Diversity and Human Rights in the Work Environment

A qualitative research study of diversity and human rights in the workplace

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Acknowledgements

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Thanks especially to the MSH employees who with honesty and courage shared their experiences of the workplace with us. We will endeavour to honour your participation by listening and ensuring that everyone who works here has the opportunity to contribute fully in a safe, respectful environment.

The Mount Sinai Hospital
Diversity & Human Rights Committee

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Executive Summary

"A couple of weeks ago a resident stuck her head into the nurse's room and said 'are there any nurses around?'… then she actually said 'any other nurses?'."

Introduction

In 2001 the hospital established the Office of Diversity and Human Rights, (D&HR). The office provides education, training, policy development and complaints management. Administration also convened a hospital – wide committee to advise on the outcomes and process for diversity and human rights organizational change throughout the organization. Once structures and policies were in place, the need to obtain staff perspectives on diversity and human rights within the workplace (Mount Sinai Hospital) became clear. We needed to know more about the perceptions and experiences of staff, in particular, members of identity groups that are socially marginalized. We wanted to ensure that as an organization committed to leading best practice in the area of Diversity and Human Rights, that our policies, practices and education genuinely reflect staff experience and that our framework ensures a positive, respectful work environment for all staff.

With the support of senior leadership, a commitment was made to embark on a research study in order to better understand staff attitudes, perceptions and needs within the organization. We wanted to capture the voices of staff and the richness of their day-to-day experiences. To accomplish this, focus groups were utilized in this exploratory, non-experimental study. The study, Diversity and Human Rights in the Work Environment, received research ethics board approval.

Methodology

The research project, Diversity and Human Rights in the Work Environment, is an exploratory, non-experimental qualitative study in which researchers interviewed 97 staff members in focus groups. Focus groups are a qualitative research methodology that generates qualitative rather than quantitative data. This approach is particularly useful with socially sensitive, complex topics that resist effective elaboration through questionnaires and other quantitative methods.

The current study explored staff members' in-depth perceptions of diversity and human rights issues in their workplace environments. The investigators were particularly interested in the perceptions of members of specific identity groups identified under the Ontario Human Rights Code (2000) who might be more likely to experience problems related to diversity and equity in the workplace (Agocs and Jain, 2001; Agocs, 1997; Agocs and Burr, 1996; Agocs, Burr and Somerset, 1992). Focus groups were convened in relation to the following identity categories: people of colour, gender, ethnicity/religion, persons with

disabilities, sexual orientation (LGBTT), status/role (service assistant, kitchen staff, ward clerk), managers of colour, general or open.

The protocol used in all of the focus groups is appended in the form of a discussion guide. (Appendix A: Diversity and Human Rights in the Work Environment: Discussion Guide.) Most groups were led by : one of the principal investigators and a member of the Diversity & Human Rights Committee who was trained to co-facilitate the focus group. The committee co-facilitator was, whenever feasible, a member of the current identity group being assessed.

Participation in the study, whether in identity groups or general groups was open to any full or part-time permanent staff member of Mount Sinai Hospital.

For the development of the discussion guide and detailed study plans, the D&HR committee struck a subcommittee. The subcommittee brought each section of work back to the D&HR committee's monthly meetings for their approval. One of the important decisions taken was to move the study beyond the realm of quality assurance and to submit to the hospital's Research Ethics Board.

Data were analyzed using QSR NVivo 2, a qualitative analysis software package.

Findings

"We have patients from time to time that refuse, they'll say, I don't want a Black nurse, I don't want anybody of colour in my room…"

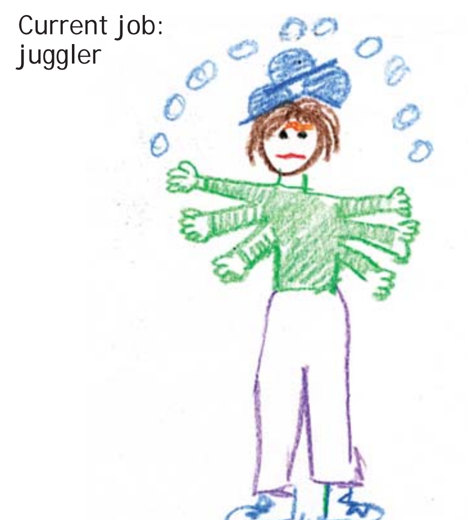
"The only time I've ever [felt discrimination] was in D&HR training… it helped me realize the extent to which my fears were grounded in a reality that the hospital still has a long way to go and we're still living in a very homophobic environment."

Work sheet # 1 results:

Study participants were asked to fill out a work sheet by labelling attributes of current and ideal work environments and create simple drawings to illustrate their ideas.

Pretend your **current** work environment was a person. What kind of person would it be?

Current job: juggler



Pretend your **ideal** work environment was a person. What kind of person would it be?

Ideal job: Patient care

"A person of colour disappears at a power table - they're invisible."

"I think it's easier to work with [non-disabled] people [or people who don't have communication/language problems]... And I feel that limitations are put on us and you're ghettoized into this part-time position forever."

"In order to get to certain types of positions, you have to follow the male model and speaking as a woman with young children, that male model is often unfriendly to the other realities of things that I'm juggling in my life."

"I must say I've gotten to the point where I say very little, because I don't think they would value... sometimes my hand is up forever and they pick everybody else, so now I hardly speak, you would hardly hear me say a word in a meeting."

Participants in the focus groups recognized the efforts the Hospital has made to support and encourage equity and diversity. At the same time, this study has identified how social inequality and social exclusion are reproduced in the seemingly innocuous and mundane day to day activities of work in the hospital. The stories that focus group participants shared with us are about moments in the day in which power differences affect marginalized staff in negative and injurious ways. Importantly, the impact of these marginalizing practices is recognized and felt exclusively by the targeted staff member; those perpetuating the inequalities are largely oblivious to the impact of their actions.

While they constitute acts of subtle discrimination that may not, in and of themselves, form violations of codes and policies, this does not render them innocuous. Rather, they contribute to a workplace culture that is perceived by some in marginalized groups as unwelcoming and inequitable.

Recommendations

For some who work in this hospital, discrimination is experienced on an almost daily basis. We need to act decisively and immediately to eliminate systemic barriers to equal opportunity so that all who work here can contribute fully to the workplace environment, to the patients we serve and to the larger community. The following are some recommendations we feel can help to begin this process.

Planning

1. The Hospital's strategic plan and balanced scorecard should emphasize the importance of diversity at all levels of the workforce and as part of all the work we do.

2. The hospital should emphasize the values of inclusivity and fairness that are a proud part of its history and origins. These values should be reflected in everything we do – from patient care, to budgeting, to partnership.

3. Senior leaders should spearhead efforts in the area of equity and diversity, holding managers and others accountable for achieving results.

Ensure representation of diversity amongst board, staff, physicians and volunteers

4. A systemic employment review should be conducted in order to identify and eliminate any barriers to equal employment opportunities.

5. Increase the number of underrepresented staff from designated groups in leadership roles including: senior management, management, and supervisory positions.

5.1 Human Resources, together with the Diversity & Human Rights Committee should develop targets and timelines for recruitment and hiring of underrepresented groups.

5.2 A diversity expert should be hired in Human Resources to ensure equitable recruitment and hiring from diverse communities. HR staff with expertise in diversity recruitment should be enlisted.

5.3 Human Resources should develop relationships with external partners for the recruitment of individuals from designated groups e.g. Career Bridge, TRIEC, SES.

6. All hiring should follow principles outlined in Fair Employment Opportunities policy and training sessions. All hiring managers must attend Bias-Free Hiring training.

6.1 Managers should be held accountable for actively supporting the recruitment, training and promotion of qualified underrepresented staff through meeting hiring targets.

6.2 Underrepresented staff and patients must be included on interview panels for all positions, including management positions.

6.3 Search firms should be required to present a mix of candidates that reflect the diversity of Toronto.

6.4 The Fair Employment Opportunity policy should be cited on all job postings and posted on the internet.

7. Using principles of good governance, Sinai should develop a skill and competency matrix that creates an open process for selecting and identifying diverse Board Membership in keeping with the LHIN initiative on eliminating health disparities and other recognized best practices.

8. Physician hiring should also follow the principles and processes outlined in the Fair Employment Opportunities policy.

Performance management and accountability

9. Performance indicators for managers need to be instituted that require the demonstration of equitable participation by staff in committees, conferences and learning opportunities.

10. Hiring and promotion for all staff should include consideration of the candidates' commitment to diversity and human rights as well as other qualifications.

11. All staff should be evaluated on equity and cultural competencies, including compliance with human rights and diversity policies and procedures.

12. Managers should be trained to identify possible bias in performance evaluations and promotions.

13. Questions on the workplace environment and manager fairness should be incorporated into the Staff Satisfaction survey.

14. Managers should be required to solicit staff feedback on their performance and staff should be guaranteed protection from reprisals.

15. A centralized scheduling service should be instituted to ensure equitable distribution of work opportunities for scheduled staff. This will reduce the perception of unfairness.

Succession planning

16. Succession/advancement planning for managers should be linked to our overall diversity goals.

16.1 Racialized and other underrepresented staff from designated groups should be included in the organization's succession planning process and its implementation.

"Coming to Canada, I was a physician and had to start all over again... people sometimes make you feel like you're stupid."

"I like working here… It's a different story every single day… it's an adventure."

16.2 Senior leaders should develop a clear process that identifies individuals, particularly those from marginalized groups, for participation in a formal mentorship program for career advancement which promotes leadership from within the organization.

Diversity & Human Rights Committee

17. The results of the Workforce Census should be communicated; identified issues should be acted upon.

17.1 Compliance with the recommendations in this report should be monitored as well as their impact.

17.2 Resources should be made available to implement these recommendations.

18. Equitable partnerships should be created with organizations that serve diverse communities.

19. Diversity Awards should be instituted for staff who have made significant contributions to diversity in regards to staff, patients, or community linkages.

Equitable workplace environment

20. Mount Sinai Hospital should be a leader in addressing discrimination at all levels.

21. Determine whether staff decide to leave their jobs because of barriers or biases in the workplace.

22. Monitor through exit interviews the reasons for staff resignations and develop a strategic plan to respond appropriately.

23. The organization should conduct periodic focus groups of marginalized staff, to monitor organizational progress and identify barriers to achieving an equitable, diverse workplace.

24. A Diversity Campaign should be implemented utilizing posters representing various groups in order to increase awareness and to demonstrate MSH's commitment to equity. The purpose of the campaign is to challenge attitudinal barriers.

25. D and HR office should provide training on racism, homophobia, and ableism on a regular basis throughout the hospital.

25.1 Current training programs should be evaluated and redesigned to address key issues identified in report.

26. A training curriculum and materials to assist all staff to interact with non-English speaking patients and families should be developed and implemented.

Accommodation

27. Senior management should be champions of workplace accommodation due to disability as defined under the Ontario Human Rights code. A centralized budget should be allocated to support work accommodation in the workplace.

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"You're at the table and you're only one person, and therefore there's this impression that you're representing everyone. As a white person you don't carry that responsibility, so why is that expected from a person of colour?"

Introduction

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The context for this study: equality and inequality in workplaces

"I can definitely sense that there is discrimination and I can see that it could be because of my sexual orientation… I've become a target."

Prepared by Sheryl Nestel, PhD

In Toronto, Canada's most multicultural and multiracial city, the workplace is where members of the city's diverse population are most likely to encounter and interact with one another on a daily basis (Lopes and Thomas 2006). While possibilities for productive collaboration, learning and exchange can result from this encounter, so can conflict, miscommunication and discrimination. As Prasad and Mills (1997) note, "much of the diversity literature is characterized by an upbeat naiveté that averts its eyes from the rampant conflicts and ruptures that are endemic to a changing and diverse workplace" (Prasad and Mills 1997). With an eye towards recognizing and subsequently ameliorating such conflicts and ruptures, this literature review will survey inequality in the healthcare workplace in order to contextualize the findings of this research report.

What is diversity?

Diversity refers to the many differences – race/ethnicity, citizenship, gender, sexual orientation, physical and mental capacity, age, religion – that contribute to an individual's identity and which impact on his/her workplace experience (Marsden 1997). Those whose identities are distinct from the majority society often experience a sense of marginalization or exclusion from full participation in economic, cultural and political institutions. The Ontario Human Rights Code protects people in Ontario against discrimination in employment, accommodation, goods, services and facilities, and membership in vocational associations and trade unions and recognizes 16 grounds of discrimination under the code including: race, ancestry, place of origin, colour, ethnic origin, citizenship, creed (religion), sex (including pregnancy), sexual orientation, handicap, age, marital status, family status, and same-sex partnership status (Commission). While, in Canada, we tend to see ourselves as guilty of fewer rights violations than many other countries, the number of human rights complaints at the federal level has continued to grow over the last 20 years (Agocs and Jain 2001). In Ontario alone, 2,399 new complaints were received and added to the Commission's caseload in 2005-6 (Commission).

What is inequality in the workplace?

No workplaces are free from what Acker (2006) defines as "inequality regimes" – "loosely interrelated practices, processes, actions, and meanings that result in and maintain class, gender, and racial inequalities" (Acker 2006). Acker goes on to define inequality in organizations as:

systemic disparities between participants in power and control over goals, resources, and outcomes; workplace decisions such as how to organize work opportunities for promotion and interesting work; security in employment and benefits; pay and other monetary rewards; respect; and pleasures in work and work relations. (P. 443)

Such inequality regimes can arise when organizational cultures reflect the values and behaviours of the most socially-privileged members of society: those who are white, male, heterosexual, and abled bodied (Agocs 2004). Prasad and Mills (1997) have dubbed this "organizational monoculturalism" (p. 15), arguing that cultural norms regarding dress and behaviour as well as cultural norms around employee commitment and performance "do not easily accommodate multicultural preferences on a number of issues, including the boundaries between work and home, the role of work in society, and the conduct of interpersonal relationships within organizations" (p. 15). As Konrad (2003) notes, historically excluded identity groups such as women, members of gay/lesbian/bisexual/transgendered/transsexual communities, and people of colour have fewer opportunities to influence group process because "high status individuals in groups speak longer and more often, take up more space, interrupt members of powerful groups, use hard influence tactics and have more influence over the content of the interaction" than do those accorded lower social status (Konrad 2003). Monoculturalism and the practices that it fosters, notes Carol Agocs "may render minority group members invisible, create a glass ceiling, or perpetuate a poisoned environment that is intimidating, abusive, hostile, humiliating or offensive" (Agocs 2004). Moreover, organizational policies are often represented as the expression of commonly held goals and values rather than as the outcome of formal and informal processes that frequently exclude women, visible minorities and other marginalized groups (Tomei 2003). In a comparative study of U.S. and New Zealand nurses, participants made evident that the "stereotypical ideal nurse was female, White, middle class, heterosexual, abled bodied and nice, with the added qualities of the mythical Nightingale nurse – obedient and nurturing" (Giddings 2005). Ideological notions of who is a good nurse and who is not are normalized in the everyday world of the hospital workplace, rendering the social injustices instituted by such normalizing practices all but invisible.

Microagressions and everyday practices of inequality

While systemic forms of discrimination are a major concern, the microprocesses that underpin and entrench such discrimination are frequently overlooked. Sue et al (2007) describe racial microagressions as "brief and commonplace daily verbal, behavioral, and environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults to the target person or group" (p. 273).

Recent research has identified and categorized subtle forms of racism which are "detrimental to persons of color because they impair performance... by sapping the psychic and spiritual energy of recipients and by creating inequalities" (Sue, Capodilupo et al. 2007). Examples of such microagressions include routinely asking people of colour "where are you from?" (conveys that the person is an outsider/non-Canadian) or professions by white people of "colour blindness" (denying the role of racism in the lives of people of colour). While the research on microagressions cited here focuses primarily on racial inequality, the authors acknowledge that gender, sexual orientation and disability microagressions "may have equally powerful and potentially detrimental effects on women, gay, lesbian, bisexual and transgender individuals and disability groups (Sue, Capodilupo et al. 2007).

"One girl in my department she was East Indian and her job was made very difficult…The people that were giving her the most trouble were white, they're Canadian, they're quite aggressive…and they're thinking that this person is not capable of doing their job…I know her well, what's she can do. This girl's tough, but when you see her, she's so gentle, she's so sweet that they don't think that she's mature. I don't think they really understand the cultural aspect"

Identity groups and workplace equity

Some data is available on the workplace experience of individuals from various identity groups. While some of this data is of use in formulating workplace policy that is fair and equitable, individual identities often overlap the categories mapped out in government equity policy and strict categorization misses the complexities of workplace experience for many people. With this in mind, we offer a survey of some of the literature on workplace inequality.

"I'm a nurse clinician and I'll arrange to meet [staff/ students] at the front desk… and they'll be talking away, they won't even think to say 'Are you so and so?'…They'll just keep talking. I'll be standing there and nobody will say anything until I say 'ok it's me!' They just don't think it would be a Black person."

Gender discrimination

Cultural beliefs about gender difference continue to shape workplace cultures (Schilt 2006). Gendered pay gaps persist in Canada with women's earnings, on average, only 62% of men's (O'Donnell 2006). This discrepancy can be understood to reflect other measures of gender inequality including: devaluation of "women's work", viewing women as second income earners, and women's greater responsibility for household labour and child care. Patriarchal workplace cultures also contribute to women's marginalization in the workforce. In a unique study, female to male transsexuals described how, after transitioning to become men found themselves "as men receiving more authority, reward, and respect in the workplace than they received as women, even when they remain in the same jobs" (Schilt 2006). Workplace sexual harassment also affects women disproportionately and can create an unsafe environment. Workplace harassment plays a major role in maintaining inequality on the job and can affect the victim's physical, psychological well being (Berdahl and Moore 2006). Ontario Human rights law imposes a statutory duty on an employer or a service provider to provide a safe and healthy environment and the Ontario Human Rights Commission can hold employers and unions responsible for not taking action to prevent or to stop sexual harassment. Attention to issues of gender equity is particularly crucial in the health care workplace inasmuch as women continue to account for 97% of nurses in Canada and occupational and income status between doctors and nurses remains significant (Baumgart and Larsen, 1992). A recent survey of nurses reported that 72% of the respondents experienced sexual harassment. Of those respondents who were harassed by coworkers (including physicians), only 17% took action, ie. by confronting the harasser (Swart, Wendt et al. 1996).

As Berdahl and Moore point out, research on sexual harassment has largely focused on the experience of white women, leading to the development of theories that overlook the experiences of minority women who experience significantly more overall harassment than minority men, white women and white men (Berdahl and Moore 2006). That sexual harassment can represent an expression of racism must be considered. Moreover, we would caution against any analysis which fails to take into account the interlocking nature of identity categories. As Razack (1998) points out, additive models of oppression which view different identities as discrete categories that simply intersect one another, fail to describe the hierarchies which dwell within these categories (such as racial hierarchies within the category "women" or hierarchies of ability within racial categories). Rather, what is important is to recognize the "histories, social relations and conditions that structure groups unequally in relation to one another and that shape what can be known, thought, and said (Razack 1998) p.10.

Racial discrimination

Economic and social marginalization are a way of life for racialized minority people in Canada. Data from the 2001 census reveals that there is a 20% gap between the incomes of visible minority people and other Canadians (Cheung 2005). Data on the healthcare labour forces in England (Beishon, Virdee et al. 1995), the U.S. (Dreachslin, Hunt et al. 2000; Dreachslin, Jimpson et al. 2001; Dreachslin, Weech-Maldonado et al. 2004) and Canada (Stasiulis and Bakan 2003) reveal disparities in compensation and advancement for healthcare workers of colour and white workers. A 2005 Ipsos-Reid survey reported that approximately 4 million Canadians have been the target of racism (Lopes and Thomas 2006). Another study, issued by the Canadian Council on Social Development in 2003 reported that 7.3% of workers experienced racial harassment or discrimination at work. Given the fact that 12.5% of the workforce is made up of workers of colour, this represents a shockingly large percentage (Cheung 2005).

Recent findings by Catalyst[1] and The Diversity Institute in Management and Technology at Ryerson University's Ted Rogers School of Management indicate that visible minority corporate employees are less satisfied with their careers, less likely to have positive feelings towards their workplaces and more likely to experience barriers to workplace advancement than their white colleagues(Catalyst and Technology 2007). Visible minority employees perceived numerous barriers related to systemic disadvantage including: being held to higher standards than white colleagues, lack of role models and lack of high visibility assignments (p. 14). In addition, visible minority employees born outside Canada expressed lower levels of career satisfaction than visible minority employees born in Canada. More visible minority employees felt that social contacts within the workplace were more important to advancement than talents or accomplishments, and fewer felt included in social networks at work. Overall, career satisfaction scores were 23% higher among visible minority employees who felt that senior management maintained a significant commitment to cultural diversity.

Indicators of inequality and dissatisfaction among visible minority workers raise substantial concern in the healthcare arena where a significant percentage of nurses belong to visible minority groups. Recent data indicates that RN immigration increased from 1999-2002 and that the more than 45,000 registered nurses who immigrated in those years represented 21.8% of all immigrants listed under health professions (Bauman, et al 2004, 18). Nearly 40% of RNs immigrated from the Philippines, Hong Kong, India or Jamaica indicating that a substantial percentage of these nurses are people of colour. Nearly 30% of RNs immigrating to Canada come from the United Kingdom, which has historically been the sending country for a substantial proportion of nurses of colour (Stasiulis and Bakan 2003, 116), likely increasing the total percentage of recent immigrant RNs of colour.

Racial inequality in the Canadian healthcare workforce, particularly in respect to nurses is well documented. Nurses from the Caribbean were required to possess qualifications superior to those of white immigrant nurses from traditional source countries such as Britain and yet faced more barriers to landed immigrant status. Caribbean nurses immigrating to Canada in the 1950s and 1960s were denied equal citizenship rights and skills upgrading and faced discriminatory attitudes about their

"I had a few opportunities to do translation for [South Asian language] patients and sometimes I see those patients don't receive the same kind of care…It's not like the doctors don't know how to treat these patients, but they don't understand the culture."

[1] Catalyst is a nonprofit corporate membership research and advisory organization which works with businesses and the professions to build inclusive environments and expand opportunities for women and business

professional credentials and credibility. Despite their status as registered nurses, RNs from the Caribbean were frequently forced to work as lower paid and less skilled Registered Nursing Assistants because their training was seen to be lacking (Calliste, 1992 p. 7).

Racism in Canadian nursing has been put on the table as a social issue in recent years through a series of complaints to the Ontario Human Rights Commission (Das Gupta, 1996 p. 62). In the most celebrated of these, seven Black nurses dismissed from Toronto's Northwestern hospital in 1990 charged that systemic racism was behind the firings. The nurses brought a complaint to the Ontario Human Rights Commission after they failed to receive adequate representation in the matter from their union, the Ontario Nurses Association (ONA) (Hardhill, 1993 p. 17). After four years a settlement was finally reached with the hospital but not without the concerted advocacy efforts of groups like the Congress of Black Women (Gray, 1994 p. 29).

"Until you probably have people of colour who are running [the organization] or major decision makers, people like us will be excluded."

Philomena Essed (1990) has described the mechanism of "everyday racism" in the lives of Surinamese nurses in Holland. Essed defines everyday racism as "the various types and expressions of racism experienced by ethnic groups in everyday contact with members of the more powerful (white) group" (p.31). In the case of the Surinamese nurses, racism took several forms: "inferiorization" through the denigration of black nurses by white co-workers and superiors and the exercise of excessive control over work processes, "social distancing" by white nurses through refusal to assist or work with nurses of color, and "social aggression" through the verbalization of both general and personally-targeted racist remarks (pp. 94-95). Such practices are echoed in more recent research with nurses of colour. Collins' (2004) study of Caribbean nurses in Canada describes these women's experience of occupational disadvantage and discrimination despite qualifications which were equal or superior to those of their white colleagues(Collins 2004). Work by Hagey and her colleagues and that of Das Gupta has documented similar evidence of marginalizing practices in relation to nurses of colour in Canada (Das Gupta 1996; Hagey, Choudhry et al. 2001; Hagey, Jacobs et al. 2004).

Homophobia and sexual minorities in the workplace

Sexual orientation has been largely absent from most workplace studies of diversity (Ragins, Cornwell et al. 2003). Existing research into the experience of gays and lesbians in the workplace reveals that discrimination is pervasive, with 25-66% of those questioned having experienced discrimination including job loss, lack of job mobility, ostracism and violence. (Beatty and Kirby 2006). Beatty and Kirby argue that concealing sexual orientation in order to avoid "intrusive or offensive behavior" requires gay and lesbian workers to "carefully separate the personal and work domains of their lives, creating passing strategies to mask their difference (p.33). Concealment, they argue, leads to "fragmentation of the self and feelings of isolation common among many invisible social identities" (p. 33). Invisibility and non-disclosure also prevent workers from receiving spousal benefits and from engaging in social interaction that is considered routine in the workplace such as discussions of leisure time activities, etc. Giddings and Smith (2001) describe the irony of lesbians being both invisible in the workplace through "self-imposed closeting" (p. 16) and hypervisible as the

focus of gossip and other marginalizing practices both subtle and overt (Giddings and Smith 2001). They argue that a profession that has increasingly developed a professional ethic that recognizes the importance of diversity in the relationship between nurse and patient problematically persists in discriminating against lesbians within its ranks. Such discrimination, they argue "serves to deprive nursing administration, education, and practice of nurses who have the potential to contribute most to the new policies acknowledging diversity among patient populations" (p. 19).

Disability in the workplace

People with disabilities have experienced the least progress in the workplace since the passing of the Federal Employment Equity Act in 1986 (England 2003). Only 2.4% of the workforce consists of people with disabilities despite the availability of 6.5% (England, 2003, p. 430). As is the case for other identity categories discussed here, workplaces are shaped by those from dominant groups, including those without emotional, perceptual, cognitive and/or mobility impairments. Consequently both physical and social barriers are commonplace in the workforce. "Ableist" attitudes of employers, argues England are the "most significant barrier that women with disabilities face in getting and keeping a job" (p. 432).

Addressing discrimination in the workplace

Konrad (2003) argues that diversity initiatives that fail to question power relations between socially dominant and socially subordinate groups in the workplace deny the existence of structural barriers and related processes of harassment and marginalization. She suggests that a number of strategies for breaking down processes that favour dominantly positioned workers:

such as monitoring the representation of historical excluded groups in feeder jobs likely to lead to management positions, calculating turnover rates separately for different demographic groups, appraising line managers on their posture toward equal employment, creating special mentoring programs for members of historically excluded groups, using recruitment sources likely to reach a diverse group of job candidates, and developing interest groups for employees of varying demographic backgrounds (Konrad 2003).

Work sheet # 1 results:

Pretend your **current** work environment was a person. What kind of person would it be?

Work sheet # 1 results:

Study participants were asked to fill out a work sheet by labelling attributes of current and ideal work environments and create simple drawings to illustrate their ideas.

Pretend your **current** work environment was a person. What kind of person would it be?

[ ] Female [ ] Male Age ______ Both Male & female

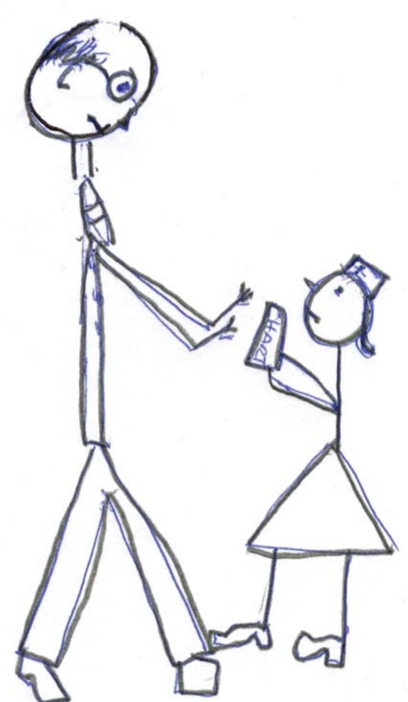
Job Multidisciplinary

What is his/her favourite music? Variety

What does s/he wear? Smart (& Jeans)

Where does s/he live? [ ] City [ ] Suburbs [ ] Country doesn't Matter

[✓] Lives with spouse/partner [ ] Single [✓] How many kids?



Male looking down on female
female looking up to male
female always giving
male always taking

Optional: Circle 5-7 Adjectives

- Approachable
- Bureaucratic
- Business like
- Caring
- Disrespectful
- ✓ Distant
- Fair
- Forward-thinking
- Free of discrimination
- Good Listener
- Hands On
- Helpful
- Insincere
- ✓ Knowledgeable
- Narrow Minded
- Old Fashioned
- Personal
- ✓ Professional
- ✓ Rigid
- Sloppy
- ✓ Traditional

Methodology

Design

The research project, Diversity and Human Rights in the Work Environment, is an exploratory, non-experimental qualitative study in which researchers interviewed 97 staff members in focus groups. Focus groups are a qualitative research methodology that generates qualitative rather than quantitative data. This approach is particularly useful with socially sensitive, complex topics that resist effective elaboration through questionnaires and other quantitative methods.

[Focus groups] use guided group discussions to generate a rich understanding of participants' experiences and beliefs… Focus groups draw on three of the fundamental strengths that are shared by all qualitative methods: (1) exploration and discovery, (2) context and depth, and (3) interpretation… Focus groups are frequently used to learn about either topics or groups of people that are poorly understood. (Morgan 1998, 11-12).

The current study explored staff members' in-depth perceptions of diversity and human rights issues in their workplace environments. The investigators were particularly interested in the perceptions of members of specific identity groups identified under the Ontario Human Rights Code (2000) who might be more likely to experience problems related to diversity and equity in the workplace (Agocs and Jain, 2001; Agocs, 1997; Agocs and Burr, 1996; Agocs, Burr and Somerset, 1992). Focus groups were convened in relation to the following identity categories:

- people of colour
- gender
- ethnicity/religion
- persons with a disability
- sexual orientation (LGBTT)
- status/role (service assistant, kitchen staff, ward clerk)
- managers of colour
- general or open

Subjects

The subjects of this study were recruited through advertisement within the hospital. Staff members were given the option to participate in either self-selected identity focus groups, or in general staff groups that were open to anyone.

Inclusion criteria

Participation in the study, whether in identity groups or general groups was open to any full or part-time permanent staff member of Mount Sinai Hospital. Prospective participants were enrolled once they understood and consented to the nature of the study, the timing of the groups and the required processes (e.g., limitations re: confidentiality and ground rules for the discussion as outlined in the appended consent form, information letter and "what to expect" information sheet).

"You're not seen… You are invisible I think because of your colour…" "That's the paradox of the 'visible minority'. I don't like it."

"…If I wanted to go after a certain job, and if I felt like I was not getting somewhere, I know where to go to place a complaint…how to go about it and how to be assertive. But if I was brand new to the country or to nursing or an acute care setting, I... probably would go and talk to someone who I know was from my background…"

Intervention

The protocol used in all of the focus groups is appended in the form of a discussion guide. (Appendix A: Diversity and Human Rights in the Work Environment: Discussion Guide.) Most groups had two group leaders: one of the principal investigators, and a member of the Diversity & Human Rights Committee who was trained to co-facilitate the focus group. The committee co-facilitator was, whenever feasible, a member of the current identity group being assessed.

Primary outcome

This study is a qualitative exploration of the experience of staff in relation to diversity and human rights in the hospital workplace.

Study endpoints for withdrawal

The study consisted of a series of one-time focus group interviews. Participants were told that if they wished to withdraw at any time before or during the focus group interview they might do so without any consequences to themselves or their jobs.

Sample size rationale

The study used a theoretical sampling model in which participants were recruited to reflect a range of the total study population and to test particular hypotheses (Kitzinger, 1995). Focus groups for social science purposes generally contain 4-12 participants (Asbury, 1995; Kitzinger, 1995; Powell and Single, 1996). In this study, participant numbers ranged from 2-13, with most groups having 3 – 7 participants.

The number of focus groups was determined by the number of major identity clusters in the hospital, as identified by the committee for Diversity and Human Rights. In addition, 7 general staff population groups were convened so that the study reflected a broad range of hospital staff.

Significance of the study

The findings from this study will help to inform the Diversity & Human Rights Committee and Hospital Administration of the perceptions of staff in relation to the following:

- the nature of diversity and human rights issues in the hospital
- the effectiveness of current policies and practices designed to address harassment and discrimination, and
- opportunities for improved policies, procedures and practices throughout the organization to ensure a positive, respectful work environment

The study also has the potential to contribute to the literature on staff perceptions of diversity and human rights in the workplace.

Risk/benefit estimates

There was no perceived risk or benefit to participants. When issues arose during the groups that respondents wished to pursue, they were given information about contacting the Diversity and Human Rights office and/or the Employee Assistance Program.

Study development and methodology

For the development of the discussion guide and detailed study plans, the D&HR committee struck a subcommittee consisting of 3 social workers, a clinical nurse specialist and the hospital's Patient Relations Facilitator. The subcommittee made a point of bringing

each section of work back to the D&HR committee's monthly meetings for their approval. One of the important decisions taken was to move the study beyond the realm of quality assurance and to submit it for ethics review to the hospital's Research Ethics Board.

The roster of groups proposed was as follows: people of colour (x2); gender (x2); ethnicity/religion (x2); persons with disability (x2); sexual orientation (x2); status/role, such as service assistant, kitchen staff or ward clerk (x2); managers of colour (x1), and general groups (x7). However, the final distribution of groups was different from what was proposed (See Table 1). In particular, the number of groups of Disability, Service, LGBTT and Ethnic and Religious Minorities was each reduced to one owing to self-selection in recruitment. The number of Gender groups increased from 2 to 4, as did groups with People of Colour. In order to preserve confidentiality, the use of the more general term "Identity Group" is used in reporting results from the following groups: Disability, LGBTT, Service, and Ethnic and Religious Minorities. For a similar reason, the responses from the Managers of Colour group were included with the responses from the People of Colour groups. Sub-analyses can still be performed separately on results from groups with the original designations.

Analysis

Data were analyzed using QSR NVivo 2, a qualitative analysis software package.

Table 1: Group composition

Number of participants: (approx 4/5ths) [1]	97
Number of groups:	20
Open	7
Women	4
Women of colour (1 was serendipitous, not self-selected)	4
Service role	1
Ethnic & religious minorities	1
Managers of colour	1
LGBTT	1
Disability	1

[1] Proportion of male employees at Mount Sinai Hospital = ~10%

Analysis

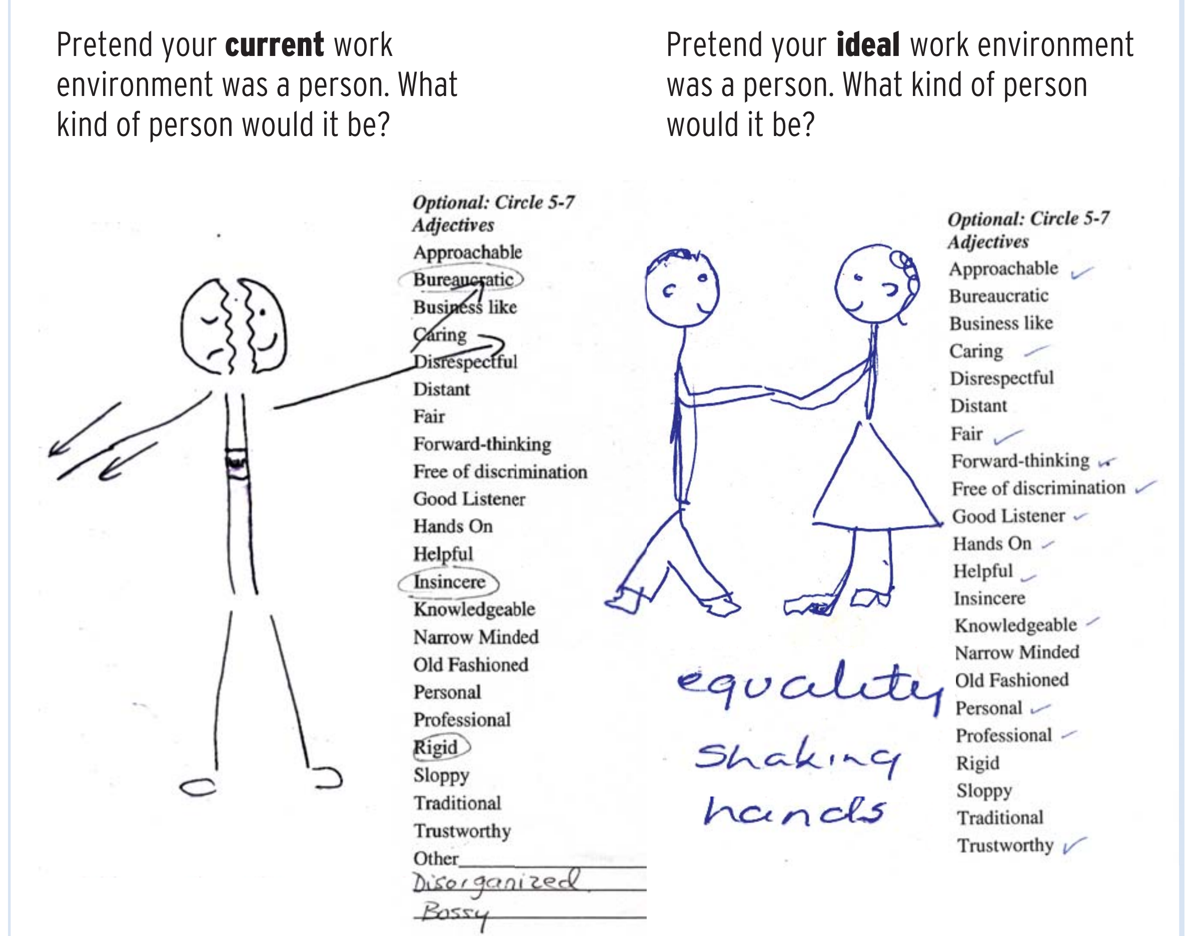
Data were analyzed using QSR NVivo 2, a qualitative analysis software package

Results

1. Experience working at the Hospital

As a warm-up, each group was asked the following question: "Today we're going to talk about your experience working at the hospital. When you think about your work here, what comes to mind?" Each participant had writing materials and was asked to jot down the first thing that came to mind. Then the groups discussed their impressions. The following is a table that outlines the frequency of the themes that arose in the various types of groups. While a number of participants characterized their experience working at the hospital as "hectic, busy, fun, exciting and changing", participants in identity groups comprised of Women and People of Colour were more likely to report their experience as "challenging, stressful or pressured".

Work sheet # 1 results: Study participants were asked to fill out a work sheet by labelling attributes of current and ideal work environments and create simple drawings to illustrate their ideas.



1.1 Table 2: Participants' experience working at the hospital *(top of mind)*

Attribute

	Open	Women	Of colour	Identity
1. Hectic, busy	4	7	1	5
2. Fun, exciting, changing	5	1	1	1
3. Challenging, stressful, pressure	3	10	13	6
3 a) people make you feel stupid			1	
3 b) tough to get ahead			1	
3 c) the commute			2	
3 d) not organized	1			
4. Need to work				1
5. Personally fulfilling	2	0	1	1
6. Being an asset	1	0	0	1
7. Learning opportunity				1
8. Multicultural, diverse	7	0	0	3
9. Supportive, opportunity	3	0	0	4
10. Family	1	0	1	0
11. Positive	2	1	4	0
12. Good and bad	3	2	0	1
13. Touchy-feely			1	
14. Education-focused			1	
15. Restrictive			1	
16. Isolating			3	
17. Proud		2		
18. Respectful		1		
19. Progressive, forward-thinking, excellence	4	0	0	1
20. Rhetoric		1		
21. High-quality patient care	1			
22. Research			1	
23. Closed doors			1	
24. Pleasant environment			1	
25. Out of decision-making loop				1
26. Team	1			
27. Love job but...	1	0	2	0
28. Jewish heritage	1	0	0	1

1.2 Narratives from "Participants' experience working at the hospital"

(Some editing has been necessary to disguise participants' identities while retaining meaning.)

As mentioned above, participants' initial associations to their experience working at the hospital prompted these comments. Some of the comments are identical to what participants had jotted down on their worksheets. Other comments constitute participants' elaboration of their initial associations.

"In order to get to certain types of positions, you have to follow the male model and speaking as a woman with young children, that male model is often unfriendly to the other realities of things that I'm juggling in my life."

The most frequent comments in all groups had to do with the tempo or climate of the work environment. Themes included:

- **the hectic, busy pace:**

"All the time, non-stop" and "it could be hectic at times, but I'm very aware that there could be someone that's coming in for a bad reason."

- **a fun, exciting, changing atmosphere:**

"I like working here... It's a different story every single day... it's an adventure."

- **challenging - stressful, pressure:**

"So much of what I have to do is fighting fires..." and "...I like to have time to do quality work, but that's not the highest priority any more... you get worn down and you can't do as good of a job as you really wanted to do..."

Positive initial responses included: "personally fulfilling, being an asset, a learning opportunity, multicultural, diverse, supportive, collaborative, welcoming, a family, positive, 'touchy-feely', pleasant environment, education-focused, proud, respectful, progressive, leading edge, happy, unique, top-notch care, team, research, the best." In an elaboration upon their responses, participants expressed the following:

"For me this has probably been the best hospital that I've worked at in terms of getting things done myself, in comparison to the culture and the environment of other hospitals I've worked in."

"I'm very proud to be at Mount Sinai, I've worked in many different sectors and one of the things, besides being world class in best medicine... but it's also for me a very safe environment, it's very respectful, more so than anywhere else I've ever been."

"I work in a pretty dynamic team and that's what makes us what we are."

There were also negative initial responses such as "restrictive, isolating, rhetoric, closed doors, marginalized, left out of major decisions, love job but..." Elaborations included such comments as:

"My first thought that came out was 'rhetoric'. I'm kind of torn, because on the one hand I think this is an excellent place to work. On the other hand, there's so much rhetoric about the image of Mount Sinai. What actually goes on are two different things."

"I love what I do, but I just find that the climate is a bit different now...There's a pressure to discharge people. Sometimes I find it conflicts with our philosophy of working with patients."

2. Fair and equitable work environment

As a flip chart exercise, participants were asked, "What makes a work environment fair, equitable and free of harassment and discrimination?" Several groups chose to include "what makes a work environment **unfair**?" Taken together, the results of this exercise can be understood to form the basis of a comprehensive quality assurance checklist for 'what makes an equitable work environment'.

2.1 What makes a work environment unfair?

Participants outlined their perceptions of an unfair work environment based on experiences throughout their work life. They told us that lack of demonstrable equity in an organization, wherein the face of authority is almost exclusively that of the dominant culture, is a key feature of an unfair work environment. Another is inconsistency in implementing standards of equity throughout the organization. Participants perceived as inequitable the variability in the quality of the physical work environment. Unresolved conflict was also seen to exacerbate inequity. The subjective climate of the workspace was seen to contribute to the experience of inequity; e.g., chronic overload, power differentials, politically driven decisions and lack of fun. The following are some examples:

Favouritism, exclusion and organizational culture

"When the dominant culture norms are the rules"

"Glass ceiling for minorities in senior management"

Conflict

"Turf wars", "dirty stares", "nagging"

"Not feeling comfortable enough to talk to manager about problems"

Work environment

"Inadequate physical environment: space, tools, furniture"

"Really high workloads that just seem to go on and on"

"Not a team just because we call ourselves one"

2.2 What makes a work environment fair?

Conversely, participants had little difficulty articulating those elements of a work environment that promote equity. The following are flip chart responses from brainstorming in the various groups.

The first category of responses dealt with features of structure and accountability that participants felt make a work environment fair:

Respectful structure and accountability

Employment policies and guidelines

- Adherence to all aspects of the Human Rights Code
- Accessible, no visible barriers
- Fair employment, discipline, promotion
- Equal pay for work of equal value
- Zero tolerance for discrimination – not lip service
- Respect for various religious traditions
- Equitable consistency in process
- Equal access to information

"Different departments shouldn't look down on the other ones because they're in a higher position. For example housekeeping, they've had a history of feeling that they're being disrespected in some way because of their position… You don't want to come to work [if] someone else is not being nice to you."

"There's some type of acceptance standard that's been set [for white people] to say you're more important and we'll listen to you and we're open to listening to you. Whereas if it's someone else [a person of colour], then you can see that there's this closed- mindedness that comes on. It's like 'you're wasting our time, just get on with it'. You know, that's the impression I get in most of those situations."

Leadership

- Leaders should model fairness, transparency
- "Walk the talk"

Organizational culture of diversity

- Diversity and human rights are everyone's responsibility
- Adherence to policy at all times: no private space in the workplace with regard to disrespect, discrimination and harassment
- Inclusive, non-discriminatory public artwork

The second category of responses illustrates features of respectful process that participants felt make a work environment fair:

Respectful process

- Inclusiveness, working together, discussing issues and resolving concerns
- Staff involvement in decision-making or consensus decision-making
- Place where goals are attainable
- Respectful leadership, non-punitive management

  "No blaming, pointing fingers"

  "Two sides to every story – judgment only with all the facts"

  "Feel comfortable talking to my manager when I have a problem"

- Consistent practice: no favouritism, similar treatment to all staff re: handling their questions, their ideas and disciplinary matters
- Each one valued for his/her skill

Finally, groups talked about fostering a culture of diversity.

Diversity - fostering the culture

Participants said that differences must be valued, actively accommodated and celebrated in a spirit of respect and sharing. Leadership and education are perceived as critical elements in creating an organizational culture that is proactive and diverse at all levels.

3. Barriers to doing your best work, communication and decision-making (excluding ethno-racial discrimination)

In this exercise, participants described experiences in the work environment that can act as barriers to doing their best work[2], as well as barriers to communication and decision-making. The category of Ethno-racial Discrimination is not included here because the themes generated in that category called for special attention in the analysis; they therefore form a separate section of the report. Since discussion in the groups was free-flowing, participants also commented on barrier-reduction in the hospital. The question posed to participants was:

"As compared to other people in the hospital with the same role or job as yours, do you experience any barriers to being able to do your best work or to reach your potential in the workplace?"

[2] Participants spoke - often passionately - about a number of barriers that related primarily to organizational culture. In many instances these themes have been edited out of this report because they did not refer directly to diversity and human rights issues.

3.1 Gender

Even though the question asked was about barriers, respondents also replied by making a number of positive comments about gender-equity in the hospital. However, "the male advantage" is still perceived by some as a factor in the culture of the organization. LGBTT participants had both positive and negative experiences.

Positive comments

- Many women in senior positions
- Male respondent said that he is now very sensitive to his own behaviour around women
- More women professionals entering previously male-dominated areas

Concerns

- *"Striking lack of women on Board and MAC"*
- *"Male work ethic: Women who rise to the top follow this model"*
- *"Lower pay"*
- *"Women founded the hospital – men have their big portraits in the main lobby."*

Male advantage

- *"A lot of our male nurses get mistaken for doctors right away"*
- Male staff person at a lower level than female staff was sent for special training

LGBTT

Positive comments

"Not totally out to everyone… [some staff have] very traditional views… But it certainly has not inhibited me from being successful in doing my job here."

"I find that I'm out and I'm open."

Concerns

"I can definitely sense that there is discrimination and I can see that it could be because of my sexual orientation… I've become a target."

"The only time I've ever [felt discrimination] was in D&HR training… it helped me realize the extent to which my fears were grounded in a reality that the hospital still has a long way to go and we're still living in a very homophobic environment."

3.2 Hierarchy

The issue of hierarchy as inequity is identified by participants in a number of ways: knowledge and communication as power, lack of inclusion, attitudes regarding diversity, structural barriers, and command behaviours, including micromanagement.

Gender-neutral hierarchy barriers

- *"There is a gap between where we sit and people above us."*

Communication as power

- *"The way the information is delivered, you think you're getting the information, but [there's] no substance to it. So you leave the room thinking, 'did I really just hear anything?' and end up with no direction as to what you're supposed to do."*

Lack of inclusion

- *"I'm a line worker and a lot of information filters down to us… Our perception is that the decision has already been made. I don't want to go to a meeting where the outcome has already been decided. This is not inclusion."*

Attitudes can profoundly affect work environment

- *"If a new boss comes in from the outside who's homophobic and takes a dislike to me, that would completely change the way I feel about my job and my future here."*

"I was arguing one day about patient's rights. By the time I got back to my office there were three people lining up to tell me that I was implying something other than patients' rights: 'Now you're doing human rights'. Another one told me I was the next Martin Luther King."

"I come to a meeting, there is even an agenda but sometimes my item will get skipped and it goes to the next person and they have this long discussion... Then I'm left with like 2 minutes or less before the meeting is over."

Command behaviours

- *"It was made quite clear to me that my communication was welcomed to a certain point, but when I got to a committee meeting of the Board I was not to speak."*
- Boss told employee that young child should be able to go home from school alone to enable employee to work overtime.

Micro-management

- *"We had someone in our department that was very much a micro-manager and over-supervising. And that prevented me from continuing to show initiative, changed my work habits and my approach to a lot of things."*

3.3 Academic – training limitations

Participants discussed their perception of the impact of unequal resources and opportunities across the hospital. Some perceived a lack of support when seeking promotion and others felt that their ideas were not valued as highly because of their limited education.

Unequal access to educational funds

- *"There are scholarships and education set out for nurses but for others there's no scholarships, there's nothing without you paying out of your pocket, and then I don't think you'd be reimbursed."*

Lack of information

- *"There's no information about promotions"*
- Not given credit without credentials
- *"The person bringing the idea is taken more seriously if they are at a higher education level"*

3.4 Personnel management

A set of issues that participants felt prevented staff from doing their best work relates to labour practices and personnel management. Participants voiced concerns about shift work, a lack of support for family roles, unequal expectations of single people during crises, union rules that consistently favour seniority, the negative labeling of staff who act as advocates, and the perception that certain staff are bypassed for promotion. Other barriers relate to perceptions about disability and dealing with accommodation.

Shiftwork

Shiftwork is stressful in and of itself, and inequities in work distribution can add to the stress.

- *"We operate 7 days a week, 24 hours a day. So there's off hour shifts and there are certain people who can take those and a lot of people who can't. So that's a problem when they have to rotate into those."*

Support for family roles

- *"In order to get to certain types of positions, you have to follow the male model and speaking as a woman with young children, that male model is often unfriendly to the other realities of things that I'm juggling in my life."*

Unequal expectations

- *"There are times because you're single and live close to work during snow storms – the people who had children and lived in Oakville got to leave – but you, the single person, had to stay that's really not fair either."*

Advocacy

- Persons who advocate, have strong voices can be labeled a 'troublemaker': "I do feel that because I bring up concerns, yes, I do feel I was being held back."

Stereotypes re disability

- *"First I have a feeling like [clinicians are] looking at me trying to figure out, 'Is he a patient?' Does he know what he's talking about?"*

Accommodation/Lack of accommodation

As a particularly vulnerable group, persons with a disability felt that their concerns are only rarely heeded in the organization.

- *"I have been accommodated, and even in terms of work hours, I've been told 'if you can't work a full day, just let us know' and they'll let me go... Where I found the problem was that... the rules or procedures are a little fuzzy. People didn't know exactly what to do. In my case I can end up dealing with Occupational Health and Safety, Occupational Therapists, Building Engineering, my manager, my manager's manager, many different people. And so if there was one person to go to..."* [need coordinator for disability accommodation]

3.5 Operational culture of the workplace

Every workplace has a unique culture, with its own norms, roles and patterns of interaction. The varied work areas in an intensive, complex organization can have a wide range of sub-cultures. Keeping in mind the very positive aspects of hospital culture reported by participants, in some areas they noted ongoing barriers to doing their best work. These included lack of follow-up on strategic planning, unrealistic job definition and expectations, a need for optimal orientation, inhibition of creativity by a bureaucratic mindset, limited expectations, power and control issues, lack of teamwork, resistance to change, and barriers created by boundaries between teams and groups.

Unrealistic job definition

- *"You can't keep telling people [that they are] the problem; the problem is the job. The way you've got it set up, it's undoable, and the system is also the problem."*

Orientation and communication

- *"When you're new coming in here, it's a real barrier. Orientation, as good as it was, it didn't orientate you enough and then there's a lot of roadblocks."*
- *"New internally-promoted managers get inadequate orientation"*

Bureaucracy, rules and customs that impede patient care, creativity, autonomy

- *"For me I am a creative thinker. I find it very difficult to work in an environment where everybody sees one colour, when we know that there are thousands and thousands of colours."*

Power and control issues/Lack of teamwork

- *"...people are jealous, people don't want to give the chance to somebody else. They want to grab the success only for them..."*
- *"Because nurses don't have any control over physician's actions, that makes the rest of our lives awful. It's a structural barrier."*
- *"We do have a voice, but we're not listened to; you could talk until you're blue in the face."*

Resistance to change

- *"All I keep on getting everywhere I go in the hospital is: 'we didn't do it that way, we don't do it that way, that's not how we do it'."*

Barriers between groups

- *"There are four things that come to mind: Personalities, Perceptions, Points of Views and Politics. People are very comfortable in their own groups and don't necessarily want to go outside of them. But then you become tolerant of the intolerant..."*

"We have patients from time to time that refuse, they'll say, I don't want a Black nurse, I don't want anybody of colour in my room..."

"I didn't know the way you needed to approach people, because I'm from an absolutely different part of the world."

3.6 Interpersonal barriers and status barriers

Others reported barriers related to difficulties in interpersonal interaction and status. Participants cited other staff's disrespectful behaviour, perceptions of being undervalued, lack of Canadian credentials, and cultural isolation. Cultural isolation in the workplace as a result of differences in communication patterns, work expectations and gender roles can create conflict among staff as well as barriers to doing one's best work.

Budget restrictions are inevitable in organizations. However, when these restrictions were perceived as inequitable, respondents experienced hardship. If the person working in an under-resourced, under-staffed area is burdened with unrealistic and unfair expectations, the hardship is compounded. In the culture of overload, this is called "do more with less". Feelings of unfairness, resentment and low morale can impact employee behaviour. In some instances, departments are perceived as being under-resourced because of low status in the organization, and middle management feels the nagging pressure of the bottom-line.

Disrespectful behaviour by colleagues

- [new staff] "*A couple of weeks ago a resident stuck her head into the nurse's room and said 'are there any nurses around?'… then she actually said 'any other nurses?'.*"

Underappreciated, undervalued

- "*Sometimes you do so much… and it all goes unnoticed. Because they're always demanding more and more… no matter how much you do.*"

Lack of Canadian credentials

- "*Coming to Canada, I was a physician and had to start all over again… people sometimes make you feel like you're stupid.*"

Cultural isolation

- "*I didn't know the way you needed to approach people, because I'm from an absolutely different part of the world.*"

3.7 Budget restrictions

Culture of overload -"More with less" attitude

- "*The expectation of the work has increased – there used to be more people, now it's just me. Can't keep your head above water… and because [my boss] is putting in an 11-12 hour days, [there's an expectation] that I do as well.*"

Pay equity and lack of

- "*After amalgamation I'm in the same position [doing 3x the work] and someone else in the same position level is only [doing a third] and is being paid more.*"

Physical resources

- "*Lack of equipment, lack of room in the physical work space causing back and leg problems for lots of nurses.*"

Unequal treatment of departments

- "*Different departments shouldn't look down on the other ones because they're in a higher position. For example housekeeping, they've had a history of feeling that they're being disrespected in some way because of their position… You don't want to come to work [if] someone else is not being nice to you.*"

Pressure on middle management

- "*There is a lot of pressure that comes to bear on middle management about bottom line.*"

3.8 Communication and decision-making

Issues of communication and decision-making in the hospital elicited a number of spontaneous positive comments from

participants as well as some suggestions for improvement. The positive comments, outlined more fully in another section, reflected changes in reporting structures meant to foster openness and inclusion, management's support for autonomy and open-door policies, and opportunities to work on egalitarian teams which utilized collective decision-making processes. In relation to areas needing improvement, participants reported workplace barriers involving disability-related discrimination, poor communication, gossip and unresolved conflict.

Harassing or discriminatory

- *"I think it's easier to work with* [non-disabled] *people [or people who don't have communication/language problems]. I used to have more hours and now they've brought in more people and I have less hours. And I feel that limitations are put on us and you're ghettoized into this part-time position forever."*

Not listened to

- *"There's what I would call 'pseudo-autonomy', where something is presented as if you have a say, but it's an illusion, it doesn't exist in any meaningful way. It's meant to placate you."*

Lack of feedback

- *"You're always trying to second guess, 'am I doing a good job?' Nobody ever tells me."*

Gossip

- *"The only thing I can actually complain about my department is that there's a lot of gossip going around."*

Unresolved conflict

- *"A few nurses on my unit [we] had some challenges with, and as a result, they stopped talking… Even just to say hi or good morning, they ignore you."*

Work sheet # 1 results:

Study participants were asked to fill out a work sheet by labelling attributes of current and ideal work environments and create simple drawings to illustrate their ideas.

Pretend your **current** work environment was a person. What kind of person would it be?

[✓] Female [ ] Male Age 55

Job administrator in charge of happiness

What is his/her favourite music? light jazz

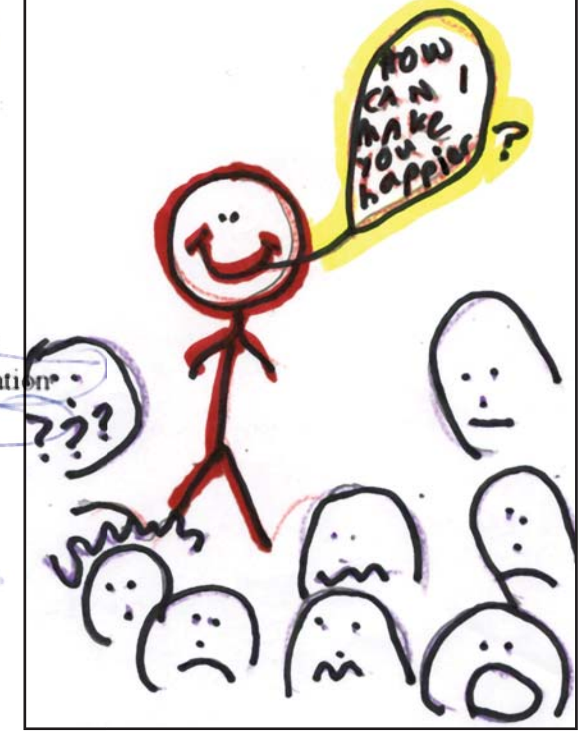
What does s/he wear? casual/presentable clothing

Where does s/he live? [ ] City [✓] Suburbs [ ] Country

[✓] Lives with spouse/partner [ ] Single [ ] How many kids?

Optional: Circle 5-7 Adjectives

- Approachable (circled)
- Bureaucratic
- Business like
- Caring (circled)
- Disrespectful
- Distant
- Fair
- Forward-thinking
- Free of discrimination (circled)
- Good Listener (circled)
- Hands On
- Helpful (circled)
- Insincere
- Knowledgeable (circled)
- Narrow Minded
- Old Fashioned
- Personal
- Professional (circled)



"I love what I do, but I just find that the climate is a bit different now… There's a pressure to discharge people. Sometimes I find it conflicts with our philosophy of working with patients."

4. Barriers to doing your best work – ethno-racial discrimination and harassment

Themes in this section of the report were primarily, though not exclusively, generated from participants who had self-selected into groups designated for ethnic and religious minorities and people of colour. As in the other focus groups, these participants were asked:

"As compared to other people in the hospital with the same role or job as yours, do you experience any barriers to being able to do your best work or to reach your potential in the workplace?"

Their responses have several features unique to respondents who are members of these identity groups and these are clustered into 3 major themes and a number of related sub-themes. The major themes were:

- **Lack of organizational fit**;
- **Rendering person invisible/inaudible**; and
- **Exclusionary processes**.

There is naturally some overlap among the themes. However, the similarities underscore the consistency with which these issues arose across identity groups.

4.1 Lack of Organizational Fit

Restricted/censored communication

- *"There are very important things that I don't know, that I should know to help me to work more effectively. And things are not communicated. It's like some things are privy… But who are we here for, are we here for the clients, what are we here for?"* [Facilitator: If you were a white person do you think you would get that information?] *"Of course I would, immediately."*
  [group discussion]
  "I think the reason for that is because this information comes up in little chitty chatter that you have. While you're having informal discussions where…"

Allegations of intimidation

- *"When you're trying to fend for yourself [you're told that the problem is] 'the way you come across'… For years I sat in a room where [9 out of 10] people were dominant. How could one [non-dominant] person intimidate [the rest of them] and the other 9 have no effect on anybody else? It just boggles my mind… Like you said, there's two systems here…. But somebody [i.e. 'white'] can go down the hall and use the "F" word and its O.K."*
- *"I was told it's because I'm big and can articulate, so I intimidate. 'It's not discrimination, it's because of your presence'."*
  [group discussion]
  "That's interesting because I'm small, but I've been told that too, that I intimidate."

Stereotyping and tokenism

- *"You're at the table and you're only one person, and therefore there's this impression that you're representing everyone. As a white person you don't carry that responsibility, so why is that expected from a person of colour?"*
- *"Your accent is not appreciated. As soon as they hear the English accent 'oh you're suddenly educated or you're a bit more intelligent, we love the accent.'… Someone else who might not speak good English is seen as maybe not as intelligent. People get scared to express themselves*

because they can't get the words properly, and someone else who maybe speaks English is listened to."

- *"People would assume certain things about me and would kind of have a certain posture when they met me, but when I opened my mouth and said something that would change… I think it is a colour thing."*
- *"Anyone new to the country as an immigrant, it's almost like you're doing a needs assessment for a few months, or a few years… You have to know how to be assertive, you need to know how to communicate when to be firm… You have to pick up on those skills otherwise you're not going to get anywhere in your career."*
- *"I for one remember having to write up an incident where one of the people in our team was doing some work that might have caused an adverse event. And immediately there was this meeting called and it had the person's name in it, [e.g.] 'Bob's Problem', something like that but it was really derogatory and I thought 'holy crow', this person must have done something really, really bad. And then I noticed that he wasn't part of the meeting… There were 6 managers sitting around the table. Count that up, and the meeting was set for an hour. This is how much money we've spent talking about an issue where the central person that needs to be there was not there. And I see that as a total waste of time. It just so happens that this person is a person of colour and they do speak a second language, so it's sort of hard to understand. So all of that is always taken into account when there's an issue: 'Well you know we can't understand what he's saying and he's this way and he's that way.'" [Facilitator: If that person had been a white person… would that not have happened?] "Absolutely not. That was labeling, that was stereotyping, it was just so bad."*

Cultural dissonance

- *"One girl in my department she was East Indian and her job was made very difficult… The people that were giving her the most trouble were white, they're Canadian, they're quite aggressive… and they're thinking that this person is not capable of doing their job… I know her well, what she can do – going from school, helping out with her family business to staying the night at her dad's bedside in the hospital, then coming back to school in the morning. This girl's tough, but when you see her, she's so gentle, she's so sweet that they don't think that she's mature. I don't think they really understand the cultural aspect."*
- *"A lot of staff with different cultural backgrounds don't feel comfortable talking at meetings or voicing any concerns…"*

Ascribing a non-professional role to professionals of colour

- *"I'm a nurse clinician and I'll arrange to meet [staff/students] at the front desk… and they'll be talking away, they won't even think to say 'Are you so and so?'… They'll just keep talking. I'll be standing there and nobody will say anything until I say 'ok it's me!' They just don't think it would be a Black person."*

Disqualification

- *"Until you probably have people of colour who are running [the organization] or major decision makers, people like us will be excluded."*
- *"In my department they are always full time positions… [When] I've gone to my manager to say I'd like to transfer, she'd make some excuse, always putting me off. She says, 'you don't have the knowledge.' [But I do] have the experience, I have*

"We'd be having a meeting and I would give an idea… one person who is white, as soon as she opens her mouth, it's as if what I was saying is erased and everybody is in awe: 'that's a good point'!"

more qualifications than most of the people in the department… So I had a meeting with her and my Union Rep. and told her exactly how I felt, how she's always discouraged me, not encouraged… I just feel I constantly have to prove myself, it's on paper, I've done my degree, I've done this, that and the other. And it never seems to match up… I don't know if I would apply the next time. I'd rather go somewhere else I think, because I've tried so many times that it's…" [Facilitator: That you're discouraged?] *"Yes."*

"I have had a couple people tell me from other hospitals how we place value on human rights and diversity and we talk about it, and other organizations they just don't."

4.2 Rendering person invisible/ inaudible: paradox of the 'visible minority'

Silencing

- *"There's some type of acceptance standard that's been set [for white people] to say you're more important and we'll listen to you and we're open to listening to you. Whereas if it's someone else [a person of colour], then you can see that there's this closed – mindedness that comes on. It's like 'you're wasting our time, just get on with it'. You know, that's the impression I get in most of those situations."*
- *"I was arguing one day about patient's rights. By the time I got back to my office there were 3 people lining up to tell me that I was implying something other than patients' rights. 'Now you're doing human rights.' Another one told me I was the next Martin Luther King."*
- *"There's a thing called 'backlash' and a lot of… people of colour are not empowered to go out there and choose any job you wish. There's this element of fear that if you blow the whistle, it can be used against you."*

Erasing

- *"We'd be having a meeting and I would give an idea, and there are two other people of different races, especially one who is white. And as soon as she opens her mouth, it's as if what I was saying is erased and everybody is in awe: 'that's a good point'. You know that is not fair, because each of us has something to contribute."*
- *"You're not seen… You are invisible I think because of your colour…"*
- *"That's the paradox of the 'visible minority'. I don't like it."*

Ignoring

- "We talked about the barriers. I kind *of experienced something like that since I've been here. On one of those cards you handed out 'Ignoring', making someone feel like they don't belong… I think it could be colour… You hate to think that way, but when I try to eliminate everything and try to look at all the reasons…* [Facilitator: At why you're being ignored?] *"Yes."*

Don't get credit for ideas

- *"I don't get sent to meetings and yet before they go, they ask me [my opinion] and my ideas are being implemented but the credit doesn't go to me."*
- *"Others may do something really simple and you hear, 'oh such and such a person did such a grand job a great job' and you look, 'oh my god that's great?' Look what I have accomplished and you're sitting in the same meeting and no one even acknowledges that E. is capable of managing such a project or spearheading such a thing. You sit there and wonder, why the hell do I bother?"*

Reluctant to contribute

- *"I must say I've gotten to the point where I say very little, because I don't think they would value... sometimes my hand is up forever and they pick everybody else, so now I hardly speak, you would hardly hear me say a word in a meeting."*

4.3 Exclusionary process

Lack of mentoring

- *"I have to learn the ropes on my own, because I'm not privy to the informal networks and the chats about the dog and what else we have in common or do we even live in the same neighbourhood. Do we shop at the same place, wear the same labels? Those things are taken into account and there's this way of deciding 'well, where do you fit?'"*
- *"I have seen people being groomed for positions with no qualifications for those positions and you're never groomed."*
- *"They're groomed, they're sent to school, they're sent to courses, they're told specifically that 'you will have a position here' and that has happened right in front of me with people. Where as, you are never told."*
- *"I'm being supported, because they're paying for it [advanced degree] and I get time off to do it, but I have not been told like some others about what would be a good fit for me... My experience is that people of colour graduate, a year later still there's no job difference and I don't understand that process and so that makes me a little bit suspicious..."*
- *"The experience I've had is 'you know we have to be transparent', 'we have to go through the right course'. And then if you decided to go after something [it's] advertised all over Canada, while other people you've never seen expect the announcement. So what's driving that, in this organization, that you never hear about the process, you've never seen the advertisement, all you see is the announcement?"*

Subtle inequalities

- *"I come to a meeting, there is even an agenda but sometimes my item will get skipped and it goes to the next person and they have this long discussion. That item is seen as more important. Then I'm left with like 2 minutes or less before the meeting is over. I'm not able to get to it. So this person goes ahead and they're able to take their time and get the acknowledgement and all of that gets said."*

Ignored for benefits, perks, promotions etc.

- *"Yes, I've had a Master's Degree since 199* And I have seen in this establishment people in leadership roles with a Bachelor's had to be sent to school, given days off to go, because they are already in leadership roles. I had to use my own time to do my Master's and yet those [leadership] roles were denied. It isn't that their schooling, their education makes them more capable of certain roles... it must be something else that excludes you from those roles."*
- *"I worked here for 3 years back and forth, and there was a part-time position because somebody was leaving and I'm casual. I wasn't given the part-time position... and it was given to somebody else and when I spoke about it, the person said to me, 'No it doesn't go by seniority.' But I'm not a person to fight, I could have and I know I could have won... I had more skills than that person."*

"The only time I've ever [felt discrimination] was in D&HR training…it helped me realize the extent to which my fears were grounded in a reality that the hospital still has a long way to go and we're still living in a very homophobic environment."

Greater comfort with people of colour: 'Organizational fit' through the lens of 'informal affinity support and mentorship networks'.

- *"I don't have a lot of interaction with a lot of people in the hospital, but I do notice that if I'm in hallways or in the elevators, I do talk to more people [of colour] and they talk to me more."*
- *"It kind of makes you feel more comfortable. People seem to be nice and smile or whatever, but you don't seem to get as much conversation from people who aren't [of colour]. Other people just keep walking."*
- *"...you can see there are cliques anywhere in life. You can see [it in] your own ethnicity – it's very natural... It's a feeling, just when you see cliques when they're talking, you know they're closer, I just see that the commonality is colour. I'm not saying that they're racist towards anyone, I'm just saying they're closer. Because of my personality, I probably would not let that stop me. I know my rights, what I'm capable of, so I would find another way to get what I need. If I wanted to go after a certain job, and if I felt like I was not getting somewhere, I know where to go to place a complaint... how to go about it and how to be assertive. But if I was brand new to the country or to nursing or an acute care setting, I probably wouldn't open my mouth unless I needed help. I probably would go and talk to someone who I know was from my background, because I would feel like they'd be more helpful and they would understand my experiences..."*

Work sheet # 1 results: Study participants were asked to fill out a work sheet by labelling attributes of current and ideal work environments and create simple drawings to illustrate their ideas.

Pretend your **current** work environment was a person. What kind of person would it be?

Optional: Circle 5-7 Adjectives

- Approachable
- Bureaucratic
- Business like
- Caring
- Disrespectful
- Distant
- Fair
- Forward-thinking
- Free of discrimination
- Good Listener
- Hands On
- Helpful
- Insincere
- Knowledgeable
- Narrow Minded

5. What the hospital is currently doing to create a fair, respectful, harassment and discrimination-free work environment

"Top Employers walk the talk." Participants had no difficulty in detailing they ways in which the hospital is increasing its efforts to create a respectful, fair workplace that is harassment and discrimination-free. Themes included a demonstrable belief in the value of diversity, equitable organizational policies and processes, efforts to promote connections throughout the organization, staff appreciation, and support and respect for concerns.

Participants identified the following as indications that the hospital values diversity:

- Accommodation
- Culture of diversity
- The existence of a D&HR Office and Committee
- D&HR calendar
- D&HR training
- D&HR celebrations
- Interpreter Services
- Lobby displays and programs
- Program's uniqueness, leadership in this area
- Chaplains' work

The following are areas where equitable organizational policies and processes were seen to be working:

- Code of conduct
- Responses to inappropriate behaviour
- Hiring practices
- HR for SLRI
- Pay equity
- Performance appraisals

These efforts were seen as promoting connectedness:

- Ask the President
- Staff forums
- Opportunity to meet senior management
- Sinai Scene
- Intranet
- Interdepartmental forums

These initiatives were seen to convey staff appreciation, support, and respect for concerns:

(Acknowledgement of and support for staff, valuing staff, respecting staff needs and concerns)

- Debriefing critical events
- EAP
- Occ Health and Safety
- Focus groups
- Karen McGibbon Awards
- Staff Appreciation events
- Special Interest Groups
- Support for new staff
- Wellness program
- Training opportunities

What the hospital does now to create a fair and equitable work environment

- *" When I came to Mount Sinai and they were celebrating Black History Month I thought I was in heaven. Here's a place that acknowledges the fact that there is a history and Black people have historical contributions. I was happy to be part of an organization that I thought was right on the frontier of health or human rights for that matter... I know that there are issues with it, in terms of what it could be versus how the things are done and so we're still struggling. Even within that, there's the acknowledgement, 'let's move it a step further'."*

"First I have a feeling like [clinicians are] looking at me trying to figure out, 'Is he a patient?' Does he know what he's talking about?" (employee with a disability)

- *"I just want to state that I think Mount Sinai is good because I know two people that were disabled and they were given jobs at Mount Sinai."*
- *"I have had a couple people tell me from other hospitals how we place value on human rights and diversity and we talk about it, and other organizations they just don't."*

Work sheet # 1 results:

Pretend your **current** work environment was a person. What kind of person would it be?

[ ] Female [✓] Male Age 50
Job
What is his/her favourite music? no music - silence
What does s/he wear? Suits
Where does s/he live? [✓] City [ ] Suburbs [ ] Country
[ ] Lives with spouse/partner [✓] Single [0] How many kids?

Optional: Circle 5-7 Adjectives
Approachable
Bureaucratic
Business like
Caring
Disrespectful
Distant
Fair
Forward-thinking
Free of discrimination
Good Listener
Hands On
Helpful
Insincere
Knowledgeable
Narrow Minded
Old Fashioned
Personal
Professional
Rigid
Sloppy
Traditional
Trustworthy
Other not trustworthy
cold
duplicity
Perfectionist

6. Discrimination and Harassment

One of the primary goals of this research is to determine where opportunities for improvement lie with regard to diversity and human rights in the workplace. To this end, participants were asked the following question:

"Have you ever experienced or seen communication or behaviour that you would consider harassing or discriminatory?"

Issues that emerged as problematic included: colour/race, ethnicity, religion and language. In addition, harassing or discriminatory behaviour that participants had witnessed included: disrespect, inappropriateness, rudeness, and homophobic comments. These issues are similar to those raised in the category of 'barriers to best work' that were outlined in previous sections of the report.

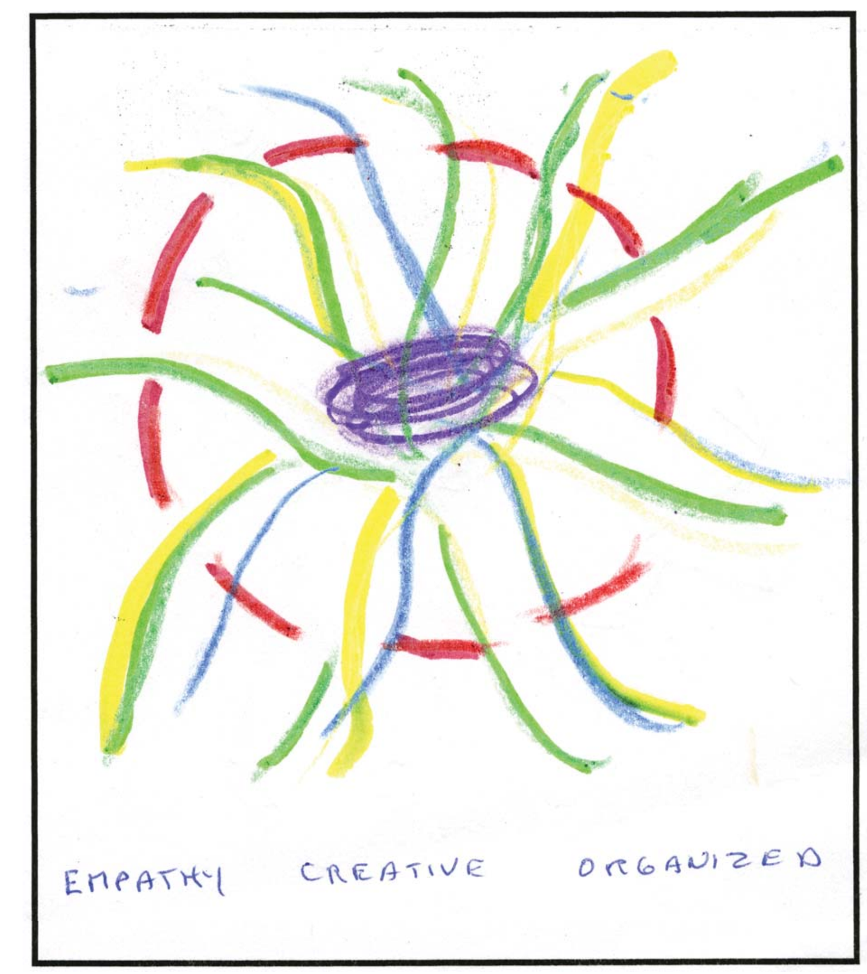
Race, Ethnicity, Religion and Language

- *"We have patients from time to time that refuse, they'll say, I don't want a Black nurse, I don't want anybody of colour in my room..."*
- *"Speaking about and coming forward about issues of racism as a person of colour is like going through surgery without anesthesia. There's a level of vulnerability that comes with it as well, because to call things what they really are, there is that threat whether it's real or perceived of the finger being pointed. So what you get is that these issues get talked about in such a way that you almost are saying nothing is really happening. It's a constant struggle, even when they allow you to be at the table and you're the most qualified person at that table to speak about the issue, nobody will hear you or space is given to you to speak, as quick as you're done, it's on to the next topic without even validating your input."*

- "There's still an inequity for people *of colour in certain positions within the organization. Women in general have been progressing in the positions of power. In terms of positions of power, race is the main inequity I see, more than gender."*
- *"For me it was the time during the Iraqi war… and someone came in and started saying that the Iraqis are burning oil wells and that Iraqis are stupid. And I was very offended. I'm not Iraqi, but I was very offended. We have staff that are Iraqi and I am a Muslim, primarily the Iraqis are Muslim."*
- *"I can think of situations with some patients that I work with… A lot of time because of their Chinese language they cannot communicate with the nurses and there are some subtle, less obvious kinds of discrimination. They seem to notice there's a difference in terms of the care given by the nurses. They said [staff] don't come in as often, or they would come in and ask the other [Caucasian] patient if they need anything but ignore them. They seem to think it's not so much the language."*
- *"I had a few opportunities to do translation for [south Asian language] patients and sometimes I see those patients don't receive the same kind of care… It's not like the doctors don't know how to treat these patients, but they don't understand the culture. I was doing a translation for a psychiatric patient [who] didn't speak English, and the doctor asked him to spell WORLD backwards. To a patient who doesn't even speak English, assessing whether he has a psychiatric problem or not, let's do something sensible…"*

Work sheet # 1 results:

Pretend your **ideal** work environment was a person. What kind of person would it be?



- *"These three girls I know had a very difficult time with their core training, inappropriately harassed to the point of breakdowns and crying. It was as if this person was waiting for them to do something wrong. All were Indian… Hindu and Muslim… and they're excellent [professionals]."*
- *"It's a new experience for me [both within and outside the hospital]… I feel that I've been excluded or discriminated against because I work in what could be perceived as a Jewish hospital, and hence I must be Jewish."*

"I have seen people being groomed for positions with no qualifications for those positions and you're never groomed. They're groomed, they're sent to school, they're sent to courses, they're told specifically that 'you will have a position here' and that has happened right in front of me with people. Whereas, you are never told."

- *"Sometimes the way you are spoken to by individuals, it's not respectful, like 'you cannot understand therefore I have to be very basic'. And the tone. I find those things very offensive. [Or] you are having a conversation with someone who is moving: What is that? No respect whatsoever. They're looking all over the place, and I don't think they would do that to others – they would be standing there conversing face to face. Those are the things I think are disrespectful and it doesn't happen to other groups [who are not 'of colour']."*
- *"There's one example that sticks in my head of someone very, rather high up in the department came out and said [to some people], 'we're all Jewish, aren't we?'. I thought 'ok'. A lot of things made sense after that [such as] the way things were done."*

  [Facilitator: You mean like for vacation and stuff like that?]

  "Yes right down to office space, everything... once I'd heard that, I just thought, 'behaviours are different if you're Jewish and you're not Jewish... I wear a cross and some days I don't."
- *"Specifically someone mentioning it was during Ramadan, 'That doctor's always off, gone doing his prayers."*
- *"I've witnessed comments about people's language skills, like there's lots of people in the organization where English is their second language and people are very comfortable saying derogatory things about their language skills. You'll hear it all the time, you can tell they think they're complaining about performance, but what they're really complaining about is a heavy accent."*

Disrespect, inappropriateness, rudeness

- *"I've heard a manager say to someone 'If we want to hear from you, we'll jerk your chain'. I've seen a lot within my own department. 'If you want more money get another job'."*
- *"It's like when you get up in the morning and you say I don't even think I can go in today. Your stomach's in a knot: What's going to happen today? Who's going to take a strip off?"*

Homophobic comments

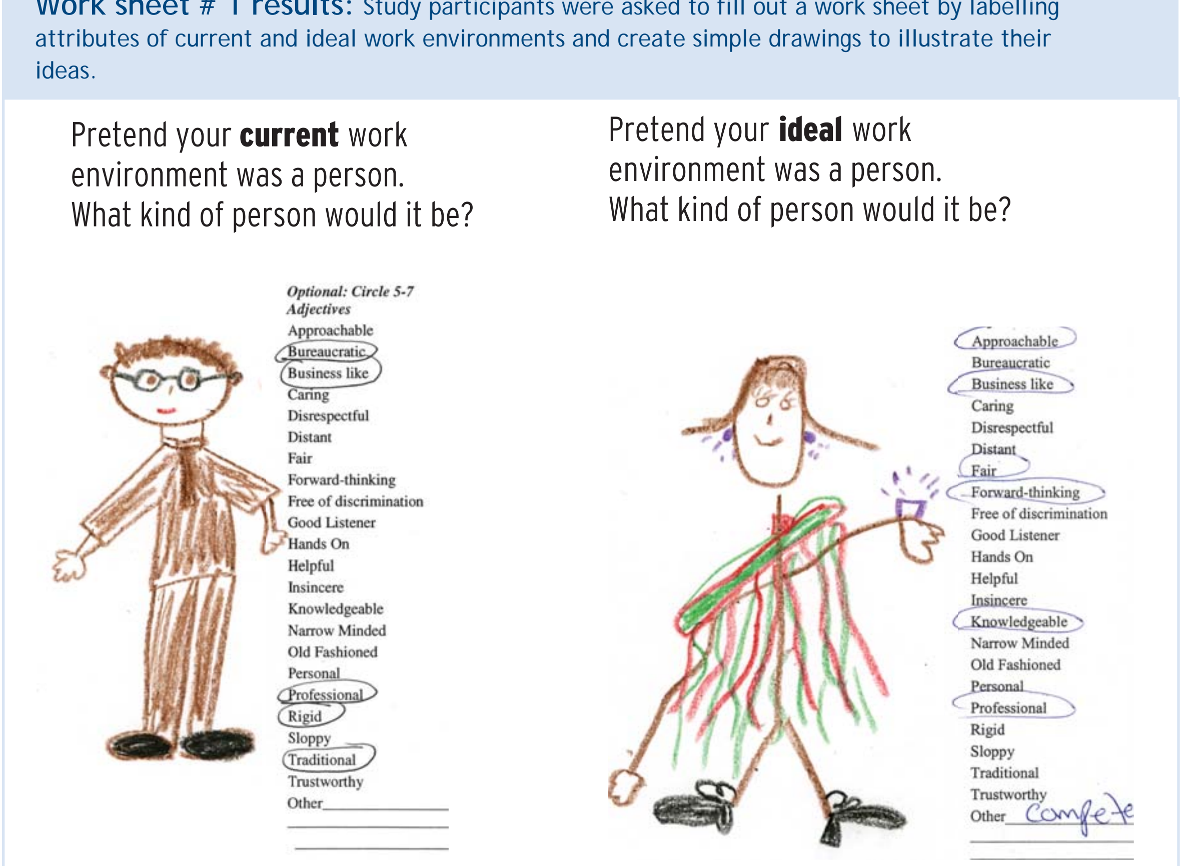
- *"...discriminatory comments that were made about me from one of the staff... They were very harsh comments about my sexuality... So stuff like that, he'd be wishing me dead that I would die of AIDS... and you know it was just awful."*

Conclusion

This research study has identified how social inequality and social exclusion are reproduced in the seemingly innocuous and mundane day to day activities of work in the hospital. The stories that focus group participants shared with us are about moments in the day in which power differences affect marginalized staff in negative and injurious ways. Importantly, the impact of these marginalizing practices is recognized and felt exclusively by the targeted staff member; those perpetuating the inequalities are largely oblivious to the impact of their actions. Discriminatory or harassing behaviours and attitudes such as those described by participants rarely come forward as complaints to the D&HR office. While they constitute acts of subtle discrimination that may not, in and of themselves, form violations of codes and policies, this does not render them innocuous. Rather, they contribute to a workplace culture that is perceived by some in marginalized groups as unwelcoming and inequitable.

The cumulative weight of these acts undoubtedly affects the ability of individuals to create an environment of trust and collaboration.

Work sheet # 1 results: Study participants were asked to fill out a work sheet by labelling attributes of current and ideal work environments and create simple drawings to illustrate their ideas.



Diversity and Human Rights in the Work Environment

Recommendations from the Diversity & Human Rights Committee

"I have to learn the ropes on my own, because I'm not privy to the informal networks and the chats about the dog and what else we have in common or do we even live in the same neighbourhood. Do we shop at the same place, wear the same labels? Those things are taken into account and there's this way of deciding 'well, where do you fit?'"

For some who work in this hospital, discrimination is experienced on an almost daily basis. We need to act decisively and immediately to eliminate systemic barriers to equal opportunity so that all who work here can contribute fully to the workplace environment, to the patients we serve and to the larger community . The following are some recommendations we feel an help to begin this process.

Recommendations

Planning

1. The Hospital's strategic plan and balanced scorecard should emphasize the importance of diversity at all levels of the workforce and as part of all the work we do.

2. The hospital should emphasize the values of inclusivity and fairness that are a proud part of its history and origins. These values should be reflected in everything we do – from patient care, to budgeting, to partnership.

3. Senior leaders should spearhead efforts in the area of equity and diversity, holding managers and others accountable for achieving results.

Ensure representation of diversity amongst board, staff, physicians and volunteers

4. A systemic employment review should be conducted in order to identify and eliminate any barriers to equal employment opportunities.

5. Increase the number of underrepresented staff from designated groups in leadership roles including: senior management, management, and supervisory positions.

5.1 Human Resources, together with the Diversity & Human Rights Committee should develop targets and timelines for recruitment and hiring of underrepresented groups.

5.2 A diversity expert should be hired in Human Resources to ensure equitable recruitment and hiring from diverse communities. HR staff with expertise in diversity recruitment should be enlisted.

5.3 Human Resources should develop relationships with external partners for the recruitment of individuals from designated groups e.g. Career Bridge, TRIEC, SES.

6. All hiring should follow principles outlined in Fair Employment Opportunities policy and training sessions. All hiring managers must attend Bias-Free Hiring training.

6.1 Managers should be held accountable for actively supporting the recruitment, training and promotion of qualified underrepresented staff through meeting hiring targets.

6.2 Underrepresented staff and patients must be included on interview panels for all positions, including management positions.

6.3 Search firms should be required to present a mix of candidates that reflect the diversity of Toronto.

6.4 The Fair Employment Opportunity policy should be cited on all job postings and posted on the internet.

7. Using principles of good governance, Sinai should develop a skill and competency matrix that creates an open process for selecting and identifying diverse Board Membership in keeping with the LHIN initiative on eliminating health disparities and other recognized best practices.

8. Physician hiring should also follow the principles and processes outlined in the Fair Employment Opportunities policy.

Performance management and accountability

9. Performance indicators for managers need to be instituted that require the demonstration of equitable participation by staff in committees, conferences and learning opportunities.

10. Hiring and promotion for all staff should include consideration of the candidates' commitment to diversity and human rights as well as other qualifications.

11. All staff should be evaluated on equity and cultural competencies, including compliance with human rights and diversity policies and procedures.

12. Managers should be trained to identify possible bias in performance evaluations and promotions.

13. Questions on the workplace environment and manager fairness should be incorporated into the Staff Satisfaction survey.

14. Managers should be required to solicit staff feedback on their performance and staff should be guaranteed protection from reprisals.

15. A centralized scheduling service should be instituted to ensure equitable distribution of work opportunities for scheduled staff. This will reduce the perception of unfairness.

Succession planning

16. Succession/advancement planning for managers should be linked to our overall diversity goals.

16.1 Racialized and other underrepresented staff from designated groups should be included in the organization's succession planning process and its implementation.

16.2 Senior leaders should develop a clear process that identifies individuals, particularly those from marginalized groups, for participation in a formal mentorship program for career advancement which promotes leadership from within the organization.

Diversity & Human Rights Committee

17. The results of the Workforce Census should be communicated; identified issues should be acted upon.

17.1 Compliance with the recommendations in this report should be monitored as well as their impact.

"I'm very proud to be at Mount Sinai, I've worked in many different sectors... besides being world class in medicine… it's also for me a very safe environment, it's very respectful, more so than anywhere else I've ever been."

17.2 Resources should be made available to implement these recommendations.

18. Equitable partnerships should be created with organizations that serve diverse communities.

19. Diversity Awards should be instituted for staff who have made significant contributions to diversity in regards to staff, patients, or community linkages.

Equitable workplace environment

20. Mount Sinai Hospital should be a leader in addressing discrimination at all levels.

21. Determine whether staff decide to leave their jobs because of barriers or biases in the workplace.

22. Monitor through exit interviews the reasons for staff resignations and develop a strategic plan to respond appropriately.

23. The organization should conduct periodic focus groups of marginalized staff, to monitor organizational progress and identify barriers to achieving an equitable, diverse workplace.

24. A Diversity Campaign should be implemented utilizing posters representing various groups in order to increase awareness and to demonstrate MSH's commitment to equity. The purpose of the campaign is to challenge attitudinal barriers.

25. D and HR office should provide training on racism, homophobia, and ableism on a regular basis throughout the hospital.

25.1 Current training programs should be evaluated and redesigned to address key issues identified in report.

26. A training curriculum and materials to assist all staff to interact with non-English speaking patients and families should be developed and implemented.

Accommodation

27. Senior management should be champions of workplace accommodation due to disability as defined under the Ontario Human Rights code. A centralized budget should be allocated to support work accommodation in the workplace.

Work sheet # 1 results:

Pretend your **ideal** work environment was a person. What kind of person would it be?

Approachable
Bureaucratic
Business like
Caring
Disrespectful
Distant
Fair
Forward-thinking
Free of discrimination
Good Listener
Hands On
Helpful
Insincere
Knowledgeable
Narrow Minded
Old Fashioned
Personal
Professional

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Work sheet # 1 results: Study participants were asked to fill out a work sheet by labelling attributes of current and ideal work environments and create simple drawings to illustrate their ideas.

Pretend your **ideal** work environment was a person. What kind of person would it be?

- Caring
- Disrespectful
- Distant
- Fair
- Forward-thinking
- Free of discrimination
- Good Listener
- Hands On
- Helpful
- Insincere
- Knowledgeable
- Narrow Minded
- Old Fashioned
- Personal
- Professional
- Rigid
- Sloppy
- Traditional
- Trustworthy
- Other Humble

Appendix A

Diversity and Human Rights in the Work Environment

Discussion Guide

Introduction (5 minutes)

- Thank everyone for coming
- Explain that we're talking to a number of staff groups in the hospital about their experience of diversity and human rights in the work setting
- Facilitator and participant introductions *(who the facilitators are, their role in project, hospital; who the participants are, their roles in hospital)*.
- Discuss REB process
- Procedural rules etc. *(Give out "what to expect" sheet during recruitment)*
- Confidentiality
- Audiotaping, note taking
- No right or wrong answers.

Warm-up (5 minutes)

Today we're going to talk about your experience working at the hospital. When you think about your work here, what comes to mind? *(associations to concept)*

Discussion

1. **Personality Profile of the Work Environment – Current** (10 minutes)

   Explain worksheet and have participants go through the exercise.

   (See Appendix A for Worksheet. This exercise allows participants to make visible those emotional and conceptual aspects of their work environment that they experience but may not have articulated.)

2. **Picture Sort** (15 minutes) *(We have collected magazine clips.)*

   Now we're going to break up into 2 teams:

   Select pictures that give you a feeling of what your work environment has been like for the past few months. Pin up the pictures that you all agree on together in this area of the display board. The pictures that just relate to you, pin up over there… *(There will be two areas designated for each team.)* Tell us about what each of those pictures says to you…. Taking the collection as a whole, what do they say to you?

3. **Flip chart** (10 minutes)

Now let's look at what makes a work environment fair, equitable and free of harassment and discrimination. We'd like everyone to take a couple of minutes to jot down a few ideas, or make pictures of what you think makes a workplace fair or unfair to its employees. Discuss.

4. **Exploring issues of diversity:** (15 minutes)

Card sort - show the group 8 cards with pictograms describing human rights and diversity aspects of the work environment that the facilitators read out. Then ask the group to place them in order of seriousness or importance. The following are the statements, along with matching pictograms:

4. a) **Power Balance**

Some people abuse their power and discriminate against others because of such things as colour, sex or gender, language or disability.

4. b) **Respect**

People feel disrespected when others exclude them, ignore them, yell at them or don't care what they think.

4.c) **Belonging**

That person doesn't belong here.

4. d) **Behaviours**

The way people behave at work can make others have a good day or make them dislike their job.

4. e) **Sexual Harassment**

The way someone stares, touches, talks, follows another person can make her or him feel very uncomfortable.

4. f) **Communication**

If we were better listeners, we would have less conflict.

4. g) **Bullying**

Bullies humiliate, over-supervise, shun, criticize and pick on anybody they want to get rid of.

4. h) **Conflict Resolution**

By resolving conflicts in the workplace respectfully, people can work together professionally.

(Questions 5-7 - 30-40 minutes)

5. **Barriers**: As compared to other people in the hospital with the same role or job as yours, do you experience any barriers to being able to do your best work or to reach your potential in the workplace?

   Prompts: any problems that make it tough for you:

   - to do your job
   - to reach your fullest potential
   - to receive training opportunities
   - to get a promotion
   - to get support or encouragement about your work
   - to get access to jobs
   - to achieve your career goals, or to have the type of job you want

6. **Communication and Decision-making**: Let's talk a bit more about communication and decision-making at work. Compared to others in the same job or role as you:

   - do you think you get the information you need?
   - do you feel that you have a voice, a part in making decisions?
   - as a person in *this* identity group, do you feel you are included like everyone else in communication and decision-making?

Prompts:

- When there's important news about your work, are you the first to hear about it? The last? Or about the same as everyone else?
- Do you feel you can have input into organizational decisions that affect your work?

7. **Concerns**: Have you ever experienced or seen communication or behaviour that you would consider harassing or discriminatory? Discuss.

8. **Personality Profile of the Work Environment - Ideal** (10 minutes)
   (See Appendix B for Worksheet)

   - Explain worksheet and have participants go through the exercise.

Recommendations (5 minutes)

(Flip chart) Are there things that the Hospital and managers do now to create a fair, respectful, harassment and discrimination-free work environment for all people? Are there other things that they should do?

Wrap-up (5 minutes)

Any additional thoughts or comments?

Reminder about confidentiality

Worksheet #1

Pretend your **current** work environment was a person. What kind of person would it be?

[ ] Female [ ] Male Age __________

Job ____

What is his/her favourite music? ____

What does s/he wear? ____

Where does s/he live? [ ] City [ ] Suburbs [ ] Country

[ ] Lives with spouse/partner [ ] Single [ ] How many kids?

Optional: Circle 5-7 Adjectives

Approachable
Bureaucratic
Business like
Caring
Disrespectful
Distant
Fair
Forward-thinking
Free of discrimination
Good Listener
Hands On
Helpful
Insincere
Knowledgeable
Narrow Minded
Old Fashioned
Personal
Professional
Rigid
Sloppy
Traditional
Trustworthy
Other ________________________

____

____

____

____

Worksheet #2

Pretend your **ideal** work environment was a person. What kind of person would it be?

[ ] Female   [ ] Male   Age __________

Job ____

What is his/her favourite music? ____

What does s/he wear? ____

Where does s/he live? [ ] City [ ] Suburbs [ ] Country

[ ] Lives with spouse/partner [ ] Single [ ] How many kids?

Optional: Circle 5-7 Adjectives

Approachable
Bureaucratic
Business like
Caring
Disrespectful
Distant
Fair
Forward-thinking
Free of discrimination
Good Listener
Hands On
Helpful
Insincere
Knowledgeable
Narrow Minded
Old Fashioned
Personal
Professional
Rigid
Sloppy
Traditional
Trustworthy
Other __________________________

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Diversity and Human Rights in the Work Environment

A qualitative research study of diversity and human rights in the workplace

Diversity and Human Rights Office
1536-600 University Avenue
Toronto, Ontario, Canada M5G 1X5
t 416-586-4800 ext. 7519
diversity&humanrights@mtsinai.on.ca
www.mountsinai.on.ca/about_us/who-we-are/diversity-human-rights