INTRODUCTION

Canada — when I think of Canada, the first thing that comes to mind is diversity — how Canada is this multicultural mark of globalisation and unity in an increasingly capitalist and egocentric society. At least that's the public perception, right? Looking at data by Statista (2021), we see that up to 21.5% of Canada's population today is compromised of immigrants and this number is only predicted to grow over the next few decades. A historical background into Canadian foreign policy reveals pretty quickly that Canada's shift to embracing multiculturalism in the 1980s was a big turning point, which led to Canada inviting immigrants to settle in the country for filling in these labour gaps in its own economy (Cheung, 2022a). Over years, more and more immigrants have entered Canada and have devoted countless hours to strengthening Canadian economy and building Canadian industries, filling in all of these labour gaps to make Canada synonymous with diversity today. And this is where the sugar-coated version of Canada's diversity ends. While yes, diversity is awesome, I mean, but it has its challenges and unfortunately for Canada, these challenges have not been very equitable and fairly dealt with in the country.

The labour gaps have surely been filled and are continuingly being filled in Canada using immigration with young and old, black and brown individuals from all kinds of places on the globe leaving their families, cultures and lives behind to build the Canadian dream, the Canadian economy; but the matter of fact is, these very backbones of the economy are being rewarded for their sweat and tears by disproportionately getting inequitable and diminishing returns on their investments, if not losses. The benefits of a boosted economy and massive growth are simply not reaching the very people who make it possible.

Another famously Canadian achievement I guess, perceived in the public eye globally, is Canada's public healthcare system — free, accessible, and universal. That has to be good, right? Not really. Not according to Larry Librach, the former director of bioethics at University of Toronto, who stated that "there's just not a sense of supporting people [in the system]" (Dwyer, 2016, p. 70). With endless waiting periods and 10-minute appointments being deemed 'sufficient', the system has seen a staggering de-personalization and lack of person-centric care arise due to its largely bureaucratic and mechanistic frameworks.

But these two famously Canadian features, both with numerous flaws, intersect to create a group so vulnerable that it doesn't even know it's disadvantaged. Immigrants in Canada — particularly Asian immigrants in this case. This group has consistently felt the heat of this de-personalization much more than non-immigrant populations have. Despite the humongous role that immigrants have played in this country, they have consistently seen huge health disparities affect them much more than other populations (Cheung, 2022b). With its roots in systemic racism and discrimination, health policies have been designed to favour a culturally homogenous, English speaking, fair skinned society in Canada and these policies have not been changed in decades, creating an obsolete system providing care which is neither valid nor reliable, and there are a variety of reasons how this manifests, as Cheung (2022b) touches upon. But this podcast does not intend to discuss the prevalence of these issues. There has been much research documenting these issues in detail, much of which has been discussed in this course. However, this does intend to discuss solutions. Via this podcast, I intend to dive deep into the issue of cultural incompetency in the system, an issue at the heart of many other issues, and propose solutions to how this can be corrected.

The remainder of the podcast follows the following structure: First, it explores current research and trends in seeking cultural sensitivity; secondly, it discusses reasonings on how to resolve this gap in sensitivity via an interview with a physician in the Metro Vancouver Area, and finally, it draws upon the key points from the interview to discuss future directions for a more inclusive healthcare system in a contemporary, multiethnic Canada.

CURRENT TRENDS

Cheung (2022b) reported how there's a severe shortage of ethnically and dialectally matched mental health practitioners and patients in Metro Vancouver Area. Quoting statistics from the lecture, it was reported that even though a staggering 45% of Metro Vancouver citizens reported being Asian, only 13% of psychiatrists in the same area reported being Asian, according to Counselling BC as cited in Cheung (2022b). Now this issue becomes even worse when we look at absolute numbers — that 13% of Psychiatrists? It was just 70, seven zero, a double digit, while the 45% of population in Metro Vancouver Area, was over 1 million. So essentially, we have 70 psychiatrists, who can culturally understand you and provide you with care which is sensitive to your needs, where you, is over a million people. "Cool cool cool cool cool cool cool", to quote Andy Samberg from Brooklyn Nine-Nine (Goor et al., 2013). You know what, let's just let Andy Samberg do that.

[clip]

But this takes me to the question of representation, and why it matters. I was and am curious, that can an equitable representation of the Asian community really solve the problem of this disproportionately suffering Asian diaspora? Cheung (2022b) sure puts forth a very real issue, but what is the solution? The media has hyped up how a lack of representation is what is causing all these issues, and public opinion too, even among the Asian community, has long fixated on this question of representation and how it can solve all of these issues. But I am not sure if it can. I mean, yes, representation is surely very important, but is it enough to alleviate the harms of the current system on immigrants? Is representation solely the only solution?

I rely on a study by Wang (2007) to answer this question. Wang (2007) took on research to look at rates of accessibility among Chinese and Non-Chinese immigrants in areas with substantial Chinese representation. The sample studied was of 317 Chinese immigrants and physicians in areas of North York and Scarborough in Greater Toronto Area (GTA) where Chinese immigrants made up at least about 25% of the population. And they had a very interesting finding. But we'll get to that. Firstly, they found that there was a strong preference for ethnically and dialectally matched physicians among the immigrants — 96% of Chinese immigrants who had a family physician opted for ethnically Chinese physicians. When they looked at reasons for why such aa high majority of Chinese people preferred Chinese physicians, which is a trend found elsewhere ass well, such as Cheung (2022b) they found that the most cited reason was culturally insensitive experiences such as the use of complex medical terminology in English and a lack of understanding of culturally specific medical phenomenon (for example "yin yang"). I mean come on, even a white person will have to accept that medical terminology is daunting. But up until this point, the research hadn't found anything really unexpected. It confirmed the need and demand for more cultural sensitivity given the needs of this specific diaspora.

The surprise unfolded when they looked at the accessibility scores for these immigrants. For context, the number of physicians these immigrants had access to was nearly in a ratio of 1:1 — for the 317 patients in these areas, there were over 300 physicians were present in the same area. However, the research found that despite there being a very good ratio of Chinese patients to physicians in the neighbourhoods they sampled, accessibility scores for culturally sensitive care were still especially low for Chinese immigrants. And this just did not make sense. This was rather unexpected given a high ratio of culturally matched doctors and patients. And hypothetically speaking, this is the solution, ideally speaking, which has been presented as a solution to the problem of representation.

When the researchers looked closely at the data, they found that that high physician demands in metropolitan areas like Toronto due to shortages in the Canadian medical labour market was leading to Chinese physicians to not only attend to Chinese patients but also to non-Chinese patients, which creating a significant, "spatial inequality for culturally disparate immigrants in utilising ethnically and

dialectally matched physicians" to quote the researchers (Wang, 2007, p. 670). Furthermore, this access declined even more the further away one lived from the city.

What this research implies is that even if the proportions for culturally matched patients and doctors were synched, it still wouldn't solve the accessibility problem. Wang (2007) evidenced this, and documented how Canada's structural inequality, which it is trying to fill using immigrants, is affecting these very immigrants, Chinese immigrants in this case, disproportionately. The reason for this is that representation does not by itself solve the issue of a lack of enough physicians in the country. The state of Canada's inadequate medical professionals has been well documented, and just like all other issues, this research suggests that the shortage affecting Asian immigrants much more disproportionately than it does non-immigrant populations. This study clearly suggests that representation alone, at least in proportions of patients to physicians, cannot be enough for filling the. So the question remains, how can we address this need for culturally competency in the Canadian Healthcare System?

I could not answer this question by myself, and attempted to address this question from an internal perspective, by directly asking an Asian Immigrant working in the Canadian Healthcare System.

INTERVIEW

Ramit: Alright, could you just give a brief introduction of yourself?

Dr. Soni: Sure! So My name is Dr. Ravi Soni, I'm a family physician based in South Vancouver. I'm a cisgender, homosexual, 1st generation immigrant male. I'm currently 36 years old and have been in Canada for the past 8 years working as a physician. Glad to be here!

Ramit: Awesome, thank you so much for that. So Dr. Soni, if you had to estimate, what would the proportion of patients you get be in your clinic? If you could divide them into Asian vs all other ethnicities, that would be amazing.

Dr. Soni: If I had to estimate, I'd say about 30% of my patients are Asian.

Ramit: And what if you were to include all other immigrants as well? What would the proportions look like then?

Dr. Soni: I'd say that about 40% of my patients would be immigrants in general, that is people who are not from a European-American ancestry. The proportions don't change much for me personally because I live in a very Asian centric area of South Vancouver.

Ramit: I see. That's interesting. Given how many Asian people live in South Vancouver, I would assume that you'd be getting way more Asian patients than just 30%.

Dr. Soni: That surely is interesting. Over time, I have definitely seen a steady increase in the proportion of people coming to be being Asian, but at the end of it, people need doctors regardless of their race. And there is a shortage in Canada, so they come to me. But I must say, the way my consultations go with Asian people, and immigrants in general, are very different than they are with non-immigrants. There is a much higher focus on building trust, getting the person to understand what exactly is happening, and explaining. I get that, because having grown up in Pakistan, I myself grew up in a system which valued understanding over authority. Our traditional systems of cultural medicine have reasoning built into them. I'm not saying the reasonings are always correct, but the method of choice is to have a logical basis. Turmeric reduce inflammation, ginger helps with the throat, etc. There's definately a focus on understanding medicine, and not just following it.

Ramit: Yeah, I agree. I definately agree with that, we discussed this extensively in the course as well. Even today when I take a medicine, the first thing my mom does is ask me the name, rings up the family doctor and confirms the reasoning for the medicine. It's led to interesting discussions sometimes as to whether she trusts completely me or not, but that's a topic for another time. Anyways, I wanted to ask you about the Canadian healthcare system. You mentioned that Asian individuals might have these differing needs than European-Americans might, and I have been thinking on how these needs can be met. I have personally felt that there is a lack of cultural competency in the system, and, I read this paper about how the Canadian medical system is grossly understaffed, which you touched upon slightly just now, and how the same is affecting Asian-Canadians' ability to access culturally competent care. How has your personal experience been with regards to Asian people accessing your services and in Canada? Do you think the medical understaffing that has been existent in Canada is affecting Asian Canadians disproportionately?

Dr. Soni: The gross proportions of the number of physicians available compared to the number of patients is absolutely crazy. I mean, there's a reason why doctors are paid well — there is incredible demand. But this isn't true for doctors all around: like for example, these doctor to patient ratios are much more skewed for physicians than they are for brain surgeons, for example. Certain positions within the medical classifications, like ED doctors, are much more understaffed than others. But when it comes to access, it is more about access at lower levels than at higher levels, I'd say, because many more patients are going to be coming to a general physician than to an anesthesiologist. And this definately affects access for sure. I mean, think about it, it doesn't matter what proportion of Asian doctors you have in a hospital if the total is 10 doctors where 300 people are needed. People, irrespective of race, will ransack every opportunity to see a doctor. It's a classic case of huge demand and limited supply, and unfortunately, is true for most fields, not only medicines. I have appointments a month in advance sometimes with people who want to see me the next day. Thinking of an example, let's think about anyone who works, 9-5, or in a retail position, or someone who's driving vehicles – either taxi drivers, or truck drivers. Immigrants are much more likely to have [such jobs with] less control on their type of occupation and to work hourly wage jobs. They don't really have it easy on how much free time they have during the day and my clinic is only open so many hours during the day. Also considering that my clinic is situated in South Vancouver, I would say that it can definitely make it more difficult for people who would like to access culturally sensitive care. What if they're living in Coquitlam or North Vancouver. Travel time can make it difficult to make it to the clinic, not to mention that many of them may not even have their own personal vehicles. Imagine travelling in transit for an hour and a half just to see your family physician, that can definitely be crazy.

Ramit: Right.. yeah those are all very good points, and like over the course of discussions in the course, we discussed a lot how there are so many more small challenges that immigrants have to face which non-immigrants just don't have to face, and just along the lines of what I was thinking. But following up on what you just said — the same research that I talked about earlier also suggested that even if today all of these proportions were matched these doctor to patient proportions, as in if the percentages of Asian doctors were matched to the percentages of Asian immigrants, it still wouldn't change much in terms of access for Asian immigrants. And this is because of, just what you said [about the labour gaps], and it makes sense. Now, how can we then bring about a change? It feels like the only answer to this issue, the only straightforward answer would be to increase not only representations of Asian immigrants and all immigrants in general in the workforce, but also to increase Canadian workforce numbers in general.

Dr. Soni: Um… Just a second, I want to clarify the issue we are talking about. Are we talking about the access issue faced by immigrants, particularly Asian immigrants, or is it more about the issue of reduced access [for all]?

Ramit: Oh, right, my apologies — I haven't done podcasts before, and am kind of rambling now. I'll rephrase the question. What am asking particularly is there is problem of disproportionate effects on Asian immigrants on their access to culturally sensitive care, which is clearly happening right now; and the reason for this is not only the lack of proportional representation in the healthcare system but also the understaffed nature of the healthcare system. Now clearly, only increasing representation in the healthcare system is not going to work out [to clear this issue], as the research has suggested and as you have just talked about as well.

Dr. Soni: haha, I don't believe there really is a clear answer, but I believe there are 2 ways for things that we can do. The first is what you stated — namely that we not only increase representation of Asians, whether that be linguistically, culturally, or otherwise, but that we also increase the numbers of physicians and other medical professionals in general. However, there is definately a big issue with this solution — it is a process. This is likely to happen over decades in Canada, and is not something which can be immediate in it's outcome. Infact, that's exactly what the Canadian government has been trying to do — fill this labour gap in the medical system with foreign immigrant doctors. And while there is scope for more to be done in this field, like giving incentives for immigrant students to come and study for a medical degree in Canada, among others, it's not an immediate process. It is gradual and will take time. The issue with that is, it means our Asian populations will suffer. It means that our populations will have to stand the test of time and continue to live in poor health unfortunately.

Ramit: Yeah. I guess it's not the most ideal solution [as you just put it]. But you also mentioned there are 2 ways, what is the second way you think we can change stuff?

Dr. Soni: Yeah. I think the second way is probably education. I don't recall the authors of this paper, but I read a longitudinal research study a while back and it described how educational interventions using training for practitioners successfully improved experiences of patients and at the same time improved cultural sensitivity levels of the practitioners. Well the issue is, while representation is important, the reason for it being important is because when an Asian immigrant goes to a white practitioner, they have bad experience. They feel misunderstood, they feel unheard. This is what leads to a shift in Asian immigrants showing preferences for Asian doctors — but at the root of it, they are just looking for people who can understand them hear them and also help them. Now, representation is surely one way to attack this issue, but what if we are able to reduce these initial bad experiences to begin with? Sure, we can't just provide a lifetime of history and culture from one part of the world to someone who has grown up in aa completely different part of the world. But surely we can promote this understanding, right? We can promote values like kindness, patience, and active listening, which can increase these doctors' cultural competency and reduce the negative strain ethnically different patients have to suffer? The study I was reading provided evidence of this, and if I remember correctly, these differences after the cultural sensitivity program lasted for up to 12 months. That's quite a bit. I'm not saying that don't move towards representation, but what I am saying is that change such as this also has to be considered. The Canadian population might never reach levels of doctors and patients which are proportional both in a relative and an absolute sense. That is a macro level change, which is extremely hard to reach. On the other hand, this is an intervention, and is a much more sustainable way to reach the same goal of culturally sensitive care.

Ramit: Yeah wow, that's quite a different answer than what I was expecting. I was expecting a full-on rant session [about cultural incompetency] but well. Yeah, I definitely see what you are saying on how we need to shift gears towards a more realistic approach, I guess, and away from the unrealistic and idealistic approach of how everything is going to work out and population proportions are going to fall into place. Interesting. Yeah, I'd love to read this article if you could find it later on, but the process you have described is rather fascinating. It's a lot to take in so I just want to summarise it, so what you're saying according to the research that you read, is that we need to expose people and specifically doctors to cultural practises, knowledge and make them more sensitive via these intervention programs, or even other mediums that we can, to help us tackle this issue of cultural competency a lack of access to culturally sensitive care, and we need to do this not by changing the proportions of representations, I mean that's an option I guess, but a much less feasible option, but we need to do this by improving the existing doctors' cultural knowledge and sensitivity, irrespective of race.

Dr. Ravi: Yeah, I would say that's right, at least that's my take on it. I mean, it makes sense right? Think about it. You're an international student here. Haven't you learnt about western culture more just by being here over time and become more sensitive to the same?

Ramit: I mean, sure, half my music library is country music now so sure. It makes sense, the more you get exposed to something, the more you learn about it and the more sensitive you might be. This is acculturation 101, a concept we study about in psychology, and essentially you're talking about using acculturation as a tool by reversing it as a tool and using it on doctors who are from Canada to acculturate them and essentially teach them about other cultures and it's a fascinating idea. It's much more complex and I'm sure it requires much more thinking and planning and is not as simple as it sounds. But definately it's a fascinating idea.

Dr. Soni: Hahaa, I'm glad you like it. And yes, I woulddd say it's theoretical, so requires much more nuancing before it can be implemented. Let's think about it. How will these interventions work? Will they be effective? Will they even have a measurable effect? These are all questions which will have to be answered if we go this way. But definately it's a starting point. And I feel it's conversations like these that we really need to have!

Ramit: Yeah, definitely. It's a great idea, I must say. Thank you so much for sharing your thoughts. It's been an absolute pleasure talking to you. That's all I wanted to discuss from my end, I don't have much time left in the podcast because we have some 'requirements', but is there anything else that you want to add?

Dr. Soni: No, just that I hope this professor gives you an A for this assignment.

Ramit: I hope so too, haha. I like you Ben [and Shu!]. Alright, Thank you so much.

CONCLUDING REMARKS

Following the discussion with Dr. Soni, my understanding of what can be done for this issue has changed quite a bit. I definately think there is validity to what Dr. Soni said, that we can't simply rely on the population demographics to change and for more immigrant doctors to come. There is a much larger game, one which we do not have control over andd one on which wwe simply cannot reply upon.

On following up with Dr. Soni and inquiring about the research he briefly drew upon while discussing potential solutions, I did find the research he talked about, and reviewed the same. It was a paper by Majumdar et al. (2004) which aimed to look at alleviating issues of cultural incompetency by increasing its levels using training programs, particularly for white healthcare practitioners. Recruiting 114 nursing and home care providers, and 113 middle and old age patients from an urban southern Ontario region, all of whom were predominantly white, Majumdar et al. (2004) conducted a longitudinal randomized control trail collecting data at 4 different time points. They used strong measures: measuring cultural competency using the reliable and validated index of the Cultural Competency Assessment (CCA), and validated and reliable self-report measures to track changes in cultural competency and satisfaction in both the practitioners and the patients. When they analyze the data, they found that the program significantly increased the healthcare providers' cultural competency levels (both awareness and knowledge), reduced reported cultural disparities in the provision of home care, and led to higher function in the patients post consultations. Most importantly however, these changes were not short term but were reflected even as late as 12 months post the intervention, as Dr. Soni had pointed out. While the study did fail to find many effects on the patients' cultural [competency] reception levels, largely be attributed to high attrition rates and the patient samples' homogeneity, but all of this still provides extremely strong preliminary evidence for potential solutions via intervention programs for the plaque resulting from cultural incompetency in Canada.

While this study is definitely not a concrete for of evidence of the utility of cultural sensitivity training, it surely is in line with the principles of acculturation and has some validity. The findings might not be the most concrete and after all, it was about 2 decades old when the study was conducted, but it is a starting point as Dr. Soni said.

If what Dr. Soni talks about is doable, it can change the face of inclusivity in the Canadian healthcare system drastically. Via just a couple of hours of cultural education via interventions, the Canadian healthcare system can drastically improve its function and reduce systemic biases, saving ~~hundreds~~ [millions] of dollars worth health losses, and countless lives saved from various health conditions not checked or poorly diagnosed in the current system.

It was a pleasure to be able to interact with Dr. Soni, and I thank him for the time he took out of his busy schedule to chat. Via this podcast, I have been able to grow tremendously in my ability to critically consider issues. More specifically, Dr. Soni's thinking patterns helped me understand a key skill in looking at issues, particularly in bureaucratic systems, that is to understand the main consequences and focus on alleviating them rather than the processes leading to the consequences. For the first part of my podcast, I was continually focussing on the process and how we can bring about change in the process, but Dr. Soni's thought process however was focussed on creating a completely new process and not changing existing one. I believe this is a skill which can very universally be applied, to multiple problem sets which arise. I am grateful to Dr. Soni and this assignment to have exposed me to this.

In addition, the podcast has taught me a couple other things as well. Firstly, I have a much deeper insight into what not to do for a multimedia project next time: namely, podcasts. They are way too hard to make. Secondly, I know now not to record your audio on a $300 smartphone if you do decide to do a podcast next time. It does not work out. And three, I now have a deep respect for Joe Rogan's editorial team. Man, podcast editing is a pain. Thank you.

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