Patients, Pride, and Prejudice: Exploring Black Ontarian Physicians’ Experiences of Racism and Discrimination

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Abstract

Purpose
Black physicians’ and trainees’ experiences of racism are not well documented in Canada, reflecting a knowledge gap needing correction to combat racism in Canadian health care. The authors undertook a descriptive study of Black physicians and trainees in the Canadian province of Ontario. The goal of this study was to report upon racism experienced by participant Ontarian physicians to challenge the purported rarity of racism in Canadian health care.

Method
An anonymous online survey of physicians and trainees who self-identify as Black (African/Afro-Canadian/ African American/Afro-Caribbean) was administered in March and April 2018 through the Black Physicians’ Association of Ontario (BPAO) listserv. The survey was modeled on qualitative interview guides from American studies. Snowball sampling was employed whereby BPAO members forwarded the survey to eligible colleagues (non-BPAO members) to maximize responses. Survey data were analyzed and key themes described.

Results
Survey participants totalled 46, with a maximal response rate of 38%. Participants reported positive experiences of collegiality with Black colleagues and strong bonds with Black patients. Negative discrimination experiences included differential treatment and racism from peers, superiors, and patients. Participants reported race as a major factor in their selection of practice location, more so than selection of career. Participants also expressed a lack of mentorship, and there was a strong call for increased mentorship from mentors with similar ethno-racial backgrounds.

Conclusions
This study challenges the notion that racism within Canadian health care is rare. Future systematic collection of information regarding Black physicians’ and trainees’ experiences of racism will be key in appreciating the prevalence and nature of these experiences.

Each country has its own unique history of racism and discrimination within which its medical education system is situated. This undoubtedly generates nation-specific medical education priorities, including education research priorities. Acknowledgment of racism and discrimination toward Black Canadians remains limited (at best), and this is mirrored within Canadian medical education. Despite the United Nations describing “the structural racism that lies at the core of many Canadian institutions,” many Canadians believe that racism is less of a problem today than it was over 25 years ago. However, personal experiences of racism seem to be on the rise. Literature on racism in Canadian health care education is rare, but this limited literature may be due to a lack of exploration of racism as opposed to a true rarity of racism in Canadian health care education.

Further, Canada’s medical elites are commonly White and unfamiliar with racism and consider it uncommon. Absence of data reflects a knowledge gap necessary to combat racism in Canadian health care. In the United States, where there is a more advanced discourse on racism, medical educators such as Karani et al have challenged educators, faculty developers, and researchers to identify racism across the professions’ varied educational contexts and commit to its undoing. In particular, Karani et al recommend the application of critical race theory (CRT) approaches and frameworks for exploring experiences of racism in health professions education.7 CRT “… values experiential knowledge as a way to inform thinking and research” because narrative accounts are considered important sources of data.8 Accepting their challenge, and using a CRT-aligned approach, we surveyed Black physicians and postgraduate medical trainees in Ontario to ask: “What are your self-reported health care-related experiences of racism and what are some of the associated impacts?” Our work is a nascent step in compiling the descriptive knowledge essential to address racism experienced by Black Canadians enrolled in Canadian health professions education.

Method
Study setting
The province of Ontario is Canada’s most populous province with over 13 million inhabitants and is home to 36% of Canada’s 84,260 active physicians. The Black population, Canada’s third largest visible minority group, comprises 4.7% of the population of Ontario. However, Black physicians only comprise an estimated 2.3% of practicing physicians in Ontario. The population of Black physician trainees is unknown.

Please see the end of this article for information about the authors.

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Study design
This was an exploratory, descriptive study of Black physicians and physician trainees in Ontario regarding health care-related experiences of racism. Our research team is predominantly of Black African or Caribbean descent and fits within our study population. As Black researchers, we have an inherent, personal understanding of the subject matter and may have shared lived experiences as some of the study participants. We used an anonymous electronic survey. This method was selected for multiple reasons: (1) anonymity of an electronic survey format may foster participants’ candid responses regarding sensitive material describing racism, (2) Ontario is a large province and potential participants are likely geographically dispersed, and (3) a knowledge gap exists regarding the population of Black physicians and physician trainees in Ontario. This study was completed as part of a required family medicine residency research project (J.M., first author) for the Department of Family and Community Medicine, at the University of Toronto with overall study supervision (A.L.). Residency research project objectives, protocols, and study tools are approved by a research team comprising individual project supervisor (A.L.), resident academic project coordinator, research associate, and residency program director. Our survey was conducted between March 22 and April 13, 2018.

Study population and recruitment
Eligibility requirements for study inclusion were physicians or physician trainees (residents/fellows) who self-identified as Black (African/Afro-Canadian/African American/Afro-Caribbean) and were practicing or currently in training in Ontario. We recruited potential participants via the Black Physicians’ Association of Ontario (BPAO), of which our research group includes members. The BPAO is a not-for-profit organization whose goals are to advance the representation of Black Ontarians in medical education and reduce racialized health inequities.12

The BPAO operates a listserv for regular communication with their membership of practicing Black Ontarian physicians and physician trainees, which allowed us the rare opportunity to conduct a provincial survey of Black physicians and trainees in Ontario. However, the BPAO listserv was recognized as not representing all Ontario Black physicians, so we adopted a snowball sampling method13,14 to maximize responses. Survey recipients were asked to forward the email to potential participants who were not BPAO members and met the inclusion criteria to expand our reach. The survey was originally emailed to 121 Black physicians who were identified from the BPAO listserv as practicing Ontario physicians or physician trainees. Consent was implied by participation in the survey. An initial email announcing the survey was sent to the general BPAO listserv in the BPAO newsletter on March 20, 2018. An email to the identified physicians/physician trainees in the BPAO listserv was sent on March 22, 2018, introducing the survey and including the electronic link for participation. The survey was closed on April 13, 2018, with 2 reminder emails sent before this date (total survey window of 3 weeks).

Survey
The survey consisted of 4 sections: (1) demographics, (2) experiences of racism/discrimination, (3) career influences, and (4) mentorship. The different sections helped guide the designation of themes for analysis. An initial list of questions was chosen based on previous qualitative studies that investigated African American residents15 and physicians16 experiences in medicine. We edited this list for conciseness and formatted the remaining questions for suitability to an online survey format (J.M. and A.L.). To further incorporate topics that we anticipated may not be captured in some open-ended questions, we formatted some probing topics used in interviews15 as stand-alone questions for the online survey. For example, a probing topic for discussion on the experience and impact of mentorship15 was adapted to: “How important is mentorship to you?” and “During your training, did you feel like you had adequate access to mentorship?” Rating scales were used to facilitate ease of completion and data analysis. For resident projects, a PhD-trained research associate and resident academic project coordinator reviewed research protocols. For our project, the survey went through multiple rounds of review to edit questions for clarity and relevance (see List 1).

Analytic methods
First author (J.M.) conducted an initial descriptive analysis of closed-ended survey responses with subsequent independent review by author A.L. Confidence intervals were determined using The Survey System software (Creative Research Systems, Sebastopol, California). For qualitative data (open-ended responses), we performed a thematic analysis. Two authors (J.M., A.L.) independently reviewed and coded individual responses, and thereafter derived themes which corresponded to the survey sections. Themes were reviewed to ensure accurate representation of responses. There was agreement between raters (J.M. and A.L.) with regard to derived themes.

Ethical approval
Research ethics approval was obtained through the St. Michael’s Hospital Research Ethics Board.

Results
There were a total of 46 respondents (response rate cannot be accurately calculated due to the snowball sampling method used, but it is no greater than 38% considering the 121 initial recipients).

The majority of respondents (63%) were female (see Table 1). Most (63%) respondents were practicing physicians at various career stages, with the remainder residents (30%) and fellows (6.5%). Participants were predominantly in training (37%) or 10 years or less from their training (39.1%). The majority of participants completed their training in Canada (63%) with slightly less than one-third having completed their training in the United States/Caribbean (26.1%) and Europe (4.4%).

Both closed-ended responses (see Table 2) and themes from open-ended responses were categorized as: (1) influence of race on career choices, (2) negative experiences, (3) dealing with negative experiences/inaction, (4) positive experiences, or (5) mentorship.

Influence of race on career choices
Race played multiple roles in career decisions for many participants, most commonly in practice location (53.5%), but for some, in specialty choice.
List 1
Survey Questions
• How, if at all, do you feel that your status as a minority has influenced your decision with regard to picking your specialty?
• Do you feel that your status as a visible minority has influenced your current setting of practice (urban/rural)? If currently still in training, do you feel like your status as a visible minority is likely to influence your future setting of practice?
• Have you been treated differently during your medical training/career because of your racial background?
• Have you had any positive experiences during your medical training because of your racial background?
• Have you had any negative experiences during your medical training because of your racial background?
• Have you experienced any discrimination from:
  o Your superiors?
  o Your peers/colleagues?
  o Students/juniors?
• How did you deal with these negative experiences?
• Did you feel as though there was an opportunity/ space/environment created where you could openly discuss/ debrief a negative situation were it to occur?
• Did you ever receive any particular training as to how to deal with incidents regarding discrimination or racism?
• How important is mentorship to you?
• During your training, did you feel like you had adequate access to mentorship?
• How important would it be for a mentor to have a similar ethno-racial background as yourself?
• Are you currently involved in mentorship as a mentor?
• How influential was your status as a visible minority in your decision to mentor?
• Do you have any suggestions for improving the experiences of Black-identifying physicians/physician trainees in medicine?

Respondents noted the intent to practice in urban and suburban centers, where visible minority status would be more common than in rural areas. Those reporting influence in specialty choice cited a variety of reasons including influence/presence of Black mentors in their chosen specialty, as well as increasing representation. Others stated their motivation toward improving the health of Black Canadians: “I feel that as a future family physician, I will have the option of focusing or tailoring my practice toward advancing the health of Black Canadians.” (P09)

Negative experiences
More than 70% of respondents reported negative experiences based on their race. Some responses were centered on differential treatment and differing expectations (either higher or lower) for Black trainees/physicians as compared with their counterparts with one respondent remarking: “As a medical student, myself and other Black students were told we had to work harder to appear as competent as our White colleagues.” (P45) Participants described various forms of perceived racism/discrimination/ stereotyping, such as being regularly mistaken for floor aides, housekeeping, personal support workers, or nurses, and colleagues making stereotypical assumptions about respondents, or making offensive remarks about their looks and hair. Participants expressed various experiences of being “othered”—for example, being repeatedly asked where they were from even when they were born in Canada. A few respondents wrote that they felt as though their competence was questioned by their peers or superiors, but some described feeling excluded (“Often it’s about being excluded from the ‘old boys club’ as opposed to blatant overt discrimination” [P14]), expressed lack of support, lack of mentorship, minimal support for preparation for promotion, less access to opportunities, and lack of recognition for the work that they did as compared with their peers. One respondent remarked: “I felt very isolated. I performed at a high level and did not get recognition.” (P11)

More overt discrimination was reported to come from patients. A few survey respondents recall patients walking out of a room, or asking for a “lighter doctor,” with one recalling a patient protesting “I don’t want that nigger taking care of my kid.” (P26)

Participants reported a lack of action when experiencing prejudice or racism in the presence of their White peers or supervisors. After a patient said something racist in front of one respondent and their preceptor, the respondent wrote: “My White preceptor apologized to me after but didn’t say a word to [the patient]. I will never forget the way I felt having to be in that room.” (P14)

Dealing with negative experiences/ inaction
All but 2 participants reported not receiving any training on how to deal with negative experiences of racism/discrimination. Participants reported mostly internalizing negative experiences, “just dealing” and moving on: “[1] mostly ignore and move on.” (P09) Some declined reporting for fear of repercussions, but as respondents gained seniority, some felt more empowered: “The way I faced each situation evolved throughout my training and career … as I went further, I continued to learn how to speak for myself and confront the situation directly.” (P21)

Support in dealing with negative experiences was mostly sought from outside of the medical community—from family and friends. If support was sought at work, it was mostly from other Black colleagues: “If there is another Black person at work (usually not an MD), [I would] vent to them in private. I certainly don’t feel that I can safely share these experiences with most of my non-Black colleagues.” (P14) Few respondents sought support from their superiors and did so with varying reception. While some felt supported, others had their experiences dismissed: “I was told that I should be careful about levying
accusations of racism as they would stick with someone forever.” (P01)

When asked how these negative experiences could be improved, a common response amongst participants was by raising awareness: “It needs to be talked about. We are having conversations about gender inequality. We need to have [them] about race.” (P37) Some participants also stressed the importance of better record-keeping and data to track equity statistics: “Subtle, more insidious forms of racism persist (e.g., being passed over for promotions or senior positions). This leads me to believe that more work must be done to ensure equity in medicine. For example, keeping statistics on minority hiring and advancement within the faculty of medicine. Only then can these more subtle forms of racism be examined to better the experiences of Black-identifying physicians.” (P28)

Respondents commented on the importance of increasing mentorship and fostering a better sense of community with Black physicians locally and internationally, highlighting the value of creating safe and confidential spaces to discuss concerns unique to Black physicians without fear of retaliation. Respondents wrote of increasing/facilitating educational workshops on discrimination and bias, centered on the experiences of not only marginalized patients but also visible minority physicians. Given the underrepresentation of Blacks in medicine, leveraging relationships with other visible minority allies was considered a key success factor.

Positive experiences

Respondents reported positive experiences of collegiality with other Black allied health professionals. Respondents noted a tangible sense of encouragement and support from other Black (non-physician) health staff that would express how pleased they were to see a Black physician, noting it as a rare thing. Positive experiences were also reported in the form of physician–patient interactions with one physician remarking: “Patients sometimes comment that they trust me more because I’m one of them. I’d say every single day that I work, a Black patient will tell me they’re proud of me.” (P36) One participant reported that Black families would request to join her medical practice so that their children could have a visible role model (P41). One statement summarized the sentiment amongst many respondents: “I connect with Black patients and staff differently. I don’t think it’s demonstrably better than my experience; there is less to explain or try to understand.” That being said, I don’t think it’s impossible for mentors or those who should teach to gain enough understanding to be able to fill those roles effectively. (P22)

Discussion

The key finding of this paper is that racism has a significant impact on Black physician and trainee experiences in Canada. To our knowledge, this is the first study to explore Black Canadian physician experiences of discrimination. Respondents described microaggressions and stereotyping from patients, peers, and preceptors; feelings of exclusion; and fewer opportunities for support, mentorship, advancement, and promotion. They also described building community among Black health professionals and allies to find support, and moments of pride experienced with Black patients who saw a Black physician for the first time, shattering the stereotypes. Our study findings are directly in line with the concept of institutionalized racism.
Table 2
Survey Results

<table>
<thead>
<tr>
<th>Theme</th>
<th>Responses</th>
<th>N*</th>
<th>Responses % [95% CI]</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Career influences</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Impact of race on picking career/specialty</td>
<td>No</td>
<td>34/43</td>
<td>79.0 [68.8, 91.2]</td>
</tr>
<tr>
<td>Influence on current setting of practice</td>
<td>Definitely/very yes</td>
<td>23/43</td>
<td>53.5 [38.6, 68.4]</td>
</tr>
<tr>
<td></td>
<td>Definitely/very no</td>
<td>10/43</td>
<td>23.3 [11.8, 41.5]</td>
</tr>
<tr>
<td></td>
<td>Probably/definitely yes</td>
<td>8/43</td>
<td>18.6 [7.0, 30.3]</td>
</tr>
<tr>
<td></td>
<td>Probably/definitely no</td>
<td>12/43</td>
<td>27.9 [14.5, 41.3]</td>
</tr>
<tr>
<td><strong>Negative experiences</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Differential treatment because of racial background</td>
<td>Yes</td>
<td>29/41</td>
<td>70.7 [56.8, 84.7]</td>
</tr>
<tr>
<td>Negative experiences because of racial background</td>
<td>Yes</td>
<td>29/41</td>
<td>70.7 [56.8, 84.7]</td>
</tr>
<tr>
<td>Discrimination from superiors</td>
<td>Rare/very rare</td>
<td>26/39</td>
<td>66.7 [51.9, 81.5]</td>
</tr>
<tr>
<td></td>
<td>Occasional</td>
<td>10/39</td>
<td>25.6 [11.9, 39.3]</td>
</tr>
<tr>
<td></td>
<td>Frequent/very frequent</td>
<td>3/39</td>
<td>7.7 [3.8, 16.0]</td>
</tr>
<tr>
<td>Discrimination from peers/colleagues</td>
<td>Rare/very rare</td>
<td>29/39</td>
<td>74.4 [60.7, 88.1]</td>
</tr>
<tr>
<td></td>
<td>Occasional</td>
<td>6/39</td>
<td>15.4 [4.1, 26.7]</td>
</tr>
<tr>
<td></td>
<td>Frequent/very frequent</td>
<td>4/39</td>
<td>10.3 [3.7, 19.8]</td>
</tr>
<tr>
<td>Discrimination from students/juniors</td>
<td>Rare/very rare</td>
<td>33/39</td>
<td>84.6 [77.3, 95.9]</td>
</tr>
<tr>
<td></td>
<td>Occasional</td>
<td>6/39</td>
<td>15.4 [4.1, 26.7]</td>
</tr>
<tr>
<td></td>
<td>Frequent/very frequent</td>
<td>0/39</td>
<td>0.0</td>
</tr>
<tr>
<td><strong>Dealing with negative experiences</strong>: Training on how to deal with incidents of discrimination or racism</td>
<td>No</td>
<td>37/39</td>
<td>94.9 [88.0, 101.8]</td>
</tr>
<tr>
<td><strong>Positive experiences</strong></td>
<td>Yes</td>
<td>26/41</td>
<td>63.4 [48.7, 78.2]</td>
</tr>
<tr>
<td>Importance of mentorship</td>
<td>Very/extremely important</td>
<td>36/39</td>
<td>92.3 [83.9, 100.7]</td>
</tr>
<tr>
<td></td>
<td>Moderately important</td>
<td>3/39</td>
<td>7.7 [0.7, 16.1]</td>
</tr>
<tr>
<td></td>
<td>Slightly/not important</td>
<td>0/39</td>
<td>0.0</td>
</tr>
<tr>
<td>Adequate access to mentorship during training</td>
<td>No</td>
<td>20/39</td>
<td>51.3 [35.6, 67.0]</td>
</tr>
<tr>
<td>Importance of mentor with similar ethno-racial background as yourself?</td>
<td>Very/extremely important</td>
<td>23/39</td>
<td>60.0 [43.5, 74.4]</td>
</tr>
<tr>
<td></td>
<td>Moderately important</td>
<td>10/39</td>
<td>25.6 [11.9, 39.3]</td>
</tr>
<tr>
<td></td>
<td>Slightly important</td>
<td>6/39</td>
<td>15.4 [4.1, 26.7]</td>
</tr>
<tr>
<td></td>
<td>Not at all</td>
<td>0/39</td>
<td>0.0</td>
</tr>
<tr>
<td>Current or past involvement in mentorship as a mentor</td>
<td>Yes</td>
<td>29/39</td>
<td>74.4 [60.6, 88.0]</td>
</tr>
<tr>
<td>Influence of status as a visible minority in your decision to mentor</td>
<td>Very/extremely influential</td>
<td>28/39</td>
<td>71.8 [57.5, 85.0]</td>
</tr>
<tr>
<td></td>
<td>Moderately influential</td>
<td>3/39</td>
<td>10.3 [0.7, 21.4]</td>
</tr>
<tr>
<td></td>
<td>Slightly/not influential</td>
<td>0/39</td>
<td>0.0</td>
</tr>
</tbody>
</table>

Abbreviation: CI, confidence interval.

*Responses were expressed as percentage and fraction of total respondents to the particular question. N. As not all participants responded to each question, the total number of the respondents to each question varies.

Camara Phyllis Jones defines institutionalized racism as the structures, policies, practices, and norms resulting in differential access to the goods, services, and opportunities of society by race. The United Nations recently flagged institutional racism as a pervasive problem in Canada; our study suggests that the field of medicine is no exception. A significant barrier to addressing this in the Canadian context has been a pervasive belief that racism is not a significant issue in Canada. Although Canada has had a long history of anti-oppression advocacy, it did not have a paradigm shifting Black civil rights movement; it is not the “birthplace” of CRT, nor does it have an organization such as the National Medical Association to advocate for Black physicians and patients. The tide is, however, shifting—regional and national networks of Black Canadian medical students, residents, and physicians are now emerging and advocating for change within Canadian medical schools. There is now a greater focus on social accountability in medicine and focus on diversity in medical education in Canada. Since 2015, many needed changes have occurred to address systemic racism within Canada: the acknowledgment of anti-Black racism by the government of Canada; the publication of the Truth & Reconciliation Commission report acknowledging the impacts of colonialism, residential schools, and anti-Indigenous racism in Canada; the implementation of a Canadian Anti-racism Strategy; and the establishment of the Anti-racism Directorate in Ontario.

Relationship to the literature
Studies from other countries report findings that are echoed in our study. Liebschutz et al reported themes of discrimination, differing expectations and social isolation amongst African American residents. These negative experiences were contrasted with connections with Black physicians, staff, and patients. Similar to our study, residents strongly advocated for Black mentors and spoke of creating more supportive environments and raising awareness of issues as means to improve their training experiences.

Similar issues and solutions have been identified by Black and Minority Ethnic (BME) physicians and trainees in Europe. In the British Medical Journal’s special issue on racism in medicine, it was noted that racism was prevalent in British medical schools. In an informal social media survey, BME physicians were asked about the problems they faced, and common issues included: microaggressions (e.g., being asked “where are you really from?”); being ignored, marginalized, or having their contributions minimized; and disparities in promotion and pay. Potential solutions included “the crucial need for mentorship, coaching, encouragement, and support from peers and seniors, whether BME or White British.”
Limitations

Our study has limitations. First, the response rate and representativeness of our sample responses are unknown. Second, due to the small sample size, we were unable to perform subgroup analyses. Slightly less than a third of study participants completed their training outside of Canada and may have reported experiences that occurred outside of Ontario. Third, participants were at differing career stages and some were reporting experiences from many years in the past. Finally, as this was a resident research project, we were limited to a short study time period that limited our data collection window and did not allow for piloting of survey questions.

Implication of research for medical educators

Future research regarding racism experienced by Black Canadian physicians and trainees can build upon our findings to answer questions more systematically across all of Canada's provinces and territories regarding the prevalence and nature of discriminatory events. Ideally, an in-depth CRT framework for analysis such as the one proposed by Milner et al. which involves “researching the self, researching the self in relation to others, engaged reflection and representation, and shifting from the self to system” would provide greater rigor. Canada and the United States have unique historical contexts regarding racism, discrimination, and medical education and are undeniably traversing differing paths to justice. Our group believes comparative medical education research across differing contexts (including future contributions from other countries’ medical educators) holds the potential to inform and advance a global path to justice and health for all.

Conclusions

This study disrupts the silence on institutional racism in Canadian health care and in medical education, and we consider it to be a starting point for future research. One can no longer assert that racial discrimination within Canada's health care and medical education contexts is a rare event to be managed one incident at a time. Acknowledgment, advocacy, and action combating racial discrimination are necessary for Canadian medical education and health care going forward.

By amplifying the voices from the margins, we hope that this work will be a catalyst for positive change in medical education, within and beyond Canada.

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Previous presentations: Research findings were presented as a poster at Learn Serve Lead: The 2019 Association of American Medical Colleges Annual Meeting, November 11, 2019, Phoenix, Arizona. Findings were also presented at the Canadian Conference on Medical Education (CCME), April 14, 2019, Niagara Falls, Ontario, Canada.

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