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POSITION STATEMENT

# AMA Anti-racism Statement

## 2024

### Summary


- Racism in all forms is unacceptable. It breaches national laws[i,ii] and negatively impacts on individual and collective health and the health economy.
- This statement confirms the AMA's zero tolerance approach towards racism in medicine and the Australian healthcare sector as well as its commitment to working collaboratively to eliminate racism within the health system.[1]
- It discusses the nature and impact of racism on medical practitioners in the healthcare environment, with a specific focus on Aboriginal and Torres Strait Islander doctors and international medical graduates. It also acknowledges the impact of racism on other culturally and racially marginalised groups (CARM) and the intersectional nature of racism.


### Preamble

Australia has a rich cultural history, with the oldest living Indigenous cultures in the world, followed by successive waves of immigration, creating a culturally and linguistically diverse nation. In 2021, 27.6 per cent of the population was born overseas.[iii] Almost half had a parent born overseas (48.2 per cent) and 22.8 per cent used a language other than English at home.

A lack of acknowledgment, transparency and awareness about Aboriginal and Torres Strait Islander peoples' culture and lived experience, as well as the enduring impact of colonisation and generational trauma, has contributed to a void in understanding and respect of the needs and priorities of Aboriginal and Torres Strait Islander peoples. Poorly designed policies that have excluded the voices of immigrants have also contributed to the racism experienced by people from CARM backgrounds in Australia.[iv]

It is essential to acknowledge the historical impacts of colonisation, Aboriginal and Torres Strait Islander dispossession, and Australian immigration policies,[v] to eliminate institutionalised racism within the Australian health system. Institutionalised racism has contributed to the bias and health inequities experienced by Aboriginal and Torres Strait Islander peoples[vi] and CARM groups.[vii]

[1] This is consistent with the World Medical Association Declaration of Berlin on Racism in Medicine.

## Defining racism

There are a range of terms used to define racism and its different levels and manifestations. The development of nationally agreed definitions would support meaningful and informed conversations about actions to tackle racism in medicine and healthcare. For the purposes of this position statement, the following definitions are used throughout the document, including the Australian Human Rights Commission's definitions of racism:[viii]

**Anti-racism** involves actively attempting to combat racist policies, practices, culture and ideas. It involves active decisions that seek to combat injustice and promote racial equity.

**Culturally and racially marginalised (CARM)** people face marginalisation because of their race. The term culturally recognises people may also face discrimination due to their culture or background.[iv]

**Cultural safety** is determined by Aboriginal and Torres Strait Islander individuals, families, and communities. Culturally safe practice is the ongoing critical reflection of health practitioner knowledge, skills, attitudes, behaviours and power differentials in delivering safe, accessible, and responsive healthcare free of racism.[ix]

**Deficit discourse** describes a mode of thinking that frames and represents people or groups in a narrative of negativity, deficiency and failure. It refers to discourse that places responsibility for problems with the affected individuals or communities, overlooking the larger socio-economic structures in which they are embedded.[x]

**Institutional racism** exists when racism is established as a normal behaviour within an organisation, institution, or society. It includes the policies and practices that inform the operations of organisations and institutions.

**Intersectionality** refers to the way different aspects of a person's identity intersect with and impact one another, and how the combined experience of multiple forms of discrimination is often greater than the sum of those discriminations alone.

**Microaggressions** are casual expressions that perpetuate racist stereotypes and ideas. An example of a microaggression might be commenting on how well a person of African heritage speaks English, or repeatedly mispronouncing someone's name, despite being corrected.

**Race** refers to the idea that humans can be organised into distinct biological "races" with defined physical and social traits. While today it is widely accepted that biological categories of race do not exist, ideas of race have informed the development of laws, culture and policy with certain racial identities perceived and positioned as superior to others.

**Racism** refers to the process by which systems and policies, actions and attitudes create inequitable opportunities and outcomes for people based on race.

**Structural racism** describes the inequalities and barriers that prevent people from accessing equitable opportunities within a society. It refers to the kinds of racism that operate deep within the social structures of society.

**Systemic racism** refers to the way the cultural norms, laws, ideologies, policies and practices of a particular society, organisation or institution result in unequitable treatment, opportunities and outcomes.

## Racism in the medical and health workforce

Doctors and healthcare professionals have the right to enjoy a career free of racism. This extends to medical education and training, healthcare work environments, relationships with managers, colleagues and patients, and other professional settings.

The ongoing deficit discourse regarding Aboriginal and Torres Strait Islander peoples contributes to the way in which racism systematically operates in healthcare and has flow-on effects to other CARM groups. This extends to the way data is collected, analysed and reported, influencing policy development and clinical practice.

Adopting a strengths-based approach by reframing policy issues to move the "problem" from individuals and communities to health systems is one strategy to challenge bias, stereotypes and negative thinking and address underlying racism in the health system and workplace.

Aboriginal and Torres Strait Islander doctors and international medical graduates are groups particularly at risk of racism. This risk may be elevated when combined with other aspects of their identity, such as gender, sexual orientation and disability, exposing them to overlapping forms of discrimination and marginalisation.[xi]

*Aboriginal and Torres Strait Islander doctors*

The results of the 2023 National Medical Training Survey (MTS) found 54 per cent of Aboriginal and Torres Strait Islander trainee doctors had experienced or witnessed bullying, discrimination and harassment, including racism, compared with 21 per cent of all trainees nationally.

The Australian Indigenous Doctors' Association (AIDA) and the Australian Medical Council (AMC), as well as the Australian Health Practitioner Regulation Agency (Ahpra) and the Australian Commission on Safety and Quality in Health Care, have strongly stated that cultural safety is a key priority for addressing racial inequities in workplaces and providing culturally safe services.[vii]

There is now a legal obligation under the Health Practitioner Regulation National Law[xii] for practitioners, regulators, accreditation authorities, educators and employers to ensure the development of a culturally safe and respectful health workforce that:

- is responsive to Aboriginal and Torres Strait Islander peoples and their health
- contributes to the elimination of racism in the provision of health services.

The AMA recognises that making workplaces culturally safe is vital to growing the Aboriginal and Torres Strait Islander health workforce and promoting culturally safe, accessible and appropriate healthcare for patients.[xiii]

*International medical graduates*

International medical graduates (IMGs) are medical practitioners whose medical qualifications are obtained outside of Australia.[xiv] IMGs make a vital contribution to the delivery of healthcare in Australia, particularly in rural and regional locations. In 2018, 30.6 per cent of the medical workforce had obtained their initial qualification overseas.[xv]

IMGs frequently report high levels of racism, discrimination, and prejudice from patients and colleagues, including microaggressions.[xvi] Racism is also experienced by doctors who are from second-

or third-generation migrant families, who have grown up in Australia, have Australian qualifications and work experience, and a knowledge of the Australian workplace.[xvii]

More than one third (37 per cent) of IMGs reported experiencing racial or ethnic discrimination from patients in the past five years, compared with less than one fifth (17 per cent) of Australian medical graduates (AMGs). More than one quarter (26 per cent) of IMGs reported experiences of racial or ethnic discrimination from colleagues in the past five years, while one in 10 AMGs reported the same experience. Discrimination regarding clinical practice and judgement is also common,[xviii] with experiences of racism acting as a barrier to career progression and impacting on wellbeing.

*Recommended actions to tackle racism*

*For healthcare organisations*

Cultural safety and racial equity must be embedded in governance and leadership processes. This must be guided and led by Aboriginal and Torres Strait Islander peoples and other CARM groups.

Accountability is key to achieving cultural safety and racial equity for individuals, organisations and communities. This requires a commitment across all professions at all levels, including executive and senior leadership roles, to create systems and processes that ensure individuals and groups are held responsible for their decisions and actions.[xix]

The AMA supports the following actions[vii] to address racism in healthcare organisations:

1. Embed cultural safety and racial equity strategies in organisational governance and leadership structures, strategies, systems and processes, supported by appropriate funding and resources, and co-designed by people with lived experience of racism.[xx]
2. Extend cultural safety and racial equity strategies to employment and training, including recruitment and hiring practices, monitoring and retention practices, and cultural accommodations to support staff with lived experience of racism.
3. Commit to monitor, evaluate and report on anti-racism practices, programs and policies.
4. Provide meaningful racism, diversity and bias training for all staff with built-in organisational performance and accountability measures to monitor progress.
5. Ensure staff know how to effectively respond to racist behaviour from colleagues, supervisors, auxiliary staff and patients, and how to report racist behaviours. There must be a safe, confidential and transparent avenue for reporting. The actions taken by organisations to respond to reports of racism must also be timely, transparent and accountable.
6. Provide access to occupational mental health support, including a place to confidentially address personal experiences of racism, as well as support for the person reporting an event.
7. Create opportunities for safe, open and honest discussions where doctors and staff can talk about problems or encounters with racist behaviour.[xxi]

Healthcare organisations have a duty to protect employees from racism. They should:

- have a public statement expressing a lack of tolerance for racist behaviours towards doctors and staff as a part of patient non-discrimination policies
- have guidelines in place outlining the processes to follow if a doctor or staff member experiences racism from a patient or their family members or carers, or if a patient refuses to be seen by a doctor based on their ethnicity, including policies for transferring care to other providers

- provide training to staff on how to facilitate dialogue that can productively challenge a patient's racist or biased behaviour
- make available hospital support networks to staff to discuss moments in training and practice where they have felt discriminated against based on their race.

*For medical training providers*

It is important to ensure cultural safety and racial equity is embedded within medical training and workplace programs, policies and practices. This means acknowledging the impacts of colonisation and colonialism on Aboriginal and Torres Strait Islander peoples and other CARM groups and to advocate for them to have a voice and have more influence and leadership.[xxii]

The AMC's efforts to ensure medical education and training standards "are built on the principles of self-determination and respect for Aboriginal and/or Torres Strait and Māori peoples". They set a clear direction for social accountability, equity and cultural safety in medical education and training.[xxiii]

Training providers should actively work to diversify medical curriculum to create a more culturally responsive and equity focussed experience and training. This includes providing:

- culturally safe training and learning environments for Aboriginal and Torres Strait Islander peoples and other CARM groups
- better anti-racism training for medical practitioners, including systemic approaches to support anti-racism practices.[xxiv]

Medical training providers must also adopt anti-racist practices to improve the recruitment, selection and retention of Aboriginal and Torres Strait Islander and CARM medical trainees, increasing the focus on cultural safety in medical college-led training, and providing tailored one-on-one support to current and prospective trainees to increase diversity in the future workforce and increase the number of Aboriginal and Torres Strait islander peoples studying medicine.

*For individual doctors*

Doctors must treat patients, along with their family members and carers, with respect, dignity and compassion in a culturally and linguistically safe and appropriate manner.

Embracing and understanding diversity must be at the forefront of practitioners' minds when delivering healthcare to patients. Racism towards patients from healthcare providers is unacceptable. It can result in a lower quality of care, underutilisation of health services, avoidance of healthcare systems, delays in seeking care, reluctance to follow healthcare recommendations, and a mistrust of doctors and the wider health system.[xxv] There may also be unconscious, or conscious bias in the provision of care to people of certain races.

Racism from patients or their family members towards doctors and medical students is unacceptable. It is important to acknowledge racist comments from patients or their family members may constitute a significant stressor for doctors in providing care. The burden of discrimination can also compound the stress of practicing medicine for doctors from CARM backgrounds and may contribute to burnout.[xxvi]

Doctors also have a responsibility to treat medical students, colleagues and other health professionals with respect to foster inclusivity and ensure a safe physical and psychological work environment.

Doctors should be aware of: the codes, guidelines and policies that regulators have set condemning discrimination and racism; their obligations under the Health Practitioner Regulation National Law[ii] to provide healthcare that is culturally safe and free from racism; and what is reportable to Ahpra.[xxvii]

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