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Roberta Soares, Marie-Odile Magnan, Yifan Liu, Margaret Henri and Jean-Michel Leduc

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Results: Our analysis reveals these experiences of racism occur in academic and clinical settings (classes, internships, social interactions with peers, faculty, and patients, and through the curriculum), in the form of microaggressions. The analysis also indicates that Black students and residents try to cope with racism using a hyper-ritualization strategy to better fit in (e.g., clothing, behaviours).

Conclusion: Considering that Black students and residents experience various forms of racism (subtle or explicit) during their medical training, these findings urge us to increase awareness about racism of students, residents, teachers and health care workers in universities and teaching hospitals. Pathways to increase the representation of Black students and residents seem to be part of the solution, but improving the learning environment must be a priority to improve racial justice in medical training in Québec.

Canadian Medical Education Journal

*Original Research*

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## Expériences de racisme des étudiants et des résidents noirs en médecine à Montréal : « Je porte mon stéthoscope autour de mon cou en tout temps »

*Roberta Soares,[1] Marie-Odile Magnan,[1] Yifan Liu,[2] Margaret Henri,[1] Jean-Michel Leduc[1]*

[1]Université de Montréal, Quebec, Canada; [2]University of Toronto, Ontario, Canada

Correspondence to: Roberta Soares, 90 Avenue Vincent d'Indy, bureau C-506 Montréal, Québec, Canada H2V 2S9;
email: roberta.de.oliveira.soares@umontreal.ca

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## Abstract

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## Résumé

**Contexte :** Les étudiants et les résidents noirs sont victimes de racisme dans les facultés de médecine. Cette étude qualitative documente les expériences de racisme des étudiants et des résidents noirs à l'aide de la théorie critique de la race (TCR) et explore leurs mécanismes d'adaptation à l'aide de la métaphore théâtrale.

**Méthodes :** Nous avons mené des entrevues semi-structurées avec quatre étudiants et résidents noirs en médecine (deux étudiants en médecine et deux résidents) étudiant à Montréal et analysé leurs expériences par le biais de contre-récits. Nous avons identifié des thèmes liés à leurs expériences du racisme pendant la formation médicale et à leurs mécanismes d'adaptation.

**Résultats :** Notre analyse révèle que ces expériences de racisme se produisent dans les milieux universitaires et cliniques (cours, stages, interactions sociales avec des pairs, des membres du corps professoral et des patients, et dans le cadre du curriculum), sous la forme de microagressions. L'analyse indique également que les étudiants et les résidents noirs tentent de faire face au racisme en utilisant une stratégie d'hyper-ritualisation pour mieux s'intégrer (par exemple, vêtements, comportements).

**Conclusion :** Étant donné que les étudiants et les résidents noirs sont confrontés à diverses formes de racisme (subtil ou explicite) au cours de leur formation médicale, ces résultats nous incitent à sensibiliser davantage les étudiants, les résidents, les enseignants et les travailleurs de la santé au racisme dans les universités et les hôpitaux universitaires. Les parcours visant à accroître la représentation des étudiants et des résidents noirs semblent faire partie de la solution, mais l'amélioration de l'environnement d'apprentissage doit être une priorité pour atteindre la justice raciale dans la formation médicale au Québec.

# Introduction

The experiences of Black students and residents as a racialized group in medicine have received academic attention in Western countries, highlighting experiences of racial discrimination.[1,2] More precisely, during medical school training, Black students and residents reveal that they feel excluded by their peers,[3] experience microaggressions and overt racism.[4,5] Microaggressions are defined as "brief and commonplace daily verbal, behavioural or environmental indignities… hostile, derogatory or negative racial slights."[6(p271)] Some studies also reveal that Black students and residents, during their medical careers, face institutional racism through admission policies, assessment standards and modalities, and curriculum content.[7]

Experiences of racism by medical students and residents can cause stress and anxiety, which in turn can affect their academic performance and erode their sense of belonging.[2] Some research has highlighted the fact that Black students and residents feel minoritized, socially isolated, and perceived as intellectually inferior by part of their white peers and professors.[8,9] In the hospital environment, Black students and residents report negative experiences related to belonging to a racialized group in their interactions with patients. They are even occasionally confronted with hostility and overt racist and hateful remarks from white patients.[3] They also report microaggressions related to their skin colour, name, or presumed religion.[3]

In Canada, quantitative surveys have also demonstrated the under-representation of Black students and residents in medical schools.[10–12] Recent survey data from English-speaking medical schools in Canada estimated that the proportion of Black students and residents was 1.7%, compared to 6.4% for the total Canadian population.[11,13] In the province of Québec (the French-speaking province of Canada), the proportion was estimated to be 1.2% in 2019.[13]

Although there is research on Black students in higher education in Québec,[14,15] to our knowledge no qualitative studies have specifically addressed their experiences in medical schools. Given that several Québec medical schools have recently established access programs to increase the representation of Black communities in medicine, it is important to have a clear understanding of the learning environment of these future physicians to enhance the safety of the learning environment. [16] In addition, existing research does not explore how these students and residents adopt strategies to address racism experienced in social interactions with peers, faculty, and patients.

In this study, we therefore addressed the following research questions: What is the experience of racism in medical school by Black students and residents in Montréal, Canada? What are some coping mechanisms or strategies that are enacted by the students and residents?

## Theoretical framework

Our theoretical framework is anchored both in Critical Race Theory (CRT) and in sociological concepts used by Erving Goffman. Although there are many definitions of race, most researchers agree that race is a socially constructed category.[17,18] The social construct of race leads to a racial hierarchy that normalizes white superiority and contributes to maintaining racism.[19–21] Since racism can be experienced by different communities, in our research we put our focus on anti-Black racism.[22] Based on a constructivist interpretation of race, CRT is widely used in the field of education to analyse the inequalities that affect young people from racialized groups during their educational journey.[23] Due to how colonialism has historically developed, racism is spread structurally, institutionally and is present in people's daily lives.[19] In fact, according to CRT, microaggressions occur subtly in routine daily activities and tend to not be questioned by the majority groups.[6] Experiencing these microaggressions on a daily basis can lead to a cumulative burden that contributes to feelings of poor self-confidence and isolation which impede personal integrity and could create mental exhaustion.[24]

CRT also highlights oppressions in school experiences.[25] Considering that the people who best understand racism are those who are routinely victims of it, experiential knowledge that directly identifies racism can be shared in a variety of forms, including stories, interviews, and family histories.[26] By sharing their personal and collective experiences of racism, individuals from racialized communities create counter-narratives to the dominant ideology.[27] By shedding light on and analyzing the oppressions (i.e., racism) suffered by racially marginalized groups, CRT is committed to fighting for social justice.[25,27]

We also use sociological concepts by Erving Goffman to understand participants' reactions to racism in social interactions.[28] The inductive analysis of data led to an understanding of strategies put in place by students and

residents to address racism in their medical training. In that sense, Goffman's concepts can help the analysis of racism according to the perspective of CRT. Goffman seeks to understand how individuals present themselves in face-to-face interactions through the use of the theatrical metaphor, which analyzes interactions by considering the existence of a stage, backstage and individuals as social actors. Social actors use expressive tools or props to build their façade during a performance (e.g., clothes) and inform the audience of their attributes (e.g., social class, gender, race).[29] For Goffman, the interaction rituals include the existence of *deference* and *demeanour* that are expected of individuals during interactions, that is, respect for each other and adherence to ceremonial rules in terms of conduct, dress, and attitude. The social meaning of interaction rituals comes from the cultural codes shared by individuals.[30] The presentation of the self is related to the existence of different "stigmas" established in society. For Goffman, some types of stigmas can be hidden in interactions while others cannot, that is, some information can be hidden or unknown (e.g., sexuality) and others visible or known (e.g., skin colour). In fact, visible or known stigma is more difficult to manage. In this case, individuals must deal with the tension in social interactions.[31]

Goffman also created the concept of *hyper-ritualization*, embodied by display. The display of social categories (e.g., gender or social class) works as a ritual marker of belonging to these categories. Thus, the hyper-ritualization of social categories is put in place to try answering to social expectations during interactions and allow the development of trust.[28] According to Goffman, in society, it is necessary to have evidence of alignment between how an individual presents and the expectations of society. In other words, individuals are expected to conform to ritualized ways of presenting themselves publicly[28] (e.g., wearing a white lab coat as a doctor). Otherwise, they might not be recognized by society in the intended social role.

# Methodology

In this article, we used critical race methodology in education, that is, a methodology that takes into consideration the role of racism, which is frequently ignored in other types of methodologies, intertwined with other social categories such as social class and gender.[32] Thus, in critical race methodology, racism is considered in all steps and aspects of the research process in intersection with other social categories.[32] Since methodology concerns the approach that guides the research, unifying theory, and method, we can affirm that critical race methodology is grounded in critical race theory. Therefore, how data was gathered and analyzed was done from that standpoint.[33]

## Data collection

We conducted semi-structured interviews[33] with Black medical students and residents. The interview guide was designed through an iterative process by a team from various social positions and included the following themes: family experiences (childhood and adolescence); academic path (elementary school, secondary school, and college), choice of university career, university experience, and career aspirations. Those themes allowed us to better understand the participants' university experience. Additionally, we began by answering the participants' questions about the research to foster an environment of trust. The recruitment was carried out using social networks (e.g. Facebook) and the snowball sampling technique. That is, we posted a call for participation in different university groups related to the subject and we asked participants to indicate other individuals who might be interested in participating in the research. The recruitment criteria were: 1) to be enrolled in a medical program in Montréal; 2) to be 19 to 35 years of age; 3) to self-identify as Black. Each interview was conducted online (on Zoom), recorded and lasted approximately 90 minutes and was done in either French or English (depending on the participant's preference). A member of the research team, who has experience in conducting semi-structured interviews, self-identifies as a minority student and is not involved in medical school or medical training performed all the interviews.

We aimed to document participants' experiences as people belonging to racialized groups. In general, stories are told and analyzed from the perspective of majority groups, which tend to minimize the experiences of racialized groups.[32] In that sense, *counter-stories* are necessary, that is, the narration of the stories of people from racialized groups that tend to be ignored compared to the dominant narratives of majority groups. As part of the counter-stories data collection, students and residents shared mostly personal stories, but they also mentioned the stories of other students and residents they knew who had similar experiences.

### Data analysis

Interviews underwent verbatim transcription. We chose to conduct an inductive analysis, that is, the theoretical framework was chosen after having collected the data to be sure to choose a relevant framework for analysis.[34] This was done after discussions and coding with all members of the research team, the coauthors, who come from different social positions. This ensured rigor in line with the critical epistemological perspective. More precisely, we have conducted an inductive thematic analysis in which we identified recurring general themes in order to create a thematic tree with central and associated themes.[35] The themes and subthemes presented in the results section were created according to the analysis of the interviews (the participants experiences). In this case, it was based on Black students' and residents' university experiences, that is, codes concerning their school trajectory and their discrimination experiences in university (e.g., microaggressions, racism in internships, racism at university, coping strategies), although experiences prior to medical school were discussed as well. Most of the data were coded by two members of the research team, but themes were discussed with the whole research team through an iterative process with regular meetings. The analysis and initial coding were conducted in French and relevant quotes were then translated into English for this article with the help of a professional translator.

To ensure rigor in qualitative research from a critical epistemological perspective, in accordance with the critical race methodology, it is necessary for the researchers to consider their roles during the conduct of the research (from research design to dissemination of results). [36,37] In that sense, their positionality in terms of their social attributes as well as their ideologies need to be considered since they influence how research is conducted.[38] The coauthors share a belief in equity and social justice which can only begin by the exposing of the workings of oppression systems such as structural racism, which is the goal of this article. [32] Concerning positionality of the coauthors in relation to the theme of this article, two coauthors are doctoral students who identify as minority students in Canada in terms of race, language, and immigration status; one coauthor is a professor in the faculty of medicine who identifies as Black; and two coauthors are professors who consider themselves privileged in terms of the social categories analysed in this article, one in the faculty of medicine and health sciences and one in the faculty of education. Therefore, the expertise of the coauthors as well as their experiences in terms of privileges and oppressions are complementary and allowed for a rich exchange on the subject during the inductive analysis and the choice of CRT and Goffman's concepts for the theoretical framework.

The study was reviewed and approved by the Multifaculty Research Ethics Committee of Université de Montréal (*Comité plurifacultaire d'éthique de la recherche*, Certificate number 435-2017-0422). Accordingly, pseudonyms have been assigned by the researchers to the participants for publication of results.

## Results

A total of four (4) participants were interviewed, including three (3) women and one (1) man. Two were current medical students and two were residents. Three had parents who were born outside of the country. Two participants were born in Québec, one arrived in elementary school, and one arrived in secondary school. All four participants had at least one parent who had a university degree. We also inform readers that, apart from the precautions taken to assure the anonymity of participants, the pool of Black medical students and residents in Montréal is high enough to ensure that participants were not identifiable.

### University experiences

Based on our analysis of their experiences, the following themes were identified: experiences of racism, both at university and in clerkship and internship settings, and hyper-ritualization strategies to address racism in medical training in universities and hospitals.

### Experiences of racism in medicine during medical training

***Jokes and comments.*** Students and residents reported the existence of racism in medicine at university through various forms: in interactions with peers and faculty members, in evaluations and in the curriculum. According to their testimonies, racism influenced the way others looked at them. They recounted how the legitimacy of their place in the medical program was questioned in different ways by peers, faculty, and patients.

Students and residents reported experiencing racism through microaggressions in the form of jokes or comments. Gaelle gave a few examples:

> *The derogatory comments all the time from friends who say like 'I won't leave you the keys to my car, so you won't steal it' or 'how was it for you growing up in*

> *the ghetto?' But I didn't grow up in the ghetto, why would I grow up in the ghetto? In short, stereotypes about Black people: 'you want fried chicken for lunch?' [Gaelle answers, as if in response to her friend:] 'You allow yourself to make these comments because you find it funny, but it's not funny.'* (Gaelle)

Gaelle pointed out how these jokes tended to be insidious and unchallenged:

> *But it was all about jokes, that's what was also problematic, that discrimination at the university level, by peers. It was never, 'you're Black, so you're disgusting' or 'you're Black, so I don't like you.' It was always, 'Haha, I'm just kidding, I make jokes with racial tones, I make jokes that sound discriminatory. I'm going to make comments; yeah, but you're not like the other Black people, you're cool.'* (Gaelle)

Sometimes, microaggressions were linked to misconceptions about their place of origin. For example, a peer asked Mariam about pregnancy:

> *'In your culture, does the direction that the belly points in mean anything?' I said, 'No, personally, I've never been spoken to about it, I don't feel like it's something that's really in my culture,' whatever. Then she said, 'Ah, you'll have to learn a little more about your culture.'* (Mariam)

Mariam and residents also mentioned the existence of racism from professors during internships: "Obviously, I'm the only Black person, and then this professor just finds it acceptable to explain to the group how Black patients are unreliable, for reasons that were again ultra-stereotyped and very vague." (Gaelle)

***Assessment and curriculum content.*** With respect to racism in assessments, Mariam shared these feelings:

> *I look at my evaluation, it doesn't fit, and in the end, I realize that there are other Black people that [the professor] has poorly evaluated. So, in the end I end up asking myself, like: 'okay, was it me who performed less well, is it because I'm Black?'* (Mariam)

In connection with racism in the curriculum, Nadia talked about how case studies are used in the courses, "It's like, ah, all Black people have hypertension" (Nadia). Gaelle has the same impression: "We were never taught about Black people having colds, for example" (Gaelle). She continued: "Black patients are this, Black patients are that. This was ultimately encouraged by the faculty because, in problem-based learning, there were a lot of stereotypes, really a lot" (Gaelle).

***Lack of representation and imposter syndrome.*** According to the participants, their place in the medical program was questioned in different ways, as people found it hard to believe that they were medical students and residents. Some peers judged their competence: "When I arrived in medicine, I was surprised because many people thought that I had gotten in because of a quota. A quota for Black people" (Samuel). He explained that this "surprise" was related to a lack of representation of Black students and residents in medical schools: "I was the only Black man in my class. In the entire program of 300 students, there were three Black people" (Samuel). He pointed out that even Black people were surprised to be around a Black doctor; they would have had internalized the image of the white doctor: "…the first time I saw a Black doctor, I was 22 years old. And I had assumed that she was the secretary, in fact" (Samuel). In this context, students and residents reported that professors and co-workers assumed at first that they could not be doctors. "There are times when I've arrived in a patient's room, the nurse was there, and she pointed at the garbage can" (Gaelle). Similarly, they reported that patients tended not to believe they were student or resident physicians:

> *There are microaggressions that come from patients. A typical example is that I get mistaken for an orderly because I am Black. When I call patients on the intercom, to tell them for example, Mr. … I don't know, 'Mr. Tremblay room 13.' When Mr. Tremblay arrives in room 13 and he sees that it is a Black person, well, Mr. Tremblay can't imagine a Black person being a doctor. So, Mr. Tremblay will say 'oh, I'm sorry, I'm in the wrong place, I got the wrong room.'* (Samuel)

In fact, both inside and outside of university, students and residents reported that people did not believe they were in medical school:

> *Me, when I say I'm in medicine, I swear to you, it happens to me all the time…. People ask me after, 'so you're going to be a nurse?' That's their question. I have to tell them three times. […] All the time, all the time, they're not able to connect that I'm going to become a doctor, that's something I've really noticed, even from strangers on the street, like anywhere.* (Nadia)

The lack of representation and the disbelief that a Black person could be a doctor generated imposter syndrome: "This is something that has created a sort of imposter syndrome. The impression that it wasn't my place, […] on several occasions I wondered whether it was a mistake for me to be there" (Samuel). Samuel emphasized: "we absolutely must increase the number of Black people in medicine." He noted, as well, the importance of this representation for Black patients: "It will have an impact on the quality of patient care, because patients feel safer when they receive care from people who look like them" (Samuel). In fact, some patients pointed out how important it was for them to be there:

> *Patients have said to me many times, 'We're really proud of you, we're proud that you can be in this environment, you're really rare,' things like that. So, it's not just doctors who realize there are no Black doctors, even patients realize that there are no Black doctors.* (Mariam)

This type of situation made Mariam feel privileged to be able to be a doctor, but she also felt more pressure as a Black doctor: "[I felt] really privileged. And that put extra pressure on me, because already, we don't want to make mistakes, but then you're like, 'I really don't want to make a mistake.'" (Mariam)

***Intersection with other social markers.*** In addition, students and residents recounted that it was not only about being Black, but also about being an immigrant and having other attributes that generated an accumulation of oppressions linked to different social categories (e.g., social class, sexual orientation, gender identity). Samuel said, "I always feel that I'm… disadvantaged there. It's the fact that I am a Black man, that I am an immigrant, there is also the fact that I come from a disadvantaged background" (Samuel). As a Black woman, Mariam also felt this accumulation when interacting with peers in classes, but she considered it "the usual": "There were the usual gender microaggressions, like comments about hair, about the looks of Black women, stuff like that" (Mariam). She mentioned a situation of blatant racism during her residency: "There have been some bosses who are like 'Black women, they have big butts.' The person told me this in front of several people. 'Get up, we'll see, do you have a big butt?'" (Mariam).

### Hyper-ritualization strategies for dealing with racism

To address racism and microaggression in social interactions, students and residents reported using hyper-ritualization strategies related to clothing, the use of props, and behaviour. They felt the need to meet professors' expectations by working harder: "I have to push myself more because I am always afraid […] that if I do not meet the standard, I will be treated in a way that is really harder than another colleague who is white, for example" (Samuel). He added, "I always felt that I had to do a lot more than the average to be truly irreproachable at all levels." (Samuel)

As for Gaelle, she mentioned the importance of "always" wearing clothes and accessories to identify herself as a doctor, such as her white coat, identification, and stethoscope. She pointed out that she always wore her stethoscope around her neck even if it caused physical pain:

> *For me, it's extremely important to wear my scrubs, it says on my scrubs: 'Doctor [her last name].' It's an additional identifier that limits the chances that people will confuse me for something I'm not. I also wear my stethoscope around my neck at all times. All the time, all the time, all the time. And it hurts my neck, it really hurts the neck, a stethoscope, but I wear it because it's also, again, an additional identifier that limits the chances that I'm mistaken for something I'm not. It means that when I introduce myself to a patient, some people will say 'ah, but it's pretentious of you to introduce yourself as a doctor, etc., etc. when you're just a resident.' I earned my title, I'm now allowed to use it, I say it every time because, if I don't say it, the patient thinks I'm his nurse or thinks I'm the orderly.* (Gaelle)

However, these hyper-ritualization strategies did not always seem to work:

> *I remember one time I walked into the room, literally six seconds after the last student, six seconds. I open the door and I go into the room. I go in so that we can all sit together, and I have my lab coat, I have my stethoscope, my lab coat, which is clearly written, "[her name], Faculty of Medicine." I have my stethoscope around my neck, my colleagues recognize me, and the professor just asks me: 'Are you sure you're in the right place?' Why? But why is that? But then they'll say, 'Yeah, but maybe he thought you weren't in the right group.' There weren't several groups that day, there was only one group.* (Gaelle)

# Discussion

Students and residents in this study reported experiences of racism and microaggressions in their training in medicine in universities and hospitals. Like other research, our data show that experiences of racism are reported in the evaluation,[39] the curriculum,[5,7] interactions with peers, faculty,[1–3] and patients.[40] Our analysis also shows the impacts of a lack of representation of Black students and residents in medical programs,[10,11] generating self-questioning about their place in the programs. This self-questioning is amplified by microaggressions, and sometimes overt racism experienced in their training.

The question of perceived differences in assessment raises the subject of differential attainment due to unconscious bias and overt racism. Woolf demonstrated that this differential attainment was still observable in medical training,[41] and participants in our study could have likely perceived this as an unjust situation.

Microaggressions, in the form of racist jokes,[42] were part of the daily lives of students and residents interviewed in this research. The socially constructed superiority of white people[19] was reflected in students' and residents' daily lives, since their legitimacy in the medical program, as Black doctors, was constantly questioned directly or indirectly by peers, faculty, and patients. The social construct that a doctor would be white was present daily in interactions and even internalized by some Black students and residents in our study. This shows how the socialization of race has affected the overall system and not just individuals. It highlights the role of colonialism and institutional and structural racism that also might have led to these experiences of racism–in a context of institutional whiteness, more specifically anti-Black racism.[43]

In relation to expectations regarding deference and demeanour of individuals during social interactions[30] in the field of medicine, students and residents seemed to use hyper-ritualization[28] strategies in terms of behaviour, clothing, and props to cope with racism and microaggressions. Students and residents reported feeling the need to try and prove on a daily basis that they were medical students and residents to counter the social representation of the "white doctor." They used hyper-ritualization, for example, guaranteeing that they were always dressed in a lab coat or choosing to wear the stethoscope around their neck at all times so that they did not have to explain every time that they were doctors, and they thus reduced the chances of dealing with surprise reactions from peers, faculty, and patients. However, this strategy of hyper-ritualization seemed to work sometimes, but not always. This could be explained by societal expectations about the social role of "physician." Indeed, to be considered a doctor, it is necessary to look and act like a doctor, or in other words, to behave and dress like a doctor, to set the "stage," as Goffman would say (e.g., diploma on the wall, white coat, stethoscope around the neck). These "dramaturgical" elements give coherence to the figure projected by the doctor. These are manifestations of belonging to a social role.[44] In fact, the patient has expectations about what a doctor should be. When the patient meets with a doctor who does not meet expectations, there is a break in expectations, and this can generate a lack of trust. For example, most doctors would avoid wearing tank-tops, flip-flops and using slang; otherwise, the patient may not believe or trust them.[44] Our study highlights additional expectations in terms of race, gender, social class and migration. The data collected from participants point out that society does not seem to expect, for example, a doctor to be Black. In this case, their competence and belonging seem to be challenged in daily interactions. To respond to this, the students and residents interviewed tried to use hyper-ritualization to match the expectations of society in terms of behavior, clothing, and props.

As we have pointed out, hyper-ritualization[28] helped sometimes the students and residents, but it did not always work. We might theorize that this is due to the unequal race-related power relations highlighted by CRT.[18] Even if a peer, faculty member or patient saw evidence of the physician role (e.g., wearing the white coat and stethoscope, being in the doctor's office), they believed in some cases that there was a mistake based on their perception that a doctor could not be Black. Due to power relations, some situations are considered more legitimate than others, depending on who has the authority to propose and enforce a definition of the situation (e.g., a white doctor does not have to hyper-ritualize his presentation as a Black doctor does).[45]

Moreover, the racism present in these situations can affect the *identity*[31] of medical students and residents as doctors, both in how they see themselves and how others perceive them. According to Goffman, when an individual has a visible or known stigma, their other attributes tend to fade, [31] which is the case for students and residents in our study, since race seems to be the most important social category in these interactions. That is, Goffman takes into

consideration how different attributes can be taken as negative by individuals. Our analysis, based on CRT, also makes it possible to highlight the existence of the intersection of social categories (e.g., race, gender, social class and migration) that generate the intersection of privileges and oppressions,[46,47] since the excerpts presented also showed that gender combined with race and social class influenced students' and residents' interactions. Given these results, it would be interesting to explore the intersection of social categories more directly in future research, in particular by mobilizing the theory of intersectionality.[46,47]

### Limitations

One limitation of this study is the recruitment targeting the Montréal area, which comprises two medical schools and a vast network of teaching hospitals. Arguably, the reality of Black medical students and residents may be different in other parts of Québec or Canada. However, we must highlight that the area of Montréal is the city with the highest representation of Black people in the whole province. Although our recruitment was done in Montréal, we nevertheless believe that the elements mentioned by the students and residents in our study are comparable to the realities described in other contexts, such as the Canadian one, making several observations likely transferable to other institutions. Another limitation is the small sample size, which may not have allowed us to fully reach theoretical saturation. However, we must argue that the technique of counter-stories allows us to draw valid observations, as theoretical saturation was not our goal in this case–the goal being to listen and to analyze the narration of the stories of people from racialized groups that tend to be ignored compared to the dominant narratives of majority groups. Moreover, we were careful to obtain testimonies from both current and past medical students and residents, increasing the variety of perspectives collected in this study. In addition, the use of the concept of hyper-ritualization helped us to better understand how individuals face an environment that can sometimes be hostile, where representations of the "white doctor" are still omnipresent and considered to be the reference point. Therefore, the results are not representative of a population, but that is also not the aim of a qualitative research based on counter-stories. The goal of this study is to encourage reflection by highlighting the experiences of a group of people who are often invisibilized.

### The way forward

In accordance with our data, some measures could promote fairer university experiences in Québec for Black medical students and residents. Part of the solution starts with a better representation of Black communities in medicine, so that admitted students and residents are no longer considered "exceptions" or "rarities" (as Samuel mentioned). Thus, a just representation of Black communities at all levels (students, residents, professors, health professionals) is urgently necessary.[15] In teaching and care settings, we suggest that peers and faculty be made aware of the existence of racism and microaggression through training workshops where some of the described experiences cited here could be used to enhance the conversation and provide concrete examples.[48] Dedicated support resources should also be available to people experiencing racism and some of the possible consequences of these situations (e.g., anxiety, depression). Mentoring and supporting Black communities can also contribute to a sense of belonging by creating counterspaces. Counterspaces are spaces on the university campus where students and residents are able to preserve and develop a sense of belonging by aligning with students and residents who share their experience. These spaces can contribute to a feeling of comfort, which helps to reduce the alienation that students and residents belonging to racialized groups may experience on the university campus.[49,50] Therefore, our data suggest that, although progress is currently being made regarding the representation and inclusion of Black people in medical school and residency programs, there is still a lot of work ahead of us to create welcoming and anti-racist environments, in universities and in hospitals.

## Conclusion

Considering that Black students and residents experience various forms of racism (subtle or explicit) during their medical training, these findings urge us to increase awareness about racism of students, residents, teachers and health care workers in universities and teaching hospitals. Pathways to increase the representation of Black students and residents seem to be part of the solution, but improving the learning and working environment must be a priority to achieve racial justice in medical training in Québec.

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# References

1. Hill KA, Samuels EA, Gross CP, et al. Assessment of the prevalence of medical student mistreatment by sex, race/ethnicity, and sexual orientation. *JAMA Intern Med.* 2020;180(5):653–65. https://doi.org/10.1001/jamainternmed.2020.0030
2. Orom H, Semalulu T, Underwood W. The social and learning environments experienced by underrepresented minority medical students: a narrative review. *Acad Med J Assoc Am Med Coll*. 2013;88(11):1765–77. https://doi.org/10.1097/ACM.0b013e3182a7a3af
3. Kristoffersson E, Rönnqvist H, Andersson J, Bengs C, Hamberg K. "It was as if I wasn't there" – Experiences of everyday racism in a Swedish medical school. *Soc Sci Med*. 2021;270:113678. https://doi.org/10.1016/j.socscimed.2021.113678
4. Espaillat A, Panna DK, Goede DL, Gurka MJ, Novak MA, Zaidi Z. An exploratory study on microaggressions in medical school: what are they and why should we care? *Perspect Med Educ.* 2019;8(3):143–51. https://doi.org/10.1007/s40037-019-0516-3
5. Hariharan B, Quarshie LS, Amdahl C, Winterburn S, Offiah G. Experiencing racism within medical school curriculum: 2020 ICCH student symposium. *Patient Educ Couns*. 2022;105(7):2599–602. https://doi.org/10.1016/j.pec.2021.12.018
6. Sue DW, Capodilupo CM, Torino GC, et al. Racial microaggressions in everyday life: implications for clinical practice. *Am Psychol*. 2007;62(4):271–86. https://doi.org/10.1037/0003-066X.62.4.271
7. Johnson M, Seide W, Green-Dixon A, Randall V. Black students' perception of belonging: a focus group approach with Black students at the uniformed services university of the health sciences. *Int J Med Stud*. 2021;9(2):124–8. https://doi.org/10.5195/ijms.2021.877
8. Acheampong C, Davis C, Holder D, Averett P, Savitt T, Campbell K. An exploratory study of stress coping and resiliency of Black men at one medical school: A critical race theory perspective. *J Racial Ethn Health Disparities*. 2019;6(1):214–9. https://doi.org/10.1007/s40615-018-0516-8
9. Diaz T, Navarro JR, Chen EH. An institutional approach to fostering inclusion and addressing racial bias: implications for diversity in academic medicine. *Teach Learn Med.* 2020;32(1):110–6. https://doi.org/10.1080/10401334.2019.1670665
10. Dhalla IA, Kwong JC, Streiner DL, Baddour RE, Waddell AE, Johnson IL. Characteristics of first-year students in Canadian medical schools. *CMAJ Can Med Assoc J J Assoc Médicale Can.* 2002;166(8):1029–35. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC100877/
11. Khan R, Apramian T, Kang JH, Gustafson J, Sibbald S. Demographic and socioeconomic characteristics of Canadian medical students: a cross-sectional study. *BMC Med Educ.* 2020;20(1):151. https://doi.org/10.1186/s12909-020-02056-x
12. Young ME, Razack S, Hanson MD, et al. Calling for a broader conceptualization of diversity: surface and deep diversity in four Canadian medical schools. *Acad Med J Assoc Am Med Coll.* 2012;87(11):1501–10. https://doi.org/10.1097/ACM.0b013e31826daf74
13. Leduc JM, Kpadé V, Bizimungu S, et al. Black students applying and admitted to medicine in the province of Quebec, Canada: what do we know so far? *Can Med Educ J.* 2021. https://doi.org/10.36834/cmej.72017
14. Lafortune G, Kanouté F. Récits d'expériences de jeunes issus de l'immigration en situation de décrochage : quand l'école « ne marche pas » ou est un bad trip. *Éducation Francoph.* 2019;47(1):131–48. https://doi.org/10.7202/1060851ar
15. Magnan MO, Collins T, Darchinian F, Kamanzi PC, Valade V. Student Voices on Social Relations of Race in Québec Universities. *Race Ethn Educ*. 2021;1–17. https://doi.org/10.1080/13613324.2021.1890564
16. Adler S, Boivin-Côté J, Ouizzane C, Gravel I, Leduc JM. Experienced or witnessed racism and microaggressions during medical education: an exploratory survey of medical students at a large Canadian medical school. Paper presented at the AMEE Conference, Lyon, France. 2022.
17. Haney López IF. *The social construction of race*. In*:* Critical race theory: the cutting edge. 2nd ed. Philadelphia: Temple University Press; 2000. p. 163–75.
18. Solórzano DG, Yosso TJ. A critical race counterstory of race, racism, and affirmative action. *Equity Excell Educ*. 2002;35(2):155–68. https://doi.org/10.1080/713845284
19. Delgado R, Stefancic J, Harris A*. Critical Race Theory: an introduction*. 3rd ed*.* New York: NYU Press; 2017. https://doi.org/10.2307/j.ctt1ggjjn3
20. Gillborn D. Rethinking White supremacy: who counts in 'WhiteWorld.' *Ethnicities.* 2006;6(3):318–40. https://doi.org/10.1177/1468796806068323
21. Sue DW. *Overcoming our racism: the journey to liberation.* Jossey-Bass; 2003. https://doi.org/10.1002/9780787979690
22. Cameron ES, Jefferies K. Anti-Black racism in Canadian education: A call to action to support the next generation. *Healthy Popul J*. 2021;1(1):11-15. https://doi.org/10.15273/hpj.v1i1.10587
23. Der GS. Reframing critical anti-racist theory (CART) for contemporary times. *Counterpoints.* 2013;445:1-14.
24. Sue DW, Capodilupo CM, Nadal KL, Torino GC. Racial microaggressions and the power to define reality. *Am Psychol*. 2008;63(4):277–9. https://doi.org/10.1037/0003-066X.63.4.277
25. Pérez Huber L. Using Latina/o Critical Race Theory (LatCrit) and racist nativism to explore intersectionality in the educational experiences of undocumented Chicana college students*. Educ Found*. 2010;24(1–2):77–96. https://eric.ed.gov/?id=EJ885982
26. Yosso TJ. Whose culture has capital? A critical race theory discussion of community cultural wealth. *Race Ethn Educ.* 2005;8(1):69–91. https://doi.org/10.1080/1361332052000341006
27. Sleeter CE. Critical race theory and education. In: Banks JA, editor. Encyclopedia of diversity in education [Internet].

Thousand Oaks: SAGE Publications, Inc.; 2012. p. 491–4. Available from: http://sk.sagepub.com/reference/diversityineducation/n154.xml
28. Goffman E. *Gender advertisements*. London: Palgrave; 1976. https://doi.org/10.1007/978-1-349-16079-2
29. Goffman E. *The presentation of self in everyday life*. New York: Anchor books; 1959.
30. Goffman E. Interaction ritual: essays in face-to-face behavior. New York: Pantheon Books; 1982.
31. Goffman E. Stigma: notes on the management of spoiled identity. New York: Simon & Schuster; 1986.
32. Solórzano DG, Yosso TJ. Critical race methodology: Counter-storytelling as an analytical framework for education research. *Qual Inq*. 2002;8(1):23–44. https://doi.org/10.1177/107780040200800103
33. Savoie-Zajc L. L'entrevue semi-dirigée. In: Bourgeois I, editor. Recherche sociale : De la problématique à la collecte des données. 7th ed. Québec: Presses de l'Université du Québec; 2021. p. 273–96.
34. Cohen L, Manion L, Morrison K. *Research methods in education.* 8th ed. London: Taylor & Francis Group; 2017. https://doi.org/10.4324/9781315456539
35. Paillé P, Mucchielli A. L'analyse thématique. In: L'analyse qualitative en sciences humaines et sociales. 5th ed. Paris: Armand Colin; 2021. p. 269–357. Available from: https://www.cairn.info/l-analyse-qualitative-en-sciences-humaines--9782200624019-p-269.htm
36. Hunting G. *Intersectionality-informed qualitative research: a primer.* Vancouver: The Institute for Intersectionality Research & Policy, SFU; 2014.
37. Rodriguez JK. *Intersectionality and qualitative research*. In: Cassell C, editor. The SAGE handbook of qualitative business and management research methods: history and traditions. London: SAGE Publications; 2019. p. 429-461. https://doi.org/10.4135/9781526430212.n26
38. Krumer-Nevo M, Sidi M. Writing against othering. *Qual Inq.* 2012;18(4):299-309. https://doi.org/10.1177/1077800411433546
39. Girgulis K, Rideout A, Rashid M. Performance of Black and Indigenous applicants in a medical school admissions process. *Can Med Educ J.* 2021 Dec 31;12(6):35–42. https://doi.org/10.36834/cmej.72121
40. Morrison N, Machado M, Blackburn C. Student perspectives on barriers to performance for black and minority ethnic graduate-entry medical students: a qualitative study in a West Midlands medical school. *BMJ Open*. 2019;9(11):e032493. https://doi.org/10.1136/bmjopen-2019-032493
41. Woolf K. Differential attainment in medical education and training. *BMJ*. 2020; 368. https://doi.org/10.1136/bmj.m339
42. Beagan BL. "Is this worth getting into a big fuss over?" Everyday racism in medical school. *Med Educ*. 2003;37(10):852–60. https://doi.org/10.1046/j.1365-2923.2003.01622.x
43. Ahmed S. *on being included: racism and diversity in institutional life*. Duke University Press. 2012. https://doi.org/10.1515/9780822395324
44. Gastaldo É. O Projeto Teórico de Erving Goffman: Erving Goffman e suas obras. 2022. Available from: https://www.youtube.com/watch?v=jPDl-L1sFtE
45. Gastaldo É. Goffman e as relações de poder na vida cotidiana. *Rev Bras Ciênc Sociais*. 2008;23:149–53. https://doi.org/10.1590/S0102-69092008000300013
46. Collins PH, Bilge S. Intersectionality. Malden, MA: Polity Press; 2016.
47. Crenshaw K. Mapping the margins: intersectionality, identity politics, and violence against women of color. *Stanford Law Rev*. 1991;43(6):1241–99. https://doi.org/10.2307/1229039
48. Union Étudiante du Québec. La communauté étudiante noire et racisée: Expériences vécues et défis rencontrés. 2023. https://unionetudiante.ca/Media/publicDocuments/7763fe5f-7a64-46b9-93c4-dd326dbe1505.pdf
49. Von Robertson R, Bravo A, Chaney C. Racism and the experiences of Latina/o college students at a PWI (Predominantly White Institution). *Crit Sociol*. 2016;42(4-5):715-35. https://doi.org/10.1177/0896920514532664
50. Solórzano D, Allen WR, Carroll G. *Keeping race in place: racial microaggressions and campus racial climate at the University of California, Berkeley. Chicano-Latino Law Rev*. 2002;23(15):14-112. https://doi.org/10.5070/C7231021142