Antiracist practice for pediatric surgeons in Canada

Oluwatomilayo Daodu MD MPH, Shahrzad Joharifard MD MPH, Melanie I. Morris MD, Dickens Saint-Vil MDCM, Pramod S. Puligandla MD MSc, Mary E. Brindle MD MPH; on behalf of the Canadian Association of Pediatric Surgeons

■ Cite as: *CMAJ* 2022 June 13;194:E813-4. doi: 10.1503/cmaj.211128

Over the past 2 years, the bodies of more than 1800 Indigenous children have been discovered in unmarked graves at the sites of former residential schools in Canada — a horror showing how our country's racist systems have failed even the youngest among us. The systematic separation of Indigenous Peoples from their children, land, culture and language has led to alarming health inequities.[1] In addition, although slavery was outlawed in Canada 27 years before the United States, Black people have continued to face restrictions of their civil rights. The government has formally acknowledged that systemic racism is directly responsible for a multitude of human rights abuses in Canada.

Disparities in health outcomes for Black, Indigenous and other children of colour in Canada are arresting. It is insufficient for physicians and surgeons to merely acknowledge the harm caused by systemic racism. As pediatric surgeons, we must help transform health and social systems to prevent these harms. The practice of identifying and eliminating racism and its harms is called antiracism. In our view, antiracism is an essential duty for all physicians.

The consequences of a legacy of oppressive colonialism for Indigenous children in Canada include child poverty rates approaching 40% and markedly inequitable access to primary and specialist health care.[2,3] Children living on reserves often suffer the harmful consequences of poor access to clean water, fresh food and preventative health services.[4] A recent systematic review found that Indigenous patients in Canada had more complications and a 30% higher rate of death after surgery than non-Indigenous patients.[5] In 2007, the House of Commons committed to "Jordan's Principle," the purpose of which was to ensure that Indigenous children have access to the same government services as non-Indigenous children,[6] yet differential access continues.

Historical forced removal of Indigenous children from their homes and communities has resulted in distrust of the medical system. For many Black and Indigenous children, illness can act as a gateway to foster care.[7] Biases among health care workers give rise to pervasive and inequitable signalling of Black and Indigenous children to child protective agencies, with subsequent apprehension and family disruption. In 2015, the Ontario Human Rights Commission identified that the assessment tools used to evaluate the risks to a child in their home were more likely to identify Indigenous and racialized families as high risk than similar white families.[7] Biases of health care workers also lead to diagnostic delays or errors, differential treatment and communication breakdowns between health practitioners and families.[8] Although the Canadian literature is sparse, disparities are readily apparent. For example, health care workers' biases have been shown to negatively affect the dynamic between Indigenous mothers and nurses in the neonatal intensive care unit.[9]

Key points

- Many children in Canada experience the health effects of generations of systemic racism and colonization.
- These effects include poor access to health care and to environmental factors that promote health, compared with the general population, as well as ongoing bias and discrimination that affect health outcomes.
- Pediatric surgeons in Canada must be educated about racism and systemic inequity, actively work to promote diversity within the field and practise antiracism in all spheres.

Medical education often perpetuates inequities. Black and Indigenous individuals remain underrepresented in medicine and surgery. A dearth of diverse mentors in Canadian educational institutions, as well as microagressions and experiences of undervalued expertise, challenge racialized medical trainees.[10] Surgical culture, in particular, has maintained a status quo in which abuse of power and mistreatment are commonplace. Those who experience discrimination during training have higher rates of burnout, suicidal ideation and thoughts of attrition.[11] Racial prejudice also comes from patients, families and other allied health staff.[12] Such factors contribute to the underrepresentation of racialized physicians in surgery despite the understanding that diverse representation matters, especially for children.

Pediatric surgeons can practise antiracism by educating themselves on the history of systemic injustice and the deleterious effects thereof that continue today. National pediatric surgery organizations should provide members with vetted resources, including training tools on implicit bias and contemporary

peer-reviewed literature. Researchers must be trained to recognize and reflect on the concept that racism, not race, contributes to disparity. Principal investigators must enhance diversity within their teams and participant populations. Clinical teaching within surgery should be racially inclusive; for example, trainees should be taught to recognize how clinical conditions commonly present in patients with darker skin tones. Finally, antiracism and unconscious bias training should be mandatory requirements of continuing medical education by The Royal College of Physicians and Surgeons of Canada (RCPSC), across all programs. In addition, the RCPSC should implement policy that embeds antiracism as an accreditation standard for programs, including mandating equitable search and selection processes for residents and fellows that enhance access for equity-deserving trainees.

Surgeons must listen to patients, families, colleagues and friends with lived experiences of systemic racism and its effects. Hearing these narratives helps avoid perpetrating these behaviours and enables allyship when witnessing such acts. Surgeons must use their positions of leadership to call out actions and systems that ingrain racism and discrimination in hospitals, organizations and communities.

Children's hospitals and pediatric surgery departments should create and implement antiracist policies. Implementation of reforms cannot be left to racialized members of hospital communities, a concept inherent in the Truth and Reconciliation Commission's Calls to Action. The primary responsibility to repair broken systems must be borne by those who have benefitted from the privilege of those systems. Pediatric surgeons must work with hospital administrations to develop antiracist policies and ensure that patients and racialized faculty members have a voice in policy development. This includes promotion of leadership and meaningful participation of diverse individuals throughout the organizational infrastructure; antioppression training during onboarding for all health care providers; provision of racialized medical students and residents with equitable access to career and academic mentorship; and creation of robust safety mechanisms for trainees and faculty to report acts of discrimination without the threat of punishment. To ensure success, plans should include evaluation metrics and commitment to a time frame.

As Justice Murray Sinclair wrote, "Reconciliation will never be achieved so long as one side sees it as a recognition of rights, and the other side sees it as an act of benevolence." We encourage fellow pediatric surgeons to use all the resources within reach to ensure that all children are free from the devasting impact of systemic racism and discrimination. Access to equitable health care and better health outcomes is our common goal. We must aspire to true "liberation" from the obstacles and oppression that systematic racism has woven into the fabric of our society.

References

1. Allen L, Hatala A, Ijaz S, et al. Indigenous-led health care partnerships in Canada. *CMAJ* 2020;192:E208-16.
2. Morris MI, Sioui R, Sioui M. Conference proceeding from the annual meeting of the Canadian Association of Pediatric Surgeons: "Caring for indigenous children: a CAPS perspective." *J Pediatr Surg* 2020;55:793-5.
3. Johnson S. Jordan's Principle and indigenous children with disabilities in Canada: jurisdiction, advocacy, and research. *J Soc Work Disabil Rehabil* 2015;14:233-44.
4. Frohlich KL, Ross N, Richmond C. Health disparities in Canada today: some evidence and a theoretical framework. *Health Policy* 2006;79:132-43.
5. McVicar JA, Poon A, Caron N, et al. Postoperative outcomes for Indigenous Peoples in Canada: a systematic review. *CMAJ* 2021;193:E713-22.
6. Blackstock C. Toward the full and proper implementation of Jordan's Principle: an elusive goal to date. *Paediatr Child Health* 2016;21:245-6.
7. King B, Fallon B, Boyd R, et al. Factors associated with racial differences in child welfare investigative decision-making in Ontario, Canada. *Child Abuse Negl* 2017;73:89-105.
8. Chamberlain JM, Joseph J, Patel K, et al. Differences in severity-adjusted pediatric hospitalization rates are associated with race/ethnicity. *Pediatrics* 2007;119:e1319-24.
9. Doucette E, Antonacci R, Chevrier A, et al. Exploring Indigenous cultural bias and the impact of the mother–nurser dynamic and care within a tertiary neonatal intensive care unit (NICU). *Can J Crit Care Nurs* 2017;28:32.
10. Mocanu V, Kuper T, Marini W, et al. Intersectionality of gender and visible minority status among general surgery residents in Canada. *JAMA Surg* 2020;155:e202828.
11. Filut A, Alvarez M, Carnes M. Discrimination toward physicians of color: a systematic review. *J Natl Med Assoc* 2020;112:117-40.
12. Yuce TK, Turner P, Glass C, et al. national evaluation of racial/ethnic discrimination in US surgical residency programs. *JAMA Surg* 2020;155:526-8.

Competing interests: Melanie Morris is the Indigenous Lead with the Children's Hospital of Winnipeg. Pramod Puligandla is director of the pediatric surgery board of the American Board of Surgery, governor of the American Pediatric Surgical Association and an executive committee member with the Canadian Association of Pediatric Surgeons. Mary Brindle reports a grant from the Canadian Institutes of Health Research, honoraria for speaking at academic events (Harvard University, Massachusetts General Hospital, Memorial Sloan Kettering, University of Manitoba, Hong Kong University) and participation on a nonindustry-funded data safety monitoring board for a clinical trial, outside the submitted work. No other competing interests were declared.

This article has been peer reviewed.

Affiliations: Department of General Surgery (Daodu), University of Calgary; Department of General Surgery (Daodu), Alberta Children's Hospital, Calgary, Alta.; Department of Pediatric General & Thoracic Surgery (Joharifard), University of British Columbia; British Columbia Children's Hospital (Joharifard), Vancouver, BC; Department of Surgery (Morris), Max Rady College of Medicine, University of Manitoba; Departments of Pediatric Surgery and Urology (Morris), Children's Hospital, Winnipeg, Man.; Faculty of Medicine (Saint-Vil), University of Montreal, CHU Sainte-Justine, Montréal, Que.; Harvey E. Beardmore Division of Pediatric Surgery (Puligandla), Department of Pediatric Surgery, Montreal Children's Hospital, McGill University Health Centre, Montréal, Que.; Departments of Surgery and Community Health Sciences (Brindle), Cumming School of Medicine, University of Calgary, Calgary, Alta.

Contributors: All of the authors contributed to the conception and design of the work. Oluwatomilayo Daodu, Shahrzad Joharifard, Melanie Morris and Mary Brindle drafted the manuscript. All of the authors revised it critically for important intellectual content, gave final approval of the version to be published and agreed to be accountable for all aspects of the work.

Correspondence to: Oluwatomilayo Daodu, tdaodu@gmail.com