Transcript of Accidental Intellectual Episode 13: The Power of Awareness

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[Intro Music]

Bronwyn Lamond 0:07
Hi, and welcome to the Accidental Intellectual, a podcast where we talk to people working in health related fields, and get to know the human behind the expert. Today you're hearing from me, Bronwyn Lamond, and Lee Propp.

Lee Propp 0:19
In today's episode we sat down with Dr. Lisa Richardson was so thoughtful and generous with her time. Let's hear Dr. Richardson introduce yourself.

Dr. Lisa Richardson 0:30
My name is Dr. Lisa Richardson. I don't usually put the doctor in front, but I guess [laugh] today I will, and I'm an internal medicine physician. I'm mixed blood Anishinaabekwe, my home community is called Shebahonaning, also known as Killarney, but I grew up in northern Ontario and then in Toronto. I am in addition to being an internist assignment strategically in Indigenous health for the Faculty of Medicine and Women's College Hospital, and I have, you know, various other leadership roles doing, equity and inclusion work.

Lee Propp 1:06
With that said, let's get right into our conversation. We hope you enjoy as much as we did.

[Interlude Music]

Lee Propp 1:16
Well hi and welcome to the Accidental Intellectual we're so excited to have you on the show today.

Dr. Lisa Richardson 1:23
Very excited to be here. Thanks.

Lee Propp 1:25
So we're gonna start, or we're just gonna ask you some of these rapid fire questions just for fun, so give us the first thing that comes to mind. Would you rather be too warm or too cold?

Dr. Lisa Richardson 1:39
Too cold.

Bronwyn Lamond 1:40
Okay, fair enough.

Lee Propp 1:43

Me too.

Bronwyn Lamond 1:44
Paper agenda or electronic calendar.

Dr. Lisa Richardson 1:49
Oh boy. I used to love the agenda and realized it wasn't working in this new world so I'm having to adapt to the electronic calendar.

Bronwyn Lamond 1:58
Me too. Me too.

Lee Propp 2:02
Be able to fly or turn invisible.

Dr. Lisa Richardson 2:06
Oh [laugh] both if possible, I'd love both. Can't choose.

Bronwyn Lamond 2:15
Fair enough. Dogs or cats.

Dr. Lisa Richardson 2:18
Definitely dogs.

Lee Propp 2:21
Mhm, me too.

Bronwyn Lamond 2:22
Fair enough. [laugh].

Lee Propp 2:24
You're saying this, I have a dog and Bronwyn has two cats.

Bronwyn Lamond 2:26
Yeah.

Dr. Lisa Richardson 2:30
Sorry Bronwyn.

Bronwyn Lamond 2:32
That's okay, that's okay [laugh].

Lee Propp 2:35
Introvert or extrovert.

Dr. Lisa Richardson 2:40
Definitely an introvert. Took me a while to realize that, you know, one can, can enjoy being around people and have no problem speaking in front of people or doing this sort of thing but still be an introvert in terms of what I need to replete myself. Definitely time privately.

Bronwyn Lamond 3:00
I think that resonates with me as well. While you're walking, listening to music or podcasts.

Dr. Lisa Richardson 3:10
Music, definitely I feel like I have a lot of cognitive activity going [laugh] most of the time and walking and listening to music, it gives some nice meditative time for me.

Lee Propp 3:24
Mhm. Yeah, cake or pie.

Dr. Lisa Richardson 3:27
Ooh, yeah. Any, any dessert. Anything that I don't have to make [laugh]. I would love either.

Bronwyn Lamond 3:36
And morning person or night owl.

Dr. Lisa Richardson 3:40
Definitely a morning person. Yeah.

Bronwyn Lamond 3:46
I like both for different reasons. I think I'm a mid morning person, not too early. [laugh]

Lee Propp 3:52
Yeah, same.

Bronwyn Lamond 3:53
So jumping into sort of the interview, interview questions, we thought we would start by just acknowledging that your academic background is quite diverse. How did you come to study biology and English literature, and then go to medical school, how did that path happen?

Dr. Lisa Richardson 4:10
Thanks for asking it is a little bit unusual, although it seems like it's becoming more and more common for people to have disparate backgrounds before coming into medicine, but I so I started, I was, I was one of those kids who loved both science and the arts, and couldn't really decide what to apply to but decided that I did love biology so started at McGill University studying that and then really within a few months thought that I was missing a lot from my life. Although, although I did enjoy some of those science courses they definitely did not enjoy some of the other pre-req first year science, I really felt that my love of reading of narrative of art of culture, by that I mean, you know, the way in which we've grown up and our ways of being in the world. I wasn't able to explore that at all and in the sciences and felt like a big part of my life was missing, so I was taking an English course at the time which I loved and thought well maybe I'll create more space, if I can advocate somehow to do a double major in English and bio so I did that. At the time they didn't have the conjoined degrees that you can now do so I was having to do, like I took a philosophy of linguistics course. And because there was a fair bit of linguistic science in it I managed to get it to count for my science degree, and also towards my towards my English degree. So it was there was a lot of finagling to make it happen, but I realized in hindsight that that idea of not having to be reduced to a sort of a single discipline was really important and certainly when we look at the practice of Indigenous health and well being, we don't just look at the science of biomedicine, but think about the role of narrative and story and you know connection to land

and history as a big, big part of wellness. So, I think in fact that disparate background is really healthy in medicine.

Bronwyn Lamond 1:26
That's yeah, I think we've heard that from, from a few guests now but I think you do have a very specific perspective on it. And I was actually just moving into asking you how these previous studies impact your current work, and perspectives and medicine, you briefly just touched on it, but I think there's a lot more there than I'm sure you have to say.

Dr. Lisa Richardson 6:36
Yeah, I mean the most the most striking thing for me is in our relationships with our patients and how we're taught in medicine like in our first year of medical school, you learn to take a history. And then, and there's this very structured way in which we do that and then we're taught to document that in a very particular way and I think about everything that gets lost hopefully translates a person's story, their experience of, you know a particular health condition, a story of their life, and how we then distill that and translate that into this - it's like it goes through the medical machinery, and so you'll take this rich story of someone's life, and of their experience of being unwell and you translate that into this medical history, and so much gets lost, so actually as I feel a lot of what I do is, how do we go full circle, and, and once - and recognize that we can't, we need to go back to our, the stories of our patients and our own stories as clinicians as well and realize that that relationship building is at the heart of being a great practitioner. So, I think in some way, listening, and appreciating the words and appreciating the diverse perspectives that everyone has, is how the study of literature and English helped me in medicine.

Bronwyn Lamond 8:09
Mhm. Are there, are there any other ways that you integrate the arts, I know that's a broad term, the arts into your practice?

Dr. Lisa Richardson 8:18
Yes so I think, I think the other piece I have, you know, numerous other ways. Certainly in my teaching practice I tried to get us to think beyond, you know, beyond the numbers, so there's that reductionism that happens with before the diagnosis so I would, you know, the language that we use in medicine can be really restrictive and actually can be quite judgmental. And, so I do urge the learners I work with to pay a lot of attention to the language that we use. And so just even that, that's a really tangible connection with the study of literature right but I, I also love how engaging in, like, with the Arts and Social Sciences, expands our way of thinking about medicine so I actually do that in some pretty specific ways through teaching at the Art Gallery of Ontario, I run a course within an amazing colleague of mine called Dr. Allison Crawford. Unfortunately it's been on hold during pro-COVID but when we do, we actually take medical students into the art gallery and we engage in this activity called a group looking, where we would look at a work of art together and hone our, our observation skills but also understand the difference between what one's observing and then how one interprets that and how, you know, even just based on our different experiences, lived experiences and perceptions, we may even perceive something differently so what one person sees as 'Oh, that woman in the in the painting looks, looks like she's frowning,' another person in the group may observe and say 'wow that's interesting to me, cause to me she just looks like she's really deep in - deep in thought,' and so when you hear that people are observed, are looking at the same work of art together and interpreted it differently, you start to understand the subjectivity, not just of how we interpret the world but even of perception. So that's a really cool way to get people to understand diverse lived experiences. And also we, we look at art from different, from artists of different backgrounds so I love looking at the work of, after we've looked at classics in the Western canon, like, you know De Vinci or, or, or Rembrandt, then, to look at the work of

someone like Norvell Morisseau who just, has such a different approach to art and to really documenting his own you know, spiritual world and beliefs. And so, understanding how different worldviews, influence the way in which we experience the world was pretty powerful that way too.

Bronwyn Lamond 11:05
Yeah, that's such a, sounds like such a thoughtful and important course and it's funny because I, we interviewed Dr. Allison Crawford this season, actually, as I was preparing for this interview I said wow they seem to have so much in common, this, this integration of the arts into medicine so I did see that you taught the AGO class but I never knew that it was with Dr. Crawford, so that's really interesting.

Dr. Lisa Richardson 11:29
Yeah and I think…

Bronwyn Lamond 11:29
That sounds like a great fit.

Dr. Lisa Richardson 11:30
…well we work together on numerous - on quite a few projects, so that's funny that you interviewed or not funny, but yeah we've written together and we love working together. So.

Bronwyn Lamond 11:42
That's great.

Lee Propp 11:42
In listening to talk to us now, I was so curious about the piece that you brought in about language and how you know, telling stories, and studies of English literature informs that tremendously, but I was wondering if you could give some, some examples of - of how that shows up in the practice of medicine or in your practice of medicine.

Dr. Lisa Richardson 12:03
Mhm. Yeah such an important question and how can we be intentional around, being aware of it. Okay, well, even the way we introduce the stories, introduce a patient. When we're presenting a quote "case history" like when we're presenting the story of a patient to a colleague or an attending physician who is supervising that, even language like I have a 55 year old gentleman, it's really interesting when we look at, you know, or a lady or a gentleman, it's really interesting to look at the specific location of that language like, oh, where does that come from, that's from a very particular era in a particular class right? But we just start, we didn't, rather than saying, a man or a woman or a non-binary person who is coming in describing an experience of chest pain. You know it's interesting how the language gets codifies and, you know, who do we call a gentleman and are there some people that we don't actually refer to that way. So just the way in which we even start to speak about sex and gender, and then layer on some of that old school language that very classist is really interesting, but some of the things that I think impact the care that we give in a very specific way and then get carried out, and carried forward in a patient's chart for example, our language like non compliance. I really, really dislike that word. Oh, they're not compliant with treatment. Well, let's actually unpack that a little bit, and understand why a person may not be able to follow a treatment plan that you as a provider have created, maybe you actually haven't co-created a plan to care, you know, a care plan that they agree with. Maybe there are reasons why they can't afford their medication, maybe there are reasons why they don't have a proper living situation and or can't afford specific foods to follow a particular diet that you've recommended, whereas the term compliant implies that it is quite a judgmental term and it implies on what I think it's come to imply in medicine

that a person is, you know, deliberately not adhering to recommendations that we made. So I think it's interesting how the language that we use starts to carry these particular judgments with it. Another term that we use a lot that becomes very problematic is ‘failure to cope ‘and I've actually written about this and, you know, a patient will come in with failure to cope and inevitably when you look at the literature, there are many reasons, and often it's not that there's actually a specific reason why a person has suddenly had to come into hospital because they haven't been doing well at home, and there may be extenuating social circumstances that are making it difficult for them to cope at home, but when we need immediately labeled this person as ‘oh, failure to cope,’ we actually stopped looking for other things that are going on, that could have caused them to have to be admitted to hospital in this urgent way, and it also I think takes the onus off, it really centers, the onus on the individual like if you are, and it's often used in the context of an elderly person who may have some cognitive impairment, where is it, where it's like, oh, there's something wrong with them that they can't cope as opposed to well what should we be doing as a system to support them in their home environment so that they can thrive. Right? It's just, it's just interesting language that actually leads to oversights in our care because we often jump to, we often stop. Stop looking for, you know, infections or, or, you know, changes in their neurologic status or something that may have caused, caused them or you know, something that's happened in the home environment, or someone's blad - like a caregiver had to leave or been hospitalized that's caused this sudden change. And then the last thing I think is when we refer, and this is really quite classic when we refer to a patient by their diagnosis. Like, I feel revere, or, oh the heart that, that heart failure person. So actually, their medical condition becomes the metaphor by which we describe them, their humanity is literally their personhood is literally subsumed by a diag, a medical diagnosis, and that is probably to me one of the, one of the biggest errors, and like most egregious things that we do so I always then, you know, calling people out on that like, do you mean the person, Mr. So and So who has a diagnosis of congestive heart failure? So it's, but it's these processes, and these ways of communicating in medicine becomes so ingrained. And then, we don't even realize it and then they lead to a way of interacting with our patients where they are objectified. They become a you know, an object of the medical gaze, and of the medical diagnosis, as opposed to a human being, who happens to be living with like a stage four, you know renal cell cancer, or have presents with decompensated heart failure or whatever it may be, but we lose track of their personhood and so that's why the, the arts are important.

Lee Propp 17:54
Mhm yeah, that was, those were such illustrative examples and I think I had this thought while you were talking about sort of the moral onus that that gets placed when we are not deliberate, we're not thoughtful with, with the language that we choose and in the history of that language, I wonder if how aside from, you know, you know, training the next generation of physicians and providers. Are there any other areas that you've seen, or that you're hoping to see change be made in this field from a more systemic lens?

Dr. Lisa Richardson 18:29
Well I mean a lot of the work that I do is around thinking about not just the language that we use, but the bias and the stereotyping and the, you know, the plays out in the way we interact with our clients, our patients, and you know how that has a toll on those who have been structurally marginalized, specifically for my work a lot of it is on, on how that affects the way Indigenous peoples are treated in the healthcare system, and the assumptions that are made, the biases that go into assumptions around well, you know, they, they're - I'm going to assume that they're intoxicated as opposed to assuming that they have a decreased level of consciousness from, you know, a terrible urinary tract infection that's gone to their blood, so interesting how, what, what are our judgments and what is our default assumption based on what the person in front of us, looks like and what their background is, and how we jump to specific assumptions and conclusions that really have a terrible outcome - can have terrible impacts on their care. So, we need to do that broad training around bias and anti racist practice and anti oppressive practice, but

I think that's, so that's a system level intervention because that needs to be for every single person in the system, not just the clinical psychologists and physicians and nurses and social workers that need to be, like admin, the people who are welcoming people, the word clerks in the hospital, the people who are registering our clients, the people who are receiving complaints, the people who are drawing blood work, that broad scale training so that we can create safer environments I think needs to happen. And then we need to, we need our, our healthcare workforce to be representative of the clients of patients who we're seeing. So we need to recruit more, my work is around recruiting and supporting Indigenous learners. And in our Faculty of Medicine at University of Toronto we have a huge commitment and I'm very supportive of the recruitment of black learners as well because into medicine, those people have been underrepresented we know that when a black or indigenous patient is treated by a provider who is black or indigenous has the same background that they have, so when you have that what's called congruence, the outcomes are better, and we've got good evidence, particularly in the US for black patients being cared for by black physicians, how that changes, not just the care experience for the patient, how that changes the outcome, like that changes the, you know, the, the endpoint of their health outcome. Like that. Like that's a big, big system level change that needs to happen right because it's recruitment of the providers and then looking at the organization like I say we need, we need those people to be leading the health care system as well to be leading at the governance level to be at the senior management level to be represented across the organization.

Lee Propp 21:56
Uh yeah, I've, especially lately I've lately have had many conversations with, you know if it was immediate family over, over Friday Night Dinner about that sort of representation in many areas medicine and healthcare being one of them, and how that how that kind of really shifts perspective, not only at the provider level but just across the whole organization. And also, also with patients and I, when we start to make these sort of system wide changes, and work to diversify and change the way that we train healthcare providers, and physicians, what's the downstream effect there on - on the patient care, that is received.

Dr. Lisa Richardson 22:43
We hope that we're creating better care experiences, obviously through all of our education, whatever educational interventions, but I think, I think. I'm thinking a little bit about how, how we need to understand that diversity is not just done because it's a good thing to do. But when we bring together people with different backgrounds and different lived experiences and different ways of looking at the world. We create better systems, we create more inclusive environments, and we for example - I'm going to give a concrete example. When you think about an issue, when I think about an Anishinaabe, way of considering wellness. First of all, health is not - health is not the absence of disease from when I think about it in that Anishinaabe way. Health is about all of the things that bring you wellness. So it's actually flipping from a negative sort of deficit based model, which is really the way a lot of our medical training is is founded on what it's founded on, it's founded - founded on path-pathology and pathophysiology, as opposed to what are the things that bring you wellness and strength. What are the things that support your well being and how that shifts in the way we care for our patients can be really monumental because rather than always focusing on what you don't have. Let's say we're focused on what you do have and how can we work with that to actually allow you to thrive in the environment that you're, you're in and even though in my case because I'm an internist, you're living with a chronic condition like diabetes or like peripheral vascular disease or like chronic kidney disease, how can we actually allow that not - allow that to take over your life, but all of how allow you to have thrive and do the things that you love, while living with this chronic condition right so it's just a different model. For another, another way of thinking in that, again from Anishinaabe approaches to wellness or well being, is what I often talk about the four directions of health and well being where we – we're taught in medicine really to

focus on the physical health and mental health, but we don't think about emotional well being, and how relationships, and our social environment, and our family and community are so important, and we certainly don't think about spiritual well being, whereas if we are being thinking in that Anishinaabe way we're thinking about mental health, physical health, emotional health, spiritual health, and how they are all interacting and all related, so that one may, you know, one, you may have a physical illness, let's say, if you're like an advanced cancer diagnosis, but that clearly will have an affect on your, on your mental health and your emotional health and your spiritual health, and that really we although we're trained in my specialty in internal medicine to think about physical health. I have to, I try to think about the well being of the whole patient so I think about how is, how is living with this condition affecting your, you know, family life, your relationships, and how are you being supported how, you know, what is, how are you supporting your spiritual well being and by that I don't need it for some people that's a religious question, but from an Anishinaabe perspective the spirit the role of spirit is, is really, I think, much, much less. It's not religious, it's about understanding those spiritual connections to land and culture and people and community and ancestors, and how all of that supports our wellness.

Lee Propp 27:04
Yeah, I think that's…

Dr. Lisa Richardson 27:04
I don't know if that answered your question.

Lee Propp 27:06
Oh absolutely it's does and I really, I really like that distinction between, between mental health and emotional health because I think for in so many fields it kind of gets kind of wrapped up into sort of one mishmash of it. But, but really there are, there are some, some not subtle some, some big distinctions. There it sort of reminds me about a concept that in sort of the therapy practice that I've been sort of learning and training in from dialectical behavior therapy the idea of creating a life worth living. And it's it's wonderful to hear that you're making big waves and sort of bringing that into an area of medicine that is at least from my very outsider perspective seems like it's very much always focused on, like, just physical health, in internal medicine. So I think, sort of related but in sort of looking into a lot of the things that you've written and sort of the work that you do. The idea of - of cultural safety came up a number of times in - in my googling. And I wonder if you could give us a, just sort of a brief just to start maybe a brief explanation of what cultural safety is what it means.

Dr. Lisa Richardson 28:24
Sure, so definitely has spent a lot of time thinking and thinking about cultural safety. So cultural safety is different than, a couple of other concepts that we really commonly think about and I think I need to I need to mention them in order to illustrate the distinction. So, cultural, there's cultural awareness, which is recognizing that there are people with cultures, other than your own, and cultural sensitivity, which is being sensitive to the fact that there are people with cultures other things that are different from your own from your own, and then cultural competence, where, which is this idea that you will learn about and understand the cultures of your clients or providers, and be able to competently, communicate with them across cultures. But cultural safety and we often think of it as a continuum and cultural safety and cultural humility, are on the far end of that continuum because what cultural safety means is that you as a provider, understand that your, that your patient client or client, depending on the world that you're practicing and I'm using clients because of your, your psychology practice but has a distinct background, and culture, and lived experience that is affecting the way in which they are engaging in healthcare and it evolved initially by a mounting or scientist named Dr Ramsden who noticed that Māori people, when they were in the healthcare system, were having these terrible experiences, and leading to bad health

outcomes, as well, so health inequity. And cultural safety is about recognizing that, not, not only there is a person in front of me with a specific experience, but I need to understand the history of their community, and the history of mistreatment within the healthcare system of Indigenous people, and how that's playing out in this institutional environment and in this relationship that I have right now, and that's about a relationship of power. So there's always a power dynamic that plays out between a patient and a provider because you know the provider is the one with knowledge and expertise to treat someone, and then the patient often is feeling disempowered if they're in a state, of their, their lacking health are in a state of illness. And so, a provider needs to be aware of how power dynamics are playing out, but cultural safety takes us to a next a next step, by saying those who are from structurally marginalized communities who then are seeking health care have an even greater power gap that exists, and we must think about how to overcome that and how to write that injustice that's playing out because of colonization and other aspects of historical and ongoing mistreatment. And then the other dimension, so it's an awareness of power, cultural safety also means understanding that we are all there as a culture. So just because I put on my white coat does not mean I erase my own history, and my own perspective, and my own experience and practice in a completely objective way, I'm still bringing those experiences and those biases in many cases into that interaction that I have and, you know, the choices that I make, offer to a patient or the way in which I engage - may engage with a patient. And then, lastly, cultural safety is different from cultural competence, because it is about putting the - that is about giving the patient the opportunity to determine whether an experience is safe or not. So, cultural competence is all about the skill of a provider, whereas cultural safety is about saying, this is giving the patient the opportunity to set, to determine whether they felt okay, whether they felt respected whether they felt cared for in a respectful, in a whole holistic way as a, as a person. So, a provider may feel like they're fantastic. And then, you know, [laugh] perhaps they've interacted with a patient in this amazing way and, then you may have the patient might read me - leave the room and be asked, oh, how did that person do and the person might say 'I felt terrible,' like that didn't go respected, I didn't feel like my Indigeneity was honored or understood, and, and really cultural safety is determined by the patient, not by what the provider thinks. So those are some of the really key points about culturally, cultural safety sort of in that patient-physician interaction or patient-provider interaction it could be any healthcare provider, But then we also need to look more broadly at how do we create institutions that are safe ones for Indigenous people and other people from, from structurally marginalized communities. So, although this was developed by a Māori scientist, and has been adapted for Indigenous patients it's also now being used to think about others who don't feel welcomed, or have not been welcomed into our healthcare institution.

Bronwyn Lamond 33:45
As you're speaking about this it's - this balance of power and feeling isolated it's making me think of something you tweeted recently, which is along the lines of feeling very isolated when you were doing your training and felt that you really needed a mentor, could you tell us a little bit about that, how it might link to cultural safety how it might not, I don't know, and what it was like for you during your training.

Dr. Lisa Richardson 34:15
Yeah, thank you for asking that it's, I've only recently started to speak about and understand my experiences as a resident, I think I'm quite a few years out now and I feel like I can do so without affecting my career negatively as well established enough now that I, it's safe for me to do that. But I also think I haven't spoken about it because it's still, it is still quite emotional for me to remember what it was like for me to be a resident, it's, it's a difficult experience at the best of times the, the, the hours are long, and there's a lot of stress, because one's learning and, you know, often you're tired and you're trying to do the best job possible. And so they're in, and, you know, maybe you're overtired or not feeling supported. And then, I think, in my first-year residency, I became pregnant, and I had an incredible,

beautiful daughter who's now [laugh] in university. So that was a while ago that I had her, but my experience was so - was one of feeling very lonely and very isolated, and I immediately thought about dropping out of medicine, leaving medicine, I had in addition to, you know being pregnant and then raising a daughter. I had a lot of other stuff going on in my life outside of medicine, and I honestly felt like I could not talk to anyone about it, because there was a very particular understanding of the good residents, or the good doctor, and I felt like I would not fit in any of those boxes, even though when you ask the people who supervise me they said you know I was doing a great job - in some cases a great job, but I felt like I just was not fitting in, and there was no space to actually be outside of the box of what of the definition of a great resident. And so, I felt like I really had to hide a huge part of myself through my training. Otherwise, I would be judged, I would be considered not as good as, and that over a prolonged period of time because I extended my residency because I had another child as well, [laugh] and it, an amazing son, so I had two children, and all this other stress, and I took time off to be able to raise them and look after them. So had prolonged my training and just the pull through that long period I felt like I was hiding a big part of myself, and that is - that destroys your spirit. And, yeah, that, that is hard and I think, like, emerging from that took years, actually. And so my commitment as someone in academic medicine to mentoring people and teaching people all the time, is to create base for the whole person, and no matter, no matter what that is for those times when you're struggling for the times when you're in pain, for those times when you just feel like you didn't do a good job for those experiences, when you feel like nobody will understand they won't relate because they don't understand this particular background or culture or ceremony, or whatever it may be, how do we create those spaces. That's what inclusion is. And when we create environments like that everyone can thrive.

Bronwyn Lamond 38:08
Yeah, thank you for sharing that. I know it's not easy to talk about and it is a really sensitive time and I think your previous discussion about power really plays into a lot of these conversations and, you know parts of it are, I'm sure resonating with – well they are resonating with me and I'm sure resonating with other graduate students because it can be a really difficult time, I don't know the medical student perspective, but I think in some ways it's probably even more difficult. Aside from this, very important idea of inclusion and making space for the whole person. Is there anything else do you think you would have benefited from. In those moments, or a different type of mentorship that you wish that you had?

Dr. Lisa Richardson 38:50
You know, mentorship period would have been great. [laugh] I feel like I think we need to be really, we need to be really intentional about letting students, graduate students, medical students, other students, undergraduates students, others know that having a mentor or mentors is is really valuable and important. And actually, will make your life better. So how do we do that in a structured way and when I talk about mentorship, especially for people from underrepresented groups, mentorship is not necessarily going to be a single person who's like, you know your prof who you adore and you want to be just like them in terms of their, you know, their publications or the way they teach, mentorship comes in many forms. So you can be mentored it turns out, there are, there's good research now that are emerging around peer mentorship. And actually, not just a single person, but having a network of peers who are in the same field or, you know from the same background, where you can connect and actually share your experiences and learn from one another and learn to these navigate systems that can be sometimes exclusive or not a welcoming one. So, that form of mentorship. Strong, recognizing the importance of having a sense of community, and I think the peer to peer networking, helps with that, but who is your community within your school, within graduate school, or within medicine, and also outside. We know for physician well being, that having that strong relationships with, with community and it may be, you know, we use that word in Indigenous contexts to often meet your specific First Nation or your specific group that you're connected to, but it can be much, I think we need to think of community very, very

broadly. So, being intentional about that, and supporting learners to build that and to, to value that at creating those opportunities, I think would be helpful.

Bronwyn Lamond 41:11
Thank you.

Lee Propp 41:12
Absolutely I think, when I think about my graduate student experience so far, I think, I don't know if I would have made it this far without the sort of, you know, the horizontal mentorship or as some people might find might call, you know, friends in your training program, but it is, it is tremendously invaluable. And I, as we sort think to wrap up our interview, I often ask a question about, you know, some sort of advice that whoever we're interviewing would pass on, it's often directed at trainees. But I think what the you know the short conversation that was just had kind of subsumes that and I think I'm gonna flip the script a little bit and - and sort of feed off of the, one of the themes of our conversation today which is that of power and ask if you have any advice to some mentors, you know people who are, you know, early, mid, later in their career in how they can maybe be a bit more of a positive - offer more helpful and positive and good mentorship to those who are in their training.

Dr. Lisa Richardson 42:28
So, great question again. I'm going to go back to another Anishnaabe a concept which is or is not, not exclusively Anishnaabe but a foundational idea or ontological question, which is relationship. And I think understanding how we are all in relation, and in relationship with one another, is really, is not only beautiful and how we're all connected, but I think it's very fruitful especially when we're living through sort of the traumatic times that we're living through right now. So thinking about, how does one connect and build meaningful relationships with people. And to me, when we think about the mentor - mentee relationship that's usually one which is fraught with power. There's one person who knows a lot, the mentor, and there's another person who's sort of in that banking model of education is receiving all of that wisdom. How about we flatten that relationship, and understand how we're in relation and learning from one another, how that it is mutual exchange and dialogue. And I think when we think of relationships in that way, when we try to mitigate the power dynamic, and understand how we can grow and learn from one another together and both are contributing to a relationship so there's a reciprocity to it. I think that can actually build much stronger relationships for mentors, and be very enriching and nurturing in a different kind of way, but one that's different, and one that's different from the way in which we usually think about the mentorship model, so I believe that as an idea for all of us who are, who are mentoring.

Lee Propp 44:34
Mhm, I really like that, that is, that is thought provoking and I think a, a radical sort of rethinking of the traditional mentorship model, especially in academia and in healthcare and, but I think it could be tremendously valuable to so many. So thank you, thank you for that.

Dr. Lisa Richardson 44:52
You're welcome.

Lee Propp 44:54
And, yeah, and I think this was such a wonderful and thought provoking conversation so thank you so much for being here, virtually today with us. Yeah, it was, it was a real pleasure,

Dr. Lisa Richardson 45:06

Thank you so much and thanks for the amazing work that you're doing on the podcast. So, yeah, I wanted to acknowledge all of the work that you've done is fantastic.

Lee Propp 45:22
Oh, thank you so much, it is a, it is a team effort in the realist sense, but it's, it's been a real pleasure.

[Interlude Music]

Bronwyn Lamond 45:35
I'm so glad that we were able to speak with Dr. Richardson today, it was such a lovely interview, and I can't help but think what a good example she is of someone who's really taken the support that she didn't have during med school or during her training and has tried to make it better for the next generation of students.

Lee Propp 45:56
Yeah, I always it's always so wonderful to see people who kind of find what they were missing in mentors and try to really thoughtfully incorporate that into the way that they mentor trainees. Which sounds like it would be intuitive but it is really difficult. I think even just reflecting on you know the small bit of mentorship that in the late stages of my training I've started to do it's, it's hard to remember how it felt to be in that stage and I think that's, that seems to be one of the keys of what it really means to be able to do that kind of mentorship.

Bronwyn Lamond 46:32
I think that's a really good point because yeah as you move along, there's new challenges that arise with different stages of your career and there's probably someone above you, that's having new challenges and having a hard time integrating this mentorship and, and I appreciated her point about the importance of friendship and having mentors sort of at the same level as you and it made me think about our interview last season with Melanie Penner talking about horizontal membership, aka friendship. And I know that's been incredibly important for me personally throughout my time in in graduate school.

Lee Propp 47:10
Yeah, I think I - same I echo the sentiment it's impossible to go through it alone and I think, you know when you share these kinds of things with others who are at a similar level to you, you realize that everyone's kind of feeling the same way and we're all kind of moseying along and not really sure what we're doing and I – it's helpful to remember that - that most people at different stages feel like that a lot of the time and I mean I think it helps with empathy, but it also helps to change the way that you act as a mentor, and as a friend.

Bronwyn Lamond 47:42
Yeah, and normalize the experience. [laugh]

Lee Propp 47:43
Oh absolutely, Yeah that's critical. I think another thing that's, that really stuck with me and that I've been reflecting on is the really thoughtful way that Dr. Richardson talked about language and how we use language as clinicians and as researchers and just as people and how it influences the way that we interpret the world.

Bronwyn Lamond 48:06
Interpret the world and interact with the world and the biases that language can bring along with it. She

talked about a couple of examples of that in the interview and yeah, I have too been really reflecting on the use of language in what we do.

Lee Propp 48:24
Yeah, yeah I think so, I think maybe if, maybe that's part of the reason why it takes me so long to write up case notes and reports because I'm always, you know, editing the language and really trying to reflect on the experience of, you know, a session with a client or how I'm trying to describe you know for whoever is going to be reading the report that I'm writing and it's, it's really hard, it's easier to do it in a templated manner, but that doesn't serve the people you want it to and I think that's an important thing to remember.

Bronwyn Lamond 48:56
Yeah, and like, why are we saying the things that we're saying in a note as well, what value is it giving and what – maybe not value but also like what is it, could someone else picking it up interpret from your language.

Lee Propp 49:11
Yeah, yeah I think so. I think that the thought I had is also in reflecting on it is, you know, we talked a lot about incorporating the arts and how that is really also influential in the way that we see things and I think similarly to language, I don't, we don't put enough value emphasis on - on the arts and on language and on the way that we use those in our day to day lives. I think this year living through COVID I think many people will really have an appreciation of the arts, I mean, you know, the things that we read and we see on - binge watch on Netflix and everything in between that, that's all the arts and that's a huge part of what's gotten us through and I think, I hope that it sends the message of how critically important the arts are in our lives,

Bronwyn Lamond 50:07
Hmhm. While also being the first thing that often gets cut, unfortunately when it comes to budgets.

Lee Propp 50:14
Oh, yeah, that is a sad, a sad reality, but one that I hope, yeah, I'm hopeful for change in the future I think that's…

Bronwyn Lamond 50:21
We can shift it…

Lee Propp 50:22
Yeah, maybe that's the - one of the messages I take from our conversation is hope for the future. Well, we really hope that you enjoyed listening as much as we enjoyed having the conversation with Dr. Richardson.

Bronwyn Lamond 50:38
Cheers.

[Outro Theme Music]

Lee Propp 51:12
You've been listening to the Accidental Intellectual. Our podcast is produced by Holly Boyne, Manon Feasson, Lauren Goldberg, Bronwyn Lamond, Rachael Lyon, Harrison McNaughton, Stephanie Morris,

Lee Propp, and Ariana Simone. Our theme music is by Alexandra Willett and our branding by Maxwell McNaughton. You can check us out on Twitter @accidental_pod and on Instagram @accidentalintellectual. Our website is www.accidentalintellectual.com. We'll be back next time with more stories from the humans behind the experts.

[Interlude Music]