Six ways to get a grip by calling-out racism and enacting allyship in medical education

Six stratégies pour lutter contre le racisme et pour promouvoir la solidarité dans l'éducation médicale

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Abstract

Actively addressing racism in our faculties of medicine is needed now, more than ever. One way to do this is through allyship, the practice of unlearning and re-evaluating, in which a person in a position of privilege and power seeks to operate in solidarity with a traditionally marginalized group. In this paper, we provide practical tips on how to practice allyship, giving educators and leaders background understanding and important tools on how to actively promote equity and diversity. We also share tips on how to promote inclusivity to more accurately reflect the communities we serve. Through six broad actions of being, knowing, feeling, doing, promoting, and acting, we can empower individuals to become allies and address racism in medical education and beyond. Creating psychologically safe spaces, educating ourselves on our complex histories and how they influence the present, recognizing racism, and advocating for change, augments awareness from which we can pivot conversations. Acknowledging potential feelings of shame, guilt, and embracing our loss of privilege, allow necessary, but challenging, personal growth to occur. Finally, dismantling the racist structures that exist within medicine, moving us beyond individual interventions, will address the systemic nature of racism in medicine. Everyone can find a starting place within this guide, as simple, consistent actions foster change in our spheres of influence; and the ripple effect of these changes will impact attitudes and behaviours broadly.

Résumé

Il est plus que jamais nécessaire de s'attaquer activement au racisme dans les facultés de médecine. Une des stratégies qu'on peut adopter à cette fin est celle de l'allié, désignée en anglais par le terme *allyship*. Il s'agit de la pratique du désapprentissage et de la réévaluation, par laquelle une personne en position de privilège et de pouvoir s'efforce d'agir en solidarité avec un groupe marginalisé. Cet article vise à proposer aux enseignants et aux responsables des conseils pratiques sur la façon d'agir en alliés, notamment en offrant les informations nécessaires à une compréhension générale de la problématique en toile de fond, ainsi que des outils importants pour promouvoir activement l'équité et la diversité. Nous partageons également des stratégies pour encourager l'inclusivité afin de représenter plus fidèlement les populations auxquelles nous offrons nos services. Grâce à une démarche à six volets (être, savoir, ressentir, faire, promouvoir et agir), nous pouvons donner aux personnes les moyens de devenir des alliées dans la lutte contre le racisme de façon générale et dans l'enseignement médical en particulier. La création d'espaces psychologiquement sûrs, la sensibilisation aux vécus complexes et à leur influence sur le présent des individus, la reconnaissance du racisme et le plaidoyer pour le changement contribuent à une prise de conscience qui permet d'orienter le dialogue. La croissance personnelle, aussi difficile que nécessaire, passe par la reconnaissance des sentiments de honte et de culpabilité et par la renonciation au privilège. Enfin, le démantèlement des structures racistes présentes dans le monde médical permettra de s'attaquer à la nature systémique du racisme dans le milieu de la santé, au-delà des interventions au cas par cas. Tout un chacun trouvera un point de départ dans ce guide, car ce sont les actions simples et cohérentes qui favorisent le changement dans les sphères d'influence; l'effet d'entraînement que produisent les actions individuelles se traduira par un changement général des mentalités et des comportements.

Introduction

Actively addressing racism in our faculties of medicine is an ongoing imperative. As global educational and healthcare communities, we have begun to acknowledge that systemic and institutional racism exists and requires focused attention for meaningful impactful change to occur. In September 2020, in a series of national and international conferences,[1-3] we facilitated workshops examining allyship within the context of institutional racism and discrimination in medical education, building upon our previous work in this field. In response to requests to share content from these workshops, this paper provides a synthesis of our approach.

Allyship can be defined as "an active, consistent, and arduous practice of unlearning and re-evaluating, in which a person in a position of privilege and power seeks to operate in solidarity with a marginalized group."[4] Allyship is not an identity and thus it cannot be self-identified. It involves taking actions to dismantle the structures of inequity. Allyship is, therefore, a practice where inclusivity, equity, and social justice constitute the major pillars of solidarity. To effectively dismantle structures of inequity, we need to reframe our commitments and understanding of the roles we play in upholding the "supremacist systems" that perpetuate it.[5,6] It is essential that allyship be authentic.[6] We must focus our efforts on systemic changes and fundamentally address structural racism as opposed to only framing efforts as the "privileged helping the oppressed," which only continues to perpetuate a harmful narrative.[7]

For too long, power and privilege have been afforded to certain individuals and populations over others, which have been dependent on factors beyond skills, including, but not limited to, race, gender, socioeconomic status, and cultural beliefs. Nixon poignantly uses the coin model to describe how these social structures (the coin) offer unearned advantages to those on the top of the coin and unearned disadvantages to those on the bottom of the coin.[5] The "coin", as used in her paper, refers to specific relational paradigms, where an individual is found to belong to either a privileged (e.g., educated, rich, etc.) or oppressed (e.g. illiterate, poor, etc.) group. She uses this metaphor to explain that practicing allyship is for those on the top of the coin (i.e. privileged) who wish to actively dismantle the coin; it is not about saving those on the bottom of the coin, where the expertise (and experience) regarding the problem actually lies. All too often, those on top of the coin

are made invisible in the equation, nullifying their role in the systemic problem and disconnecting them from accountability in the solution.

Historically, medical curricula have inadequately addressed health equity, allyship, diversity, and inclusivity, leaving them in the null curriculum.[8,9] Absent, or only peripherally discussed, is the role medicine has played in perpetuating and supporting societal systemic racism. Medicine, as noted by Boyd and colleagues, "ignores racism as the mechanism by which racial categorizations have biological consequences."[10] While increasingly recognized as critical to address in medical education, microaggressions, defined as "statements and/or actions directed towards a traditionally marginalized group, such as a racial minority that act as indirect, subtle, and unintentional discrimination" need to be addressed in and by medical education.[11-14] Many of us have witnessed or perpetrated microaggressions in our learning environments. Some examples include inappropriate remarks framed as jokes referring to another's sexual orientation, race, or religious affiliation, or an individual continuing to interchange names of trainees of a racial minority because they "look alike."[15] Microaggressions have a significant impact on the individual(s) directly affected, with further ripple effect on learners, staff, and patients, through ambient racism.[13] While insidious, there is a way forward.

How to get a grip on calling out racism and promoting allyship

Taking practical steps to help move this dialogue forward in our spheres of influence can make a considerable difference. We provide the following recommendations on how to begin practicing allyship to address racism in medical education through being, knowing, feeling, doing, promoting, and acting differently.

1.   *Being*: Create safe spaces.

Psychological safety, according to Edmundson, is "a belief that one will not be punished or humiliated for speaking up with ideas, questions, concerns, or mistakes."[16] Psychologically safe spaces allow for constructive and effective dialogue. Individuals in the learning environment must be able to voice concerns, without fear of repercussions, to allow destabilization of the status quo that will promote learning and re-learning together. Research on high-performance teams indicates their approaches to conflict and feedback processes support personal development, foster curiosity, and preserve human connection.[17] Safe spaces are crucial on our journey

towards effectively changing the culture within medical education. As a leader, creating psychologically safe spaces means you should aim to operate from the point of view of "what others want," and not what you think they need. Fostering a sense of trust, by admitting mistakes and acknowledging ignorance, is critical and promotes open dialogue. It is important to acknowledge that Black, Indigenous, and other racialized individuals in medicine have historically, and continue to face, psychologically unsafe and toxic situations in their work, learning, and healthcare environments due to racism. Furthermore, the creation of safe spaces does not absolve privileged individuals from their complicity in upholding racist structures and associated discomfort.[18] Psychologically safe settings should foster these difficult feelings and result in personal and organization growth.

2. *Knowing*: Educate yourself.

It is critical that we make a concerted effort to educate ourselves on the history of race and medicine, and to incorporate this content into our teaching and formal curricula. We must acknowledge the fact that our healthcare systems and perspectives on health and wellness are based in our colonialist systems in healthcare and in education. Further to this, gaining insights into our individual biases is critical, helping to shape our personal development. Implicit association testing (IAT) highlights our hidden biases, promoting reflection on attitudes and stereotypes that are multifactorial yet impactful.[19] Having created safe spaces, we can address topics across the continuum of medical education, including the role the medical professions have played in Indigenous colonization, displaced populations, and other practices and policies that have contributed to systemic bias, health disparities, and healthcare apprehension among minorities. It is important to note that it is the responsibility of privileged individuals to educate themselves and that the responsibility for this education does not, and should not, fall on the shoulders of traditionally marginalized individuals. Educating and reflecting will make you feel uncomfortable with the role of medicine, both past and present, in perpetuating systemic racism. By understanding the systems of inequalities, we must acknowledge the healthcare system's role in creating and maintaining racial disparities of health. We point to several works to start and continue your learning journey.[5,7,20]

3. *Feeling:* Acknowledge your feelings.

Allyship involves addressing power dynamics and trying to "level" the playing field. As you embark on a journey towards allyship, expect a "rollercoaster" of emotions. These feelings may include shame, guilt, and/or anger around previous (in)actions. Given the commonness of this response, the term "white fragility" has been given to Caucasians and their difficulties in talking about racism.[21] As such, it is important to acknowledge these feelings, share them with others, and commit to allyship and effective mitigation of racism moving forward. Further, you may experience feelings of discomfort around "loss of privilege"; some will experience this as persecution. Despite having worked diligently for our achievements, the humility to recognize that systemic advantages have contributed to our career and life opportunities is uncomfortable and remains unacknowledged by many. As we practice allyship, and witness medicine's evolution to a more diverse, equitable, and inclusive profession and environment, privileged individuals may wonder how acts of allyship may affect their personal endeavours. We may start to consider the personal and professional "costs" of structural change, which may lead to discomfort. Having an open conversation about this is essential to ensure movement towards equity, diversity, and inclusivity in medicine. We need to embrace that discomfort and those in positions of power and privilege have the opportunity to normalize these feelings and engage others in this uncomfortable process. Health professionals must acknowledge that not actively being anti-racist is complicity in upholding structures rooted in colonialism, which have disadvantaged Black, Indigenous, and persons of colour for far too long.

4. *Doing:* Recognize and address microaggressions.

Microaggressions, as defined earlier, are "statements and/or actions directed towards traditionally marginalized groups that act as indirect, subtle, and unintentional discrimination," which perpetuate marginalized experiences.[11-14,2] At the time of the transgression, breaking the silence by asking "really?" or "perhaps I have misunderstood you?" allows for clarification and does not allow it to passively slip by. Check-in with the individual(s) exposed to the microaggression. Validate their experience and offer support if/when individuals want to further discuss their feelings. The important step of a conversation with the individual who has perpetrated the microaggression has been shown to reduce recidivism.[23] Approaches will vary depending on the incident itself, our

relationship with the individual, and team dynamics; and additional resources are available.[24] Additionally, in practicing allyship, it is important to be receptive to feedback on our own microaggressions and take steps to address them. Apologize, regardless of the intent, if others feel uncomfortable with our actions. While we may not have meant to cause harm, this should be approached as a learning opportunity.[25] Reflect on both the impact and the original intent.

5. *Promoting:* **Promote diversity in your spheres of influence.**

Incremental change, led by individuals, is key to more meaningful systemic change. Allyship involves purposefully promoting diversity and inclusivity within your spheres of influence. Consider the spheres where you have influence. Is there meaningful representation from racial, ethnic, gender, sexual, and other minorities? Reflect on missing voices and advocate for a minority voice (a true act of allyship). Actively seek out ways to achieve diversity. Dispel racist myths. Excluding diverse perspectives weakens our productivity and overall effectiveness.[17,26,27] Develop a list of individuals you will sponsor and redistribute power by sharing your platform, supporting them, and helping remove barriers. Individual change may seem small, but it leads to systemic change. Leadership structures that reflect diversity and are built using the principles of equity and inclusivity are critical to dismantling racist structures.

6. *Acting:* **Actively dismantle racist structures in medicine.** Ultimately, we must move beyond the individual interventions and address the system's systemic nature of racism in medicine, regardless of comfort. Interpersonal changes, which have been highlighted thus far, are critical and lie within our control. As we seek to understand our roles in upholding systems of oppression, we must reflect on these systems, their histories and the impact of these, and identify the structures and processes that intend to continue these harms. We must address these, even through our inevitable discomfort.

Rising to the challenge and taking the first step

These steps can be taken to avoid the buildup of the treacherous black ice of not calling out racism. When we fail to critically assess the colonialist systems in which we work, we become a barrier instead of paving ways that will allow critical inroads toward more inclusive, diverse, and equitable learning environments in medical education. We recognize that these six actions will not always be easy to take, so the referenced material may further guide your

steps. By practicing allyship, we can all contribute to addressing racism in all facets of medicine. Simple, consistent actions to foster change in our spheres of influence, and the ripple effect of these changes, will impact attitudes and behaviours broadly. We are better, together.

References

1. Sonnenberg LK, LeBlanc C, Do V, Busari JO. Owning allyship: leading through the tensions of racism and relationship. Workshop presented at Toronto International Summit on Leadership Education for Physicians (TISLEP); 2020; Ottawa, Canada.

2. Busari JO, Sonnenberg LK, LeBlanc C, Do V. From diversity to inclusivity: shifting the culture in medical education together. Workshop presented at The Royal College Program Administrator's Conference; 2020; Ottawa, Canada.

3. Busari JO, Sonnenberg LK, LeBlanc C, Do V. From diversity to inclusivity: shifting the culture in medical education together. Workshop presented at International Conference on Residency Education (ICRE); 2020; Ottawa, Canada.

4. The Anti-Oppression Network. Vancouver. Allyship; 2015 [about 4 screens]. Available from: https://theantioppressionnetwork.com/allyship/. [Accessed on Feb 5 2021]

5. Nixon SA. The coin model of privilege and critical allyship: implications for health. *BMC Public Health*. 2019;19:1637. https://doi.org/10.1186/s12889-019-7884-9

6. Williams WC, Castagna L, Willison JS. Cultural humility and allyship in action. Reflections (Long Beach) 2020 26(2): 28-38. Available from: https://reflectionsnarrativesofprofessionalhelping.org/index.php/Reflections/article/view/1755 [Accessed on Mar 1, 2021].

7. Nixon S. Understanding the role of privilege in relation to public health ethics and practice. National Collaboration Centre for Healthy Public Policy; 2020 October 6. Video: 10 min. Available from: https://www.youtube.com/watch?v=a30a_NiT5zc&list=PLNWUsONW1NHKByYnDkqHAFpoCXcGuIGa4&index=5 [Accessed on Feb 5, 2021].

8. Dogra N, Williams R. Applying policy and evidence in developing cultural diversity teaching in undergraduate

medical education in the UK. *Evid Policy*. 2006;2(4):463–477. https://doi.org/10.1332/174426406778881809

9. Muntinga ME, Krajenbrink VQ, Peerdeman SM, Croiset G, Verdonk P. Toward diversity-responsive medical education: taking an intersectionality-based approach to a curriculum evaluation. *Adv Health Sci Educ Theory Pract.* 2016;21(3):541-559. https://doi.org/10.1007/s10459-015-9650-9

10. Boyd RW, Lindo EG, Weeks LD, McLemore MR. Health Affairs Blog. On racism: a new standard for publishing on racial health inequities; 2020 July 2 [about 8 screens]. Available from: https://www.healthaffairs.org/do/10.1377/hblog20200630.939347/full/. [Accessed Mar 1, 2021].

11. Acholonu RG, Cook TE, Roswell RO, Greene RE. Interrupting microaggressions in health care settings: a guide for teaching medical students. *MedEdPORTAL.* 2020;31(16):10969. https://doi.org/10.15766/mep_2374-8265.10969

12. Espaillat A, Panna DK, Goede DL, Gurka MJ, Novak MA, Zaidi Z. An exploratory study on microaggressions in medical school: what are they and why should we care*? Perspect Med Educ.* 2019;8(3):143–151. https://doi.org/10.1007/s40037-019-0516-3

13. Wheeler DJ, Zapata J, Davis D, Chou C. Twelve tips for responding to microaggressions and overt discrimination: when the patient offends the learner. *Med Teach.* 2019;41(10): 1112-1117. https://doi.org/10.1080/0142159X.2018.1506097

14. Young K, Punnett A, Suleman S. A little hurts a lot: exploring the impact of microaggressions in pediatric medical education. *Pediatrics.* 2020;146(1):e20201636. https://doi.org/10.1542/peds.2020-1636

15. Bullock JL, Lockspeiser T, Del Pino-Jones A, Richards R, Teherani A, Hauer KE. They don't see a lot of people my color: a mixed methods study of racial/ethnic stereotype threat among medical students on core clerkships*. Acad Med.* 2020;95(11S): S58-S66. https://doi.org/10.1097/ACM.0000000000003628

16. Edmondson AC, Lei Z. Psychological safety: The history, renaissance, and future of an interpersonal construct. *Annu Rev Organ Psychol Organ Behav.* 2014;1(1):23–43. https://doi.org/10.1146/annurev-orgpsych-031413-091305

17. Nathan M, Lee N. Cultural diversity, innovation, and entrepreneurship: firm-level evidence from London. J Econ Geogr. 2013;367-394. https://doi.org/10.1111/ecge.12016

18. Broido EM. The development of social justice allies during college: a phenomenological investigation*. J College Stud Devel.* 2000;41:3-18. https://doi.org/10.1037/a0019093

19. Project Implicit. Boston, MA: IAT Corp; 2011; Implicit Association Test; 2011 [1 screen]. Available from: https://implicit.harvard.edu/implicit/canada/takeatest.html [Accessed on Mar 1, 2021].

20. Link Year. Privilege/Class/Social inequalities explained in a $100 Race. Kanakuk Link Year; 2017 October 4 Video: 4 min. Available from: https://www.youtube.com/watch/4K5fbQ1-zps [Accessed on Feb 5, 2021].

21. DiAngelo R. White fragility: why it's so hard for white people to talk about racism. Boston: Beacon Press; c2018.

22. Overland MK, Zumsteg JM, Lindo EG, et al. Microaggressions in clinical training and practice. J Injury, Funct Rehab. 2019;11:1004-1012. https://doi.org/10.1002/pmrj.12229

23. Czopp AM, Monteith MJ, Mark AY. Standing up for a change: reducing bias through int*erpersonal confrontation*. J personality soc psychol. 2006;90(5):784.

24. Torres MB, Salles A, Cochran A. Recognizing and reacting to microaggressions in medicine and surgery. *JAMA Surg*. 2019;154(9):868–872. https://doi.org/10.1001/jamasurg.2019.1648

25. Tannenbaum M. But I didn't mean it! Why it's so hard to prioritize impact over intents, 2013 Oct 14; [about 7 screens]. *Scientific American*. Available from: https://blogs.scientificamerican.com/psysociety/e2809cbut-i-didne28099t-mean-ite2809d-why-ite28099s-so-hard-to-prioritize-impacts-over-intents [Accessed on Mar 1, 2021].

26. Levine SS, Apfelbaum EP, Bernard M, Bartelt VL, Zajac EJ, Stark D. Ethnic diversity deflates price bubbles. *Proc Natl Acad Sci USA.* 2014;11(52):18524-18529. https://doi.org/10.1073/pnas.1407301111

27. Phillips KW, Liljenquist KA, Neale MA. Is the pain worth the gain? The advantages and liabilities of agreeing with socially distinct newcomers. *Pers Soc Psychol Bull*. 2008;35(3):336-350. https://doi.org/10.1177/0146167208328062