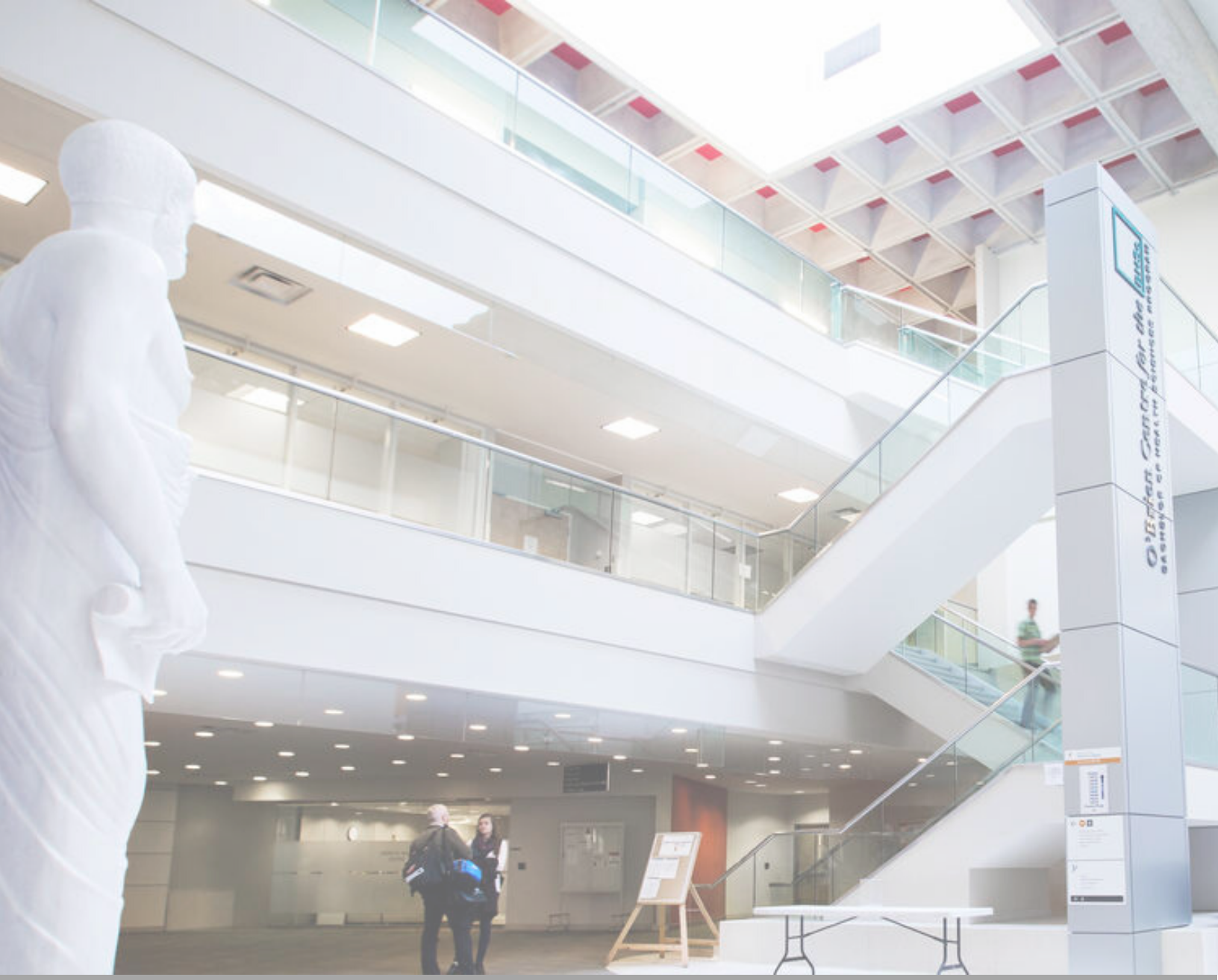

# Calls to Action to Address Institutionalized Racism in Medical Education and Health Care

Aya Ebdalla, McNiel-Inyani Keri, Mursal Mohamud and Chidera Nwaroh

BMSA Calgary
BLACK MEDICAL STUDENTS' ASSOCIATION

UNIVERSITY OF CALGARY
CUMMING SCHOOL OF MEDICINE

# University of Calgary Black Medical Students' Association

## Calls to Action to Combat Institutionalized Racism in Medical Education and Health Care

### THEME 1: COMMITMENT TO INCREASING DIVERSITY

**Increase Diversity in Student Body and Admissions Committee**

Generate a stream for Black applicants with the goal of overcoming explicit and implicit racial biases in the admission process. Applicants are still expected to meet the same requirement as their peers.

**Community Support for Undergraduate BIPOC Students**

Implement a program to guide BIPOC undergraduates through the admissions process, provide mentorship and assist in eliminating any financial barriers to admissions.

**Collection of Demographic Admissions Data**

Collect data on race, income, parental occupation and other socioeconomic factors in order to identify admission barriers and monitor longitudinal impacts of the proposed initiatives.

### THEME 2: EQUIPPING ALL CSM GRADUATES TO CARE FOR BIPOC PATIENTS

**Mandatory Education and Clinical Experience with Racial Minorities**

All medical students should be equipped to identify and manage pathology in both white and BIPOC patients through didactic teaching and clinical training.

**Mandatory Bias Training**

Training on the effects of racial bias on health outcomes led by the Equity and Diversity Office in collaboration with BIPOC community members.

**Safe Reporting and Ensured Action Against Acts of Racism**

The University should take a firm, zero-tolerance stance on racism, empower students to report without barriers or risk of consequences and act swiftly to hold perpetrators accountable.

### THEME 3: PROMOTING WELLNESS IN BIPOC STUDENTS

**Supporting Mental Health for BIPOC Students**

Counsellors, psychologists, psychiatrists and other mental health counsel should receive anti-racism training and be equipped to counsel students suffering from racialized traumas.

**Providing Mental Health Resources for Students**

Include mental health resources specifically designed to address the unique challenges faced by BIPOC students should be in all mental health related correspondences to students.

**Encouraging Inclusivity in Student-Run Activities**

Include a student-run event coordinated by the CMSA executives in collaboration with the BMSA to ensure that BIPOC voices are amplified and celebrated.

# Table of Contents

Not everything that is faced can be changed, but nothing can be changed until it is faced.

JAMES BALDWIN

# Preface

The recent murders of George Floyd, Ahmaud Arbery, Breonna Taylor and Kenneth Ross Jr., have sparked an international public outcry, peaceful protests, and corporate grief never before seen in this generation. The United States is currently under global scrutiny for its unlawful treatment of Black, Indigenous, and People of Colour (BIPOC), and particularly the anti-Black racism that has persisted over centuries yet continues to result in the unjust and inequitable treatment of those radicalized in society. Citizens across the globe are demanding change. These recent murders are a tragic and traumatizing manifestation of the prejudiced practices that continue to be subliminally legitimized and perpetuated by the multi-systemic presence of racism in the various institutions of American society. However, Canadian society is not immune to racism, and has a long history of discrimination for people of colour. Anti-Black racism is unfortunately similarly pervasive in Canada. In fact, Black Canadians are more likely to be racially profiled, to be targets of hate crimes, and to be denied adequate health care as compared to their White counterparts (Welch 2007). Anti-Black racism is perpetuated in every single facet of our society, and we cannot allow it to continue.

The harms of a system that promotes inequality, along with the legacy of colonization and slavery, have provided the grounds for structural inequities and systemic discrimination. This system has deeply impacted the health and well-being of Black Canadians. It is no longer enough to merely acknowledge the historical roots of anti-Black racism in Canada. It is now time to act. As future health care professionals, we must demand the dismantling of the power structures rooted in White supremacy that allow any form of racism to persist. We must not only recognize racism as a social crisis, but also as a public health crisis. This burden cannot be carried by BIPOCs alone. It must be tackled by society as a whole, in solidarity with BIPOC members. As health care professionals, it is our duty to address racism in medicine.

# Acknowledgements

We at the University of Calgary Black Medical Students' Association (BMSA), are truly grateful for the many messages of support and kindness received from our classmates, other student organizations, and our various faculty allies. We are especially grateful for the cofounders of the BMSA, Drs. Wauldron Afflick and Fartoon Siad who not only established a platform for past, present and future Black medical students to advocate for themselves and their communities, but who have been excellent mentors and sources of inspiration to BIPOC students across Canada. Further, we thank the BMSA faculty advisors Drs Rabi, Kachra, Brown and Kassam for their guidance, support and most importantly, for standing in solidarity with BIPOC students.

It is clear that we are all frustrated and outraged by these recurrent injustices and many of us are looking for ways to promote systemic, sustainable changes. Our goal is to channel our mutual indignation towards injustice into actionable efforts. In order to tackle these issues, we plan to organize our communities, collaborate with our allies, and put forth tangible action items.

# Introduction

**Genesis of Systemic Racism**

Systemic racism is deeply rooted in Canadian history. This well-documented and undeniable fact must be understood if we are to progress as a society. The eradication of the individual prejudices and stereotypes that exist in general society and the microcosm of medicine will not be enough, rather it must be the first step towards the end-goal of an equitable, inclusive and more accountable future in medicine. To achieve this goal, we must work towards decolonizing medicine. Specifically, we must dismantle the power structures and racist systems that continue to disadvantage and harm BIPOCs. Lest we forget that in 1918, Canadian medical schools, such as Queen's School of Medicine, enacted formalized policies prohibiting Black students to apply, as a strategy to promote and protect their rankings (Black Medical Students at Queen's University n.d.). It wasn't until 2019 that these policies were formally rescinded. An understanding of the Flexner Report and its description of the ideal physician — a wealthy White male — provides insight into why such a policy in Canada existed. The lasting impact of the Flexner report on current medical school demographics must be made clear to students and those within the Cumming School of Medicine (CSM) community. The conceptualizations of historical figures including Flexner, Osler, and Sims as heroes in medicine must be juxtaposed with their racist ideologies and subsequent disregard, exclusion and even abuse of BIPOCs within the realm of medicine (Duffy 2011; Hunt 1993; Tauber 1992). Further, less than 30 years ago in 1996, the last residential school in Canada was officially shut down; an institution wherein countless Indigenous students were involuntarily subjected to a variety of medical experiments, separated from their families and stripped of their culture (Corntassel, Chaw-win-is, and T'lakwadzi 2009). CSM graduates must understand the impact of such historical atrocities as they continue to manifest into the lived experiences of BIPOCs.

Such historical events and practices are emblematic of the structural and institutional policies rooted in White supremacy and patriarchy. These oppressive attitudes have inevitably manifested within Canadian health care and social institutions as silent, but pervasive discrimination towards Black and Indigenous peoples. Countless studies show a disproportionate burden of chronic illnesses amongst Black Canadians and Indigenous peoples, along with overall poorer health outcomes and reduced access to care among racialized communities (Copeland 2005; Marrone 2007; Veenstra 2009). CSM graduates must be socially conscious of Canada's history of racism and oppression, and its manifestation into health disparities across our country.

**Working Collaboratively**

Change within an institution is only possible through the collective efforts of its members. Therefore, within our medical community, it is incumbent upon us as public servants to join together in an effort to actively seek structural reform within our health care system. We must commit ourselves to tangible changes for the benefit of the populations we serve. We must also ensure that we do not mislead the public by exalting false narratives of change and inclusivity. Meaningful action is required for sustainable success in this important endeavor.

As members of the BMSA, we are devoted to continued advocacy to eradicate the health inequities faced by the Black population, providing educational opportunities focused on overcoming racial biases, as well as providing continued mentorship opportunities for youth within the Black community and other underrepresented populations. Despite all our efforts and best intentions, we know we cannot dismantle racism and White supremacy alone. Our institutions have been created to grant privilege to some, while disadvantaging others. As such, removing the policies, processes, and structures that perpetuate inequity must be torn down collaboratively.

The aforementioned challenges may seem daunting, but with the explicit support of our various allies, including the Cumming School of Medicine, we can combat and eradicate the elements within our institution that continue to perpetuate harmful prejudices and stereotypes, and result in unjust outcomes for BIPOCs.

The presence of racial diversity within all the levels of the Cumming School of Medicine, including medical students, residents, administrators, lecturers, faculty, and leadership is paramount. Creating a community of support in which this is possible is the first step. We also believe that the implementation of educational reforms and initiatives aimed at tackling racialized biases will improve the overall delivery of health care and the relationship between health care professionals and the populations we serve. Again, we are dedicated to the dismantling of racism in medicine. We must not allow this historical societal stain to continue to propagate any further. Change is uncomfortable but it is required for growth. Now is the time to grow and this is our call to action!

# Calls to Action

Medical schools are socially accountable for meeting the health care needs and demands of the populations they serve, especially those who are vulnerable, marginalized, and underserved. We must also be aware that the Canadian demographics are changing, and as a result, so will the health care needs and expectations of its populations. Therefore, it is important that medical schools recognize these changes, in order to quickly adapt and provide informed, anti-oppressive practices to prevent health inequities. This document outlines the major themes that govern our calls to actions and recommendations as we work towards increasing inclusivity, equity, and accountability in medicine.

Firstly, we draw on the theme of diversity to call upon improving Black representation in medicine as a crucial step to reduce barriers to care for underserved communities. In effect, this increased diversity will enhance health care to vulnerable patients, especially those from minority communities that face unique health challenges. Research indicates that Black patients who receive care from Black doctors have better clinical outcomes, including a reduction in mortality and an increase in their life expectancy (Alsan, Garrick, and Graziani 2019). Further evidence also suggests that physicians from marginalized populations are more likely to practice in underserved communities (Black Medical Students at Queen's University n.d.). Moreover, evidence also supports that increased diversity of medical students encourages unique learning opportunities which culminate to physicians with a greater understanding of diverse communities (Bandiera et al. 2015; Copeland 2005; Grumbach and Mendoza 2008; Mays, Cochran, and Barnes 2007).

Secondly, we outline the theme of anti-racist training and policies. We believe it is imperative that every single Cumming School of Medicine graduate is appropriately trained to care for patients of all backgrounds. Further, we emphasize the need to foster safe spaces for BIPOC students to report racism within learning environments. Research indicates that BIPOC medical students experience less supportive and positive learning environments, and are more likely to define their race as an obstacle to their success in medical school (Orom, Semalulu, and Underwood 2013).

Thirdly, we emphasize the theme of enhancing the wellness and mental health of BIPOC medical students, as they face unique challenges due to racialized trauma and experience racial discrimination throughout their medical training – from patients, peers, faculty, and health care providers. As a result, BIPOC medical students are at an increased risk of suffering from depressive and anxiety symptoms, as compared to White medical students (Hardeman et al. 2015).

We recognize that change will not occur overnight, and that adopting our recommendations and calls to action will require a long-term commitment by the Undergraduate Medical Education office here in Calgary. However, we are confident that change can be accomplished with the support of our various faculty allies and in consultation with the BMSA.

# Theme 1 Increasing Diversity in Undergraduate Medicine

**Increase Black Representation in the Student Body and Admissions Committee**

We believe that representation within the student body should be reflective of the diverse populations we serve, and that the Cumming School of Medicine (CSM) should be actively attempting to recruit students in order to best represent this diversity. The CSM can achieve this by establishing a specific - but optional - application stream targeted towards Black applicants who self-identify as Black. This includes Black North Americans, Black Caribbeans, Black Africans, and multi-racial students identifying with their Black ancestry, etc. Recognizing that students from marginalized backgrounds face additional barriers in the medical school application process, this stream aims to limit any disadvantages Black applicants face during the application process attributed to their race or ethnicity. Other medical schools in Canada, such as the University of Toronto, have pioneered such initiatives and have witnessed encouraging results.

The application stream would include an admissions and file review sub-committee involving Black Healthcare workers, Black physicians, Black faculty members, Black medical students, and other Black community members. The Black admissions sub-committee should also be composed of executive roles and positions that promote self-governance and self-sustainability. The selection of the members of this committee should involve active participation of members of the Black community. Furthermore, we also encourage the Black lead Admission sub-committee to periodically consult and present updates on progress to the Black community.

Black applicants are still expected to meet the same admissions requirements (MCAT, GPA, and course prerequisites) as applicants in the general application stream. It is crucial that the CSM does not establish designated seats for Black applicants, and that Black applicants should have the option of applying through the general stream.

By establishing diversity in the admission process, this program aims to overcome the role of explicit and implicit racial biases in the admissions process. The involvement of Black community members would also help empower the Black community by enabling them to take part in shaping the future physicians that may serve their communities.

**Community Support for Undergraduate BIPOC Student**

As Canadian demographics change, medical schools must adapt to the changing needs of its populations. For this to occur, we urge the UME office to begin acquiring demographic data (e.g., race, ethnicity, income, parental occupation, and other socioeconomic factors) on medical students who apply to Calgary in order to identify admission barriers amongst underrepresented communities and factors that are associated with privilege or unearned advantage. This data would enable the UME office to take action based on evidence and to eradicate admission biases and unearned facilitators that perpetuate inequity. Many of the barriers that marginalized students face in applying to medical school begin early in the application process. Due to the lack of healthcare representation within their own communities, many are unfamiliar with the requirements needed to apply to medical school. Therefore, the implementation of a dedicated community of support program (CSP) would aim to provide BIPOC students, as well as students from low income backgrounds, with support and guidance during their medical journey. This can be realized through (1) actively engaging with the Black community to encourage Black students to apply to medical school; (2) more collaborative initiatives which provide racialized students with access to mentors (e.g., Summer mentorship programs, workshops, etc.), job-shadowing, volunteer and research opportunities, medical-school admission information and guidance; and (3) mentorship during medical school from the professional Black community including university faculty, physicians, medical students, and other members of the community.

**Collection of Demographic Admissions Data**

As previously mentioned, Canadian demographics are continually changing, and medical schools must adapt to the changing needs of their populations by collecting demographic data. Collection of such data and transparency involving the admissions criteria would also help to reduce financial barriers associated with the admissions process faced by the BIPOC population. Detailed data from incoming students that outlines the various costs (direct and indirect) incurred during application as well as applicants' sources of funds (scholarship, family support, employment, etc.) should be shared and publicly accessible for prospective medical students. Increased transparency involving the admission process would empower prospective applicants from low SES backgrounds, by allowing them to make informed decisions on how to allocate their limited financial resources (Walji 2015). Moreover, current methods of data collection should be reviewed to ensure it is collected in an equity-oriented, intersectional, and disaggregated manner, as it relates to the application process and admissions.

Furthermore, it has been cited that the expenses involving the application process (pre-application, application, and interview) may exceed $5000 (Fortin et al. 2018; Tobin 2008; Walji 2015); the Medical College Admission Test (MCAT) alone can costs an average of $3059 per year as a result of exam fee ($415), prep course fees ($2000), and resources (such as books and practice exams; $644) (Fortin et al. 2018). Therefore, the CSM should recognize the role financial barriers have on the various stages of the application process in preserving racial disparity in medicine. Studies have suggested that socioeconomic factors may contribute to lower MCAT scores among underrepresented minorities (Fortin et al. 2018). Financial constraints may reduce an individual's ability to access opportunities such as the MCAT exam (including preparation courses) as well as limiting study time for applicants concurrently supporting their families.

The CSM can help reduce these financial barriers by creating UME organized MCAT preparation courses, and providing MCAT study materials (via scholarships, subsidies, donations, etc.) to students from low socioeconomic backgrounds. Of course, these are but one set of actions that can be taken by the CSM to address this concern.

Furthermore, data will not only allow the UME to closely monitor the effectiveness of their engagement, but it would also hold the UME accountable in reducing any unjust barriers faced by applicants. Lastly, data collection would allow monitoring of the longitudinal impacts of the proposed initiatives on the health of underrepresented populations. It is also our recommendation that data is collected in consultation with BIPOC faculty and allies and is made public and accessible to prospective students.

# Theme 2 Equipping all CSM Graduates to Care for BIPOS Patients

**Mandatory Education and Clinical Experience with Racial Minorities**

All medical students should be given the opportunity to see different pathologies in racial minority groups through mandatory clinical time at refugee clinics, community practices with diverse populations, standardized patients from diverse ethnic backgrounds and greater racial diversity in patient presentations. Currently there is a gap in cultural dexterity when serving BIPOC patients due to a lack of adequate education. As medicine strives to shift towards a model of culturally competent care, it is important that students have educational experiences in under-represented communities.

Concurrent with more diverse clinical experiences, course content should be reviewed to include content specifically addressing differences in health outcomes based on race, as a result of racism. We request the Population Health Course include dedicated lectures and safe discussion on racism and its effects on health outcomes. When discussed on examinations, we request that questions be mindfully worded and considerate of the trauma associated with certain phrases. A review of language in all educational material is advised for examination questions and answers, notes packages, slide decks, small group notes, preceptor guides etc. Appropriate language should be used when referring to racial minorities. For example, the use of the term “African American” should be reserved for patients with African and American descent, not for a recent immigrant to Canada from Africa, and this distinction should be made clear. Additionally, when describing a Black patient in a case stem, supplementary information such as images of skin manifestations should match the patient described — a case describing a Black patient should not be accompanied by images portraying White skin. Further, in clinically relevant instances where disease presentations differ between White and BIPOC patients, it should be highlighted. It is important that students are competent in identifying pathology so as not to delay diagnosis and treatment.

| COURSE | COMPETENCY OBJECTIVES |
|---|---|
| HEMATOLOGY AND IMMUNOLOGY | Identify jaundice, pallor, flushing, erythema and other clinical presentations in BIPOC patients<br>Avoid stigmatization of Sickle cell patients in the ER setting and address previous trauma experienced by these patients |
| MUSCULOSKELETAL SYSTEM AND DERMATOLOGY | Identify dermatologic pathology on White and BIPOC skin tones |
| CARDIOLOGY AND RESPIROLOGY | Identify Acute Coronary Syndrome clinical manifestation in a Black patient<br>Identify skin manifestations of respiratory infections in Black patients<br>Identify erythematous rash in patients with Kawasaki disease |
| RENAL, ENDOCRINOLOGY AND OBESITY | Identify differences in chronic disease outcome amongst minorities and tackle these in clinical setting |
| PSYCHIATRY | Identify and manage delirium in Black patients, while understanding the stigma Black patients presenting with delirium face<br>Identify and manage mental health complications with cultural sensitivities<br>Discussion of police brutality and its effects on mental health |
| OBSTETRICS AND GYNECOLOGY | Understand the impact of stigma on maternal outcomes among Black mothers<br>Be aware of the racist experiments performed by James Marion Sims, “Father of Modern Gynecology” on enslaved Black women without anaesthesia |

**Table 1:** A Non-exhaustive list of competencies all medical students should be capable of addressing to properly serve marginalized communities. Note, these are but a few examples, focusing on the Black community. A more in-depth survey of the curriculum is required to serve a wider range of underrepresented groups.

**Mandatory Education on Bias**

We believe that all medical students and staff would benefit from on-going mandatory hours of cultural competency training and education on bias. Specifically, medical students must understand and appreciate how racial bias can affect the health of BIPOC individuals. This education can be provided in the form of didactic teaching by trained professionals from the Office of Diversity, Equity and Protected Disclosure followed by small group case explorations to delve into the specific detrimental effects of racial bias on health outcomes. These sessions should be accompanied by resources for further education outside of designated lecture hours. It is our recommendation that these sessions are interwoven within each course, as minimal mandatory hours will not be sufficient to address racial biases that students may have been carrying their entire lives. We would also like to emphasize that these educational sessions should be led by preceptors from the BIPOC community with adequate training on facilitating racism-sensitive discussions. Further, we strongly recommend long-term training on implicit bias beyond the Undergraduate Medical Education level and encourage continuity in anti-racism training at the Postgraduate Medical Education level.

Residents and practicing physicians must also adopt an anti-racism stance.

**Self Reporting and Ensured Action Against Acts of Racism**

Literature suggests that medical students who are subject to racism, implicitly or explicitly, perform worse academically. A review by Orom et al of 28 published studies reported that underrepresented minority (URM) students experienced less supportive social and leaning environments.

These students also reported being subjected to racial discrimination and harassment and were therefore more likely to view their race as having a negative impact on their medical school experience when compared to their non-URM counterparts. Additionally, when compared to their non-URM peers, URM students performed worse on standardized exams, had less timely progress and high rates of attrition (Orom, Semalulu, and Underwood 2013).

We believe that all medical students should be able to learn in a safe, non-toxic environment, free of racism. We ask that the University of Calgary takes a firm, zero tolerance anti-racism stance. In order for all students to feel empowered in their learning, there must be no barriers to reporting acts of racism and removing them from the learning environment. Clerkship representatives should be responsible for ensuring that students have a safe space to report racist behavior such that preceptors and all other members of the healthcare team, including but not limited to nurses, administrative staff and allied health workers, are held accountable for such action. Further, residents and practicing physicians should also have safe spaces to report similar issues.

# Theme 3 Prioritizing Wellness of BIPOC Students

## Supporting Mental Health of BIPOC Students

BIPOC students face unique challenges, and many suffer from racialized trauma — the cumulative effects of racism on an individual's mental and physical health. Research indicates that African American students have a greater risk of experiencing depressive or anxious symptoms, and an increased risk of lacking social support (Hardeman et al. 2015). Such disparities may be attributed to the cumulative toll of consistent and persistent experiences of racism.

Given the unique challenges faced by BIPOC students and the impact of racialized trauma, we believe that all counselors, psychologists, psychiatrists and other mental health counsel affiliated with the Student Advising and Wellness (SAW) Office should receive anti-racism training and be equipped with appropriate tools to counsel students suffering from racialized traumas. Further, we urge all SAW staff to complete anti-racism training to ensure a safe space for BIPOC students at all times. We also encourage the UME to invite BIPOC psychologists for drop-in sessions to counsel victims of racialized traumas. BIPOC psychologists may be able to offer insight and guidance from their own lived experiences, which may be particularly encouraging to BIPOC students. However, with adequate training regarding racial trauma, we are confident that the SAW office can continue to support BIPOC students.

## Mental Health Resources for BIPOC Students

Throughout medical school, students are often reminded of the mental health resources made available to them, and this is immensely helpful to all medical students given the shared stresses of medical school. However, we believe that mental health resources specifically designed to address the unique challenges faced by BIPOC students should also be included in all correspondences to students. It is our worry that BIPOC students will continue to feel they only have safe spaces to share medical school related stresses, and not to share the stresses accompanied by carrying the burden of racialized traumas.

Acheampong et al discussed the experience of Black students at one medical school in the United States and highlighted the additional stressors experienced by Black students along with the baseline stressors that all students face (Acheampong et al. 2019). We urge the UME to acknowledge the added layer of stress and trauma that BIPOC students face.

**Student-Run Activities**

We believe that at least one student-run event coordinated by the Calgary Medical Student Association (CMSA) Vice President (VP) of Wellness, CMSA VP Events, and associated Directors should be designed to specifically address racism within the medical community and to encourage students to speak up against racism. It is our recommendation that such an event be run in collaboration with the BMSA and other BIPOC student groups to ensure that BIPOC voices are amplified, and to reiterate to the student body how crucial collaboration is to move towards a more inclusive and equitable future in medicine. We also recommend the introduction of a CMSA role focusing solely on ensuring equity and diversity within medical school communities, and monitoring Calls to Actions put forth by BIPOC organizations. It would be ideal for this role to be filled by a medical student from the BIPOC community.

# Conclusion

The journey towards a more inclusive, equitable, accountable and anti-racist future in medicine may seem daunting, but it is long overdue. It is no longer sufficient to be non-racist. Medical education and health care must be anti-racist. We must not only embark on the journey of unlearning harmful prejudices and stereotypes, but we must also engage in action to decolonize medicine and end institutionalized racism. The incorporation of our Calls to Actions within CSM education and health care will only be the first step of the necessary commitment by the CSM to be an anti-racist institution and to produce physicians capable of providing high-quality care to Canadians of all backgrounds.

We cannot allow the historical stain of racism to propagate any further, nor can we allow it to continue to manifest in the lived experiences of BIPOC students, faculty, staff and patients. Change is uncomfortable but it is required for growth. Now is the time to grow and this is our call to action!

# References

Acheampong, Cassandra et al. 2019. “An Exploratory Study of Stress Coping and Resiliency of Black Men at One Medical School: A Critical Race Theory Perspective.” Journal of Racial and Ethnic Health Disparities 6(1): 214–19.

Alsan, Marcella, Owen Garrick, and Grant Graziani. 2019. “Does Diversity Matter for Health? Experimental Evidence from Oakland.” American Economic Review 109(12): 4071–4111.

Bandiera, Glen et al. 2015. “Access and Selection: Canadian Perspectives on Who Will Be Good Doctors and How to Identify Them.” Academic Medicine 90(7): 946–52. “Black Medical Students at Queen’s University.” https://meds.queensu.ca/academics/undergraduate/black medical-students-queens-university.

Copeland, Valire Carr. 2005. “African Americans : Disparities in Health Care Access and Utilization.” Health & Social Work 30(3): 265–70.

Corntassel, Jeff, Chaw-win-is, and T’lakwadzi. 2009. “Indigenous Storytelling, Truth-Telling, and Community Approaches to Reconciliation.” English Studies in Canada; Edmonton 35(1): 137–59. http://www.dec.org/pdf_docs/PNACL168.pdf.

Duffy, Thomas P. 2011. “Historical Perspectives In Medical Education The Flexner Report — 100 Years Later.” YALE JOURNAl OF BiOlOGY AND MEDICINE 84: 269–76.

Fortin, Yannick et al. 2018. “The Direct Economic and Opportunity Costs of the Medical College Admissions Test (MCAT) for Canadian Medical Students.” MedEdPublish 7(4).

Grumbach, Kevin, and Rosalia Mendoza. 2008. “Disparities in Human Resources: Addressing the Lack of Diversity in the Health Professions.” Health Affairs 27(2): 413–22.

Hardeman, Rachel R. et al. 2015. “Mental Well-Being in First Year Medical Students: A Comparison by Race and Gender: A Report from the Medical Student CHANGE Study.” Journal of racial and ethnic health disparities 2(3): 403–13.

Hunt, S. 1993. “The Flexner Report and Black Academic Medicine: An Assignment of Place.” Journal of the National Medical Association 85(2): 151–55.

Marrone, Sonia. 2007. “Understanding Barriers to Health Care: A Review of Disparities in Health Care Services among Indigenous Populations.” International journal of circumpolar health 66(3): 188–98.

Mays, Vickie M., Susan D. Cochran, and Namdi W. Barnes. 2007. “Race, Race-Based Discrimination, and Health Outcomes Among African Americans.” Annual Review of Psychology 58(1): 201–25.

Orom, Heather, Teresa Semalulu, and Willie Underwood. 2013. “The Social and Learning Environments Experienced by Underrepresented Minority Medical Students: A Narrative Review.” Academic Medicine 88(11): 1765–77.

Tauber, A. I. 1992. “The Two Faces of Medical Education: Flexner and Osler Revisited.” Journal of the Royal Society of Medicine 85(10): 598–602.

Tobin, Anne-Marie. 2008. “Med School Costs Discourage Applicants: Study.” THE CANADIAN PRESS.

Veenstra, Gerry. 2009. “Racialized Identity and Health in Canada: Results from a Nationally Representative Survey.” Social Science and Medicine 69(4): 538–42. http://dx.doi.org/10.1016/j.socscimed.2009.06.009.

Walji, Moneeza. 2015. “Diversity in Medical Education: Data Drought and Socioeconomic Barriers.” Canadian Medical Association Journal 187(1): 11.

Welch, Kelly. 2007. “Black Criminal Stereotypes and Racial Profiling.” Journal of Contemporary Criminal Justice 23(3): 276–88.