UNIVERSITY OF ALBERTA BLACK MEDICAL STUDENTS' ASSOCATION

Presents

CALLS TO ACTION: RECOMMENDATIONS TO ADDRESS RACIAL DISPARITIES IN THE FACULTY OF MEDICINE & DENTISTRY

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CALLS TO ACTION

SUMMARY

DIVERSITY & REPRESENTATION

- Increase representation of Black students in Medicine by addressing systemic barriers in admissions process
- Collect demographic and socioeconomic data on all applicants to identify underrepresented groups
- Ensure representation of Black Faculty at every major decision making-body in the Faculty of Medicine & Dentistry
- Ensure representation of BMSA alongside MSA and IMDSA at all levels of student government

CURRICULUM

- Broaden current pre-clerkship curriculum to include disease presentation and nuances in BIPOC patients
- Include anti-racism, critical race theory, and intersectionality of social determinants of health in curriculum
- Integrate mandatory discrimination intervention training for all medical students
- Train preceptors to disrupt racist behaviour from patients and colleagues

WELLNESS

- Commit to staffing counsellors trained in cultural safety and debriefing racial trauma for students
- Create spaces and resources for peer support for racialized students, both in pre-clerkship and clerkship
- Develop a confidential process to safely report racist behaviour by health professionals in clinical settings, and policies should ensure due process

FINANCIAL SUPPORT

- Commit to waive fees and/or create a financial bursary for students with demonstrated financial need applying to medical school
- Financially support initiatives such as the BMSA that aim to enhance the diversity of the student population and raise awareness of health disparities in minority groups

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Rosemary Brown

We must open the doors and we must see to it they remain open, so that others can pass through

PREFACE

The world has propelled into action against racism in the wake of the tragic losses of George Floyd, Ahmaud Arbery, Breonna Taylor, Rayshard Brooks, Regis Korchinski-Paquet, D'Andre Campbell, Chantel Moore and many others. We have become confronted with the experiences of Black, Indigenous, and People of Color (BIPOC) citizens in our society and are now engaging in mass education to address biases, understand microaggressions, acknowledge systemic racism, and agree emphatically that we all have a role to play in resolving these issues. Addressing the effects of racism in our society is much like formally introducing ourselves to someone for the first time; though they have existed all along, we now recognize them everywhere.

The legacy of systemic racism, and anti-Black systemic racism is not confined to the United States. Black people in Canada are more likely to be racially profiled by police, with Black Edmontonians being 3-5 times more likely to be carded than non-Black citizens (1). Black individuals are also more likely to be victims of hate speech, be overrepresented in our criminal justice system, experience disparities in health outcomes, and be underrepresented in academia (2-4). Specifically at the University of Alberta, we see that Black individuals make up approximately 6% of the Edmonton population but only represent 1.2% of students in the MD program - There is only one Black student in the Class of 2023 (5). Needless to say, the challenges of being Black in Canada permeate to many facets of life.

The plight of Black Medical Students has not fallen on deaf ears. We have been inundated with support from colleagues, Faculty allies and student interest groups. However, the MD program has a mandate of social accountability to the populations we serve, including representation from minority and marginalized communities. As physicians, we must be equipped with the knowledge and tools to advocate for our BIPOC patients and understand the intersection of social determinants with health outcomes. As citizens of Canada (which prides itself on multiculturalism) we must recognize the systemic injustices inflicted upon BIPOC. Identifying and calling-out injustices is necessary but not sufficient. This Call To Action provides numerous suggestions for meaningful change and should be integrated into the Faculty of Medicine & Dentistry (FOMD) Strategic Plan. Many of the actions can be implemented immediately, while others might take time. Regardless, all meaningful change requires action, and the time for that is now!

LAND ACKNOWLEDGEMENT

We respectfully acknowledge that the University of Alberta is located on Treaty 6 territory, and respect the histories, languages, and cultures of First Nations, Metis, Inuit, and all First Peoples of Canada, whose presence continues to enrich our vibrant community.

ACKNOWLEDGEMENTS

First and foremost, we would like to thank Dr. Tracey Hillier for her service to students of the MD Program as the Associate Dean and for her support in the growth and development of our BMSA as a genuine ally. We would also like to thank our Faculty advisors Dr. Sita Gourishankar, Dr. Helly Goez, Dr. Jill Konkin, Dr. Melanie Lewis, Dr. Cheryl Goldstein, Dr. Kim Kelly, Dr. Shelby Haque, Dr. Deng Mapiour, Dr. Ophillia Ziwenga and Dr. Brenda Hemmelgarn for their support in our initiatives and for pushing our BMSA's vision forward. We thank Dr. Bukola Salami from the Faculty of Nursing for her public health perspective. We thank all administrative staff in the MD program who have been instrumental in our many consultations. We thank Ike Okafor and Dr. Onye Nnorom from the University of Toronto for sharing with us their successful program frameworks and their mentorship on its implementation. We thank the University of Calgary BMSA for inspiring the creation of our own Calls To Action. We also thank the Black Medical Students' Association of Canada (BMSAC) and all of our local BMSA chapters for continued collaboration, for empowering our voices, and for cultivating a strong and extensive network. Last, but not least, we thank our student colleagues, friends, and community members for their outreach and for standing in solidarity with us.

INTRODUCTION

Legacy of Anti-Black Racism in Canada

Canada's legacy of racism is not as commonly discussed as that of the United States, however we too have an extensive history of systemic anti-Black racism that must be understood in order to appreciate their contributions to today's current social and political climate. Here we mention just a few manifestations of this legacy:

Anti-Black Immigration Policies

Amber Valley was an all-Black settlement 160 km north of Edmonton and was made up of Black migrants fleeing racial tensions in the United States between 1909-1911. These migrants built their town from the ground up and as urbanization increased, dispersed to Edmonton, Calgary and surrounding areas, where many of their descendants still live today. Additionally, migrants contributed immensely to the cities they lived in, with Oliver Bowen (an amber valley descendant) engineering Calgary's first C-train (6). However, regardless of their contributions, the migration and overall influx of Black immigrants in Alberta, caused uproar. Several organizations, including a women's group, petitioned in Parliament to ban Black people from Edmonton (7).

This uproar against Black immigrants was not isolated to Alberta. In 1911, Prime Minister Sir Wilfrid Laurier approved Order-in-Council P.C. 1324, which would ban Black persons from entering Canada because, "the Negro race is deemed unsuitable to the climate and requirements of Canada." Finally, when Canada was encouraging a wave of immigration in the early 1900s, the interior ministry created a prioritization list used to approve immigrants based on ethnicity. Black people were at the bottom of this list (7).

Racial Segragation in Canadian Schools

Although segregation was not directly enforced by legislation in Canada at the primary and secondary school level, it was enforced in informal ways by White parents, teachers and trustees who were supported by law enforcement. In 1850, the Common Schools Act in Ontario added the Separate Schools Clause which allowed Protestants, Catholics, and Black people to request separate schools (8). However, school trustees used this as a way to enforce racial segregation of Black students, even when Black parents objected (8). Such legislation would then expand into more eastern provinces like Nova Scotia (9). These practices which continued until the late 1960s, allowed for racial segregation of students into different desks, classrooms, or schools entirely (10).

While legislation did not directly support such segregation in Alberta, Saskatchewan, New Brunswick, and PEI, it was a common and acceptable practice for residents and teachers to deny Black students access to local public schools without any fear of interference from legislative bodies (8).

Ku Klux Klan in Alberta

The history of anti-Black racism in Alberta is also manifest in the popularity and power held by anti-Black racists groups in Alberta, such as the Ku Klux Klan (KKK). The Alberta chapter of the KKK was established in 1923, and was very prominent in Edmonton in the 1930s, having approximately 7,000 members in comparison to the Edmonton population of 80,000 at the time (11). Dan Knott, the mayor of Edmonton (1931-1934), was associated with the KKK and granted them permits to hold public picnics in the Northlands of Edmonton where they were allowed to erect burning crosses (12). While it remains unclear whether Knott had official membership in the KKK, Knott was pictured attending several KKK meetings and the KKK convention in Calgary in 1931 (13). Although the KKK's registry in Alberta lapsed in the 1950s, their registration was renewed in 1980 and remained in effect until 2003 (14).

Legacy of Anti-Black Racism in Medicine

The legacy of anti-Black racism in North America is also pervasive in the context of medicine. We see such manifestations in various incidents of unethical medical experimentation on Black people, institutional anti-Black bans in medical education, and cases of clear racial profiling of patients.

Medical Experimentation

Tuskegee Syphilis Study

One of the most notorious examples of unethical experimentation conducted by the United States Public Health Service (USPHS), was the Tuskegee Syphilis Study in 1932. In this study, 600 Black men were enlisted and misinformed that they were receiving treatment for anemia over the course of six months, when in reality the purpose of the study was to examine the effects of untreated syphilis in a study that lasted 40 years. Participants were not informed of their syphilis diagnosis and did not receive treatment. At times, they were even barred from treatment - even though penicillin had already been established as an effective therapy at the time of the study (15,16).

Immortalized Without Consent

In 1951, Henrietta Lacks' cancer cells were harvested without her family's consent and without compensation, while she was receiving cervical cancer treatment at Johns Hopkins Hospital. Lacks' cancer cells are the source of the first immortalized human cell line, which is in common use to this day – the HeLa cell line (17).

James Marion Sims

Known as the "Father of Modern Gynaecology," much of James Sims' medical breakthroughs in gynaecology were achieved through unethical experiments on enslaved Black women. These experiments were conducted without anesthesia, or consent of the women; however, their owners were financially compensated. Historians report that Sims was often more interested in the experiments than the therapeutic treatment, and that he operated under the erroneous notion that Black people did not feel pain (18,19).

The Flexner Report

In 1908, Abraham Flexner was indirectly contracted by the AMA to review and report on the 155 medical schools across North America to guide the reformation of medical education. Flexner released the Flexner Report which became the basis of medical education reformation and is followed by most medical schools in North America, even in the present day. Additionally, the Flexner report suggested that five of seven predominantly Black medical schools across North America be closed down and that Black physicians should only treat Black patients, as subordinates to white physicians (20). Flexner recommended that "the practice of the Negro doctor [be] limited to his own race…[because] the physical well-being of the Negro is not only of moment to the Negro himself… Not only does the Negro himself suffer from hookworm and tuberculosis; he communicates them to his white neighbors… self- interest seconds philanthropy. The Negro must be educated not only for his sake, but for ours (21)." For the fifty years directly following the release of this report, Black medical student admissions declined substantially in North America. It is believed that the Flexner report is directly responsible for the disproportionately poor admission rates of Black medical students to this day (22).

Anti-Black Medical School Policies

From 1918 to 1965, there were various official policies enforced to exclude Black students from being admitted to medical schools across the University of Toronto, McGill University, Dalhousie University and Queen's University (8). The policy excluding Black students from Queen's, although no longer enforced since 1965, was still in place until 2018 when the ban was repealed and a formal apology was given (23).

The American Medical Association (AMA) strongly supported such policies, and in fact, AMA itself did not welcome Black physicians until 1965 – 118 years after its establishment (8).

John River's Story

While there is an extensive history of unfair treatment of Black people in the history of medicine, John River's story is a contemporary one in Canada. In December 2017, award-winning Black Canadian rapper, John River began experiencing extreme neck pain, blurry vision, loss of senses, and sensitivity to light. Given that River had recently had a spinal tap, he visited more than five Greater Toronto Area hospitals seeking help. On various occasions, his symptoms were completely ignored by nurses and physicians, and he was accused of faking symptoms to receive narcotics. River claims that he was accused of being a drug user and dealer, and not "educated enough" to understand that the pain he was feeling was conjured up in his imagination. After 60 days of pain, River and fellow artists shared his story on their platforms, thereby increasing media pressure on doctors to take his condition seriously. Three months after his initial hospital visit, River was diagnosed with Spontaneous Cerebrospinal Fluid Leak and required an emergency procedure (24).

The aforementioned injustices, though numerous, reflect only a small fraction of the inequities Black people have faced in Canadian history and the history of medicine. In 2017, the United Nations reported that they were "... deeply concerned by the structural racism that lies at the core of many Canadian institutions and the systemic anti-Black racism that continues to have a negative impact on the human rights situation of African Canadians (9)." "...The cumulative impact of anti-Black racism and discrimination faced by African Canadians in the enjoyment of their rights to education, health, housing and employment, among other economic, social and cultural rights, has had serious consequences for their overall well-being." Of particular note, the UN report highlighted health disparities for Black Canadians, stating, "Several factors contribute to these health disparities, including historic barriers to access and continuity of health care, long-standing systemic racism, low socioeconomic status, lack of cultural specificity in health education and underrepresentation of Black health professionals in the system (9)." The legacy of colonialism, the social construct of racial classification, and the Flexner Report, in addition to institutional policies against Black immigration, education, and prosperity, are all foundational and contributory to the injustices Black people face today.

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DIVERSITY & REPRESENTATION

FOMD's COMMITMENT TO EQUITY, DIVERSITY & INCLUSION

As detailed in the University of Alberta Faculty of Medicine & Dentistry (FOMD) Diversity Policy, the FOMD "believes its faculty, staff and students will be best able to serve diverse populations, if their own personal backgrounds and training create an understanding and appreciation of the diversity of human experience" (25). In order to achieve this, the FOMD commits to supporting "compositional diversity" (in which the diversity of the Faculty's members, support staff, and students reflect the population of greater Alberta and Canada), and promoting inclusion and cultural competence in all members of the Faculty (25). The University of Alberta BMSA shares this same vision and commits to being continually collaborative with the Faculty in efforts to accomplish these goals.

DIVERSITY & REPRESENTATION

ADMISSIONS

We call for the MD Program to increase representation of Black students in the MD program. Black Canadians in Edmonton constitute 5.9% of the population, yet Black students within the MD program only comprise 1.2% of the student body (5). It is evident that there needs to be a change in the admissions process that addresses this disparity as graduating medical students should reflect the population they serve. Moreover, studies have shown that Black students are more likely to practice in underserved communities (26), and that receiving care from someone of the same cultural background results in improved patient care and satisfaction scores (27,28). Increasing the representation of Black, Indigenous and People of Colour (BIPOC) students thus creates more equitable access to quality healthcare for BIPOC patients and would be a step towards fulfilling the FOMD's social accountability mandate. While increasing representation partly addresses the barriers to accessing culturally safe care for patients, it does not excuse the responsibility of medical programs to train all students in social accountability and cultural safety. At the moment, the MD program does not meet its mandate of training medical students to serve a population representative of Edmonton, Alberta, and Canada at large. As such, we are proposing a few key changes to the admission process to help increase representation of Black students and other underrepresented groups.

Demographic Data Collection

We propose that the Faculty of Medicine collects demographic and socioeconomic data on all applicants. This data would allow the Faculty to effectively identify underrepresented groups. In addition to Black students, there is underrepresentation of visible minorities such as Indigenous and Filipino students, and of people with disabilities in medicine (see Figure 1) (29). Additionally, medical schools in Canada are primarily composed of students from affluent backgrounds and with parents who have obtained higher education (30). By collecting and sharing demographic data for MD program applicants, we can develop metrics to hold ourselves accountable to the public we serve, identify underrepresented groups, and assess our progress towards goals of promoting equity, diversity and inclusion within our incoming classes.

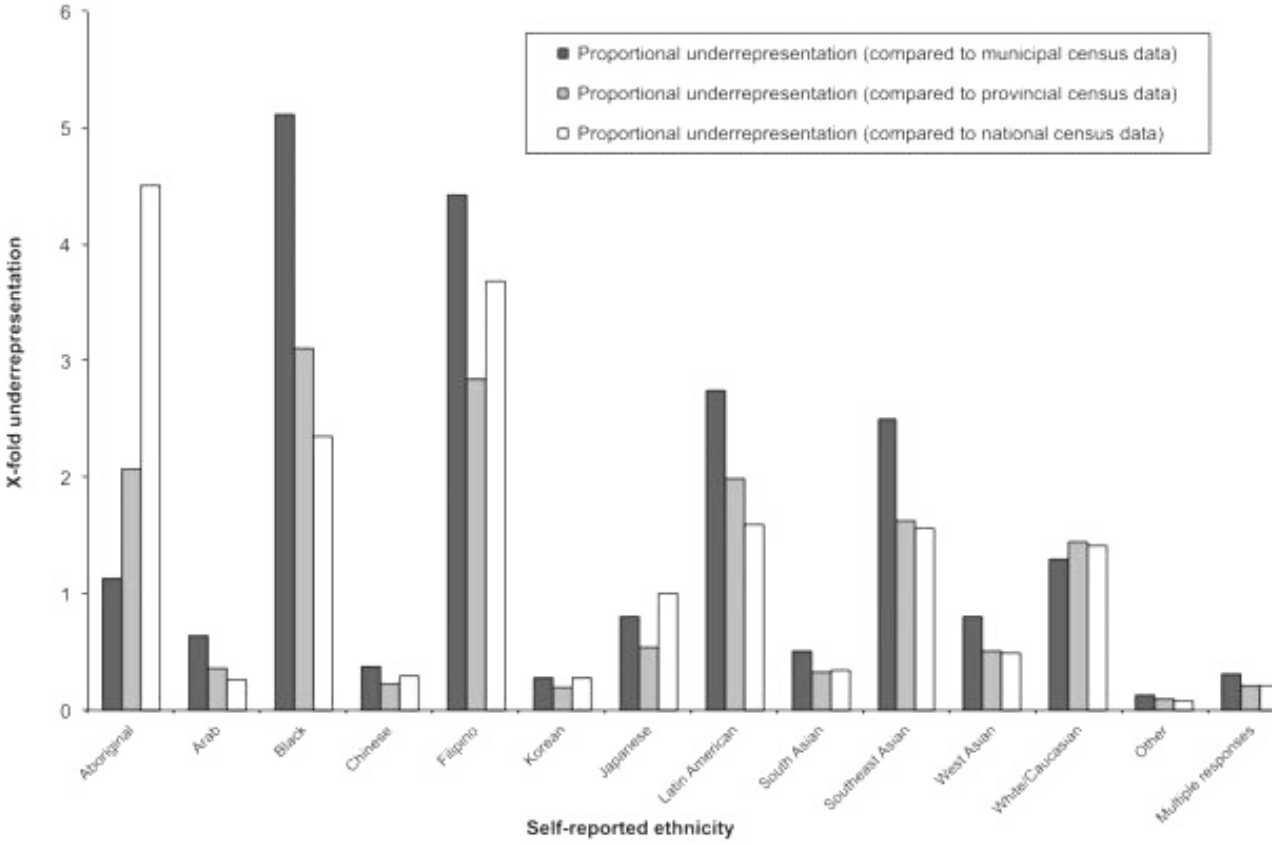

Figure 1: A graph from a study by Young et. al displaying underrepresentation of self-reported minority groups at four medical schools, compared with municipal, provincial, and national census data (29).

Black Canadian Admissions Working Group:

We propose that the MD program establish a Black Canadian Admissions Working Group, similar to the one successfully created and implemented at the University of Toronto (31). The goal of the Working Group will be to increase efforts in the outreach to, and recruitment of Black Canadian students, and to increase the number of Black Canadian students in the Undergraduate Medical Education program.

The working group will be composed of:

- Black physicians, faculty, and community leaders
- Allied Health Professionals
- Post-graduate medical education residents/fellows
- BMSA representatives
- Assistant Dean of Admissions MD Program
- Assistant Dean EDI Faculty of Medicine & Dentistry
- Registrar representation

Black Student Application Process (BSAP):

Mirroring the great work done at the University of Toronto medical school, we propose the formation of a Black Student Application Process (BSAP) (32).

The purpose of BSAP will be to decrease the systemic biases, whether implicit or explicit, within the MD admissions process so that we can better identify gaps in the admission process for qualified Black applicants. Black students are often hesitant to share extracurriculars related to Blackness or culture for fear of their experiences being judged or disregarded by file reviewers. Applicants will be given the opportunity to self-identify as Black* and the opportunity to tell a narrative about their experiences as a Black individual through an optional application process. Furthermore, BSAP applicants will meet the same requirements as all other applicants (MCAT, GPA, Extra-curriculars etc.). To reduce the role of bias within the admission process, file review and interview will include Black physicians and/or Black community members. The active participation of the Black community during this application process will empower the community and help them choose physicians that will serve their community as well as others in the future. We believe that this admission process will encourage Black applicants to share their unique experiences. Moreover, Black applicants will feel confident knowing their application is being reviewed by someone qualified to understand their experiences.

Expand Existing Pipeline Programs

The strength of applications processes such as BSAP, and the Indigenous Health Initiatives Program (IHIP) rely on the ability to get students to the stage where applying to medical school is plausible. Students must have access to “pre-med” mentorship, research, job-shadowing, MCAT financial support, CASPER preparation, application review, and interview support before applying. Notably, many students of higher socioeconomic status and greater social capital already have ample access to these resources. Furthermore, there is evidence to suggest that support is needed as early as middle school because “failure to aspire” is often a consequence of lower socioeconomic status (33).

In the FOMD, some of these disparities are already being tackled by MD Admissions Initiative for Diversity & Equity (MD AIDE), a program which provides free MCAT and interview prep for low-income and Indigenous students. In a survey done in 2018, 100% of MD AIDE survey respondents claimed that the program was an important pre-entry support, which helped them address barriers of entry into medicine (34).

*Black African, Black Caribbean, Black North American, or multi-racial students who identify with Black ancestry

We propose that this much needed program expand its reach in the following ways to continue to remove barriers for underrepresented students:

1. Expand its target to underrepresented populations within the FOMD including students who are Black, Indigenous, Filipino, economically disadvantaged or identify with having a disability.
2. Work with community leaders in the underrepresented minorities to establish grassroots engagements, better understand the challenges specific to these groups, and identify avenues to rectify them.
3. Extend recruitment of MD AIDE to other post-secondary institutions within Edmonton such as NAIT, MacEwan University, Concordia University College, and Norquest College. We hope this will better engage students who may not otherwise have supports and inspire their schools to implement similar programs.
4. Collaborate with the Community of Support program at the University of Toronto, which historically has mentored BIPOC students on their successful journeys to medicine, and other programs with shared goals.
5. Engage with middle schools and high schools consisting of identified underrepresented populations to promote pursuit of higher education and the notion that a career in medicine is attainable. We propose this be done in collaboration with existing student outreach organizations in the FOMD, including but not limited to: Venture Healthcare, MD Ambassadors, Rockin' Docs, and Asclepius Medical Camp.
6. Assign a staff lead to work with student Co-Leads in expanding the scope of the program and its execution. The FOMDs' utmost pre-entry EDI initiative should not be entirely student-driven.

The journey to medical school starts long before the MCAT. There are several barriers inhibiting students several stops before, which we must address to ensure that all groups are represented in our incoming medical classes.

DIVERSITY & REPRESENTATION

FACULTY REPRESENTATION

In the pilot FOMD voluntary Diversity Census Results in 2017, only 15% of respondents reported as racialized, which is significantly lower in comparison to the percentage of racialized undergraduate students and racialized doctoral degree holders in Canada at 36% and 31% respectively (4, 35). Similarly, in the FOMD, there is limited visibility of Black instructors in our medical education. We encourage the FOMD to continue to assess best practices in departmental hiring committees, as the survey data admittedly raises questions about our hiring processes and whether they are as equitable and inclusive as they can be (35).

FoMD Diversity Census key results
6.3 per cent of respondents self-identified as a person with disability
3.6 per cent self-identified as LGBTQ
15 per cent of respondents said they felt they were racialized
0.3 per cent people self-identified as being raised in northern Canada
11 per cent identified as being raised in rural communities in Canada or elsewhere
57 per cent were raised in Western Canada
23 per cent were raised in a country outside of Canada
30.5 per cent reported that the persons that raised them had a graduate degree or professional designation
22.8 per cent reported that the persons who raised them completed secondary schoo

Figure 2: A table from the FoMD voluntary pilot Diversity Census in 2017 (35).

We call that the FOMD increases representation of Black physicians as preceptors for lectures, longitudinal clinical experiences (LCE), communications, and physical exam sessions in the MD program by considering how calls for these opportunities are delivered. We encourage course coordinators to welcome and support a diverse cast of teachers in creating and instructing their courses. Additionally for opportunities such as discovery learning (DL) and physician discussion groups (PDG), where participation is open to all faculty, we recognize that there are barriers to participation. Therefore we call for professional development and support opportunities, which address the differential barriers that BIPOC faculty face in engaging these opportunities. It is crucial to endorse a diverse cast of educators to demonstrate cultural and racial nuances, while being mindful of tokenism, in patient care.

We believe this will contribute to addressing the current gaps identified in our medical education (see “Curriculum”). Having diverse faculty will also help to minimize biases and oversights towards racialized groups among physician educators and deter the transfer of such biases to students. Furthermore, we demand that Black Faculty be present at all major decision making bodies within the FOMD, including but not limited to: the MD Curriculum & Program Committee (MDCPC), the Faculty Academic Standings and Promotions Committee (FASPC), the Pre-Clerkship and Clerkship Sub-Committees, Faculty Council, and the Admissions Committee. Nonetheless, the service that Black faculty provide to their communities and on committees should be greatly valued, and measures must be taken to ensure the limited number of Black faculty are not overtasked and thus hindered from career advancement. Increasing the number of Black faculty would be useful in mitigating this.

Additionally, we propose a Black Health Lead to oversee educational elements as they pertain to Black Health in Canada (see “Curriculum”). We also recommend that demographic data collected on our Faculty members continue to be available to the students, faculty, University, and public. This transparency in our metrics will continue to ensure accountability to the Faculty’s long-term equity, diversity and inclusion goals. Lastly, we ask that all faculty receive group-based, interactive training in cultural safety. We acknowledge that this training is part of on-boarding faculty in many departments but seek to improve this process.

STUDENT REPRESENTATION

In addition to addressing admission barriers for prospective Black students, we call for representation of the BMSA alongside the Indigenous Medical Students’ Association (IMDSA) and Medical Students’ Association (MSA) at all levels of student government and Faculty decision-making bodies with student representation including but not limited to: MDCPC, Admissions Committee and Faculty Council. We look forward to representing and advocating for the health of BIPOC within our medical program and within the community at large.

CURRICULUM

PRE-CLERKSHIP (Y1-Y2)

We call for the FOMD to require all students to learn and understand critical race theory and its relation to medicine. Students should be provided with skill-based training in anti-racism, cultural safety, and human rights. This will be accomplished by broadening areas of the pre-clerkship medical curriculum to ensure that courses are more racially conscious. Anti-Black and anti-Indigenous teachings must be removed from the curriculum. A curriculum focusing on minority health can improve students' perceived skill at treating minority patients and increase the likelihood that they will practice in underserved areas (36). Modifications can also be made to Physicianship and Discovery Learning to focus on anti-racism, and student experiences (see Figure 3).

Figure 3: Quotes shared by Black pre-clerksip students in the MD program

We have identified various areas for improvement across various learning settings in pre-clerkship below:

Amendments to Course Blocks*

DMED 511 - FOUNDATIONS OF MEDICINE (HEMATOLOGY)	• Hematologic reference ranges do not apply to all ethnic groups and differ in Black patients (37). • Jaundice can be harder to notice in darker skinned individuals. Students should be instructed to examine the hard palate of the mouth and inner canthus of the eyes if jaundice is suspected in a darker skinned individual. • Emphasis should continue to be placed on the possibility of sickle cell anemia or thalassemia trait in darker skinned patients with hematologic abnormalities.
DMED 511 - FOUNDATIONS OF MEDICINE (PAIN MANAGEMENT)	• Pain in BIPOC patients is often underestimated or attributed to drug seeking behavior (38). • Black patients may be more stoic in their presentation of pain, which may lead to physicians using inadequate pain medication in this population (38). • Some students have the notion that there are racial differences in pain perception. This is a misconception and it should be emphasized in lectures that individuals differ in their expression of pain rather than in their perception of it. • The aforementioned disparities should be referenced in acute and chronic pain lectures.
DMED 515 - CARDIOLOGY	• Black patients are more likely to develop hypertension and heart disease compared to Caucasian patients (39). • Black patients respond less to ACE inhibitors compared to Caucasian patients. Beta-blockers and diuretics have demonstrated better efficacy in Black patients (40-43). • These differences in treatment guidelines should be taught in more detail during the cardiology block. • Students should be advised on how to examine discoloration in melanated patients in response to critical ischemia. • An element of chronic disease management and lifestyle changes for racialized/low-income populations should be incorporated into the curriculum.
MED 522 - REPRODUCTIVE MEDICINE & UROLOGY	• Black women experience higher rates of morbidity and mortality during pregnancy, and receive inadequate care compared to Caucasian women (44). • Black women have higher rates of preterm births compared to White women (45). • Students should be made aware of the socioeconomic factors that lead to these disparities and should be encouraged to advocate for pregnant Black women during their care.

*Dr. Onye Nnorom from the University of Toronto and Dr. OmiSoore Dryden from Dalhousie have assembled a team of scholars across Canada that are developing an online primer for medical students to learn about Black health, and how anti-Black racism functions as a driver of health inequities.

DMED 523 - MUSCULOSKELETAL SYSTEM (DERMATOLOGY)	• There is a limited scope of learning with regards to how dermatological conditions manifest in individuals with darker skin. Sample images of skin conditions in darker skinned individuals should be included in case presentations. • The case-based tutorial session should include BIPOC patients. • Malignant melanoma is learned in the context of fair-skinned individuals. Emphasis should be placed on the increased likelihood of acral lentiginous melanoma in darker-skinned individuals and where it presents (i.e. fingernails, soles of hands and feet) (46).
DMED 529 - PSYCHIATRY	• Black patients with mental health issues are considered to be more violent than their Caucuasian counterparts and are more likely to be involuntarily admitted (47-48). • Black patients with mental illness are less likely to be offered psychotherapy and more likely to be offered pharmacotherapy (47-48). • Every student should be aware that Black patients presenting with delirium are more likely to be turned away and accused of malingering or drug usage (47). • Students should be made aware that mental health issues are more prevalent and less effectively treated in Black communities.
ALL COURSE BLOCKS	• We recommend that each block highlight racial and ethnic differences in the presentations of common diseases **Discovery Learning** • Cases should feature a more diverse cast of patients that highlight some of the racial differences taught in lecture but without subscribing to only stereotypical racialized presentations (e.g. a Black patient can just have a URTI). • Learning objectives should highlight racism and mistreatment in the vignettes and prompt students to have discussions about addressing and reporting racism within medicine.

Table 1: A list of medical competencies all University of Alberta Graduates should have when treating Black patients.

Amendments to Physicianship*

PHYSICIAN DISCUSSION GROUPS (PDG)	• Sessions that are designed to address racism should be facilitated by preceptors from the BIPOC communities and/or preceptors that are adequately trained to facilitate racism-sensitive discussions. • A protocol should be developed for addressing racist incidents. • Students should be aware that racist behavior warrants use of the Professionalism button. • There should be meaningful discussion of race as a social construct during discussion groups.
CRITICAL RACE THEORY (CRT)	• An overarching theme of Physicianship should be Critical Race Theory (CRT). A fundamental principle of CRT is that power structures in society (including healthcare) are based on White privilege and that these power structures often preserve the marginalization of people of color (49). • In many courses, health disparities are noted but the reason for them is not explored. While noting these differences is a good first step, students must understand why these differences exist. • We propose that the structural inequalities that cause health disparities be taught in lecture. These include social, historic, and economic legacies that have generated health disparities in persons of color and that continue to sustain these disparities.
RACISM IN MEDICINE	• Students should be informed on the racist history of Medicine and the manifestations seen in unethical testing and experimentation. • Students should be informed on the racist ideologies of many of Medicine's influential figures, how their ideas were conducive to cultivating ethnocentrism in institutional medicine, and how those ideas still persist today. • Students should be educated on the deleterious effects of racism as a social determinant of health and racial stress as a risk factor for disease.
SOCIAL DETERMINANTS OF HEALTH	• Students should be educated on the effects of the social determinants of health, including but not limited to: food insecurity, education, socioeconomic status, neighbourhood/environment, and community/social context. • Students should be educated on how these social determinants intersect, disproportionately affect marginalized and minority populations, and contribute to higher prevalence of disease.

PATIENT EXPERIENCES	• Patients sharing their experiences with disease to the medical class, or patients participating in PIE (Patient Immersion Experience) should come from different backgrounds and socioeconomic status to better equip students to recognize the intersectionality of race, SES and disease.
DMED 529 - PSYCHIATRY	• Black patients with mental health issues are considered to be more violent than their Caucuasian counterparts and are more likely to be involuntarily admitted (47-48). • Black patients with mental illness are less likely to be offered psychotherapy and more likely to be offered pharmacotherapy (47-48). • Every student should be aware that Black patients presenting with delirium are more likely to be turned away and accused of malingering or drug usage (47). • Students should be made aware that mental health issues are more prevalent and less effectively treated in Black communities.

Table 2: A list of cultural competencies all University of Alberta Graduates should have when treating Black patients.

As students early in our medical careers, we humbly recognize that the areas listed here for improvement are in no way exhaustive. We propose that our student Course Representatives work with faculty Course Coordinators and BIPOC faculty members to identify gaps in our current curriculum and ensure these objectives are met for our student body.

CURRICULUM

CLERKSHIP (Y3-Y4)

Medical students from minority communities have expressed a number of concerns regarding the clerkship experience, particularly within rural communities. Here we propose a number of changes that would make the clerkship experience more inclusive and safe for BIPOC. There have been a number of concerns by Black students regarding clerkship (see Figure 4), including but not limited to:

- Fear of being mistreated by patients and staff in rural settings
- Hearing racist discrimination and inappropriate jokes from students, staff, and residents about Black patients and health care workers
- Anxiety surrounding performance due to stereotype threat
- Stress regarding finances during clerkship (e.g. buying a car, insurance, travel, books etc.)

Figure 4: Quotes shared by Black clerkship students in the MD program

Based on the concerns of clerks we recommend several amendments to clerkship that will improve the experience for all students.

1. A process to safely report racist behaviour by healthcare professionals (i.e. physicians, nurses, clinical assistants etc.) and patients without fear of repercussions is greatly needed. Furthermore, clerkship representatives should ensure that preceptors are held accountable for racist behaviour.
2. To enrich the learning experience of BIPOCs, we believe the diversity of preceptors during clerkship should be expanded when possible. Learning from someone of a similar phenotypic and cultural background is a powerful and enriching experience for students of colour. As aforementioned, increasing the number of Black physicians in leadership positions within the faculty is crucial.
3. Seminars on financial management during clerkship and greater financial support for clerks is necessary to reduce anxiety surrounding clerkship that many students struggle with.
4. Cultural safety workshops prior to clerkship for all students should be developed. The purpose of these workshops is to encourage critical thinking regarding race and bias in clinical medicine. The goal of this would be to increase structural competency of students entering clerkship so that the experience of BIPOC patients is improved. The Association of American Medical Colleges (AAMC) defines structural competence as “the ability to identify how disease and symptoms are informed by access to health care and food, urban zoning, racism, and educational systems” (51). These workshops should be held in person and require active participation of all students before the start of rotations.
5. Finally, preceptors need to be trained to disrupt racist behaviour from patients and debrief with BIPOC learners. Too often these exchanges are marked by a double silence, silence towards the remarks directed at the BIPOC learner, and failure to address what occurred afterwards with the learner. With training, preceptors can be allies in these moments and set the tone of an inclusive culture.

CURRICULUM

BLACK HEALTH LEAD

To champion the necessary updates to curriculum, we propose the role of a Black Health Lead at the Faculty level. This MD Program Lead for Black Health Education position relates to health education regarding the Black people of Canada. The Lead would be responsible for the design, implementation, and evaluation of educational elements that constitute a curricular theme in Black Health across all four years of the MD Program. The necessity and success of such a role has been shown at the University of Toronto (52). This position would reflect:

1. The FOMD's mandate of social responsibility to develop and work towards specific health goals for underserved communities.
2. The FOMD's commitment, as identified in the Diversity Statement, to celebrate the strength in diversity and promote diversity, equity and inclusion at all levels including: employment, medical education, and patient care delivery.
3. The University of Alberta's commitment, as identified in the Diversity Statement to welcome applications from visible minorities and all those who contribute further to the diversification of ideas.

WELLNESS

STUDENT WELLNESS

The ongoing racial trauma that BIPOC students face has significant impacts on their mental health and wellness. Literature demonstrates that for Black university students, their experience of being Black can exacerbate the sense of imposter syndrome and feelings of being intellectually inferior (53, 54). This is especially true for Black medical students who face the distress of being racialized in addition to the recognized pressures of medical education (55). In Black medical students, race contributes to this psychological distress (56). Moreover, for medical students whose self-concept is linked to their race, that is having a strong racial identity, there are higher rates of everyday discrimination and lower feelings of acceptance (57). Furthermore, we can consider the effect of stereotype threat, the fear of being perceived in accordance to negative stereotypes of one's race/ethnicity, on behaviour. Literature demonstrates that this phenomenon may prevent Black patients from accessing healthcare (58). Considering the high expectations and performance based nature of medical education, Black students who are used to experiencing stereotype threat may continue to deal with its effects afterward.

Given the experiences of Black medical students at the University of Alberta, which include, but are not limited to peer comments that , devalue Black student experiences, target certain ethnic groups, and demonstrate a lack of empathy to lived experiences, we call the FOMD to:

1. Commit to staffing counsellors trained in cultural safety and debriefing racial trauma for students. All counsellors should be knowledgeable in basic mental health needs of racialized populations, and the effect of intersectionality on the experience of underrepresented students.
2. Create a space and resources for peer support for racialized students, both in pre-clerkship and clerkship. This peer support mandate should be integrated into existing, funded student wellness programs, to ensure its sustainability.
3. Integrate mandatory discrimination intervention training for all medical students. This training must be skill based and interactive, using techniques supported by literature such as role playing, small group discussions and simulation based learning. This training should also address how to identify and respond to microaggressions. This training should be co-designed by the BMSA, IMDSA, the Office of Professionalism and the Office of Advocacy and Wellness.

4.Track formally and informally reported cases of hate based incidents, including racism, sexism, islamophobia and homophobia. This will allow the program to monitor deficits in Faculty and student training and better equip students to be successful.
5. Hire diverse staff which mirror the community we serve. Student groups such as the BMSA and Indigenous Medical Students' Association (IMDSA) can work with Faculty on looking at job descriptions for staff roles (i.e. personal counselors, career counselors, etc.) and such roles can be promoted through community connections.
6. There should be sound policies and consequences for faculty or staff that harass/mistreat students, and policies should ensure due process.

FACULTY WELLNESS

The challenges to wellness faced by BIPOC are not unique to students, but also affect BIPOC Faculty. As stated from the FOMD Office of EDI, "we need to be aware of the well-being of people we hire to be part of the faculty, and how we groom them for promotion, for success, for happiness and satisfaction at work" (59). We encourage the continued assessment of our practices to ensure that all Faculty are in good well-being and equitably equipped with tools for success and advancement in their careers.

FINANCIAL SUPPORT

The FOMD should commit to waive fees and/or create a financial bursary for students with demonstrated financial need applying to medical school. This will help alleviate financial barriers that some BIPOC face when applying to medicine. The FOMD should financially support initiatives such as the BMSA that aim to recruit more Black students and enhance the diversity of the student population. Furthermore, financial scholarships covering all four years of medical school should be made available to BIPOC students. This will encourage more BIPOC students to choose the University of Alberta for their medical education.

SOLIDARITY

WITH ALL PROFESSIONAL PROGRAMS

We recognize that the challenges of BIPOC students and staff are not limited to the MD Program. Similar challenges are seen in programs within the Faculty of Medicine & Dentistry, and broadly within professional programs at the University of Alberta including: the Faculty of Law, Faculty of Pharmacy and Pharmaceutical Sciences, Faculty of Rehabilitation Medicine, Faculty of Nursing, Faculty of Education, School of Public Health, Faculty of ALES, Faculty of Engineering, Faculty of Native Studies, Faculty of Science, Faculty of Graduate Studies and Research, and the Alberta School of Business. We encourage all faculties to examine their current practices, identify areas for improvement in serving BIPOC students, and work with BIPOC Faculty to optimize curricula in ways that produce culturally safe professionals. The University of Alberta BMSA advocates for and stands in solidarity with all BIPOC and marginalized groups at the University of Alberta and within our community at large.

CONCLUSION

We recognize that the FOMD is continually working towards practicing equity, diversity, and inclusivity, and not simply the philosophy of it. We also recognize the FOMD's progress over the years in diversifying our classrooms and Faculty and the space created for this work by the pioneering accomplishments of the Faculty's Office of EDI (60). Nonetheless, it remains evident that some groups remain consistently underrepresented within the FOMD. We encourage continued transparency with the student body, Faculty, University, and community at large regarding the metrics used to assess EDI progress, and the initiatives implemented to address current gaps. In addition to increasing representation of Black students and Faculty in the MD program, it is crucial that we develop a curriculum, which elaborates important nuances in the health of minorities. Additionally, we must continue to cultivate a culture that is safe and welcoming for members of all minorities, conducive to their success and development, and cognizant of their wellness.

Dr. Goez, the Assistant Dean of Diversity, provides an eloquent analogy regarding EDI discussions at the institutional level: "It's like opening a box that was firmly closed for years, and now when opening it up, questions and concerns are raised" (60). By opening this box, we allow for continued reflection on our practices, feedback from members within our Faculty, and identification of areas for continual improvement; all of which are cardinal traits of successful institutions. We commit to collaborating with the FOMD in achieving our shared goals and look forward to the incorporation of these proposals in the FOMD Strategic Plan.

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STUDENT GOVERNMENT

Medical Students' Association
University of Alberta

Education Students' Association
University of Alberta

Law Students' Association
University of Alberta

Canadian Federation of Medical Students
President
Victor Do, MD
PGY1 Pediatrics, University of Toronto

Rehabilitation Medicine Students' Association
University of Alberta

Interdepartmental Science Students Society
University of Alberta

STUDENT INTEREST GROUPS

MD Admissions Initiative for Diversity & Equity (MD AIDE)
University of Alberta

Indigenous Medical & Dental Students' Association
Univesity of Alberta

Filipino Association of Medical Students
University of Toronto

Black Medical Students' Association
University of Calgary

Ethiopean & Eritrean Students' Association
University of Alberta

Black Medical Students' Association of Canada

Nigerian Students' Association
University of Alberta

Black Graduate Students' Association
University of Alberta

COMMUNITY ORGANIZATIONS

CEFA

Council of Edmonton Filipino Associations

Africa Centre

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