A Framework for Integrating Structural Competency into Physician Leadership Curricula

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mental health is health

Overview

Audience

This framework is for educators in continuing professional development (CPD) or continuing medical education (CME). The audience includes program directors, curriculum developers, faculty and any other people involved in developing and delivering leadership training programs for physicians.

Purpose

This framework describes how to integrate structural competency into physician leadership curricula. Educators do this to build the necessary attitudes, knowledge and skills among learners so they can challenge inequities in medicine and lead structural change (e.g., in academic, educational and health care settings).

This document:

- defines structural competency and enabling competencies for physician leaders
- explains how to incorporate structural competency into curricula
- provides practical examples and resources
- outlines core components of transformative learning
- explains how to apply transformative learning in CPD/CME programs for physician leaders
- aligns with the "CanMEDS leader role" key competencies.

What is structural competency for physician leaders?

The first definition: The downstream implications of upstream decisions

In 2014, Jonathan Metzl and Helena Hansen introduced and defined structural competency as a paradigm for medical education:

> "[Structural competency is] the trained ability to discern how a host of issues defined clinically as symptoms, attitudes or diseases (e.g., depression, hypertension, obesity, smoking, medication 'non compliance,' trauma, psychosis) also represent the downstream implications of a number of upstream decisions about such matters as health care and food delivery systems, zoning laws, urban and rural infrastructures, medicalization, or even about the very definitions of illness and health" (Metzl and Hansen, 2014).

These "downstream implications" often connect to inequities that are deeply embedded in individuals, systems and structures (e.g., policies, procedures and practices); they can be entrenched in personal biases and prejudices that produce and perpetuate unfair treatment of racialized groups, women, Indigenous peoples and other socially and structurally marginalized groups.

Our definition: Challenging inequities in medicine and leading structural change

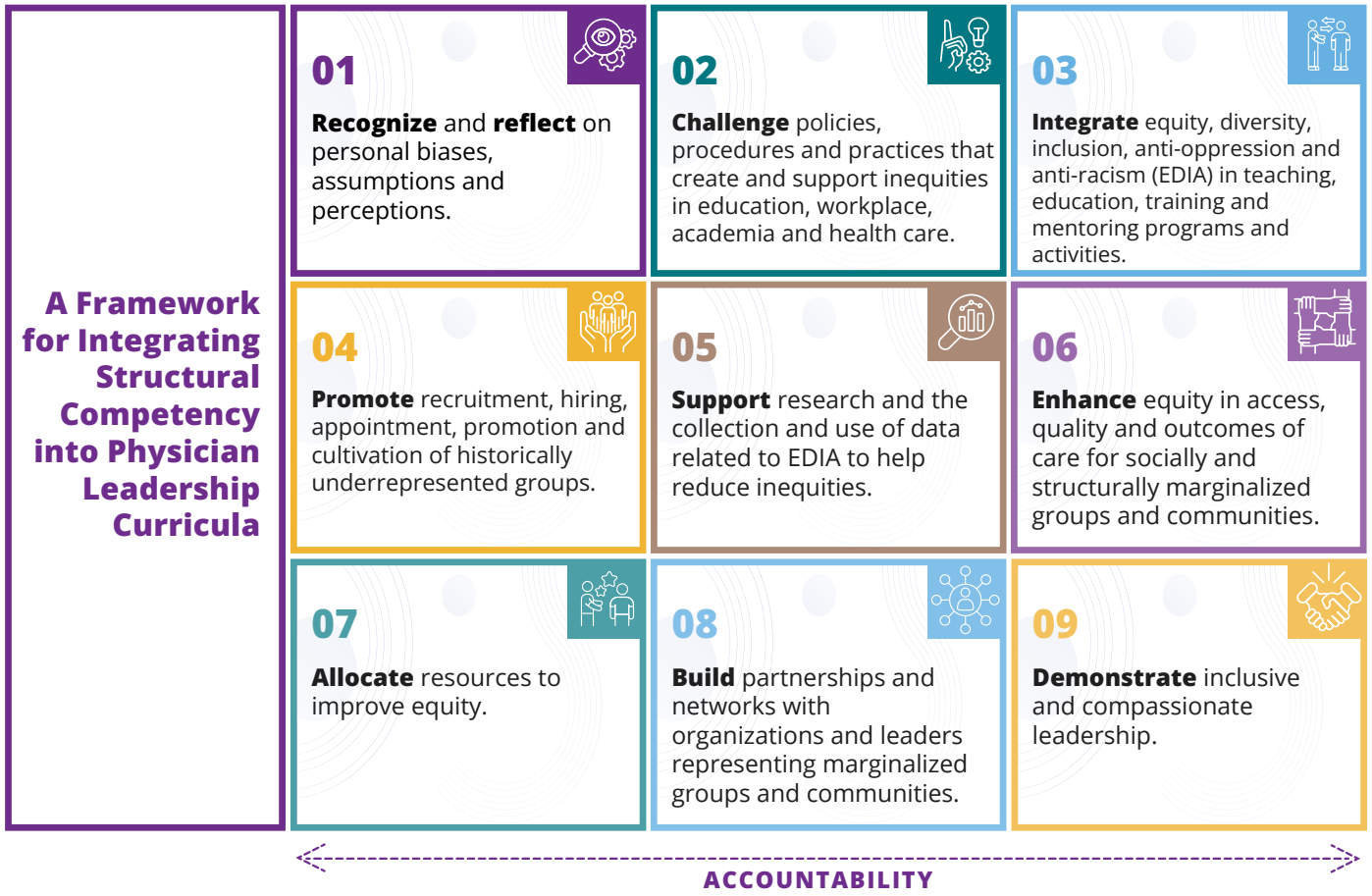
Physician leaders are well-positioned to lead change and innovation in medicine and health care. All physicians assume leadership responsibilities, and some become senior executives in their institutions. This means they are responsible for delivering high-quality care and transforming the health system through their activities as clinicians, administrators, scholars and teachers (Frank et al., 2015).

Therefore, we build on Metzl and Hansen's work and define structural competency for physician leaders as being able to apply the knowledge, skills and attitudes (KSAs) required to challenge inequities in medicine (e.g., in patient care, workplace, academia and education) and lead structural change.

When physician leaders have structural competency and agency, they can act in creative ways to transform medicine (Soklaridis et al., 2022). To prevent and reduce inequities, they need to build structural competency into all aspects of their work, including patient care, administration, education, research and beyond.

However, in 2022, we conducted a literature review, which produced meager results. Almost none of the articles defined structural competency or they cited Metzl and Hansen's definition, which focuses primarily on clinical care, suggesting this field remains in its infancy. It also suggested directions for future work addressing the integration of structural competency into physician leadership programs. Our framework supports this work.

Our nine enabling competencies required to achieve structural competency



Physician leaders hold themselves accountable for their decisions and actions, and for the effects these have on patients, team members, learners, stakeholders and the wider community.

Depending on the scope and goals of the physician leadership program, educators can incorporate one, a few or all the enabling competencies, irrespective of order.

How to integrate structural competency into your training programs

The next sections describe each enabling competency and include relevant learning activities, discussion topics, case studies and additional resources.

The how-to sections aim to inspire educators to tailor material that suits their needs (e.g., to explore and address various issues or to simply start a conversation). They are neither exhaustive nor prescriptive.

Adapt them as needed to help integrate structural competency into physician leadership curricula and to foster transformative learning (e.g., by exploring and addressing issues or simply by starting a conversation).

For every enabling competency, consider asking learners to keep a private journal during their training, where they can record and reflect on their thoughts and dilemmas. Self-reflection is a critical component of transformative learning, which we describe in detail. Then, after critical discourse with other learners, they can write about whether their perspectives have changed and how or why.

Alternatively, during training, consider asking learners to respond in writing to an open-ended question that challenges their perspective on a topic. For example, regarding unconscious racial or gender bias in academia, a question could be: "Why do inequities exist in the professional outcomes of academic medicine, such as those related to compensation and career advancement?"

Throughout the framework, we use various terms that might be unfamiliar or require definition. We recognize language is fluid and many definitions can change, so we have included a glossary in Appendix B, which we hope will ensure a common ground of understanding among our audience.

Some topics can be emotionally challenging to contend with. We encourage everyone to engage empathically and thoughtfully with this material. If necessary, disengage with it for well-being, and consider asking the same of learners.

COMPETENCY #1:

Recognize and reflect on biases, assumptions and perceptions

What does this mean?

With this ability, physician leaders recognize, acknowledge and work on consciously changing their biases, assumptions and stereotypes. They can identify microaggressions that disrupt learning and collaboration in clinical, education and research spaces, and they can intervene to mitigate potential harms.

Reflection is a powerful leadership tool. When leaders identify their unconscious biases (e.g., during experiences that challenge their current frame of reference), they can begin to reframe their perspectives and challenge structural inequities in medicine (Sukhera et al., 2020).

Activities: Self-reflection

- Complete the Harvard Implicit Association Test or use a similar tool that can shed light on an individual's unconscious bias. What did you discover? Describe the experience.
- Review and discuss the Whiteness Project.
- Review and discuss these anti-Indigenous racism resources for health professionals.
- Complete the reflective exercise, Stanford's anti-racism and allyship seven-day journey.

Example case study: Anti-Black microaggression

Scenario (provided by Dr. Akwatu Khenti): You are a staff physician at a university-affiliated hospital. During an academic meeting, a Black colleague speaks about the lack of racialized representation on the clinical team and about the effect of this on the quality of care and the perception of inclusion. A white colleague responds, "Patients only care about receiving the best care. They don't have the slightest concern about the race of their health care provider, and most don't even see colour."

Question 1: How is this comment appropriate or not?

Feedback: The white colleague seems to assume the quality care does not relate to racialization (i.e., quality is colour blind). This ignores many realities (Nair and Adetayo, 2019).

For example, among diverse racialized groups, many delay seeking help due to experiences of racism in clinical encounters (Hamed et al., 2022). Such experiences seldom involve recognizable acts of explicit discrimination. Often, they comprise imperceptible slights, insults and invalidations. For example, someone might demonstrate this behavior through poor listening, limited empathy, low levels of understanding about somatizing presentations (i.e., expressing distress through physical symptoms), or inadequate prescribing. Such racializing interactions can fall below the threshold of discrimination (e.g., by legal standards), but they have been found to engender negative mental health effects for Black participants (Nair and Adetayo, 2019).

Racialized populations often interpret the lack of representation among clinical staff as racial and cultural insensitivity, especially given the normalized racism many Black people experience daily (Nair and Adetayo, 2019).

While the white person may be well intentioned, their response can feel dismissive and ignorant of everyday oppression and microaggressions. By dismissing the Black colleague's racialized realities and equity concerns, the white person ignores the concrete, health harming effects of ongoing institutional and systemic racism, and they reinforce the likelihood of poorer health outcomes across Black populations (Clay, 2017).

Question 2: As a bystander or witness to a microaggression, what can you do?

Feedback: Learn about the concept of allyship and how to be an ally. Stay current on microaggressions in working and learning spaces. Develop responses that can prevent health harms. For example, speak up about how someone's language or behavior makes you feel—but do not speak on behalf of someone who has experienced microaggression as this can also be unintentionally harmful.

For more information, read "Did you really just say that?" (Clay, 2017).

Example case study: Antisemitism

Scenario (provided by Dr. Daniel Buchman): You are the co-chair of an equity, diversity, and inclusion (EDI) committee, which your hospital established recently. Together with your other co-chair, you are reviewing applications for potential membership on the committee.

One of the applicants is an openly Jewish colleague who is deeply committed to progressive causes and anti-oppressive practice. This person has a strong track record of academic scholarship on EDI in medical education, and they chair social justice-oriented committees at the hospital and at a university. You express interest in this person's application, but your co-chair dismisses it.

"We have too many white people on the committee already," your co-chair says. "What would this person know about oppression or trauma? We also need to be careful that they wouldn't try to influence the committee by promoting Zionist interests."

Question: What aspects of antisemitism are relevant to this example? As a leader, how would you respond to your colleague?

Feedback: There are at least three main points to make about your co-chair's comment.

First, your colleague is conflating all Jews into whiteness. This goes against the idea of race as a social construct. While many Ashkenazi Jews (i.e., descendants from Central and Eastern Europe) tend to have pale skin tones and pass as white, whiteness is fluid for many Ashkenazim.

For those who are able to pass in contemporary Western society, their whiteness often depends on social context and the political orientation of the observer (Baddiel, 2022) Overt antisemitism is an integral facet of contemporary white supremacism, making it extremely uncomfortable and destabilizing for many Jews to identify as white.

Efforts to characterize Jews as a degenerate race and people distinct from the dominant population has been a defining feature of antisemitism. In 2024, antisemitic hate crimes are rising in Canada and the United States (Government of Canada, 2023a; ADL, 2023). Many Jews are the victims of violent attacks because they are not considered white (Lind, 2018).

Your co-chair's comment could also be construed as racist: it assumes Ashkenazi (i.e., white-passing) normativity and erases the existence of diverse groups of Jews of colour (e.g., descendants from Asian, Middle Eastern, North African or Latin American countries) (Breger, 2020).

Second, Jews are a minority population. They represent approximately 0.2% of the global population, approximately 2.4% of U.S. and 1.4% of Canadian populations.

Jews of colour are an even smaller minority (Pew Research Center, 2020). They have their own histories of persecution in and expulsion from their ancestral homelands and experiences of antisemitism.

Your co-chair's assumption that your Jewish colleague would not have experienced trauma or oppression because of their identity/ies is also noteworthy. It entrenches Jews as members of the dominant (white) cultural group, and it overlooks any relevant intersectional factors (Stögner, 2020). It ignores the reality of the harms of Holocaust inter-, trans- and generational trauma (Dever, 2023) let alone everyday antisemitic microaggressions experienced by many Jews in the diaspora, and Jews of colour in particular (O'Malley, 2021).

Third, your co-chair's comment draws on millennia-old antisemitic tropes. For example, your colleague raises the suspicion of dual-loyalty (Davis, 2019; note: requires subscription) with respect to "Zionist interests"—another longstanding antisemitic conspiracy theory—where Jews are accused of showing insufficient or false allegiance to their work or the

country where they live, while their true allegiance lies with the Jewish community or Israel (World Jewish Congress, 2022).

Additionally, while not all criticism of Israel is antisemitic, your colleague appears to be using "Zionist" and "Jewish" interchangeably, an approach used to mask antisemitism with criticism of the Jewish state (see this video—Unpacked, 2021). Using "Zionism" as a slur is a technique with origins among Soviet propagandists in their antisemitic campaigns during the cold war period (Tabarovsky, 2022). Many Jews consider the derogatory use of "Zionist" or "Zionism" deeply offensive.

How could you respond to your co-chair's comment? It might seem easier to say nothing, but this would perpetuate antisemitism in two ways. First, this person's antisemitism would go unchallenged. Second, their dismissal of this application—and presumably any other application by Jews—would perpetuate institutional and structural antisemitism.

So, you could see this as an opportunity to educate your co-chair about the history of antisemitism and how their comment is inconsistent with anti-racist and anti-oppressive values. You could discuss antisemitism and its relationship to race as a social construct, to intergenerational and collective trauma, and to common antisemitic tropes.

Example discussion with feedback: Microagressions

Question 1: As leaders, physicians must build a culture against microaggression, which happen everywhere. How can they do this?

Feedback: Educate yourself on the concept of microaggressions. Reflect on your actions, attitudes, ideas and beliefs, and set an example for others. When addressing a microaggression, the first step involves recognizing that one has occurred.

Question 2: What is wrong with asking, "Where are you from?" (Adapted from Sue et al., 2007.)

Feedback: This can seem like an innocent question asked out of curiosity, but it can turn into a microaggression and have harmful effects on the person being asked. The question implies the person is foreign-born and does not belong. For people who may already feel different, it can reinforce differences. It can trigger feelings of alienation or retraumatize people who have had painful experiences related to this.

Question 3: If you want to ask someone where they're from, what can you do instead?

Feedback: Reflect on your unconscious bias and ask yourself why you want to know this information. Listen to what people want to share. If you offend someone, recognize what you did and apologize.

For more examples see "Racial microaggressions in everyday life" (adapted from Sue et al., 2007).

Example discussion with feedback: Privilege

Questions: How do you define various forms of privilege (e.g., male privilege, straight privilege, white privilege), what are their effects, and what does it mean to check your privilege?

Feedback: Multiple and intersecting social identities can inform a person's experiences of privilege and oppression (e.g., racialization, ethnicity, gender, class, sexual orientation). Some identities result in privilege and more opportunities, while others can result in oppression and multiple barriers.

As leaders, physicians should reflect on privileges they may experience due to their identities. Checking one's privilege involves acknowledging and confronting structural discrimination.

Example readings for discussion

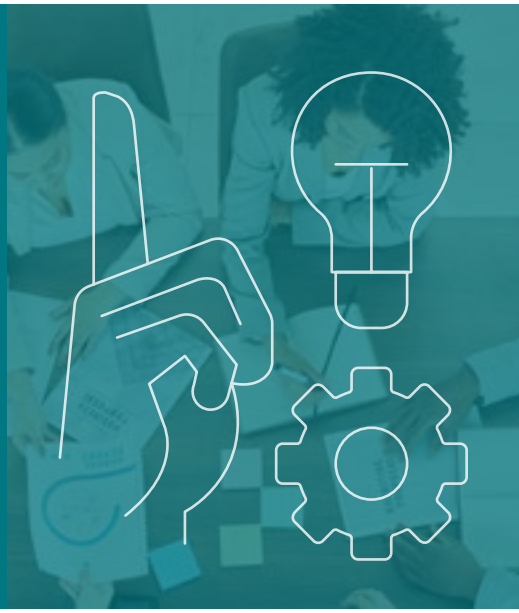
- White privilege: Unpacking the invisible knapsack (McIntosh, 1989).
- Women leaders' career advancement in academic medicine: A feminist critical discourse analysis (Cameron et al., 2020).
- Lower-class origin professionals in Canadian health and social service professions: "A different level of understanding" (Beagan et al., 2022).

More example discussion questions

- Meritocracy: What assumptions do you make about this concept, and what are the strengths and weaknesses of those assumptions?
- Unconscious biases: How can you identify these and how do they relate to the diverse backgrounds of physician leaders?

COMPETENCY #2:

Challenge policies, procedures and practices that create and support inequities in education, workplaces, academia and health care



What does this mean?

With this ability, physician leaders identify, question and contribute actively to changing any policies, practices or procedures (e.g., at the program, institutional and system levels) that create and perpetuate inequities in education, workplaces, academia and health care.

Leaders take responsibility for their decisions and actions. They recognize their power and privilege, practise critical allyship, and help others in positions of power to do so. They ensure periodic reviews to identify existing or emerging problematic issues, and they work in solidarity with socially and structurally marginalized and oppressed groups towards eliminating systems of inequity.

To practice critical allyship, leaders must take active steps to learn about the systems of inequity for which one is in a position of privilege. This can involve unlearning various roles they have taken on throughout their lives (Nixon, 2019). For example, physician leaders can use their status to advocate on behalf of team members who occupy lower positions of power and status (Reddy et al., 2022). This is a way to share privilege.

Leaders should support the implementation of equitable policies, while recognizing the challenges in transitioning policy from theory to practice. To mitigate inequities and related power differentials, leaders must be aware of the dominant discourses and complex dynamics that sustain inequities (Blanchet Garneau et al., 2019).

Activities: Self-reflection

- What systemic and organizational barriers and structures can shape a person's experiences in my workplace? How do I know?

Activities: Online

- Health equity impact assessment (HEIA): How can this (or other health equity assessment tools) help assess and address potential inequities resulting from policies, programs or services?
- RacialEquityTools.org: How can these resources help people assess and change policies, programs and practices that perpetuate inequities?

Example case study: A policy that supports inequity

Scenario: In March 2020, as the COVID-19 pandemic was first ramping up, the Ontario Ministry of Health established temporary funding for doctors to provide health care to people without coverage under the Ontario Health Insurance Plan (OHIP). Around the same time, the Ontario government announced they would end this program at the end of April 2023 (DeClerq, 2023).

Question: What should physician leaders do in this circumstances like this?

Feedback: In a statement, the Ontario Medical Association (OMA) expressed concern about this decision, saying it would be "detrimental to the livelihood of marginalized Ontarians who often face the greatest barriers in our society" (DeClerq, 2023).

Example case study: Marginalized populations

Scenario (shared by Dr. Meb Rashid): Your clinic works with socially and structurally marginalized populations, and there has been a problem with patients not attending their scheduled appointments. This takes away opportunities for other patients to be seen, while wait times lengthen for scheduled appointments. Many staff members want the clinic to charge patients for missed appointments. Staff argue that even if the fees are not collected, the practice would deter patients from missing appointments.

Question: How would you address this request?

Feedback: Consider these questions:

- Why do people from socially and structurally marginalized groups (e.g., people with disabilities, racialized people, refugees) miss appointments?
- Would missed appointment fees be effective? Why or why not)?
- Will these fees disproportionately affect a subgroup of people? How and why, or why not?
- How else could the clinic minimize missed appointments?

Example discussion with feedback: Supporting colleagues with less power and status

Question: How can physician leaders support colleagues who do not have the same level of institutional power and status?

Feedback: In collaboration with those colleagues, leaders could identify and discuss opportunities for:

- actively supporting any socially and structurally marginalized and oppressed populations
- addressing and dismantling discrimination.

For example, leaders could speak out with and among peers, and they could amplify Black voices (Prendergast, 2023).

Example readings for discussion

- Canadian Doctors for Refugee Care v. Canada (Attorney general): In 2013, two refugee claimants, with the support of Canadian Doctors for Refugee Care and the Canadian Association for Refugee Lawyers, took the federal government to court over the cuts to the Interim Federal Health Program (IFHP), which provided public health care to all refugees and asylum seekers in Canada, including victims of human trafficking, people in immigration detention, and other migrant groups (Weinstein, 2020).
- Ignored to death: Systemic racism in the Canadian health care system (Gunn, n.d.)
- Understanding competing discourses as a basis for promoting equity in primary health care (Blanchet Garneau et al., 2019)

More example discussion questions

- Can you identify a policy where you work that you consider inequitable? How could you improve it?
- What are dominant discourses, and how can they act as barriers to equity?

COMPETENCY #3:

Integrate equity, diversity, inclusion, anti-oppression and anti-racism (EDIA) in teaching, education, training and mentoring programs and activities

What does this mean?

With this ability, physician leaders model what they teach, incorporate practice into learning activities and support learners, mentees and colleagues. They sustain accountability for such efforts through active and engaging feedback mechanisms.

Medical students, residents and physicians have various social identities (e.g. related to racialization, ethnicity, gender, sexual orientation, ability and other aspects). To be effective, learning environments and experiences must reflect learner diversity, foster inclusion and mitigate against biases, stereotypes and other significant inequities. Therefore, leaders should:

- integrate an equity lens into the planning, development and delivery of education and training initiatives
- provide individuals from groups underrepresented in medicine (see the glossary in Appendix B) with appropriate resources, support and mentorship to realize their full potential within the profession
- take direct action to address, confront and interrupt racism and discrimination in their work environments.

Activities: Self-reflection

- In what ways do my identities represent privilege or marginalization?
- What do I believe about race, gender identity and sexual orientation in society and education? How do I manage these beliefs in my practice and teaching?
- How do their social identities influence how my students or residents experience the world? How do I know?

Example case study: Biased mentoring

Scenario: Spencer is the new physician-in-chief at his hospital. While eating lunch in the food court, he overhears a staff member saying she was passed over for a leadership position because of gender bias.

"I can't help but think that I shouldn't have followed my mentor's advice," she says to some colleagues. "He told me to wait until after my maternity leave before assuming a leadership role, and I think that caused a lag in my promotion, given that my male colleagues are further along in their careers."

Even though Spencer did not mentor this person, he worries: "Am I perceived as sexist or having gender bias when I mentor women?"

Question: What could he do?

Feedback: If you're worried about being perceived as sexist by your mentee, you could initiate an authentic conversation about it.

For example, Spencer could tell a female mentee that he is in a privileged position, which means he might not be as sensitive to gender issues as he could be, and he wants to learn from her experiences. He could demonstrate positive intent by being honest and asking her to give constructive feedback if he says something that might be gendered or unhelpful to her career. He could tell her he worries about saying the wrong thing or being misinterpreted, so in this mentoring relationship, they must both assume the other is acting with the best intentions.

Spencer could also shift the power dynamic by characterizing mentorship as a bidirectional relationship. He could express interest in learning about his mentee's current experiences and where she sees herself in the near and distant future. He could give her the lead by asking her to identify ways he can help with her career, and he could describe what worked for him. He could also ask how he should give advice in situations where their views of her achievements or capabilities conflict, particularly when she might perceive the feedback as negative. And he could stress the need for patience and open-mindedness.

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Example case study: Racism against a resident

Scenario (shared by Dr. Constance Leblanc): You are the supervising physician. A Muslim resident is working with you in the emergency department (ED), and she reports that a patient refuses to be treated by her. The ED is very busy, and the resident does not appear upset. She asks you to see this patient so she can see another person in need.

Questions: What would you do in this situation? Should you address this patient's behavior now, later or not at all? Why or why not? How could you address it?

Feedback: Among health care professionals, abuse by patients is rampant, and leaders must keep students and residents safe. Leaders must address racist behaviours in health care settings. In an emergency setting, patients need treatment first; afterwards, leaders can follow-up on a patient's behaviour. If possible, talk to the patient about the potential consequences of refusing treatment (Tojersen, 2023).

In this scenario, you must support the resident. If you ignore with patient's behavior, you demonstrate to the resident and others that you prioritize the speed of care and reducing the number of patients in the ED over the safety of staff and residents. Leaders must find a balance between care and safety, and between providing support and conducting invasive and upsetting interrogations.

Ask the resident how she is feeling. Ask for the patient's exact words and explore the resident's ideal approach. Extend support to the resident for now, at the end of the shift and/or later. Ask the resident how best to support her or whether it would help to have a longer discussion at the end of her shift. Consider ways to address the racist behaviour with the patient.

Example readings for discussion

- Health equity and inclusion framework for education and training (CAMH, 2023): What does anti-oppressive teaching involve? How could you ensure a safe and inclusive learning environment?
- "How do I deal with a racist patient?" (Torjesen, 2023)
- "Inequities in medicine take personal toll on physicians, students" and its accompanying webinar, "Structural inequities in medicine: Impacts on the person and the profession" (1:00:32) (American Medical Association, 2021)
- Racial discrimination from patients: Institutional strategies to establish respectful emergency department environments" (Chary et al., 2021)
- Restitution through equity-focused mentoring: A solution to diversify the physician workforce (Walker and Williams, 2022)

COMPETENCY #4:

Promote recruitment, hiring, appointment, promotion and cultivation of historically underrepresented groups

What does this mean?

With this ability, physician leaders actively search, recruit, hire, cultivate and promote members of historically underrepresented groups (see the glossary in Appendix B).

Equity in medicine happens when every person can build, advance and sustain a career as a medical professional without discrimination or any other identity-related negative bias or barrier (CMA, 2023).

Unfortunately, physicians from underrepresented groups continue to experience inequities at all stages of their careers. Often, unfair practices result from of biases common during hiring, appointment or promotion, such as confirmation bias or affinity bias. This can creep in when advertising positions, for example in the composition of selection committees, in the language of evaluations and in the application of rubrics developed by dominant cultures (Cohen and Kiran, 2020; Dryden and Nnorom, 2021).

Activities: Self-reflection

- In what ways do my identities influence how I evaluate and interpret others?

Example case study: Biased interview

Scenario: Jamal was nervous going into the medical school interview, but he had studied this school, reviewed his application, and aced several mock interviews. The interviewer, Professor Smith, MD, was a veteran of the admissions committee and prided himself on being a compassionate physician and educator.

After a cordial greeting, Smith began to ask the standard questions and evaluate Jamal's

answers. *Good understanding of his research, check. Good answer to what he'd do if he couldn't be a doctor, check.* Things were going fine from the professor's perspective—*pretty typical*.

But Jamal noted that Smith did not look comfortable. Smith seemed to be cutting off Jamal's answers and making less eye contact than other interviewers. The usual small talk about sports, music and hometown was omitted, and the conversation felt mechanical. Then it was over, and they were shaking hands. Both felt it was a standard interview, but something was missing.

It is quite possible that an undetected influence soured this interview. Perhaps the very moment the professor heard the name "Jamal" or the instant he met a dark-skinned African-American man, he unconsciously made certain associations—danger, trouble, less intelligent—and these associations affected his rating of Jamal's application.

Despite his best intentions, the professor exhibited a form of implicit or unconscious bias, often called "implicit white race preference." People with this bias unwittingly associate a white face with positive words or feelings and a black face with negative words or feelings, and they might act on those associations.

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Example case study: Productivity problems

Scenario: David is the cardiology department chair at an academic medical centre. Sarah is an assistant professor in his department. She was hired four years ago, but she still has no independent grant support and no published work. John is an assistant professor hired at the same time, and he has met these milestones. Two years ago, Sarah took two months of maternity leave and now she has steady daycare coverage.

David knows he needs to talk to Sarah about her lack of academic productivity, but he's wary of coming across as sexist. He worries that Sarah sees John's success as the result of discrimination.

Question: How should David approach this issue?

Feedback: He could consider whether his expectations are explicit or whether men and women have equal access to unwritten rules and to mentorship and supervision. Then he could work to correct any inequities that he identifies.

He could examine previous performance reviews to recall what guidance, advice and mentorship he gave each junior colleague in the past. He could ask these kinds of questions:

- Was Sarah's lack of productivity pointed out to her previously? If so, how, and what was the result?
- Did she have the same mentorship and supervision as John did to increase the chances of obtaining grants? If so, what happened? If not, why?

- Was she given formal feedback about academic expectations? If so, how?
- What are the departmental guidelines outlining performance expectations?
- What other barriers exist for Sarah in the department, and are they invisible to David? For example, are there after-hours meetings or research teams made up of in-groups, or is there a lack of space, support, funding or recognition of certain types of work?

If guidelines and assistance are in place and the situation is equitable, David can focus on productivity in his discussion with Sarah. He can convey his desire to understand what might be preventing her from meeting expectations. He can assure her that he's there to help her reach her potential, ask what support she needs and set reasonable timelines.

If no guidelines exist, then perhaps men are getting more targeted mentorship and gaining access to unwritten expectations or rules, while women are being excluded. People tend to mentor those who remind them of their younger selves, and men comprise most of the department leadership.

David could bring these concerns to his executive committee, which could take steps to improve mentoring for women and create written guidelines on academic expectations. He could also implement a process to accommodate for leaves of absence during evaluations (e.g., for promotions).

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Example discussion question

If you participated in a hiring or promotion committee, describe how the interview process was (or was not) equitable?

Example readings for discussion

- Tackling barriers in Canadian medical school admissions for students with disabilities (Gertsman et al., 2023)
- Unconscious bias resources for health professionals (AAMC, 2023b).

COMPETENCY #5:

Support research and the collection and use of data related to EDIA to help reduce inequities

What does this mean?

With this ability, physician leaders lead and support research and the collection and use of socio-demographic data, which can help to identify and reduce inequities in medical training, career progression and health care. They use data to monitor and evaluate progress toward equity goals and to continuously improve.

Socio-demographic data includes a person's racialized status, ethnicity and gender, among other variables. It is essential for measuring, identifying and addressing inequities in medical leadership, academia and health care that stem from racism, bias and discrimination (Canadian Institute for Health Information, 2022; Menezes et al., 2022).

Such data has been misused in the past (e.g., racial profiling by the police). Therefore, to prevent reinforcing biases and stigma, physician leaders must work with trusted community partners, organizations and leaders to determine how to interpret and disseminate socio-demographic data.

Activities: Self-reflection

- How does my organization collect and use patient-level socio-demographic data?
- What is the relationship (if any) between how my learners progress and their socio-demographic characteristics?
- How can I use physician demographic data to reduce inequities in medical leadership and academia?

Example readings for discussion

- Addressing gender equity and diversity in Canada's medical profession: A review (CMA, 2018)
- The Canadian war on drugs: Structural violence and unequal treatment of Black Canadians (Khenti, 2014)
- Dying to learn: A scoping review of breast and cervical cancer studies focusing on Black Canadian women (Nnorom et al., 2019)
- Facilitators and barriers of sociodemographic data collection in Canadian health care settings: A multisite case study evaluation (Williams-Roberts et al., 2018)
- Measuring health inequalities: A toolkit (CIHI, 2018)

COMPETENCY #6:

Enhance equity in access, quality and outcomes of care for socially and structurally marginalized groups and communities

What does this mean?

With this ability, physician leaders take a socially accountable approach to reducing barriers and advancing equity in the access to care, as well as the quality and outcomes of care, for socially and structurally marginalized groups and communities. Leaders use community engagement and feedback to identify gaps in care and the efficacy of health interventions.

Every human being has a fundamental right to the highest attainable level of health (World Health Organization, 1946), but there are pervasive and widespread health inequities in Canada (PHAC, 2018).

Leaders play a key role in addressing health inequities and creating socially accountable health care that is accessible and responsive to diverse needs. A socially accountable approach involves:

- advocating for addressing social determinants of health
- collaborating with community partners and policymakers to create a socially accountable health care system
- providing education and training that model and teach advocacy, community responsiveness and the equitable provision of health care
- supporting and conducting research that is responsive to diverse populations (Buchman et al., 2016).

Activities: Self-reflection

- As a leader, what responsibilities do I have toward society?
- How can I be an active advocate of interventions addressing the social determinants of health?
- Do I (or my students and residents) make assumptions that can add barriers to meaningful care and/or lead to misdiagnosis? How can I help people avoid making assumptions and premature judgments?

Example case study: Providing a vaccine to marginalized populations

Scenario (shared by Dr. Meb Rashid): It is 2021, and your workplace has organized a COVID-19 vaccine clinic for your patients. It has diverted a considerable number of staff from their regular activities to ensure patients obtain their vaccines, but staff members notice that the most vulnerable and isolated patients are not getting vaccinated (e.g., elderly people, those with multiple comorbidities or mental health issues, new immigrants).

Question: What could explain this, and how could you increase uptake?

Feedback: Consider whether people have access to reliable information when making decisions around vaccinations. If not, how can you provide it? For people who want vaccination, how can you help facilitate access to it?

Example readings for discussion

- Climate change and the different roles of physicians: A critical response to "A Planetary Health Pledge for Health Professionals in the Anthropocene" (Wiesing, 2022)
- Health care availability, quality, and unmet need: A comparison of transgender and cisgender residents of Ontario, Canada (Giblon and Bauer, 2017)
- Impacts of racism on First Nations patients' emergency care (McLane et al., 2022)
- Jordan's principle: Canada's broken promise to First Nations children? (Blackstock, 2012)
- Practising social accountability (Buchman et al., 2016)
- Principles of community engagement (National Institutes of Health, 2011): How does meaningful community engagement help shift the power dynamic in relationships between health care institutions and marginalized communities?
- Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites (Hoffman et al., 2016)
- Rethinking the use of "vulnerable" (Munari, et al., 2021)
- The SAFE for health institutions evaluation tool (SAFE for Health Institutions, 2021)

COMPETENCY #7:

Allocate resources to improve equity

What does this mean?

With this ability, physician leaders make resource allocation decisions to implement equity-focused improvements in education, workplaces, academia and health care. They recognize and consider the needs of socially and structurally marginalized and underrepresented groups.

To advance equity and related issues (e.g., anti-racism, anti-oppression, diversity and inclusion), leaders must commit to it and distribute resources fairly, which means investing more in areas that need more. They must prioritize marginalized and underrepresented groups.

It is not only ethical but also cost-effective to invest in programs that aim to reduce inequities in education, workplace, academia and health care. Evidence shows that by reducing inequities and increasing diversity in physician leadership, organizations can help to reduce health disparities, improve population health and drive research and innovation (Crews and Wesson, 2018; Soklaridis et al., 2022).

Health inequities are rooted in unequal socio-economic conditions, and this costs Canada's health care system an estimated $6.2 billion annually. By improving the health of socially and structurally marginalized populations, leaders could help to significantly reduce these costs (PHAC, 2016).

Activities: Self-reflection

- In practice, what is an equitable distribution of resources?
- What resources would I need to support and cultivate residents and physicians from underrepresented groups?

Example case study: A policy that supports inequity

Scenario (shared by Dr. Morag Paton): You are chairing a departmental grant review committee. They are reviewing a grant application that would allocate 30 per cent of its funding to pay for consultation time with members of an Indigenous community (external to your organization), named as collaborators in the application.

The grant would be disbursed from a funding envelope, but a departmental policy does not allow external community members to be paid for their time.

Your committee members suggest approving the application but reducing the amount by 30 per cent to align with this policy.

Question: To address inequity as a leader, what could you do?

Feedback: You could recognize this is likely to be a disorienting dilemma for many members of the committee, who might not have encountered this kind of situation before.

As committee chair, you could encourage the committee to reflect on their privileges as members of the department and on the possible reasons behind the policy.

The committee could discuss the need for leadership and representation by Indigenous groups on projects that affect them, noting the final report of the Truth and Reconciliation Commission (2015) and the United Nations' (2007) declaration on the rights of Indigenous peoples.

The committee could raise this case with the department chair and advocate funding the Indigenous community collaborators. It could also suggest revising the policy.

Example readings for discussion

- Achieving health equity by normalizing cardiac care (Pegus et al., 2018)
- Addressing the minority tax: Perspectives from two diversity leaders on building minority faculty success in academic medicine (Campbell and Rodríguez, 2019)
- Bias in peer review: Online training module (SSHRC, 2023).
- Health care equity audits (Health Standards Organization, 2013): These tools examine how fairly resources are distributed relative to the health needs of different groups
- Assessment of potential bias in research grant peer review in Canada (Tamblyn et al., 2018)
- How to fairly allocate scarce medical resources? Controversial preferences of health care professionals with different personal characteristics (Pinho and Araújo, 2021)

COMPETENCY #8:

Build partnerships and networks with trusted organizations and leaders representing marginalized groups and communities

What does this mean?

With this ability, physician leaders actively seek, create and maintain partnerships, and they collaborate with organizations and leaders from underrepresented and marginalized groups. Leaders demonstrate allyship by working in solidarity with marginalized and oppressed groups to address community needs and reshape health care services, policies, processes and practices.

By creating and strengthening connections between health systems and marginalized and oppressed communities, leaders help address specific gaps in the health care system and ensure equitable access, quality and outcomes. This requires building relationships based on trust and accountability, fostering equitable partnerships and working in solidarity with trusted community-based organizations and leaders from marginalized and oppressed groups.

Medical institutions have a complex history of abuse, including experiments, coercive sterilization (see Boyer & Bartlett, 2017; Collier, 2017) and assaults on marginalized populations—in particular, Indigenous peoples and Black people. Therefore, to create successful partnerships, leaders must build trust. Here are three key principles:

- Partnerships benefit everyone involved.
- Partnerships require commitment, time and effort.
- Power-sharing is necessary.

Activities: Self-reflection

- How can I demonstrate that a community is an equal partner in their health care?
- How can I identify potential opportunities for partnerships with community leaders?
- How can community partnerships enhance my outreach and build trust?
- How can I proactively build trust with communities, especially among socially and structurally marginalized groups?
- How can I engage meaningfully and respectfully with communities?
- What differentiates meaningful from superficial engagement?
- What is the concept of positive deviance, and how can it drive positive change?

Example case study: Engaging immigrant communities

Scenario (shared by Dr. Meb Rashid): Your clinic is in an area of the city where many new immigrants settle. You begin seeing several newly arrived refugees, who lived in a refugee camp for decades. Many are polite but appear to be reluctant to share their concerns.

Question: How could gain the confidence and trust of this community?

Feedback: You could begin with educating yourself: explore and learn about the history of their migration. Reach out to community leaders and settlement organizations, and consider using language and cultural interpreters to facilitate discussions.

Example readings for discussion

- Black Lives Matter and racism in health care (Dryden, 2020)
- Community engagement to improve access to health care: A comparative case study to advance implementation science for transgender health equity (Thompson et al., 2022)
- External review: Tubal ligation in the Saskatoon Health Region: The lived experience of Aboriginal women (Boyer and Bartlett, 2017)
- In plain sight: Addressing Indigenous-specific racism and discrimination in B.C. health care (Government of BC, 2020).
- Investigation report: Law on the investigation of the causes and circumstances of death, concerning the death of Joyce Echaquan (Kamel, 2020).
- The positive deviance approach (Baxter and Lawton, 2022).
- The potentials of actively engaging refugees in creating Canadian health care policies aimed at improving their mental health (Kostiuk, 2019).
- The power of positive deviance (Marsh et al., 2004).
- Racism, prejudice contributed to Joyce Echaquan's death in hospital, Quebec coroner's inquiry concludes (Nerestant, 2021).
- Reports of coerced sterilization of Indigenous women in Canada mirrors shameful past (Collier, 2017).

COMPETENCY #9:

Demonstrate inclusive and compassionate leadership

What does this mean?

With this ability, physician leaders create psychologically safe, inclusive and supportive environments that value and respect diversity. Team members report on their sense of belonging and full involvement in relevant decision-making, planning, implementation and evaluation.

Evidence shows a link between leadership, psychological safety, supportiveness, positivity, empathy and innovation. By building trust and mutual respect, leaders create stronger connections between people and stimulate innovations. Compassionate leadership can help to create a culture of caring, inclusion, integrity and psychological safety, which can support effective and innovative ways of addressing the challenges in medicine (West et al., 2017).

Activities: Self-reflection

- How can compassionate leadership stimulate innovation in health care?
- How do I solicit feedback on my leadership?
- What do I believe about leadership? What are my goals in leadership? What are my strengths and weaknesses as a leader?
- What does it mean to be a compassionate leader? What are the key elements of compassionate leadership?

Example reading for discussion

- Caring to change: How covmpassionate leadership can stimulate innovation in health care (West et al., 2017)
- Compassionate leadership: The shortcut to good outcomes for clinicians and patients alike (West and Sinsky, 2022)
- Health care education needs radical reform to emphasize careful and kind care (Bailey et al., 2023)
- Four qualities of compassionate leaders who reduce burnout, turnover (Henry, 2023)

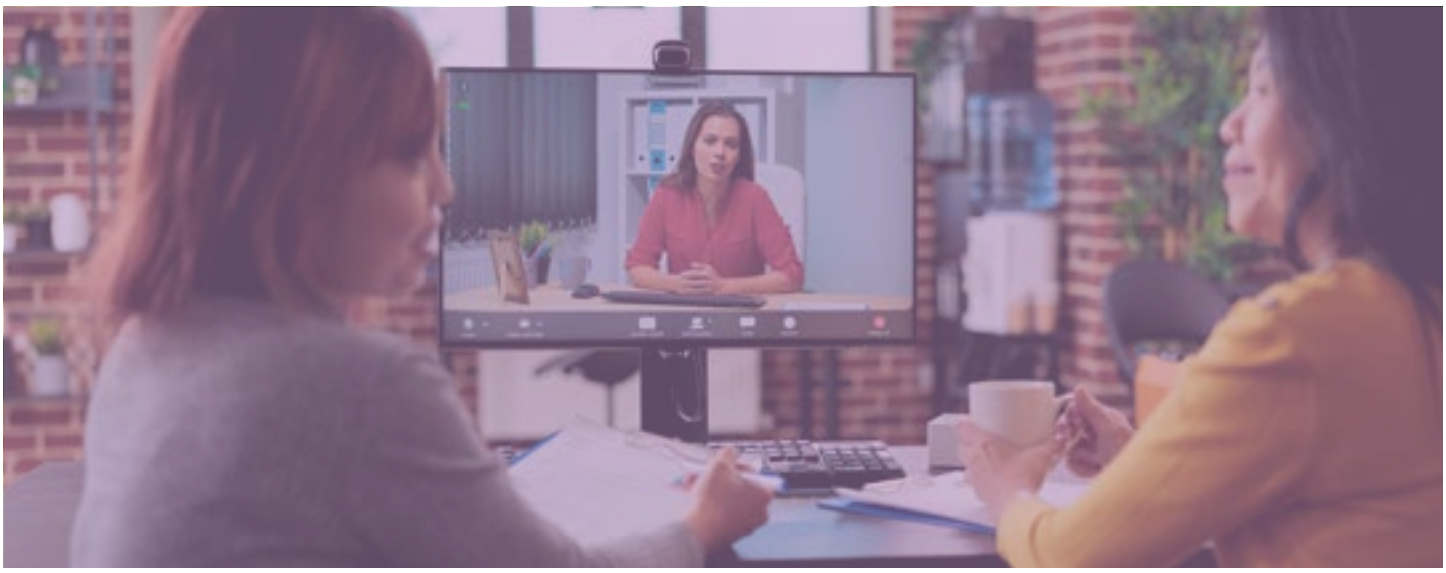
Accountability

Accountability is a key component in leadership. Physician leaders must hold themselves accountable for their:

- decisions and actions
- effects on patients, team members, learners, stakeholders and the wider community.

Therefore, leaders must:

- ask for feedback regularly
- be open to receive feedback
- look for ways to make positive changes.



Putting it together: Building structural competency through transformative learning

Transformative learning theory (TLT) has been recommended as a paradigm for developing leadership programs that inspire physicians to become agents of change (Soklaridis et al., 2022). It is a process of examining, questioning and changing our beliefs, perspectives and underlying assumptions. As such, transformative learning leads to "respect for others, self-respect, willingness to accept responsibility for the common good, willingness to welcome diversity and to approach others with openness" (Mezirow, 2000, p. 14).

The process begins by introducing learners to a disorienting dilemma, which sparks uncomfortable feelings that "disrupt" a person's perspective on what they "have seen, heard and experienced" (Howie and Bagnall, 2013). The dilemma should trigger people to engage in self-reflection by examining their perspective, which can generate new meaning and beliefs.

The process continues with learners engaging in rational discourse with their peers. Rational discourse allows everyone to share their

previously held perspectives in a discussion format, which can reveal gaps in knowledge, biases and experiences (Howie and Bagnall, 2013). The practical examples and resources provided in this framework can help engage learners in this kind of critical reflection and discourse.

To build structural competency through transformative learning, educators and learners must commit to it. Educators must adhere to the principles of transformative learning by reflecting on their pedagogical practice and training content. Then they can engage in rational discourse with colleagues and learners to gain greater perspective into how they created a course and into its quality.

Similarly, learners must play active roles in transformative learning (Halupa, 2017). They must self-reflect, engage critically with their peers and accept transformative learning as a process that takes time. Ultimately, educators and learners must collaborate to transform perspectives (Halupa, 2017).

For educators and learners, this process of self-reflection and discourse must be ongoing. The transformative learning process does not end with the conclusion of a training program.

Conclusion and next steps

We hope CPD/CME educators use this framework to integrate structural competency into physician leadership curricula. This framework is neither prescriptive nor exhaustive. Rather, we encourage its use as a guide to enable structural change at the curriculum level.

To help develop capacity among physician leaders to challenge inequities and lead structural change, we recommend beginning by reviewing the example activities included in the framework, which can help to identify easy wins that leaders can readily adopt.

Appendix A: Evidence, development, positionality and language

Evidence and alignment

Evidence shows that to reduce inequities in access and outcomes of care for diverse populations, medical leadership requires more diversity. However, due to bias and discrimination at the individual, organizational and systemic levels, there is still a lack of physicians from underrepresented groups in leadership positions (Canadian Medical Association, 2020).

Equity-focused leadership development has been identified as a key element in continuing professional development for addressing systemic inequities in medicine that produce and perpetuate unfair treatment of structurally marginalized groups. Unfortunately, a 2021 environmental scan found a dearth of content related to equity, diversity and inclusion (EDI) in physician leadership programs in Canada and the United States (Soklaridis et al., 2022).

As a way forward, we recommend embedding structural competency into physician leadership curricula and using transformative learning techniques (Mesirow, 2000). This can prepare physicians to identify and address the structural factors that perpetuate inequities in medicine.

At its core, our framework embodies principles of equity, diversity, inclusion, anti-oppression and anti-racism (EDIA). We based our framework on a review of relevant literature, and it was informed by several key models and approaches, including these:

- Health equity and inclusion (HEI) framework for education and training (CAMH, 2023)
- Transformative learning theory (Mezirow, 2000)
- The coin model of privilege and critical allyship: Implications for health (Nixon, 2019)
- Compassionate leadership approach (West et al., 2017)

This framework aligns with the following:

- The CanMEDS physician competency framework (Frank et al., 2015), specifically with its competencies for leaders
- The Canadian Medical Association's policy on equity and diversity in medicine (CMA, 2020)
- The LEADS framework (Canadian College of Health Leaders, 2022)

Development

This framework is based on the findings and recommendations of an environmental scan of physician leadership programs in Canada and the United States (Soklaridis et al., 2022). It is informed by a review of the literature on structural competency, key competency frameworks and guiding documents for physician leaders, as well as consultations with its intended audience.

An advisory group guided the creation process. This group comprises individuals with some or all these qualities:

- Demonstrated leadership in EDIA
- Experience with physician leadership programs
- Knowledge of underrepresented and marginalized groups

Positionality statement

This statement aims to acknowledge how our perspectives and experiences influenced and shaped the framework.

It was created by people representing multiple perspectives, strengths and limitations. Our worldviews influenced why we chose to be engaged in this project and the choices and decisions we made in producing this framework.

The project team formed out of common interests in health-professions education (HPE) and personal, community-based or institutional commitments to equity, diversity, inclusion and/or social justice. We have affiliations primarily, but not exclusively, with HPE organizations located in English-speaking urban Canada, including academic health centres, hospitals and universities. One member of the team is affiliated with an academic health centre outside of Canada (Aruba).

Many team members have multiple advanced credentials or are pursuing advanced research or professional degrees. Team members include administrative staff, physicians, researchers, research assistants and students. Some hold senior leadership positions within their respective organizations; some are influential leaders who might not identify as having formal leadership positions; and some neither hold a leadership position nor identify as leaders.

This project received funding from the Royal College of Physicians and Surgeons of Canada.

We do not claim any objective truths. Leadership and health care structures vary across locations and health systems. Outside of our lived/living experiences with inequity, our knowledge of it comes primarily from our relational experiences, educational backgrounds and professional work. These have taught us there are multiple factors of advantage and disadvantage that intersect and overlap, which can be empowering and oppressing depending on our context.

Given that we operate within and are influenced by the Canadian health care system, and given our individual and collective positionalities, we recognize we can have knowledge gaps (e.g., perspectives from various professions associated with health care delivery and operation; perspectives from patients, families and those outside formal health care or educational settings for health professions). Some of our perspectives have a North American tilt.

To broaden our understanding and mitigate against biases, we established the advisory group (mentioned above and listed as co-authors below) for broader representation and to speak for different histories and responsibilities.

Language and terminology

Our vision is to motivate and energize learners to explore their biases, strengths and areas of improvement. We recognize language constantly evolves to reflect changing societal values. Accordingly, the relevance of terms and resources might shift over time.

Our goal is to update this framework and the suggested resources as needed. We welcome feedback on our language, and we commit to being sensitive and thoughtful about our words.

Appendix B: Glossary

Anti-oppression: A practice in which an individual, institution or system actively works to dismantle systems of privilege and oppression with a goal towards equity and social justice. This approach recognizes systems of inequity and offers methods to actively redress power imbalances (Dalrymple and Burke, 1995; Larson, 2008).

Anti-racism: An active and conscious choice that anyone can take to challenge ideological, individual and systemic/institutional racism. It translates into resisting and fighting all forms of oppression against racialized people (Zine, 2004) and a move forward towards an egalitarian society that is free of ideological, systemic/institutional and individual racism (CAMH, 2021).

Compassionate leadership: An inclusive, supportive and empathic leadership approach that promotes a culture of learning, positivity, psychological safety, cultivating the necessary conditions for innovation (West, 2021; West et al., 2017).

Critical allyship: A practice of critically examining and transforming one's beliefs and biases that uphold systems of oppression, while unlearning and re-evaluating one's position of privilege and power. It aims to work actively in solidarity and partnership with marginalized and oppressed groups towards eradicating systems of oppression (Ayyala and Coley, 2022; Bishop, 2015; Nixon, 2019).

Discrimination: The unequal treatment or exclusion of members of various groups based on race, gender, social class, sexual orientation, physical ability, religion and other categories (Fibbi et al., 2021).

Diversity: A measure of representation within a group or population that includes but is not limited to identity, background, lived experience and culture (Rodriguez, 2016; University of Toronto, 2019).

Equity: A concept based on the principle of human rights, justice and fairness in policy, process and outcomes for historically and/or currently underrepresented and marginalized groups, while accounting for diversity. It considers power, access, opportunities, treatment, impacts and outcomes to uphold the rights of individuals and groups to an equitable share of the resources and influence in society (CMA, 2020; Lopes and Thomas, 2006).

(Groups) Underrepresented in medicine (URM): Often defined in the literature numerically as population groups underrepresented in the medical profession relative to their numbers in the general population (AAMC, 2023c).

However, this lens does not acknowledge the persisting disparities faced by many groups who have reached numerical parity (e.g., women, Asian individuals), including in terms of compensation and leadership positions.

Accordingly, we offer a broader definition of URMs as population groups who continue to face significant inequities and injustice within the field of medicine. These groups include (but are not limited to):

- 2SLGBTQ+ individuals (Two-Spirit, lesbian, gay, bisexual, transgender, queer, intersex, and others who identify as part of sexual and gender diverse communities; CMA, 2023; Government of Canada, 2023b; Ruzycki et al., 2021)
- Indigenous peoples (Osei-Tutu et al., 2023; Ruzycki et al., 2022)
- members of racialized groups (Dryden & Nnorom, 2021; Osei-Tutu, et al., 2023)
- women (CMA, 2023; Gawad et al., 2020).

Inclusion: The creation of an environment where everyone shares a sense of belonging, is treated with respect, and can fully participate (University of Toronto, 2019; Tan, 2019).

Marginalized and oppressed groups: Groups and communities who experience discrimination and exclusion (social, political and economic) because of unequal power relationships across economic, political, social and cultural dimensions (Baah et al., 2019; Given, 2008).

Microaggression: The everyday verbal, nonverbal, and environmental slights, snubs, or insults, whether intentional or unintentional, that communicate hostile, derogatory or negative messages to target people based solely on their membership to marginalized groups (Temerty Faculty of Medicine, 2023; Williams, 2020)

Positive deviance: An asset-based improvement approach. At its core is the belief that solutions to problems already exist within communities, and that identifying, understanding, and sharing these solutions enables improvements at scale (Baxter and Lawton, 2022).

Prejudice: A pre-judgment or unjustifiable, and usually negative, attitude of one type of individual/group towards another group and its members. Typically, it is based on unsupported generalizations (or stereotypes) that deny the individuality of the person. No one is free of prejudice (Brochu and Cadwalader, 2021).

Privilege: A set of unearned benefits accorded by the formal and informal institutions of society to all members of a dominant group (e.g., white privilege, male privilege), granting them economic, political, social and cultural advantages at the expense of members of marginalized groups. Privilege is often invisible to those who have it because people are taught not to see it (Nixon, 2019; Anti-Oppression Network, 2014).

Racism: The systemic and institutional use of power in a society to deny rights and freedoms of individuals and groups based on racialization. It is rooted in the prejudice, stereotyping and discrimination that arise from the social construct of race, which is designed to legitimize and perpetuate the unequal treatment of individuals and groups who are perceived as inferior (Braverman and Parker Dominguez, 2021). Racism operates at individual, institutional and societal levels, and it is sustained by various historical legacies (e.g., eurocentrism, colonialism/imperialism, enslavement) (Garner, 2010).

Social accountability: The social contract that medicine has with society. For care to be socially accountable, it must be equitably accessible to everyone and responsive to patient, community and population health needs (Buchman et al., 2016).

Stereotypes: A set of cognitive generalizations (e.g., beliefs, expectations) about the qualities and characteristics of the members of a group or social category based on various social identities, such as sex, gender identity, racialization and ethnicity, nationality, age, socioeconomic status, religion and language (Stanford University, n.d.)

Unconscious/Implicit bias: Attitudes or behaviours that exert powerful influence over individuals outside their awareness. Individuals and/or groups may have biases towards or against other individuals and groups based on various social identities (e.g., ethnicity, gender identity, religion, sexual orientation), which can widen health inequities. Everyone has unconscious bias (Haselton et al., 2005; Sukhera et al., 2019).

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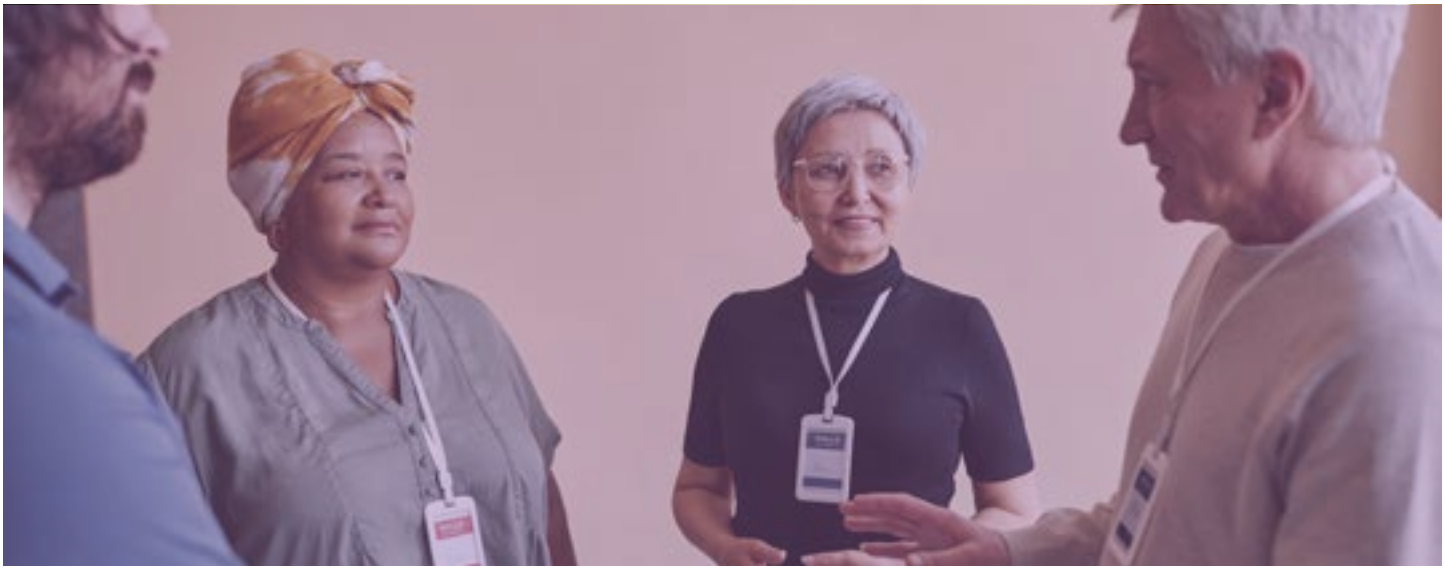

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Land acknowledgement

CAMH is situated on lands that have been occupied by First Nations for millennia; lands rich in civilizations with knowledge of medicine, architecture, technology, and extensive trade routes throughout the Americas. In 1860, the site of CAMH appeared in the Colonial Records Office of the British Crown as the council grounds of the Mississaugas of the New Credit, as they were known at the time. Today, Toronto is covered by the Toronto Purchase, Treaty No. 13 of 1805 with the Mississaugas of the Credit. Toronto is now home to a vast diversity of First Nations, Inuit and Métis who enrich this city. CAMH is committed to reconciliation. We will honour the land through programs and places that reflect and respect its heritage. We will embrace the healing traditions of the Ancestors, and weave them into our caring practices. We will create new relationships and partnerships with First Nations, Inuit and Métis and share the land and protect it for future generations.