example of that would be, you know, a lot of the times when I worked as a psychiatrist, people would give treatment plans to people and say, you know, well, for depression, you need to the lifestyle changes, you need to sleep better, you need to eat better, you need to exercise more, and not really taking into mind that person's circumstances. So where I worked at that time on Six Nations of the Grand River Territory, you know, people lived, multi-generations of families, lived in a single home in some cases. So getting a good night's sleep isn't necessarily always possible. And then eating healthy. I mean, if you are experiencing poverty, or food insecurity, that's not something that you can necessarily achieve all the time. And exercising there were, you know, the community at that time just had mainly dirt roads. There was a couple of paved roads, but people drove like maniacs. So you can't just go for a walk on the side of the road, you risk your life. So when a parent brings a child back and says, Well, we weren't really able to do that, then, of course, you know, in a culturally unsafe way, the practitioner says, well, you know, patient and their family are non-compliant with my treatment plan. And that's just an example. So cultural safety is an outcome and the health system will be safer, including against racism, when First Nations and other Indigenous P eople tell us that it is.

And I guess the last thing I'll say the, the other kind of corollary to this thinking is about, you know, diversity and inclusion. And we have some real challenges still, in our Canadian healthcare system in terms of representation of Indigenous health care providers, including physicians. Again, when I started, like 100 years ago, there were only I went to my first meeting of the Indigenous Physicians

Association, there were 20, Indigenous practicing physicians in the country 10 Indigenous medical students, and this was when I was in first year. Now we probably have five or 600 indigenous physicians in this country. But in BC, for example, we make up less than 0.5% of all physicians in British Columbia. So in order to deliver that safer, culturally safer care, we also need to increase the diversity of our healthcare workforce, be more inclusive, and support our Indigenous health professionals over the course of their career, but most, especially when they're learners.

Katharine: Yeah, thank you for that. And I think you've given us lots to think about both in our own personal actions and commitment, but also starting us thinking a little bit about what's it going to take to take these principles into our broader system. So I'm curious now from your perspective, and then JC I'll ask you to weigh in. What do you think are the key things that need to happen to really embed these principles into the system in a meaningful way, so we can get further down the road to these changes?

Nel: Yeah, I mean, you know, as far as racism is concerned, here in British Columbia, you know, we were under two public health emergencies, obviously, the COVID pandemic, which is, you know, turned into a slightly different thing. And we have the toxic drug crisis, toxic drug poisoning crisis. Our CEO of FNHA, Richard Jock, always says that racism, anti-indigenous racism is the third undeclared public health emergency in this province. And that is very, you know, that was substantiated in some ways. By the release of the In Plain Sight report, which is available online. There's both the executive summary report, a final report and the data report, which is quite interesting if you look through things. And that was about three years ago. And there were 24 recommendations in that report, both at the directed at the individual level, and also at the organizational level. So I really encourage you to take a look at the recommendations that came out of that report. Another thing that happened, there are so many resources available actually online, where you know, you and your organizations can look at where to start.

So one of the things that we did in British Columbia and I really do think that we're the leaders across the country in terms of really addressing the widespread racism that exists in our healthcare system, is we formed a technical committee that was co-chaired by myself and this unbelievable beautiful elder. And we created with quite a large group, this committee, Indigenous people, non-Indigenous people, everyone involved in the health care system, and most importantly, including the voices of patients and users. And we have developed that what's called the BC Cultural Safety and Humility Standard for the province. And again, that standard, which was a partnership between FNHA and the Health Standards Organization is available. And it consists of eight different domains with criteria within each domain that you can take a look at. And as an organization or even a small clinic, you can go through those guidelines and say, you know, where can we start to make changes, and it can be even as something as simple as having people want to see themselves where they come to seek care if they, if they come if you do house calls, for example, which are rare these days button, but not altogether. They still happen. But have people feel comfortable in that healthcare setting where they're seeking care. So there's all kinds of resources available. And I really encourage you, after the session today to check out our website, but also specifically the In Plain Sight report and the BC Cultural Safety and Humility Standard.

Katharine: Thank you. JC Can you share a bit about your experience?

JC: Yeah, sure. The work that we've been doing now for the last four or five years focuses on an idea of health equity integration, what we call our Health Equity Integration Project. And as I start to answer I want to make note here, similar to what Nel was talking about, that the language we use evolves, it's evolving all the time around these ideas, these things we do as humans, these things that impact how well we treat each other. Health Equity is one of the current terms, if you come back in five years to this conference, or 10 years, we'll be talking slightly differently.

But when I talk about health equity, what we use that for at our hospital is shorthand for a large number of concepts, ideas, things like racism, anti-racism, bias, equity, inequity, social determinants of health, etc. There are many concepts that will push us either towards health equity, which is the good that we are striving for, or away from health equity. And so I'll use that as shorthand today, when you hear me say health equity integration, I'm talking about the idea of equity, but also all the other pieces that connect to it. So in our project, you know, we've, over the years come up with, with three big ideas, I want to share those right away at the outset. And then we can talk further about those ideas as they apply.

The first big idea that we came upon was that we have to have fundamental integration. It might sound sort of like an obvious thing to say right now. But what we found in the first 10 years of our work, we started doing our work around, sort of formally addressing EDI and health equity about 15 years ago. So we formed an Office of Equity and Diversity we had in our hospital at a large standalone Children's Hospital, about 8500 employees. We have multiple campuses; relatively big organization focused on child health. And we realized we needed a home for this work. And so we made that home. And we started to accrue expertise and experience and we grew the office. And as people learned about it, this is amazing that JC and all these other people are taking care of equity for us. This is so cool. Because I'm really busy. And I don't know how to do that. I don't know how to do that. I'm a nurse, or I'm a doctor, I'm an administrator. So I want to do it. But I'm so glad they're here to do it. And that led to us not getting very far in 10 years, we did a lot of amazing things. We were seen as experts in the area nationally, internationally, we'd get asked advice all the time. About how did you set up these structures. And of course, when George Floyd's murder happened, and there was this huge rise around COVID, and concerns about racism and inequities. We were one of those people people came to, and yet we hadn't made nearly the progress that we need to make. The way we talked about it, I know we're gonna be we're doing some audio, but I'm gonna put my hand up. The place we know we need to get with health equity is up here, let's call it that would be the ideal state, we're all treating each other equitably. Everyone has their best chance to do well. And so we were ahead of a lot of other people like this. And then everyone else was kinda like this. And the goal was up here. And we recognize that. We were proud of what we've done, but we realized we are not even in sight of our goal. And we thought we're victims of our own success here. We need to have fundamental integration across all people.

So that led us to our second big idea, which is that health equity has to be everyone's work. Literally everyone's work. Nobody is off the hook. It doesn't matter how enlightened you feel you are. It doesn't matter what position you have in your hospital, whether you're a leader, whether you're a middle manager, whether you're on the frontlines doing work, everybody has to be on the hook.

And then the third big idea we came across as we started to do our work was often in healthcare, we want to standardize solutions, we want to bring a solution. And similar to what you said now about treatment plans. Well, I already know the standard solution for depression. It's x y&z things, so you should just go do that now. And, you know, that usually doesn't work. We do though, find that there is a power in standardization in certain settings. It can get rid of variability that is harmful. So what we worked on was standardization, not of solutions, but of questions. So if we take a question based curiosity mentality, and we start to embed and standardize that across all work. Everyone's everyday work, not special projects, special efforts to the side of your everyday work. But getting into your individual, everyday work, and having some tools so that you feel empowered, hey, I can act on this, I can move into my responsibility for my part, in inequity. All of us have a role in inequities. How can I move into that? And so we started to work on standardizing questions on the operational side of that.

But I want to call back to what Dr. Lafontaine shared with us yesterday. Some wording that he used around mental models. We talked about a mindset of health equity integration. I can talk to you all day about ideas to hand you to work on but if your mindset is in the mental model that we've had for a long time, which is an expertise-based model. That the way we're gonna get this done is I'm gonna go find an expert, who knows this, and then they're gonna teach me how to do it. We have to move away from that because we're not getting, we're frankly, not getting very far at all with that model. And move into a mental model, where each one of us co-owns health equity. So we can co-create health equity. This is a fundamental shift. And so I'll ask all of you as we're talking today, to kind of interrogate yourself. How empowered do I feel? How much capacity do I have today to go to my own everyday work, not special projects, that stuff I do every day in my work. And recognize where I have woven in equitable actions as fundamental like breathing, of course, I wash my hands before I go into a room. Of course, I put my sharps in the sharps container instead of leaving it out on my field, right? Of course, I do that it'd be a bad doctor, if I didn't do that. What is it for your work from equity, that is the handwashing, that is the sharps container, whatever it is that you should do, fundamentally. And my challenge to you is what I give to myself all the time, is that if we're going to implement this broadly, we need knowledge. We need reports, we need suggestions. But I have to have a mental model that puts myself in the center, gives myself agency to actually make a difference here and not just shy back and say, well, who am I to do it? I'm not the expert. So I'll just wait until someone else delivers the answers to me.

Katharine: Yeah, thanks for sharing that. I think that is so important. And I think for everyone in this room, right? That is a bit of that call to action for all of us is how do we take these values and live them in our work? I'm curious, JC like you obviously have a lot of experience sort of trying to motivate your team and your institution in that direction. What are the some of the key things or learnings you've had where you think you've had some success and getting you know, that average person that person worker bee, frontline provider to really start to engage with this and want to make a difference in the way they approach their work?

JC: Yeah, one of the things we do right away is we use an analogy. And we tell stories, you know, we all know that stories is really the thing that drives us most deeply, rather than charts and figures and numbers. And so we talked about stories, and we want to relate it to something that people in our hospital in the hospital setting will already understand quite well, which is safety. So when we say health equity is everyone's work, we say health equity, like safety, is everyone's work. And so I'll make

the analogy and say, you know, if I were to say, you know, I'm just a doctor, I'm not a safety expert. So safety is not really my thing to solve. That's the safety office's work. I'm so glad we have a safety office, they're keeping us safe, because I'm really busy as a doctor, so I'll just do my doctor thing while they keep us safe. Well, see people laughed. It's laughable to say that. We know that now because we've moved from a place in safety of an expertise-based mentality or mental model to one of co-ownership of safety. And we point out that health equity is exactly the same. Safety is the good that we're trying to achieve. It's the state we're trying to get to. And health equity is the same. In my hospital if one person's not acting safely, I don't have a safe hospital. Even if all 8499 other people are being safe. We don't have a safe hospital. If one of us isn't acting equitably in our hospital, even all the rest of us might be enlightened and doing great – we're aren't equitable. We're not equitable. And so we want to shift people's minds into the idea that you have things you do for safety and your work all the time. We need to find those similar things in health equity that we can do. And then if people agree, and they say, hey, okay, yeah, I get it, I'm ready, I'm ready to engage in this, they still aren't quite sure what to do. And the other thing that we need to focus on when we start our work is to understand that every person is the expert in their own work. And so, I cannot come and sit down with you, even though I've worked on this a long time and tell you how to do this in your work. But I can be a coach for you, I can provide questions so that you can start thinking more about what is it in my work that I already feel I'm successful at that I do well with. So we like to celebrate success first. And allow people to say, Hey, I'm, we're really good at calling families in this way. And that allows us to have more equal or better equitable treatment for families. And we'll say that's fantastic, that's amazing. Where are you worried about equity in your work? What are you concerned about? And this starts people down that path of curiosity. But also in a space that is assuming you want to be amazing at your work, you wanted to be the best possible nurse, you can be the best possible physician you can be. The only way to do that is to be equitable. If you don't have equity, you aren't the best person you can be in your work. And so we want to partner to talk about this with a curious mindset. And one that's also not about blaming and shaming and guilting people about the fact that none of us is adequate at this. I've never met a single person and the work I've done, I've done 25 years of work in this area. I've been all over the place talking to people. I've never met someone who's fully adequate at equitable behavior. None of us does it all the time. But we all can get better at it.

So we want to inspire people from that place of you are the expert in your work. And what do you worry about, and let's work on that and start to create steps that make sense to you. It has a lot to do with motivational interviewing for those of you who might have that as part of your profession. It has a lot to do with different approaches to coaching and therapy, where you really want to bring the agency to the person and make sure that they can then find steps forward to be more equitable.

Katharine: Given your experience in this in the amount of work your hospitals done, are there any specific tools or resources that folks listening could go to or look at? And Nel you've mentioned a few things from your experience. So I'd be curious if you guys want to share that with our listeners?

JC: Sure. I'll talk just briefly about some of the things that we've worked on in our specific project, which are all publicly available. And on our website and tell you how to how to find that website. But we in partnering with, with folks and let me say here that there's another key mental model to use Dr. Lafontaine words, mindset. And Nel's already talked about it today. That comes, the way I'm going to

talk about it comes from the tradition of restorative justice. But it's applicable across many of our interactions with others. Is that people tend to do better when you work with them, rather than doing things to them or for them. And we have habits in healthcare, of doing things to people and doing things for people. Thankfully, out of good intent, but the impact is usually not equitable. When we work with people, we partner with people, to think about what matters to them, and how we can actually serve them the way they want to be served and cared for, rather than the way that I think you should be cared for, then we're off to a good start. And so that piece is key. So we have partnered with folks that we will coach and consult with and talk about with this kind of health equity integration approach. And co-developed, co-created tools.

A couple of the tools that we find our most popular with people are our EDI checklist, of which there are many varieties, and universal questions. Universal questions are questions you'll ask at a bottleneck. So any work process you have, you will often be able to find a place where everyone or everything passes through that bottleneck. And this is where you'll have a stopping point and say we're going to ask this question every time we get to this point. So an example would be we have an education process at our hospital where all the different nursing staff who want to do education have to go through a form where they talk about what their learning goals will be and all the rest for continuing education credits. Well, our nursing leaders decided they would put a universal question in that form that talks about how will your teaching incorporate or talk about equity. No matter what the training is, it could be how to deliver drugs, it could be, it doesn't need to be something specially about equity. It's just to make it universal. We always think about this. And we have many other examples of those universal questions.

The other is this checklist idea. The checklist is a checklist full of questions. So we have a clinician version. We have a researcher version, we have a learner version, we have leader versions, we have strategic planning versions, we have board of director versions, and this is a checklist they'll pull out periodically and make sure everyone can run through these universal questions. Again, we're always going to ask this to make sure that we are not forgetting that equity is central to the way that we need to be behaving.

Katharine: One of the pieces of work from the First Nations Health Authority I thought was really interesting is how they shared some of the traditional values and knowledge from Coast Salish people with the help of other Health Authorities as sort of a way of bringing Indigenous ways of knowing and being to providers in the system. And Nel, I wonder if you could tell us a little bit more about that I think this idea of two-eyed seeing and the fact that we actually have a lot to learn from Indigenous ways of knowing and being that could actually help us improve our system. Can you tell us a little bit more about that framework? And what that impact has been like in the work that you're doing?

Nel: Yeah, sure. And I think, partly the word that keeps coming up in our conversation this morning is curiosity. And I think that's really where it starts. For example, yes. And, you know, in our health authority, we do a lot of advocating around, especially in in my office, the Chief Nursing Office, we talk about this notion of “two-eyed seeing”, which originated out on the East coast of Canada with Elder Albert Marshall and his wife, Murdena. And they basically said it, in some ways, it's almost intuitive, that, you know, providing the best care to, in this case, First Nations people were, this is my lens, from

where I'm coming from. You can acknowledge, respect, use the best of the Western medical system and knowledge. And you can also use Indigenous knowledge, the best, you know, the ways of being and knowing, and we advocate strongly for, you know, traditional knowledge. Being out on the land, ceremony, culture. One of the best parts about my job is that I get to, almost on a daily basis, participate in some sort of ceremony, or interaction with an Elder. And for me, myself as a First Nations person, I can't tell you how much that strengthens me. So that curiosity for you as perhaps non-Indigenous health care providers is, first of all, I think as JC has said, you have to kind of reflect on where you're coming from. And how did you learn to think about, in this case, Indigenous People, First Nations Métis, Inuit, what are your views?

And I think it's very much influenced by what you see on the media, which has in you know, I'll just say it, you know, a horrible way of misrepresenting us. And the media, we're always argumentative, putting up roadblocks, being murdered, killing other people. You very rarely, I mean, have you ever seen Dr. Lafontaine on the - you might have? Because he's the CMA president. But okay, that's a bad example. But have you ever seen, you know, I know on my, you know, I watch the local BC news at dinnertime. I almost never have seen a positive story. Here's a community that's doing something amazing. You know, and one thing that we had, we had a call for proposals for communities to access funding to work on their mental health, because that's obviously a huge priority. And what people came back with was not in some cases they did, they said, we would like to use the funding for a psychologist to visit our community. But in many cases, they said, we would like to use the funding, for example, for children to have an afterschool program. That includes being out on the land, fishing, berry picking, learning how to dance, learning the language is super important. Another community, there was a traditional road that went out to a place of cultural significance. So they use their funding as a community to get out there and clear the road again, do whatever they needed to, you know, replant trees, and it was a real coming together of family, from the youngest to the oldest as a community to work on this project. So again, I think for other health care professionals, it's like was already said is when you're in that patient or clinical encounter, ask people you know, what do you think would benefit your health in this scenario?

And a lot of the times you'll hear people say, well, I would like to be able to access a traditional healer. And back when I was doing my training, I keep saying 100 years ago, in psychiatry, I was trained to you know, by the people that I, my supervisors, they would basically say to Indigenous patients back then, well, if you don't want to take the antidepressant, then I have nothing to offer you. So you might as well just go away, because and do your own thing. There's not that curiosity into how can we work together. And oftentimes later in my clinical work at CAMH, for example, in Toronto. I worked in the what was called done the Aboriginal Services Program, I worked with an elder, and we would see the patient together. And sometimes the patient would say, you know, Dr. Weiman, you're great, but, and thanks for seeing me, but really, I want to carry on with the elder. And it's like, okay, my feelings aren't hurt. Well they're a little bit hurt. But you know, and we were both open to that. And we learn from each other. And for example, if someone wanted to take a Western prescribed medication, but also use traditional medicines, then me and the elder would say, well, let's start low, go slow. Let's keep talking to each other and the family, the patient, how are they feeling in case there are any potential interactions.

So there are different ways that one can go about being more curious as the first step to cultural safety. And the last thing I'll say is, you know, here in this province, we have actually enshrined the United Nations Declaration on the Rights of Indigenous people into law in this province called DRIPA. And there's a DRIPA action plan that includes being respectful of Indigenous knowledge, traditional knowledge. And using that in the work when you work with your indigenous clients in any scenario.

JC: I just held my hand up to together and to say, I want to say something, what you're talking about brings to mind some something else that we bring up all the time. And it's been very powerful for me in the way I think about myself and others. It's from it's a haiku actually written by, it's a little bit tongue in cheek, but it's written by a guy called Michael Bungay Stanier, who's kind of a coaching person from Australia. And he's very funny. He wrote a haiku that says, “Tell less, and ask more. Your advice is not as good as you think it is.” And this is something that can apply directly to you. We're talking about that just now. Right now, this sort of like whatever advice I think I have is, is undoubtedly not as good as I think it is. But as there's a variation on this, which is tell less and ask more. If you've come up with a solution yourself, your solution is not as good as you think it is. When we do it on our own, when we don't co-create solutions in whatever space we're in. Whether it's with our teams in the hospital, whether it's with a family, or a patient, in community, or anywhere else outside of our work, when we're coming up with solutions, and then telling you I've got the smart idea for you. Stop. That should be a warning flag to yourself, Wait a minute, did I come up with this by myself? Or have I actually come to this by asking questions of others, and then we come up with a way forward together? So anyway, I'd wanted to just share that Nel, because as you're talking, I thought, no, haiku is living in your story.

Nel: I didn't know I was so. But what I was gonna say is one of the ways the wording if it's helpful for you that when I used to work clinically, and I worked mainly in emergency and crisis care settings, is I would say, right from the beginning, you know, my role here is to listen to you, is to listen to your story. And I want to know more about you. And then when we got to the end of the history taking because it's psychiatry, I would say, okay, so my training makes me think of a couple of options based on what you've said. But do you think that there's anything that would be helpful for you? So let's, let's do a menu of things that you think might be helpful. And then let's work together to pick a couple because I used to use the New Year's Day, you know, analogy going, we can’t pick 100 things that you want to be better, because, you know, it's like, New Year's day for me is I wake up, you know, every New Year's Day, and I go, I'm gonna be a better person and I'm gonna be healthier. I'm gonna walk 5000 steps a day, and you know, and then by the afternoon, I'm like, okay, well, next year, you know. Same thing happened to me when I met the Dalai Lama in an airport. I was so bowled over as like, oh my god from now. I'm gonna be like the nicest person ever. And it lasted until, you know, my next encounter with an Air Canada employee.

And so, you know, I would say to people, let's pick a couple things. Just a few that you think are important, and we'll work on those together and I will support you. And I think even hearing that from patient, like, from the patient's perspective, they would say, you know, that really made a difference for me that I had that power to choose. And you didn't give me something that was completely unrealistic, you know, like, go and buy this $5,000 sunlamp because the winter months are coming, right like that, for a lot of people isn't possible. So it's, it's working together in partnership. And it sounds so obvious. But a lot of our training doesn't help us do that, right. In medical school, we're taught that you know, we

know everything, we're perfect, we have all the advice, we know what to do. It's a very much like a taught hierarchical model, very paternalistic. It's changing. But with cultural safety, you can even change it more.

JC: And it's really interesting. Totally agree now with that experience of there's a movement within clinical work for us to do more of what you're talking about, which is fantastic. But it's not a big leap to do the exact same thing with our teams. If we're leaders, and you're going to lead your team, whatever that team is, or you're even the highest leader in the hospital; this approach works. Not to come and tell teams, here's what we're going to do. We figured out what we're going to do, but actually asking teammates, right? Or the people that you're leading to say, what do you think would be a good options solutions for this? What's your story? How can you do your work better, not me telling you how to do it better, you need to get it done on time, you need to do this better. It doesn't work for us as patients or as people seeking help. It doesn't work for us as teammates, either. It just doesn't. We've all felt that before resulting in a meeting or a room, they were like, we've got the answer. This is what we're gonna do. And you're sitting there going, Yeah, that's not gonna work. Like that's, I can't do that, right.

And so to make this a more and more universal way of acting with each other. This idea of curiosity, telling less, asking more, letting people share what solutions might be because most of us know the solution is best in our own lives, rather than having someone else tell us what to do. And I think that's important for equity in our clinical care. And it's really critical for equity in our workspaces. We do not have equitable workspaces. In healthcare, we focus a lot on the equity of how we work with communities, families and patients. And of course, we should do that. But we have to be equally concerned about the inequities in our hospitals. They're everywhere. If any one of you works on a hospital, you've got them. The question is not are they there? It's, can we see them? And what are we going to do about it?

Katharine: Yeah, so many great themes, and I think principles for us to reflect on. Unlearning, right? What are all the things we've learned through our lived experience, through our training, through our work, that we need to unlearn. Humility about all these things, as well as our own expertise, because I agree, often the patients know what they need more than we do. And that idea of curiosity, which I love, because I think it's a great way to approach relationships, really, with anybody in our teams, our colleagues, but our patients as well. So I think you guys really unearthed, for us some of those really important principles that we can use in this work. We're getting towards the end of our time, but we're not quite there yet. So I want to ask you guys, if you have any initiatives, you want to share with the room that you think are working really well that they could think about or things that could be scaled to impact children's health. Any success stories that we should know about?

Nel: I think, you know, in my current work, I can't necessarily talk about a specific model that works. You know, here in British Columbia, we have over 200 First Nations communities. And at First Nations Health Authority, our vision is for healthy, vibrant, self-determining, First Nations children, families, communities and nations. And so I guess what I could share is, I think the most, while they're all important pieces, that vibrancy, right, not that we're just not surviving life or children are not just surviving, getting through their childhood years, but thriving. That's really what we're aiming for. But the self-determination is a really important piece. And it ties into what we've talked about, about being

curious. One of the first steps to allow people to be self-determining is to be curious about how they think they can do that. And so, for me, my answer, I guess, in some ways, is you're going to find over 200 models of how we're going to accomplish equity and better health outcomes.

First Nations communities have their own ideas, and I really wish that they were highlighted more. But I will emphasize that part about respecting and enabling as a Western trained healthcare provider, the inclusion of traditional approaches. And a lot of people say to me, you know, like, well, I'm not a traditional healer. And I say to people, too, I am not a traditional healer, I am a Western trained physician. And if I hadn't been, you know, if I hadn't been so naive, I mean, nobody in my family was a doctor. My parents didn't go past grade six. So I didn't know about psychiatry, and some of the negative connotations with psychiatry. But when I started, you know, it was about acknowledging those two facets. You know, being a Western trained physician, and being open to learning throughout my career from Elders, knowledge keepers, people with cultural expertise. So you don't have to know a lot, you just have to be open to it, and in some cases, be able to help people access it.

So, you know, even in the downtown Toronto, at the Center for Addiction and Mental Health, you know, we had resources, in our clinics in the emergency department, about friendship centers, about clinics that had traditional healers, and we could refer people. So I think sometimes people really feel a pressure like, oh, I need to know a lot about this. You don't really, you just have to be respectful and curious and say, what would you like, and if they mentioned traditional approaches, then at least know where to send people. And I think that's probably key. But in terms of models that work, you know, there's so many. I think the other flipside to what I said earlier about the media having such negative portrayals of us. If you actually hear from communities like I have the absolute privilege of doing, you will see that there are healthy children, there are healthy families, there are people who are so immersed in their culture, that's what gives them their strength. And that's what leads to better health outcomes.

JC: Similarly, even in the model I'm describing that we've used and our health equity integration project. It manifests in, you know, dozens, if not hundreds of ways. So the mental model piece, the mindset that we've talked about already curiosity, asking questions, having humility. That's the fundamental piece of the of whatever model that we are using that I think is has led to success, when we see successes. But, you know, we have we have lots of stories from our hospital. And that really are... focus us on the idea that when we rely on our talents, and strengths and resilience, and others as well, and we build towards our goal, which is equitable care, treating each other well, everyone having a great opportunity, the best opportunity for, for wellness. We have often been caught in a deficiency mindset, and inadequacy mindset. That does not tend to inspire us internally, and we can't inspire others well, externally, if we're going to be talking always from a deficiency and an inaccuracy mindset. There are so many stories in every hospital, if I visited with every one of you today, you I know could tell me about successes in your own work or in people's work in your hospital, that are pushing towards equity. That are moving us towards equity. So celebrating that, and recognizing we have strength we have all of us have the ability to be more equitable. Be curious about where we're not doing as well as we might. One of the theories that we talk about is positive psychology and the idea that we accept who we are, all of who we are the things that are wonderful and beautiful about who we are and the things that are problematic, that are dysfunctional about who we are. Then we can start to focus in and not try to have the perfect the

perfect be that I'll never be biased. I'll never do anything racist. That cannot be the goal. That's not we will never get there. We will always end up frustrated and feeling inadequate.

But instead we can move towards how can I treat people well? How can I move towards treating them better all the time and our system treating people better all the time? I can do that. I can do that. And so I know I've gone off a little bit from what you asked, which is sort of stories of success, but I see stories of success all the time when I talk with people and I like to highlight those When people tell me. They'll say, Oh, we did this thing the other day, JC has had, oh, let me just tag that for a minute. That's health equity integration, what you're talking about. I'm so inspired by you, hey, can I take that idea and share it with others because I love what you're doing. That tends to make us feel good about what we're doing. And then we can say, oh, by the way, though, this other thing, kind of looks, you know, what are you doing with that? Oh, yeah, we're really bad at that.

So anyway, I won't ramble on I know, we're getting to the end. But I think that's key for us to keep coming back to equity is not the absence of inequity. Just like health is not the absence of illness. Right, we've used to talk about health as the absence of illness. Health is actually a thing is something that we actually is based on our actions, and our wellness. And equity is a constantly active process, it's not a default state, we'll get to if we can just get rid of the injustices.

Katharine: I think both of you today have shared lots of tangible and practical ways all of us can work towards more equitable practice for ourselves and in our institutions, and lots of inspiring learnings and examples of how we can really take these ideas and principles and try to lean into them and live them. So I want to thank both of you, Nel and JC, for sharing your stories and your expertise with us today. And I think everyone will leave feeling inspired and motivated to co-create that reality in their work.

JC: I forgot to mention something earlier, I'm so sorry, about this website, there are some concrete tools. If you're interested, if you go to health equity integration project on Google. You just put in health equity integration project, you'll find our public website there. All this stuff is freely available and adaptable, you can do anything you want with it in case it's useful.

Katharine: We're always happy to have a resource. So thank you so much. So I again, I want to thank you both for your time. It's been wonderful. It's been a real pleasure speaking with you today. So thank you both.

Nel: Thanks.

JC: Thank you so much.