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Exploring the Effect of Discrimination on Ethnic Minority Medical Students' Mental Well-Being in the Netherlands

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Abstract: Racial discrimination is a global concern affecting education, including medical programs in the Netherlands. Covert racial discrimination in academia has been linked to adverse academic outcomes and unequal opportunities. This qualitative study explores the relationship between racism, well-being, and academic success among ethnic minority students in Dutch medical education. Conducted in 2021 at a southern Netherlands university, this research employed interviews to delve into the racial discrimination experiences of 11 diverse medical students. Utilising a phenomenological approach, the study conducted semi-structured interviews and applied thematic content analysis to understand how racial discrimination impacted the students' well-being. The findings revealed the prevalence of both overt and covert racial discrimination in predominantly white educational environments. Ethnic minority students encountered discrimination that negatively affected their well-being and academic performance. Racism manifested in overt and covert ways, with students often normalising exclusionary and racist situations. Ethnic minority students reported experiencing more racial discrimination than their white European peers, resulting in feelings of exclusion and academic challenges. The study suggests that implementing student-centred inclusivity measures through structural and institutional changes, such as support structures, mentoring programs, and inclusive course content, can mitigate racial discrimination, enhance diversity and inclusion, and improve ethnic minority medical students' mental well-being and academic performance. Addressing covert racism is crucial for fostering an equitable and inclusive educational environment. These findings underscore the importance of proactive action to combat racial discrimination in educational settings.

Keywords: racial discrimination; medical education; well-being; ethnic minority; academic achievement

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1. Introduction

Worldwide (racial) discrimination remains a persistent global concern due to its impact on all sectors of life [1]. Specifically, in Europe, racial discrimination, also termed racism, is considered the most common type of prejudice, with 59% of respondents claiming that they have experienced ethnic or skin colour-related discrimination, which creates social biases and exclusionary behaviours against people [2].

According to the American Psychology Association (2019) [3], discrimination is the unjust treatment of different categories of people based on race, age, sex, and disability. The term "discrimination" itself is neutral in that it refers to the ability to recognise differences and make distinctions. However, in the context of social discussions and issues,

"discrimination" often carries a negative connotation due to societal influences [4]. Among these, racial and ethnic aspects are particularly prominent [5]. When used in such a context, discrimination reflects the act of favouring or being against certain groups and people and making unjust judgments in the process. The actions or decisions that emerge from this process result in the "good" or "bad" typification of the people involved [6]. In essence, every observed discriminatory act or decision is based on our choices as a society under a structure, starting from systems and institutions, to groups that can be addressed.

Structural racism and institutional racism are frequently used interchangeably, but can be distinguished using different concepts. Structural racism encompasses the entirety of societal mechanisms that cultivate racial discrimination through interconnected systems like housing, education, and more, reinforcing prejudiced beliefs [7]. On the other hand, institutional racism refers to discriminatory policies and practices within organisations or governments that treat people differently based on their race [7]. While some of these policies mention race, like historic segregation laws, many are less explicit, such as employers using neutral criteria that still affect racial groups [1]. There is extensive evidence indicating that structural and institutional racism play a crucial role in health inequities and outcomes [8–10]. Groos et al. [11] conducted a systematic review associating the health impacts of structural racism and the entire lifespan, "from womb to tomb", and discovered specific health effects on the physical and mental well-being of the study population, e.g., high blood pressure, stress, anxiety, and poor psychological well-being.

The concern over racism's presence within institutions, particularly educational ones, has been recognised on a global scale [12]. Nuances in European contexts, however, shed light on the unique challenges. Europe's history of migration and colonialism has nurtured a rich cultural diversity, shaping unique facets of racism within educational systems [13–15]. This article explores racism's dynamics in European educational institutions and its impact on student well-being. Well-being encompasses an individual's contentment across physical, emotional, social, and mental aspects, which can significantly influence academic performance and dropout rates [16]. This highlights the need for a heightened focus on student well-being in higher education, especially within the European context.

Racial Discrimination in Educational Institutions in Europe—Netherlands Case Study

In Europe, race can be construed as a flexible notion that categorises people based on a range of attributes, including religion, accent culture, ancestry, ethnicity, ascribed foreignness, or visual features like skin colour [17]. This categorisation might use terms like race, culture, background, or ethnicity. While there are differences among various European countries regarding their manifestations of racism, the core of the racial division often revolves around postcolonial immigration and the status of foreign individuals [18]. Racism materialises through a range of avenues, including beliefs, stereotypes, prejudices, and discriminatory actions. However, despite the inherent richness in cultural diversity, the (un)intended traumas linked to migration and past colonial legacies manifest in the different forms of racism that we observe within our educational institutions. This includes a broad spectrum of explicit threats and insults to subtler intricacies embedded within social systems and structures [19].

The Netherlands is historically known for its tolerance and acceptance, but currently, there is a growing sense of increased racism in its educational systems, the impact of which is considered significant and complex [20]. Although overt forms of racism are less prevalent, the subtle forms of prejudice such as "categorisation" and "othering" persist and influence students' experiences [21]. The phenomena of categorisation and othering stem from perceptions of being either inferior or superior to others, and are rooted in perceived biological and cultural distinctions [13,20]. The Dutch government's description of "allochtoon" for example, refers to foreign-born residents and their locally born children, even if one parent is Dutch [22] However, in practice, it is also used to refer to "non-white" members of society. Conversely, "autochtoon" implies indigenous, native Dutch identity, underscoring a higher societal value [20]. Ultimately, these terms, i.e.,

autochtoon versus allochtoon, are used to distinguish the "Dutch insider" from "minority outsider" in everyday conversation. For example, it is common to witness situations where third-generation descendants born to African parents, living in Amsterdam, speaking Dutch fluently, and assimilated in the Dutch culture are still viewed as "allochthoon" and considered not entirely "from here" [22]. This understanding of "Dutch" as "white" often carries advantages and inclusion for some across Dutch society, including in educational institutions [23]. This leads to the othering and categorisation of people into an "insider" or "ethnic majority" and a "minority outsider" or "ethnic minority". Therefore, we define ethnic minority students (EMSs) in this paper as socially constructed categories of learners with different racial/ethnic backgrounds from the majority, within a particular society at a particular time, and who are perceived as inferior and have a predisposition to experience the consequences of racial discrimination. [13,24,25].

Although overt acts of racism, such as explicit slurs and exclusion, are dangerous, they are becoming less frequent, and subtler, covert manifestations persist and are known to contribute to poor academic outcomes, increased student attrition rates, and unequal opportunities for professional development or promotion [26]. The generally perceived idea of tolerance and diversity in the Netherlands may hide these issues, making them harder to see. Covert racism in Dutch educational institutions takes on forms like microaggressions, where seemingly innocuous comments perpetuate bias and stereotypes [27]. This can be coined as a modern form of racism, where racism is subtle, hidden, presumed to be unintentional, and may be the product of implicit, unconscious bias [21,27].

In Dutch higher education, the participation rates in university studies vary across different ethnic groups. Available data reveal that while 20% of white Dutch students enrol in higher education, only 10% of Dutch-Surinamese/Antillean and 5–7% of Dutch-Turkish/Moroccan students do the same [28–30]. Woolf [31] emphasises the ongoing challenges faced by EMSs, specifically in academic medicine. The proportion of ethnic minority medical students, doctors, and faculty members in academic medicine continues to be disproportionately low when compared to the ethnic diversity of the general population of patients in the Netherlands [32]. Furthermore, ethnic minority medical students encounter implicit biases from both residents and patients during their studies, which very often difficult to identify or challenge, and allow perpetrators to claim reasonable deniability of any form of racist act [33]. Interestingly, it has been suggested that covert racism may affect mental well-being, dissatisfaction, and self-esteem much more than conventional overt forms of racism due to the everyday experiences that define it [34]. These factors significantly contribute to a higher likelihood of EMSs deciding to discontinue their university education, as highlighted by Stegers-Jager and Themmen [35].

Creating an inclusive educational environment for minority students is essential for their academic success and well-being. Research has shown that when minority students are included in educational settings, they experience a number of benefits, including improved academic achievement, better health outcomes, and greater social–emotional well-being [36,37]. This study draws from the sociology symbolic interactionist tradition which asserts that one's development is significantly influenced by the individuals and environments with which they interact [38–40], and is grounded in research, continuous observation, and learning from others' behaviours and responses, which aid in constructing self-identity and guiding conduct [38,39]. For students, this means that frequent interactions with students from different social locations and cultural backgrounds can have a significant impact on their identities. By learning about different perspectives and experiences, students can develop a more nuanced understanding of themselves and the world around them. This can have a number of positive benefits for students. For example, students who are exposed to diversity are more likely to be open-minded and tolerant of others. They are also more likely to develop critical thinking skills and empathy, and to be able to see the world from different perspectives, which prepares them for a multicultural society. This aligns with research, which emphasises equity and multiculturalism in education as fundamental principles for a harmonious and progressive society [41,42].

Given the advantages of an inclusive and safe environment for both ethnic minorities and society, it is crucial to acknowledge that both explicit and subtle forms of racism affect ethnic minority students. Understanding these distinctions is vital for fostering an equitable educational landscape. However, the current body of research on race and ethnicity is primarily quantitative and does not adequately capture the lived experiences of minority students dealing with racial discrimination. This is especially true within universities, where there is a significant gap in understanding the interplay between racial discrimination, its various manifestations, and its impact on student well-being. Hence, conducting qualitative research in this area would be highly beneficial, as it would provide a more comprehensive understanding of students' experiences with racial discrimination.

2. Materials and Methods

2.1. Aims

This study's overall aim was to investigate the experiences of ethnic minority students with racism in Dutch higher medical education and the implications for their mental well-being. Our qualitative study focused on the students' lived experiences, guided by the research question:

> *"What are the experiences of ethnic minority medical students with racism, and how do they correlate these experiences with their mental well-being and academic success?"*

We anticipate that this endeavour will raise awareness regarding the nuanced nature of racial discrimination and its profound consequences on the well-being of EMSs.

2.2. Setting

Conducted in 2021 at a university in the southern Netherlands, this is a primary qualitative methodological study that delved into the contextual accounts of racial discrimination among medical students. Notably, the university hosts a substantial number of international students, although this might not necessarily signify a reflection of an ethnic minority or majority demographics. Data collection took place from May to August 2021, coinciding with the COVID-19 pandemic restrictions, necessitating the utilisation of online interview platforms. These interviews were skilfully administered by two adept female researchers (first and second authors), one of whom had already completed her master's degree in health sciences while the other was currently pursuing hers at the same institution, equipping them with substantial research experience. Significantly, both interviewers self-identified as ethnic minorities and international, fostering a shared understanding of the experiences. Employing a constructivist paradigm, this study facilitated a collaborative construction of experiences between the participants and researchers [34]. The goal of selecting this approach is to support students in understanding and making sense of their experiences with racial discrimination.

2.3. Research Design

This study utilised a primary qualitative research approach, and this allowed for a phenomenological overview that centralised the voices of the participants [43]. Employing this qualitative approach allowed for the generation of contextual and personal experiences with medical students, as the students progressed through medical school. This method was selected as it allowed students to articulate their experiences liberally. The study design facilitated a collaborative construction of experiences between the participants and researchers [44]. The goal of selecting this approach was to listen to students and articulate their experiences with racial discrimination.

2.4. Participants

The researchers extended an invitation to all medical students to participate in the study, employing the university's intranet and newsletters as platforms for outreach. Comprehensive information regarding the study's objectives, structure, and participation requirements was disseminated across these platforms. A total of 11 interested participants,

encompassing diverse ethnic backgrounds including both minority and majority groups, initiated contact with the researchers through email. These students hailed from the initial three years of bachelor's-level education or pre-clinical years, as well as the final three years of master's-level or clinical education. Notably, students on a gap year yet still enrolled in the medical faculty were also part of the participant group, mirroring the structure of the medical faculty. Eligibility criteria solely rested on active enrolment in the faculty of health sciences, a criterion that all participants fulfilled. Through email correspondence, all participants were engaged, and an information sheet and informed written consent was obtained. Given the number of students involved and all 11 interviews conducted, data saturation was achieved [35].

2.5. Data Collection

Participants' consent was confirmed before commencing interviews. Neither the researchers nor the participants had prior knowledge of each other. A total of 11 virtual semi-structured interviews and one focus group discussion, lasting 40 and 80 min, respectively, were facilitated through the secure Zoom software provided by the university. The interviews and focus group discussion were sufficient for the data saturation [45]. The interview guide emerged from the broader research question and aims. The focus group discussion guide and sessions enabled additional in-depth explorations after the individual interviews, to identify shared perspectives and differing viewpoints. The questions in both guides aimed to comprehend students' discrimination experiences and coping strategies, spanning from their attempts to secure admission to the medical school to their current stage in school. Interviews began with open-ended questions, allowing researchers to delve into participants' experiences using in-depth and follow-up questions for clarity and introspection. Post interviews, researchers exchanged notes and memos detailing preliminary observations.

2.6. Data Analysis

Braun and Clarke's [46] six-stage thematic content analysis was employed as it best fits, understanding student experiences. Audio-recorded interviews were transcribed verbatim. The recordings were split between the two researchers for transcription, and similar preliminary codes were observed. The first author coded all transcripts further using ATLAS.ti 9.1 software; open coding techniques were used, and multiple codes were formed and further categorised into themes, which were based on their experiences at different stages of their medical education. Subsequently, the themes under each specific stage in their journey as medical students were reviewed with the broader team to ensure consistency.

2.7. Reflexivity

The researcher's professional background and identity might exert influence on the research process. Due to this, both interviewers identified themselves as members of ethnic minorities, potentially establishing rapport with ethnic minority students through a shared sense of identity. However, given their experience as early-career researchers, with one having completed a master's degree in health sciences and the other currently pursuing one at the same institution, efforts were made to ensure impartial treatment of all students.

Furthermore, the researchers' qualifications could introduce power dynamics between the participants and the researchers. To mitigate this, the researchers adopted a humble and non-authoritative approach, emphasising that the purpose of the research was to learn about the participants' experiences and reassure them of the complete confidentiality of the information they shared.

3. Results

Eleven students partook in the study, consisting of seven females and four males, all within the 20–25 age range. Among them, two students had both Dutch parents

and seven identified as ethnic minorities or hailed from non-Dutch backgrounds such as African and Dutch Caribbean Islands. One student had immigrant parents but considered themselves a person of colour in the Netherlands, while another came from a Western European country and identified as Caucasian. Of these participants, three were from the bachelor's/preclinical years (years 1–3), and eight were from the master's/clinical years. Four pursued the International Track in Medicine, and seven were enrolled in the Dutch Track. At the time of the study, nine students were engaged on the medical course, while two had taken a yearlong hiatus to complete a master's program. The International Track is taught in English, spanning the bachelor's years, while the Dutch track is taught in Dutch and continues through both the bachelor's and masters' years. In the master's phase, all students from both tracks merge and receive clinical training within the Dutch health system. The study's outcomes are organised around four phases: (i) applications and admission, (ii) experience with the course content, (iii) experiences during the bachelor's, and (iv) master's phases. Each phase is divided into two sub-themes: discriminatory, encapsulating feelings of exclusion or discrimination, and coping strategies, encompassing the strategies of students to deal with this discrimination. This is illustrated in Table 1.

Table 1. Illustrations of participants' responses.

Themes	Illustrative Quotes
Experiences during application and admission	"For the second round, I had to come here to make the test. So, it was literally during the Easter vacation. So, I had to pay all the costs and everything to come here from Curacao to take the test. And when I made a test, I didn't get in due to all the stress probably." (B08)
Experience with the course content	"When I started it was a bit disappointing because it was just- to me, it just seems like an English version of the Dutch track and there wasn't much, there wasn't much different. We weren't really talking about cultural differences or differences between countries or high- and low-income countries" (B04)
Experiences during bachelor's program	
Discriminatory settings	"It's also a thing that I think is funny because [this] university, let's just say, they advertise themselves as the most international university or most diverse. But it's mostly still as you say German or Belgian students." (B02)
Coping strategies	"So, when I managed to find different events or meet different people that were of similar background then I felt like I can definitely relate to them, and I guess relating to someone and feeling like you belong is so important to yeah, just survive I guess". (B01)
Experiences during the master's	
Discriminatory settings	"I do hear a lot of black friends who clearly say that there was dis-crimination going on. And one of my friends who had a very bad experience, felt like they were attacking the fact that she was a woman, and she was black." (B09)
Coping strategies	"In the beginning definitely, one has to grow a tough skin and thick skin to deal with some of the comments that were said, yeah" (B03)

3.1. Experiences during Application and Admission

Regarding Experiences during application and admission, participants shared insights into their school registration experiences. Learning about the university application process stemmed from sources like websites, friends, international excursions, and university fairs. University fairs, open days, and promotions predominantly took place in Europe. While European students attended these fairs, EMS participants highlighted their lack of access to such services, making registration and application more challenging. Additionally, EMSs expressed stress due to travelling worldwide for exams (Table 1), a task Dutch-born students did not encounter. They believed this disparity might have negatively impacted their exam

performance compared to their ethnic majority peers. Also, despite the popularity of the international track, participants revealed inadequate advertising, leading EMSs to perceive higher chances of entering the Dutch track due to its larger capacity. This potential perception was seen as possibly discouraging non-Dutch applicants. For example:

> *"This educational system is in Dutch. So, I was like, yeah, I might as well just do Dutch. And I also had a higher chance to get into the Dutch track. You know [it has] 300 spots and then the international track has like 55 spots."* (B08).

One student explained how legitimising foreign medical certificates and grades was complicated, particularly for international students from non-European, English-speaking countries. They felt prejudiced due to differing application processes that created categories perceived as unjust and unfair hierarchies in qualification. The students believed their qualifications were regarded as less valuable than European degrees. A student explained:

> *"I think it was, it was a lot more challenging than I've heard from any other person that applied to [this] University so far because the thing is, I feel like OK, there's no other African that at applied to [the program] So, like [European students] mostly have the IB diplomas, or they had like European Baccalaureate and stuff like that. So, for them the process was like a lot easier to get in because their diplomas are like worldwide recognized."* (B03).

In summary, EMS participants felt that limited access to information and support necessitated harder efforts for acceptance. This perception made EMS participants consider the application process and spot availability as advantageous to Dutch-born students, overlooking the unique challenges faced by EMS individuals during application.

3.2. Experiences with the Course Content

Students shared thoughts on course content in their bachelor's and master's programs. They appreciated practical delivery methods, small-group learning, and early patient engagement. However, students expressed concerns regarding the diversity and representation of course content. They observed that the materials lacked an international perspective in terms of health systems and diseases, leaving them ill-equipped for practice, both locally and globally. This sentiment was particularly pronounced among ethnic minority master's students who described the curriculum's tendency to "whitewash" medicine, rendering them unprepared for diverse healthcare contexts. Furthermore, students addressed attempts to incorporate diversity into the curriculum. While they recognised the importance of discussing such topics, they noted that these efforts often felt awkward and uncomfortable. The portrayal of diverse cultures and backgrounds in this manner was perceived as negative and contributory to a narrative of the "deviant other." This raised concerns about the university's approach to inclusivity and highlighted the need for more sensitive and effective strategies in fostering an understanding and appreciation of diversity.

3.3. Experiences during the Bachelor's Program

Delving deeply into the stages, during this interview portion, participants discussed their distinct encounters in the first three years of medical school: the bachelor's years. They explored instances of discrimination faced by EMSs and shared their coping mechanisms.

3.3.1. Discriminatory Setting during the Bachelor's Program

All EMS participants uniformly referred to the experience of "culture shock". This feeling was associated with the European lifestyle and exclusion by their majority peers being markedly different, leading to their perception of "culture shock". This notion impacted both their social integration and academic performance. One student aptly described this sentiment:

> *"When I came to University, and during the introduction week, everyone was forming their small cliques and small niches, and I was going to study a Dutch program, so I was*

> *trying to surround myself with Dutch. Um, and quickly enough, I realized that didn't work properly because I didn't feel understood. My humor was not gotten, it just felt- I felt very alienated, and that pushed me to just try to do things to compensate for a lot of things, to get liked and stuff like that. So, year one for me was, the worst year I've had academically, so I stopped that"* (B03).

This stood in contrast to Dutch-born and Caucasian participants who reported enjoying their experience of starting school and felt well-integrated into the program:

> *"I think my first year was fine, I had a really nice experience, met a lot of nice people made some good friends that I am still friends with now. So, I think overall, I managed to adapt quite well to the switch from high school to university"* (B10).

Moreover, students voiced their dissatisfaction with the evolving course structure. They initially enrolled based on the promise of an inclusive, English-taught international environment that embraced diversity. However, as their studies progressed, they found that the internationalisation efforts seemed more tailored to Europe, failing to truly encompass a global demographic. EMS participants particularly felt that the university's portrayal of being "international" was misleading, leaving them feeling overlooked and unseen within a predominantly European student body (Table 1). Furthermore, students recounted their challenges in forming friendships, largely due to feeling excluded by their Dutch-born peers. EMS participants perceived this exclusion as rooted in stereotypes like "laziness", prompting them to work even harder to demonstrate their competence and be considered equals by their classmates. One participant shared their early experience:

> *"In my first year, I didn't have any friends. Like, literally everyone made their own group, and everyone excluded me, especially when we have like those project groups. No one wanted to work with me. I don't know why. I think maybe because they didn't know me, probably because of my skin or because I'm different."* (B08).

When EMS participants did interact with their peers, they described feeling patronised due to preconceived notions about their countries of origin. These questions, often based on stereotypes like "not having Wi-Fi or good roads" or engaging in "criminal activities", were perceived as microaggressions. While participants attributed these queries to "ignorance", they noted that these encounters heightened their sense of exclusion and isolation, hindering their ability to form meaningful connections:

> *"So, you just put people in certain boxes based on their ethnicity or the place they're coming from? Yeah, I mean, in the Netherlands, there is this stereotype towards people from the Antilles or Curacao and other islands, that they're genuinely lazier and they have low-income jobs, and they do just criminal activities."* (B06).

3.3.2. Coping Strategies

Only ethnic minority students reported looking for coping strategies and within the institution; students highlighted avenues of supportive systems that enhance their well-being and counteract feelings of exclusion. Orientation week featured a "Buddy" program, pairing new students with current ones to build connections. Moreover, students created associations, particularly those centred on African and Caribbean backgrounds, as they facilitated the establishment of friendships. Forming connections with fellow EMSs experiencing similar feelings of exclusion emerged as a vital coping strategy. Diverse hobbies and interests also contributed to their well-being. Cultural events organised by and for EMSs became pivotal community-building opportunities, allowing connections with others who shared comparable backgrounds. These occasions promoted discussions and relationships, ultimately fostering a sense of belonging.

3.4. Experiences during the Master's Program

The clinical years mark the integration of all medical students into a unified stream, where they collaborate closely with the broader medical team comprising doctors and

patients. During this phase, participants encountered distinct challenges. Dutch-born and Caucasian students faced issues with the intensity of this phase, and EMSs faced similar challenges. This was compounded for the latter group by navigating discriminatory settings and cultivating coping mechanisms. Notably, EMS participants identified this period as being particularly fraught with racism and discriminatory experiences.

3.4.1. Discriminatory Settings during the Master's Program

Students from the international track were disappointed, as they were promised the master's track would be available in English but later discovered that they were required to learn the language with minimal support from the university. This unexpected situation put this group of students in a disadvantaged position. Language was a huge issue among EMSs. Several EMSs reported that the Dutch language, commonly spoken during the clinical rotations and which they learned with varying levels of difficulty, formed a basis for discriminatory experiences. Some EMSs felt prejudiced against the way superiors dealt with their (expected) language skills. Some of them experienced being considered unprofessional or unintelligent during interactions with doctors and patients, and suggested the language standards they were held to did not consider the added difficulty of translating from their native tongue to Dutch. One student shared:

> *"And then the doctor just kind of gestured to [medical student], and he was like 'It's fine, she doesn't know anything, so she won't understand you anyway.' Which is, it's just a horrible thing to say because, like I know how smart she is, and for a doctor to just be like 'oh no, she doesn't know anything just because Dutch is not her native language"* (B07).

Additionally, it was reported that some doctors made derogatory statements and laughed at racial jokes in this learning environment. EMSs felt that being in a competitive clinical environment, on top of the environment being mainly white and Dutch, made them "easy targets" of bullying and racism because of the obvious differences in their ethnicity. One shared:

> *"I never really felt like the other Dutch kids when starting my masters. It was like a whole different world and like very little things that-, the way they work and their etiquette and the things they talk about, I really felt like wow, I don't really fit in with them. Also, like when talking to the doctors about like my heritage, I'll get very, you know, borderline racist comments about [Country of origin]"* (B12).

These experiences of discrimination faced by EMSs were also noticed and validated by Dutch majority students (Table 1). These experiences led EMSs to feel singled out and isolated, which affected their mental well-being and self-esteem, and some dropped out of the program. A student explained:

> *"Mentally I was not in a good place. I had to do something else, and I think unfortunately, if it had been in another country or maybe in English, I would have kept going, but here I just couldn't. So, I had to change the course"* (B07).

In contrast, Dutch and European students mainly reported negative experiences with the logistics and structure of the program, but liked the program overall. A Dutch (white/non-ethnic) student explained:

> *"I'm really enjoying it so far. Yeah, I haven't had any difficulties with it so far"* (B10).

3.4.2. Coping Strategies

EMSs described certain (coping) behaviours that helped them to go through the master's years as "managing their expectation". Some mentioned growing a "tough skin" and trying to be "less sensitive" to mitigate the blunt and derogatory racist statements made by their peers and superiors. Several excused discriminatory behaviours due to ignorance and believed some of the doctors acted unintentionally or were peer pressured, and believed that it was their responsibility to deal with the racial encounters. EMSs reported cases of racial discrimination to their supervisors, and sometimes received positive results. Overall,

students mentioned that sharing experiences with friends and reporting uncomfortable situations to supervisors made it easier to manage their experiences during the master's years and improved their mental well-being. One mentioned:

> *"I just went to my supervisor and talked to him about it, and he was like, yeah, it's very good that you talked about it, and he talked to the person about it. At the end of the day, and you know, that made me kind of feel good afterwards, like, okay, he heard me, and he also did something"* (B08).

EMSs appreciated the presence of a mentor, who was present to listen to individual students' issues and guide them. A student mentioned how their mentor was a pillar of support after the loss of a family member. A student shared:

> *"I had a mentor, and that mentor was really good. She kind of helped me to break the barrier. Just talk to people, even though if they are not, well, they're not welcoming to talk to. She, she helped me with that. So, my mentor helped me a lot."* (B03).

4. Discussion

The outcomes of this study contribute to the growing body of evidence that underlines the profound impact of racial discrimination on both well-being and academic performance [13,28,47–49]. However, this research enriches the existing literature by delving into the lived experiences of minority students, offering qualitative insights into the contexts and instances in which racial discrimination commonly occurs. Notably, ethnic minority students revealed that they faced racial discrimination more frequently than their white European counterparts, who predictably did not report any finding of discrimination of any kind. This led to social exclusion and compromised overall well-being for EMSs, specifically. Importantly, our study also uncovered coping strategies adopted by EMSs, which has important implications for future research and institutional response.

An earlier premise in this paper theorised that racism manifests in overt and covert manners [27]. Our investigation confirms that despite the Netherlands' reputation for tolerance, racial discrimination persists in both these forms. From the narratives of EMS participants, it is evident that racism indeed exists in both contexts, emphasising the responsibility of institutions to actively address these issues.

Exploring medical education, overt discrimination among EMSs is a persistent issue, particularly within medical schools and healthcare institutions [50]. The study highlighted instances of language-based discrimination, racial stereotyping, and intimidation experienced by EMSs during clinical rotations. The clinical phase emerged as a particularly challenging period, rife with racial discrimination. Notably, language struggles led to EMSs being unfairly labelled as less intelligent compared to their peers, significantly impacting their well-being, self-confidence, and, eventually, academic performance, aligning with established literature on racial discrimination and well-being [16]. Similarly, a Dutch medical school study found that language and cultural barriers hindered interaction between ethnic minority and majority students, increasing their feelings of exclusion [51].

Our findings also shed light on the phenomenon of EMSs being perceived as exotic, and being "othered" as problematic by peers, and derogatory representations of their culture or ethnic minority groups in course material. The curriculum predominantly centred on Caucasian patients, with any mention of ethnic minority cases often framing them as deviant or problematic, consistent with Zanting's [52] research. This skewed representation hampers integration between EMSs and Dutch-born students, reinforcing stereotypes and perpetuating discrimination [53]. In line with Carter's [54] observations, students facing discomfort due to othering, as evident in our study, encountered significant academic consequences. Notably, one participant even transferred from the medical program due to academic decline stemming from experiences of overt discrimination.

Covert racism emerged as the most prevalent form of racial discrimination, spanning all levels of students' medical education. This finding resonates with the existing literature on the shifting landscape of racial discrimination [17]. Instances during registration exem-

plified this covert racism, where the university emphasised advertising within Europe and subjected only non-European applicants to meticulous scrutiny, despite equal qualifications. Interestingly, students did not mention the substantial discrepancy in school fees between international and European peers, which itself could be viewed as a form of price and racial discrimination [55].

Furthermore, in the bachelor's and master's years, EMS participants reported feeling involuntarily designated as spokespersons for their countries or cultures, a phenomenon known as overgeneralisation. This practice strips individuals of their uniqueness and can erode self-confidence [56]. Such incidents resembled microaggressions, which offended EMSs while allowing Dutch students and faculty to claim ignorance. Their responses suggest that the experiences of microaggressions and microinsults put ethnic minority students in a psychological bind of uncertainty, making them unable to ascertain how to react. We can understand these responses as a way for students to "normalise" their experiences. Our findings echo those of Isik [57], where minority medical students often felt it was essential to minimise their discriminating experiences and give them a positive twist to cope. Students in our study associated these coping mechanisms with a negative impact on their mental well-being, such as feeling isolated, especially when they did not receive support, a lack of belonging, and feeling the need to prove themselves.

Additionally, the disregard for their language struggles and social integration by the university could also be construed as covert discrimination, as their fundamental needs were overlooked. Instances of their diversity needs being overlooked support the argument that, in addition to overt discrimination, routine procedures and interactions also contain covert (i.e., hidden,) and often "unintentional" forms of racism. Unfortunately, these covert forms of discrimination are challenging to address, given their concealed nature and ambiguous intentions, leading to manifestations of racial bias that may not be evident to those perpetrating them [58]. Nevertheless, both covert and overt forms of discrimination had similar detrimental effects on EMS participants' mental well-being and hindered their progress in completing their medical programs.

Students actively responded to instances of discrimination, highlighting tokenism and spotlighting, often by reporting or confronting the wrongdoers. Paradoxically, ethnic minority students sometimes faced self-accusations of hypersensitivity to racism when addressing broader, persistent, and concealed institutional and cultural issues. Our findings indicate that EMS participants tended to reinterpret specific experiences, attributing them to intentions other than racism, such as labelling them as "culture shock", assuming ignorance, or even blaming themselves. Their reactions were evident in responses to microaggressions, where excuses were made for the perpetrators, and strategies like developing a "tough skin" or modifying behaviour to gain acceptance were adopted.

Collectively, our participants outlined strategies for navigating racial situations and enhancing mental well-being, mirroring the principles outlined by Faircloth and Hamm [59]: (1) developing a network of positive friends through which the student feels recognised; (2) positive interactions with teachers or other adults through which the student feels appreciated, supported, and assured of help in difficult times; and (3) participation in extracurricular, cultural, or sports activities, access to mentoring and advising, and lack of societal barriers. All the students mentioned that having close friends, good tutors, and mentors, including participating in extracurriculars, was essential to integration and contributed to a healthy sense of mental well-being. In addition, the EMSs felt that it was easier to make friends with other international students, as there was a common bond in transitioning and shared discriminatory racial experiences, which was also found in similar medical student studies [60].

Strengths and Limitations

This study adds to our understanding of the impact of discrimination in higher education settings. We take a student-centred approach, focusing on their experiences, which offers insights for practical recommendations. The study's strengths lie in its diverse

range of student perspectives, although the sample size of 11 interviews, though sufficient for saturation, may not represent the entire student body. In terms of methodology, we employed inductive research methods to explore students' perspectives, an area that has received limited attention thus far. While this approach enhances our investigation, it prompts consideration of a more deductive exploration of student perceptions of racism, aligning with established frameworks. It is worth noting that the students we interviewed may not entirely reflect the broader student population, potentially influenced by their interest in the topic or ethnic minority backgrounds, demonstrating the "ally" phenomenon against racism and discrimination. Due to the open-ended nature of our questions, instances of racism are not always explicit in students' responses. This arises from our aim to capture a comprehensive picture of their experiences throughout their medical education. Future research could delve more specifically into the impact of racism on their well-being, particularly in terms of their psychological and emotional state. Using a qualitative research design and adhering to Consolidated Criteria for Reporting Qualitative Research (COREQ) guidelines, our study draws comprehensive conclusions from in-depth conversations with participants [61]. However, this qualitative approach cannot provide quantitative insights. This limitation restricts our ability to establish causal relationships between different forms of discrimination and their effects on well-being. Furthermore, our qualitative design does not quantify the significance of various factors. As a potential avenue for further inquiry, integrating mixed methods or quantitative designs could offer a more nuanced understanding of the complex relationships between different types of racism and their impact on mental well-being.

5. Conclusions

The prospects of our society's future hinge on conducting a thorough assessment of the pervasive influence of discrimination in the lives of all students. Addressing students' encounters with discrimination necessitates enacting structural and institutional changes that foster inclusivity and diversity, ultimately leading to enhanced well-being and improved academic performance. Policies must be formulated with a student-centric approach, delving beneath the surface to confront both overt and covert instances of racism. The overt and covert manifestations of discrimination that emerged from student interviews during this study provide valuable insights into the distressing experiences within the realm of medical education. To transform these experiences into positive ones, structural and institutional shifts are essential to nurture inclusivity, diversity, and a sense of belonging among students, thereby improving their mental well-being [62].

First and foremost, institutions should foster an environment empowering ethnic minority students to report negative experiences, knowing that the university will promptly address such incidents and reform any systems or individuals perpetuating discrimination [63]. This approach promotes intergroup communication and equips students from diverse backgrounds with tools to confront discrimination [64]. Secondly, strengthening support systems is vital, including accessible mental health professionals with an awareness of racial dynamics. Thirdly, fostering group cohesion and providing mentoring opportunities among ethnic peers can contribute to improved mental well-being [65]. Notably, assertiveness training has been shown to elevate self-esteem among medical students [66]. The early implementation of language- and culture-sensitive assertiveness courses can enhance interactions among medical students, doctors, and patients [67]. Lastly, curricula should reflect the diversity of the student body, ensuring course content, lectures, and tutorials are inclusive [35]. However, as cautioned by Garibay [68], focusing solely on one perspective risks tokenism.

The study's findings vividly underscore the prevalence of overt and covert racism, manifesting in discriminatory experiences faced by EMSs in predominantly white environments. Proactive measures and inclusive practices in educational and medical settings hold the potential to mitigate instances of racism, amplify diversity and inclusivity, and enrich the educational journey of marginalised students. While these insights are not ground-

breaking within the anti-discrimination discourse, this paper advocates for a shift beyond a mere awareness of best practices, urging the proactive identification and rectification of both overt and covert instances of discrimination within institutions. Acknowledging the existence of discrimination, and adopting policies, staffing, and education to prevent its perpetuation, represent the way forward. With the generational persistence of lower educational and occupational attainment among Dutch minorities, policies that enable immigrant integration, combat educational discrimination, and counteract racial tensions are crucial [20]. Dutch tolerance must evolve beyond passive acceptance to active rejection of racism, and embrace cultural diversity, embodying a societal commitment. Thus, the next phase necessitates extensive research in this field and the implementation of targeted strategies to eliminate discrimination, addressing both overt and covert forms at institutional and structural levels.

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