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Canadian Medical Education Journal

Emerging Concepts

Anti-racism in CanMEDS 2025

La lutte contre le racisme dans CanMEDS 2025

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Introduction

Black, Indigenous, and people of color are frequent targets of racism and oppression in Canada. Black people in Canada have diverse origins–centuries old communities and communities of recent immigration in the last few generations (such as with those of Caribbean or African descent). All share a common experience of oppression by policies and practices rooted in Canadian educational, healthcare, and justice organizations that reinforce beliefs, attitudes, prejudice, stereotyping, and/or discrimination. Indigenous peoples have been oppressed by the race-based discrimination, negative stereotyping, and injustice stemming from the legacy of settler colonial policies and practices that have established, maintained, and perpetuated power imbalances, systemic barriers, and inequitable outcomes. People of color span a myriad of groups with diverse histories and backgrounds that are oppressed in similar ways. Additionally, intersecting identities of race, religion, ability, sexual orientation, socioeconomic status, gender and gender identity exacerbate exclusion and discrimination.[1]

Although not widely acknowledged by our medical institutions, racist practices and ideologies are foundational underpinnings of Western Medicine[2,3] and continue to cause harm. Our profession has yet to confront this truth in a meaningful way. When we examine the environments in which care providers practice, racialized care providers are overrepresented in the experience of workplace-related mistreatment and trauma. An alarming seventy percent (70%) of Black physicians[4] and eighty-eight percent (88%) of Black nurses[5] report experiences of racism in workplaces in Canada. One can only imagine what the data would show if robustly collected on racialized patients. Racial biases–conscious or unconscious (i.e. the incredulous belief that Black patients do not feel pain[6])–persist in aspects of the current day physician workforce and can permeate the clinical learning and work environment, making it less safe, exacerbating health inequities, and eroding patient trust.[7]

At an individual level, racial bias can affect interactions with racialized patients and colleagues. When racial bias permeates the learning and clinical environment patient care is compromised and outcomes are worse.[8–14] Researchers found that white trainees with an implicit preference for white individuals were more likely to treat white patients, and not Black patients, with thrombolysis for myocardial infarction.[8] This study showed that physicians' unconscious biases may contribute to racial/ethnic disparities in clinical decision-making and may predict the use of medical procedures. Left unchecked, such bias persists as shown in a systematic review which found white physicians, regardless of specialty, have an implicit preference of favoring white people and will sometimes treat non-white patients in an inferior fashion.[9]

At the systemic level, racial bias can lead to active racialization and create unsafe work and regulatory environments for Black, Indigenous and racialized physicians and patients.[15] Indigenous patients in

healthcare settings continue to experience significant and pervasive anti-Indigenous racism which has an impact on their health outcomes.[10] Recent evidence demonstrates: that First Nations status is associated with lower odds of receiving higher acuity triage scores in the emergency department in comparison to white patients;[7] Black, Indigenous and racialized patients wait longer than white patients to receive care;[11] and systemic racism is a proven cause of death.[12] In short, racist care kills.

Despite racism being declared a public health emergency in Canada[16] full-scale, coordinated, and systemic action from our medical institutions and regulatory bodies is lacking.[17] Our profession needs to become anti-racist. The revision of the 2015 CanMEDS Physician Competency Framework[18] provides an opportunity for the medical community to reflect, inform the skills, and support the conditions needed for anti-racist medicine. This manuscript aims to summarize emerging anti-racism concepts in medical education and to provide recommendations for incorporating them into the 2025 CanMEDS Physician Competency Framework.

What is anti-racism and why is it important to physician competency?

Anti-racism is a process, a systematic method of analysis, and a proactive course of action rooted in the recognition of the existence of racism, including systemic racism. It actively seeks to ***identify, remove, prevent****, and* ***mitigate*** racially inequitable outcomes and power imbalances between groups and change the structures that sustain inequities.[13]

Anti-racism is important to physician competency for several reasons. First, as outlined above, racism ***directly*** impacts the health and wellness of our learners, colleagues, patients, and communities. Second, it is racism—and not race—that contributes to disparate health outcomes, health inequities, and even death.[19–21] Third, the increasing racial and ethnic diversity of the Canadian population provides an opportunity and a responsibility for medical professionals to grow and develop new dispositions and skills to meet the needs of our shifting demographics. Finally, in order to combat racism in medicine, all physicians in Canada –whether they are engaged in medical education, training, scholarship, or practice—must recognize and accept an uncomfortable truth; the foundation of Western medicine is grounded in racist practices and ideologies[2,3] which persist today and affect patient care and interactions with racialized colleagues.

We argue that all physicians in Canada must demonstrate ongoing competence in anti-racist, anti-oppressive praxis, to address the impact of racism both on patient outcomes and on their physician colleagues who identify as Black, Indigenous, or people of color.[12] The gravity of this situation demands urgent action and corrective responses from medical professionals, including but not limited to the setting of new practice standards.[10] Anti-racist action requires the use of explicit language and solid conceptual understanding of the origins of racism and oppression, and counteractions to eliminate these; Table 1 provides a detailed glossary. Intentionally absent from Table 1 are terms that are frequently embraced by health care institutions and organizations to define what they aspire to achieve in this area: *equity, diversity,* and *inclusivity.* While these terms are comfortable and aspirational, we find them unhelpful within the context of racism because they are not action-oriented, and they do not *explicitly* name the issues that prevent racialized equity-deserving groups from moving forward: racism and oppression.

Within this manuscript we briefly review key concepts related to anti-racist praxis and provide recommendations for incorporating them in the 2025 CanMEDS Physician Competency Framework. Importantly, a previously published Royal College document describes the key approaches, ideas and background knowledge for health care providers, learners and educators in caring specifically for Indigenous Peoples[22] while a related emerging concepts manuscript in this series addresses equity, diversity, inclusion, and social justice as they relate to other oppressed populations.[23] We also draw our readers attention to a compelling commentary which suggest that the Framework, itself, may be permissive of racism.[15] We are hopeful that this suite of documents will be effectively translated into the 2025 version of CanMEDS to ensure that — in the future – physicians are able to competently engage in action-oriented, anti-racist and anti-oppressive, structurally competent, and culturally safe praxis in the care of our patients and our communities.

Table 1. Glossary of terms

Term	Definition
Anti-Black racism	The policies and practices rooted in Canadian institutions, such as education, healthcare, and justice, which mirror and reinforce beliefs, attitudes, prejudice, stereotyping, and/or discrimination towards people of African, Black, and Caribbean descent.[24,25]
Anti-Indigenous racism	This is evident in discriminatory federal policies such as the Indian Act and the residential school system. It is also manifested in the overrepresentation of Indigenous peoples in provincial criminal justice and child welfare systems, as well as inequitable outcomes in education, well-being, and health. Individual lived-experiences of anti-Indigenous racism can be seen in the rise in acts of hostility and violence directed at Indigenous people.[24]
Anti-oppression	An anti-oppression approach recognizes the power imbalance within society that attributes benefits to some groups and excludes others. This approach seeks to develop strategies to create an environment free from oppression, racism, and other forms of discrimination. It acknowledges the intersections of identity and diversity, both visible and invisible, including race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex (including pregnancy), sexual orientation, gender identity, gender expression, age, record of offences, marital status, family status, and disability, and aims to promote equity between the various identities.[24]
Anti-racism	Anti-racism is a process, a systematic method of analysis, and a proactive course of action rooted in the recognition of the existence of racism, including systemic racism. Anti-racism actively seeks to identify, remove, prevent, and mitigate racially inequitable outcomes and power imbalances between groups and change the structures that sustain inequities.[13]
Colonialism	A practice or policy of control by one people or power over other people or areas, often by establishing colonies and generally with the aim of economic dominance. In the process of colonization, colonizers may impose their religion, language, economics, and other cultural practices.[26] It is broadly classified into four types: 1) settler colonialism, 2) exploitation colonialism, 3) surrogate colonialism, and 4) internal colonialism.
Critical consciousness	A concept, popularized by Paulo Freire, defined as the ability to intervene in reality to change it. Also known as "consciousness raising", it includes taking action against the oppressive elements in one's life that are illuminated by that understanding.[27] Contemporary formulations divide critical consciousness into three components. Critical reflection is an awareness of both the historical and systemic ways oppression and inequity exist. Critical motivation is the perceived capacity or moral commitment to address perceived inequalities. Critical action is participation in individual or collective action to change, challenge, and contest perceived inequity.[28]
Cultural safety	Cultural safety is an outcome determined by the recipient of care. It requires healthcare providers to reflect on their own cultural background and the nature of power relations in the provision of services to a minority culture by a dominant culture, so that the providers can work to dismantle the inherent hierarchy. Providers do not need to research and understand other groups' beliefs and cultural practices; rather, they acknowledge and promote the strengths of those who may differ from them in age, occupation or social class, ethnic background, sex, sexuality, gender, religious belief, and disability. Cultural safety requires providers from the majority culture to challenge their own stereotyped views of a minority culture. It promotes positive recognition of diversity.[29]
Epistemic racism	Refers to the positioning of the knowledge of one racial group as superior to another, it includes a judgment of not only which knowledge is considered valuable but is considered to be knowledge.[30]
Intersectionality	A framework that acknowledges the ways in which people's lives are shaped by their multiple and overlapping identities and social locations, which, together, can produce a unique and distinct experience for that individual or group, such as by creating additional barriers or opportunities. In the context of racialization, this means recognizing the ways in which people's experiences of racism or privilege, including within any one racialized group, may differ and vary depending on the individual's or group's overlapping (or "intersecting") social identities, such as ethnicity, Indigenous identification, experiences with colonialism, religion, gender, citizenship, socio-economic status or sexual orientation.[31]
Microaggression	Brief and common daily verbal, behavioral, or environmental indignities, comment or action that subtly and often intentionally or unintentionally expresses a hostile, derogatory, or negative slights and insults toward a member of a marginalized group (such as, but not limited to BIPOC, LGBTQ2S+, disability), also referred to as casual and everyday racism.[24]
Positionality	Refers to the how differences in social position and power shape identities and access in society.[32]
Power	Access to privileges such as information, knowledge, connections, experience and expertise, resources, and decision-making that enhance a person's chances of getting what they need to live a comfortable, safe, productive, and profitable life.[23]
Privilege	Unearned power, benefits, advantages, access, and opportunities that exist for members of the dominant group(s) in society. Can also refer to the relative privilege of one group compared to another. See Peggy McIntosh's article and tool "White Privilege: Unpacking the Invisible Knapsack."[33]
Race	A term used to classify people into groups based principally on physical traits (phenotype), such as skin colour or other apparent differences perceived as "inherent" or "unchanging."[34] For example, a social group's culture or religion may sometimes be treated as unchanging and inherent. Racial categories are not based on science or biology but on differences that society has created (i.e., "socially constructed"), with significant consequences for people's lives. Racial categories may vary over time and place, and can overlap with ethnic, cultural, or religious groupings.
Race Correction	Also referred to as "race adjustment", "race modification" or "race norming". This harmful practice results from health care providers using different criteria, "diagnostic algorithms and practice guidelines that adjust or "correct" their outputs on the basis of a patient's race or ethnicity."[10] The use of this practice has implications for patient's access to treatment and support.
Self-determination	Refers to each person's ability to make choices and manage their own life. It plays an important role in psychological health and well-being, and allows people to feel that they have control over their choices and lives, which positively impacts motivation to engage and even outcomes for individuals.[35]
Settler Colonialism	This form of colonialism involves the large-scale immigration of settlers to colonies, often motivated by religious, political, or economic reasons. This form of colonialism has been experienced by Indigenous peoples in countries such as Canada, the United States and Australia as settlers supplant prior existing populations. This form of colonialism involves a large number of settlers emigrating to colonies for the expressed purpose of claiming land and prosperity.
Structural competency	The trained ability to discern how a host of issues defined clinically as symptoms, attitudes, or diseases (e.g. depression, hypertension, obesity, smoking, medication "non-compliance", trauma, psychosis) also represent the downstream implications of upstream decisions about such matters as health care and food delivery systems, zoning laws, urban and rural infrastructures, medicalization, or even the very definitions of illness and health.[36]
Structural racism	A system in which public policies, institutional practices, cultural representations, and other norms work in ways to reinforce and perpetuate racialized group inequity. It identifies dimensions of our history and culture that have allowed white privilege and disadvantages associated with "colour" to endure and adapt over time. Structural racism is not something that a few people or institutions choose to practice; instead, it has been a feature of the social, economic, and political systems in which we all exist.[37]
Systemic racism	Organizational culture, policies, directives, practices, or procedures that exclude, displace, or marginalize some racialized groups or create unfair barriers for them to access valuable benefits and opportunities. This is often the result of institutional biases in organizational culture, policies, directives, practices, and procedures that may appear neutral but have the effect of privileging some groups and disadvantaging others.[19]
Trauma-informed care	An approach to care that acknowledges that a complete picture of a patient's life situation — past and present — must be understood in order to provide effective health care services with a healing orientation. This approach must be implemented at both the clinical and organizational levels of institutions to be effective.[22]
Upstander intervention	An upstander is someone who witnesses a behavior that could lead to something high risk or harmful and makes the choice to intervene to make things better. Situations an upstander intervenes in include daily acts of harm (i.e., street harassment, bullying, discriminatory comments, sexist jokes), or high risk situations (i.e., situations that may lead to physical violence, sexual assault, relationship violence).[38]

How is anti-racism represented in the 2015 CanMEDS competency framework?

While there are no explicit references to anti-racism within the 2015 CanMEDS Physician Competency Framework (Table 2A), there are Communicator, Scholar, Health Advocate, and Professional competencies that touch on related concepts. The closest enabling competency, Communicator 4.1, calls for culturally safe communication with patients (Table 2B). The absence of anti-racist competencies in CanMEDS may contribute to the negative experiences of racialized health care providers and the worsened outcomes of racialized patients. Scholars have highlighted a tension between the Professional and Health Advocate roles when it comes to racism, with professionalism being weaponized against racialized physicians who are advocating for racial equity and social justice.[39] Thus a compelling argument can be made that the Framework may itself perpetuate racism.[15]

How can anti-racism be represented within the 2025 CanMEDS competency framework?

Since racism exists within the culture and fabric of the health care system and broader society, addressing racism within the healthcare and medical education systems presents many challenges. We propose the incorporation of an anti-racist approach throughout the fabric of our organizations as an effective approach to addressing racism. An anti-racist approach is enabled when individuals are knowledgeable and skilled in appropriately utilizing concepts of *critical consciousness, cultural and psychological safety, trauma-informed care, and upstander intervention* to create a culture of safety and belonging both within the learning environment and the clinical care environment.

We believe anti-racism is a cross-cutting physician competency, and that the existing CanMEDS competency framework requires evolution with explicit statements for expectations of physicians related to anti-racist, anti-oppressive praxis. We call for *nineteen modifications* and *twenty-four additions* that would make anti-racism a prominent component within each of the CanMEDS roles. These competencies, and others described in Table 2, are required for the 21st century physician to promote health equity and actively support more diverse and inclusive environments.

While incorporating these new competencies within CanMEDS would be a small step forward, a more effective way to demonstrate the fundamental need for anti-racist and anti-oppressive praxis would be a complete reimagining of the CanMEDS 'flower' to raise awareness that it was grown in soil corrupted by racist elements.[2,3] The image of a flower with roots firmly established in anti-racist soil would deliver a message of acknowledgement and possibility while supporting a stem representative of our common humanity[40] and sprouting petals infused with anti-racism. A new physician identity[15] is required to meet the urgent needs and growing expectations of our times, and anti-racism must be a foundational physician competency.

Conflicts of Interest: Dr. Kannin Osei-Tutu is a member of the steering committee for CanMEDS25 and the co-chair of the CanMEDS25 Anti-racism Expert Working Group (EWG). Dr. Brent Thoma has received payments for teaching, research, and administrative work from the University of Saskatchewan College of Medicine, payments for teaching and administrative work from the Royal College of Physicians and Surgeons of Canada, honoraria for teaching or writing from Harvard Medical School, the New England Journal of Medicine, the University of Cincinnati Children's Hospital, and NYC Health + Hospitals, and research grant funding from the Government of Ontario and the Canadian Association of Emergency Physicians. Dr. Jerry Maniate is the co-chair of the CanMEDS25 Equity, Diversity, Inclusivity (EDI) & Social Justice Expert Working Group (EWG). This is a volunteer position. Dr. Saleem Razack is a member of the steering committee for CanMeds 2025 and co-chair of the Expert Working Group (EWG) on physician humanism, also for CanMeds 2025

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Table 2. Anti-racism competencies for the CanMEDS physician competency framework.

A. CanMEDS 2015 Competencies directly applicable to anti-racism.	
None	
B. CanMEDS 2015 Competencies partially (but not directly or intentionally) related to anti-racism	
Communicator 4.1: Facilitate discussions with patients and their families in a way that is respectful, non-judgmental, and culturally safe. Scholar 2.2: Promote a safe learning environment. Health Advocate 1.1: Work with patients to address determinants of health that affect them and their access to needed health services or resources. Health Advocate 2.1: Work with a community or population to identify the determinants of health that affect them. Professional 3.2: Recognize and respond to unprofessional and unethical behaviours in physicians and other health care professionals.	
C. Suggested additions or modifications for the CanMEDS 2025 Framework related to anti-racism.	
New or Modified Competency	*Rationale for change*
Medical Expert	
1 (REVISED): Practice medicine in an anti-racist manner within their defined scope of practice and expertise.	Racism worsens patient outcomes[8–14] and is best addressed through the incorporation of anti-racism and, when applicable, trauma-informed care into these competencies. Integrating these concepts should improve both the patient experience and patient outcomes by supporting the co-creation of management plans that resonate with patients and their lived experiences.
1.1 (REVISED): Demonstrate a commitment to high quality anti-racist care of their patients.	
1.3 (REVISED): Apply knowledge of the impact of racism on patient outcomes, and the clinical and biomedical sciences relevant to their discipline.	
1.4 (REVISED): Perform appropriately timed anti-racist and trauma-informed clinical assessments with recommendations that are presented in an organized manner.	
1.6 (REVISED): Recognize and respond in an anti-racist manner to the complexity, uncertainty, and ambiguity inherent in medical practices	
2 (REVISED): Perform a patient-centered clinical assessment using an anti-racist approach, and co-design a management plan.	
2.5 (NEW) Articulates race as a social construct that is a cause of health and health care inequities, not a risk factor for disease.	Physicians need to recognize that race is a social construct that is used to understand the world around us. This social construct has resulted in policies and structures that have led to inequities in health and health care delivery with negative health outcomes and care experience. As such, race itself is not a risk factor for disease, but rather, a source of inequities in health and health care delivery.
5.2 (REVISED): Adopt strategies that promote patient safety and address human and system factors using anti-racist principles.	Racism has been demonstrated to worsen patient outcomes and is best addressed through the incorporation of anti-racism into these competencies.
5.3 (NEW): Recognize the harms of race correction and adopt strategies and practices to reduce or eliminate its impact.	Race correction is endemic in medicine and results in harms to racialized patient populations by changing care (most frequently in a way that has an adverse impact on patients) due to their race and/or ethnicity.[10]
5.4 (NEW): Identifies and corrects the misuse of clinical tools and practices that are used in and support race-based medicine.	Misuse of clinical tools and practices that substantiate race-based medicine can lead to patient harm and should be avoided to better assure patient safety.
Communicator	
1.3 (REVISED): Recognize when the values, biases, perspectives, or positionality of patients, physicians, or other health care professionals may have an impact on the quality of care, and modify the approach to the patient accordingly.	Physicians must be skilled in communicating with a diverse Canadian population. Including positionality acknowledges that a patient's experience and care are impacted by the patient's identity which is shaped by their social and political context with respect to race, class, gender, sexuality, and ability status.
1.7 (NEW): Communicate using an anti-racist, anti-oppressive, culturally safe, and trauma-informed approach that encourages patient safety, trust, and sense of belonging.	Trust and belonging are integral to engaging patients with regards to their experience and care in the health system.
1.8 (NEW): When racist attitudes of patients, learners, physicians, or other health care professionals impact the quality of care, modify the approach to the patient accordingly.	Racism has historically permeated our institutions and efforts are needed to reduce the impact that this has on the care that patients receive due to its demonstrated harms.[8–13]
1.9 (NEW): Intervene in a timely and appropriate manner when racism or discrimination is encountered in the clinical environment whether the recipient is a patient, a learner, a physician colleague, or another health care professional.	It will be impossible to address racism until physicians become skilled at identifying it in the clinical environment, intervening to disrupt racist behaviors, and making it unacceptable.
2.4 (NEW) Uses language-interpretive services to reduce language barriers in patient interactions.	Physicians must be skilled in communicating with a diverse population and use available tools, services, and technologies available to obtain accurate health information from their patients and ensure the safest possible care.
5.1 (REVISED): Document clinical encounters using non-biased, non-stigmatizing language in an accurate, complete, timely, and accessible manner that complies with regulatory and legal requirements.	Biased and stigmatizing language is prevalent in medical charts and leads to poorer patient care[14]
5.4 (NEW): Correct any bias, stigmatizing, or racializing language in the medical record and report it appropriately.	It will be impossible to address racism within our health system until physicians become skilled at correcting it in patient records and making it unacceptable.

Collaborator	
2.2 (REVISED): Implement strategies that utilize anti-racism and culturally safe practices to promote understanding and critical consciousness, manage differences, and resolve conflicts in a manner that supports a collaborative, just, and equitable culture.	Racism within our health system is well documented. It will be impossible to address until physicians become skilled at identifying it in the clinical and learning environments, intervening to disrupt racist behaviors, and making it unacceptable.
2.3 (NEW): Initiate and/or support strategies to address epistemic racism in medicine and its' impact on colleagues.	Epistemic racism negatively impacts racialized physicians and patients, and we all need to play a role in disrupting it.
2.4 (NEW) Engages with the health care team to identify the impacts of racism and oppression and challenges these behaviors and practices in the local setting and uses upstander interventions to address discriminatory statements or issues that arise within the care team.	Addressing racism and oppression within the health system requires engagement of the entire health care team to ensure their diverse perspectives and experiences are incorporated into the proposed approaches. Health care providers need to shift from being unaware or bystanders to discriminatory events, to that of upstanders who intervene to address these issues within the clinical learning and work environment. [38]
Leader	
1.4 (REVISED): Use health informatics and race-based data to improve the quality of care for patients, optimize patient safety, and improve patient outcomes.	Race-based data is integral to revealing the inequities of care that are experienced within the health system. Integrating these data along with traditional data found in health informatics systems provides a greater understanding of the care needs of a community or population.
1.5 (NEW): Use anti-racism best practices to improve the quality of patient care, overall experience, and optimize patient safety.	High standards need to be employed to promote and improve patient outcomes.
2.1 (REVISED): Allocate heath care resources for optimal and equitable patient care.	Efforts to achieve optimal patient care have resulted in systemic inequities in our health system. The addition of the word equitable underscores current race-based health care inequities.
3 (REVISED): Demonstrate anti-racist leadership in professional practice.	Leadership should represent and reflect the populations it serves. Leaders must lead by example and champion anti-racism principles to address the inequities in health perpetuated by the health system, its providers, and leaders themselves.
3.3 (NEW): Model the use of influence and leadership to support a culture that promotes anti-racism within the health system.	All measures to successfully address racism within the health system require active engagement, support and role modeling of leaders and leadership teams to those within the health system.
3.4 (NEW): Appraise outcomes-based anti-racism policies, protocols, and procedures in clinical environments, teams, organizations, and health systems.	It is critical to assess the impact of new measures to address racism within the health system, and to ensure negative unintended consequences are recognized early and remediated appropriately.
3.5 (NEW): Lead others in the practice and promotion of anti-racist healthcare practice.	Physicians need to recognize the importance of leading, mentoring, and actively teaching others to actively integrate anti-racism principles and practices into all aspects of our health system.
3.6 (NEW) Leads or participates in organizational and public policy approaches to promote social justice, eliminate health care disparities, and address social determinants of health.	In keeping with World Health Organization Social Accountability of Medical Schools Framework,[41] medical schools respond to the changing needs of the community by developing formal mechanisms to maintain awareness of those needs and advocate for them to be met.
Health Advocate	
1.1 (REVISED): Work with patients to address determinants of health, structural factors, and racism that affect them and their access to needed health services or resources.	Structural racism has been shown to impact patients' ability to access and receive care.[42]
1.4 (NEW): Work with patients to identify, reduce, and eliminate racism and structural factors within the health system.	Through a patient partnership approach, we can identify and explore ways to address racism and structural factors that are of importance to patients.
2.4 (NEW): Work proactively with patients and racialized communities to identify, reduce, and eliminate systemic racism within the health system.	Active and meaningful engagement with racialized communities is critical to addressing systemic racism they encounter in the health system.
2.5 (NEW): Work with patients and racialized communities to address the impact of epistemic racism and structural factors on the health outcomes of patients.	Racism has historically permeated our institutions and efforts need to be made to reduce the impact that this has on the care that patients receive. Physicians need to develop the trained ability to discern how a host of issues defined clinically as symptoms, attitudes, or diseases also represent the downstream implications of upstream decisions about such matters as health care and food delivery systems, zoning laws, urban and rural infrastructures, medicalization, or even the very definitions of illness and health.
Scholar	
2.2 (REVISED): Promote a culturally and psychologically safe learning environment.	Safety in the clinical and learning environments has often focused on physical aspects. To address racism and oppression, we must consciously ensure that cultural and psychological safety concerns are addressed as they impact an individual's sense of belonging within the institution.
2.7 (NEW): Apply an approach to reduce the impact of racism on trainees by incorporating anti-racist practices in teaching, feedback, and assessment.	All trainees, including racialized trainees, should be able to rely on the expectation that their clinical and learning environments will be safe and that they will receive unbiased feedback, fair assessments, and promotion.

3.5 (NEW): Appraise the impact of racism on health in clinical and non-clinical settings using a critical consciousness approach.	Physicians should have the ability to intervene in reality to change it. This includes acting against the oppressive elements in one's life that are illuminated by that understanding.
4.6 (NEW): Demonstrate the ability to identify the impact of racism on health and work to reduce it by incorporating anti-racist practices in clinical and non-clinical settings.	It will be impossible to address racism until physicians become proactively engaged in efforts to dismantle and eliminate it from all clinical and learning environments and make it unacceptable.
Professional	
1 (REVISED): Demonstrate a commitment to patients by applying best practices, adhering to high ethical standards, and utilizing an anti-racist approach.	To address racism in healthcare physicians must become skilled at recognizing racism, practicing anti-racist medicine, and making racism unacceptable in health care.
1.1 (REVISED): Exhibit appropriate professional behaviours and relationships in all aspects of practice, demonstrating honesty, integrity, humility, commitment, compassion, respect, altruism, respect for diversity, confidentiality, cultural safety, and anti-racism.	The CMA Code of Ethics and Professionalism articulates the ethical and professional commitments and responsibilities of the medical profession. The Code provides standards of ethical practice to guide physicians in fulfilling their obligation to provide the highest standard of care and to foster patient and public trust in physicians and the profession.[43] Anti-racism is not included as an expected ethical or professional standard in The Code. Racism must be considered professional misconduct.
1.3 (REVISED): Recognize and respond to unethical, racist, and discriminatory issues encountered in practices.	Physicians should have the ability to intervene in reality to change it. This includes acting against the oppressive elements in one's life that are illuminated by that understanding.
2.2 (REVISED): Demonstrate a commitment to patient safety, cultural safety, psychological safety, and quality improvement.	Racism must be considered professional misconduct. Racism makes patients unsafe and leads to poorer outcomes. Physician must be competent in providing culturally safe care.
5 (NEW): Demonstrate a commitment to anti-racism.	Racism must be considered professional misconduct. Anti-racism is required to address it.
5.1 (NEW):Treat racism and discrimination as an unprofessional and unethical behaviour in physicians and other colleagues in the health care professions.	It will be impossible to address racism until physicians become skilled at intervening in the clinical and learning environments and making racism unacceptable.
5.2 (NEW) Models anti-racism in medicine and teaching, including strategies grounded in critical understanding of unjust systems of oppression.	Professionalism includes the role modeling of appropriate behavior and actions; physicians should role model anti-racist practice to positively influence learners and colleagues, and to increase the safety of the clinical and learning environments.

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