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Coláiste na Tríonóide, Baile Átha Cliath
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**Immigrant
Council of
Ireland**

**Trinity Equality
Fund 2022**

Stand Up, Speak Out! Racial Justice in Healthcare Education

Experiences of Minoritised Ethnic Students

Report 2022

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Contact Us

If you have any questions in relation to this report, please do not hesitate to contact the Project Co-leaders Aaron Koay (cheechek@tcd.ie) and Miriam Galvin (galvinmi@tcd.ie).

Executive Summary

What is Trinity's responsibility for racism?

- Trinity has legal obligations under the Equality Status Acts 2000-2018, Public Sector Equality and Human Rights Duty and Employment Equality Acts, as well as policy commitments under the Trinity Dignity and Respect 2016 and Equality Policy 2016 to ensure students do not experience racial discrimination or harassment in higher education.
- Other public healthcare bodies, such as the Health Service Executive (HSE) and various healthcare regulatory bodies, who might be involved in the teaching, learning and assessment of healthcare students also bear similar obligations.

What is this report?

- Funded by **Trinity Equality Fund 2022**, the Faculty of Health Sciences Equality, Diversity and Inclusion (EDI) Group and Immigrant Council of Ireland launched a project entitled **'Stand Up, Speak Out! Racial Justice in Healthcare Education'**.
- This report articulates the lived experiences of racism in minoritised ethnic healthcare students (MEHSs) and recommends strategies to embed racial justice in healthcare education at Trinity.
- The report will be made available to staff and students in the Faculty of Health Sciences, Equality Office and relevant healthcare and higher education bodies in order to promote the inclusion of students' voices in future racial justice strategies.

Why is this report important?

- International evidence suggests MEHSs can experience discrimination, bullying and hate speech due to their racial and ethnic backgrounds.
- Although this area is underexplored in Ireland, there have been numerous reports of racism directed at MEHSs at Trinity. These reported incidents included microaggressions, bullying and assaults of both physical and sexual nature, with alleged perpetrators including patients, colleagues and teaching or clinical staff.

How did we generate the report?

- A racial justice convening for MEHSs was held in May 2022. Attended by eleven MEHSs from diverse backgrounds across the Faculty of Health Sciences, the convening involved keynote presentations and breakout sessions to discuss racism in a safe and empowering environment. Drawing on international and national evidence, the perspectives of the MEHSs were analysed to generate this report.

What are the key points?

- MEHSs experience racism as a complex, pervasive and harmful phenomenon.
- **Institutional Racism**
 - **Underdeveloped Support Systems:** The pathways for reporting incidents of racism and accessing support were perceived to be unclear, fragmented (particularly between Trinity and clinical sites) and bureaucratic. Some students were actively dissuaded from using them.
 - **Lack of Accountability:** Lack of clarity, transparency and accountability about how reports of incidents are processed and if alleged perpetrators of racism face real consequences.
 - **Lack of Diversity and Representation:** Lack of racial and ethnic diversity among staff members, particularly at senior levels, and students in leadership positions.
 - **Mind the Gap:** Inequitable entry and attainment gaps in healthcare courses.
 - **Curricular Deficiency:** Healthcare curricula remain largely white- and Euro-centric with no, inadequate or uncritical attention to race and ethnicity.
- **Interpersonal Racism**
 - **Patients:** Clinical sites are perceived to be more hostile where racist patients ignore, assault or refuse care from MEHSs, who have to negotiate between their safety and duty of care.
 - **Academic and Clinical Staff:** While some had positive experiences with staff members, others reported discrimination and bullying perpetuated by academic and clinical staff. Concerns we raised around implicit racial biases in grading for clinical exams that are not anonymous.
 - **Students:** There appears to be an entrenched division and lack of integration between international or minoritised ethnic students and white Irish students. Racist comments made by healthcare students towards minoritised ethnic groups were also reported.
- **Internalised Racism**
 - **Self-fulfilling Prophecies:** Internalisation of racist stereotypes can lead to students minimising their self-worth and not achieving their full potential.
 - **Helplessness:** Passive acceptance of racist incidents, often resulting in a sense of helplessness.
- **Dealing with Racism**
 - **Emotional Support:** Immediate acknowledgement and emotional support by colleagues and friends who witness racism as well as seeking psychological interventions were reported to be helpful.
 - **Not Reporting:** Students who experience racism tend not to report incidents to seek justice due to the emotional labour and trauma associated with reporting and fear of retaliation, and a distrust of institutions.

What should be done?

- Grounded in collective action and accountability, **systems, cultural and policy changes** by Trinity, Faculty of Health Sciences, clinical training sites as well as regulatory and professional bodies are required to fulfil their legal, policy and ethical responsibilities for MEHSs.
 - Upholding **Accountability** by evaluating the effectiveness of racial justice policies and strategies and publicising this data.
 - Establishing clear, unambiguous, comprehensive and accessible guidelines on **Reporting Mechanisms** for incidents of racism in both college and clinical training sites.
 - Enhancing **Supports for the Victimised** by providing or signposting students to timely psychological support as well as advisory services regarding their rights and means to report incidents.
 - Promoting **Leadership** representation from minoritised ethnic groups at both staff and student levels.
 - **Diversifying the Faculty of Health Sciences** to ensure equitable representation and inclusive integration of minoritised ethnic students and staff.
 - Interrogating and promoting **Curricular Change** that reflects the principles of decolonisation and equitably addresses the health and disease of minoritised racial and ethnic populations.
 - Having **Open Dialogue** about racism amongst and between students and staff.
 - Investing in **Research Capacity** to enhance the evidence base about the experience of racism by MEHSs.
 - Delivering mandatory **Racial Justice Training** to equip students and staff with the knowledge about racism and competencies to address it.
 - Enhancing the **Preparation for Clinical Placements** across all schools in the Faculty of Health Sciences to include preparedness for racism as both witnesses and the victimised.

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Project Team

This innovative project is based on multi-level collaborations: 1) student-staff collaboration; 2) interdisciplinary collaboration between the Department of Sociology, School of Medicine and School of Nursing & Midwifery; and 3) intersectoral collaboration between Trinity College Dublin and the Immigrant Council of Ireland. Team members are listed below.

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List of Abbreviations

Abbreviation	Full Form
EDI	Equality, diversity and equality
FHS	Faculty of Health Sciences
HSE	Health Service Executive
ICI	Immigrant Council of Ireland
MEHS	Minoritised ethnic healthcare students

1. Background

Ireland experienced little population diversity until the mid-1990s when positive net migration was recorded, followed by an exponential increase in immigration due to rapid economic growth (Glynn, 2014). Contemporary Irish society is diverse - approximately 12% of the Irish society are people of a migrant background, with Travellers accounting for 0.7% (CSO, 2016). In parallel, international mobility and migration within higher education and labour markets have resulted in increasing workforce diversity in healthcare systems worldwide (Bhopal, 2014; Oikarainen et al., 2017; Parker, V. and McMillan, 2007). Of note, this diversification in the past few decades was in major part due to overseas recruitment to tackle persistent staff shortages in medicine and nursing (Humphries et al., 2013; 2015; Humphries, Crowe and Brugha, 2018).

In Ireland, there has been a significant increase in minoritised ethnic¹ healthcare students (MEHSs), particularly in medicine, as Ireland attracts more non-EU students (O'Connor, 2018). Indeed, the body of healthcare students in high-income countries has been increasingly diversified, whereby the students' race, ethnicity, culture and/or first language differ from the prevailing ones in the country in which they study (Mikkonen et al., 2016). Due to their different cultural and linguistic characteristics, MEHSs can be classified as a minoritised group (Akombu, 2013) and are at risk of being subjected to racial incidents during their healthcare education (Mikkonen et al., 2016; Oikarainen et al., 2017).

Race is a social construct related to “essentialised innate phenotypical, ancestral, and/or cultural difference” (Paradies, 2006, p. 888). Racism can also be understood as deeply embedded and organised social structures and systems that produce, maintain and deepen avoidable inequalities in the distribution of power, resources, capacities and opportunities based on the notion of race (Paradies, 2006; Paradies et al., 2015). Expressed through beliefs, emotions, prejudice and discrimination, racism can manifest at multiple levels: internalised (internalising racist ideologies into one's worldview); interpersonal (racist individual-individual interactions); and systemic (racist policies, practices and processes in institutions) (Paradies et al., 2015). The Irish Network Against Racism (INAR) defined racism as:

“Any action, practice, policy, law, speech, or incident which has the effect (whether intentional or not) of undermining anyone's enjoyment of their human rights, based on their actual or perceived ethnic or national origin or background, where that background is that of a marginalised or historically subordinated group. Racism carries connotations of violence because the dehumanisation of ethnic groups has been historically enforced through violence” (INAR, 2022a p. 2).

In Ireland, ‘race’ (including race, colour, nationality, ethnic or national origins) is one of the nine grounds protected under the Equal Status Acts that prohibits discrimination in the access to and use of goods and services (IHREC, 2016a), as well as the Employment Equality Acts that prohibits discrimination in employment (IHREC, 2016b). Nevertheless, incidents of racism are high in Ireland.

¹ Terms like ethnic minority, minority ethnic, BAME (Black, Asian and minority ethnic), BME (Black and minority ethnic) and people of colour (PoC) have been used to describe racial and ethnic groups that are in the minority. In this project, we choose to use the term minoritised ethnic to acknowledge that the experience of minoritisation is contributed by social processes of power.

In 2021, 404 reports of racial incidents across criminal offences (assault, harassment and threats), discrimination (access to goods and services, accommodation and workplace) and hate speech were made by the public to the iReport.ie system in Ireland (INAR, 2021). Whilst most racial crimes targeted Chinese, South Asian and other Asian groups potentially due to COVID-19, people from Black backgrounds were most discriminated against in Ireland (INAR, 2021). Even though the Public Sector Equality Duty created under the Equality Acts legally obligates public bodies to eliminate and prevent discrimination (IHREC, 2016c), 30% of racial discrimination was perpetuated by staff in the public sector (INAR, 2021). Importantly, under-reporting of racially motivated incidents is a significant issue in Ireland (Buczowska, 2019) where only 1 in 8 people who experience racism reported it to the An Garda Síochána² (INAR, 2020a). A recent report found that 40% of international students in Ireland have either witnessed or experienced racism, with only 5% reporting it (ICOS, 2021).

In healthcare settings, the Health Service Executive ‘Dignity at Work’ policy (HSE, 2009) noted that discriminatory experience by employees based on race/ethnicity should not occur. Notably, there is a lack of research on the experience of racism by healthcare workers in Ireland. However, some research on foreign-born healthcare workers in Ireland, particularly doctors and nurses, found issues around cultural integration, communication problems, bullying, exploitation and downward career mobility (for example, Bobek and Devitt, 2017; Humphries, Brugha, R. and McGee, 2009; Humphries et al., 2013). Additionally, a report by the Irish Nursing and Midwifery Organisation found that 13% of nurses and midwives experienced offensive remarks and/or behaviours motivated by race or ethnicity (INMO, 2013).

International evidence suggests that racism can contribute to a multiplicity of mistreatment, discrimination, harassment, bullying, verbal, sexual and physical abuse faced by healthcare students from perpetrators like patients, peers, and clinical and academic staff (Rees et al., 2015). Medical students in the United States who identified as underrepresented racial minorities or multiracial experienced a higher percentage of mistreatment, at a rate of 38% and 32.9% respectively, than their white peers, 24% of whom reported such experience (Hill, 2020). Moreover, approximately 20% of nursing students in New Zealand (Minton et al., 2018) and Australia (Budden et al., 2017) have reported experiences of racist incidents. In New Zealand, Māori students reported a higher incidence of bullying than other ethnic groups (Minton et al., 2018). On the other hand, Australian nursing students reported a higher percentage of exposure to racist remarks and there was a higher level of bullying reported by non-native English speakers in the UK (Birks et al., 2017).

Nonetheless, this area remains a severely unexplored topic in Ireland. The available grey literature in Ireland pertains to newspaper reports on racially motivated crimes, incidents and hate speech experienced by MEHSs, most of which were published around the Black Lives Matter movement in 2020 (Adeleye, Adeniran, and Fidel, 2020; Adeleye et al., 2020; Bermingham, 2020; Koay, 2020; Malekmian, 2020). There is also a conference abstract exploring the journalistic experience of the author in reporting racism faced by minoritised ethnic pharmacy students (Koay, 2021). Of note, most of these publications describe experiences of racism by MEHSs at Trinity (Adeleye, Adeniran, and Fidel, 2020; Adeleye et al., 2020; Koay, 2020, 2021; Malekmian, 2020). These reported incidents

² An Garda Síochána is Ireland’s National Police and Security Service.

include racially motivated microaggressions, bullying and assaults of physical and sexual nature, with alleged perpetrators including patients, colleagues as well as teaching and clinical staff. Thus, they constitute racial harassment as defined by Trinity as:

“[H]arassment on the grounds of race, including national or ethnic origins, [based on] unwanted or unwelcome conduct, or incitement to such conduct, based on a person’s race, which is offensive to the recipient and which might threaten a person’s security or create a stressful, hostile or intimidating work or study environment” (TCD, 2016a, p. 13).

2. Project Goals

Racial justice could be defined as:

“The systematic fair treatment of people of all races, resulting in equitable opportunities and outcomes for all...[and] [i]t goes beyond 'anti-racism'. It is not just the absence of discrimination and inequities, but also the presence of deliberate systems and supports to achieve and sustain racial equity through proactive and preventative measures” (Race Forward, 2015, p. 31-32).

Funded by **Trinity Equality Fund 2022**, the Trinity Faculty of Health Sciences (FHS) Equality, Diversity and Inclusion (EDI) Group and Immigrant Council of Ireland (ICI) launched a project entitled **‘Stand Up, Speak Out! Racial Justice in Healthcare Education’**. Aligning with Trinity’s Dignity and Respect Policy (2016a) and Equality Policy (TCD, 2016b) as well as the Race Equality in the Higher Education Sector Report 2021 (Kempny and Michael, 2021), this community involvement and social action project aims to develop racial justice in healthcare education at Trinity by drawing on the lived experiences of MEHSs to inform strategy, policy, education and research directions. Through this project, it is hoped that the participating MEHSs would build confidence, advocacy skills and community to grow as racial justice advocates through community empowerment. It is also hoped that this project will benefit future MEHSs in the Faculty and wider University.

This project has two phases: 1) a racial justice convening for MEHSs involving keynote presentations and breakout sessions to discuss racism in a safe and empowering environment, generating a report capturing the MEHSs’ lived experiences of racism and racial justice priorities; and 2) report dissemination to the Faculty, Equality Office (including the Racial and Ethnic Equality Working Group and Inclusive Curriculum Project) and Students’ Union in order to promote the inclusion of students’ voices in future racial justice strategies. An intercultural competency workshop for FHS staff members will also be made available by the ICI.

This report details the conduct of the convening and our analysis about racism in healthcare education based on the lived experiences of MEHSs.

3. Convening

International best practice suggests the importance of creating safe spaces for marginalised communities to enable unrestricted conversations (Iyer, 2016). As a first-of-its-kind event in Ireland, the Trinity FHS EDI Group and ICI collaboratively held a racial justice Zoom convening for MEHSs at Trinity.³ The convening was held from 1 pm to 5 pm on the 19th of May 2022.

3.1 Participants

3.1.1 Target Audience

Undergraduate and postgraduate healthcare students across all disciplines in the Trinity FHS who self-identify as being part of (a) minoritised ethnic group(s) in Ireland were the focus of this work. These include but are not limited to Irish Traveller and Roma, Black African, Asian, Arab and mixed backgrounds.

3.1.2 Invitation

An email invitation was circulated to students across all four schools within FHS, namely Dental Science, Medicine, Nursing and Midwifery, and Pharmacy and Pharmaceutical Sciences. The event was also promoted both online, i.e. on the Trinity Calendar, Eventbrite and social media platforms, and offline, i.e. posters on notice boards and video screens in the main campus and Trinity centres in St. James's Hospital and Tallaght University Hospital.

To confirm participation, students were required to read a participation information leaflet and complete a consent form. As a token of appreciation, each participant was given a €15 One4all gift card.

3.1.3 Participant Characteristics

At the virtual convening, students were asked to complete an anonymous demographic questionnaire on SurveyMonkey.

Eleven Trinity MEHSs of diverse backgrounds participated in the convening (see Table 1). All undergraduate, the students were from the School of Medicine (55%), School of Nursing & Midwifery (18%) and School of Pharmacy and Pharmaceutical Sciences (27%). No students from the School of Dental Science were present. Seven (64%) students were of Irish nationality whilst the other four (36%) had non-EEA nationalities. In terms of ethnicity, almost half (46%) of the students were of Black/Black Irish (African) backgrounds, whilst the other approximate half (46%) consisted of Asian/Asian Irish students across various backgrounds, i.e. Chinese (18%), Indian/Pakistani/Bangladeshi (9%) and other backgrounds (18%). One student (9%) identified as Latinx.

³ Notably, this event followed the structure of a convening for racial justice leaders in Ireland undertaken by the ICI in late 2021 to identify racial justice funding priorities.

Table 1. Demographic characteristics of participants.

Characteristics	Frequency	%
School		
School of Medicine	6	54.5
School of Nursing and Midwifery	2	18.2
School of Pharmacy and Pharmaceutical Sciences	3	27.3
Undergraduate/Postgraduate		
Undergraduate	11	100.0
Course		
Medicine	6	54.5
Nursing	2	18.2
Pharmacy	3	27.3
Year of Study		
Junior Fresh (Year 1)	1	9.1
Senior Fresh (Year 2)	1	9.1
Junior Sophister (Year 3)	3	27.3
Senior Sophister (Year 4)	3	27.3
Year 5	2	18.2
Other ⁴	1	9.1
Age		
17 to 20	2	18.2
21 to 30	8	72.7
31 to 40	1	9.1
Nationality Status		
Irish	7	63.6
Non-EEA	4	36.4
Ethnicity⁵		
Asian or Asian Irish - Chinese	2	18.2
Asian or Asian Irish - Indian/Pakistani/Bangladeshi	1	9.1
Asian or Asian Irish - Other Asian background	2	18.2
Black or Black Irish - African	5	45.5
Latinx	1	9.1
Gender		
Non-binary	1	9.1
Woman	10	90.9
Transgender		
No	11	100.0
Sexual Orientation		
Bisexual	1	9.1
Heterosexual	8	72.7
Queer	2	18.2

⁴ Detail not provided as it could make the individual easily identifiable.

⁵ Based on Census 2022 in Ireland.

Approximately 75% of the attendees were aged between 21 and 30 years old and most students (82%) were in Year 3 or above in their degrees. All but one were women (91%); there was one non-binary student (9%). No student identified as transgender. Whilst one student identified as bisexual and two as queer, most students (73%) identified as heterosexual.

3.2 Structure

This convening involved two parts, i.e. keynote presentations followed by breakout group discussions.

3.2.1 Keynote Presentations

The keynote presentations served to 1) equip students with state-of-the-art knowledge about the progress, and lack thereof, of racial justice across the civic sector, academia and policy and the wider socio-political context both in Ireland and internationally; and 2) build their confidence for the following breakout group discussions.

Following an opening remark emphasising the importance of speaking out against racism by **Dr Phil Mullen**, Assistant Professor in Black Studies at Trinity, three 30-minute keynote presentations were given by three renowned racial justice experts. Firstly, **Maria Elena Costa Sa** (Rights and Development Worker at Irish Network Against Racism) established ‘The state of racism and discrimination in Ireland’ by detailing the nature of racial incidents and reporting pathways in Ireland. Drawing on her work on the Higher Education Authority ‘Race Equality in the Higher Education Sector’ report (Kempny and Michael, 2021), **Dr Lucy Michael** (Director at Lucy Michael Research, Training and Consultancy) spoke about ‘Tackling institutional racism’ in higher education. Finally, **Dr Vibhuti Arya** (Clinical Professor at St. John's University, New York) provided guidance on ‘Embracing your Agency to dismantle structural oppression’ and advice for speaking out on racism. Each presentation was followed by a Q&A session and discussions. Two scribes (CC and CM) were present to take anonymous notes of (and where feasible, anonymously transcribe) the discussions.

3.2.2 Breakout Group Discussions

The breakout group discussions aimed to enable students to discuss their experiences of racism and potential racial justice strategies in a safe, empowering and confidential environment.

Table 2. Breakout groups.

Role	Breakout Group 1	Breakout Group 2
Co-facilitators	Teresa Buczkowska (ICI) Aaron Koay (Trinity)	Valéria Aquino (ICI) Olayinka Aremu (Trinity)
Scribe	Cathy Cunningham (Trinity)	Claire Murphy (Trinity)

The students were randomly divided into two groups: Group 1 (five students) and Group 2 (six students). See Table 2. Each group was co-facilitated by an ICI staff and Trinity member who was a healthcare professional. A scribe was present in each group to take anonymous notes of (and where feasible, anonymously transcribe) the discussions.

The breakout group discussions were guided by prompts based on both international literature and newspaper evidence of racism faced by MEHSs in Ireland (Appendix A). Whilst most literature focused on the interpersonal nature of racism, the prompts were structured using Jones' three-level framework (Jones, 2020) (institutional, interpersonal and internalised racism) to conceptualise the experience of racism as a multi-layer sociopsychological phenomenon. In line with the literature, how students deal with experiences of racism was also explored (e.g. Beagan, 2003; Nightingale et al., 2022; Rees et al., 2015). Additionally, students were encouraged to consider intersectionality⁶ throughout the discussions.

The session ended with a full group discussion where each student articulated one racial justice action they deemed most urgent.

3.3 Reporting

Using the structure of the discussion prompts as a framework, the anonymous scribe notes⁷ were collated and thematically categorised and summarised. To enrich rigour, the analysis not only draws on the accounts of the MEHSs in this project but also contextualises their experiences within the literature.

3.4 Ethics

An exemption from ethics approval was given by the Department of Sociology, where the Project Organiser was based, as this project was considered low-risk and not research. A Data Protection Risk Assessment Form (Non-research) was also completed by the Project Co-leaders and approved by the Trinity Data Protection Office.

No identifiable information was collected from the breakout room discussions. All data is stored in a Trinity-controlled Microsoft SharePoint file protected by two-factor authentication. The consent forms will be stored until May 2024.

Since discussing or listening to experiences of racism can be distressing, participants were free to withdraw from the event at any point without providing any reasons. After the event, all participants were provided with information about Trinity support services for follow-up if they felt necessary.

⁶ Intersectionality explores the interconnected and interlocking systems of inequalities based on, for instance, gender, race, ethnicity, sexual orientation, gender identity, disability and class that shape the unique experiences of discrimination, oppression and privilege of each individual.

⁷ To ensure confidentiality, the event was not recorded. Instead, the discussions were transcribed anonymously by the scribes during the event where feasible. Thus, the quotes presented here are unattributed and might not have been said verbatim, though the integrity of the meanings expressed was retained.

4. Experiences of Racism: “Not white”

Although healthcare students might perceive the university setting as a ‘safe space’ (Cassidy, Norris and Williams, 2018), this is often not the case for MEHSs. Racism faced by healthcare students has been interpreted as the use of the power associated with being ‘white’ by the perpetrators to enforce discriminatory culture and practices (Hall and Fields, 2013; Scammell and Olumide, 2012). At the convening, students unequivocally expressed that they have “different experiences because they are not white” and that it is important to acknowledge the effects of racism on MEHSs. Notably, workplace abuse is accepted by some students as a ‘rite of passage’ where confrontation would not be beneficial (Birks et al., 2018). Racism was understood to have a serious impact on their mental wellbeing, self-esteem, self-acceptance and welfare. These issues can cause negative consequences on the safety and learning outcomes of MEHSs (Oikarainen et al., 2017).

This analysis presents four themes. Jones’ framework (2020) was used as a heuristic to delineate and parse out the experiences of racism by MEHSs into three distinct themes: ‘Institutional Racism’, ‘Interpersonal Racism’ and ‘Internalised Racism’. Nonetheless, it should be noted that the experiences of racism are often inextricably multi-layered. Thus, the boundaries between the categories often intersect, reflecting the complexity of the students’ experiences. Recognising how and why students react and respond to racism, or not, often cuts across the three conceptualised layers of racism, and is explored under a distinct theme ‘Dealing with Racism’.

4.1 Institutional Racism: “Nothing was done”

Institutional racism refers to “racism expressed in the practice of social and political institutions; to the way institutions discriminate against certain groups, whether intentionally or not, and to their failure to have in place policies that prevent discrimination or discriminatory behaviour” (INAR, 2020b, p. 8). Racist policies, norms and institutions privilege certain racial groups over others, resulting in gaps in student achievement, assessment and teaching diversity (Hariharan et al., 2020).

The experiences of MEHSs demonstrates some instances of institutional, policy and organisational issues that sustain racism at Trinity.

4.1.1 Underdeveloped Support Systems

MEHSs often face significant organisational barriers in navigating pathways to report racism. Students articulated that they received “very poor” support regarding reporting pathways that exist within Trinity and clinical placements for racist incidents: “Who do you go to?” Likewise, a Black nursing student at Trinity previously expressed that Trinity does not prepare students to deal with racist comments on clinical placements (Adeleye et al., 2020). Signposting to the reporting and support mechanisms for MEHSs was said to be fragmented, unclear and inadequate, particularly since different policies and structures pertain to Trinity and clinical placement providers in the public or private sector. In particular, the position of an MEHS as a student (undergraduate or

postgraduate), care provider and sometimes employee⁸ introduces structural complexity in how one might report incidents of racism (Koay, 2020; Meller, 2020).

“Within the healthcare environment, doctors, patients, academic staff, students have different pathways.”

There is a lack of straightforward guidance that can support students who experience racism regarding “this is who you go to, these are the steps [and] this is what will happen.” It was also raised during the convening that racist incidents could intersect with other offences, such as sexual misconduct, complicating how one might report those incidents. However, even if students attempt to report incidents, the procedure was perceived to be overly lengthy, bureaucratic and, thus, discouraging.

MEHSs were also explicitly and implicitly discouraged by their peers and academic or clinical staff members from raising concerns about racism. Acceptance of microaggressions by staff and fellow students who bear witness to racist incidents were reported. In particular, new academic staff members were reported to be unaware of the reporting pathways available for these students. Evidence shows that some healthcare lecturers are aware of racism in their classrooms, but many feel challenged and thus avoid addressing it, leading to unresolved conflicts and escalating tension (Markey and Tilki, 2007).

Anticipating how staff members who may witness those incidents would respond can be stress-inducing for MEHSs – the students want the incidents to be acknowledged and resolved yet do not wish to be perceived as problematic (Nightingale et al., 2022). Notably, in some cases, MEHSs were explicitly told “not to bring up their [race] problems” and dissuaded from reporting incidents of racism, further victimising them.

“When I have a complaint, I was told to be quiet, make [my] money and go back home.”

4.1.2 Lack of Accountability

Despite Trinity’s voiced commitment and policies to support racial and ethnic diversity, equality and inclusion, there were some concerns that sometimes “what institutions say they represent is not equal to what they do”.

In particular, dissatisfaction with how incidents of racism, when reported, are handled by Trinity and clinical placements was expressed. As reported by the students, there was a lack of clarity and transparency regarding how reports of racism are processed, responded to and acted upon, when and by whom. Research shows that staff members in the caring professions often show a lack of interest and support for students who experience racism (Hallett, Wagstaff and Barlow, 2021; Mattila, Pitkäljärvi, and Eriksson, 2010; Nightingale et al., 2022).

“There is an issue with transparency with respect to what’s happening...we raise [an issue] and we are told that is already in hand...but who is on those working groups?”

⁸ For instance, some pharmacy students on placement are paid by their clinical placement providers.

“No follow up from [a school in FHS] on what happened to students who [experienced racism], even asking ‘are you ok?’ And [stories about the incident] spread among friends in the class.”

Therefore, distrust also arises from the lack of accountability for 1) Trinity when reported incidents of racism by MEHSs are not effectively addressed – “nothing was done”; and 2) perpetrators of racism often do not face tangible “consequences”.

4.1.3 Lack of Diversity and Representation

The MEHSs expressed that the composition of the academic and clinical staff members in FHS is generally not reflective of the significant racial and ethnic diversity within the 1) students in FHS and 2) staff and patients in clinical settings. From their experiences, this was particularly true at the “top levels within the University” where there are “no staff representing minoritised ethnic students”. Where racial and ethnic diversity exists within staffing, it was either asymmetrical or perceived as tokenism.

“Many clinical staff in final year are from ethnic minorities – this is a complete change from the early years in medicine in which staff are predominantly white.”

This is in line with reports from minoritised ethnic pharmacy students at Trinity who emphasised the blatant lack of representation of minoritised ethnic people, particularly at senior leadership levels, within academic, clinical, regulatory and leadership settings, in which those positions are most often occupied by white Irish people (Koay, 2020). Thus, it can be difficult to trust that those people in power would understand the complexity and nuances of racism (Koay, 2020).

Whilst issues of diversity in staff and leadership must be addressed, students highlighted the gaps in student representation for those from minoritised ethnic backgrounds in FHS, such as members of the Traveller communities. Often being the only black person in their clinical environment, a Black nursing student at Trinity also reported feeling isolated (Adeleye et al., 2020). It was also expressed that student representative mechanisms in FHS and through student unions and societies are not representative and inclusive of racial and ethnic diversity, leading to disenfranchisement, disillusionment and disengagement.

“Why bother? I won’t get voted in?”

“Even if I was to become a [student] representative, because most [people] are white Irish, they will not understand...Why bother....when nothing will be done?”

4.1.4 Mind the Gap

Inequitable entry into healthcare courses by students from racial and ethnic minority backgrounds were also raised by some students, with a particular reference to people from Traveller backgrounds and the racism against the Traveller communities that is perpetuated within medicine:

“There are [very few] Traveller students in medicine...and there is no one to defend the slurs said by other students toward Travellers. There are [some] Irish people teaching international people to be racist towards Travellers.”

Furthermore, the issues of racial and ethnic attainment gap were raised, preventing and challenging the advancement of some MEHSs in healthcare education. This manifested, in some instances, as a higher likelihood of assessment failure for MEHSs, especially in clinical exams where assessments are often unblinded. Additionally, some Irish students were perceived to be privileged by stronger social capital, due to family and social connections, which they can leverage to advance their healthcare careers, in some instances.

“[Some] Irish students have parents in the [healthcare] system...so they know how to get the good spots versus international students who do not.”

4.1.5 Curricular Deficiency

Healthcare curricula at Trinity were perceived to be largely white- and Euro-centric, where teaching regarding race and ethnicity (and health inequalities) is either completely absent or done uncritically. Drawing on intersectionality, the curricula centre the health and disease of “male and white bodies” and so, “meaningful integration around conversations of racism within curricula, ethics [and] problem-based-learning sessions” are urgently needed. An example given was dermatological teaching where white skin is evidently privileged and students are not taught about how skin diseases manifest on other skin colours. Similar views were provided by a Black pharmacy student at Trinity where the curriculum focuses mainly on diseases affecting Caucasians, neglecting the specific health needs of people from minoritised ethnic backgrounds (Malekmian, 2020). Additionally, a medical student from Cork mentioned that they were taught racist “pseudoscience” where they were told longer needles are needed to draw blood from Black people, who have “thicker skin” (Bermingham, 2020).

The possibility of accessing the Trinity Black Studies elective as a means to partially fill the gap in the healthcare curricula was raised during the convening. However, since healthcare curricula are typically highly prescriptive, rigid and tightly accredited, they might not offer students opportunities to take on Trinity elective modules (Koay, 2020). Nonetheless, it was pointed out that some “individual lecturers themselves [have made] it their business” to fill the healthcare curricular gaps regarding race and ethnicity at Trinity.

4.2 Interpersonal Racism: “Disregarded”

Interpersonal racism can manifest as discrimination and biased behaviours and attitudes from more racially privileged individuals (e.g. white people) towards other individuals (Boynton-Jarrett, Raj and Inwards-Breland, 2021).

Perpetrators of racism as experienced by the MEHSs include patients, staff and students. Of note, many of the incidents of racism discussed are perpetuated by all three cohorts and can be classed as microaggressions, which are subtle, hard to clearly identify and articulate, “brief and commonplace daily verbal, behavioural and environmental indignities” which “could be intentional or unintentional” (Sue et al., 2007, p. 271). This is frequently experienced by MEHSs in the form of language where others expressed their names as a hurdle to pronounce or their accents as challenging to understand. Indeed, research shows that MEHSs’ cultural appearances,

demographic characteristics and accents are commonly subjected to racial microaggression (Koch et al., 2014; Rees and Monrouxe, 2011).

“Well-meaning people ask ‘what’s your real name’...this is offensive.”

“Mid-way through your presentation, there would be a comment on your accent.”

“Your English is better than I thought it would be.”

Similar incidents of microaggressions were previously reported by minoritised ethnic pharmacy students at Trinity where some minoritised ethnic Irish students described that microaggression often prompted or required them to “defend or clarify” their identities as Irish people (Koay, 2020).

Racism specific to each cohort of perpetrators is elaborated next.

4.2.1 Patients

Overt racism perpetuated by patients was understood by MEHSs to be pervasive: “The atmosphere is more toxic in hospitals”. Experiences of being ignored or spoken over by patients in clinical settings were recalled by some students, where patients expressed a preference for white and/or Irish healthcare colleagues. There were instances where patients called MEHSs racist names and even “refused to be seen” by students and healthcare professionals of minoritised ethnic backgrounds. Of note, a student also reported observing a patient declining treatment from a fellow MEHS based on their ethnicity in a clinical exam situation, resulting in that MEHS failing that exam.

“People ignore you until you speak with an Irish accent...then their attitude changes.”

Accounts of minoritised ethnic pharmacy and nursing Trinity also revealed experiences of being bypassed by patients due to their race, ethnicity or accent (Adeleye, 2020; Koay, 2020). This resonates with research in Australia (Koch et al, 2014) and Finland (Mattila, Pitkääjärvi, and Eriksson, 2010) where some patients outright refused care from minoritised nursing students.

Of note, evidence shows that patient perpetrators can also be from vulnerable groups (Hallett, Wagstaff and Barlow, 2021; Nightingale et al., 2022). Two Black nursing students at Trinity reported that their experiences of racism were often caused by vulnerable patients grappling with alcohol addiction or older patients with dementia, with whom other staff often empathise, neglecting the victimised students (Malekmian, 2020). Additionally, increasing anti-Asian racism due to COVID-19 could also pose issues for MEHSs and healthcare workers of Asian backgrounds (Koay, 2020).

Negotiating their clinical duty of care and the costs of enduring racism, students also articulated the complex challenges they face around reporting patients who are racist towards them or others: “[The] [p]atient comes first so you suppress the racism – how to address this in [clinical settings]?” Similarly, two Black nursing students at Trinity reported racial abuse, in verbal, physical and sexual forms but “the care still has to be given” (Malekmian, 2020).

4.2.2 Academic and Clinical Staff

Mistreatment by instructors and clinical staff can be a significant source of stress for MEHSs (Arieli, 2013). Students who participated in the convening articulated mixed experiences regarding academic and clinical staff as perpetrators of racism.

Students of different ethnicities, nationalities and cultural backgrounds (who are often non-native English speakers) are easy targets of racist workplace discrimination by clinical staff (Birks et al., 2017; 2018; Koch et al., 2014; Minton and Birks, 2019; Minton et al., 2016; Rees et al., 2015). Racist comments are invariably based on the students' ethnicities, accents, English abilities or cultural practices and blatantly neglect the students' clinical competencies, intelligence and personal strengths (Koch et al., 2014). In the convening, first-hand accounts of racially motivated bullying perpetuated by clinical staff were provided by a student. This resulted in the student taking a year out, a decision made due to perceived coercion by academic staff in their school. Similarly, a minoritised ethnic pharmacy student at Trinity previously reported their experience of racial discrimination on clinical placement:

“The supervisor didn’t like me so she rarely interacted with me, the technicians would again look at me in disgust. It was often horrific and I often spent time in the bathroom crying about it as I came there as [a] student to learn but rather humiliated and saddened, and I felt it was because [of] the colour of my skin” (Koay, 2020).

Reports of lecturers at Trinity making inappropriate comments towards a minoritised ethnic student and towards the Traveller communities are evident (Koay, 2020). In addition, a Malaysian medical student in Cork overheard a consultant commenting that they would not engage her because she “probably doesn’t speak English well” (Bermingham, 2020).

Notably, the “incestuous nepotism” in the Irish healthcare system could oppress and silence MEHSs who experience racism perpetuated by clinical staff members with connections with authorities.

“The manager is the sister of the person who is bullying you.”

On the other hand, students highlighted that they had no direct experiences of overt racial discrimination from academics and that discrimination often “comes from patients and peers than those evaluating you.” Indeed, some ethnic minority pharmacy students at Trinity thought that most of their lecturers are considerate and open-minded (Koay, 2020). Some academic staff recognise their colleagues exhibit racist behaviours towards students (Koch et al, 2014; Markey and Tilki, 2007), but feel challenged to resolve issues of such complexity as racism is perceived as “rarely intended, explicit or easily discernible” (Markey and Tilki, 2007, p. 391). Nonetheless, such experiences of racial discrimination can lead to students feeling alienated (Nightingale et al., 2022) and deciding not to be employed in healthcare institutions when they qualify as healthcare professionals in the future (Andrews et al., 2005; Rees et al., 2015).

Furthermore, concerns regarding implicit racial biases in the context of clinical exams were raised by some students at the convening where MEHSs are likely to be treated unfairly, albeit unknowingly at times by the staff assessing them: “You can’t keep [anonymity] in a clinical exam.” A Black nursing student at Trinity also said that her placement preceptors “have usually been harder on me than my fellow students” (Adeleye et al., 2020). Research found that MEHSs commonly feel that they are constantly ‘being watched’ by their supervisors (Thomas, Howe and Keen, 2010), held to higher standards than their peers (Fairtlough et al., 2014) and thus have to over-achieve to be perceived as competent (Hughes et al., 2021). Ethnicity differentials in pre-registration fitness for practice that disadvantage MEHSs have been found (Nightingale et al., 2022). These students have also been highlighted by practice educators and clinical staff to exhibit ‘problematic’ behaviours,

e.g. poor timekeeping, bad communication, deviating from procedures and confrontational mannerisms.

4.2.3 Students

Despite the racial and ethnic diversity of healthcare students in FHS, racism enacted by (white) Irish students was evident. Research shows that racism, perceived inadequate English language literacy and perceived hard-to-understand accents of MEHSs by native students can lead to active segregation, hindering the integration of MEHSs with their peers in both academic classroom and clinical settings (Koch et al., 2014; Randall, Crawford and River, 2020). Indeed, there appears to be an entrenched culture of division and “lack of integration” in some schools at Trinity: “It was Irish versus international students.” The division might have happened along racial or ethnic lines too as there are Irish students from minoritised ethnic backgrounds and international students who are white. Experiences of being “spoken over [or] disregarded” by their white Irish peers in both academic and social circumstances were articulated by some MEHSs. The students also reported phenomena where MEHSs and international students were actively excluded by their white peers from accessing academic information and study notes.

“Class rep shared information with Irish students only, not international students.”

“The... ‘I’ll share with you [but] not you’...it’s not obvious but it does happen and it is subtle.”

This concurs with the experience of a Black nursing student at Trinity who feels like their peers “don’t really want to talk to [them]” and that they are mostly “separated from [their] friends, which makes the experience of placement even more isolating” (Adeleye, Adeniran and Fidel, 2020).

‘Casual’ racist comments towards minoritised ethnic groups were not uncommon and appeared to be culturally embedded. In particular, anti-Traveller sentiments amongst Irish medical students were raised. It was also observed that teaching assistants who are “not indigenous to Ireland” are avoided by white students who tend not to ask them questions.

4.3 Internalised Racism: “Part of who I am”

The internalisation of racism, such as racial stereotypes, values, images, and ideologies, by the racially subordinated can lead to the acceptance of racism, belief in white supremacy, hatred of their racial groups and self-hatred (Pyke, 2020).

The MEHSs at the convening believed that internalised racism “is not spoken about enough.” It was articulated that the impact of internalised racism on MEHSs’ education, self-esteem, confidence and their relationships with other minoritised ethnic groups needs to be interrogated. Indeed, internalised racism is potentially damaging to students’ long-term professional experiences and attainment (Nightingale et al., 2022).

4.3.1 Self-fulfilling Prophecies

Expressing the inevitability of internalising racist stereotypes in a racist world, the extent of internalised racism in MEHSs can also be reinforced by their experiences of institutional and interpersonal racism. This can lead to the internalisation of racist beliefs that they are less than

others, leading to some students minimising their own self-worth, withdrawing from their fellow students and staff and ultimately, not achieving their full potential: “It makes you accept less and reach out [less] and achieve less.” For some MEHSs of Asian backgrounds, they experience internalised racism by conforming to the ‘model minority myth’ where they feel pressurised to excel in their healthcare education.

“[It becomes a] part of who I am.”

4.3.2 Helplessness

Furthermore, some students expressed that internalised racism leads them to passively accept the occurrence of racist behaviours and incidents to themselves and others, which often leaves them with a sense of internal conflict, helplessness and alienation: “There is an acceptance of this is the way it is.” Highlighting the complexity and nuances in how internalised racism can manifest, the experiences of racism inflicted by other minoritised ethnic groups were also raised by some students.

4.4 Dealing with Racism: “[Not] worth it”

Literature shows some MEHSs have accepted racism as part of the indoctrination into healthcare (Hallett, Wagstaff and Barlow, 2021; Malekmian, 2020). However, many indicated feeling scared, sad, humiliated and intimidated, which they hide from staff and patients to ‘demonstrate their clinical competence’ (Mattila, Pitkääjärvi, and Eriksson, 2010). Although there are support strategies that help MEHSs to deal with the psychological aftermath of experiencing racism, most of them choose not to formally report the incidents and pursue justice.

4.4.1 Emotional Support

An immediate offer of emotional support and “solidarity” by colleagues or friends who witnessed a racial incident to the victimised student was acknowledged to be positive by some MEHSs. It was perceived to be able to help students to process and deal with incidents of racism better. This aligns with the literature that suggests, when faced with abuse or bullying, healthcare students most commonly respond by inaction or discussing with family and friends (Rees et al., 2015). Indeed, some minoritised ethnic pharmacy students at Trinity reported feeling welcomed by their Irish friends, attributing it to the “welcoming and inclusive nature of the Irish people” despite often lacking knowledge about their cultures (Koay, 2020). Whilst support can be sought from other students from minoritised ethnic backgrounds (Koay, 2020), the support of white colleagues is also considered important (Adeleye, Adeniran and Fidel, 2020).

“The support aspect for the student is so important...[if] nothing else was done, if no other pathways existed...simply [ask] people are they [are] okay...[acknowledge] the incident.”

Additionally, seeking formal psychological support, such as counselling services, was also seen as a beneficial strategy to deal with the impact of racism.

4.4.2 Not Reporting

MEHSs often do not actively deal with incidents of racism they experience or seek justice due to a perception that incident reporting is “[not] worth it.” This resonates with the literature where MEHSs often decide not to raise these issues to not be perceived as too sensitive (Beagan, 2003; Hammond et al., 2019; Hinze, 2004). Instead, they are “desensitised” to racism as a coping mechanism (Malekmian, 2020). Thus, strategies like reporting or confronting the perpetrators were infrequently taken (Rees et al., 2015).

This phenomenon could be attributed to various factors elaborated below.

4.4.2.1 Disillusionment and Distrust

Under ‘Institutional Racism’, challenges around accessing reporting mechanisms by MEHSs who experience racism (‘Underdeveloped Support Systems’) and the organisational culture where Trinity and perpetrators of racism can evade accountability (‘Lack of Accountability’) are explored. The negative experience and dissatisfaction that MEHSs have could cause disillusionment and distrust, leading to a lack of engagement with the available incident reporting systems.

“If you can’t see any positives or good outcomes from previous incidents, then you are not encouraged to report.”

Similar sentiments were also expressed by minoritised ethnic nursing and pharmacy students at Trinity who perceived that their concerns about racism would not be taken seriously (Adeleye, Adeniran and Fidel, 2020; Koay, 2020). In particular, those who have experienced and/or reported incidents of racism seem less likely to engage with reporting mechanisms (Koay, 2020).

4.4.2.2 Emotional Labour and Trauma

In highlighting experiences of racism, MEHSs acknowledged the importance of going beyond “facts and figures” in incident reports to centre their “lived experience[s]” as MEHSs. Nevertheless, the emotional labour of having to engage with an exceedingly bureaucratic process to seek justice was considered “draining”, both “physically and emotionally.” Students considered the experience of “retelling...the incident over and over to different people” and filling out a report with “twenty to thirty” questions as “not helping the victims”. Thus, MEHSs could be discouraged by using a reporting system that is overly extensive and insensitive to their emotional trauma.

4.4.2.3 Fear of Backlashes

The existence of a significant “power imbalance” was articulated as a factor that prevents students from raising issues regarding racism. This often unfolds in the context where patients (see ‘Patients’ under ‘Interpersonal Racism’) and academic or clinical staff are perpetrators of racism (see ‘Academic and Clinical Staff’ under ‘Interpersonal Racism’). Although incident reporting is considered “aspirational”, it requires students to navigate through challenging power dynamics. Importantly, there is often a fear that speaking out against racism would make them considered problematic and troublesome: “If I speak out, I am labelled the angry nurse.”

Expecting all MEHSs who experience racism to report their experiences is considered “idealistic” and “not safe” for some MEHSs since it can potentially cause retaliations, “backlash[es]” and,

especially when the perpetrator is a clinical or academic member evaluating them for assessment, affect their grades. This is evident in the account of a student:

“I reported [my incident] to individuals in TCD [but] they weaponised and used [it] against me.”

5. Racial Justice Strategies: “Lots of work to do”

Underpinned by the principles of equality and justice, MEHSs must be enabled and empowered to flourish in a safe environment that is free of prejudice and discrimination. Nonetheless, the lived experiences of MEHSs at Trinity have revealed the significant structural and institutional deficiencies in supporting MEHSs against racism.

The commitment of Trinity to ensure equality, diversity and justice for minoritised ethnic students are also outlined in the Trinity’s Dignity and Respect Policy (2016a) and Equality Policy (2016b) and articulated by senior officers (e.g. Sloane, 2022). Of note, Trinity also has legal obligations to protect MEHSs from racism: 1) The Equality Status Acts (IHREC, 2016a) prohibits racial discrimination and harassment in the provision of higher education; and 2) as an organisation that receives public monies, Trinity must also promote equality and prevent discrimination under the Public Sector Equality and Human Rights Duty (IHREC, 2016c). The Employment Equality Acts (IHREC, 2016b) also requires Trinity to prevent experiences of racism in students who are paid by Trinity for teaching and/or research work. Similarly, the Equality Status Acts, Public Sector Equality and Human Rights Duty and Employment Equality Acts also apply to healthcare bodies, e.g. the Health Service Executive, which has a Dignity at Work Policy (HSE, 2009), relevant regulatory bodies and other public healthcare organisations, who may be responsible for the teaching, learning and assessment of MEHSs in healthcare education.

To achieve racial justice in healthcare education at Trinity, systems, cultural and policy changes that are impact-driven are required. Grounded in collective action, intersectionality and accountability, racial justice initiatives must centre the lived experiences of MEHSs, strive to create an open culture within FHS and must not serve as another tokenistic institutional exercise. Racial justice initiatives should also recognise the collaborative role white people could play to promote racial and ethnic equality.

Drawing on the perspectives of the MEHSs and project members, this report suggests the following racial justice strategies for Trinity, FHS, clinical training establishments as well as relevant regulatory and professional bodies of healthcare professionals to fulfil their legal, policy and ethical responsibilities for MEHSs. These strategies should be adopted collaboratively and, where appropriate, could be integrated into existing policies and strategies addressing other grounds of equality to enhance EDI.

“Lots of work done, lots of work to do.”

5.1 Accountability

It is crucial to ensure that the college, Faculty, schools and clinical training establishments are accountable for incidents of racism within their institutions. Racial justice strategies should be evaluated. Reports of racism, their nature as well as how they are handled, processed and acted upon must be evaluated and publicised to ensure accountability from institutions and perpetrators of racism.

5.2 Reporting Mechanisms

Drawing on relevant policies in Trinity and associated clinical establishments, guidelines illustrating clear and unambiguous racism reporting pathways specific to MEHSs in each healthcare course and incidents in college and clinical placements must be produced. These guidelines must be accessible and widely disseminated to students and staff, both academic and clinical.

5.3 Supports for the Victimised

The potential physical, mental and emotional trauma of those victimised by perpetrators of racism must not be trivialised. Timely psychological support should be made available to MEHSs who wish to avail of it, e.g. Trinity Student Counselling Service. MEHSs should also be signposted to advisory support that could provide timely guidance on their legal rights and policy pathways to seek justice, e.g. Students' Union. Support that is available from external organisations such as the ICI, Irish Network Against Racism (INAR) and International Council for International Students (ICOS) should also be outlined to MEHSs.

5.4 Leadership

Minoritised ethnic students and staff should be appointed, platformed and empowered to lead racial justice initiatives at Trinity and FHS. The intellectual and emotional labour of minoritised ethnic people in producing racial justice work must be acknowledged and appropriated incentivised.

5.5 Diversifying the Faculty of Health Sciences

The racial and ethnic composition of students and staff in FHS should be examined. Where inequity is evident, evidence-based policies and mechanisms, e.g. ring-fenced positions, should be implemented to increase representation and diversity. Particular attention should also be paid to the leadership representation of students (e.g. student representatives) and staff (e.g. senior academic staff) to ensure symmetrical and equitable representation. Initiatives to ensure an inclusive integration of minoritised ethnic students and staff into the College should also be promoted.

5.6 Curricular Change

The Euro- and white-centric nature of healthcare curricula in FHS needs to be interrogated and decolonised. Healthcare curricula should equitably address the health and disease of people in society from all walks of life, including those of minoritised ethnic backgrounds. Racism in healthcare, racial inequalities in health and health issues affecting minoritised ethnic groups should be meaningfully integrated into all years of lectures, practical work, problem-based learning sessions, clinical training and clinical placements.

5.7 Open Dialogue

To foster a culture of inclusion and to platform the voices of MEHSs, regular and open discussions amongst and between students and staff about racism should be held. This could be delivered in the form of closed spaces for MEHSs as well as town hall meetings open to all.

5.8 Research Capacity

Investments must be made to prioritise the interdisciplinary research capacity at Trinity to address issues of racism faced by MEHSs. Future research should 1) respond to relevant legislations and policies; 2) apply principles of co-production⁹ to ensure research is “with [MEHSs] rather than for or about them” (Campus Engage, 2018, p. 2); 3) draw on sociological expertise by framing racism as a complex, dynamic and multi-layer societal issue using conceptual or theoretical models like Jones’ three-level framework (internalised, personally mediated and institutional) (Jones, 2000) or critical race theory (Hughes et al., 2021); and 4) draw on both qualitative and quantitative research approaches to generate deeper and nuanced insights into the experiences of racism by MEHSs.

5.9 Racial Justice Training

A mandatory racial justice training programme should be developed for students and staff in FHS. Centring the lived experiences of MEHSs, the programme should advise students and staff of the legal rights of minoritised ethnic people, the prevalence and nature of racism faced by MEHSs and professionals and how to address racism as witnesses and the victimised, for effective racial justice advocacy across academic and clinical settings.

5.10 Preparation for Clinical Placements

Recognising the complexity and impact of racism that could manifest on placements, particularly when it is perpetuated by patients and senior clinical staff, students should be adequately prepared to deal with racism as witnesses and the victimised.

⁹ Opportunities to link in with the Trinity PPI Ignite Office.

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7. Appendix A: Discussion Prompts

Bullet points in italic font were offered to prompt discussions if needed.

Institutional racism

This part explores policies, norms and institutions that privilege certain racial groups over others.

- About 1 in 8 people in Irish society are of migrant backgrounds. Do you think that is reflected in 1) your peers, 2) academic staff and 3) clinical staff? Why?
 - *What do you think are the barriers that prevent non-white students from 1) entering or 2) progressing in healthcare education at Trinity?*
- Do you think your healthcare course content is racist?
 - *For example, do you learn about race correction (e.g. estimated glomerular filtration rate in kidney function test)?*
- Do you think your healthcare course content is inclusive of people of different racial and ethnic identities?
 - *Are people of minoritised ethnic groups represented in your clinical case studies?*
 - *Do you study how diseases manifest in minoritised ethnic groups or diseases affecting minoritised ethnic groups?*
- **Suggested Actions: What should be done by Trinity, Faculty of Health Sciences, clinical placement establishments and/or external bodies like professional regulators?**

Interpersonal racism

This part explores the most commonly discussed type of racism that involves biased behaviours, attitudes and thoughts from more racially privileged individuals (e.g. white people) towards other individuals.

- Explore experiences of racism in healthcare education from various perpetrators.
 - Academic staff
 - *Evidence suggests that minoritised ethnic healthcare students feel that are held to higher standards than their white peers and have to over-achieve to be perceived as competent. What do you think?*
 - *Do you think non-white students are being treated unfairly by academic or clinical staff members, particularly in assessments that are not blinded, e.g. OSCE?*
 - Clinical staff on placements
 - *Workplace bullying by clinical staff members based on race, ethnicity, accent, English abilities or cultural practices is common. What do you think?*
 - Patients and patients' family members
 - *Evidence suggests that patient perpetrators are often from vulnerable patient groups, e.g. older patients, patients with dementia or patients recovering from addiction. What do you think?*
 - Peers
 - *Some students feel like they can be overlooked, interrupted or excluded by their peers based on racism and their level of English language literacy. What do you think?*
- **Suggested Actions: What should be done by Trinity, Faculty of Health Sciences, clinical placement establishments and/or external bodies like professional regulators?**

Internalised Racism

This part explores the internalisation of racism, such as racial stereotypes, values, images, and ideologies, by the racially subordinated, leading to the acceptance of racism, belief in white supremacy, hatred of their racial groups and self-hatred.

- In a healthcare education environment that is not inclusive of different racial and ethnic identities, have you seen internalised racism manifested in yourself and/or your colleagues?
 - *Examples include colourism, intra- or inter-racial discrimination and stereotyping, believing in racial stereotyping, adaptation to the predominant white cultural norms to gain validation from white colleagues*
- **Suggested Actions: What should be done by Trinity, Faculty of Health Sciences, clinical placement establishments and/or external bodies like professional regulators?**

Dealing with racism

This part explores how students deal with the experiences of racism.

- Evidence suggests that some minoritised ethnic healthcare students think that the experience of racism is a 'rite of passage'. Most students engage in inaction or 'active avoidance' strategies like allowing incidents to pass rather than be addressed, emotional withdrawal from their workplace and 'keeping a low profile'.
 - How do you deal with incidents of racism that happened to 1) yourself 2) colleagues and 3) patients?
- What is the impact of racism on you?
- What do you think of the current reporting pathway for racial incidents?
 - *Are students aware of how to report incidents (in college and on placements) and how they will be dealt with?*
 - *Should the onus be on students to report?*
 - *Should College be responsible for incidents that happened off-campus on clinical placement?*
- Racist incidents are often not reported by healthcare students. Why do you think that is?
 - *Fear of retaliation, perceived impact on career, not sure if they would be taken seriously*
- **Suggested Actions: What should be done by Trinity, Faculty of Health Sciences, clinical placement establishments and/or external bodies like profession regulators?**

Other

Please ask students to raise and explore anything that has not been covered yet.

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