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Social Justice and Health Equity in the Teaching and Learning Environment: Perspectives of Academic Leaders in Health Profession Education Programmes

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Social Justice and Health Equity in the Teaching and Learning Environment: Perspectives of Academic Leaders in Health Profession Education Programmes

Abstract

It is the responsibility of all health profession education programmes to prepare their graduates to champion social justice and health equity (SJ/HE) within and beyond the healthcare system. However, little is known about the perspectives of educational leaders within health professional programmes regarding the teaching and learning environment (TLE) with respect to SJ/HE. The objective of this study was to explore the perspectives of health profession education leaders about their individual and collective vision for a TLE that promotes SJ/HE and its actualization. A qualitative descriptive approach was utilized to gather, synthesize and make meaning of the perspectives of academic leaders in one Canadian health professional faculty. Using semi-structured interviews, participants (n=14) representing five different colleges including medicine, nursing, oral health, pharmacy, and rehabilitation sciences, were interviewed in-person in the academic setting. Following inductive thematic analysis, one overarching theme resulted, "We Need to Walk the Talk." Five sub-themes also emerged, including understanding of SJ/HE; the current TLE; facilitators and barriers to a TLE promoting SJ/HE; and actions required to further develop a TLE promoting SJ/HE. Academic leaders expressed hope and willingness to create a TLE that promotes SJ/HE, acknowledging that there was a lot to be done and a unified vision for the faculty is important. The results of this study underscore the need for academic leaders to have a clear and unified articulation of a TLE that embodies SJ/HE for all.

Il incombe à tous les programmes de formation aux professions de santé de préparer leurs diplômés et leurs diplômées à défendre la justice sociale et l'équité en matière de santé au sein du système de santé et au-delà. Cependant, on sait peu de choses sur le point de vue des responsables pédagogiques des programmes de formation aux professions de santé concernant l'environnement d'enseignement et d'apprentissage en matière de justice sociale et d'équité en matière de santé. L'objectif de cette étude était d'explorer les points de vue des responsables de la formation aux professions de santé sur leur vision individuelle et collective d'un environnement d'enseignement et d'apprentissage qui promeut la justice sociale et l'équité en matière de santé et sa mise en œuvre. Une approche qualitative descriptive a été utilisée pour recueillir, synthétiser et donner un sens aux points de vue des responsables universitaires d'une faculté canadienne de formation aux professions de santé. À l'aide d'entretiens semi-structurés, les participants et les participantes (n=14) représentant cinq collèges différents, dont la médecine, les soins infirmiers, la santé bucco-dentaire, la pharmacie et les sciences de la réadaptation, ont été interrogés en personne dans le cadre universitaire. L'analyse thématique inductive a permis de dégager un thème principal : « Nous devons joindre le geste à la parole ». Cinq sous-thèmes ont également émergé, notamment la compréhension de la justice sociale et de l'équité en matière de santé, l'environnement d'enseignement et d'apprentissage actuel, les facilitateurs et les obstacles à un environnement d'enseignement et d'apprentissage promouvant la justice sociale et l'équité en matière de santé et les actions requises pour développer davantage un environnement d'enseignement et d'apprentissage promouvant la justice sociale et l'équité en matière de santé. Les responsables universitaires ont exprimé leur espoir et leur volonté de créer un environnement d'enseignement et d'apprentissage promouvant la justice sociale et l'équité en matière de santé, tout en reconnaissant qu'il y avait beaucoup à faire et qu'il était important d'avoir une vision unifiée pour le corps enseignant. Les résultats de cette étude soulignent la nécessité pour les responsables universitaires d'articuler de manière claire et unifiée un environnement d'enseignement et d'apprentissage qui incarne la justice sociale et l'équité en matière de santé pour tous.

Keywords
social justice, health equity, healthcare education, teaching and learning environment, health professional education, Indigenizing post-secondary, equity, diversity, inclusive education, public health, decolonizing education, justice sociale, équité en matière de santé, éducation en matière de soins de santé, environnement d'enseignement et d'apprentissage, formation des professionnels de la santé, indigénisation de l'enseignement postsecondaire, équité, diversité, éducation inclusive, santé publique, décolonisation de l'éducation

Cover Page Footnote
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"Reducing health inequities is…an ethical imperative. Social injustice is killing us on a grand scale." The World Health Organization's [WHO] Commission on the Social Determinants of Health delivered this dire conclusion, and accompanying calls to action, in 2008 (WHO, 2008). Since then, the need to address health inequities—those differences in health associated with structural and social disadvantages that are modifiable and considered unfair (National Collaborating Centre for Determinants of Health [NCCDH], 2015a)—have become an increasingly articulated health priority, globally and in Canada (Lucyk, 2020; NCCDH, 2016; Public Health Agency of Canada [PHAC], 2014). Equity-deserving populations are at higher risk of negative health and social outcomes due to numerous and complex contributors, such as climate change and infectious disease pandemics such as COVID-19 (Canadian Public Health Association [CPHA], 2019; Fuentes et al., 2020; Guttmann et al., 2020; Kumar, 2018; Poole et al., 2020). Reducing health inequities is an ever evolving ethical imperative and a matter of social justice (SJ).

While root causes of health inequities need to be tackled within broad social and economic arenas, the health sector's role in reducing these inequities is well recognized (Health Disparities Task Group of the Federal/Provincial/ Territorial Advisory Committee on Population Health and Health Security, 2004; NCCDH, 2013; Rasanathan et al., 2011). Essential areas of health equity action have been identified at the systems level, (NCCDH, 2014; NCCDH, 2015b; Pauly et al., 2016; WHO, 2010) and within professional competencies and practice standards (e.g. Canadian Dental Hygienists Association [CDHA], 2010; College of Registered Nurses of Manitoba [CRNM], 2019; National Association of Pharmacy Regulatory Authorities [NAPRA], 2014; Royal College of Physicians and Surgeons of Canada [RCPSC], 2015); and accreditation standards for health profession education programmes (HPEPs) (Canadian Association of Occupational Therapists [CAOT], 2017; Canadian Association of Schools of Nursing [CASN], 2014; Committee on Accreditation of Canadian Medical Schools [CACMS], 2023; Physiotherapy Education Accreditation Canada [PEAC], 2017).

Pre-licensure HPEPs have a key role in influencing health equity (HE) action, as they educate future generations of healthcare professionals who have enormous potential to positively influence policies contributing to health inequities (Allan et al., 2013; Andermann, 2016; Arya, 2018; Sivashanker & Ghandi, 2020). Many structurally disadvantaged and socially excluded individuals have negative experiences with the healthcare system, and healthcare professionals continue to be complicit in maintaining structures perpetuating inequities (Allan & Smylie, 2015; Lee et al., 2017; Nestel, 2012). For healthcare professionals to fulfill their role in disrupting health inequities, it is imperative that HPEPs prepare students and graduates to champion SJ and HE within and outside of the healthcare system.

Review of Relevant Literature

There is a large body of literature on pedagogy related to SJ/HE in pre-licensure health professional programmes. The literature focuses on examples of teaching and learning *strategies* to develop knowledge and skills related to SJ, such as poverty simulations (Hellman et al., 2018); community service learning (Lattanzi & Pechak, 2011; Taboada, 2011); web-based equity resources (Effland & Hays, 2018); and cultural safety training (Curtis et al., 2019). Empirical studies evaluating the impact of educational approaches find that strategies increase understanding of the complexities of living in poverty; motivate students to advocate for patients, become change agents, and enhance their social empathy and promotion of SJ (Sivashanker & Ghandi, 2020).

Much of the focus is on racism/anti-racism (Allan & Smylie, 2015; Andermann, 2016; Belknap, 2008; Hellman, 2018), and meeting the needs of those living in poverty (Reis et al., 2014; Sivashanker & Ghandi, 2020), with a disability (Smith et al., 2011), or from culturally diverse (Stanley, 2012), racially diverse (Nestel, 2012), or LGBTQ populations (Beagan et al., 2015).

A salient feature of the *general* literature on teaching SJ-related concepts in health professional education is the absence of discussion about SJ issues related to Indigenous populations specifically (WHO, 2008)[1]. However, there is a growing body of literature focused on integration of Indigenous health content into health professional curricula in Canada (Hojjati et al., 2018; Van Bewer et al., 2020), the United States (Lewis et al., 2017) and Australia (Phillips, 2004; Te et al., 2019).

Several broad SJ-/HE-focused pedagogical approaches and curricular frameworks have been identified (Ambrose et al., 2014; Beavis et al., 2015; Belknap, 2008; Blanchet et al., 2017; Ford & Airhihenbuwa, 2010; Gordon et al., 2016; Nestel, 2012). However, there is little attention in the literature to the teaching and learning environment (TLE) more broadly. Effland and Hays (2018) refer to 'equity-focused learning environments,' as a more representative student body and "ensuring that health professions students have the opportunity to graduate with a meaningful awareness of unearned advantages and privilege as well as how implicit biases impact the provision of clinical care and interactions with colleagues" (p.71).

Lack of racial diversity among faculty who teach in HPEPs, and limited knowledge about racism among some faculty members, are identified as problems (Hellman et al., 2018; Su & Behar-Horenstein, 2017). A need exists for professional development opportunities that promote becoming 'colour-conscious' and understanding of privilege and biases, that model instruction on discussing race and racism, and that extend beyond a brief workshop (Hellman et al., 2018). Hellman suggests that non-minority educators and administrators take individual and systemic actions to facilitate teaching and learning about race, racism, and anti-racism, Sharma et al. (2018) notes there is little evidence to support the assumption that teaching students about the social determinants of health (SDH) and health inequities will lead future health professionals to take action to help achieve HE. The authors suggest a pedagogical approach that emphasizes knowing *about* the SDH rather than knowing *how* to take action on the SDH may perpetuate inequity by maintaining the status quo and curtailing the ability of health professionals to engage in transformative social change. Rather than calling for minor curricular modifications, the authors argue that major structural and cultural transformations within medical education needs to occur to make educational institutions truly socially responsible.

Despite increasing attention to concerns such as decolonization, anti-racism, diversity and inclusion within the academy more broadly (Cote-Meek & Moeke-Pickering, 2020; Newton, 2019; Tamtik & Guenther, 2019) we could not locate evidence of comprehensive examples of structural and cultural transformation of pre-licensure health professional TLEs in Canada.

While this transformation will require input from multiple partners, the vision and perspectives of educational leaders is integral in shaping the culture and environment in an academic institution (Mundt, 2005; Patterson & Krause, 2015). However, little is known about the views of educational leaders within *health* professions regarding TLEs with respect to SJ/HE. In the qualitative study described here, an interprofessional team of researchers explored academic leaders' perceptions of the extent to which TLEs incorporated SJ/HE into HPEPs.

[1] We use the word, Indigenous, as a hypernym to describe First Nations, Metis, and Inuit peoples, recognizing that there may be significant differences in experiences and needs both between and within these groups.

Study Objectives

1. To explore the perspectives of academic leaders within a health sciences faculty (FHS) about their vision for a TLE that promotes SJ/HE; the extent to which the TLE in the faculty reflects that vision; factors that may facilitate or hinder achieving their vision; and next steps needed to move their vision forward.

2. To explore the extent to which there is a unified vision of a TLE that promotes SJ/HE among academic leaders in one university.

Method

Design

A qualitative descriptive approach was used to explore the perspectives of academic leaders in HPEPs about the incorporation of SJ/HE in TLEs. Qualitative description is appropriate when little information exists about the subject, and detailed descriptions of a phenomenon are required (Sandelowski, 2010). The researcher's role is to discover and understand a phenomenon, a process, or the perspectives and worldviews of the people involved (Bradshaw et al., 2017).

Sample, Setting, and Recruitment

Using purposive sampling (Speziale & Carpenter, 2011), individuals with formal leadership positions in a mid-western Canadian university FHS were recruited. The FHS, established in 2015, houses 10 health professional programmes within five Colleges (Dentistry, Rehabilitation Sciences, Pharmacy, Medicine, and Nursing). The Colleges enrollment combined represents more than 3,100 students across the professional programmes as follows dental hygiene, dentistry, occupational therapy, physiotherapy, respiratory therapy, pharmacy, physician assistant, medicine, nursing, and midwifery. At the time of the study, respectfully, the FHS was early in the process of establishing policies and processes to support an institutional culture of inclusivity, diversity, equity, and accessibility attending to social justice. Participants were required to have held leadership positions for at least six months to ensure a minimum level of familiarity with their specific HPEP. After receiving ethics approval, a letter of invitation was sent to 19 academic leaders including deans, vice deans, associate deans, directors, and department heads. Interested individuals who met the inclusion criterion were sent an information package, including an outline of interview questions, and a consent form that was reviewed and completed prior to data collection.

Data Collection

Data collection consisted of 45-minute, face-to-face, semi-structured key informant interviews, conducted by a team member not directly affiliated with any of the individual FHS Colleges. The digitally recorded interviews began by asking about participants' understanding of SJ and its relationship to HE from their own professional perspective, and to what extent the current TLE in their programme reflects a commitment to SJ and HE. They were then asked to

identify barriers and facilitators for creating a TLE that facilitates SJ/HE, and next steps toward achieving this goal.

Data Analysis

Interviews were transcribed verbatim, and transcripts were analyzed thematically. When using a qualitative description approach, the researchers follow the data as concepts emerge, and stay close to what the data said and how it was said (Bradshaw et al., 2017). The advantage of this approach is that data analysis is more likely to remain true to participants' accounts and contribute to ensuring the researchers' own interpretations are transparent (Bradshaw et al.).

To begin the analysis, a sub-group of four project researchers (including the first author) reviewed three transcripts, discussed general impressions regarding the data and identified preliminary broad themes. In keeping with the intent of qualitative description to remain as near to the participants' meaning as possible by using their own words (Bradshaw et al., 2017), the first author and the research assistant (RA) subsequently completed initial coding of these three transcripts, using the interview guide to categorize data. The RA then coded the remaining transcripts.

In the second round of coding, initial codes were combined, and key themes were identified. The data was organized in tables to create a visual and contextual interpretation. The tables were used during research team meetings to finalize the themes and sub-themes.

Results: "We Need to Walk the Talk"

Fourteen academic leaders from five Colleges (Pharmacy, Dentistry, Nursing, Rehabilitation Sciences, Medicine), volunteered to participate, including three deans, four associate deans, five directors, and two department heads. Five were male; nine were female.

"We need to walk the talk' was the overarching theme. Subthemes included understanding of SJ/HE; current strategies to create a TLE facilitating SJ/HE; facilitators of and barriers to a TLE that promote SJ/HE; and actions required to further develop a TLE that promote SJ/HE. The overarching theme emerged as participants spoke about current strategies, but explicitly expressed the need to do more to turn talk into action, beginning with small persistent steps. As one participant said: "I do think that we do a lot of talking and minimal actioning, which is a problem. I think you need to take a little snippet of something and start working on it" (P1). Another participant noted that fear of doing the wrong thing can lead to doing nothing: "…we need to start taking a few steps and stop worrying about if it's the right step because doing nothing is just letting the status quo rule" (P7). The need to monitor progress was also identified: "I think we need to have a way that we can do a little bit of a report card on ourselves about how we all are doing across the faculty" (P7). Lastly, it was noted, "There's got to be that buy-in from the top and then there has to be that commitment to sustain the information and going out to each college" (P3).

Understanding of SJ/HE

The majority of participants defined SJ as creating equal opportunities for health. Two individuals focused on access to health services when speaking of equity, but another challenged this perspective:

> It's more than the right to access services. It's very much how we help people participate in their daily lives... When people are faced with disability or faced with other forms of diversity challenges, what's their ability to do what they need to do to become meaningfully engaged in the world? (P2)

Only one participant articulated a clear link between the concepts of SJ and HE:

> Social justice is kind of a means or process to help to achieve health equity; health equity being more of the outcome and social justice being more of the process, policies, framework, values that you would have that would allow that to be achieved. (P7)

The main influence on participants' understanding of these concepts was clinical experience. This was especially the case for those who had practiced in First Nations communities.

> I spent a lot of time up north where you're kind of confronted with these inequities… and you pretty quickly come to the conclusion that there are lots of determinants of those allocation decisions and not all of them are pleasant. (P4)

Personal experience of economic hardship, the influence of mentors, and professional/pre-licensure education were identified as additional factors shaping how one understands SJ/HE. One participant attributed their understanding of SJ/HE to the foundational values of their profession:

> As a student…we were exposed to these ideas of the broader determinants of health...I don't know that the concept of health equity was really present at that point... But there was always this talk of fairness and social justice and how we need to contribute to making society more equitable—those are really values and philosophies of our profession. (P6)

Current Strategies to create a TLE facilitating SJ/HE

Participants identified several current strategies to create a TLE that facilitates SJ/HE. These included: policies to increase diversity of students; strategies to address SJ/HE in the curriculum, especially in the context of interprofessional education and opportunities for experiential learning in settings serving equity-deserving populations; increased efforts to 'Indigenize' the curriculum and to support Indigenous students; the recent hiring of a Director of Equity, Diversity and Inclusion as well as an Anti-Racism Lead; and work to build relationships/allyships with equity-deserving community partners.

Several aspects of the current TLE were identified as problematic. Six participants described the SJ/HE perspective as limited, not overt, or inconsistent across courses and disciplines. Importantly, programmes need to be explicitly accountable like ensuring graduates are practice-ready to address SJ/HE in the practice-setting.

> We need to do a better job of having both stand alone and integrated teaching around things like social justice, Indigenous health and health equity...You should not be able to graduate without a working knowledge of health equity and how to apply it into your practice… (P8)

Six participants expressed that the faculty still does not offer a safe social/cultural space for all students and staff. Indigenous students were primarily the focus of this discussion. As one participant stated, "We have done a terrible job with the TRC [Truth and Reconciliation Commission of Canada's] Calls to Action" (P7). Safety for 2SLGBTQIA[2] and low-income students was also mentioned:

> It's the safety of the learning environment overall. So, if we cannot provide a safe learning environment that's free of racism, free of homophobia, free of misogyny, then we can fundamentally not teach our students about social justice equity. (P8)

As for the populations that participants identified as a priority for SJ/HE efforts, Indigenous peoples were the main priority population identified, both in terms of students and communities served by the university. Still, immigrant and refugee, 2SLGBTQIA, and low-income populations were mentioned though not the main focus.

Facilitators of a TLE that Enables SJ/HE

Leadership

Most participants stated that strong support and commitment to equity, diversity, and inclusion (EDI) from senior leadership in the faculty and the university, especially related to Indigenous peoples, is essential. It was noted that all deans had signed a joint commitment to EDI of faculty, staff, and learners; however, as one person remarked, it is not enough to sign such a document: "A dean or a director of the programme should simply say, you know what? We're going to make it work. Until you reach that political will, because that's all it is, it's not going to happen" (P2).

Building Relationships with Communities

It was noted engaging with community partners is a strategic priority and that relationship is essential for identifying how to best meet the needs of equity-deserving populations. One participant noted there was still work to be done: "We haven't really established that fluid relationship between community and academia that would begin to meet their needs as they see it, as opposed to their needs as we see it" (P9). There was acknowledgement that building trusting relationships takes time, and there was optimism about current efforts to foster relationships with community partners.

Professional/Academic Expectations

The accreditation process, as well as professional standards/competencies—both of which require consideration of equity, justice, and human rights issues—were identified as important external facilitators of a TLE that enables SJ/HE. The process of preparing for a recent accreditation provided opportunity to raise awareness of gaps in the current curriculum. The same participant mentioned their national professional and regulatory organizations were in the process

[2] Acronym for Two-Spirit, Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, Intersex, Asexual.

of reviewing their professional competencies, “so there's an opportunity there to again see how SJ/HE are clearly articulated within the competencies for our programme—our profession” (P6).

Changing Societal Views About Diversity/Equity

Several participants suggested that a younger generation of students is more accepting of diversity/equity initiatives, and in some respects, they are ahead of some of the faculty in taking action to promote SJ/HE. An example provided was that medical students had demanded more accountability for Indigenous content in the curriculum and “pushed” the College of Medicine to grade that content. An interprofessional, student-run clinic, which provides free health services to residents of a low-income community, was another example of a student-led initiative. However, this commitment to SJ/HE was not limited to a younger generation:

> Our students and our faculty are more and more interested in giving back to the community with respect to doing that, recognizing, you know, we are in a somewhat privileged situation and that we would like to be able to get people who normally wouldn't be able to access our services, some access. (P3)

Barriers to a TLE that Enables SJ/HE

Participants identified several barriers, some originating within the FHS, others originating at the broader university level or externally.

Dominance of Western ‘Lens’ for Learning

The barrier identified most frequently was that a western perspective of knowledge and learning predominates in the faculty (and university), and that this ‘lens’ is different from Indigenous ways of knowing and learning:

> We have a system that says you have to be this way to survive it [the education programme]. And our approach or lens for learning is quite different than maybe an Indigenous person. And they [Indigenous students] wouldn't necessarily make it through the western way of learning because it's not how they learn. (P1)

Another participant acknowledged the dominant western perspective becomes taken for granted among non-Indigenous members of the university: “It's [western way of thinking] so inherent we don't even think about it until it's pointed out and when it's pointed out we think, yeah, of course” (P6).

Lack of Time and Resources

Several participants mentioned not having enough time and resources, especially to support Indigenous students. This can be overwhelming for academic leaders and others who are trying to make a difference but recognize change will not happen overnight:

> People just get overwhelmed … there's just too much to do... I think what it comes down to, when we talk about, for example, our Indigenous students, is that the resources are so thin - we have one [designated position] to support all of our Indigenous students and it's huge - it's way too much. So we need to think about… what principles and values guide our funding allocation within the faculty, and we could make that part of our budgeting process, right? Some of those principles. (P6)

Faculty Resistance to Change

Several participants identified faculty members' resistance to change as a barrier. One participant shared that some faculty members have taught a certain way for so long that they find it difficult to make changes in their approach to course content/delivery. Another, in reference to Indigenizing the curriculum and promoting cultural safety, remarked: "I think that a lot of folks are well-meaning, and they want to do this, but are nervous because we don't have the cultural background or expertise" (P14).

Racism

Racism, both within the university and more broadly, was described by several participants. One person noted anti-Indigenous racism is structural in nature and influences societal attitudes:

> Legislation in Canada is such that it actually encourages Canadians to be racist against Indigenous People. I'm speaking specifically of the *Indian Act* where government really focused on their ability to take any shred of power or independence away from Indigenous People. (P9)

P14 stated: "I think there are examples of racism that probably continues to be within the system, and I think that needs to be addressed as well, both within the Colleges, at the university and just generally within the population." The need for anti-racism training among clinical preceptors was also identified. One participant noted there is a risk of backlash against students who have been admitted in 'special consideration' (i.e., underrepresented) categories:

> I think there's still a lot of work to be done in those special considerations categories so you don't tokenize people, so you don't put them in a place where people will say well, you got in because they lowered the standard. (P1)

University Hiring Practices

Only one participant identified hiring practices at the university as a barrier to increasing diversity of faculty:

> …it's usually about who's superior in the system versus really what they bring, their background. Like you might have somebody that's really ethnically diverse but if someone in the system has been there longer, you don't have a chance of getting the job. (P1)

This participant acknowledged that standards needed to be maintained but suggested educational systems lack "fluidity" in hiring practices and privilege certain people who can succeed and maintain power. While the existence of racism in hiring practices was not stated explicitly by this participant, it was implied.

Lack of an Activist/Advocacy Ethos Among Faculty Members

Several participants lamented the lack of an activist/advocacy ethos among faculty members in relation to addressing SJ/HE. One participant suggested students were ahead of faculty in this regard: "I don't see that we're very active in the social, political arena at all. The med students have a lobby day. It's kind of embarrassing that med students have a lobby day and faculty do not." (P8) Another suggested there was no forum for a faculty member "to pull together people and say… we should stand up to this latest declaration of government on this" (P2).

Political Climate

Half of the participants identified the political climate as a barrier, suggesting the government was more concerned with efficiency than equity. "[I]f there's no support for social justice and health equity, how does that trickle down to the university and to curriculum and to preparation of healthcare providers?" (P6). However, the same participant thought this would probably be more of a barrier once FHS students had graduated: "It would affect practice; I think more so when you're out and you're seeing that there isn't this ability to create greater access or equitable access" (P6). Cuts to funding that supports students from structurally disadvantaged backgrounds to access health professional education was also identified as a barrier.

Actions Required to Further Develop a TLE that Enables SJ/HE

For the most part, participants did not articulate an overall vision of a future TLE that facilitated SJ/HE. Instead, they emphasized areas requiring further attention.

Increased Support for Structurally Disadvantaged Students

Most participants identified the need for more resources to support students who are structurally disadvantaged. Indigenous students were mentioned most commonly, but also 2SLGBTQIA and low-income students. Increased funding, from government and the university, was the main resource identified.

> We've had so many students who have just, just made it economically; it's been so hard to stay in the programme…a shame that someone cannot get an education because they cannot afford to stay in a programme that they deserve to be in. They've worked to be here, they've made it through all the steps but economically they can't be here because they don't have money to stay in the programme - that should not happen. So, we need better financial emergency resource supports. I think it was so great that [the Faculty] has created the emergency fund for students…but we definitely need to put more of that in place. (P6)

Increased non-financial support was mentioned as well: “The supports need to be in place for when folks start into the programme, so it’s not as much of a challenge or a shock, when you first come into the new environment” (P14). One participant suggested there should be more pre-programmes for students with lower GPAs:

> What if, before …. applying for nursing or any of the other [programmes], we spent a year developing their academic ability, teaching them how to write, how to do well on multiple interviews or on mission statements, getting them to understand what it really takes to study and survive? (P5)

Create a Safer Space for Students

Several participants spoke about the need to do more to create a safe learning environment for students. While this was mostly related to Indigenous students, one participant emphasized this was a broader concern:

> … [a safe environment] for everybody, and I mean that for our Indigenous students, for our LGBTTQ students, even for our students of lower socioeconomic status…. There's lots of situations where they're working with peers from different socioeconomic status, where they're made to feel ‘lesser’ sometimes, where they don't feel safe necessarily talking about that. (P6)

Continued Engagement/Consultation with Indigenous Communities to Decolonize Structures

Various actions to engage Indigenous partners were identified as a starting point to decolonize structures. One individual was hopeful that an Indigenous Elder based in their programme would help to build momentum. The need for continued, meaningful engagement with Indigenous community partners was expressed. One participant described the benefits of this process:

> Being able to have that community lens when working in the northern communities to not just work with access to [specific type of] care but then being a resource for the community in addressing the social determinants of health. Because unless we address the social determinants of health, things are not going to change. (P12)

Integration of SJ/HE in the Curriculum

Many participants identified the need to integrate Indigenous knowledges/ways of knowing in their curricula. One participant thought there had been some foundational work to integrate Indigenous knowledges but much more could be done. Another suggested fundamental education about the principles of reconciliation would be important. Another expressed the view that the process of ‘Indigenization’ of the curriculum could have broader impact: “This push on Indigenous education and curriculum and Indigenizing things I think is actually having an effect on overall looking at diversity and will help to influence and facilitate people thinking along the lines of social justice and equities” (P3). One participant stated that SJ/HE perspective “can be inherent in almost everything we do because even if you're teaching a practice skill you can do that in the

context of thinking about it with a lens of health equity" (P6). Another participant expressed the view that a lot more work will need to be done with faculty members before a SJ/HE perspective would be accepted and integrated throughout their programme. One participant identified the need to map SJ/HE-related curriculum content to ensure there is adequate integration:

> We just went through an accreditation process. It was clear to us that we needed to be able to tease out more how we're integrating that content and do some mapping … which we haven't quite yet done in a way that we're satisfied with. And to then be able to say for certain what the gaps are after we've done that mapping. And yeah, we've got mapping to do particularly around health equity. (P6)

Diversity of Clinical Placements and Experiential Learning

Several participants spoke of the importance of providing diverse clinical placements, including in equity-deserving communities such as First Nation communities, where students would be exposed more fully to the conditions producing inequities. As one participant stated: "My vision would be, that every student has a placement in an Indigenous community or in rural or northern communities, where you can see more, firsthand, some health inequities" (P11). Another elaborated on the value of firsthand experience:

> I think there needs to be a real intention around diversity in the clinical placements, so people have to live it a little bit and not just read about it and really, you know, go into the north and see how access to care is different and the factors that impact that, whether it's funding or environment or whether, you know, it's different. And then, also how the types of resources that are available are different. (P1)

Interprofessional Education (IPE) Opportunities

While some concerns were expressed about the complexity and resource-intensiveness of IPE initiatives, several participants noted these initiatives could be an excellent opportunity to explore SJ/HE, including interprofessional placements in equity-deserving communities. One individual spoke about the way IPE could better meet the needs of diverse communities: "…rather than the siloed approach to professional education, we have seen that having people work together with their strengths and abilities and expertise really makes it better for the people we serve" (P9). Another participant described a vision for interprofessional service-learning:

> We've talked about having joint service-learning opportunities, where the students would work with a particular organization in our community. It would be attached to a course and it would relate to health equity and social justice but it would be about them actually acting and doing advocacy…and the students really working to help them [the organization] address what they identify as their needs and concerns. (P6)

Equity-Based Recruitment, Hiring and Diversity of Faculty

Many participants identified the need for increased diversity among faculty members, with a focus on hiring Indigenous teaching staff. One noted, “As we Indigenize the curriculum, the next step is where are your Indigenous faculty?” (P1)

> In terms of recruitment and retention, we've talked about wanting to recruit an Indigenous scholar to work within the College that would support all of the programmes. But beyond that we know we need more than just one—we need far more—every department, at a minimum, should have at least one Indigenous faculty member... (P6)

This participant also noted faculty members in their College are “very white Christian” and “white female”—although, this person acknowledged this has changed in recent years. The challenge of recruiting and retaining women, and the need to support them and remove barriers to women moving into leadership roles, was raised by another participant: “Some of it's very basic like having a daycare available. We're working to put that in place here” (P4). Another participant noted that the *Employment Equity Act* includes women, Indigenous Peoples, persons with differing abilities, members of racialized communities, and sexual/gender minorities, and suggested that further work needs to be done to recruit faculty from all these historically underrepresented groups. Lastly, one participant stated that diversity for their programme would be having male faculty members (there were none at the time).

Discussion

While SJ/HE are established foundational values for many health professions in Canada, for example occupational therapy (ACOTRO et al., 2021), medicine (CanMeds, 2015), and dental hygiene (FDHRC, 2021), there is a paucity of research exploring their application to HPEPs in Canada. Further, little is known about how the TLE promotes SJ/HE in pre-licensure programmes. The findings of this study begin to fill this knowledge gap by articulating the perspective of academic leaders in one health sciences faculty regarding such a TLE.

Overall, academic leaders expressed humility, hope, and a will to make a difference in creating a TLE promoting SJ/HE. While they acknowledged there was still a lot to be done, they were optimistic there would be continued progress. This perspective is not surprising, as Canadian universities have recently been engaged in efforts to address EDI (Tamtik et al., 2019). At this university, the strategic plan stated that equity and inclusion are core values of the institution, and identified increased student, staff, faculty, and leadership diversity that reflects society—especially with respect to the inclusion of women, Indigenous Peoples, people with differing abilities, gender and sexual minorities, and racialized minorities—as a specific goal to achieve an outstanding learning and working environment. Although, interestingly, at the time of the interviews, there was no mention of the university’s strategic plan as a facilitator that enabled developing a TLE promoting SJ/HE, it may have facilitated some initiatives. Since the interviews took place, significant institutionally driven initiatives have been implemented. Examples include the FHS establishment of the Office of Anti-racism; Office of Equity, Access, and Participation; and a policy on the disruption of all forms of racism.

A recent policy analysis of EDI initiatives in Canadian universities (Tamtik et al., 2019) concluded that, although Canadian universities are gradually taking a pro-active approach to EDI,

there has been a tendency to treat these distinct issues as one, and the approach of the majority of universities was unlikely to result in changes that can potentially secure the maximum success for equity-deserving groups. Tamtik et al. argued that Canadian universities have focused on increasing the diversity of student populations by removing barriers to access to education. The less frequent radical approach of 'equity as fairness' involved the redistribution of resources that included practices such as the preferential hiring of equity-deserving groups for faculty and administration positions and designated funding for students and faculty of equity-deserving groups. Like Tamtik, the current study participants expressed that policies and values need to be explicit and cannot be dormant. What is needed are continual actions including redistribution of enabling resources to enact the policies.

Tamtik et al. noted that EDI offices appeared to have some benefits for data gathering and recommendations. Though important alone, they may not be sufficient to evoke SJ change needed as expressed in the current study. Thobani (2022) cautions the EDI portfolios established by North American universities are a way of restricting the praxis of more radical approaches to dismantling the colonial structures embedded in these universities. A SJ approach with roots in upholding people's rights as entrenched in global declarations including the Universal Declaration of Human Rights (1948), United Nations Convention on the Rights of Persons with Disabilities (2006), and the United Nations Declaration on the Rights of Indigenous Peoples (2007), requires the dismantling of colonial structures and systems that have created and sustained inequities and injustices. A justice approach includes an emphasis on people's rights to dignity, safety, and nondiscrimination. Thus, dismantling of the many and often hidden ways that rights to dignity, safety and non-discrimination are denied to equity-deserving groups in universities and healthcare settings is required. Some study participants noted the importance of creating safer spaces for students and a desire to decolonize structures within healthcare provided to Indigenous communities, but there was little discussion on the ways more radical changes would be needed within the academy to dismantle structures that are a threat to the rights of equity-deserving groups.

A salient thread throughout the findings was that participants focused primarily on Indigenous issues/examples when discussing the TLE in relation to SJ/HE. This was primarily expressed in relation to creating a supportive and safe TLE to ensure the success of Indigenous students; however, the need to 'Indigenize' curricula was also acknowledged. This Indigenous focus is congruent with the university's strategic priority of fostering pathways to Indigenous achievement, and broader attention to decolonizing and Indigenizing education in Canada (Cote-Meek & Moeke-Pickering, 2020). The distinction between Indigenous inclusion and decolonial restructuring (Gaudry & Lorenz, 2018) was not raised.

While there was acknowledgement of the need to improve student and faculty diversity in general, there was not a unified vision of a TLE promoting SJ/HE more broadly, especially with respect to the inclusion of individuals with differing abilities, gender and sexual minorities, low-income, and non-Indigenous racialized persons. Equally absent was the notion of accountability of the leadership to SJ/HE in the TLE for faculty, students, and staff.

Limitations

This study explored perspectives of academic leaders in one FHS of a western Canadian university. The findings may not be transferable to other contexts. The concept of transferability in qualitative research implies that the study findings can be applicable to similar situations or individuals; however, this is left to the reader to decide (Sandelowski & Leeman, 2012). The focus

on views of academic leaders regarding the TLE in their programmes may have resulted in social desirability bias (Bryman et al., 2012). Further research is required to explore perspectives of students, faculty, and staff on SJ/HE in the TLE as the current study focused on academic leadership.

Conclusion

There is little known about the extent to which TLEs in HPEPs embody and promote the values of SJ/HE and develop the knowledge and skills health professionals require to tackle health inequities that are the result of social injustice.

In this qualitative descriptive study, 14 academic leaders shared their perspectives of how the TLE addressed and promoted SJ/HE in pre-licensure HPEPs in a FHS at a western Canadian university. A thematic analysis identified "we need to walk the talk" as the overarching theme with these sub-themes: understanding of SJ/HE; current strategies to create a TLE facilitating SJ/HE; facilitators of and barriers to a TLE that promote SJ/HE; and actions required to further develop a TLE that promote SJ/HE. While the realization of TLE embodying SJ/HE for both staff and learners may be elusive, it remains the goal.

Academic leaders were hopeful about the future and identified key areas requiring attention to ensure that students, faculty, administrators, and future healthcare professionals promote SJ/HE. Participants identified policies and programmes required to support the inclusion of structurally disadvantaged students and faculty in HPEPs. Most participants focused on addressing the needs of, and providing safe spaces for, Indigenous students and strategies to promote SJ/HE in partnership with Indigenous communities. The results of this study underscore the need of academic leaders to have a clear, unified articulation of a TLE that embodies SJ/HE for faculty, staff and learners. Beyond a unified articulation, recommendations based on the study include advancing support for structurally disadvantaged students; ensuring safe space for students; decolonization of structures through continual engagement and consultation with Indigenous communities; explicit integration of SJ/HE in the curriculum; diversity of clinical placements and experiential learning, particularly through IPE; and upholding equity-based recruitment, hiring and diversity of faculty. These actions position HPEPs to 'walk the talk,' educating future generations of healthcare professionals to be the change and to take action upholding health equity and social justice.

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