



“It was as if I wasn’t there” – Experiences of everyday racism in a Swedish medical school

Emelie Kristoffersson^{a,b,*}, Hanna Rönnqvist^a, Jenny Andersson^a, Carita Bengs^c, Katarina Hamberg^a

^a Department of Public Health and Clinical Medicine, Family Medicine, Umeå University, 901 87, Umeå, Sweden

^b Umeå Centre for Gender Studies, Umeå University, 901 87, Umeå, Sweden

^c Department of Food, Nutrition and Culinary Science, Umeå University, 901 87, Umeå, Sweden

ARTICLE INFO

Keywords:

Sweden
Medical education
Minority students
Interviews
Everyday racism
Racial microaggressions

ABSTRACT

The aim of this study was to explore and analyze how cultural/ethnic minority students at a Swedish medical school perceive and make sense of educational experiences they viewed as related to their minority position. We interviewed 18 medical students (10 women, and 8 men), who self-identified as coming from minority backgrounds. Data were collected and analyzed simultaneously, inspired by constructivist grounded theory methodology. The concepts ‘everyday racism’ and ‘racial microaggressions’ served as a theoretical framework for understanding how inequities were experienced and understood. Participants described regularly encountering subtle adverse treatment from supervisors, peers, staff, and patients. Lack of support from bystanders was a common dimension of their stories. These experiences marked interviewees’ status as ‘Other’ and made them feel less worthy as medical students. Interviewees struggled to make sense of being downgraded, excluded, and discerned as different, but seldom used terms like being a victim of discrimination or racism. Instead, they found other explanations by individualizing, renaming, and relativizing their experiences. Our results indicate that racialized minority medical students encounter repeated practices that, either intentionally or inadvertently, convey disregard and sometimes contempt based on ideas about racial and/or cultural ‘Otherness’. However, most hesitated to name the behaviors and comments experienced as “discriminatory” or “racist”, likely because of prevailing ideas about Sweden and, in particular, medical school as exempt from racism, and beliefs that racial discrimination can only be intentional. To counteract this educational climate of exclusion medical school leadership should provide supervisors, students, and staff with theoretical concepts for understanding discrimination and racism, encourage them to engage in critical self-reflection on their roles in racist power relations, and offer training for bystanders to become allies to victims of racism.

Credit author statement

Emelie Kristoffersson: Conceptualization. Methodology. Investigation. Formal analysis. Writing – original draft. Writing – review & editing. Hanna Rönnqvist: Investigation. Validation. Writing – review & editing. Jenny Andersson: Validation. Writing – review & editing. Carita Bengs: Validation. Writing – review & editing. Katarina Hamberg: Conceptualization. Methodology. Formal analysis. Writing – review & editing. Supervision. Funding acquisition.

1. Introduction

A growing body of research from different countries points out challenges regarding discrimination and adverse treatment of medical students from cultural and ethnic minority groups (Hill et al., 2020; Orom et al., 2013), henceforth referred to as ‘minority students’. These experiences may induce stress, impair academic performance, and lead to attrition among those affected (Dyrbye et al., 2007; Orom et al., 2013; Stegers-Jager et al., 2012). While blatant discrimination is undoubtedly harmful, there is evidence that these experiences represent only a small fraction of the oppression faced by minority students. Implicit cultural

* Corresponding author. Department of Public Health and Clinical Medicine, Family Medicine, Umeå University, 901 87, Umeå, Sweden.

E-mail addresses: emelie.kristoffersson@umu.se (E. Kristoffersson), jenny.andersson@umu.se (J. Andersson), carita.bengs@umu.se (C. Bengs), katarina.hamberg@umu.se (K. Hamberg).

<https://doi.org/10.1016/j.socscimed.2021.113678>

Received in revised form 10 December 2020; Accepted 30 December 2020

Available online 2 January 2021

0277-9536/© 2021 The Authors. Published by Elsevier Ltd. This is an open access article under the CC BY license (<http://creativecommons.org/licenses/by/4.0/>).

bias is widespread in health care (Maina et al., 2018; van Ryn, 2011) and medical education (Beagan, 2003; Leyerzapf and Abma, 2017), with potentially dire consequences for minority students. Recent studies have begun to look beyond unconcealed discrimination and to examine more subtle interactional practices that contribute to marginalization and alienation, communicating messages about belonging and not belonging in medical school (Beagan, 2003; Dickins et al., 2013; Odom, 2007; Sandoval et al., 2020).

Today, most universities and medical schools have formal commitments to equality and the eradication of discrimination (Umeå University, 2018; 2019; Orom et al., 2013). Prevailing processes of ‘Othering’ do however continue to obstruct the actual practice of equal treatment and inclusion (Leyerzapf and Abma, 2017; SOU, 2006:40). Thus, researchers agree that for comprehensive changes in the medical school climate to take place goals at the overall political or policy level are insufficient (Beagan, 2003; Leyerzapf and Abma, 2017). Changes must also take place in the everyday interactions that enable structural inequalities.

Previous studies on minority students’ educational experiences have primarily been quantitative, using pre-formulated questions and focusing on overt racism (Hill et al., 2020; Orom et al., 2013). This approach brings with it the risk of overlooking subtle challenges that minority students face. And, while there is a lively discussion among researchers in some countries, for example, the US, UK, and the Netherlands, about the challenges of cultural bias and racism in medical education (see for example Acosta and Ackerman-Barger, 2017; Ansell and McDonald, 2015; Kmietowicz, 2020; Verdonk and Abma, 2013), the subject has hardly been addressed in Sweden.

The aim of this interview study was, therefore, to analyze narratives of minority students in one Swedish medical school, to explore how they perceived and made sense of interactions during their education that they perceived to be connected to their minority position. We sought concrete examples of how inequality between majority/minority students is (re)created – a necessary starting point for designing measures to counteract such unjustified differences. We first outline our theoretical framework. Next, we describe the research context.

1.1. Theoretical points of departure

In line with emergent design, the analysis of the empirical material with prevalent examples of hostilities and prejudices related to presumed country of birth or religion, skin color, and race, advised our choice of theory (Charmaz, 2014). Our understanding of racism is positioned within the fields of critical race, whiteness, and postcolonial studies (Ahmed, 2007; de los Reyes et al., 2002; Ford and Airhihenbuwa, 2010). Thus, racism is understood as a social structure, which has its background in a colonial history, where people have been divided into groups based on notions of ‘race’. This division is hierarchical with whiteness constituting the invisible norm. Racism works as a guiding principle for how power and resources are distributed and for how relationships in-between individuals and groups are manifested in society.

Over time, the discourses that legitimize racial discrimination have adapted to modern norms, policies, and practices so that while inequalities remain, they appear to not be explicitly racist (DiAngelo, 2018; Essed, 1991; Said, 1978; Sue, 2010). In this process, blatant notions of biological ‘racial’ inferiority have generally become unacceptable. Instead, they have been replaced by the idea of cultural inferiority and superiority, with Western majority culture (We) as the norm and positive standard against which other cultures (Others) are measured and considered falling behind. However, such ideas are not detached from notions of race since affiliation is still often attributed to groups based on biological characteristics such as skin color. Hence, the discursive distinction between ‘We’ and ‘Others’ naturalizes and legitimizes current socio-economic inequities and perpetuates existing power structures.

In this article, we use the concepts ‘everyday racism’ and ‘racial

microaggressions’ for examining challenges and subtle forms of racism that construct an unfavorable climate for minority students in medical schools (Essed, 1991; Sue, 2010). These concepts describe actions that, intentionally or unintentionally, convey disregard, marginality, and contempt based on presumed cultural and/or racial ‘Otherness’. These practices permeate everyday life and come to be considered “normal” since the underlying cultural and/or racial bias and hierarchies are normalized – even in contexts embracing a formal commitment to equality (Essed, 1991; Sue, 2010). Seen one by one, such episodes might at first seem trivial – the negative impact of subtle racism, however, lies in its accumulated burden (Essed, 1991; Sue, 2010).

In the present study, concepts like race, ethnicity, and culture are understood as social constructs where people with different experiences and backgrounds are assigned group affiliation, based on, e.g. physical characteristics (e.g. skin- and hair color), clothing, language, or religion – i.e. they are being racialized (SOU, 2005:41).

1.2. The Swedish context regarding migration and racism

Sweden has a history of in-migration (Statistics Sweden 2005; 2019). After World War II and until the mid-1970s labor immigration, primarily from other Nordic countries and southern Europe, dominated. Thereafter, labor migration decreased and was replaced by refugee immigration from, e.g., Chile, Iran, Iraq, Somalia, and former Yugoslavia. In 2015, just before this study was conducted, many refugees of war, foremost from Syria, applied for asylum in Sweden. Currently, about 25% of Swedish residents are foreign-born or have two foreign-born parents, and the majority of these live in urban areas in southern Sweden (Statistics Sweden, 2019).

In Sweden, the concept ‘Immigrants’ has come to signify people whose appearance and culture are perceived as ‘non-Swedish’ – whether or not they have actually immigrated (SOU, 2005:41). Notions of Swedes and Immigrants as separate social categories have proven to be a basis for discrimination in different areas (SOU, 2005:56; 2006:79). Thus, structural discrimination manifested through inferior health, lower life expectancy, standards of living and education levels, as well as higher unemployment rates is directed at a heterogeneous group of people (de los Reyes and Wingborg, 2002; SOU, 2005:56; 2006:79; Wolgast et al., 2018).

Recently, concerns have been raised about a more harsh and polarized social and political climate in Sweden, one in which xenophobia and open racism is increasingly evident (Ericson, 2018). Marking this change, a nationalist right-wing party with an anti-immigration policy, The Sweden Democrats (SD), entered parliament in 2010 and is today the country’s third largest party (Hübinette and Lundström, 2014). During what is referred to as the ‘refugee crisis’ in 2015, liberal and right-wing politicians portrayed a scenario where Swedish society was on the brink of collapse (Ericson, 2018). The alarmism was charged with racist discourses on, e.g. migrant men being sexual offenders and unable to adjust to the gender-equality that Swedish society purports to model.

As with many other White-dominated societies, Sweden’s self-image of equality, social justice, and tolerance for diversity, where racism is of minor importance does not align with reality (see e.g. Beagan, 2003; Essed, 1991; Habel, 2012; Hübinette and Lundström, 2014). Habel (2012) has referred to this as a ‘discourse of exception’ to racism. When racism occurs, it is therefore perceived as the fault of ill-informed individuals with moral shortcomings rather than a result of structural inequality (Habel, 2012).

In Sweden, describing people in terms of their race or skin color has become taboo, likely because these terms are strongly intertwined with beliefs in essential biological differences. However, scholars underline that essentialist ideas are also embedded in alternative concepts like culture, religion, and ethnicity – and signal various degrees of non-Whiteness (Habel, 2012; Wolgast et al., 2018). Furthermore, researchers claim that the concept, ethnicity, refers to a kind of collective, cultural, and historical community, which hardly corresponds with the

heterogeneous immigrant population in Sweden – and people who have immigrated to Sweden rarely identify themselves in terms of ethnicity (de los Reyes and Wingborg, 2002; SOU 2005: 41).

2. Method

2.1. Medical school setting

This study was conducted at Umeå University in Sweden. In Sweden, undergraduate medical education comprises 5,5 years (11 semesters). The last 6 semesters include half-time clinical training at hospitals and health care centers. The undergraduate curriculum is followed by 18–24 months of internship, after which one can apply for a license to practice medicine and for a residency position.

Swedish Universities are not allowed to register the race or cultural background of students or staff, which makes it difficult to estimate the actual number of either racialized students or those not born in Sweden. However, a statistical investigation including all medical faculties in Sweden in 2016–2017 showed that 18% of the students were foreign-born or had two foreign-born parents (Statistics Sweden, 2018). According to previous research, the corresponding figure is less than 10% minority students in Umeå medical school (Andersson et al., 2012). In Umeå, each class comprises approximately 100 students.

Like all Swedish Universities, Umeå is legally obliged to work against discrimination related to sex, ethnicity, religion or other beliefs, disability, age, sexual orientation, and transgender identity or expression (SFS, 2008:567). Therefore, a local Equal Treatment Plan has been established, outlining how equal rights are to be promoted and how to minimize discrimination (Umeå University, 2018; 2019). It includes a ‘zero tolerance’ policy for discrimination, harassment, and abusive treatment.

2.2. Study design

In this interview study, we employed a constructivist grounded theory (GT) approach (Charmaz, 2014). Individual interviews were chosen to facilitate an in-depth exploration of the potentially sensitive topic of social exclusion. Constructivist GT was selected since the aim of this method is to view problems from participants’ perspectives and by the researchers’ interpretative understandings of participants’ subjective experiences (Charmaz, 2014).

2.3. Recruitment

Students eligible for recruitment were described as belonging to an ethnic, cultural, or linguistic minority – as determined by the students, themselves. Due to the Swedish context where minorities constitute a heterogeneous group, we emphasized a broad definition of minority with examples such as “having moved to Sweden as an adult, child, or being born here with parents born abroad” or “having a first language other than Swedish”.

Participants were recruited through e-mail, verbal information conveyed during lectures, snowball sampling, and direct contact. E-mails containing information about the study and about how to get in contact with the researchers were sent to all students registered in clinical semesters (6–11).

Recruitment through e-mail and information during lectures yielded eight participants. Some of them volunteered immediately while others made contact after some time. One participant was recruited by one of the researchers when they met in the clinic. The remaining nine contacts were made through snowball sampling, where interviewees asked other students they knew of, with similar or different experiences from their own, if we could contact them and inform them about the study.

2.4. Participants

In total, 18 students (10 identified as women and 8 identified as men), aged between 22 and 38 participated in the interviews. Students from all clinical semesters (6–11) were represented. Half of the participants were born in Sweden but had parents born abroad. The remainder had come to Sweden as refugees or moved to Sweden as children, teens, or adults. For ten, their country of birth or parents’ country of birth was Middle Eastern and/or Asian, for four European countries, and for the remaining four African countries. Apart from a few white participants originating from European countries, most participants would likely be read as racialized. Before entering medical school, nearly half had lived in multicultural suburbs in one of the three metropolitan areas of Sweden. More than half had a prior academic degree or had started their medical studies abroad.

2.5. Data collection

The interviews were conducted between 2016 and 2018. Prior to the interviews, the interviewer (first or second author) went through an information letter, collected written consent, and asked the participants to complete a brief demographic questionnaire.

The interviews were carried out using a topic guide, informed by a literature review. The broad topics included: participants path to medical school; own experiences of medical school – including the overall academic atmosphere, interactions with co-students, supervisors, staff, and patients; situations where their cultural origin became important in a positive or problematic way; and perceptions of education aimed at creating (inter)cultural competence. Follow-up questions were posed in response to the participants’ narratives, asking them to give examples, reflect upon their experiences, and clarify ambiguities.

Effort was made to encourage each participant to be the narrator and to address both positive and negative experiences (Charmaz, 2014; Magnusson and Marecek, 2015). The interviewers tried to create a safe and respectful atmosphere, and be sensitive when discussing experiences of social exclusion.

Interviews lasted 47–125 min, were digitally recorded, and transcribed verbatim. Records on laughter, sighs, and longer pauses were marked in the transcripts.

2.6. Analysis

In line with GT research design (Charmaz, 2014), the interviews and analysis were conducted in parallel to let the emerging insights of the research process guide us in refining interview questions and be alert when new aspects were described in order to saturate the emerging categories. For example, as the interviews proceeded, it became obvious that support from classmates – or lack thereof – were important aspects of the participants’ experiences. This led us to modify the interview guide to focus more on the relationship with fellow students. After 18 interviews had been performed we assessed that saturation was reached in the sense that on a higher abstraction level the accounts were easily recognizable from previous interviews (Charmaz, 2014).

The main analysis was informed by the constant comparison technique of GT and by our theoretical framework. In the first analytical step, the first, second, and last author individually read and coded the transcripts. Codes were noted and questions such as: “what is happening here?“, “which feelings and attempts to create meaning are indicated in the data?“, and “what is the participants’ main concern?“ were posed to the data. In joint meetings, the codes were then successively compared, discussed in light of the theoretical framework, and grouped into preliminary categories that included the content and meaning of participants’ experiences. Each interview was also re-read and condensed into a case narrative of one to four pages, reflecting the previous coding and the heart of the participant’s narrative.

At the second analytic step, the first author scrutinized the codes,

categories, and case narratives. Based on the insights gained from this review, she re-read the interview material and interpreted it by means of focused coding. The preliminary categories were then compared, merged, and refined. Constant comparisons were made between different experiences and between emerging categories, in order to explore similarities and differences in the data. Conceptual relationships between categories were sought and verified in the data, and a core category – central to the data – was identified. This analytical step also included several discussions involving all five researchers.

In the final analytic step, the entire interview material was re-read by the first author, and the other authors reviewed a sample of four interviews to ensure that the interpretations and categories were grounded in the data.

Epistemologically, we acknowledge that the interview material is the result of an ongoing co-construction between participants and researchers (Charmaz, 2014). Therefore, it is of importance to consider both how we as researchers position the participants, as well as how they responded to us. We are all white women, born in Sweden or other Nordic countries. At the time of interviewing, the first author was a medical intern and a PhD-student and the second author was a medical student – and later a medical intern. During the entire process, the researchers maintained reflexivity through critical considerations and discussions about the assumed associations between the emerging categories, and their own roles in the research process (Verdonk and Abma, 2013).

2.7. Ethical considerations

We recruited participants on the basis of their perceived ethnic or cultural ‘Otherness’ and asked them about experiences related to this identity. Researching a marginalized group in this way always comes with the risk of reifying them as a fixed category (Ghorashi and Sabelis, 2013; Spivak, 1988). We attempted to handle this dilemma by trying to understand the participants’ perspective, relating this understanding to their social context, searching for ‘negative cases’ and varieties in the participants’ experiences, and by being transparent in our role as researchers.

The small proportion of minority medical students in Umeå warranted extra caution to ensure confidentiality. Therefore, detailed background information for participants has been withheld, and details about staff, co-students, and patients occurring in the students’ descriptions have been deleted or changed.

Participants received both verbal and written information about the study. Prior to the interviews, their written consent was obtained. The Regional Ethics Committee in Umeå approved the study: (Dnr, 2016/446–31).

3. Results

Overall, participants described their academic climate as inclusive and characterized by equality. Still, from the moment their medical studies commenced, most participants were aware of being different in a medical school environment where almost everyone had “a Swedish name” and few students had “immigrant backgrounds”. Furthermore, they shared a range of mostly negative experiences related to their minority position in interactions with classmates, staff, and patients. Detrimental treatment was described as recurrent and unpredictable, seemed to occur regardless of what interviewees did or said, and eventually became normalized as something they expected. The white interviewees presented more of an external perspective and added valuable contrasts to the study since they had noted differences in how they were treated compared to racialized minority students.

The analysis resulted in three categories with a total of nine subcategories, describing participants’ experiences of their minority position in medical school, and a core category outlining their efforts to make sense of their experiences. (see Table 1).

Table 1

Core category, categories and subcategories following individual interviews with 18 minority students.

Core category	Making sense of feeling out of place			
	Categories	Being downgraded	Being excluded	Being designated as different
Subcategories	Encountering hostility and overt racist talk Enduring patronization and scrutiny Being attributed negative and/or constraining characteristics	Becoming invisible, ignored, and rejected Being trapped by degrading images of minorities Missing out on support from bystanders	Accounting for one’s supposedly foreign background Representing a homogenous group Symbolizing security for minority patients	

Below, the core category and categories are presented in bold with subcategories in italics. Quotes are interspersed to ground the presentation in the participants’ accounts. Each quote is marked with the participant’s number (1–18) and gender (Man = M, Woman = W). The presentation starts with the categories and subcategories followed by the core category.

3.1. Being downgraded

This category organizes various forms of downgrading treatment described by the participants – ranging from overt racist comments to subtle patronization and being reduced to negative stereotypes.

Participants occasionally *encountered hostility and overt racist talk*. They recalled incidents where their skin color, name, or assumed religion was used in order to offend them through hostile stereotypes and name-calling:

The patient checked my nameplate, tried to pronounce my name and said: “Are you one of them terrorists as well?” (14W)

Co-students and supervisors were also engaged in blatant racist talk and in voicing resentment and hostility: “My co-students said (that) refugees bring a rise in criminality” (6W). One participant, himself a refugee, described a physician who referred to refugees as “parasites”, and proclaimed that Sweden should have more restrictive immigration policies. Another student who overheard a physician using the word “nigger” said: “I thought by myself: I’m sitting right next to you, maybe you should think about what you say” (9M).

Participants *endured patronization and scrutiny*, having their medical knowledge mistrusted or their behavior and awareness of Swedish habits questioned. For example, a female student, born in Sweden, recalled:

If you talk about something in class that is like ‘typically Swedish’ it feels like they wonder if I know what it is – just because I look a certain way. It’s like: “Do you know, since you are not completely Swedish?”, although I am raised here. It feels frustrating. (7W)

Assumptions about their lack of assimilation were perceived as humiliating and annoying, especially by interviewees born or raised in Sweden – as were compliments for their “good Swedish”. Another common experience, also among interviewees born and raised in Sweden, was to have their grammar or pronunciation corrected or mocked by supervisors and co-students. In contrast, two participants from Western European countries, both white, experienced actual language difficulties. Despite this, they could not recall being questioned about their abilities to speak Swedish. This indicates that comments about language might have more to do with racism than with alleviating risks of miscommunication.

Apart from grammar, interviewees felt there was a tendency to

control and apply rules more strictly to minority students regarding, for example, knowledge requirements or being on time. A male participant who was late for a meeting received massive criticism from the supervisor:

I'm one, two minutes late, saying: "Sorry I'm late". I get a brutal exclamation: "Do you know how important it is to be on time? Do you know what it means to be a physician? You can't just be late" ... Then a girl comes twenty minutes after me. She says "Hi" and just sits down. Then he was silent. (5M)

Incidents like this made participants feel that, compared with other students, their position in medical school was conditional.

As members of minority groups, *negative and/or constraining characteristics* were regularly attributed to participants. One student said his majority peers assumed he, with a background from the Middle East, was ill-disposed towards gender equality and homosexuality. Other examples indicated that some people considered male participants potential criminals or drug addicts. Assumptions about where immigrants belong in the health care hierarchy also surfaced. One participant regularly encountered patients who either wouldn't or couldn't grasp that he was neither an assistant nurse nor working with patient transport:

Patients say: "Are you an assistant nurse?" ... Then you have to explain. Yeah, people might think: "He doesn't look like a medical student", or it's like: "Is it you who will help me with transport to the X-ray?" I just: "No ..." Then their like: "Well, who are you then?" This has happened often, yes on all my clinical placements. There is nothing wrong with being an assistant nurse, but you still have to explain. They think that you have to be a certain person to be a physician. Like you don't meet their requirements. (3M)

He and other interviewees also shared episodes where they had experienced that supervisors gave them less responsibility and/or less advanced work than their majority classmates or explained things to them in an over-simplified manner: "Like as if you're dumber just because you look foreign" (3M).

In contrast to the narratives above, one participant from a Western European country described how her cultural background led to positive, albeit stereotyped, expectations: "There have been very positive opinions about me before people even know me, just because of my cultural background" (8W). Thus, not everyone with "foreign" background was underestimated – suggesting a prevailing hierarchy among different countries, or since this participant was white, a racial hierarchy.

3.2. Being excluded

The second category is grounded in the many narratives about situations where participants felt overlooked and excluded or that their feelings were unimportant.

Participants recalled instances of *being made invisible, ignored, and rejected* such as having supervisors skip their names while taking attendance or ignoring their presence in seminars or clinical exercises. One female interviewee, thinking back on a supervisor who failed to make eye contact for two weeks straight, reflected:

I have never felt someone is mean to me; it's more to be overlooked. At this clinical placement, the senior physician never looked at me when he talked. He looked at the other two students. While, me, it was as if wasn't there. (12W)

Participants had also encountered reluctance or outright refusal from patients for whom they were providing care. Others found supervisors and staff less likely to include minority than majority students in clinical work: "If we are two people in the clinic, many times they choose the other person, who does not have a foreign background" (14W). Being

sidelined in this way, the participant later concluded: "They would probably like to educate their Swedish students more". Here, this participant names her own 'Otherness' by referring to peers as "Swedish students".

Interviewees found themselves *trapped by degrading images of minorities* conveyed in formal educational contexts. Both racialized and white participants described that in written cases and group discussions, minority patients seemed to be introduced only to exemplify problems perceived as related to specific cultures and religions, like "genital mutilation" and "honor violence". Islamic culture in particular was depicted as patriarchal and controlling. Participants felt singled out and caught by these more or less prejudiced, stigmatizing, and homogenizing images:

It feels like teachers are trying to be very diplomatic and like: "Keep in mind that people with an immigrant background can act out very much and it is cultural." They say it in a fairly neutral way, but they do not add: "Not all of them." Because now I think many people believe that everyone is that way, which is a bit sad. Like: "They usually bring their whole family, when a person is sick" – as if there is something wrong with that. And like: "The men usually take over." (14W)

Thus, the education seemed to reinforce salient negative beliefs about minority groups. Still, interviewees believed the aim of education about cultural differences was to stimulate intercultural competence – which they found important.

When participants felt unfairly treated and offended they *missed out on support from bystanders*. Instead, it seemed as if supervisors, staff, or classmates passively tolerated prejudiced and racist comments, jargon, and degrading treatment – or remained oblivious – which added to participants' feelings of exclusion. One female student recalled:

There is this guy in my class that I think ... or I know he is a racist ... and everyone else knows that too, but nobody says anything. And I do not dare start a discussion with him in front of fifty other people in the class when he says degrading things about Muslims and immigrants. (14W)

She, like many other participants, had wished for but had learned not to expect back up or support from peers. Many thought that even if majority students recognized their vulnerable position, fear of negative repercussions likely prevented any acts of open support:

They just mind their own business. They don't want to end up in a situation where they also risk losing something. (3M)

Only one example was given of a lecturer who had openly protested when hostile attitudes towards cultural minorities were being voiced in class.

3.3. Being designated as different

This third category outlines the numerous situations where participants were assigned group affiliations based on external characteristics and preconceived ideas about their culture or religion.

"Foreign" or "immigrant" status was regularly imposed upon participants. Compared to their majority classmates their origin was often a source of comments that were uncalled for, e.g. through intrusive and unwelcome questions about their physical appearance or birthplace, coercing them to *account for their supposedly foreign background*:

I can be approached differently than Swedes, and it's not something negative like they hate me. It's more that they ask somewhat strange questions, which I had not received if I were Swedish. There was a physician who wondered where I came from and when I mentioned my hometown, the physician kept asking: "But where do you really come from?", wanting to know which country I came from. But I'm

from Sweden. I was born here. It's like: "We know you have a foreign background. Can't you just tell us where you're from?" (10M)

A few participants, though, perceived questions about origin as a way for patients and staff to make contact. One male student depicted it as positive standing out from the crowd of medical students, in the sense that it made him more (interesting and noticeable, and more) easily remembered by supervisors. White participants had not been expected to account for their background in the same way.

Repeatedly, participants were approached as *representatives of a homogenous group*. e.g. "black people", "immigrants", "refugees", or "Muslims" – groups with whom they did not necessarily identify:

I'm not a Muslim. And even if I was, who says all Muslims think in a certain way? (5M)

Majority students and supervisors also turned to them when various cultural or religious issues were addressed. This kind of homogenizing and stereotyping made them feel accountable for the customs of an entire religion or country.

Participants felt that they could *symbolize security for minority patients*, which meant that their background might also be an asset. With pride, they recalled encounters where "mutual understanding", "connection", and "trust" had been established. In situations where an interpreter was needed, for instance, their language skills had often been crucial. Being bicultural, participants perceived themselves as more flexible, tolerant, and patient compared to majority students and physicians:

It is fun to get to help out and do something extra. [laughter] I guess one has an understanding for people's differences and one becomes more adaptable for different situations. Because you have grown up with one culture at home and one in school and one with your friends. And you learn to adapt and accept things. (7W)

Albeit positive, this dual expectation is built upon and reinforces a dichotomy of 'We' and 'Others'. Furthermore, the perceived advantage in interactions with minority patients seemed to presuppose that participants contributed with something "extra", and risked creating higher expectations: "Minority patients want more than you can offer, they feel: "You can help us, you understand" (17W). Others underlined their own origin could be a liability in contact with minority patients, for example, if the patient had prejudices about other minority groups, or due to conflicts between ethnic groups: "I met a patient with a foreign background, who was ... I don't know if you can call it racist, but he didn't like me not being from the same country as him" (10M).

3.4. Core category: making sense of feeling out of place

The core category, "Making sense of feeling out of place" illustrates the participants' continuous striving to make sense of their experiences of being downgraded, excluded, and perceived as different – in a context they primarily described as exempt from racism.

As their studies progressed, adverse experiences accumulated and, understandably, participants' initial feelings of alienation did not subside: "I really feel I don't fit in here" (15W). Rather, becoming fixed in a position of 'Otherness' was internalized as a sense of somehow being lacking as medical students. Concurrently, being excluded from important privileges held by majority students in interactions with patients, supervisors, and staff were noted. While participants easily identified racism in its more overt forms, they felt the underlying meaning of many "subtle" interactions conveying humiliation and feelings of being out of place remained contestable. Most were cautious and uncertain about whether it was right to interpret these experiences as "discriminatory" or "racist": "It's only when I hear 'fucking negro' I dare to call it racism" (5M). Thus, participants struggled to find other explanations for their predicament, using their apprehensions about what constitutes racism. Different approaches to these dilemmas were identified, ranging from

individualizing, renaming, and relativizing their experiences as outlined below.

Instead of focusing on how the unfair treatment they encountered contributed to inequity, participants focused on whether or not the individual committing the offense really was a conscious racist, i.e. *individualizing a structure*. However, few people in medical school fit their definition of a conscious and/or ideological 'racist'. One female student's acceptance of a joke made by a lecturer and that she perceived as racist, seemed rooted in the idea that racial discrimination can only be intentional: "I thought what he said was wrong, but I think he was just clumsy since I don't think he's a racist" (15W). Participants emphasized that most people had good intentions: "They mean no harm" (7W), and/or excused their actions: "Perhaps people don't understand what's inappropriate to say" (13M). They found rationales for peoples' actions such as "curiosity", "fear", "ignorance", or "un-accustomedness to foreign people": "Of course you get the hate and fear attitude towards other ethnic groups if you never meet other kinds of people" (16M). Thus, many believed prejudices and skepticism about cultural minorities were confined to people they assumed had less interaction with immigrants, e.g., elderly, uneducated, or people from rural areas. When people's actions are seen in this way – not as the result of racist structures – but as a result of fear or ignorance, they become justified as natural reactions that will disappear if these people interact more with immigrants.

Participants sometimes transformed potentially racist incidents into something less threatening: "You make it so hard for yourself if you constantly think that maybe it's because I'm an immigrant" (6W). They considered other sources of discrimination, for example, whether an incident might be contingent upon something else like age or gender, i.e. *renaming oppression*: "The patient said: "A dark and beautiful woman as you, where do you come from – It must be somewhere exotic?". But he would have found something else to say even if I was blonde" (4W). This student chose to see the comment as an aspect of sexism, linking her with half the population and moving her from outside to inside. In this way the offence is normalized – she is one among many women. Also, participants yielded to self-accusation, underlining that their suspicions about unfair treatment might just be a matter of them being "paranoid", imagining", or "negative". This way of reasoning reduces racism from a question of systematic oppression into a matter of individual interpretations.

Interviewees said that although racist opinions had become more prevalent in Sweden in recent years, they thought most Swedes, and especially those with higher education, were "tolerant", "respectful", and "open-minded". Hence, they had expected medical school to be free from prejudice and discrimination and reacted with surprise at their experiences: "I thought it was a bit strange because academics usually don't think like that, in my experience. They tend to be more tolerant" (18M). Having to acknowledge that adverse incidents did occur in medical school, participants compared these incidents with knowledge about and experiences of racism in other countries and/or contexts, compared to which they found their medical school experiences to be rather benign, i.e. *relativizing inequality*: "Compared to the rest of society, I think medical school is much better and more protected ... So I guess I'm happy now that I compare it to society and not to the ideal picture I had at the beginning" (5M). However, even if many incidents were outlined as minor, they could be equally or even more devastating than overt racism, especially when perpetrated by physicians or supervisors. Furthermore, this idea about tolerance leads participants to be grateful for how well they have been received in medical education, thereby confirming the white majority who so tolerantly welcomed them – to an education they have the same right to as everyone else.

4. Discussion

In this study, we explored how minority medical students perceive and make sense of experiences during their education that they

comprehend as related to that minority position. Participants regularly encountered adverse treatment in their interactions with supervisors, co-students, staff, and patients related to their skin color, name, clothing, or imagined cultural background and religion. Black- and Muslim participants were especially set apart – reflecting hierarchies among different countries of origin and religions. Participants felt fixed in a position of ‘Otherness’ and denounced for being lacking as medical students. However, a general view of Sweden and, in particular, medical school as international models of equality and as free from discrimination and racism made interviewees uncertain about whether their experiences could be labeled “discriminatory” or “racist”. To therefore make sense of systemic injustices they individualized, renamed, and relativized their experiences.

4.1. Manifestations of everyday racism and racial microaggressions

The medical school experiences outlined in our results are framed by the dichotomous thinking about ‘We and Others’ – or rather ‘Swedes or Others’. Since whiteness was often the invisible referent against which our minority students’ ‘Swedishness’ was measured, the position as ‘Swede’ was seldom available. Instead, they were positioned as ‘Others’, or rather as, ‘Immigrants’, ‘Blacks’ or ‘Muslims’, categories denoting them as different from ‘Swedes’. Ideas about irrational, obsolete, and uncivilized ‘Others’ are directly opposed to the construction of ‘We’ as modern, gender-equal, civilized, rational, and developed ‘Swedes’ – as these categories presuppose one another (Essed, 1991; Said, 1978; Sue, 2010).

The challenges our participants encountered based on their presumed racial and/or cultural ‘Otherness’ constitute typical manifestations of subtle, recurrent incidents of ‘everyday racism’ or ‘racial microaggressions’; a series of seemingly trivial incidents that, consciously or unconsciously, communicated marginality and even contempt (Essed, 1991; Sue, 2010). Racist talk, humiliation, patronizing behavior, and punishment contribute to subordination and vulnerability. Having negative characteristics, like criminal status or intellectual inferiority attributed to the group one is presumed to be part of impedes individual credibility and perhaps even self-perception as competent physicians-to-be. Being ignored and rejected, in turn, maintains an unequal distribution of support and supervision. Questions about origin convey the message that participants are not true Swedes and compel them to justify their right to be in Sweden. When being assigned different group affiliations, participants are deprived of the possibility for individual expressions, and focus is drawn away from their role as students. And when minority groups are represented as deficient and problematic compared to majority Swedes in formal, seemingly scientific, and ‘objective’ educational contexts, the apparent implication is that by being ‘Others’ participants, too, are inferior. Lastly, when racist treatment passes unchallenged, whether it is due to bystanders’ obliviousness or fear of punishment, it contributes to normalization of discrimination and protection of white privilege. Our present findings are in concordance with studies from other countries and suggest that in Sweden racial/ethnic/cultural biases in medical education and health care contribute to marginalization and alienation of minority students (Beagan, 2003; Leyerzapf and Abma, 2017).

To fully understand the impact of participants’ experiences we have to consider that relational dynamics at the clinic are structured around a hierarchy of authority and power (Essed, 1991). Physicians and other staff were often the offenders. As members of the (white) majority group, and in positions of dominance as supervisors, they inflicted significant discomfort. Although patients are not in the same position of power, hostility and reluctance from them can create more work for minority students as they attempt to uphold the therapeutic alliance. For the participants, meetings with supervisors and patients were often short and volatile. The relationship with classmates on the other hand – or lack thereof – extended over years. Being forced to deal with hostility, exclusion, and lack of solidarity from fellow students may thus be even

more challenging.

4.2. Strategic minimizing of racism from the in-group

Subtle racism tends to instigate efforts among those targeted to determine whether an incident qualifies as ‘racist’ (Sue, 2010). Previous experiences, general views on racism, and societal discourses all function as important tools in this process (Essed, 1991; Sue, 2010).

Participants’ ways of making sense of their feelings of being out of place pointed to a deep ambivalence and mistrust in their own experiences of reality. They recalled numerous adverse episodes but were hesitant to call their experiences discriminatory or racist. This may be one of the most insidious and exhausting things about being systematically disadvantaged: to be constantly guessing and doubting your experiences. As Sue (2010) writes, the power of microaggressions lies in their invisibility, not only to the offenders but also to the victims – and the more subtle and ambivalent the incident, the more energy the victim will expend trying to determine whether that incident was really racist.

However, as Habel (2012) argues: disinclination to acknowledge racism should not be understood as people lacking critical insight or solely being passive victims of exclusion. Rather it should be read as a subconscious form of strategic blindness aimed at maintaining one’s dignity and self-esteem within the discourse of a society exempt from racism. As seen in other studies, participants drew on dominant societal discourses of Sweden and downplayed or negated the presence of (structural) racism in medical school (Schmauch, 2006). When concrete experiences contradicted this image, it resulted in processes of individualizing structural injustices, renaming oppression, and relativizing inequalities. Typical of most Swedes, participants understood racism to be conscious acts of cruelty and ideological convictions (Habel, 2012). As few offenders fit this definition of a conscious racist their actions were reinterpreted and excused. To relieve the pain of oppression it was transformed into something less threatening. Further, by comparing their experiences with racism elsewhere, a picture was maintained whereby their medical school was, if not free from racism, then at least better than other contexts. Thus, our findings support studies, which have raised concerns about how the idealization of Sweden as an exceptionally equal and tolerant society promotes silencing and normalization of excluding practices and racist power hierarchies (de los Reyes et al., 2002; Ericson, 2018; Habel, 2012; Schmauch, 2006).

Being medical students, our participants are seeking access to a prestigious profession, making them especially vulnerable to adverse treatment from supervisors and physicians, i.e. the in-group. This likely made them more willing to justify, explain away, or turn a blind eye to uneasy behaviors. It seemed easier for participants to imagine patients, with whom they did not identify, being carriers of racist beliefs. This is in line with research showing that victims of microaggressions are more likely to interpret the situation as non-biased and engage in self-deception by denying, minimizing, and excusing the offender upon whom they are dependent (Sue, 2010) – and dependency is certainly an important dimension in the student-supervisor relationship. Thus, drawing on our core category, participants’ ways of making sense could be interpreted as a strategic minimizing of racism from the in-group.

4.3. Calling on bystanders to redress the normality of racism

Like many other institutions, the medical school that formed the context of this study has a zero-tolerance policy for discrimination, harassment, and abusive treatment (Umeå University, 2018; 2019). However, such policies can leave subtle racist practices unchallenged. As our results show, subtle forms of racism remain invisible or normalized, bystanders stay passive and victims are left with nothing more to do than to deny or minimize their experiences.

Currently, there is a discussion among researchers on how to deconstruct the normalcy and redress the negative impact of subtle exclusion in medical education (see e.g.: Acosta and Ackerman-Barger,

2017; Leyerzapf and Abma, 2017). Many agree that key to succeeding in this goal is for bystanders to talk to, support, and become ‘allies’ to those targeted by discrimination (Came and Griffith, 2018; DiAngelo, 2018). Recent studies have shown that teaching bystanders – both faculty and students – to identify and respond to microaggressions is a promising strategy for prevention and intervention (Manzi et al., 2020; Sandoval et al., 2020; Wheeler et al., 2019). When it comes to immediately confronting the offender, fear of retribution poses an important challenge (Sandoval et al., 2020) and could put the bystander in jeopardy. Nevertheless, there are effective ways to act such as giving victims emotional support afterward, confirming that the hostility was seen and identified as unacceptable, and supporting victims who ask for support from medical school leadership or student groups.

Supported by previous studies (Manzi et al., 2020; Sandoval et al., 2020; Wheeler et al., 2019), we suggest that medical school leadership should provide students, supervisors, and teachers with a structural account of racism and with strategies and training on how to intervene as bystanders. A more fruitful way of looking at racism, than to talk about ‘racists’ versus ‘non-racists’, is to focus on how racism is reproduced in everyday interactions, and to see it as something that we all – also bystanders – consciously or unconsciously, help to recreate (Beagan, 2003; DiAngelo, 2018; Essed, 1991). This also implies reflection on the taken for granted white norm and on the accompanying advantages and privileges of belonging to the majority (DiAngelo, 2018). Such theoretical and skills-based education should be mandatory and an explicit part of teaching. Concrete examples, like the ones described in this study, may serve as a basis for creating educational materials and exercises aimed at identifying and addressing subtle racism. There is a risk otherwise, that students will acquire theoretical knowledge about racism, but stick to the notion that this does not really apply to their context.

4.4. Methodological considerations, strengths, and limitations

The participants in this interview study were self-selected, indicating that they wanted to share their experiences. They may differ from minority students who abstained from participating. Non-participants may have had more severe experiences, but did not trust the researchers enough to volunteer for the project. Or, they might have found their situation satisfactory and therefore did not want to spend time being interviewed. Many informants did, however, agree to participate after hearing about the study through several means of communication. This we believe highlights the importance of establishing trust with participants in research on minority groups and on sensitive subjects (Leyerzapf and Abma, 2017).

Inherent in snowball sampling is the risk that those recommended have similar experiences and views as the previous interviewee. To reduce this risk, we specifically asked the interviewees to recommend minority students from other cultures than their own, or students they thought had different experiences. We cannot know to what extent our intention was successful. Still, the interviewees’ experiences and concrete examples varied, as did their ways of creating meaning, indicating that enrollment was broad – and offers credibility to the results.

Sharing the experience of being medical students with the interviewing researchers may have enhanced relationship building during the interviews and thus deepened and enriched responses. Some participants, however, may have avoided sharing sensitive information because they doubted the motives and understanding of white female researchers. Thus, we might have gathered other, richer, or deeper data, had the interviewees come from cultural or ethnic minority backgrounds. Further research undertaken by researchers with minority backgrounds would be valuable.

Our choice of method resulted in a heterogeneous group of participants, and in rich and nuanced interview material. With empirics from a previously unexamined context, this study extends previous knowledge on how everyday interactions maintain inequity in medical school. The

study, however, is limited by its reliance on data from a single medical school. Compared to other countries, and likely to other Swedish medical schools, Umeå has a low number and low proportion of minority students (Leyerzapf and Abma, 2017; Orom et al., 2013). Nevertheless, the cultural/ethnic bias outlined by our participants parallels descriptions from many other contexts (Beagan, 2003; Leyerzapf and Abma, 2017; Orom et al., 2013; Sandoval et al., 2020). We, therefore, believe the results, including participants’ strategic minimizing of racism from the in-group, are transferable to, and relevant for, other Swedish Universities, and also Euro-American contexts – and to health professional training programs more generally. With our description of the research context, we hope to have provided the readers with enough information to assess transferability to their own context.

5. Conclusions

Despite their medical school’s formal commitment to equality, minority students encountered everyday racism or racial microaggressions – i.e., practices that, intentionally or inadvertently, convey disregard or contempt based on ideas about racial and/or cultural ‘Otherness’. Participants were downgraded, excluded, and stereotyped as representing a homogenous group, which was inherently different from their white majority classmates.

The current discourse, reducing racism into conscious acts committed by immoral or ignorant people – and the pretense that racism no longer poses a problem in Sweden or in medical school – however, obscures the structural nature of racism. Instead, this limited view of racism leaves inequities unchallenged and disempowers targets of exclusion.

In order to improve the medical school climate, there is a need for medical school leadership to implement education and discussions about cultural hierarchies and everyday racism in the curriculum. Additionally, students and staff should receive bystander training to help them recognize subtle forms of racism and exclusion, learn how they can mark offensive behavior as unacceptable, and offer training on how to act to support victims.

Declaration of competing interest

None.

Acknowledgements

The authors wish to thank the participants who generously shared their experiences with us, and acknowledge Professor Susan Phillips for her advice and input. The study was financed by grants from the Västerbotten County Council, grant number RV753991.

References

- Acosta, D., Ackerman-Barger, K., 2017. Breaking the silence: time to talk about race and racism. *Acad. Med.* 92, 285–288. <https://doi.org/10.1097/ACM.0000000000001416>.
- Ahmed, S., 2007. A phenomenology of whiteness. *Fem. Theor.* 8, 149–168. <https://doi.org/10.1177/1464700107078139>.
- Andersson, J., Verdonk, P., Johansson, E.E., Lagro-Janssen, T., Hamberg, K., 2012. Comparing gender awareness in Dutch and Swedish first-year medical students—results from a questionnaire. *BMC Med. Educ.* 12, 3. <https://doi.org/10.1186/1472-6920-12-3>.
- Ansell, D.A., McDonald, E.K., 2015. Bias, black lives, and academic medicine. *N. Engl. J. Med.* 372, 1087–1089. <https://doi.org/10.1056/NEJMp1500832>.
- Beagan, B.L., 2003. ‘Is this worth getting into a big fuss over?’ Everyday racism in medical school. *Med. Educ.* 37, 852–860. <https://doi.org/10.1046/j.1365-2923.2003.01622.x>.
- Came, H., Griffith, D., 2018. Tackling racism as a “wicked” public health problem: enabling allies in anti-racism praxis. *Soc. Sci. Med.* 199, 181–188. <https://doi.org/10.1016/j.socscimed.2017.03.028>.
- Charmaz, K., 2014. *Constructing Grounded Theory*. Sage, London.
- de los Reyes, P., Molina, I., Mulinari, D., 2002. Maktens (O)lika Förklädnader. Kön, Klass & Etnicitet I Det Postkoloniala Sverige [The Different Disguises of Power: Gender, Class and Ethnicity in Post-colonial Sweden]. Atlas, Stockholm.

- de los Reyes, P., Wingborg, M., 2002. Vardagsdiskriminering Och Rasism. En Kunskapsöversikt. Integrationsverket: Norrköping.
- DiAngelo, R., 2018. *White Fragility: Why It's So Hard for White People to Talk about Racism*. Beacon Press, Boston.
- Dickins, K., Levinson, D., Smith, S.G., Humphrey, H.J., 2013. The minority student voice at one medical school: lessons for all? [published correction appears in Acad Med. 88, 1104. Acad. Med. 88, 73–79. <https://doi.org/10.1097/ACM.0b013e3182769513>].
- Dyrbye, L.N., Thomas, M.R., Eacker, A., Harper, W., Massie, F.S., Power, D.V., et al., 2007. Race, ethnicity, and medical student well-being in the United States. *Arch. Intern. Med.* 167, 2103–2109. <https://doi.org/10.1001/archinte.167.19.2103>.
- Ericson, M., 2018. "Sweden has been naïve": nationalism, protectionism and securitisation in response to the refugee crisis of 2015. *Soc. Incl.* 6, 95–102. <https://doi.org/10.17645/si.v6i4.1512>.
- Essed, P., 1991. *Understanding Everyday Racism: an Interdisciplinary Theory*. Sage, New York.
- Ford, C.L., Airhienbuwa, C.O., 2010. The public health critical race methodology: praxis for antiracism research. *Soc. Sci. Med.* 71, 1390–1398. <https://doi.org/10.1016/j.socscimed.2010.07.030>.
- Ghorashi, H., Sabelis, I., 2013. Juggling difference and sameness: rethinking strategies for diversity in organisations. *Scand. J. Manag.* 29, 78–86. <https://doi.org/10.1016/j.scaman.2012.11.002>.
- Habel, Y., 2012. Challenging Swedish exceptionalism? Teaching while black". In: Freeman, K., Johnson, E. (Eds.), *Education in the Black Diaspora: Perspectives, Challenges and Prospects*. Routledge, London, pp. 99–122.
- Hill, K.A., Samuels, E.A., Gross, C.P., Desai, M.M., Sitkin Zelin, N., Latimore, D., et al., 2020. Assessment of the prevalence of medical student mistreatment by sex, race/ethnicity, and sexual orientation. *JAMA Intern. Med.* 180, 653–665. <https://doi.org/10.1001/jamainternmed.2020.0030>.
- Hübinette, T., Lundström, C., 2014. Three phases of hegemonic whiteness: understanding racial temporalities in Sweden. *Soc. Ident.* 20, 423–437. <https://doi.org/10.1080/13504630.2015.1004827>.
- Kmietowicz, Z., 2020. Are medical schools turning a blind eye to racism? *BMJ* 368, m420. <https://doi.org/10.1136/bmj.m420>.
- Leyerzapf, H., Abma, T., 2017. Cultural minority students' experiences with intercultural competency in medical education. *Med. Educ.* 51, 521–530. <https://doi.org/10.1111/medu.13302>.
- Magnusson, E., Marecek, J., 2015. *Doing Interview-Based Qualitative Research: a Learner's Guide*. University Press, Cambridge.
- Maina, I.W., Belton, T.D., Ginzberg, S., Ajit Singh, A., Johnson, T.J., 2018. A decade of studying implicit racial/ethnic bias in healthcare providers using the implicit association test. *Soc. Sci. Med.* 199, 219–229. <https://doi.org/10.1016/j.socscimed.2017.05.009>.
- Manzi, J., Casapulla, S., Kropf, K., Baker, B., Biechler, M., Finch, T., et al., 2020. Responding to racism in the clinical Setting: A novel use of forum theatre in social medicine education. *J. Med. Humanit.* 41, 489–500. <https://doi.org/10.1007/s10912-020-09608-8>.
- Odom, K.L., Roberts, L.M., Johnson, R.L., Cooper, L.A., 2007. Exploring obstacles to and opportunities for professional success among ethnic minority medical students. *Acad. Med.* 82, 146–153. <https://doi.org/10.1097/ACM.0b013e31802d8f2c>.
- Orom, H., Semalulu, T., Underwood 3rd, W., 2013. The social and learning environments experienced by underrepresented minority medical students: a narrative review. *Acad. Med.* 88, 1765–1777. <https://doi.org/10.1097/acm.0b013e3182a7a3af>.
- Said, E.W., 1978. *Orientalism*. Vintage, New York.
- Sandoval, R.S., Afolabi, T., Said, J., Dunleavy, S., Chatterjee, A., Ölveczky, D., 2020. Building a tool kit for medical and dental students: addressing microaggressions and discrimination on the wards. *MedEdPORTAL* 16, 10893. https://doi.org/10.15766/mep_2374-8265.10893.
- Schmauch, U., 2006. *Den Osynliga Vardagsrasismens Realitet*. Diss. Umeå universitet, Umeå.
- SFS 2008:567. Diskrimineringslag [Discrimination Act]. Arbetsmarknadsdepartementet, Stockholm.
- SOU 2005:41. Utredningen Om Makt, Integration Och Strukturell Diskriminering. Bortom Vi Och Dom: Teoretiska Reflektioner Om Makt, Integration Och Strukturell Diskriminering: Rapport. Stockholm: Fritze.
- SOU 2006:40. Utredningen Om Makt, Integration Och Strukturell Diskriminering. Utbildningens Dilemma: Demokratiska Ideal Och Andrafierande Praxis: Rapport. Stockholm: Fritze.
- SOU 2005:56. Utredningen Om Strukturell Diskriminering På Grund Av Etnisk Eller Religiös Tillhörighet. Det Blåga Glashuset: Strukturell Diskriminering I Sverige: Slutbetänkande. Stockholm: Fritze.
- SOU 2006:79. Utredningen Om Makt, Integration Och Strukturell Diskriminering. Integrationens Svarta Bok: Agenda För Jämlikhet Och Social Sammanhållning: Slutbetänkande. Stockholm: Fritze.
- Spivak, G.C., 1988. *Can the subaltern speak?* In: Williams, P., Chrisman, L. (Eds.), *Colonial Discourse and Post-colonial Theory*. Columbia University Press, New York, pp. 64–111.
- Statistics Sweden, 2005. Together – Integration in Swedish Society. https://www.scb.se/contentassets/f80dee2a541e44ef88646fbc3b8fcb4/be0101_2004a01_br_be55st0501.pdf. (Accessed 13 April 2020).
- Statistics Sweden, 2018. Higher Education Foreign Background Among Students and Doctoral Students in Higher Education 2016/17. <https://www.scb.se/publication/35261>. (Accessed 19 July 2020).
- Statistics Sweden, 2019. Befolkningsstatistik I Sammandrag 1960–2019. <https://www.scb.se/hitta-statistik/statistik-efter-amne/befolkning/befolkningens-sammansattning/befolkningsstatistik/pong/tabell-och-diagram/helarsstatistik-riktet/befolkningsstatistik-i-sammandrag/>. (Accessed 6 April 2020).
- Stegers-Jager, K.M., Steyerberg, E.W., Cohen-Schotanus, J., Themmen, A.P., 2012. Ethnic disparities in undergraduate pre-clinical and clinical performance. *Med. Educ.* 46, 575–585. <https://doi.org/10.1111/j.1365-2923.2012.04265.x>.
- Sue, D.W., 2010. *Microaggressions in Everyday Life: Race, Gender, and Sexual Orientation*. Wiley & Sons, Inc, Hoboken.
- Umeå University, 2018. Riskbedömning och handlingsplan för lika villkor 2019-2021. Document in Swedish. (English title: Risk assessment and action plan for work environment and equal opportunities 2019-2021). [https://www.aurora.umu.se/globalassets/dokument/universitetsforvaltningen/personalenheten/regler-och-riktlinjer/arbetsmiljo-och-lika-villkor/work-environment-and-equal-opportunities-policy-fs-1.1-1526-19_eng.pdf](https://www.aurora.umu.se/globalassets/dokument/universitetsforvaltningen/personalenheten/regler-och-riktlinjer/arbetsmiljo-och-lika-villkor/riskbedomning-och-handlingsplan-arbetsmiljo-och-lika-villkor.pdf). (Accessed 14 January 2020).
- Umeå University, 2019. Work environment and equal opportunities policy. https://www.aurora.umu.se/globalassets/dokument/universitetsforvaltningen/personalenheten/regler-och-riktlinjer/arbetsmiljo-och-lika-villkor/work-environment-and-equal-opportunities-policy-fs-1.1-1526-19_eng.pdf. (Accessed 14 January 2020).
- van Ryn, M., Burgess, D.J., Dovidio, J.F., Phelan, S.M., Saha, S., Malat, J., et al., 2011. The impact of racism on clinician cognition, behavior and clinical decision making. *Du. Bois Rev.* 8, 199–218. <https://doi.org/10.1017/S1742058X11000191>.
- Verdonk, P., Abma, T., 2013. Intersectionality and reflexivity in medical education research. *Med. Educ.* 47, 754–756. <https://doi.org/10.1111/medu.12258>.
- Wheeler, D.J., Zapata, J., Davis, D., Chou, C., 2019. Twelve tips for responding to microaggressions and overt discrimination: when the patient offends the learner. *Med. Teach.* 41, 1112–1117. <https://doi.org/10.1080/0142159X.2018.1506097>.
- Wolgast, S., Molina, I., Gardell, M., 2018. Anti-black Racism and Discrimination in the Labour Market. <https://www.lansstyrelsen.se/download/18.4e0415ee166afb5932419bf7/1542881639062/Rapport%202018-22%20Anti-Black%20racism%20and%20discrimination.pdf>. (Accessed 14 January 2020).