

# **Practice-related racism faced by physician graduates of the Saskatchewan International Physician Practice Assessment program**

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## **Background:**

The Saskatchewan International Physician Practice Assessment (SIPPA) program is a “practice-ready assessment” that assesses internationally trained physicians for practice in Canada. The program was implemented in 2011. The program has been successful in recruiting internationally trained physicians residing in Canada.<sup>1</sup> This is essential, especially with the province’s growing need for family doctors.<sup>2</sup> However, international physicians often face racism and may end up leaving the province.

Systemic racism is a process by which societal regulations, practices and laws create a hierarchy based on race.<sup>3,4</sup> This often leads to racialized individuals being seen or treated as inferior to their non-racialized counterparts. Sadly, this form of racism is common in healthcare. However, racism on an individual level can lead to unconscious bias and racial disparities. Physicians are not exempt from these distinct forms of racism or racism in general. The continual exposure to racism and bias can have significant impacts on physicians’ health and their ability to work. This, in turn, affects their capacity to provide adequate care to their patients. This cascade of effects will eventually have an impact on the healthcare system.<sup>5,6</sup>

## **Question:**

1. Are there incidents of racism faced by internationally trained doctors (individuals who are often racialized) in rural Saskatchewan?
2. Does racism contribute to reduced practice satisfaction and thus adversely affect physician retention within the province?

## **Methods/Methodology:**

This project aimed to use a mixed-methods approach to gather both quantitative and qualitative data. With approval from the University of Saskatchewan's behavioural research ethics board (Beh3657), SIPPA administrative staff emailed a survey invitation and a two-week reminder to all 189 SIPPA participants who graduated from the program within the previous five years. Data was collected via the University of Saskatchewan's SurveyMonkey platform as a one-time, cross-sectional survey. The closed-ended questions gathered demographic data such as ethnicity/citizenship, age, and gender. The open-ended questions centred on providing participants space to detail their experiences related to racism. Quantitative responses were analyzed using frequencies; these responses were also cross-tabulated with the occurrence of a work-related

experience of racism and evaluated using Chi-square or Fisher's exact tests. Alpha was set at 0.05 for all analyses, and SPSS version 28 (IBM Corp, Armonk, NY) was utilized. Qualitative variables were analyzed by a single researcher using thematic analysis. Direct quotations were used to generate codes that were then gathered to create first-order themes. These themes were then reviewed and used to generate the core themes.

## Results/Findings:

The survey was sent to a total of 189 SIPPA physicians, and a total of 42 respondents participated in the survey, giving a response rate of 22%. The survey was available for completion from January 9, 2023, to February 13, 2023.

### Quantitative data

Respondents most frequently indicated their racial group as West Asian/Middle Eastern, although just over one-third were black. The male gender was more frequent than the female. Just over half had worked in Saskatchewan for 1-3 years following the SIPPA program, and a similar proportion were located in communities with less than 5000 residents. Additional demographic information is available in Table 1.

Table 1. Characteristics of respondents (N=42)

Age, years	
26-35	4 (9.5)
36-45	16 (38.1)
46-55	22 (52.4)
Gender*	
Cis-man	27 (65.9)
Cis-woman	14 (34.1)
Racial Identification*	
West Asian/Middle Eastern	17 (41.5)
Black	15 (36.6)
South/Southeast Asian	7 (17.1)
White	2 (4.9)
Location of medical school	
West Asia/Middle East	21 (50.0)
Africa	16 (38.1)
South Asia	5 (11.9)
Length of Saskatchewan practice	
< 1 year	11 (26.2)
1 to 3 years	22 (52.4)
4 to 5 years	8 (19.0)
> 5 years	1 (2.4)
Practice location community size†	
Less than 5 000 residents	22 (53.7)
5 000 to 10 000	11 (26.8)
10 000 to 50 000	6 (14.6)

More than 100 000	2 (4.9)
Currently in Return of Service period*	
Yes	28 (68.3)
No	13 (31.7)
Currently practicing in Saskatchewan <sup>‡</sup>	
Yes	35 (87.5)
No	5 (12.5)

\*One participant did not disclose; <sup>†</sup>Respondents who had practiced in more than one community were asked to indicate the one where racism was experienced most strongly; if no experiences of racism, they were asked to provide the community size where they had practiced longest. <sup>‡</sup>Two participants did not indicate.

Twenty-eight (67%) participants identified at least one incident of racism related to work or community. Among the 42 participants who provided responses to questions regarding the source of racism, the proportions indicating that the incident(s) originated from patients, staff, physicians, or the community were 41%, 41%, 31%, and 10%, respectively. Two individuals indicated that their experiences of racism arose from all four sources; the distribution of experiences across the sources can be appreciated in Figure 1.

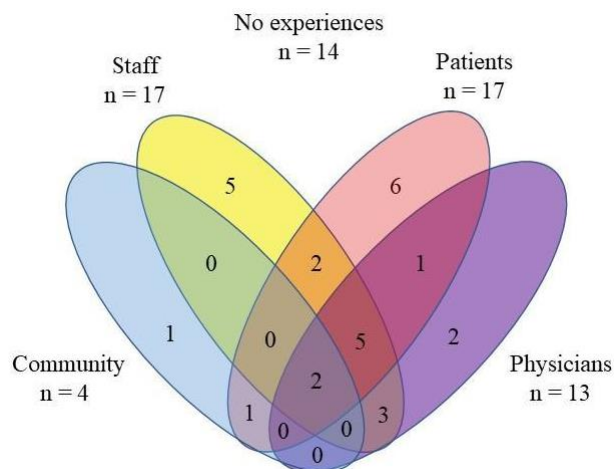


Figure 1. Frequencies of racism sources as identified by respondents. Fourteen respondents indicated more than one source of racism experiences.

Among the 28 individuals who experienced racism, only one identified it as solely occurring in the community. As such, 27 had experienced at least one racism-related event in their workplace. Among these, four indicated that they had reported the experience(s), and one indicated that it was helpful to do so. Nine respondents (33%) also felt that the experience(s) affected patient care. Overall, 12 of 40 respondents (30%) felt that the Saskatchewan healthcare system was negatively biased towards racialized physicians. However, 20 of 28 in their Return of Service (ROS) period had yet to decide if they were planning to stay in the province upon service completion. Five of 12

respondents who were beyond their ROS indicated that they had left the province, two citing racism as a contributing factor, respectively, influencing their decision-making a moderate amount and a great deal.

Cross tabulations compared respondent characteristics by whether an experience of racism had been encountered. Categories with small counts were collapsed where proportions were similar. Findings are presented in Table 2. No statistically significant associations were found for any of the collected characteristics, although black physicians were more likely to have experienced racism than West Asian/Middle Eastern physicians in our sample at a marginally significant p-value of 0.06.

Table 2. Cross tabulations of respondent characteristics by any experience of racism (N=42)

	Experienced racism		p-value
	Yes (n = 28)	No (n = 14)	
<b>Age</b>			
<45 years	14 (70.0)	6 (30.0)	0.66
≥45 years	14 (63.6)	8 (36.4)	
<b>Gender</b>			
Cis-Male	18 (66.7)	9 (33.3)	>0.99
Cis-Female	9 (64.3)	5 (35.7)	
<b>Years in practice in Saskatchewan</b>			
<1	8 (72.7)	3 (27.3)	NA
1 to 3	13 (59.1)	9 (40.9)	
≥4	7 (77.8)	2 (22.2)	
<b>Community size</b>			
≤5000 residents	15 (68.2)	7 (31.8)	0.74
>5000 residents	12 (63.2)	7 (36.8)	
<b>Racial identification</b>			
West Asian/Middle Eastern	9 (52.9)	8 (47.1)	NA*
Black	13 (86.7)	2 (13.3)	
South/Southeast Asian	5 (71.4)	2 (28.6)	
White	1 (50.0)	1 (50.0)	

\*Pairwise comparison between the two groups showing the greatest difference in proportions (West Asian/Middle Eastern versus Black) had a marginally significant Fisher's exact p-value of 0.06. NA = not available due to small expected cell sizes.

### Qualitative data

The answers to the open questions in the survey were used to create themes in order to better answer the review question and explore the data in more detail. Five key themes were identified. The themes mirror participants' experiences, perceptions, and responses to racism faced both at work and within the wider rural community that they live(d) in. Though key themes were identified, it should be noted that there was some overlap and interplay between themes. The themes were classified as follows: 1) Racism in the emergency room; 2) Microaggressions/racism from nurses and allied health professionals; 3) Covert racism; 4) Comparison between international and Canadian

training; 5) Lack of support. These themes and their development are explained in Table 3 using extracts from the survey.

Table 3. Thematic analysis findings		
Explanatory quotation (first order themes)	Second order themes	Key themes identified (third-order theme)
<p>“2 patients informed me they will not allow me to touch them in the ER. ‘This N***a cannot touch me’. On both occasions, the nurses talked to the patient on my behalf. However both patients did not allow me to assess them and left against medical advice.”</p>	<p>Emergency rooms being the first point of contact for new patients and physicians. This combination can often lead to racism.</p>	<p>Racism in the emergency room</p>
<p>“Racism from staffs are subtle when some often make reference to one’s accent that had no bearing with one’s skill or knowledge about patient care.”</p> <p>“...Also when I work with some nurses, I get a different treatment than what they do with Caucasian doctors. Some are a great team but some aren’t. I just pray am lucky to have my team when at work.”</p>	<p>Workplace racism with individuals who often work in a team i.e., physicians and nurses and clinic staff. This relationship limits what can be said or done to physicians and often results in microaggressions.</p>	<p>Microaggressions/racism from nurses and allied health professionals</p>
<p>“Some of these experiences not overt action so difficult to put into words but it appears the Canadian trained Caucasian colleagues are less likely to face complaints related issues from the College or from patients, even though many of these complaints are later found to be baseless but the emotional scars are long lasting.”</p> <p>“...staff at the hospital/clinic respect them more because they are White Canadians, the way they talk to them is completely different than the way they talk to us...”</p>	<p>Racism is often experienced in attitude changes and undercurrents that are felt but difficult to articulate fully.</p>	<p>Covert racism</p>

<p>“there is systematic discrimination between CMG's an IMGs especially obvious from nurses. This is so intense that I have given up working in the ER. The discrimination is so subtle that you can not relate it directly to racism but it is there. It comes about in the form of disobeying your orders or wrist resisting your treatment plan, contacting other physicians implying you are incompetent in what you do and so on. I have asked many colleagues and they all shared somewhat similar opinion.”</p>	<p>Views that internationally trained physicians do not have the same knowledge as Canadian trained doctors</p>	<p>Comparison between international and Canadian training</p>
<p>“ lack of support when requested and prejudiced opinions (“he doesn't know this or that because he is African”)- no effect”</p> <p>“Am black. I reported. Nothing was done...I would rather resign than go through that quietly”</p> <p>“The system tries to put a lid on cases of racism instead of speaking out...”</p>	<p>Feelings that reports of racism go unheard. Also feeling like other staff, supervisors, and physicians don't seem to care about their concerns</p>	<p>Lack of support</p>

## Discussion:

International medical graduates (IMGs) are essential members of the healthcare system in Saskatchewan. However, this study demonstrated how SIPPA graduates often face racism and discrimination as added barriers to their clinical practice in Saskatchewan. The doctors described feeling unsupported, isolated, judged, and insulted. Some physicians in the study discussed wanting to leave Saskatchewan for other provinces. However, as most participants were in their Return of Service period and were undecided regarding future practice location, it was unclear as to how experiences related to racism impacted practice location decisions. Vulnerability to racism appears to extend beyond basic demographic characteristics.

However, there is a great deal of work that needs to be done regarding racism experienced by physicians in Saskatchewan. The study indicated that physicians facing racism either become complacent to it or face significant psychosocial impacts in their own lives. They also pointed out the possible impact that racism can have on patient care. Unfortunately, participants pointed out that their reports of racist incidents fell on deaf ears. The participants felt unsafe in their work environments. This should not be the case in any workplace. With the growing need for family physicians across the country, it is pertinent that provincial governing bodies recognize that racism is a problem that needs to be addressed.

Relatively little had been studied about the experience of racism among racialized physicians in rural Canada. A recent survey of Alberta's physicians found that among the approximately 300 racialized physicians who responded, 90% reported experiencing or witnessing workplace racial discrimination.<sup>7</sup> Although the study is more broadly focused, an included quotation clearly articulates an experience of racism in the rural Alberta context and its potential to drive physicians away from such practice locations. This shift towards practice in larger urban settings is echoed in a 2020 study of Black physicians in Ontario, where half of respondents indicated that race impacted where they would practice, tending towards urban and suburban areas with larger populations of visible minorities.<sup>8</sup> Our finding of the reporting of racism in our study as being generally ineffective has also been noted in these two studies. The greater presence of racialized physicians in larger centers is evidenced in work by Wenghofer et al who found that the proportion of IMGs in Ontario decreased with increasing rurality.<sup>9</sup>

As highlighted by Mowat et al in their review of Manitoba's IMG assessment program, physicians must form an attachment to the community in order to remain.<sup>10</sup> However, it is appreciable how the under-evaluated and oft-times subtle dynamic of racism may work against integration, potentially neutralizing other supportive elements such as appropriate remuneration, mentorship, housing, spousal employment, etc. Cultural sensitivity among members of the healthcare team has been recognized as an important component of IMG practice settings, and it is necessary that this be intentionally cultivated throughout the organization.<sup>11</sup>

Limitations of this study include a relatively low response rate, opening the potential for selection bias. The relatively small sample size limited detailed comparisons of characteristics between those who did and did not experience racism; true differences suggested in our data, such as differences in occurrence between racial groups, may have been underpowered. Although our study identified specific sources of racism, it did not quantify the frequency or magnitude of experiences. Qualitative analysis was undertaken by a single researcher; rigor could have been further strengthened by the independent assessment and subsequent consensus of multiple researchers. The sampling framework was limited to IMGs who entered Saskatchewan practice via an established assessment program that aims to increase physician access in significantly under-resourced areas; as such these results may not be generalizable to other provinces or even some areas of rural Saskatchewan.

In spite of the above, the methods used in this study paint a more complete picture of racism experienced by IMGs in Saskatchewan. As noted, this study involved a small pool of participants but even so provides a deeper understanding of the multidimensional

effects of racism faced by racialized physicians. Although the survey data could not show a direct correlation between racism and the rate at which SIPPA graduates leave the province, it does highlight the need to provide safer and more inclusive working environments for them.

### **Conclusions:**

This study supports the understanding that racism is commonly experienced by internationally trained physicians in rural Saskatchewan. The data implies that racism is systemic and deeply imbedded within the healthcare system. It comes in many forms including microaggressions, comparison, exclusion, and isolation. The data also suggests the continued silence and complacency surrounding racism in medicine. SIPPA graduates facing racism undergo significant personal and professional implications, the impacts of which have the potential to influence practice decisions. Both staff and patients contribute to these negative experiences. Reflecting on these findings makes it clear that systemic changes are required to combat racism in healthcare.

### **Recommendations:**

The researchers propose the following recommendations based on the study findings:

1. Further research regarding racism in rural Saskatchewan. This can be done by conducting in-person interviews. Specific areas to be covered could include SIPPA graduates' ideas regarding integration, diversity, and education. It would also be useful to explore their thoughts regarding areas of improvement, especially regarding the creation of safer and more supportive systems for racism reporting.
2. Provincial governing bodies such as the Saskatchewan Health Authority and the Saskatchewan Medical Association need to address discrimination international medical graduates face. They need to develop better support networks and encourage advocacy in healthcare and within the wider community. It would also be beneficial if continued cross-cultural sensitivity, implicit bias, and relational workshops were held. These could be rolled out for both healthcare staff and patients.

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