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

Joseph Mpalirwa, MD, Aisha Lofters, MD, PhD, Onye Nnorom, MD, MPH, and Mark D. Hanson, MD, FRCP C

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.2 However, personal experiences of racism seem to be on the rise.1 Literature on racism in Canadian health care education is rare,3–6 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.4

Further, Canada’s medical elites are commonly White and unfamiliar with racism and consider it uncommon.3 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.7 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,7 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.3 The Black population, Canada’s third largest visible minority group, comprises 4.7% of the population of Ontario.10 However, Black physicians only comprise an estimated 2.3% of practicing physicians in Ontario.11 The population of Black physician trainees is unknown.
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. The BPAO listserv was recognized as not representing all Ontario Black physicians, so we adopted a snowball sampling method 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 Ontarian 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 residents and physicians’ 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 interviews as stand-alone questions for the online survey. For example, a probing topic for discussion on the experience and impact of mentorship 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.
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, or patients not acceding with their plan until a White physician agreed with it: “I also had an experience where a family did not follow through on a treatment plan until a White, tall MD with a British accent (my White preceptor) 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 connection/relationships with people of other backgrounds, but there is certainly a tangible familiarity that is not present in other professional interactions.” (P28)

Mentorship
Mentorship was important to all participants. However, approximately half of respondents reported not having enough access to mentorship in their training. One physician noted: “I found that I have needed to be my own advocate and be more proactive about finding opportunities for mentorship. Of course, this is fraught with difficulty when you don’t even know what the opportunities are that you should be looking for.” (P21) Many participants were currently, or had previously been, mentors, and all expressed the influence of their racial background on their decision to mentor. All identified the importance of having a mentor of similar ethno-racial background:
“I think it’s extremely important as I would more openly be able to share my experiences and get some advice from someone who has been in a similar situation.” (P27) Respondents reported that mentorship of Black-identifying trainees, specifically by other Black faculty mentors, was important in improving the experiences of the trainees, who would benefit from role models that looked like them. Respondents commented on the importance of cultural sensitivity/competency of mentors of a different race but with other shared backgrounds:

I think the most important factors in mentorship are willingness to understand and listen with intention. People who share a given background (whether gender, race, language, age, etc.) automatically have a lot in common due to some degree of shared 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 [66.8, 91.2]</td>
</tr>
<tr>
<td>Influence on current setting of practice</td>
<td>Definitely/probably yes</td>
<td>23/43</td>
<td>52.2 [38.6, 66.4]</td>
</tr>
<tr>
<td></td>
<td>Might or might not</td>
<td>8/43</td>
<td>18.6 [7.0, 30.2]</td>
</tr>
<tr>
<td></td>
<td>Probably/definitely not</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>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 [0.7, 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 [0.7, 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><strong>Mentorship</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Importance of mentor</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>69.0 [48.5, 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>26/39</td>
<td>89.7 [78.6, 100.7]</td>
</tr>
<tr>
<td></td>
<td>Moderately influential</td>
<td>3/29</td>
<td>10.3 [0.7, 21.4]</td>
</tr>
<tr>
<td></td>
<td>Slightly/not influential</td>
<td>0/29</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 al16 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 a short study time period that limited our data collection window and did not allow for piloting of survey questions.

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.

Acknowledgments: Aisha Lofters is supported as the Chair in Implementation Science at the Gilgan Centre for Women’s Cancers at Women’s College Hospital in partnership with the Canadian Cancer Society and as a clinician-scientist with the University of Toronto Department of Family and Community Medicine. The authors wish to thank Sophia Oke, MSc—a third-year medical student at the University of Toronto—for her assistance with formatting of the manuscript.

Funding/Support: None reported.

Other disclosures: The authors have no conflict of interests to disclose.

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

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.

J. Mpaliwira is a family physician, Casey House, and a member of the Black Physicians’ Association of Ontario, Toronto, Ontario, Canada.

A. Lofters is a family physician, associate professor, and clinician-scientist, Department of Family and Community Medicine, Women’s College Hospital and University of Toronto, adjunct scientist, ICES, and a member of the Black Physicians’ Association of Ontario, Toronto, Ontario, Canada; ORCID: https://orcid.org/0000-0002-7322-0894.

O. Nnorom is a public health and preventive medicine physician and assistant professor, Dalan School of Public Health and Department of Family and Community Medicine, University of Toronto, and president of the Black Physicians’ Association of Ontario, Toronto, Ontario, Canada.

M.D. Hanson is a child and adolescent psychiatrist, Hospital for Sick Children, and professor, Department of Psychiatry, Faculty of Medicine, University of Toronto, Toronto, Ontario, Canada; ORCID: https://orcid.org/0000-0002-8280-4521.

References
3 Robb N. Racism can rear its ugly head at medical school, study finds. CMAJ. 1998;159:66–67.
4 Vogel L. Doctors on their own when dealing with racism from patients. CMAJ. 2018;190:E1118–E1119.
21 Soudat J. Faces of U of T Medicine: The Black Medical Student Association. https://medicine.utoronto.ca/news/faces-


29 Linton S. Taking the difference out of attainment. BMJ. 2020;368:m438.

30 Oliver D. David Oliver: Racism in medicine—what ethnic minority doctors told me on Twitter. BMJ. 2020;368:m484.