

“This shouldn’t be our job to help you do this”: exploring the responses of medical schools across Canada to address anti-Black racism in 2020

Amira Kalifa MSc, Ariet Okuori, Orphelia Kamdem, Doyin Abatan, Sammah Yahya, Allison Brown PhD

■ Cite as: *CMAJ* 2022 October 24;194:E1395-1403. doi: 10.1503/cmaj.211746

Abstract

Background: Protests against police brutality and anti-Black racism were catalyzed by the murder of George Floyd and other Black and racialized people in spring 2020. Addressing anti-Black racism had been historically minimized as an institutional priority across Canadian medical schools, but many swiftly released statements broadly condemning racism. Given that little has been documented about how institutions are responding with action, we sought to explore Black medical students’ and senior faculty perspectives on Canadian medical schools’ efforts to address anti-Black racism in 2020.

Methods: We conducted a qualitative, instrumental case study, grounded in critical race theory. We recruited Black medical students and deans (or delegated senior faculty administrators) and we conducted virtual, individual,

semi-structured interviews with participants between Oct. 5, 2020, and Jan. 16, 2021. Interviews were transcribed and iteratively analyzed through inductive and deductive techniques.

Results: We interviewed 19 participants, including 8 medical students (6 in pre-clerkship; all of whom identified as Black) and 11 senior faculty administrators (4 deans, 7 delegate faculty administrators; 3 racialized). We had at least 1 student or faculty participant from 13 medical schools, and no student or faculty participants from the 4 medical schools in Quebec. Nearly all represented medical schools were described as “starting from scratch” in their responses, having previously failed to acknowledge or address anti-Black racism. In the absence of diverse faculty leaders, participants indicated that medical schools primarily relied on Black

medical students to drive institutional responses, unfairly burdening students during an already difficult period. At the time of the interviews, a range of initiatives were in the planning stages or underway, and were largely related to admissions and curriculum reform.

Interpretation: We found that medical schools relied heavily on Black medical students to inform and drive their institutional responses related to anti-Black racism in 2020, which these students found burdensome. Medical schools lacked intrinsic capacity because of the paucity of Black faculty — a direct result of historical and ongoing structural anti-Black racism in medicine. Institutional accountability remains critical, and further research is needed to show the extent to which medical schools in Canada are successfully addressing anti-Black racism.

Systemic anti-Black racism is deeply entrenched in health systems and all aspects of medical training — from admissions and assessment, to the everyday discrimination experienced by Black medical students and physicians.¹⁻³ Medical schools in Canada have directly upheld anti-Black racism through institutional policies and practices that exclude Black people from the profession of medicine. A direct example of this is Queen’s University’s official ban on the admission of Black students that was enforced between 1918 and 1965 — and revoked only in 2018.⁴ Although Black people constitute 3.5% of Canada’s total population, they continue to be critically underrepresented in the population of

practising physicians and medical students,⁵ and this historical and ongoing exclusion of Black people from medical education has direct implications for the quality of patient care and health outcomes.⁶⁻⁹

Institutional commitment of medical schools to prioritize combatting anti-Black racism and promote racial justice is lacking, especially in Canada, where the historical and ongoing legacy of systemic anti-Black racism has largely been minimized.¹⁰ After the widely publicized murder of George Floyd in May 2020 and subsequent Black Lives Matter protests, medical schools — like many public and private organizations around the world — released

public statements condemning racism and echoing calls for widespread societal changes. This represented a unique moment in time for medical education in Canada, where institutions have largely neglected to address the deeply rooted, embedded structural and systemic racism. Medical schools are in the spotlight to take meaningful action after the widespread release of antiracism statements, many of which were considered performative. In these statements, discursive strategies were often used to minimize the pervasiveness and severity of anti-Black racism in their school and to deflect institutional accountability for any concrete commitments to dismantle the ongoing systems and structures that perpetuate racial inequities.¹¹ In this study, we sought to explore how medical schools across Canada responded to widespread calls to action to address anti-Black racism in 2020 from the perspectives of Black medical students and the senior faculty administrators at these institutions.

Methods

Study design and theoretical framework

We conducted a qualitative instrumental case study, anchored in critical race theory, to obtain an in-depth understanding of the institutional responses to racism from medical schools across Canada in 2020.¹² Qualitative case study methodologies allow researchers to empirically explore and understand unique experiences or events that are bound by time and place. The exploratory nature of instrumental case study designs allows for the flexibility to triangulate data from 2 or more qualitative sources to deepen the understanding of a case or problem.

We selected critical race theory as an overarching theoretical framework to guide our inquiry, to deepen our understanding of the institutional responses to address anti-Black racism and to generate practical insights that could improve current and future institutional efforts throughout medical schools across Canada.¹² Critical race theory is fundamentally oriented around several guiding principles that draw attention to the various ways racism and racial domination are entrenched throughout systems, structures and institutions (Box 1).^{13,15,17,18} Decades of applications across disciplines and contexts have proven critical race theory as a powerful analytic tool. Within the field of education, it has generated critical insight into the systemic and institutional nature of racism throughout education systems and structures, drawing attention to the myth of meritocracy, disproving claims of equal opportunity and race neutrality in educational policies and outcomes, and the pervasiveness and centrality of whiteness within campus climates, known as white institutional presence.^{14,19–23}

Given the historical and ongoing ways medicine has upheld and perpetuated racism, and the clear need to draw attention to such issues and phenomena in the profession, recent calls for critical race theory to become foregrounded in medicine and medical education have been articulated in the literature.^{24,25} As an overarching framework, critical race theory informed all steps of this study to draw attention to how race and racism are embedded into the systems, structures and culture throughout medical schools and academic institutions.

Participant recruitment and sampling

We designed our instrumental case study around 2 distinct groups who we knew were directly involved and affected in the institutional responses to anti-Black racism: Black medical students and deans of medical schools. We used criterion sampling to identify and recruit participants, aiming to interview at least 1 Black medical student and 1 dean from each medical school in Canada.

Our primary focus of inquiry was the perspectives and experiences of Black medical students, who were calling for medical schools to take action against systemic anti-Black racism through both institutional and national Black Medical Student Associations (BMSAs).²⁶ The lead student investigator (A.K.) contacted institutional and national BMSAs to recruit a delegate who could speak to the response of their medical school, including students who were directly engaged or consulted throughout the response. For medical schools that did not have local BMSAs or had exceedingly low numbers of Black students, we used snowball sampling to identify and recruit Black medical students by asking student participants for suggestions of who could be invited to participate.

We recruited deans of medical schools as a secondary source to explore the perspectives of those in institutional leadership. At the time of this study, deans were predominantly white and none were Black.²⁷ We chose to sample this participant pool to capture additional insight into how racism might manifest within institutional structures and cultures, and to explore how perspectives may diverge or converge between groups, which could deepen our understanding of institutional responses to address anti-Black racism and still centre the experiential knowledge and stories of Black medical students. To recruit faculty participants, a faculty investigator (A.B.) sent a letter of invitation to the dean's office at each medical school. If the dean was unavailable or did not wish to participate, they were asked to identify another senior faculty administrator who could represent the medical school.

Data collection

We conducted individual, 1-on-1 semi-structured interviews with each participant. We developed, piloted and refined 2 interview guides to tailor questions between student and faculty participants. Interviews explored participants' perceptions and recollections of the medical schools' initial statements (not shown during the interview) before focusing on the schools' subsequent responses, including how Black students, faculty and staff were engaged with these responses throughout (Appendix 1, Supplemental File 1, available at www.cmaj.ca/lookup/doi/10.1503/cmaj.211746/tab-related-content). Based on our own observations and perceptions of how Black students were engaged in the responses, we included a question in the interview guides to explore participant understanding and experiences of the minority tax, a term that refers to the additional expectations and responsibilities unilaterally placed on minoritized individuals to direct, drive and lead institutional initiatives relating to equity, diversity and inclusion, including antiracism efforts.²⁸

We used several strategies to create safe, inclusive spaces so that participants could discuss their experiences and perceptions, given

Box 1 (part 1 of 2): Summary of critical race theory and its applications throughout this study

Critical race theory is a powerful analytic tool to understand systemic racism and promote racial justice. Critical race theory evolved out of the field of legal studies in the 1970s and has been widely applied across disciplines and contexts, including higher education. Central tenets of critical race theory differ slightly in naming between its evolution in legal studies and education but commonly reflect the following foundational principles.^{13,14}

Principles of critical race theory

Social construction of race

- Race is a social construct — not a biological or genetic construct — and racialization is a process of labelling and categorizing humans to enact domination and oppression.

Everyday racism

- Racism as “ordinary” and an everyday phenomenon experienced by people of colour because racism is systemic and deeply entrenched throughout social systems and structures.

Differential racialization

- Society racializes groups and people in different manners and times in ways that serve the self-interests of those with power and privilege.

Interest convergence¹⁵

- Because racism grants systemic power and benefits to a dominant group, there is no inherent desire for those who benefit from racism to support racial justice, so systemic changes and progress only occur when there are advantages to gain for the dominant group.

Intersectionality¹⁶

- Social identities and the systems of oppression that oppress social groups are not mutually exclusive and can intersect.

Counter-storytelling^{21,22}

- Exploring and centring the lived experiences of those who experience racism is important to amplify experiential knowledge to counter existing dominant (white) narratives that reflect and perpetuate racism.

Critique of liberalism¹⁴

- The critique of neutrality and objectivity, including the “myth of meritocracy” and race neutrality in education opportunities and outcomes.

Examples of how critical race theory was used and applied throughout the study

Study conceptualization and philosophical underpinnings

- Conceptualization of research question based on recognition of historical roots of anti-Black racism in medicine as a profession, in education (including higher education) and in academic institutions, as well as the historical minimization of anti-Black racism in Canada.
- Ontological beliefs on the nature of reality, namely that reality is socially constructed based on individual lived experiences, which are shaped by social structures and systems. Race is a social construct, and racism is a system of oppression and domination. This acknowledges that racism is a legitimate phenomenon and experience, and is deeply entrenched in systems and structures throughout society.
- Epistemological beliefs that people who experience racism have legitimate experiential knowledge that is central to understanding social reality (known as standpoint epistemology).
- Axiological underpinnings in how our team values social justice and advocacy efforts to dismantle anti-Black racism, and the lived experiences and experiential knowledge of those who directly experience oppression as central to dismantling such systems.

Design

- Qualitative case studies offer a mechanism to sociologically explore and understand a single phenomenon or event — the “case” — which must be bound by time and place. Recognizing the significance of George Floyd’s murder in catalyzing a global movement calling for widespread societal change to address anti-Black racism, this was, to the best of our knowledge, the first time that nearly all medical schools in Canada publicly acknowledged such issues, and, to varying degrees, expressed a commitment to racial justice. We set parameters around the case to focus our inquiry on what we considered a unique moment in time to empirically explore how medical schools in Canada (boundary by place) were initially responding after George Floyd’s murder (boundary by time).
- Critical race theory offers a foundation to both explore and understand the historical and contemporary manifestations of racism and connect findings to larger social systems and the contemporary state of society in relation to race, racism and racial justice.
- We sampled participants from 2 key groups to, first and foremost, understand the lived experiences of Black medical students, those who have directly experienced anti-Black racism within and beyond medical education, and, second, to explore perceptions of medical school responses from faculty in positions of power, given their direct influence on institutional responses and decision-making. By sampling and interviewing both Black medical students and faculty leaders, while still centring the experiential knowledge and lived experiences of Black participants, we could illuminate how racism and racial oppression is upheld or addressed in these contexts.

Data collection

- Data collection through 1-on-1, semi-structured interviews to provide space for participants to share their lived experiences, value the experiential knowledge of Black medical students and allow for counter-storytelling for these participants.
- Incorporation of questions within the interview guide that were informed by critical race theory tenets and scholars to better illuminate experiences of racism and the ways in which racism is embedded and reflected in institutional structures, norms and activities.

Box 1 (part 2 of 2): Summary of critical race theory and its applications throughout this study

- Deliberate decision to ensure all student participants were interviewed by another Black medical student. The shared identities of interviewer and interviewee hopefully created a safe space so student participants could speak openly and honestly about their experiences and perceptions.
- Each participant had the opportunity to review their final transcript and remove any information they felt uncomfortable including in the analysis or to withdraw from the study altogether (no participants withdrew). For the Black medical students in particular, this strategy aimed to reinforce participant autonomy and give them the power to control their own narrative and stories given the importance of counter-storytelling in critical race theory.

Data analysis

- Use of critical race theory, which offers an analytic framework to deepen our understanding by illuminating how racism is deeply entrenched in systems and structures throughout society. The tenets of critical race theory provide both a series of assumptions at the outset of the analysis and explanatory mechanisms for the findings.
- Incorporation of critical race theory into analytic procedure, including labelling of coding segments that relate to critical race theory during initial open coding processes.²⁹ Several nodes in the coding framework — developed following our inductive, open coding — reflected elements related to critical race theory, including interest convergence and colour-blind racism.

Ethical considerations

- A \$25 gift card was offered as a participant incentive to students only, as we recognize that these medical students do not earn income in their role as students, are actively paying tuition and directly experience racism. In contrast, faculty participants are paid in their current positions and, at the time of our study and to this day, there are no Black deans in Canadian medical schools; thus, the prospective faculty participants were individuals who do not experience anti-Black racism. The participant incentive was meant to serve as a token of appreciation for the time and insight of medical students in a sensitive topic area that they directly experience consequences of, whereas the faculty participants are paid in their current roles and do not experience the direct consequences of racism.

Knowledge dissemination

- We report student participant quotes in the main body of the text as a form of counter-storytelling and centring their lived experiences.
- We leverage principles and tenets of critical race theory to optimize our interpretations and discussion of the findings.

the nature of the topic and events (Box 1). One medical student investigator (A.K.) conducted all interviews with student participants. We considered it particularly important for student participants to be interviewed by an investigator with a shared identity — another Black medical student — to mitigate any power imbalances, given their status as learners in a deeply hierarchical profession. The student investigator (A.K.) is a Black Canadian woman who was a student in the Leaders in Medicine dual-degree program at the University of Calgary at the time of the study. She had previous training and experience with applied, qualitative research, including interviewing.

Similar to our considerations of identity concordance for students, anticipating that most faculty participants would be white, given the demographics of senior leadership and administration across medical schools in Canada at the time of this study, we considered it would be beneficial to have faculty participants be interviewed by another white faculty member. All faculty participants were interviewed by a faculty investigator (A.B.), a white woman and faculty member at the University of Calgary whose program of research examines social issues and justice in medical education using applied social science methods of critical inquiry, including qualitative methods. At the time of this study, she was in the first 6 months of her faculty appointment, was 1 of 4 faculty members directly involved with supporting the University of Calgary BMSA during the development and release of their Calls to Action, and attended meetings between the BMSA and medical school administrators and leadership between May and September 2020.

We conducted all interviews between Oct. 5, 2020, and Jan. 16, 2021, by videoconferencing or telephone. Interviews were audio-recorded and transcribed verbatim. Transcripts were cleaned to remove identifying information before analysis, including the names of schools, locations and individuals. We emailed cleaned and deidentified transcripts to participants as a form of member checking and to provide participants with an opportunity to review their data and withdraw, if they wished to.

Data analysis

We uploaded finalized transcripts to NVivo 12 (QSR International) for analysis. Principles and tenets of critical race theory provided central foundations to guide our analysis; terms to label, classify and organize data; and explanatory mechanisms to aid our synthesis of findings and interpretation (Box 1).^{13,29} Our analysis involved a process of inductive coding and deductive categorization and synthesis. First, all transcripts underwent a process of inductive analysis through line-by-line, open coding by 2 team members (independent of one another), alternating coding dyads assigned to each transcript. This initial inductive approach informed the development and refinement of a coding framework, which was then applied across all transcripts. We separated coded segments of data for each code between faculty and student participants and exported them for further analysis and interpretation, independent of the other group, to develop a deeper understanding of student and faculty experiences and perceptions (within-group analysis) before exploring how findings converged or diverged between groups (cross-case analysis).³⁰

Researcher identities, positionality and reflexivity

Recognizing researcher positionality and reflexivity is critical in qualitative inquiry as diverse identities and experiences shape the process and outcomes of such studies. In addition to the identities and experiences of the interviewees (A.K. — a Black medical student, A.B. — a white faculty member), 4 undergraduate students (A.O., O.K., D.A., S.Y.) were central members of our research team, all of whom are Black, and, at the time of this study, were aspiring health care professionals.

We used multiple strategies to promote reflexivity, rigour and trustworthiness throughout this study, including writing field notes after each interview, investigator debriefing (e.g., between A.K. and A.B. during data collection, team debriefs throughout), investigator triangulation (multiple analytic perspectives) and memoing throughout data collection and analysis. We present our findings using participant quotes as a method of counter-storytelling to convey authentic experiences and perspectives.

Ethics approval

Ethics approval was granted through the University of Calgary Conjoint Health Research Ethics Board (CHREB File #20-1292). We recognize that, historically, Black people have been subjected to scientific study without consent, freedom to decline participation and direct benefits. We deliberately incorporated multiple strategies to prioritize the rights and safety of Black students throughout this study (Box 1).

Results

Between Oct. 5, 2020, and Jan. 16, 2021, we interviewed 19 participants, including 8 medical students (6 in pre-clerkship; all identified as Black) and 11 senior faculty administrators (4 deans, 7 delegate faculty administrators; 3 racialized). We had at least 1 student or faculty participant from 13 medical schools, and no student or faculty participants from the 4 medical schools in Quebec. Interviews were an average of 59.6 (range 36–108) minutes for students, and 46.6 (range 21–63) minutes for faculty. No participants withdrew their participation.

Our analysis illuminated commonalities and nuances among the lived experiences of Black medical students during this time and further identified diverging perspectives between students and faculty administrators. Appendix 1, Supplemental Tables 1–4, summarize these findings and provide supporting data. We purposefully incorporated student quotes to centre and amplify the voices of Black medical students as a mechanism for counter-storytelling, a tenet of critical race theory.

Development and perceptions of initial public statements

Participants thought that initial statements released by medical schools were rushed in response to external pressures from society at large, as well as internal pressure from within the medical school, including students. Given the absence of Black faculty in leadership and a perceived sense of urgency, this resulted in expedited statements primarily written by white people. Several Black medical students were asked to provide feedback on statements before their release.

But I remember like being irritated because they ... emailed us and were like “is this statement okay?” ... On one hand, I’m glad that you’re checking because it wasn’t okay, and clearly they needed help, but it was also just like, this shouldn’t be our job to help you do this. — Student 8

Although faculty participants thought that a statement was necessary, many were concerned about how the statement might be perceived by groups other than the Black community. Faculty generally felt their statements were well received but noted that they garnered some critical feedback from individuals who questioned why there was an explicit focus on anti-Black racism or on the pervasiveness of racism in medical institutions. Several faculty saw merit in these concerns. In contrast, student participants saw the statements as performative and tokenistic, and felt schools were trying to take a stance similar to other organizations at the time, while trying to remain as politically correct as possible. They expected a clearer commitment to addressing anti-Black racism within medicine and the school itself.

The statement, for me, like I mentioned, wasn’t impressive, but I don’t think they could have delivered a statement to me that would be impressive, you know? ... Like there’s nothing they could say — for me it would definitely just need to be more about the actions. That’s what I would have valued more. — Student 3

Most medical schools were starting from nothing in their efforts to address anti-Black racism

Student participants felt they needed to advocate for their voices to be heard and encourage their school to take action, including releasing calls to action through the local and national BMSAs. Participants acknowledged that addressing anti-Black racism was historically neglected in medicine and medical education, and that most schools were largely starting from nothing.

That’s where you could separate the schools that were doing things before the passing of Regis [Korchinski-Paquet] and George [Floyd] versus the schools that were doing things in response to Regis and George, because then the planning’s just started for them. So it’s hard for them to be very clear, you know? — Student 3

The lack of racial diversity among senior faculty leadership and administration meant that few, if any, had lived experiences of racism — especially anti-Black racism — which hindered their ability to take swift and effective action. Since most medical schools did not have any Black faculty, particularly in leadership positions, and had historically neglected issues of anti-Black racism within their institution, schools relied heavily on Black medical students for guidance and direction. Students saw this reliance on them to direct institutional responses as inappropriate, but they felt compelled to remain involved to keep their medical school accountable beyond the statement.

Clearly they needed help, but it was also just like, this shouldn’t be our job to help you do this. And I feel like that’s been a consistent theme since June in anything that’s happened where we need them to consult students, but sometimes the ways in which they do it... it’s like we shouldn’t have to do this particular job, but we will because if we don’t, what are you going to do? You’re probably going to mess it up. But you should already have people in your staff, in your faculty that you could ask those questions to. — Student 1

Faculty participants were generally satisfied with their institutional responses. When asked to provide specific examples of actions taken to address anti-Black racism since the statement, many described remaining in a period of reflection and early stage of planning or described previous initiatives unspecific to antiracism — let alone anti-Black racism — as evidence of a broader commitment to equity, diversity and inclusion. Some faculty provided concrete examples of actions, such as curriculum audits, admissions initiatives, hiring of Black faculty members and new task forces.

Perceived barriers to action, tensions and competing interests

When asked about the primary barrier to an effective institutional response, student participants consistently recognized how a lack of representation of Black faculty within the medical school, and particularly among leadership, meant that medical schools were trying to develop a response to a systemic issue that they neither understand nor experienced.

I feel like they're doing the best that they can with what they know and have. There are not that many Black people at the faculty level. So, I do feel like it's a Black issue that's being — it's like non-Black people are trying to solve it sometimes. — Student 7

Faculty participants considered that a primary barrier impeding their institutional response was a concern surrounding how their responses might potentially diminish any institutional initiatives in place, namely their institutional commitment to Indigenous peoples. They described perceiving tensions and competition between equity-deserving groups to “own part of the pie.” Student participants did not see these same tensions or logic, but instead described a sense of collective efforts, solidarity and shared goals for liberation.

I think definitely including Black medical school students in the conversation and other racialized minorities as well, just so that we could better tackle all of the issues that we face. And, again, it's hard to balance that because, as Black people, we technically aren't really the most oppressed group on the lands that we're in. So it's hard to like advocate for more of what we want and more of our agenda when the Indigenous agenda also has just been moving forward. — Student 4

“... a lot of Black and Indigenous student advocates ... do work together and Black people in general have really supported Indigenous people, and I think Indigenous people have generally given it back ... the two communities definitely work really well together. — Student 5

Additional barriers perceived by faculty participants included resistance from other faculty members and administrators, the influence of main campus on the medical school and the overall nature of institutional change in that change “could not happen overnight.”

Despite depending on medical students to guide their institutional response, several faculty described perceiving Black students as “angry” and “unreasonable” in their encounters (see faculty quotes in Appendix 1, Supplemental Table 2).

There's some faculty that are a bit more resistant to change and don't like being told that they're not the experts of that situation and so they might be a little bit more condescending when we try to make changes, they'll be like, “You can't expect these things to happen overnight,” and “Do you know many changes ha[ve] happened in like 2 weeks?” Or they'll act as if everything we're coming from is in the face of emotion rather than completely rational thought. Or they'll get very defensive. ... But they don't like being put on the defensive, or sometimes having to listen. — Student 1

The profound burden on medical students: the minority tax

The minority tax was a phenomenon understood by all student participants. All but 1 student participant described experiencing the minority tax and the extensive burden imposed on them to direct and drive institutional antiracism efforts, again attributing this burden to the lack of Black faculty in the medical school to help with the institutional response. In the absence of Black faculty, students felt compelled to remain involved as they did not trust leadership to respond adequately. Several described the time and energy in helping with the response as the equivalent of a full-time job, sometimes upwards of 40 hours each week — concurrent with their already busy training — inevitably resulting in burnout for many and feelings of being exploited. Because many students perceived this period as a critical window of opportunity to address anti-Black racism, they felt compelled to tolerate the minority tax, believing it would lead to concrete action on issues that had historically been neglected.

I think some of them had a full-time job of this for like 2 weeks. We were meeting maybe every other day because we knew at that time, you don't know how long people are protesting, but you just know that this is your window. And the faster you can formally make a request within this window, the faster you're going to see the policy change. And even for me, I do remember that being an extremely challenging time in my medical education. But I did realize that this was a priority. ... I think there's things bigger than medicine. There's things bigger than me, so I really thought like, “Okay, this is a really big priority.” — Student 3

I think that's the difficulty of having a nondiverse staff, they're not aware of this minority tax. And then when it comes to asking students, “Oh, what can we do?” or “Is this what we're doing right?” you're adding more responsibilities to students', quote unquote, to-do list. At the end of the day, I want to be a good doctor. But what I've been seeing is a lot of my work has been more focusing on making sure that this is an environment that accepts Black students rather than me trying to advance my career, which is really unfortunate. — Student 6

I shouldn't have to be doing all this work but I'm going to, because I feel like if I don't, it won't get done or it won't get done well. I understand that as a racialized student, but it shouldn't be your job to fix your school. But when you kind of get into that work it's hard to pull out or pull back. And so, it's like, they're listening to us and they're consulting us. Though sometimes it definitely feels we're being taken advantage of, especially because this work isn't compensated. ... like people get paid to do that, but we just give our labour for free because we feel that strongly about these things, right? So yeah, it's definitely a tough situation to be in. But I think yeah, over the past 2 months we've all definitely been feeling the minority tax a bit more than usual.” — Student 1

Although faculty participants acknowledged their reliance on students in driving their institutional response, few were aware of the concept of the minority tax nor could they describe strategies to alleviate the burden on students. Faculty considered that allyship was the primary solution to alleviating the burden on students, whereas students saw Black faculty as the solution.

Lessons learned and hope for the future

Despite the challenges associated with the institutional responses, student participants remained cautiously optimistic that addressing anti-Black racism would remain a priority. The events established and improved communication channels and working relationships between Black students, faculty and leadership and created space for Black medical students within the institution. Students expressed hope that these events would have a profound and long-lasting impact on how medical schools react and respond to all current inequities and future injustices.

I want them to all learn that it's okay to be the first. It's okay to be the first, as long as what you're doing is rooted in social justice. And this kind of extends beyond Black people, it really goes toward any type of marginalized group. You know, today it's Black people, but tomorrow might be somebody else. ... We don't have to wait for there to be such a critical mass of Black people at [medical school] before we realize we can have a Black application stream, you know? ... And it's okay to be brave. That's what I would want them to learn. And when it comes to the next group, be brave with that group. — Student 3

Interpretation

Our findings highlight the shared experiences of Black medical students and diverging perceptions between students and senior faculty administrators regarding the institutional responses and actions after the widespread call for organizations to commit to racial justice. Collectively, our findings illuminate the legacy of systemic, anti-Black racism in medical education across a number of medical schools in Canada. Nearly all medical schools were “starting from scratch” in their responses regarding anti-Black racism in 2020. Their public statements, in response to external pressures, commented on longstanding issues that institutions have previously neglected to acknowledge, let alone address. In the absence of Black faculty, medical schools relied extensively on Black students to guide their institutional responses. The paucity of Black faculty in these institutions, particularly in positions of leadership, is the result of historical and ongoing exclusion of Black people from the profession and practice of medicine through discriminatory policies and practices at admissions, hiring, promotion, tenure and retention — known as the “leaky pipeline” for Black physicians in academic medicine³¹ and corroborates an existing body of evidence about how structural racism operates in academic medicine.

Students can be powerful drivers of institutional change beyond the initial reactionary statements released by academic institutions after social injustices,³² yet it is troublesome how students are often burdened with the responsibility to dismantle the systems that actively oppress them, a phenomenon known as the minority tax.^{28,33} The intense and unjust burden of the minority tax experienced by students in our study, a burden that senior faculty

administrators were often unaware of, reiterates the critical importance of diversity and representation among medical school leaders to ensure the burden of work does not fall on minoritized students.³⁴ Amuzie and Jia³⁵ acknowledged how the unequal burden and additional pressures on Black medical students can lead to limited capacity for academic and extracurricular activities and caution how this may indirectly affect residency selection, a process already known to perpetuate structural racism.^{36–39} It is also worth recognizing how Black medical students took on an unequal burden of the collective trauma experienced from witnessing additional horrific instances of police violence and anti-Black racism,^{40,41} on top of the many additional burdens and challenges faced by Black medical students compared with their peers.

Our findings further highlight limitations associated with the public statements released by medical schools after the murder of George Floyd in 2020.¹¹ Some institutions may be responding by modifying their policies and practices, such as admissions, but concerns have been articulated regarding the performative nature of “antiracism curricula” and the tendency to focus on educating individuals as a distraction from the root causes that create and uphold institutional racism.⁴² Systems-level, top-down changes are warranted to dismantle the deeply rooted racist ideologies and practices that are embedded within academic medical institutions, drawing attention to how individuals in positions of power are often not held accountable for upholding the system.⁴³

Much like the “skeptical optimism” described by Shim,⁴⁴ students in our study felt this may have been a unique moment in time for racial justice and addressing anti-Black racism to become clear institutional priorities.⁴⁴ It will be important to continually track the progress of antiracism responses at Canadian medical schools and keep institutions accountable, specifically those designed to address anti-Black racism. A lack of racial diversity among medical school faculty is likely to remain a critical barrier to addressing anti-Black racism in medical education, particularly the paucity of Black faculty in leadership positions.⁴⁵ Since a spotlight has been put on the lack of Black faculty in medical schools, various individuals have recently been hired into different roles at medical schools. Although these hires are critical, it is also important to consider how Black faculty members can also experience the minority tax,⁴⁶ strategies to mitigate such burdens should be incorporated.⁴⁷

In the absence of racial diversity in academic institutions, whiteness remains an ideological norm that threatens inclusivity and campus climate, and, ultimately, impedes racial justice.²³ One concerning finding was that faculty often appeared reluctant to commit to acknowledge and address anti-Black racism because of anticipated criticism and backlash from other groups and individuals — often those in majority demographics (i.e., white) — or from those questioning the reality of systemic racism. Likewise, faculty participants perceived tensions and competition to address the needs of different equity-deserving groups (e.g., addressing anti-Black racism would diminish Truth and Reconciliation efforts), which suggests that senior faculty administrators may be viewing equity as a “zero-sum game” — ironically, logic rooted in colonialism, capitalism, and white supremacy that has been used to uphold systems of oppression.^{48,49} In addition to the need for

diverse identities and lived experiences among faculty, it is clear that all faculty in leadership roles must also possess a foundational awareness of, and clear commitment to, social justice.

Limitations

This study is limited by the absence of a Black faculty investigator and analytic lens. Our decision to have a white faculty investigator as part of the team was in anticipation of the faculty participants being predominantly white, given the demographics of senior leadership and faculty at medical schools in Canada at the time of the study; however, faculty responses may have differed if interviewed by a Black faculty member. Since interviews were conducted in fall and early winter of 2020, it may have been too early to examine responses, considering the slow pace of institutional change, as participants described. Although we obtained rich data from student participants, several declined to participate for 2 main reasons: fear of potential consequences for speaking out about their institution, if identified, and burnout and trauma, given what they were experiencing at the time. Several students were reluctant to relive such distressing experiences.

Although we attempted to recruit across all 17 Canadian medical schools, we were unsuccessful in recruiting any participants from Quebec. The Quebec Conference of Deans of Faculties of Medicine declined to participate as we did not have the capacity to conduct the interviews in French. As such, we lack insight into the responses from the 4 schools in this province.

This study highlights a disconnect between student and faculty perceptions of institutional responses, but given the hierarchical structure of medical institutions, it is possible that senior faculty administrators were privy to more information regarding how medical schools responded, leading to differences in perspectives. Likewise, although participants provided detailed accounts of the actions of medical schools in responding to the presence of anti-Black racism within medical education, this study relied on a single data collection method. Assessing complementary data sources, such as institutional policies, may offer further insight.

Conclusion

The so-called “racial reckoning” of 2020 catalyzed a widespread awakening of institutions, including medical schools, to the ways in which they contribute to — and uphold — racial injustice. Medical schools in Canada have historically neglected to acknowledge and address the longstanding anti-Black racism in medicine. In this study, the legacy of anti-Black racism and failure to prioritize racial justice was evident. Institutional accountability remains critical, and further research is needed to evaluate the extent to which medical schools in Canada are successfully addressing anti-Black racism.

References

1. Capers Q, Clinchot D, McDougle L, et al. Implicit racial bias in medical school admissions. *Acad Med* 2017;92:365-9.
2. Mpalirwa J, Lofters A, Nnorom O, et al. Patients, pride, and prejudice: exploring Black Ontarian physicians' experiences of racism and discrimination. *Acad Med* 2020 Nov;95(11S Association of American Medical Colleges Learn Serve Lead: Proceedings of the 59th Annual Research in Medical Education Presentations): S51-S57. doi: 10.1097/ACM.0000000000003648.
3. Dryden O, Nnorom O. Time to dismantle systemic anti-Black racism in medicine in Canada. *CMAJ* 2021;193:E55-7.
4. Vogel L. Queen's to redress harms of historic ban on black medical students. *CMAJ* 2019;191:E746.
5. *Diversity of the black population in Canada : an overview*. Ottawa: Statistics Canada; 2019.
6. Martin KD, Roter DL, Beach MC, et al. Physician communication behaviors and trust among black and white patients with hypertension. *Med Care* 2013;51:151-7.
7. Smedley BD, Stith AY, Nelson AR. Unequal treatment: confronting racial and ethnic disparities in health care. Washington (D.C.): National Academies Press; 2003. Available: <https://pubmed.ncbi.nlm.nih.gov/25032386/> (accessed 2022 Jan. 25).
8. Greenwood BN, Hardeman RR, Huang L, et al. Physician-patient racial concordance and disparities in birthing mortality for newborns. *Proc Natl Acad Sci U S A* 2020;117:21194-200.
9. McKinnon B, Yang S, Kramer M, et al. Comparison of Black-white disparities in preterm birth between Canada and the United States. *CMAJ* 2016;188:E19-E26.
10. Mullings DV, Morgan A, Quelleng HK. Canada the Great White North where anti-Black racism thrives. *Phylon* 2016;53:20-41.
11. Brown A, Auguste E, Omobhude F, et al. Symbolic solidarity or virtue signaling? A critical discourse analysis of the public statements released by academic medical organizations in the wake of George Floyd. *Acad Med* 2022;97:867-75.
12. Stake R. *The art of case study*. Thousand Oaks (CA): Sage; 1995.
13. Delgado R, Stefancic J. *Critical race theory: an introduction*. New York: New York University Press; 2001.
14. McCoy DL, Rodricks DJ. Critical race theory in higher education: 20 years of theoretical and research innovations. *ASHE High Educ Rep* 2015;41:1-117.
15. Bell DA. *Brown v. Board of Education* and the Interest-Convergence Dilemma. *Harv Law Rev* 1980;93:518-33.
16. Crenshaw KW. Mapping the margins: intersectionality, identity politics, and violence against women of color. *Stanford Law Rev* 1991;43:1241-99.
17. Bonilla-Silva E. Rethinking racism: toward a structural interpretation. *Am Sociol Rev* 1997;62:465-80.
18. Bonilla-Silva E. *Racism without racists: color-blind racism and the persistence of racial inequality in the United States*. Lanham (MD): Rowman & Littlefield Publishers; 2003.
19. Ladson-Billings G. From the achievement gap to the education debt: understanding achievement in U.S. schools. *Educ Res* 2006;35:3-12.
20. Solorzano D, Ceja M, Yosso T. Critical race theory, racial microaggressions, and campus racial climate: the experiences of African American college students. *J Negro Educ* 2000;63:60-73.
21. Solórzano DG, Yosso TJ. Critical race methodology: counter-storytelling as an analytical framework for education research. *Qual Inq* 2002;8:23-44.
22. Decuir JT, Dixon AD. “So when it comes out, they aren't that surprised that it is there”: using critical race theory as a tool of analysis of race and racism in education. *Educ Res* 2016;33:26-31.
23. Gusa DL. White institutional presence: the impact of whiteness on campus climate. *Harv Educ Rev* 2010;80:464-90.
24. Zewude R, Sharma M. Critical race theory in medicine. *CMAJ* 2021;193:E739-41.
25. Chow C, Hirshfield L, Wyatt T. Sharpening our tools — conducting medical education research using critical theory. *Teach Learn Med* 2021;34:285-94.
26. Calls to action to address institutionalized racism in medical education and health care. Calgary: University of Calgary Black Medical Students' Association; 2020. Available: <https://linktr.ee/CalgaryBMSA> (accessed 2020 July 19).
27. AFMC Board of Directors. Ottawa: The Association of Faculties of Medicine of Canada; 2020. Available: <https://afmc.ca/about/board> (accessed 2020 Jan. 11).
28. Rodríguez JE, Campbell KM, Pololi LH. Addressing disparities in academic medicine: What of the minority tax? *BMC Med Educ* 2015;15:6.
29. Winkle-Wagner R, Lee-Johnson J, Gaskew A. *Critical theory and qualitative data analysis in education*. New York: Routledge; 2019. Available: <https://www.routledge.com/Critical-Theory-and-Qualitative-Data-Analysis-in-Education/Winkle-Wagner-Lee-Johnson-Gaskew/p/book/9781138067035> (accessed 2022 Mar. 16).
30. Stake RE. *Multiple case study analysis*. New York: Guilford Press; 2006:342. Available: <https://www.guilford.com/books/Multiple-Case-Study-Analysis/Robert-Stake/9781593852481> (accessed 2018 Aug. 1).

31. Avakame EF, October TW, Dixon GL. Antiracism in academic medicine: fixing the leak in the pipeline of Black physicians. *ATS Sch* 2021 May 4;2:193-201.
32. Hailu MF, Sarubbi M. Student resistance movements in higher education: an analysis of the depiction of Black Lives Matter student protests in news media. *Int J Qual Stud Educ* 2019;32:1108-24.
33. Cyrus KD. Medical education and the minority tax. *JAMA* 2017;317:1833-4.
34. Lerma V, Hamilton LT, Nielsen K. Racialized equity labor, university appropriation and student resistance. *Soc Probl* 2020;67:286-303.
35. Amuzie AU, Jia J. Supporting students of color: balancing the challenges of activism and the minority tax. *Acad Med* 2021;96:773.
36. Boatright D, Ross D, O'Connor P, et al. Racial disparities in medical student membership in the Alpha Omega Alpha Honor Society. *JAMA Intern Med* 2017;177:659-65.
37. Low D, Pollack SW, Liao ZC, et al. Racial/ethnic disparities in clinical grading in medical school. *Teach Learn Med* 2019;31:487-96.
38. Williams M, Kim EJ, Pappas K, et al. The impact of United States Medical Licensing Exam (USMLE) step 1 cutoff scores on recruitment of underrepresented minorities in medicine: a retrospective cross-sectional study. *Health Sci Rep* 2020;3:e2161.
39. Poon S, Nellans K, Rothman A, et al. Underrepresented minority applicants are competitive for orthopaedic surgery residency programs, but enter residency at lower rates. *J Am Acad Orthop Surg* 2019;27:E957-68.
40. Kwaning KM. Being Black in medicine in the midst of COVID-19 and police violence. *Acad Med* 2020;95:1787-8.
41. Nwagwu S. No, your email does not find me well [letter]. *Acad Med* 2021;96:14-5.
42. Gutierrez KJ. The performance of "antiracism" curricula. *N Engl J Med* 2020;383:e75.
43. Zaidi Z, Bush AA, Partman IM, et al. From the "top-down" and the "bottom-up": centering Foucault's notion of biopower and individual accountability within systemic racism. *Perspect Med Educ* 2021;10:73-5.
44. Shim RS. Dismantling structural racism in academic medicine: a skeptical optimism. *Acad Med* 2020;95:1793-5.
45. Yancy CW. Academic medicine and Black Lives Matter: time for deep listening. *JAMA* 2020;324:435-6.
46. Foster KE, Johnson CN, Carvajal DN, et al. Dear white people. *Ann Fam Med* 2021;19:66-9.
47. Williamson T, Goodwin R, Ubel P. Minority tax reform — avoiding overtaxing minorities when we need them most. *N Engl J Med* 2021;384:1877-9.
48. Yuval-Davis N. Dialogical epistemology — an intersectional resistance to the "Oppression Olympics." *GenD Soc* 2012;26:46-54.
49. Michaels WB. Identity politics: a zero-sum game. *New Labour Forum* 2010;19:8-11.

Competing interests: None declared.

This article has been peer reviewed.

Affiliations: Cumming School of Medicine (Kalifa, Brown); Faculty of Science (Okuori, Abatan); Faculty of Nursing (Kamdem), University of Calgary, Calgary, Alta.; Faculty of Health Sciences (Yahya), McMaster University, Hamilton, Ont.

Contributors: All of the authors contributed to the conceptualization and design of the study. Ariet Okuori, Orphelia Kamdem, Doyin Abatan, Sammah Yahya and Allison Brown designed the study protocol and interview guides. Amira Kalifa conducted all interviews with student participants and Allison Brown conducted all interviews with faculty participants. All authors cleaned, analyzed and interpreted the data. Amira Kalifa and Allison Brown drafted the manuscript. All

of the authors revised it critically for important intellectual content, gave final approval of the version to be published and agreed to be accountable for all aspects of the work.

Content licence: This is an Open Access article distributed in accordance with the terms of the Creative Commons Attribution (CC BY-NC-ND 4.0) licence, which permits use, distribution and reproduction in any medium, provided that the original publication is properly cited, the use is noncommercial (i.e., research or educational use), and no modifications or adaptations are made. See: <https://creativecommons.org/licenses/by-nc-nd/4.0/>

Funding: This study was funded through the faculty investigator's operational funds in the Department of Medicine at the University of Calgary.

Data sharing: Original data will not be shared for ethical reasons, including the risks of directly or indirectly identifying participants. Participants did not consent to their data being shared beyond the parameters of the present study.

Acknowledgements: The authors acknowledge members of the University of Calgary Black Medical Students' Association for their collective leadership in driving institutional changes, as well as their support and contributions in conceptualizing this study. They also wish to acknowledge the Black Medical Students' Association of Canada for their leadership and advocacy at a national level, and the immense time and energy that Black students continue to put forth to promote racial justice.

Accepted: June 24, 2022

Correspondence to: Allison Brown, allison.brown@ucalgary.ca