

Unsafe learning environments: Indigenous medical students' experiences of racism

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Introduction

Despite an increase in the numbers of Indigenous students studying medicine in Canada (Spencer et al. 2005), very few studies have examined the lived experience of being an Indigenous medical student or graduate, and the impact this has on their personal, professional, family and community life (Spencer et al. 2005; Garvey et al. 2009).

In 2012, the Faculty of Medicine at the University of Manitoba approached the Section of First Nations, Métis and Inuit Health to propose a study on the experiences of Indigenous medical students and graduates so as to better understand the factors that affect course attrition rates.

The purpose of the study was to examine the experiences of Indigenous medical students and graduates at the University of Manitoba, and the influence that being an Indigenous person in this context had on their life. This paper focuses on one particular finding of the research that was universal to all participants — the experience of racism during and after medical school.

Method/Approach

A mixed methods approach was adopted for the study. Quantitative and qualitative data were collected to capture demographic information on participants as well as their personal experiences and perspectives. Following approval from the Research Ethics Board of the University of Manitoba, a recruitment list of eligible participants was generated with the assistance of the university's Faculty of Medicine, Centre for Aboriginal Health Education, and Access and Health Careers Access programs, along with the Indigenous Physicians Association of Canada. The research team then sent invitations to all those eligible. Participant referral was also used, with some of those who agreed to participate and research team members suggesting names of other potential participants for the study. The defined study population was any self-identified First Nations, Métis or Inuit person who was admitted to the University of Manitoba's Faculty of Medicine between 1980 and 2008.

Each participant was asked to fill out a consent form and a demographic information survey, and to participate in an interview. Participant interviews, both in person and by telephone, took place over a five-month period. The interviews followed a semi-structured format to give participants the

opportunity to discuss matters that were important to them, and to encourage them to share their experience of life as an Indigenous medical student and, if relevant, the impact it had had on their life post-medical education. Areas of interest included:

- support systems available to them while at medical school and beyond
- perceptions of their quality of life
- their experiences of racism at and beyond medical school
- the role that their Indigenous identity plays in their experience of being a student and/or doctor.

Each interview lasted from 40 to 90 minutes and was audio-recorded and transcribed. Analysis occurred following the transcription of each interview.

The grounded theory method of inductive coding was used to analyse the qualitative data. As common experiences emerged from the shared stories and reoccurring ideas became evident, they were grouped into themes. These continued to develop when the focus shifted to the qualitative interviews and the critical issues emerging from that data.

Results/Outcomes

Of the 45 potential participants identified and invited to take part in the study, nine responded to the invitation and were recruited. Eight of the nine had graduated from the four-year undergraduate medical program with a modal time of four years and had continued on to careers involving clinical practice, teaching and administration. One participant was still an active student at the time of the interview.

The data from the interviews showed that there were many common or shared experiences of being an Indigenous medical student, including:

- experiences of 'otherness'
- stories of the challenges of studying medicine
- the learning opportunities available to them
- the importance of strength and resilience.

The universal experience highlighted by participants, however, was of racism within the medical school learning environment. Participants reported experiencing multiple levels of racism within the organisational culture of medical school – in both classroom and clinical settings – and felt actively discouraged to challenge or report those experiences. It is this theme of racism, as experienced by study participants, that is the focus of this paper.

One theoretical framework for understanding racism looks at the multi-levels of racism, how each is constructed, the relationship between the levels, and how each impacts upon the individual (Jones 2000). To better understand the various experiences of racism from the Indigenous medical learners' perspective, the study used the three categories of multi-level racism – institutionalised racism, personally mediated racism and internalised racism – as well as racial micro-aggressions.

Racial micro-aggressions

Racial micro-aggressions are often quick and common verbal, behavioural or environmental indignities, said or done either with or without intention in order to communicate hostile, derogatory or negative racial slights and insults towards people of colour or people considered to be of an 'other' racial background (Wing et al. 2007).

Participants described many types of racial micro-aggressions including the following assumptions they experienced as an Indigenous medical student:

- medical school expenses of Indigenous students are paid for
- Indigenous students do not have to meet the same medical school entrance requirements and are, therefore, less qualified
- Indigenous students are experts in 'all things Aboriginal'
- targeted admissions processes confer an unfair advantage on Indigenous students
- Indigenous students are 'too sensitive'.

Institutionalised racism

Institutional racism can be understood as differential access to the goods, services and opportunities of society by race, or unearned privilege, and is manifested both in material conditions and in the access to power (Jones 2000). The pressure to assimilate within the dominant Western medical culture is one example of institutional racism. Such an attitude is supported when racist behaviour is tacitly permitted by the absence of any reporting mechanisms to senior authorities within the institution that are perceived as safe or effective.

Although 100 per cent of study participants described experiencing racism within the medical school environment, only two tried to challenge racism as a learner. Others expressed regret at not having challenged the racism they experienced, but felt unsafe to do so:

You can't be an Aboriginal person in medicine you have to be mainstream. And if you're not you're going to sink quickly. (P7)

I certainly observed many episodes of racism. And I did nothing about it... because I think when you're a student you're still so low down on the food chain that you don't really speak up against authority and you don't challenge people. (P2)

I think definitely that racism within our Faculty is so prevalent and so obvious it's really traumatising. (P7)

Personally mediated racism

Personally mediated racism involves prejudice – differential assumptions about the abilities, motives and intentions of others according to their race – and discrimination – differential actions towards others according to their race (Jones 2000). Indigenous medical student experiences of personally

mediated racism range from rude and ignorant comments from peers or faculty members to life-threatening examples. One participant commented:

Like when people would say really mean things and so it's like what [to] do in a hierarchical structure like when I was a third year student [on] my obs rotation and the senior resident said... in a room... just a small room not much bigger than this with... five or six medical students and residents in it... and she was the senior, [she] said that the best thing for Canada would be if native people stopped reproducing. Well considering [the] hierarchical structure where most people know that most of the time it's the senior residents who fill out your evaluations and you know the program directors are going to defend their senior residents. And anyone who complains is a trouble maker. (P5)

Another former medical student told the story of how she observed and experienced extreme racism in the hospital setting when her father had had a heart attack. Alerted by family that her father had gone to the hospital emergency room, upon her arrival the doctors attending him did not know she was the daughter of the patient; they assumed she was there because she was working.

... my dad had a breathing tube in and he was hooked up to a IV and a whole bunch of monitors and he's sitting on the edge of the bed trying to fight a bunch of people off who are trying to force him to lie down. He was not sedated which is standard of care for people who are intubated. And... I looked at the emergency doctor... and said: 'Why is he not sedated?' And he said: 'Because we didn't know what he was on.' Like they just assumed... he had a cardiac arrest because of intoxication of some kind or other, [but] your first assumption should be heart attack until proven otherwise. Because he was also visibly First Nations the[ir] first assumption was he's high or drunk on something.

So I looked at the respiratory therapist and said: 'Does he need to be intubated?' He said: 'Yes'. I looked back at the emergency room doctor and I said: 'Sedate him now'. And so they did. And then I said, 'What did the [electrocardiogram] show?', again because cardiac arrest is a heart attack until proven otherwise. And he said: 'We didn't do one'. And I said: 'Why not?' And he said: 'He was fighting too hard'. As if he was not sedated because he was drunk or high so he was uncooperative and fighting so were not going to get him any real medical care. And so I said: 'Well you better call them now'.

So they called the [electrocardiogram] down, that took a couple minutes. The [electrocardiogram] tech also knew me... and I don't think realised it was my dad [but] also thought I was just working. Printed off the [electrocardiogram] and handed it to me while the emergency doctor was still standing across the bed... dumbly and now it's silent in the room right because everyone knows that they've been caught in this. And he's having a massive heart attack.... and so I hold it around because it's not the kind of thing you need to see close up to know that he's having a massive heart attack.

And I said: 'Who's going to call the cath lab?' to the [emergency doctor]. And he was just dead silent and he didn't even have an answer. So I just looked at... my friend and said: 'Can you call Dr XXXX please'. Because I knew... exactly who was on call that night for caths and so Dr XXXX was called, I stayed in the room with my dad until he was transferred. I was the one who went

and talked to my family about what was going on and how sick he was because there was no way I trusted that doctor to do it. Plus now he was just terrified because he had delivered substandard care that put my dad's life even at more risk than it already was because of that heart attack that he was having. (P6)

This participant had been deeply impacted by the racism inflicted upon her father in the emergency room. Years later, as she told her story, she was still impacted by the lasting trauma of the incident. It affected her relations with colleagues, her trust in other medical professionals and her trust in the medical system. Never had she been given an opportunity to share her story. Instead, it remained internalised among the many other instances of racism she had experienced as an Indigenous medical student. Despite the trauma, she found the strength to continue on and complete her residency. And she was finally able to share her story when she was asked about her experience of medical school as an Indigenous learner.

Internalised racism

Internalised racism involves acceptance by members of stigmatised races of negative messages about their own abilities and intrinsic worth, which is characterised by not believing both in others who look like them and in themselves (Jones 2000). It was not uncommon for participants to describe internalised racism in their discussions about being Indigenous. Comments included the following:

When I was growing up I actually really believed that it was better to be white... as a child I used to wish for... you know, blonde hair. I used to wish for blue eyes. I used to wish that my family wasn't poor. (P1)

My background is Métis but we didn't know that... because... it was not something my grandma wanted anyone to know or [we] even talked about. (P2)

I looked at the ground because I was sure that if I looked you in the eye you would see nothing. You would see emptiness. (P4)

We might be Indians but we're not like the rest of them. (P5)

Discussion

The data show that Indigenous medical students' experiences of racism regularly impact on their lives from admission through to graduation and beyond. This is because the structural hierarchy evident in medical schools and clinical settings embeds racial power imbalances, and fosters, as a consequence, oppression and disadvantage for Indigenous students. Although there is a body of literature that describes the recruitment options and student support systems available to Indigenous medical students, with the aim of increasing the numbers of Indigenous physicians (IPAC & AFMC 2008; Spencer et al. 2005), these do little to address the structural and systematic violence that Indigenous learners experience in the medical school and learning environments. This violence, represented by the universal experience of racial micro-aggressions and racism, must be addressed as an ethical and rights-based imperative if the successful graduation of Indigenous medical students is to increase.

The data also highlight the critical need to turn the gaze from the students as the primary or sole source of academic or social difficulties to the structure, policies and discourses of the faculty that create an unsafe learning environment for Indigenous medical students. Razack et al. (2015) suggest that the current approaches of medical schools to diversity hamper their efforts to produce Indigenous physicians. Instead, they produce physicians who happen to be Indigenous. In other words, students are forced to abandon their Indigenous identity in order to succeed.

We believe that it is essential that we graduate Indigenous physicians – those who champion their Indigenous identity and context as important to their professionalism. It is a view consistent with the Royal Commission on Aboriginal Peoples (Hurley & Wherrett 1999) and the message emerging from communities who wish to be seen both by an Indigenous health care provider and as Indigenous peoples within the context of an Indigenous perspective on wellbeing.

The following recommendations from this study have been submitted to the College of Medicine at the University of Manitoba to address some of the root causes of the current unsafe learning environment:

- The need for a critical review of all written material that references ‘Aboriginal applicants’ in the medical curriculum.
- Transparency about the rationale for a separate stream on Aboriginal health.
- Transparency on the requisite information being evaluated for applicants to the Aboriginal separate stream.
- The need to address student and staff perceptions of the status of Indigenous as compared to non-Indigenous medical students.
- Faculty education to redress biases that are being transmitted to learners.
- The introduction of a course requirement that involves a critical examination of historic or contemporary Indigenous issues so as to increase the baseline knowledge of all medical students, to reduce peer bias and to decrease the need for Indigenous medical students to play the role of expert.

Current Faculty education on Indigenous issues – including racism, reconciliation and Indigenous ideologies and methods – has increased and been positively attended, and efforts are being made to move forward with all recommendations from this research.

Continued challenges, however, include resistance to change both by students and faculty, difficulty in obtaining access to student files to better understand the rates of attrition and other factors impacting upon the lives of Indigenous medical students, and lack of funding to support programs to train more Indigenous learners and staff. Further research needs to be conducted with Indigenous medical students to hear and record their shared experiences so that others can also understand the impacts of medical school on the lives of Indigenous learners. Further, without the full support of the College of Medicine, the research team was unable to use student records to collect information on graduation rates of all identified potential participants. However, analysis of this information is crucial for a better understanding of why Indigenous students do or do not graduate from medicine.

Conclusion

In these stories from former medical students, we find evidence that Indigenous learners experience various forms of racism within the medical school learning environment. Little has been described in the literature to date as to how these issues should be addressed. This study highlights the need for an ethical and rights-based approach to combatting racism and racial microaggressions if the successful recruitment and graduation of Indigenous medical students is to occur.

From the data it is evident that First Nations, Métis and Inuit people experience significant socially constructed barriers that have an impact on Indigenous medical students. A commitment has been made by the University of Manitoba to address these barriers, thereby effectively acknowledging these experiences as harmful and detrimental to advancing a healthy First Nations, Métis and Inuit health care workforce.

An example of this are the findings from the Truth and Reconciliation Commission of Canada's final report in December 2015 on the history and experiences of the Canadian residential school system for Indigenous children (TRCC 2015). Included in the report are 94 Calls to Action that must be made to redress the legacy of residential schools in Canada and to work towards true reconciliation. The continuing push to end to all types of racism experienced by Indigenous medical students resonates with the Calls to Action of the Truth and Reconciliation Commission as a step towards healing and self-determination.

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