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Medical students face racism

PERSPECTIVES

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Medical faculties in Norway can no longer act as if racism does not take place there. We need medical faculties that actively combat racism and educate anti-racist doctors.

We are medical students nearing the end of our studies at the University of Oslo. Recently, we have been involved in starting an anti-racist working group within our faculty (1, 2). Based on our own observations and stories shared by our fellow students, we wish to show how racism is a widespread and systemic problem in medical studies in Oslo. We see racism in the teaching context, among students, and in the patient-doctor situation.

Although research on racism in medical studies in Norway is limited, research in Sweden (3, 4) and the UK (5), as well as nursing research in Norway (6), shows that racism is a widespread problem. Additionally, there have been several media reports about racism in medical studies in Norway (7, 8). Norwegian medical faculties can no

longer act as if racism does not take place there and must start to combat racism actively. To achieve this, management must make efforts to establish trust and initiate measures in collaboration with the students experiencing racism.

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Direct racism

Many people think of racism in terms of direct, overt racism. There are many examples of direct racism in the teaching context of medical studies, e.g., the lecturer who said, 'Those of you who aren't Norwegian likely won't understand what I mean', and the lecturer who said to a student who spoke 'broken' Norwegian that he could not become a doctor. Some professors have used the N-word in a packed lecture hall. Students wearing a hijab are at risk of stereotyping and discrimination because of their 'visibility' and have heard from their clinical supervisor, for example, that it is not appropriate for a doctor to use a hijab.

We have also heard the same stories about students' experiences when meeting patients. Medical students with a multicultural background have experienced being referred to in derogatory terms such as 'Paki', the N-word, or 'foreigner' without this being discussed or reported – in spite of the fact that fellow students and the supervisor heard what was said. Nor is it unusual for patients to request an ethnic Norwegian doctor, and regrettably, these requests are seldom opposed by either the supervisor or fellow students.

Subtle racism

It is relatively easy to spot direct racism, but there is also racism that is more concealed. Most stories we have heard fall within a grey area, where racism is more indirect and can create doubt in the minds of those experiencing it and those observing it. We understand microaggressions, also called everyday racism, as little jabs or offensive behaviour aimed at a minority, conveying an impression that they have considerably less worth than others. It is easy for those affected to believe that they are the only ones this is happening to and that they are too easily offended. One of the goals of this article is to pave the way for a 'me too' conversation about everyday racism in medical studies so that those affected see that this is not just about them but is a systemic problem.

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One example of everyday racism is how one of our fellow students with a minority background was treated differently by a doctor during a clinical placement when the student was paired with a white ethnic Norwegian student. It started with the doctor

only greeting the white student and completely ignoring the other. Then, the white student was included in the clinical work while the student with a minority background sat in the corner of the office without being delegated any clinical tasks. Yet again, this was not reported, as the person in question had no faith in the whistleblowing system.

Some would perhaps say that this is not racism. Where is the evidence of racism? But what makes it racism is the fact that several students with minority backgrounds experience this type of discrimination again and again. The accumulation of all these small slights and instances of discrimination creates a huge burden and a sense of being treated differently because of one's minority background. For many, these small jabs are part of their everyday life, and unfortunately they get used to them.

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Discrimination

The discrimination experienced by fellow students with minority backgrounds often concerns being regarded as less resourceful, less hard-working, and less suited to the medical profession. We know medical students with minority backgrounds who find that patients do not believe them when they explain the pathogenic mechanisms of a disease, and who experience that time after time, lecturers indicate that they have less faith in their knowledge because they are dark-skinned, wear a hijab or speak with an accent, for example. A number of fellow students with minority backgrounds have said that in group teaching in their pre-clinical years, they were not given the same recognition as white, ethnic Norwegians. They raised their hands and answered correctly just as often, but the lecturer gave more positive feedback to white students. A fellow student with a minority background found that in a tutorial, although she answered the lecturer's question correctly, the lecturer paid more attention to a white student who repeated her answer.

Racism in social arenas

In some ways, medical studies are socially divided between white Norwegian students and those with minority backgrounds. In a typical lecture hall, those with dark skin sit on one side, and those with light skin occupy another part of the room. We, who have been part of four different medical classes in total, both see this. Medical students who graduated two, ten, or twenty years ago saw the same. It is difficult to impose measures deciding where students are to sit in the lecture hall, and we view this segregation as a symptom of an underlying issue, namely subtle exclusion and stereotyping. Students with minority backgrounds feel that they are different from the rest of their cohort.

Medical students with minority backgrounds report feeling excluded from social organisations due to their ethnic background. They are the target of racist comments on social media platforms linked to their studies and offensive comments from fellow

students who, for example, have drunk too much during orientation week. The social events in orientation week entail a high consumption of alcohol, creating an exclusionary environment for those who do not drink. It is not, of course, the case that no one with a minority background drinks, or the converse, that everyone without a minority background drinks, but the percentage of those who do not drink is higher among those with minority backgrounds. The issue is not the alcohol itself but the culture that develops around it.

For many, orientation week is the time they form their circle of friends and other relationships that last throughout their studies. One example we often hear is that medical students with minority backgrounds struggle to establish study groups and therefore have to study on their own. This promotes a systemic alienation process that excludes these students at an early stage of their studies. It may also help explain why a number of students drop out of medical studies in the early years. It is essential that the medical faculty investigate this.

Us and them

Overall, the diverse experiences of medical students with minority backgrounds create a perception of being different and having less value. A second-class student. It fosters the perception of an 'us', made up of white Norwegian medical students, and a 'them'/'the others', consisting of those who are different because of their dark skin and minority backgrounds.

The others have been problematised in a number of settings and are frequently regarded as more demanding. One example is surface anatomy lessons, where a large group of minimally clad students practise examining each other's musculoskeletal system under the supervision of a teacher. We know several female students who, for various reasons, wish to remain covered and have received comments from teachers that they should take off some of their clothes. This creates a feeling that religious garments are a problem and reinforces the sense of being different, problematic, and less competent than others. Another example is a student of colour who, during a course in venipuncture, was told that it is difficult to insert a peripheral venous catheter in 'people like you'. We have also met students who have been told in communication skills classes that when taking a case history, they should warn the patient that they have only lived in Norway for a few years and do not speak Norwegian very well so that the patient is prepared for a 'challenge'. These are the same students who have been admitted to one of Norway's most competitive study programmes requiring the highest grades.

Later when working as a doctor

The rumour that as a doctor with a minority background, you must work harder to achieve the same goals as white Norwegian doctors is well established and is also described in research on medical studies in Sweden (4). We have spoken to several young doctors with minority backgrounds who find that they are given less responsibility and less challenging duties than their white colleagues. They are also

regarded as more demanding and difficult. They are swiftly corrected when they make grammatical errors in their patient records. In contrast, their white peers may never be corrected throughout their entire career, even though their records are full of such mistakes. This shows that the threshold for correcting white colleagues is higher.

Constructive feedback to doctors with and without minority backgrounds is important, but differential treatment is problematic. Young doctors with minority backgrounds find that their colleagues are always looking for mistakes in their work, and they are more quickly seen as doing a poor job than white Norwegian doctors. Medical students with minority backgrounds have been advised by more experienced doctors that they should not choose the most prestigious specialties because it will be difficult to reach the top with a minority background. What does this mean for our health service?

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We need measures at the system level

We wish to emphasise that we do not accuse educators, students, and clinical instructors in medical education in Oslo of being racists. There is a difference between intention and impact, but even well-intentioned comments can be perceived as racist. The solution to racism in medical studies mainly lies in system-level measures (3–5, 8), and a great deal needs to be done at the system level.

We need active anti-racist medical faculties that take medical students' experiences more seriously and that make targeted efforts to build the trust of students with minority backgrounds. Management, staff, and students should develop the measures in collaboration. One proposal is to hold compulsory anti-racism courses in which all teachers and students have the opportunity to reflect on their role vis-à-vis racism while acquiring tools to deal with racism in the health service. Another proposal is to improve the whistleblowing system in this respect. Most students we know have never reported an incident, partly due to the lack of information about whistleblowing systems, fear of stigmatisation, and a lack of trust in management.

The first step in creating anti-racist medical faculties is for faculty management to implement concrete and binding measures. We want to be part of an anti-racist generation of doctors.

The authors are members of the Working Group on Racism, Discrimination, and Health at the University of Oslo.

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