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Research

Variegated racism: exploring experiences of anti-Black racism and their progression in medical education

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Abstract

Background: Addressing anti-Black racism in medical education in Canada has become increasingly urgent as more Black learners enter medical institutions and bring attention to the racist harms they face. We sought to gather evidence of experiences of racism among Black medical learners and to explore the contexts within which racism is experienced by learners.

Methods: Drawing on critical race and structural violence theories, we conducted interviews with Black medical faculty, students, residents, and staff at the University of Saskatchewan College of Medicine between May and July 2022. We thematically analyzed interviews using instrumental case study methodology.

Results: Thematic analyses from 13 interviews revealed 5 central themes describing experiences of racism and the compounding nature of racist exposures as learners progressed in medicine. Medical learners experienced racism through uncomfortable encounters and microaggressions. Blatant acts of racism were instances where patients and superiors harmed students in various ways, including through use of the N-word by a superior in 1 instance. Learners also experienced curricular racism through the absence of the Black body in the curriculum and the undue pathologizing of Blackness. Medical hierarchies reinforced anti-Black racism by undermining accountability and protecting powerful perpetrators. Finally, Black women medical learners identified intersecting oppressions and misogynoir that compounded their experience of racism. We propose that experiences of racism may worsen as learners progress in medicine in part because of increases in the sources of and exposure to racism.

Interpretation: Anti-Black racism in medical education in Canada is experienced subtly through microaggressions or blatantly from different sources including medical faculty. As Black learners progress in medicine, anti-Black racism may become worse because of the compounding effects of exposures to a wider range of sources of racist behaviour.

Medical education in Canada has been culpable in the mistreatment and systemic oppression of Black people, including patients, health care learners, and providers. From 1918 to 1965, Queen's University in Ontario banned Black medical students as part of an institutional policy to receive a better ranking from the American Medical Association, and the university only officially revoked this policy and apologized for it in 2019.[1] Such institutional policies have contemporary consequences, including unwritten practices at other Canadian medical schools, leading to fewer Black medical graduates and fewer Black physicians in senior leadership and teaching roles. Anti-Black racism in medical education in Canada is rooted in government-backed, historical, anti-Black racist policies. For example, in 1911, the Canadian government expressly forbade the immigration of Black people into Canada claiming "the negro race … [was] deemed unsuitable to the climate and requirements of Canada."[2] This history of oppression persists in health care delivery and medical education.

Contemporary accounts reveal how anti-Black racism in the health system leads to poor health care access for people living with HIV[3] and disproportionate increases in noncommunicable diseases.[4] Experiences of racism in the health system extend to Black medical learners and health professionals. In an Ontario-based study involving Black physicians and medical students, 70% of the participants had experienced racism in their profession, often in the form of discrimination and differential treatment, both from patients and other professionals.[5] However, academic literature on anti-Black racism and Black health in Canada is

sparse. It was only as recently as October 2022 that *CMAJ* published its first special issue on anti-Black racism in health care in Canada, which chronicled lived experiences of Black medical professionals and institutional responses to anti-Black racism.[6]

This study builds on existing literature by identifying specific contexts and sources of anti-Black racism in medical education. We sought to explore experiences of anti-Black racism among Black medical learners, faculty and staff and to describe how experiences of anti-Black racism evolved for medical learners as they progress in medicine.

Methods

Study design

We conducted a qualitative instrumental case study.[7] This methodology allows researchers to explore a case not for its own sake (as in an intrinsic case study) but to understand some broader phenomenon.[8] We explored the lived experiences of Black faculty, students, and staff to understand the broader issue of anti-Black racism at the University of Saskatchewan College of Medicine and the key challenges Black learners face as they navigate medical education.

Theoretical frameworks

We drew on 2 complementary theoretical frameworks — critical race theory and structural violence theory — to understand Black medical learners' experiences of racism.

Originating from legal studies and African American civil rights activism, critical race theory provides a framework for understanding how histories of racism disenfranchise and "inhibit and disadvantage some more than others."[9] It rejects historical notions of biological race and racial hierarchies.[10] Race is "an unscientific societally constructed taxonomy"[11] with no biological basis, developed to place humans in hierarchies, often with Black people at the bottom. Racism refers to race-based prejudices ranging from institutionally backed mistreatment to internalized ideas.[12] Anti-Black racism is related to racism against other racialized groups through the hierarchy that maintains White supremacy by ranking groups from most White to least White. The hierarchy also helps to explain why anti-Black racism is unique owing to the positioning of Blackness and Whiteness as polar opposites in racial hierarchies and to Black people's experience with slavery.[13] Furthermore, the racial hierarchy serves to divide racialized groups by inflicting different forms of oppression and affording varying levels of privilege to each group, causing conflict and racism between and among racialized groups.[13] Critical race theory contends that race was socially constructed to entrench White supremacy through limiting the ability of Black people and other people of colour to fairly access opportunities and institutions — from courts to health centres.[14,15] As an intellectual movement, critical race theory challenges mainstream epistemologies, revealing how most institutions in colonial societies — including those involved in the production of medical knowledge — are predicated on violence against Black people and political legitimization of White supremacy.[14]

A key concept developed by scholars of critical race theory is intersectionality. Black legal scholar Kimberlé Crenshaw developed the concept to demonstrate the inadequacy of race and gender alone in revealing experiences of anti-Black racism in the American legal system.[16] Intersectionality contends that, because people face discrimination based on different social identities (e.g., race, gender, sexuality, class), people who simultaneously belong to several oppressed groups may be oppressed in compounding ways.[17] Related concepts such as misogynoir have been coined to describe misogynistic anti-Black racism targeting Black women.[18] These concepts — and the emancipatory vision of critical race theory — provide a powerful lens for exploring Black medical learners' lived experiences of racism, positioning such personal experiences within the context of structural racism and oppression. Critical race theory can help map the various sites within medical education where Black learners may encounter racism and reveal how structures in medicine facilitate anti-Black racism. The concept of intersectionality can also shed light on the compounded experience of racism felt by Black women learners. Finally, critical race theory provides a framework of counter-storytelling[19] to amplify the voices of Black learners and reject strongly held beliefs of colour blindness and the notion that things are not so bad.

The second framework guiding this study is the theory of structural violence. Originating in peace studies from Johan Galtung's work[20] and popularized by late physician and medical anthropologist, Paul Farmer,[21] structural violence refers to political, economic, cultural, and social arrangements that harm people. It moves beyond interpersonal acts of physical violence to include how broader forces such as capitalism, colonization, and others may systematically reduce people's life chances and harm them. Much has been written about carceral violence against Black bodies in the public health literature[22] and medical violence enacted by physicians toward patients both generally[23] and specifically against Black people.[14] Using this broader framework allows for the consideration of medical education as a potential site of violence not only in the sense of physical violence but in the form of social arrangements (e.g., preceptor–student relationships, student–patient relationships) that may expose students to harm. The 2 frameworks complement each other in that critical race theory exposes how ongoing racism differentially creates disadvantage, while structural violence theory reveals how experiences of racism constitute violence even when physical violence is not involved. Given the focus on social arrangements, structural violence theory can be used to identify sites that expose Black learners to violence.

Study setting

We conducted the study at the University of Saskatchewan College of Medicine, one of the smaller medical schools in Canada by enrolment, with an annual intake of about 100 students.[24] Saskatchewan is a predominantly White province — in the 2021 census, 14.4% of the population self-identified as visible minorities and 14.2% of these self-identified as Black.[25] The college does not collect race-based data despite calls to do so. Although evidence has shown that Black people have been in Saskatchewan and the Prairies since the 1880s,[2] 1 of the first Black medical graduates from the University of Saskatchewan College of

Medicine (originally established in 1926) was a member of the 1953 graduating class. Recent reports have explored racism at the College of Medicine, including a report by the Saskatchewan Human Rights Commission.[26] We conducted our research to support ongoing efforts to generate empirical evidence on experiences of anti-Black racism, drawing on the calls to action from the university's Black Medical Students Association (BMSA). The BMSA group at the University of Saskatchewan, like others across Canada, was formed in 2020.[27] It has made several calls to action, including demands for better representation and requests for more mentorship opportunities. Their ongoing advocacy has led to changes such as the creation of a Black physician–student mentorship program at the University of Saskatchewan.

Participants

Between May and July 2022, we conducted individual in-depth interviews with self-identified Black faculty, staff, medical residents, and students at the University of Saskatchewan College of Medicine. We shared a research recruitment poster on the university website and the BMSA Facebook page. We purposefully selected participants if they self-identified as Black and were learners (students or residents), faculty, or staff affiliated with the College of Medicine, and aimed for maximum variation in terms of gender, age, and educational level. Those classified as residents had completed their undergraduate medical training at the University of Saskatchewan College of Medicine and were either beginning residency elsewhere or had remained for residency. All residents who were no longer learners at the University of Saskatchewan were asked to speak to their experiences during medical school.

Data collection

Two team members (J.A.K.A. and A.T.) conducted all the interviews using a semi-structured interview guide designed to explore interviewees' thoughts on anti-Black racism in medical education in Canada and their lived experiences of racism at the College of Medicine (Appendix 1, available at www.cmaj.ca/lookup/doi/10.1503/cmaj.231753/tab-related-content). We conducted interviews either virtually via Zoom or in person in a private study room at the University of Saskatchewan. No one besides the participants and researchers were present during the interviews. The research team developed the interview guide and met with the BMSA to review, pilot-test, and revise questions. We informed interviewees of their right to withdraw from the study at any time and encouraged them to not name third parties, given the sensitive nature of the topic. We did not conduct any repeat interviews. To gain a longitudinal perspective, we asked interviewees to compare how their experiences evolved as they progressed through medicine. Interviews also explored interviewees' thoughts on the uniqueness of anti-Black racism in medical education (v. racism faced by other minority groups), as well as proposed changes for making colleges of medicine more inclusive spaces. Although we analyzed all data together, here we report mainly on the experiences of the learners as this was the focal point of the first component of the study. A subsequent manuscript will focus on the experiences of Black faculty and staff.

Data analysis

Interviews were audio recorded and sent to the Canadian Hub for Social and Applied Health Research for transcription. We then imported data into NVivo 12 software for analysis. Data analysis involved a hybrid of inductive and deductive thematic analysis.[28] Deductive analysis compared lived experiences of racism with extant literature on how anti-Black racism is experienced, while inductive coding focused on participants' unique experiences of anti-Black racism in the college. One team member (J.A.K.A.) created the code book, performed initial coding, and met with 2 others (A.T. and N.S.K.) to discuss and combine codes into categories and themes. Coding, categorization, and theming drew on concepts from critical race theory and structural violence theory. Complementarily, we drew on structural violence theory to understand racist experiences as forms of violence and to see how specific social arrangements and relationships constitute sites for violence. We ensured rigour using 2 methods of member checking, namely returning interview transcripts to participants for comment and a synthesized member checking, which involved presenting emerging findings to 4 participants for comment and further refinement of findings.[29]

Reflexivity

We approached this research project as people with lived experience and as allies or accomplices. J.A.K.A. is a man and a person of African descent with lived experience of anti-Black racism, as well as relevant formal training including graduate training in African Studies. N.S.K. is a South Asian woman and family medicine resident with experience in social justice issues in both academic and community organizing spaces; she has also worked on anti-oppressive approaches to medical curricula. A.T. is a woman and a Muslim medical student of South Asian descent who has witnessed microaggressions toward other students within her medical training.

Ethics approval

This study was approved by the University of Saskatchewan's Behavioural Research Ethics Board (BEH 3326).

Results

We interviewed 9 students and 4 medical residents. The interviews lasted 30 minutes to 1 hour and 5 minutes; 1 was conducted in person and the remaining were conducted online. None of the people who expressed interest in being part of the study subsequently refused to participate or dropped out of the study.

We identified 5 major themes describing how participants experienced anti-Black racism. These included uncomfortable encounters and microaggressions; blatant acts of racism; curricular racism; racism rooted in medicine's hierarchies; and intersecting experiences of racism where other aspects of participants' identities determined how they experienced racism in medical education. Table 1 shows participant demographics, and Table 2 presents illustrative learner quotes connected to each theme.

Uncomfortable encounters and microaggressions

Several participants described situations where people within the college treated them differently or encounters that left them wondering if mistreatment was, at least in part, because of their skin colour. Experiences ranged from feeling diminished and disrespected by colleagues and superiors to domineering behaviours and harassment. Participants also described a tacit expectation that victims of racism should simply brush things off and move on. These experiences resulted in an environment where Black students felt incredibly vulnerable and insecure, with some stating that they felt they did not belong in medicine. A first-year medical student noted, for example, "I just know my presence within this field is not enjoyed by a lot of people because of my race" (Table 2). Others described microaggressions ranging from disrespectful to othering comments, such as questions that assumed they could not possibly be originally from Canada. In other situations, medical students recounted that they experienced racism through relentless questioning of their competence and scrutiny that filled them with self-doubt. One student described "pimping" (a form of on-the-spot oral quizzing, often in front of other learners, health care providers, or patients) from superiors. Although pimping is a common practice in medicine, a Black trainee who has previously experienced racism would be vigilant or primed to wonder if this treatment was because of their race. In addition, where such scrutiny was applied differently to a Black learner compared with their peers, as in the case of this student, it was experienced as a microaggression. These experiences highlighted encounters that left Black learners questioning their ability or place in medicine.

Blatant acts of racism

Participants also revealed that they faced situations where racism was not simply a subjective interpersonal experience but explicit and blatant. These ranged from the use of slurs by superiors, patients, and colleagues to obvious putdowns. In 1 instance, a student described superiors calling the Black Lives Matter movement stupid and claiming that Black people are dangerous (Table 2). In another instance, a resident revealed how a preceptor described a Black colleague in disparaging terms and repeatedly using the N-word in full. The preceptor had also described some people from Africa as "blacker than black, blacker than coal" (Table 2). Participants described racist abuse from patients and others within the clinical setting. Patients often made comments belittling Black residents or assumed they were not doctors. In many cases, Black learners looked to superiors to intervene, to no avail. Learners described several blatantly racist comments from patients, including a patient who claimed their child "usually cries around Black people" (Table 2). A resident described situations where patients explicitly insulted Black learners or compared them to social undesirables, including assuming that because of their beard, they must be "part of the Taliban" (Table 2). In these experiences, Black medical learners encountered overt racist abuse from superiors, patients, and colleagues. In most of these situations, learners suffered in silence because they believed they would be evaluated and viewed negatively for speaking out.

Table 1: Participant demographics

Characteristic	No. of participants *n* = 13
Age, yr	
20–29	11
30–39	2
Gender	
Man	7
Woman	6
Level of training	
Resident	4
Student	9

Curricular racism

Participants highlighted that they encountered racism in the curriculum either through the lack of representation of Black people or the disproportionately negative portrayal of Black bodies. Learners mentioned that they rarely ever encountered standardized and simulated Black patients. These realities limited participants' learning experiences and made them unprepared to identify certain conditions in Black bodies. One participant noted, "For example, jaundice, something that's common, they wouldn't show how that presents in a Black individual" (Table 2). On the other end of the spectrum of curricular racism, participants noted that when the Black body appeared in the curriculum, it was often in a stigmatizing way with negative portrayals, such as consistent, disproportionate representations of the Black body with stigmatized conditions such as sexually transmitted infections. These descriptions revealed that the curriculum was another major site for the enactment of anti-Black racism through lack of representation and negative portrayals.

Medical hierarchies and racism

Another critical theme that emerged from our analysis was the fact that the very culture of the field of medicine can foster racism and unaccountability. A toxic combination of hierarchy, power, and prestige bred unaccountability expressed in blatant racism, intersecting with other forms of oppression and power. One student noted, for example, how specialists with years of experience often seemed untouchable. Others described how medicine's hierarchies made students afraid of reporting superiors. One participant noted, "Medicine has this weird culture of there is the doctor, the residents, the junior residents, the senior med student, and the junior med student. If you're above the person's rank, you can do and say what you want" (Table 2). This hierarchical reality fostered racism. In the descriptions of their experiences, participants often referred to the system to acknowledge the differences between racism connected to interpersonal relationships and institutional racism connected to the very structure of medicine. Participants consistently expressed pessimism regarding any expectations of institutional change.

Table 2 (part 1 of 2): Illustrative quotes

Theme and description	Quote
Uncomfortable encounters and microaggressions Describes situations where learners have uncomfortable encounters and believe this to be connected to racialization. Also comes in the form of participants feeling scrutinized or like they do not belong.	"I just feel vulnerable, you know what I mean? Just based on my experience and based on what I've heard, I'm just like, 'Okay, so I have to act more professional, I have to be more keen, I have to, you know, work just a bit harder because of the fact that my presence is just not …' I just know my presence within this field is not enjoyed by a lot of people because of my race, you know? So, if there are just systems in place to protect the place of Black medical students within this field, you know, then that would be sufficient, I think. Just making sure that there are systems." — Interview 11, student
	"I have experienced a couple of microaggressions throughout this past year, I guess. But I wouldn't say — they weren't — I wouldn't say they were major. I was in a clinical session with my clinical partner, who is White. And our preceptor asked me where I was from, assuming that I wasn't from Canada, or asked me what country I was from, and didn't ask her. So microaggression like that." — Interview 3, student
	"There's multiple times in clerkship you sort of question yourself just because you see other superiors sort of questioning you more. Pointing exactly to a situation, when I was in [hospital] and I had a resident … . When I showed up on the unit, there was already a student there for about 2 weeks. So, when they would have questions or they would start the class, in medicine they call it pimping, which is basically when doctors start asking you a lot of questions, putting you on the spot, and just trying to get you to answer questions and almost trying to gauge the limits of your knowledge … I noticed early on, especially being new, I was like oh, it's 'cause I am new. I noticed I was pimped a lot and this wasn't necessarily like pimping me one-on-one. This is like, we're in a big group and they start asking questions. And initially, they ask me a question and I'm like okay, next time he's obviously going to ask my colleague a question or someone else a question, and he asks me another question. Sure, I answer the question, sure, I kept going. But initially, I noticed he does pimp me a lot, but I'm also a new student, so it kind of makes sense … . And then another student came in and all of a sudden, I was sort of the student that's been there for longer. It didn't really change anything. And then he was still pimping me on it." — Interview 2, student
Blatant acts of racism Describes overt acts of racism such as insults directed by preceptors, colleagues, and patients toward learners or negative comments about specific Black people or Black people in general.	"I was doing my [year] core rotation. So, I was in the OR with a surgeon as well as a family doctor … this was a couple months after the George Floyd killing and all the protests that had been happening … they weren't directly being racist to me, but I definitely felt uncomfortable. They were talking about the whole movement is stupid, that there's no need for it. That for the most part that cops are good, and there's only a few bad apples that make mistakes. And I just really felt uncomfortable in that situation knowing that they're talking like this and I'm a Black individual in that situation. And they were kind of just almost making fun of the Black people in America, saying that they don't know what they're doing, that they really have no reason to be protesting about police brutality in America, and that for the most part it's actually Black people who are dangerous and committing crimes, so there's a reason why policemen carry out these events because, you know, there's a lot of gang activity and Black people, they said, proportionally commit most of the crimes in America. So, they were almost trying to defend the police in this situation for their actions." — Interview 8, resident
	"[The preceptor] was saying about how she understands history and so, she knows that people from [African country] who are blacker than black don't look like this [light-skinned]. But because of slavery and colonialism, they brought people from East India to Africa to work for the British. 'The people from these countries, they're blacker than black, blacker than coal,' those are some of the words she used. And she repeatedly, multiple times during the same session would say the N-word and how growing up, her [parent] would use the N-word. And she grew up saying the N-word and people would ask her, "Why do you say the N-word?" She would say something like, "Oh, it's okay. I'm not racist. I can say this word" because [her parent] was [health care professional] and would serve Black patients and would even invite them to [their] home, and so it gave her the entitlement to say the N-word. And she said the full N-word while we were there." — Interview 1, resident
	"I'm a [specialist] so I work by myself in attending [specialty] at [hospital]. But when I'm there, if I'm attending and there's no one else who's more senior than me there, they will say, 'Oh, when is the doctor coming? Can I talk to the doctor, the other doctor?' Eighty-year-old White men, they'll look to their wives like, 'Honey, I can't understand a word of his accent,' like, what the hell? I was born here. What accent are you talking about?" — Interview 10, resident
	"I've been in situations where a patient said to me, when I was about to take a pediatric physical examination, 'Oh, be careful. He usually cries around Black people.' She was like, "Oh there was a Black doctor that tried to do something with him so just be …' sort of made that comment and I was supposed to be the one who was doing the next physical examination on this child." — Interview 2, student
	"In third year, I was working in a clinic with a dermatologist here and this was this elective I did in third year. So, I went in to see a patient. The patient, as soon as I walked in was looking at me in an odd type of manner. However, I decided to continue on with the consultation, so I asked him a couple questions, and again, he's being very rude and uncooperative with me. So just to ease off the tension I said I would leave the room, and I specifically forgot to grab his patient intake form. Anyways, so I had to leave the room to grab it so I could take a quick look at the health history he's already written down. So, I told him that I'd be back in a short second, and he told me that he didn't want me to come back into the room. So, then I asked why, and then he said, because I look like a terrorist that's part of the Taliban." — Interview 8, resident

Table 2 (part 2 of 2): Illustrative quotes

Theme and description	Quote
Curricular racism Describes instances where the medical curriculum is racist either through omissions (whether intentional or unintentional) or disproportionately negative and pathologizing representations of Blackness and the Black body.	"I find even with our clinical sessions sometimes; we don't really have a lot of darker skin simulated patients and things like that. But yeah, I'd say maybe one of the biggest problems, I think would be underrepresentation. Yeah … we don't really interact with a lot of Black — I don't think I've ever interacted with a Black patient. In the few patients that we do get to interact with patients, I don't think I've ever interacted with a Black simulated patient or real patient." — Interview 3, student
	"For example, jaundice, something that's common, they wouldn't show how that presents in a Black individual. So, I think just with regards, including Black but also other ethnicities and skin colours, at least during my education they did a very poor job of making the curriculum inclusive to showing pathologies in different colours of skins, except for White people. So, I would say that was probably the biggest issues." — Interview 8, resident
	"We did [course], and I remember that the pictures were always of — When there was skin rash and stuff like that, it was always White patients. But the one thing I did notice was when we were learning about some of the STDs, it was when we had pictures of genital areas, it was always Black patients. I just thought it was interesting. And I thought that was — I don't know where they got those pictures. I assume it's probably from some older textbook, because I guess the pictures look older, maybe they were taken in the 80s and 90s. But I even think there's some bias there, that whoever created those textbooks made the conscious thought to let all the normal areas of skin, the hair, the nails, the arms, that were using White patients. But pictures, I guess, sensitive areas, they were of Black patients. I don't know." — Interview 6, student
Medical hierarchies and racism Describes how inherent hierarchical structures in medicine facilitate racism and make those with less power feel extra vulnerable	"The current sort of system they have — I don't really think it's adequate, especially when we're referring to physicians … if a physician, I'll give you an example, if a physician who has a lot of leverage over the college of medicine does something racist, like I don't really think the college of medicine would do anything just based on the current system. I know this is a really difficult subject because, if a neurosurgeon who's been working here for like 30 years, and they randomly become racist one day, is the college really going to say, like, are they really going to, you know, enforce any sort of punishment that would affect this guy in any sort of way? I don't really think so, to be honest." — Interview 11, student
	"In medical school, I've experienced racism too. I think a lot of it comes from that power differential. Medicine has this weird culture of there is the doctor, there is the residents, and then there's the junior residents, and then there's the senior med student, and the junior med student. If you're above the person's rank, you can kinda do and say what you want and you don't really have to fear retaliation because they're a rank beneath you or they should just be used to getting clowned … they should be used to getting discriminated against because that's their role. They're in that stage." — Interview 14, student
Misogynoir and intersecting oppressions Describes intersections of racism and sexism, and how Black women learners have some of the most negative experiences of racism	"I think from a gender point of view, when I was in clinicals, there is the sense of not being taken as seriously as my male counterpart and my White male counterpart, or even Black male counterpart. And yeah, you just run into a lot of difficulties when you, for example, write orders or give orders to other health care professionals. Just not being take so seriously, being questioned, you have to justify your decisions more." — Interview 1, resident
	"I know that for me, there's some rotations that I felt just a bit not as confident in just by virtue of being a woman and being a Black woman. And I just felt that these rotations predominantly held by White males. And I came into those spaces feeling a bit intimidated or a bit shy, because I just felt I wasn't as good." — Interview 17, resident

Note: OR = operating room, STD = sexually transmitted disease.

Misogynoir and intersecting oppressions

Racist experiences were often compounded for Black women medical students who were not always sure if experiences of mistreatment related to their gender, race, or a combination of both. Experiences of intersecting racism included "angry Black woman" stereotypes and dismissive behaviour of preceptors, colleagues, and patients. These experiences undermined the confidence of Black women medical students; 1 participant explained that being a Black female medical student often meant being taken less seriously than Black male, White female, and White male students. One participant noted "[in] some rotations I felt just a bit not as confident just by virtue of being a woman and being a Black woman" (Table 2).

In integrating the themes, we found that, participants' responses followed a pattern where those in the early years of medicine perceived racism to be not too bad or provided instances limited to the curriculum, peers, or faculty. Learners in senior years, however, described more vivid examples of racism and highlighted sources of racism that went beyond curriculum, peers, or faculty. Learners in later years of training may have been more candid. Nonetheless, the diversity of sources of racist exposures revealed that, as learners progressed in medicine, moving further from the classroom and into clinical settings, sources of racist exposures increased. One might expect that as Black people progress in medicine, they gain more power that would protect them from racism. Counterintuively, experiences of racism may worsen partly because of increases in the sources of and exposure to racism. Drawing on the data, we illustrated this phenomenon in Figure 1.

Interpretation

We explored experiences of anti-Black racism among Black medical learners at the University of Saskatchewan's College of Medicine. We

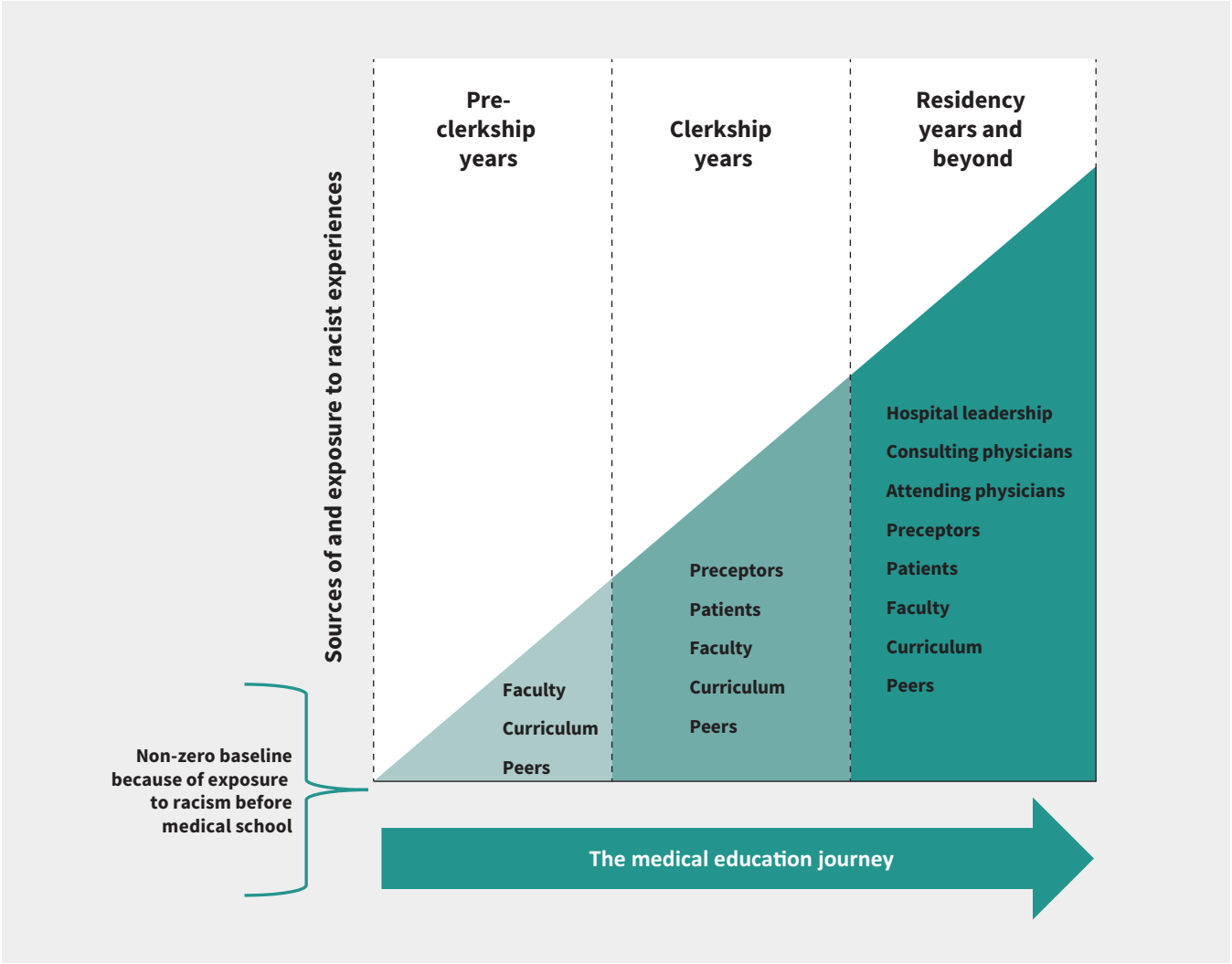

Figure 1: Racist exposures in medical education for Black learners.

found several facets of anti-Black racism and described the evolution of racist experiences for Black learners as they progressed in medical education. Our findings provide empirical evidence to reveal the extent and specific nature of racism in a Canadian medical school; we suspect Black students in many other medical schools experience similar racism. Experiences of racism are encountered through microaggressions and uncomfortable encounters, blatant comments, the medical curriculum, and medicine's inherent hierarchical structures. Intersecting oppressions (e.g., being Black and a woman) compound experiences of anti-Black racism and, as learners progress in medical education, racist experiences may worsen.

Microaggressions are pervasive in medicine and often come as microassaults (i.e., direct, discriminatory verbal abuse), microinsults (i.e., insensitive and disparaging comments), or microinvalidations (i.e., dismissive and exclusionary practices).[30] We document here how Black learners may experience these microaggressions, often through othering (e.g., "Where are you from?"). Our findings also confirm existing evidence that gender is another critical identity category for experiencing microaggressions in medicine.[31] The fact that microaggressions can come from superiors highlights the importance of antiracist training for medical faculty, particularly in contexts where perpetrators perceive themselves as "colour blind" and therefore unaware of how their actions influence leaners' experiences and how their hierarchical power is heightened by additional power dynamics based on social identities. Perceived neutrality in such interactions serves to perpetuate racist norms. Antiracist training has been suggested as a way to improve the Canadian Medical Education Directives for Specialists (CanMEDS) competencies for learners and can be useful in addressing microaggressions and medical hierarchies leading to racism.[32] We note, however, that in some cases, medical faculty can be overtly racist, requiring stringent accountability mechanisms to protect Black medical learners from the harms they may face from racist faculty.

The medical curriculum remains another major site for the enactment of racism. Medicine's history is replete with instances of anti-Black racism and unscientific beliefs focused on pathologizing Blackness while neglecting the critical role of Black people in the development of medical knowledge.[33] For example, historically unscientific beliefs in medicine include claims that Black people do not feel pain because of thicker skin or lack of sensitivity.[34] Such ideas, along with the broader dehumanization of Black

people, undoubtedly laid the groundwork for medical experimentation with gynecologic surgery on Black female slaves by Dr. J.M. Sims, who is considered a father of modern gynecology.[14] Another example of pathologization involves mental health diagnoses attributed to Black people who were fleeing enslavement (drapedomania) and protesting during the civil rights era (protest psychosis).[35] These racist ideas and their effects on medical education remain; several recent assessments of medical curricula reveal persistent and pervasive racial misrepresentation.[36] A study of assessments of pain for White versus Black patients revealed that around half of medical students and residents held incorrect beliefs about biological differences between Black and White patients.[37] Participants in our study reported that curricular racism ranged from omission of the Black body in the medical curriculum to overrepresentation of the Black body in discussions of stigmatized conditions. The medical curriculum needs to be reviewed at least annually to ensure that representations of race and Blackness are presented in a well-rounded, complete way — both in keeping with scientific knowledge and to avoid pathologizing Blackness. Learners' indications that they rarely encounter Black patients is a complex issue. Although some of our findings may be connected to Saskatchewan having a smaller Black population than a province like Ontario, the Prairies have the fastest growing Black population in Canada and, regardless of the size of the Black population, fair representation of Black people among simulated patients needs to be achieved to adequately train medical learners. Since simulated patients are usually paid and recruited via posters on and outside campus, collaboration with Black community organizations and further incentives could be used to ensure more participation of Black simulated patients.

Finally, much of this discussion highlights the need for decolonization of medicine and an examination of how the structure of medical education contributes to racist encounters between Black learners and medical faculty. Although some form of hierarchy can be useful for role modelling and maintaining order in the clinical setting,[38] many of the negative experiences described by Black medical learners show that a toxic combination of hierarchy, power, and prestige can breed unaccountability, expressed in blatant racism. Hierarchies defined by credentials interact with social hierarchies to produce a social ladder that places particular groups (e.g., Black women students) at the bottom. As we found both through instances of blatant racism against Black learners and intersecting oppressions, medical hierarchies do not protect Black learners. Indeed counterintuitively, progressing through medicine — which should mean climbing the hierarchy — actually appears to expose Black medical learners to more sources of anti-Black racism.

Our empirical evidence from the Canadian Prairies adds to the broader evidence on experiences of anti-Black racism in Canadian medical education and provides further context on how and why power differentials expose Black leaners to structural violence in the Canadian medical education system.[39,40] Future research could involve quantitative assessments of experiences of anti-Black racism across medical schools in Canada to confirm whether junior medical learners consistently report fewer incidents than senior colleagues. In addition, given our findings regarding curricular racism, an inventory of medical curricula across Canada could reveal how curricular racism looks across contexts.

Limitations

Because of the COVID-19 pandemic, we conducted most interviews online rather than in person. In-person interviews may have allowed us to build enhanced rapport with participants. Although we would have liked to organize several community events to disseminate findings and strategize on broader long-term solutions, we were able to share our findings at only a few events (such as those related to Black History Month). We are continuing to work with the BMSA and college leadership to develop longer-term solutions to the issues we identified. Finally, our descriptions focused on the experiences of 13 Black medical learners in Saskatchewan, which could be different from those of learners in other contexts (e.g., Toronto, Vancouver, the Maritimes) or from other minority groups (e.g., Asian, Indigenous) or genders (e.g., non-binary students).

Conclusion

Our research reveals the egregious nature of racism in medical education in Canada and the potential worsening of racist exposures as learners progress in medical education. We have shown that Black learners in medicine experience racism through uncomfortable encounters and microaggressions, blatant acts of racism, and curricular racism. We also found that intersecting oppressions and misogynoir, as well as medical hierarchies, compound and enable racist experiences. As literature on experiences of Black learners in medical education across Canada is lacking, further studies in other medical colleges across Canada may help to expand understanding of anti-Black racism in medicine, although our findings may be transferable to similar contexts. Demands for more research should not delay or overshadow taking action to address this known problem. Although the solutions to some of the identified issues lie in education and training of medical instructors on antiracism, we identified toxic hierarchies in medicine as an enabling factor for anti-Black racism in medical education in Canada. This necessitates more team-based approaches to medical education that are conscious of the hierarchies to provide more equitable treatment and accountability mechanisms. The extent, scope, and nuances of anti-Black racism in medical education in Canada underscore the need for decolonization of the discipline to foster genuinely inclusive spaces for Black learners and all learners to flourish.

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