Taylor & Francis
Taylor & Francis Group

Ethnicity & Health

ISSN: (Print) (Online) Journal homepage: www.tandfonline.com/journals/ceth20

Anti-Black discrimination in primary health care: a qualitative study exploring internalized racism in a Canadian context

Khandideh K. A. Williams, Shamara Baidoobonso, Jeannie Haggerty, Aisha Lofters & Alayne M. Adams

To cite this article: Khandideh K. A. Williams, Shamara Baidoobonso, Jeannie Haggerty, Aisha Lofters & Alayne M. Adams (2024) Anti-Black discrimination in primary health care: a qualitative study exploring internalized racism in a Canadian context, Ethnicity & Health, 29:3, 343-352, DOI: 10.1080/13557858.2024.2311429

To link to this article: https://doi.org/10.1080/13557858.2024.2311429

ETHNICITY & HEALTH
2024, VOL. 29, NO. 3, 343–352
https://doi.org/10.1080/13557858.2024.2311429

Taylor & Francis
Taylor & Francis Group

BRIEF REPORT

OPEN ACCESS Check for updates

Anti-Black discrimination in primary health care: a qualitative study exploring internalized racism in a Canadian context

Khandideh K. A. Williams [a], Shamara Baidoobonso [b], Jeannie Haggerty[a], Aisha Lofters[c,d] and Alayne M. Adams [a]

[a]Department of Family Medicine, McGill University, Montréal, Canada; [b]Department of Community Health & Epidemiology, Dalhousie University, Halifax, Canada; [c]Department of Family & Community Medicine, University of Toronto, Toronto, Canada; [d]Peter Gilgan Centre for Women's Cancers, Women's College Hospital, Toronto, Canada

ABSTRACT

Objectives: A growing body of evidence points to persistent health inequities within racialized minority communities, and the effects of racial discrimination on health outcomes and health care experiences. While much work has considered how anti-Black racism operates at the interpersonal and institutional levels, limited attention has focused on internalized racism and its consequences for health care. This study explores patients' attitudes towards anti-Black racism in a Canadian health care system, with a particular focus on internalized racism in primary health care.

Design: This qualitative study employed purposive maximal variation and snowball sampling to recruit and interview self-identified Black persons aged 18 years and older who: (1) lived in Montréal during the COVID-19 pandemic, (2) could speak English or French, and (3) were registered with the Québec health insurance program. Adopting a phenomenological approach, in-depth interviews took place from October 2021 to July 2022. Following transcription, data were analyzed thematically.

Results: Thirty-two participants were interviewed spanning an age range from 22 years to 79 years (mean: 42 years). Fifty-nine percent of the sample identified as women, 38% identified as men, and 3% identified as non-binary. Diversity was also reflected in terms of immigration experience, financial situation, and educational attainment. We identified three major themes that describe mechanisms through which internalized racism may manifest in health care to impact experiences: (1) the internalization of anti-Black racism by Black providers and patients, (2) the expression of anti-Black prejudice and discrimination by non-Black racialized minority providers, and (3) an insensitivity towards racial discrimination.

Conclusion: Our study suggests that multiple levels of racism, including internalized racism, must be addressed in efforts to

ARTICLE HISTORY

Received 5 September 2022
Accepted 23 January 2024

KEYWORDS

internalized racism; appropriated racial oppression; internalized racial oppression; anti-Black discrimination; health care disparities; health care equity

CONTACT Khandideh K. A. Williams khandideh.williams@mail.mcgill.ca Department of Family Medicine, McGill University, Montréal, Canada

Supplemental data for this article can be accessed online at https://doi.org/10.1080/13557858.2024.2311429

promote health and health care equity among racialized minority groups, and particularly within Black communities.

Introduction

A growing body of evidence reveals persistent health inequities within racialized minority communities (Bailey et al. 2017; Pan-Canadian Public Health Network and Public Health Agency of Canada 2018; Veenstra and Patterson 2016; Zavala et al. 2021). Also clear are the adverse effects of racial discrimination and implicit racial biases on health outcomes and health care experiences among racialized minority patients (Carter et al. 2017; Hall et al. 2015; Siddiqi et al. 2017; Williams et al. 2019). For example, experiences of perceived racial discrimination in health care have been associated with delayed or forgone utilization of various health care services, and a reduction in adherence to treatment regimens (Alcalá and Cook 2018; Blanchard and Lurie 2004; Powell et al. 2019; Trivedi and Ayanian 2006).

To elucidate and address the role of anti-Black racism in driving health disparities, it is important to understand the various processes that contribute to anti-Black racism. Jones' *Gardener's Tale* provides a framework for understanding racism on three levels – *institutionalized*, *personally mediated*, and *internalized* (Jones 2000). Institutionalized racism is defined as 'the structures, policies, practices, and norms resulting in differential access to the goods, services, and opportunities of society by "race"'; personally mediated racism refers to interpersonal expressions of prejudice and discrimination; and internalized racism denotes 'acceptance by members of the stigmatized races of negative messages about their own abilities and intrinsic worth' (Jones 2000; 2002).

While much research has examined the influence of personally mediated and institutionalized racism on health care experiences, less is known about the nature and implications of internalized racism in the primary health care encounter. This is consistent with the broader racial oppression literature (David, Schroeder, and Fernandez 2019; Pyke 2010). Further, within the psychology literature on internalized racism, the majority of studies employ only quantitative methods (David, Schroeder, and Fernandez 2019). We use a qualitative approach to elicit the diverse and nuanced perceptions and experiences of internalized racism within primary health care experiences of Black patients in Canada. Internalized racism is defined and operationalized throughout this article as the internalization of negative views, beliefs, and attitudes about one's own racial or ethnic group, including themselves as members of said racial or ethnic group (James 2020; Pyke 2010).

Materials and methods

Study design and setting: The results presented in this paper are drawn from a larger qualitative study aimed at investigating how racial dynamics manifest with primary health care systems to affect accessibility and quality of care for Black communities before and during the COVID-19 pandemic. We conducted this study in Montréal, Québec, a city known for its diverse and multicultural population, where visible

minorities comprise 34.2% of the population, with 10.3% identifying as Black persons (Statistics Canada 2017).

We employ a phenomenology research approach which highlights the meanings of subjective experiences from the viewpoint of those who have lived them (Groenewald 2004; Neubauer, Witkop, and Varpio 2022). In line with hermeneutic (interpretive) phenomenology, we have reflected on how our preconceptions about, and personal experiences with, the phenomenon in question (racism) may have influenced our subjectivity (Neubauer, Witkop, and Varpio 2022).

Participant recruitment: Sampling methods were purposive and included maximal variation (Coyne 1997; Suri 2011) and snowball sampling approaches. Participants were initially recruited via the dissemination of recruitment posters in Facebook groups connecting Black community members in Montréal, and through email newsletters and website posts created by various community organizations and academic associations serving people who identify as Black, Caribbean, and/or African in Montréal. Leaders of partnering community organizations further facilitated participant recruitment by sharing the call for participants at their events and by eliciting the interest of their organizations' clientele by approaching individuals directly through email messages or telephone calls. Recruitment posters were also shared in LinkedIn, and participants were invited to share the recruitment call within their own networks following their participation in the study.

Interested participants contacted KKAW via email, telephone, Facebook messenger, or LinkedIn messaging. KKAW assessed the eligibility of potential participants via a screening questionnaire that included questions about their racial identidy, ethnicity, age, sex assigned at birth, gender identity, immigration experience, educational attainment, and financial situation. Inclusion in the study was extended to self-identified Black adults aged 18 years and older who lived in Montréal during the COVID-19 pandemic, who were able to communicate in French or English, and who were registered with the Québec health insurance program.

Data collection: The interview guide (Supplemental Table 1) was collaboratively developed by KKAW, AMA, and JH, with input from SB, AL, and IL. Interview questions explored participants' experiences with seeking primary health care, their perceptions surrounding the role that their race and the race of their providers play in their health care interactions, and challenges that they have had in accessing health care before and during the COVID-19 pandemic. Participants also contributed insights on potential actions to address racial disparities in health care and promote health care quality and accessibility within Black communities. This article draws on participants' responses to broader questions and probes relating to patient-provider concordance. The themes it presents were generated through an interpretative analysis approach.

Eligible participants were contacted via telephone, email, or direct messaging on Facebook or LinkedIn to request a time for the interview. Data were collected from October 2021 to July 2022 via semi-structured in-depth telephone interviews. All interviews were conducted by KKAW, a qualitatively trained, Black-identifying, bilingual, female doctoral student. To accommodate the participants' language preference, interviews were conducted in French, English, or both languages. Informed consent to participate was obtained verbally before commencing the interviews and each interview was audio-

recorded with the participants' permission. Interview recordings were transcribed verbatim and anonymized by KKAW.

Data Analysis: A thematic analysis approach (Nowell et al. 2017) was applied to analyze interview transcripts. Prior to coding, KKAW read each transcript multiple times to familiarize herself with its contents. Both *inductive* and *a priori* codes (Supplemental Table 2) based on the interview guideline, Jones' *Gardener's Tale* (Jones 2000), and Levesque et al.'s conceptual framework of access to health care (Levesque, Harris, and Russell 2013) were defined and applied by KKAW with input from AMA. Regular meetings between KKAW and AMA were held to discuss patterns in the data and the development of themes and their interpretation.

Ethics approval: Ethics approval was obtained from the Research Ethics Board of the CIUSSS de l'Ouest-de-l'Île-de-Montréal – biomedical subcommittee at the St. Mary's Research Centre (protocol number SMHC-21-08).

Results

Thirty-two individuals participated in the study. Eight additional persons expressed interest in participating but were deemed ineligible due to either not being registered with the Québec health insurance program or not having lived in the city of Montréal during COVID-19. Each interview lasted between 35 min and 2 h. As shown in Table 1, the participants were predominantly women, university-educated and modestly comfortable financially, but there was a wide range in age and country of origin. The self-identified ethnic origins of each participant represented 20 countries.

We identified three major themes surrounding attitudes of internalized racism in health care interactions and their potential impact on experiences:

Table 1. Demographic characteristics of participants[a].

Characteristic		No. of participants
Age	Range, yr	22–79
	Mean, yr	42
Sex assigned at birth	Female	20 (63%)
	Male	12 (38%)
Gender identity	Woman	19 (59%)
	Man	12 (38%)
	Non-binary	1 (3%)
Immigration experience	Canadian-born	16 (50%)
	Immigrant 10 years or less[b]	6 (19%)
	Immigrant over 10 years[c]	10 (31%)
Financial situation	Poor	1 (3%)
	Tight	5 (16%)
	Modestly comfortable	13 (41%)
	Comfortable	9 (28%)
	Prefer not to answer	4 (13%)
Educational Attainment	High school or less	4 (13%)
	College or trade school	6 (19%)
	University Degree	22 (69%)

[a]All information was self-reported by the study's participants during eligibility screening.
[b]Immigrated to Canada within the last 10 years.
[c]Immigrated to Canada over 10 years ago.

1. Internalization of anti-Black racism by Black providers and patients

Many of our participants reported better experiences with racialized minority, and particularly Black, health care providers. Nonetheless, several participants, primarily those of older age, noted that some Black health care providers might harbour internalized anti-Black racist beliefs and manifest discriminatory biases while caring for Black patients. A few others reflected that Black health care providers may diminish the health concerns of their Black patients due to a perception of racial hierarchies that attribute greater privilege and importance to non-Black people. For example, one participant noted that a Black physician might avoid mistreating a White patient due to their greater voice and power:

> I think systemic racism, you know, it affects Black communities as well. It affects our interactions amongst each other. And I think that, had I been White, [my (Black) family physician] would have been afraid of mistreating me or not listening to me because he might have felt like White people might have access to resources that Black people don't have access to, or they might have a bigger voice than Black people have. He might have thought that I probably wouldn't have said anything, you know … and I didn't. (37-year-old, female, Canadian-born)

Echoing this lack of confidence in racially concordant care, some participants wondered if they would receive the same quality of care from a Black physician in comparison to a non-Black physician. For some, this skepticism emerged from experiences of having felt dismissed or treated 'rough'. Acknowledging her limited experience with Black health care providers, one participant admitted personal bias against Black providers due to experiences with judgmental Black people outside of health care:

> It's not that I'm not interested [in having Black health care providers], but I'm gonna really ask myself are they gonna care for me like, you know, my Vietnamese doctor or the Italian nurse or, you know what I mean? Are they gonna listen to me in the same way? I come from a cultural background that people judge each other. (50-year-old, female, immigrant more than 10 years)

Other dimensions, such as ethnic or cultural concordance and language discordance, were reported as potentially exacerbating the consequences of internalized racism. One participant further suggested that stereotypes against female patients generally, and Black female patients particularly, may intensify anti-Black discrimination against Black women seeking health care.

2. Expression of anti-Black prejudice and discrimination by non-Black racialized minority providers

Racial and ethnic diversity among health care providers was generally considered beneficial in improving health care encounters. However, some participants believed that similar anti-Black biases and prejudices observed among White providers could exist among those with non-Black racialized minority identities. For example, one participant commented that providers from various racialized minority communities may discriminate against Black patients due to the prevalence of colourism and internalized racism within their own cultures:

> By having a provider that's non-Caucasian, you can't let your guard down because the person, although they're non-Caucasian, can still not like [Black] people. A lot of people

> don't like [Black] people and that, my dear, is a fact. (…) If you go to India, you're going to find the Indians have their own thing going on. The Indians don't like dark-skin Indians. (…) Why would they like YOU? (60-year-old, male, immigrant 10 years or less)

Similarly, another participant reporting numerous interactions with ethnically diverse health care professionals perceived that non-Black racialized minority health care providers also exhibit anti-Black racist ideas that are either hidden or explicit:

> I feel like the same anti-Black racial biases exist in other groups. So, whether they be people of colour, whatever the term you want to use, whether they be Indian, whether they be South-East Asian, I think the anti-Black sentiments are prevalent or, you know, whether they be conscious or unconscious bias. (40-year-old, female, Canadian-born)

3. Insensitivity towards racial discrimination

While many participants expressed having had insufficient experience with racialized minority health care providers to comment on the impact of racial concordance or discordance in the care that they receive, certain others denied the existence of racial discrimination or differential treatment in their health care experiences altogether. Several of our respondents shared experiences of having been overtly discriminated against based on their race in the broader Montréal community, such as being unjustly stopped by law enforcement or being called 'negress' or 'nigger Black'. Reflecting on these flagrant instances of racism, many of our participants were unable to identify occasions when their health consultations might have been equally or similarly impacted by racism. For example, one participant explained that he might have trained himself to ignore instances of discrimination:

> I also think maybe that's how I'm conditioned and all because I don't know. (…) For me, like while growing up, I developed this filter to just like keep it moving, you know? (…) We actually have to do that in Montréal, in Canada, like it's common. Like you just have to keep it moving. Like if you stop whenever this stuff happens, I think … I don't know. I think it's a waste of time, you know, for me, personally. (26-year-old, male, immigrant more than 10 years; quote translated from French to English)

When reflecting on whether their consultations have been impacted by racism, several participants compared their experiences with health care in Montréal to the experiences that they have had in other countries. For some, these comparisons provoked an awareness of the possibility of normalization and diminishment of racial discrimination:

> Coming from the UK, where systemic racism is so, so apparent, evident, I refuse to see or believe that there is anything like that in Canada. So, maybe there is but, you know, when you've been culturally abused so much, any other racial abuse which is not as much as you've experienced in the past, to you, is not racial abuse. (39-year-old, female, immigrant 10 years or less)

For other participants, the tolerance of race-based discrimination may be a small price to pay for the opportunity to live in Canada:

> Honestly speaking, I can't say [I've been discriminated against in health care], you know? Because sometimes [in] the morning, I get up and I'm going outside, I get up and I say, 'Lord, thank you for Canada', you know? Canada has been good to me. (67-year-old, female, immigrant more than 10 years)

Discussion

Internalized racism is an under-investigated dimension of patients' experience in primary health care. From our knowledge, this is the first qualitative study to explore how internalized racism can manifest within health care to perpetrate anti-Black discrimination and affect quality of care. We identified three major themes which reveal important insights regarding the expression of internalized racism in primary health care encounters, including: (1) the internalization of anti-Black racism by both Black providers and patients, (2) the expression of anti-Black prejudice and discrimination by non-Black racialized minority providers, and (3) an insensitivity towards racial discrimination.

Various studies have demonstrated the beneficial impacts of racial concordance on health care experiences, such as in terms of patient-provider relationships and increasing health care satisfaction and service utilization (Alsan, Garrick, and Graziani 2019; Cooper-Patrick et al. 1999; Takeshita et al. 2020). However, our study's findings indicate much more complexity around the issue of concordance that relate to age, ethnic origin, and immigration experience. Of particular note are suggestions that both racialized minority patients and racialized minority providers are potential subjects of internalized racist ideas which impact their attitude towards, and interaction with, people from their own racial group or other racialized minority groups in the primary health care setting.

Although several participants shared views on how race could impact their care experiences, others perceived no relation between the race of their providers and the quality of care they received. While this perception may be true, the possibility of denial or rationalization of racial discrimination cannot be dismissed. As argued by David and Okazaki, one common manifestation of internalized racism is the tolerance, denial, or justification of racial oppression (David and Okazaki 2006). These findings resonate with a study by Plaisime et al which found, among other things, that some Black providers carried anti-Black perceptions about their Black male patients, and that some Black patients have a preference for racially discordant physicians (Plaisime et al. 2017). Such manifestations delineate some of the ways in which internalized racism can be expressed interpersonally (David, Petalio, and Crouch 2018).

Clearly, the complex dynamics of internalized racism warrant greater attention. We propose, however, that the concept of 'appropriated racial oppression' may better explain such subtle and often tentative expressions of racism than the concept of 'internalized racism'. This shift in terminology takes a sociocultural approach and emphasizes the importance of addressing broader contexts (such as social, institutional, and historical components), as opposed to over-focusing on the internal factors of individuals, as is largely done in the field of psychology (Banks and Stephens 2018; Tappan 2006). The notion of 'appropriated racial oppression' counters the implication that individuals are to blame for their oppression as is suggested in the terms 'internalized racism' or 'internalized racial oppression', and serves to focus attention on the systemic and mediated mechanisms of oppression (Banks and Stephens 2018; Tappan 2006). It also draws attention to the diverse ways in which Black people may experience racially concordant and discordant health care and the variety of mechanisms by which racism could infiltrate care services.

Conclusion

Research on internalized racism is crucial to understanding the underlying mechanisms of racial oppression, and how they are reproduced and maintained (Pyke 2010). Given the widespread recognition of how cultural competency matters in clinical settings, we argue that health care training enables the respectful exploration of the complexities of anti-Black racism and how manifestations might be addressed. This might include discussions that explore how Black patients' attitudes towards health care systems and health care personnel may be shaped by unique exposures to, and perceptions of, anti-Black racism. These reflections can serve to highlight false beliefs and unconscious biases that may arise during both racially concordant and discordant care provision, and promote adapted health care strategies that acknowledge the diverse backgrounds and perspectives of patients towards providing more holistic care. The consideration of internalized racism, alongside its institutional and interpersonal expressions, will help to enhance the quality and equity of primary health care for racialized minority, and particularly Black, populations.

Acknowledgements

We extend a sincere thanks to Yvonne Sam (from the Council for Black Aging Community of Montréal), Dwight Best (from the ACSioN Network of Canada), and Sharon Nelson (from the Jamaica Association of Montréal) for their active assistance with participant recruitment and for providing feedback on earlier versions of this manuscript. We also thank Dr. Isabelle Leblanc and Keith Williams for providing feedback on earlier versions of this manuscript, and Gregory Gooding for actively assisting with participant recruitment.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Funding

This work was supported by a Frederick Banting and Charles Best Canada Graduate Scholarship-Master's Award from the Canadian Institutes of Health Research, and a Doctoral Training Award from the Fonds de Recherche du Québec – Santé in partnership with the Strategy for Patient-Oriented Research Support Unit in Québec.

Data availability statement

Due to ethics and privacy restrictions, data cannot be made available.

ORCID

Khandideh K. A. Williams http://orcid.org/0000-0002-9251-3158
Shamara Baidoobonso http://orcid.org/0000-0002-6516-7077
Alayne M. Adams http://orcid.org/0000-0002-0961-9825

References

Alcalá, H. E., and D. M. Cook. 2018. "Racial Discrimination in Health Care and Utilization of Health Care: A Cross-sectional Study of California Adults." *Journal of General Internal Medicine* 33 (10): 1760–1767. https://doi.org/10.1007/s11606-018-4614-4.

Alsan, Marcella, Owen Garrick, and Grant Graziani. 2019. "Does Diversity Matter for Health? Experimental Evidence from Oakland." *American Economic Review* 109 (12): 4071–4111. https://doi.org/10.1257/aer.20181446.

Bailey, Zinzi D., Nancy Krieger, Madina Agénor, Jasmine Graves, Natalia Linos, and Mary T. Bassett. 2017. "Structural Racism and Health Inequities in the USA: Evidence and Interventions." *The Lancet* 389 (10077): 1453–1463. https://doi.org/10.1016/S0140-6736(17)30569-X.

Banks, Kira Hudson, and Jadah Stephens. 2018. "Reframing Internalized Racial Oppression and Charting a Way Forward." *Social Issues and Policy Review* 12 (1): 91–111. https://doi.org/10.1111/sipr.12041.

Blanchard, J., and N. Lurie. 2004. "R-E-S-P-E-C-T: Patient Reports of Disrespect in the Health Care Setting and its Impact on Care." *The Journal of Family Practice* 53 (9): 721–730.

Carter, Robert T., Michael Y. Lau, Veronica Johnson, and Katherine Kirkinis. 2017. "Racial Discrimination and Health Outcomes Among Racial/Ethnic Minorities: A Meta-Analytic Review." *Journal of Multicultural Counseling and Development* 45 (4): 232–259. https://doi.org/10.1002/jmcd.12076.

Cooper-Patrick, Lisa, Joseph J. Gallo, Junius J. Gonzales, Hong Thi Vu, Neil R. Powe, Christine Nelson, and Daniel E. Ford. 1999. "Race, Gender, and Partnership in the Patient-Physician Relationship." *JAMA* 282 (6): 583–589. https://doi.org/10.1001/jama.282.6.583.

Coyne, Imelda T. 1997. "Sampling in Qualitative Research. Purposeful and Theoretical Sampling; Merging or Clear Boundaries?" *Journal of Advanced Nursing* 26 (3): 623–630. https://doi.org/10.1046/j.1365-2648.1997.t01-25-00999.x.

David, E. J., and S. Okazaki. 2006. "Colonial Mentality: A Review and Recommendation for Filipino American Psychology." *Cultural Diversity and Ethnic Minority Psychology* 12 (1): 1–16. https://doi.org/10.1037/1099-9809.12.1.1.

David, E. J. R., Jessica Petalio, and Maria C. Crouch. 2018. "Microaggressions and Internalized Oppression: Intrapersonal, Interpersonal, and Institutional Impacts of "Internalized Microaggressions"." In *Microaggression Theory*, edited by G. C. Torino, D. P. Rivera, C. M. Capodilupo, K. L. Nadal, & D. W. Sue, 121–137. New Jersey, USA: John Wiley & Sons. https://doi.org/10.1002/9781119466642.ch8.

David, E. J. R., Tiera M. Schroeder, and Jessicaanne Fernandez. 2019. "Internalized Racism: A Systematic Review of the Psychological Literature on Racism's Most Insidious Consequence." *Journal of Social Issues* 75 (4): 1057–1086. https://doi.org/10.1111/josi.12350.

Groenewald, Thomas. 2004. "A Phenomenological Research Design Illustrated." *International Journal of Qualitative Methods* 3 (1): 42–55. https://doi.org/10.1177/160940690400300104.

Hall, W. J., M. V. Chapman, K. M. Lee, Y. M. Merino, T. W. Thomas, B. K. Payne, E. Eng, S. H. Day, and T. Coyne-Beasley. 2015. "Implicit Racial/Ethnic Bias Among Health Care Professionals and Its Influence on Health Care Outcomes: A Systematic Review." *American Journal of Public Health* 105 (12): e60–e76. https://doi.org/10.2105/ajph.2015.302903.

James, Drexler. 2020. "Health and Health-Related Correlates of Internalized Racism Among Racial/Ethnic Minorities: A Review of the Literature." *Journal of Racial and Ethnic Health Disparities* 7 (4): 785–806. https://doi.org/10.1007/s40615-020-00726-6.

Jones, C. P. 2000. "Levels of Racism: A Theoretic Framework and a Gardener's Tale." *American Journal of Public Health* 90 (8): 1212–1215. https://doi.org/10.2105/ajph.90.8.1212.

Jones, Camara Phyllis. 2002. "Confronting Institutionalized Racism." *Phylon (1960-)* 50 (1/2): 7–22. https://doi.org/10.2307/4149999.

Levesque, J.-F., M. F. Harris, and G. Russell. 2013. "Patient-centred Access to Health Care: Conceptualising Access at the Interface of Health Systems and Populations." *International Journal for Equity in Health* 12: 18. https://doi.org/10.1186/1475-9276-12-18.

Neubauer, B. E., C. T. Witkop, and L. Varpio. 2022. "How Phenomenology Can Help us Learn from the Experiences of Others." *Perspectives on Medical Education* 8 (2): 90–97. https://doi.org/10.1007/s40037-019-0509-2.

Nowell, Lorelli S., Jill M. Norris, Deborah E. White, and Nancy J. Moules. 2017. "Thematic Analysis: Striving to Meet the Trustworthiness Criteria." *International Journal of Qualitative Methods* 16 (1): 160940691773384. https://doi.org/10.1177/1609406917733847.

Pan-Canadian Public Health Network, and Public Health Agency of Canada. 2018. "Key Health Inequalities in Canada: A national portrait." Pan-Canadian Health Inequalities Reporting Initiative. Accessed August 11, 2022. https://www.canada.ca/content/dam/phac-aspc/documents/services/publications/science-research/key-health-inequalities-canada-national-portrait-executive-summary/hir-full-report-eng.pdf.

Plaisime, M. V., D. J. Malebranche, A. L. Davis, and J. A. Taylor. 2017. "Healthcare Providers' Formative Experiences with Race and Black Male Patients in Urban Hospital Environments." *Journal of Racial and Ethnic Health Disparities* 4 (6): 1120–1127. https://doi.org/10.1007/s40615-016-0317-x.

Powell, W., J. Richmond, D. Mohottige, I. Yen, A. Joslyn, and G. Corbie-Smith. 2019. "Medical Mistrust, Racism, and Delays in Preventive Health Screening Among African-American Men." *Behavioral Medicine* 45 (2): 102–117. https://doi.org/10.1080/08964289.2019.1585327.

Pyke, Karen D. 2010. "What is Internalized Racial Oppression and Why Don't We Study It? Acknowledging Racism's Hidden Injuries." *Sociological Perspectives* 53 (4): 551–572. https://doi.org/10.1525/sop.2010.53.4.551.

Siddiqi, A., F. V. Shahidi, C. Ramraj, and D. R. Williams. 2017. "Associations Between Race, Discrimination and Risk for Chronic Disease in a Population-based Sample from Canada." *Social Science & Medicine* 194: 135–141. https://doi.org/10.1016/j.socscimed.2017.10.009.

Statistics Canada. 2017. *Montréal, V [Census Subdivision], Quebec and Montréal, TÉ [Census division]. Quebec (table). Census Profile. 2016 Census.* Ottawa: Statistics Canada.

Suri, Harsh. 2011. "Purposeful Sampling in Qualitative Research Synthesis." *Qualitative Research Journal* 11 (2): 63–75. https://doi.org/10.3316/QRJ1102063.

Takeshita, Junko, Shiyu Wang, Alison W. Loren, Nandita Mitra, Justine Shults, Daniel B. Shin, and Deirdre L. Sawinski. 2020. "Association of Racial/Ethnic and Gender Concordance Between Patients and Physicians With Patient Experience Ratings." *JAMA Network Open* 3 (11): e2024583–e2024583. https://doi.org/10.1001/jamanetworkopen.2020.24583.

Tappan, Mark B. 2006. "Refraining Internalized Oppression and Internalized Domination: From the Psychological to the Sociocultural." *Teachers College Record: The Voice of Scholarship in Education* 108 (10): 2115–2144. https://doi.org/10.1111/j.1467-9620.2006.00776.x.

Trivedi, Amal N., and John Z. Ayanian. 2006. "Perceived Discrimination and Use of Preventive Health Services." *Journal of General Internal Medicine* 21 (6): 553–558. https://doi.org/10.1111/j.1525-1497.2006.00413.x.

Veenstra, G., and A. C. Patterson. 2016. "Black-White Health Inequalities in Canada." *Journal of Immigrant and Minority Health* 18 (1): 51–57. https://doi.org/10.1007/s10903-014-0140-6.

Williams, David R., Jourdyn A. Lawrence, Brigette A. Davis, and Cecilia Vu. 2019. "Understanding How Discrimination Can Affect Health." *Health Services Research* 54 (S2): 1374–1388. https://doi.org/10.1111/1475-6773.13222.

Zavala, Valentina A., Paige M. Bracci, John M. Carethers, Luis Carvajal-Carmona, Nicole B. Coggins, Marcia R. Cruz-Correa, Melissa Davis, et al. 2021. "Cancer Health Disparities in Racial/Ethnic Minorities in the United States." *British Journal of Cancer* 124 (2): 315–332. https://doi.org/10.1038/s41416-020-01038-6.