Anti-Racism and Race Literacy: A Primer and Toolkit for Medical Educators

A living and iterative resource by
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with support from UCSF Differences Matter Working Group 3

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Differences Matter at UCSF

A School of Medicine initiative designed to create the most
diverse, equitable, and inclusive academic medical system in the country

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Introduction

As medical educators and clinicians, we are often called upon to discuss race and racism, and to address health disparities while teaching and delivering care. UCSF students and trainees engage academically, personally, and professionally with concepts such as racism and power in their coursework and training. They learn that while race is a social construct with roots in the justification of slavery, racism affects one's lived experience in ways that have tangible consequences. Stereotyping, bias, lack of representation, and racism perpetuate false beliefs, lead to misdiagnosis, dangerously narrow clinical decision making, and perpetuate implicit bias, all of which lead to real health disparities. These forces also affect the integrity and safety of the learning climate and thus may impact the success of our learners. Therefore, as educators and clinicians, for our students and for our patients, we have a moral imperative to confront and dismantle racism.

Despite the introduction of these topics into the pre-clinical curriculum, interviews[1] with UCSF pre-clinical educators show that many feel unprepared or uncomfortable addressing the topics of race and racism in educational materials or the learning environment. As a result, they may provide inconsistent messaging to learners and inadvertently reinforce biases and inequitable structures that impact patient care the learning environment, disrupting equity necessary for all students to thrive. Every year that our educational approach fails to intentionally dismantle racism and bias (or worse, perpetuates it), we undermine our students' success and their future patients' health. Every year that we graduate students into the physician workforce who lack an understanding of the complex mechanisms, contexts, and manifestations of racism, we perpetuate health disparities and cause harm. As educators, we have a responsibility to our learners and community to deepen our understanding of the complex mechanisms and manifestations of racism, and to intentionally dismantle racism in the learning environment and in clinical medicine.

In this primer and toolkit, we seek to provide new and existing faculty with a shared understanding of introductory concepts and tools with which to engage learners and colleagues in discussion on the topics of health disparities, social justice, bias, and racism. While this document focuses on race, we recognize that the depiction and treatment of other identities—including, but not limited to, gender, age, sexuality, ability, education, and economic status—also require thoughtfulness and skill. In fact, because identities intersect, we often need to engage with multiple identity elements simultaneously. However, we choose to center understandings of race and racism because racial inequities are deeply rooted, pervasive, and traverse all indicators of success when other aspects of identity are controlled. Focus and specificity are necessary to drive change.[2]

Despite the discomfort and difficulty that may arise when talking about racism and race, **examining our personal and collective experience and roles in maintaining racism is essential to the pursuit of equity, a core value here at UCSF.** The work of dismantling racism in healthcare and medical education in order to build a just,

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welcoming, and inclusive environment is a collective and life-long process that requires practice, commitment, and humility. While we cannot expect faculty to achieve "competence" in this work because the growth required is continuous and dynamic, the UCSF School of Medicine expects faculty to commit to the self-reflection, self-study, humble inquiry, learning, resilience, and *action* necessary to create a welcoming and inclusive environment for all learners, especially for those who have historically been excluded from medicine's educational and professional spaces. We acknowledge that neither one's race nor individual experience of racism confers comfort discussing race and racism, especially in the complicated context (historical and current) of medical training and practice.

Who is this Primer and Toolkit for?

- Pre-clinical medical educators, especially those leading small groups and developing teaching or testing materials
- Curriculum content creators
- Invited speakers
- Any medical educator, in any setting, working with any level of medical learner (UME, GME, and CME) who wants a deeper understanding of race and racism

Objectives:

- Cultivate a basic, shared understanding of the historical context, theoretical frameworks, and commonly accepted definitions for talking about race and racism in medicine.
- Provide a structured approach for medical educators to evaluate and revise their own educational materials to help educators identify and eliminate embedded racism, promote accurate and holistic representations of patients and providers, and examine the structural causes of health disparities.
- Support faculty in developing their own reflective practice around how they incorporate discussions of race and racism in their teaching and educational materials.

How to use this Primer and Toolkit:

This document is divided into 4 sections, or steps. Steps 1-3 constitute a primer that provides an important foundation for understanding the components and history of racism in medicine. Step 4 is a toolkit for analyzing and developing anti-racist medical curriculum.

- Step 1: Prepare to talk about racism and race
- Step 2: Definitions and Frameworks
- Step 3: Historical origins of racism in healthcare and medicine
- Step 4: Implement anti-racism in medical education

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Each section can stand alone. While we strongly recommend working through the Primer and Toolkit sequentially, we recognize that educators looking for immediate support with curricular material revision may need to jump to the Toolkit (Step 4) when pressed for time.

This Primer and Toolkit are not exhaustive, but rather an entry point. Look for selected questions and resources at the end of each section that you can use to deepen your learning and growth. Additional resources and references for all cited works are at the end of the document.

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Questions for self-reflection:

- *How do you know whether your curriculum or/and teaching materials perpetuate or disrupt racism?*
- *What steps do you currently take to ensure an inclusive and equitable curriculum?*
- *Do you feel comfortable talking about race with learners and trainees? Why or why not?*
- *How would you respond in the moment, and what steps would you take to address your teaching materials if you received feedback that they were biased?*

Suggested reading:

- Brooks, Katherine C. 2015. "A Piece of My Mind. A Silent Curriculum." *JAMA: The Journal of the American Medical Association* 313 (19): 1909–10.
- Boyd, Rhea. 2018. "The Case for Desegregation." *The Lancet.* 22;393(10190):2484-2485.
- Murray-García, Jann L., et al. "Dialogue as Skill: Training a Health Professions Workforce that Can Talk About Race and Racism". *American Journal of Orthopsychiatry.* 2014;84(5): 590-596. http://dx.doi.org/10.1037/ort0000026
- Paul, Dereck W., Jr. 2019. "Medical Training in the Maelstrom: The Call to Physician Advocacy and Activism in Turbulent Times." *Academic Medicine: Journal of the Association of American Medical Colleges* 94 (8): 1071–73.
- Tsai, J. "Diversity and Inclusion in Medical Schools: The Reality". *Scientific American*. July 12, 2018.

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Step 1: Prepare to talk about racism and race

Talking about racism can be difficult. Everyone has a different expertise and experience with race, racism, and conversations about these topics. Consider the following as you begin or deepen your practice of identifying and addressing racism in medicine.

Expect some discomfort during productive dialogue. Racism can be an emotionally loaded topic because of our different experiential backgrounds and contexts. People who are used to certain racial norms (typically white people and people with race privilege) may be triggered by disruptions to that equilibrium that make them feel threatened or uncomfortable.[3] When someone identifies another's actions or words as racist, it may feel like an insult or a condemnation of that person's character and ignite defensiveness. A common impulse is to focus on defending one's intention—on reinforcing one's "goodness"—rather than focusing on the impact of the words or deed. This is an understandable response for people who have learned (and believe) that racism is morally wrong but have not also been taught the complex ways in which racism operates, including the way it can operate through them. Defending one's "goodness" forestalls productive conversation by centering the dialogue on the defense of intentions and character rather than on the way words and actions impact another person or reinforce inequitable *systems*. Inability to tolerate one's own discomfort thwarts productive dialogue. Prepare for the discomfort that arises when stretching your perspective with a new idea or another's experience and trust your ability to navigate the discomfort of the *unfamiliar*.[4]

Recognize strong emotions that surface. For example, white people, and others with race privilege, may wrestle with feelings of guilt or shame when they begin to confront the idea that their race affords them certain privileges at the expense of people of color. They may feel attacked when their hard work, struggle, and success seem undermined by the suggestion that they have benefited from unearned privilege. This is a false dichotomy. One can have worked hard to achieve success, or have faced and overcome tremendous adversity, and still have benefited from a system that elevates whiteness. If strong emotions arise in you, try to identify them, tolerate the discomfort they bring, and persist in conversations with a focus on active listening and humble inquiry. Audre Lorde[5] reminds us, "Guilt is not a response to anger; it is a response to one's own actions or lack of action". If you encounter another's defensiveness that makes a conversation unproductive or hostile, consider revisiting the conversation with a facilitator (e.g. a Differences Matter community ambassador) after a cooling-off period.

Cultivate a culture of trust, humility, accountability, and self-care when talking about racism. Sometimes discomfort arises from a place of *familiarity*. For people of color who routinely experience racism, dialogue may be greeted with trepidation due to an informed concern about psychological, professional, or physical safety. Dialogue may also be burdensome for those disproportionately asked to prove the veracity of their experience of racism, or to serve as the expert educator to others on how racism works, because society positions the white experience as normative (default). For

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people of color who experience strong emotions or the discomfort of *familiarity* from the traumas of racism, consider setting boundaries, opting out, revisiting the conversation at a later time, redirecting the conversation to an ally, and seeking support from trusted colleagues when a conversation feels too activating. White people and those with race privilege can practice humility, empathy, and personal accountability to build a culture of trust and safety and give space for colleagues to engage despite past negative experiences.

Avoid frameworks of colorblindness. Well-intended people may try to distance themselves from racism's negative connotations by adopting an attitude of "colorblindness," or of not seeing color or race. This approach ignores the actual differences in the reality of people's lived experience. Our lives are shaped by how others respond to our race and by unequal social systems that determine our access to resources and opportunities. In order to engage in meaningful conversation, we must honor divergent experiences and build authentic understanding rooted in empathy and trust of one another's stories. In other words, we must cultivate a *consciousness* about these different experiences (often called *color-consciousness*).

Be thoughtful about which voices dominate the conversation. Center historically marginalized perspectives. American society has and continues to position whiteness (*see definition in Step 2*) as the norm, or default, against which people of color are compared. This shapes the perceptual frames that we bring to conversations, and often crowds out voices or perspectives that counter dominant narratives of what is considered "normal" or true. Since there is no default human being, strive to identify and disrupt moments in yourself, others, and systems that position white people, their perspectives, and experiences as the expected norm.

Dismantling racism is everyone's work*,* including white people and those with race privilege. Sometimes white people and others with race privilege disengage from conversations about racism because they perceive that racism doesn't affect them. When someone does not have to think about their race every day, it usually means they do not often confront racism (an example of white privilege). If someone has not been personally targeted by racism, and they do not feel that they perpetuate racism (e.g. they see themselves as a good, non-racist people who treat everyone equally), they may think that it is not their responsibility to address racism, or that they do not have anything to add to the conversation, and thus disengage from necessary conversations. However, because racism is systemic, even those who do not endorse overt racism can reinforce structural inequality as they participate in inequitable social, political, and economic institutions. Thus, disengaging and doing nothing maintains inequity. Viewing anti-racism as everyone's work requires a frame shift. Since everyone plays a role in social systems, we each have a role and responsibility in dismantling the systems that perpetuate racism, especially those who are privileged by the system.

Those with race privilege can take responsibility for their own education and cultivate *racial stamina*[6]*,* or resilience for doing the difficult work of deconstructing racism. Developing racial stamina requires personal work, including active reflection on how we

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were taught to think about racism and race growing up, scrutiny of the power dynamics governing experiences across contexts, ongoing engagement and humility, and intentional *action* to practice these skills.

Questions for self-reflection:

- *How did you learn about race and racism and what were you taught?*
- *What is your relationship to your own race? In what ways has race shaped your experience in your family, communities, schools, workplace?*
- *What makes you uncomfortable discussing race and racism? What assumptions and ideas underlie your discomfort?*
- *Think back to experiences when you were aware of race and experiences when you didn't have to think about race. How were the two experiences distinct?*

Suggested reading/listening:

- DiAngelo Robin. *White Fragility: Why It's so Hard for White People to Talk About Racism*. Boston, MA: Beacon Press; 2018.
- Lorde, Audre. "The Uses of Anger". *Women's Studies Quarterly*. 1997;25(1&2)
- McWhorter, John. "The Dehumanizing Condescension of White Fragility". *The Atlantic*, July 2020.
- Menakem, Resmaa. *My Grandmother's Hands*. Central Recovery Press, 2017.
- Rankine, Claudia*. Just Us: An American Conversation.* Graywolf Press, 2020.

Suggested trainings:

- Relationship Centered Communication for Racial Equity at UCSF and ZSFG.

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Step 2: Definitions and Frameworks

To effectively create curriculum that is anti-racist or engage in discussion with learners about topics that address racism and race, it is helpful to have a shared understanding of common definitions and frameworks:

DEFINITIONS

Anti-Blackness

Anti-Blackness is a theoretical framework that describes societal devaluation and disregard for the lives and humanity of people racialized as Black.[7] The ideological roots of anti-Blackness are tied to the exploitation and dehumanization of Black people during chattel slavery. Anti-Blackness manifests as overt discrimination, violence, and structural/systemic racism against Black people, and in the de-prioritization of issues that impact them.

Anti-racism is the active process of identifying and eliminating racism by changing systems, organizational structures, policies and practices and attitudes, so that power is redistributed and shared equitably.[8] Anti-racism examines and disrupts the power imbalances between racialized and non-racialized people (white people), to shift power away from those who have been historically over-advantaged and towards people of color, especially Black people. To practice anti-racism, a person must first understand:

- How racism affects the lived experience of Black people, Indigenous people, and people of color
- How racism is systemic and manifested in both individual attitudes and behaviors as well as formal policies and practices within institutions
- How both white people and people of color can, often unknowingly, participate in racism through perpetuating inequitable systems
- That dismantling racism requires dismantling systems that perpetuate inequity, for example, predatory or discriminatory lending policies, gerrymandering, immigration policies, drug enforcement laws, etc.

Color-blindness

One mainstream approach to race in the United States is to insist that race is unimportant or unseen and does not impact a person's achievements or attainments (e.g. education, professional, financial).[9] However, because of racism, people of different races have different lived experiences and access to opportunities and resources. Espousing a colorblind ideology that race does not matter disregards the actual differences in people's lived experience that results from how others perceive and respond to different people based on perceived race in conscious, subconscious, and systemic ways. Becoming conscious of how race impacts one's experiences in the world, or becoming *color-conscious*, is an important step in addressing racism.[10]

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Implicit bias

Implicit bias refers to unconscious attitudes, associations and beliefs towards individuals and social groups that affect one's feelings, actions, understanding, and decisions, which impacts the group or person about whom the bias is held.[2] Implicit bias is one mechanism that perpetuates racism.

Race, Ethnicity, and Ancestry

The concept of **race** was constructed as a tool to categorize people with the purpose of validating racism. During historical projects such as colonialism and slavery, race was artificially imposed on people in different political positions to create a moral hierarchy used to justify the harm inflicted by inequitable systems, exploitive capitalism, and white supremacy.[8,11] Although the construct of race is dynamic and evolves with changing social, political, and historical norms,[12] it perpetuates a false idea that there are static, innate characteristics that apply to groups of people despite diverse origins, life experiences, and genetic makeups within those groups.[13] While race is socially constructed, the consequences of the social construction are experienced individually and collectively by communities in the form of racism. The effects of racism can be seen in differential outcomes in health, wealth, socioeconomic status, education, and social mobility in the United States.

Ethnicity, like race, is a social construct that has been used for categorizing people based on perceived differences in appearance and behavior. Historically, race has been tied to biology and ethnicity to culture, language, and religion, though the definitions are fluid, have shifted over time, and the two concepts are not clearly distinct from one another. The American Anthropological Society defined ethnicity as "the identification with population groups characterized by common ancestry, language and custom. Because of common origins and intermarriage, ethnic groups often share physical characteristics which also then become a part of their identification--by themselves and/or by others. However, populations with similar physical appearance may have different ethnic identities, and populations with different physical appearances may have a common ethnic identity."[14]

Race and ethnicity are often conflated with, and used as oversimplified and inaccurate proxies for, ancestry. However, race and ethnicity are distinct from ancestry. Genetic **ancestry** denotes people's shared traits based on the genetic similarities of their ancestors and better accounts for the complexity of geographic variation, fluidity, and migration patterns (e.g. from trade, migration, colonial conquest, etc.). For this reason, an individual's ancestry is often multi-layered and complicated, and most people don't know their full ancestry. Since self-reported race and ethnicity are more accessible than ancestry, race and ethnicity are often used in research to indirectly measure how outcomes differ among people of different genetic ancestries. However, racial categories lump together large, diverse groups of people with both immediate and distant ancestral lineages, aggregating populations with considerable genetic differences and obfuscating mixed ancestries. For these reasons, race is a poor proxy for genetic variants that contribute to disease risk, even though race is an important

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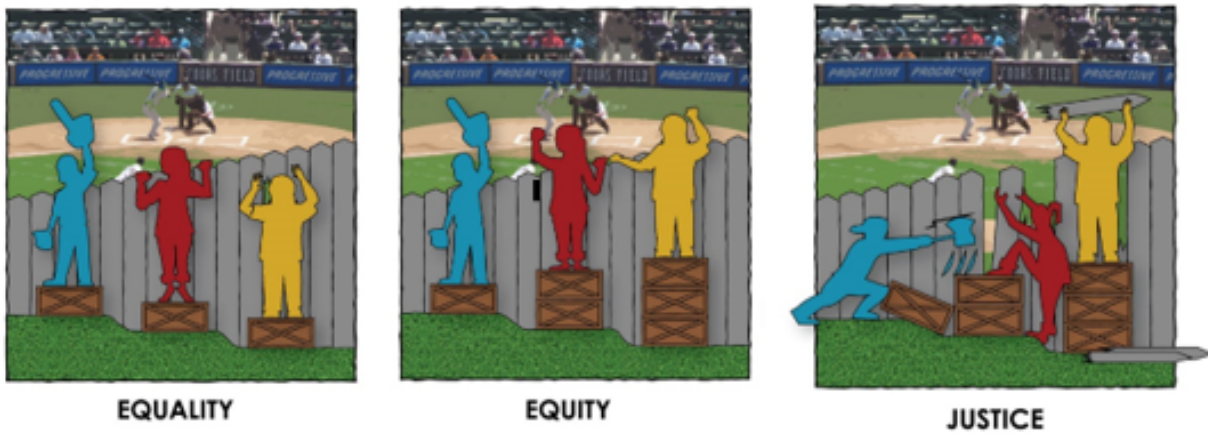
recruitment tool for research to ensure diverse representation of ancestral lineage among study participants which allows for more equitable applicability of study findings to racially diverse communities.[11,15,16] Studying how outcomes vary by race and ethnicity is a critical tool that highlights important health disparities which disproportionately impact different groups, but **unless race is contextualized as a social construction, conflating race with genetics leads to problematic conclusions that differences in disease prevalence are mostly genetic in origin rather than a resut of social forces like racism**. This conclusion further reinforces false notions that race is biological has a biological basis, when, in fact, there is no genetic basis for the social construction of race. It is important to recognize that arguments for acknowledging the racist social construction of race and the critical distinction between race and biology are not advocating to ignore race in research, to deprioritize genetics, or to encourage color-blind medicine. Instead, arguments to uncouple race as a proxy for genetics advocate for accuracy, transparency, and rigor in the way race as a variable is defined and analyzed, and the scientific conclusions based on race are applied.[17,18]

Equality vs. Equity

Equality is a state/outcome that is the same among different groups of people. Equality is sameness. **Equity** is the process by which resources are distributed according to need. Equity is fairness. Anti-racism seeks to promote equity and color consciousness, rather than equality and color blindness.[19]



Graphic description[20]: These images show three equally sized people (no innate difference) with different access to viewing the game due to structural factors, including disparate land elevation and fence height. This is akin to the way structural racism and white supremacy afford disparate opportunities and access. Offering people experiencing disparate opportunities the same intervention (one box) does not result in a fair outcome (game access).

Racism

Put simply, racism refers to the prioritization of the people who are considered white and the devaluation, exploitation, and exclusion of people racialized as non-white. While mainstream conceptions of racism often refer to outright violence toward people of color and are perceived as rooted within individuals, the concept of institutional racism expands this understanding to reflect the systemic mechanisms through which racism

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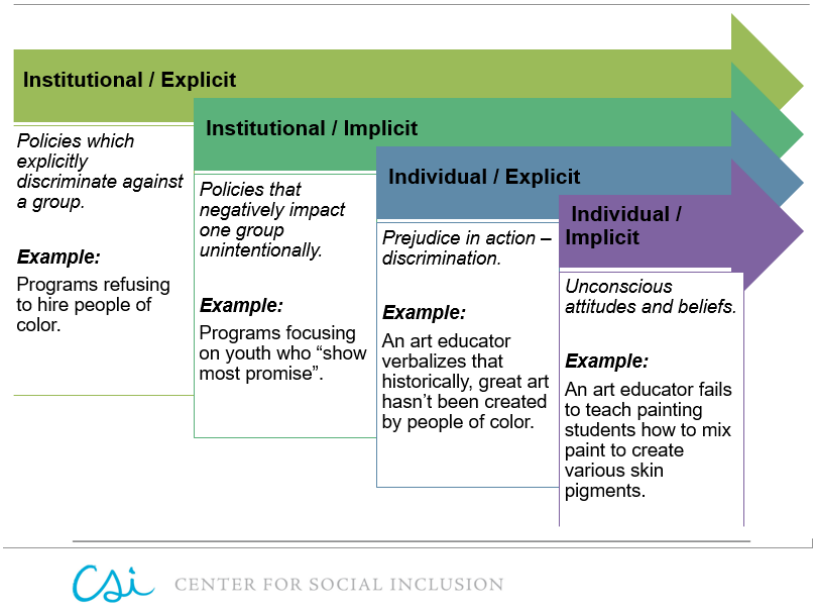
operates, and describes how racism persists beyond the acts of individual agents.[21] **Institutional racism** describes how the "representation and organizations of races"[19] is insidiously embedded in societal institutions and projects (political economic, educational, etc.) that, together, compound and reinforce inequitable access and barriers to opportunities and resources.[22] In other words, it is comprised of the: "policies, practices and procedures that work better for white people than for people of color, *regardless of intention.*"[2] When describing how these institutions combine across history and present-day reality to create systems that negatively impact communities of color, we use the term **structural racism**.

Because racism is entrenched within our society, racism manifests in many forms. Our experiences in the world and interactions with institutions and social structures result in **internalized racism** that shapes our biases and beliefs about ourselves and others. These beliefs may manifest on an interpersonal level as **individual racism,** or the "pre-judgement, bias, or discrimination by an individual based on race."[2] Although individually exercised, individual racism is internalized from racist institutions and systems. Because it exists in the context of structural racism, there is no such thing as "reverse racism" since the inequitable systems upon which racism is based are set up to benefit white people. *To effectively disrupt racism, it is important to center on how people of color experience racism, rather than focusing on how race is imagined or intended by white people.*[23]



White Privilege, Race Privilege

White privilege is a term that identifies disproportionate access to opportunities, privileges, protections, head starts, or benefits (e.g. absence of burdens, barriers, discrimination). These afford social and economic mobility to people perceived to be white and are not typically available to people of color.[24] **Race privilege** identifies people who may be afforded privileges over others, usually because of their race's relative historical or current proximity to whiteness when compared to another person identified as being of a different race. These benefits can be material, social, or psychological. Anti-Blackness is one mechanism that establishes and reinforces white privilege.

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Graphic description[25]: Privilege is having ground and a box to stand on, and no chain (barriers) to hold you down.

White Fragility

Multicultural education scholar Dr. Robin DiAngelo[26] describes white fragility as "a state in which even a minimum amount of racial stress becomes intolerable, triggering a range of defensive moves. These moves include the outward display of emotions such as anger, fear, and guilt, and behaviors such as argumentation, silence, and leaving the stress-inducing situation. These behaviors, in turn, function to reinstate white racial equilibrium. Racial stress results from an interruption to what is racially familiar." White fragility may be a learned and is often a subconscious emotional response, resulting from the lack of prior experience to develop the tools for constructive engagement across racial divides. It is nefarious in that it works to protect, maintain, and reproduce white privilege by centering the emotions of white people in dialogues about racism, thus impeding discussions about racist systems that need dismantling.

Whiteness

Often conversations about racism can feel personal, rather than focused on the systemic mechanisms that maintain or protect racism.[26] To move toward thinking about and addressing racism on a systemic level (rather than primarily individual or interpersonal), we want to introduce the concept of *whiteness*.[27] Whiteness is beyond white skin and refers to the underlying assumptions of white supremacy - that being white is the standard and being a person of color is a deviation from this norm. Whiteness influences everyone because it is a ubiquitous set of cultural assumptions to which we are all pressured to conform but most impacts people considered "nonwhite", who experience its negative consequences.[28] For example, consider what is understood to be "normal" when Band-Aid describes a pale tan bandage as "skin tone", when a patient expresses surprise that their doctor is a Black person, or when a person's name is described as "unusual" when it is really just unfamiliar to another person. One way this manifests in medical education is that race is more often mentioned when the patient is a person of color, and the patient is assumed to be white if no race is mentioned.[29–31] Defaulting to white as the norm often goes unnamed, unexamined, and unquestioned, and can influence our thoughts, behaviors, and expectations of ourselves and others. Whiteness, and its consequent white supremacy, permeate medicine and health care in complex and nuanced ways. A discussion or critique of whiteness is not a critique of people with white skin, but of a system from which they benefit and often, even if unknowingly, uphold.[22]

White Supremacy

White supremacy is a historically rooted and continuously constructed culture, ideology, and political and economic system that positions white people, their thoughts, actions, beliefs, and issues as more important than and superior to those of people of color.[32] In mainstream culture, the term white supremacy is often associated with radical and violent far extremist groups. However, the concept of white supremacy is also a helpful tool to understand how the very fabric of our larger culture and institutions (be they political, economic, or related to health, like medical education) are deeply influenced by

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the idea that there is a “true” racial hierarchy. Even if we do not consciously subscribe to this belief, it is embedded in the very structures that govern much of our lives. These structures reproduce white supremacy by advantaging white people and positioning whiteness as normal, thereby reinforcing an artificially constructed hierarchy in which white people are at the top.[22]

KEY FRAMEWORKS

Critical Race Theory (CRT)[10] emerged from legal scholarship in 1989 in response to the limited and narrow scope of how law defined and addressed racism. It offered a set of key racial equity principles and a methodology to illuminate and combat the root cause of structural racism. This methodology has since been adapted to the field of health and medicine to help scholars attend to equity while carrying out research.[33,34] Critical race theorists recognize that racism is ingrained in the United States’ historical foundation and argue that we must explicitly identify and name racial power dynamics to address racism. CRT challenges the fundamental assumption that science is objective because scientific activity occurs within, and is informed by, our biased social contexts.

Public Health Critical Race Praxis (PHCRP) is a framework[35] that applies CRT to health equity and public health research. PHCRP offers a semi-structured process to evaluate current and historical research, by applying a “race conscious orientation” to methods and offering tools for racial equity-informed approaches to knowledge generation. Researchers evaluate how racism (institutional and personal) informs their study design. They use these findings to refine their research and advance our understanding of how racism influences public health and disease.

Structural Competency

Medical anthropologists Jonathan Metzl and Helena Hansen[36] describe structural competency as a trained ability to recognize that individual health outcomes represent the downstream consequence of up-stream structures that produce and maintain illness and health. These structures include the economic, physical, environmental, socio-political, resource delivery, legal, and educational structures that control access to resources and opportunity, and which govern individual decisions, behavior, and consequence. As a pedagogical approach, it shifts attention away from cross-cultural understandings of individual patients towards the forces that influence health outcomes at the level *above* individual actions. The framework consists of training in five core competencies: 1) recognizing the structures that shape clinical interactions; 2) developing language to describe structures; 3) rearticulating “cultural” formulations in structural terms (focusing on cultural causes obscures recognition of the structural forces reproduce inequality, thereby preventing action); 4) observing and imagining structural interventions; and 5) developing structural humility (or the trained ability to recognize the limitations of structural competence).

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These concepts are complex and conversations about them can be challenging. Lean into discomfort with the goal of talking about systems, and our roles in perpetuating or dismantling unjust structures, rather than attacking or defending one's character.

Questions and exercises for self-reflection:

- *Before engaging this toolkit, how did you know what race and racism meant? How has your definition of race and racism shifted over time?*
- *Assess your implicit biases with the Implicit Association Test. What surprised you about your results? What feelings did you notice bubbling up? Consider finding a colleague who shares your background and who is also interested in taking the IAT to reflect on these findings together. Identify opportunities for shared discussion and reflection to promote growth.*
- *How does institutional racism or structural racism manifest in the criminal justice system? In your educational training? In your workplace?*

Suggested reading/listening:

- Barceló Nicholás E, Shadravan, Sonya. Race, Metaphor, and Myth in Academic Medicine. *Academic Psychiatry* (2020). doi.org/10.1007/s40596-020-01331-9
- Biewen, John. Seeing White. *Scene on Radio.* Center for Documentary Studies at Duke University. 2017.
- Cabrera, Nolan L. "Never Forget" the History of Racial Oppression: Whiteness, White Immunity, and Educational Debt in Higher Education. *Change: The Magazine of Higher Learning*. 52:2, 37-40. doi.org/10.1080/00091383.2020.1732774
- Jones, Camara Phyllis. Levels of Racism: A theoretical framework and a gardener's tale. *American Journal of Public Health.* 2000 August;90(8): 1212–1215. doi:10.2105/ajph.90.8.1212

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Step 3: Understand race in the historical context of health care and medicine

Before you create curriculum or engage in discussion with learners about racism and race in medicine, we must have a shared understanding of historical and political context.

The evolving construction of "race"

To understand how the concept of race is forged by social beliefs and influenced by political and economic power dynamics in the United States, it is helpful to look back at how the concept of race has evolved with and was shaped by historical projects and institutions, including biomedical research and clinical medicine. In pre-Darwinian times, European colonizers encountered people with unfamiliar customs, language, and physical traits in the Americas that formed their basis for creating racial categories, which they described as products of God's creation.[37] Categorized people were ranked into races based on invented notions of superiority, which were in turn used to justify colonialist exploitation.[13]

In the 18th and 19th centuries, various physician-scientists (e.g. Paul Broca, Robert Bennett Bean) developed "scientific" theories of innate racial difference between categorized people that sought to root the concept of race in speciation and evolution to affirm race's independent position in the natural scientific order. Building on scientific constructions of race, the prominent antebellum physician Samuel Cartwright theorized that Black people had dysesthesia, a disease in which slaves experienced inadequate breathing due to insufficient decarbonization of blood in their lungs. Cartwright invented the spirometer to measure his subjects' lung capacity and used it to conclude that the brutal working conditions of slavery provided an appropriate treatment.[38,39] In this way, biomedical research was used to provide scientific legitimacy to institutions promoting white racial dominance, including colonialism, slavery, and later: eugenics, anti-immigration, and anti-miscegenation laws.[39–41] Indeed, the mutability of racial categories in response to the need to justify politically sanctioned endeavors, and oppression, reflects the mutability of race towards political purposes.

Before the 1950s, the parameters used to "scientifically" define race were primarily anatomical and phenotypical, based on visible differences in human stature or skin tone. As genetic technology developed, and as American society became increasingly multiracial, attempts to "scientifically" define race shifted away from morphological taxonomy and towards elucidating the genetic ancestral roots.[11,13,42] This shift incentivized genetic explanations for diseases disproportionately observed in racialized populations. For example, in 1962, scientist James Neel put forth his thrifty gene hypothesis[43] to explain the high rates of Type II Diabetes among indigenous people and people of color, suggesting that genetic-based differences in glucose handling helped non-white populations endure times of famine. Neel later reflected in 1999 that his investigations did not support the hypothesis that the high frequency of Type II Diabetes among Indigenous Americans living on reservations was due to ethnic predisposition

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and most likely reflected lifestyle (e.g. access to resources). Despite this, racialized notions of the biologic basis for disease persist and cloud the impact that historical trauma, dispossession, demoralization,[44] and an underfunded Indian Health Services system have on the health disparities experienced by America's indigenous people.

Biological conceptions of race lead to clinical harm

In the 1990s, the National Institutes of Health mandated that federally funded biomedical studies were required to report the race/ethnicity of their participants using the main racial categories established by the Office of Management and Budget: White, Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian or Pacific Island, and Hispanic.[11,42,45] The mandate was issued to address historical underrepresentation of people of color in clinical research and ensure equity in available health data. The mandate to include race as a variable has led to important insights into racial health disparities. However, the ubiquitous use of racial categories, which are often uncontextualized and poorly defined, has also given biological interpretations of racial difference the veil of scientific objectivity, reinforcing false notions that the social construct of race is biologically based. While there is overlap between genetic ancestral lineage and self-described race for some racial groups (e.g. European and Asian Americans)[46], as well as interplay between socioenvironmental factors and genetics (e.g. through epigenetics and mating pressures), race as a categorical research variable is neither granular nor specific enough to reflect the gradations of human genetic variation,[47] and it more readily captures exposure to social forces like racism, which are often obscured by biological interpretations of racial data.[48]

This is not to say race should be excluded from research or medicine should be colorblind. On the contrary, race is a *vitally* important consideration for characterizing and mitigating inequality, and for recruitment of diverse participants to remedy the structural racism of homogenous participant pools that limit applicability of scientific discovery (especially genetics). However, when race as a variable is inadequately defined, uncontextualized, and interpreted biologically—as is often the case—the application of race data may formally cement evidentiary bias in clinical care.[48] For example, the Society of Thoracic Surgeons' short term risk calculator for complications and death in cardiac surgeries incorporates race as a prediction factor. When used preoperatively to assess patient risk, it determines that minoritized patients have a higher risk and may steer them away from needed surgery. The mechanism by which race confers added risk remains unidentified, with only prevalence data to support it. Nonetheless, race's incorporation into clinical guidelines qualifies its role as inherent and immutable, reinforcing notions that race is biological, and its use in this manner may independently function to exacerbate disparities.[18] Race can, however, be equitably incorporated into clinical guidelines intended to mitigate the burden of disease in populations affected by racism.

In addition, the uncontextualized presentation of racial disparities and the use of "race-based" predictions for disease can promote errors in clinical reasoning by reinforcing associations of diseases with particular races, causing premature diagnostic closure and important diagnoses to be inappropriately overlooked in clinical settings. For

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example, in the United States, sickle cell anemia is often taught as synonymous with Black race. However, sickle cell disease is prevalent among people from malaria-endemic regions including South & Central America, Saudi Arabia, India, Turkey, Greece, and Italy, in addition to those racialized as "Black" (descendants of people from Sub-Saharan Africa). This conflation of race with ancestry and genetics may lead to improper, delayed, and missed diagnosis when the disease goes unrecognized in non-Black populations.[49] Further, knowledge of racial health disparities without a complex structural understanding of the forces causing them, pathologizes people of certain races as less fit and may drive statistical discrimination,[50] or differences in clinical decisions and outcomes experienced by people of different races as a result of the rational application of probabilistic decision rules to individual patients in times of clinical uncertainty.

The historical and present conceptual entanglement of race and biology impacts how providers and trainees think about race. In 2002, the Institute of Medicine was commissioned by Congress to uncover etiologies of the United States' ongoing and persistent racial and ethnic disparities in health outcomes. The study,[51] entitled *Unequal Treatment,* demonstrated that provider bias, in the form of implicit bias, has a large contribution to these unyielding differences. False notions of race being biologically based likely contributes to bias. For example, researchers at the University of Virginia (UVA)[52] found that differences in pain treatment recommended to African-Americans is associated with endorsement of false beliefs in underlying physiological difference (e.g. that Black people age more slowly than whites, their nerve endings are less sensitive, and their skin is thicker). Half of participants endorsed more than one false belief, and those who did had less accurate assessments of Black patients' pain levels.

The issue is racism, not race

Although race is a social construct, the consequences of racism are real and manifest as health disparities. While the genetic underpinnings of health disparities are also important to study and address, the variable of race, a social construct, reflects exposure to racism rather than genetic predisposition, which is better captured by ancestry. Thus, **racism, not race, is the risk factor for disease.**[53]

Conflating the social construct of race with biology can reinforce false notions of racial biological difference, which perpetuates bias, influences clinical care and policy decisions, and obfuscates social drivers of health disparities (e.g. exposure to racism) resulting in missed opportunities for targeted interventions. Avoid this by:

- Using **nuanced and precise language to disambiguate the concepts of race from genetic ancestry.**
- Defining race as a social construct and **identifying the role of racism** and other structural drivers of health outcomes.
- **Acknowledging when race has been used as an inadequate stand-in** for genetic ancestry (for example, due to an inability to access more accurate genetic variables), *and* who benefits from or is harmed by this approach.

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- **Critiquing methodology that insufficiently contextualizes race as a variable** or offers biological interpretations of data without contextualization in structural drivers of outcomes.

Questions for self-reflection:

- *What were you taught about race and racism in medical school?*
- *How do you use a patient's race in your clinical practice? How do you know what their race is? How does it impact your clinical decision making?*
- *When you do include a patient's race in your notes or presentations, which patients do you mention it for? Why?*
- *If a patient says something that strikes you as racist, how do you respond? How does your response change when a learner is present? Why?*

Suggested reading:

- Chada, Noor; Kane, Madeleine; Lim, Bernadette; Rowland, Brenly. *Towards the Abolition of Biological Race in Medicine: Transforming Clinical Education, Research and Practice.* Institute for Healing & Justice in Medicine. 2020.
- Duster, Troy. "Lessons from History: Why Race and Ethnicity Played a Major Role in Biomedical Research." *Journal of Law, Medicine & Ethics.* 2006; 34(3), 487-496. doi:10.1111/j.1748-720X.2006.00060.x
- Lee, Catherine. "Race" and "ethnicity" in biomedical research: how do scientists construct and explain differences in health?" *Social Science & Medicine*. 2009;68(6):1183–1190. doi: 10.1016/j.socscimed.2008.12.036
- Tsai, Jennifer. "Racial Differences in Addiction and Other Disorders Aren't Mostly Genetic: The assumption that health disparities are caused by race rather than racism permeates many organizations, including the NIH". *Scientific American.* Jan 30, 2018.

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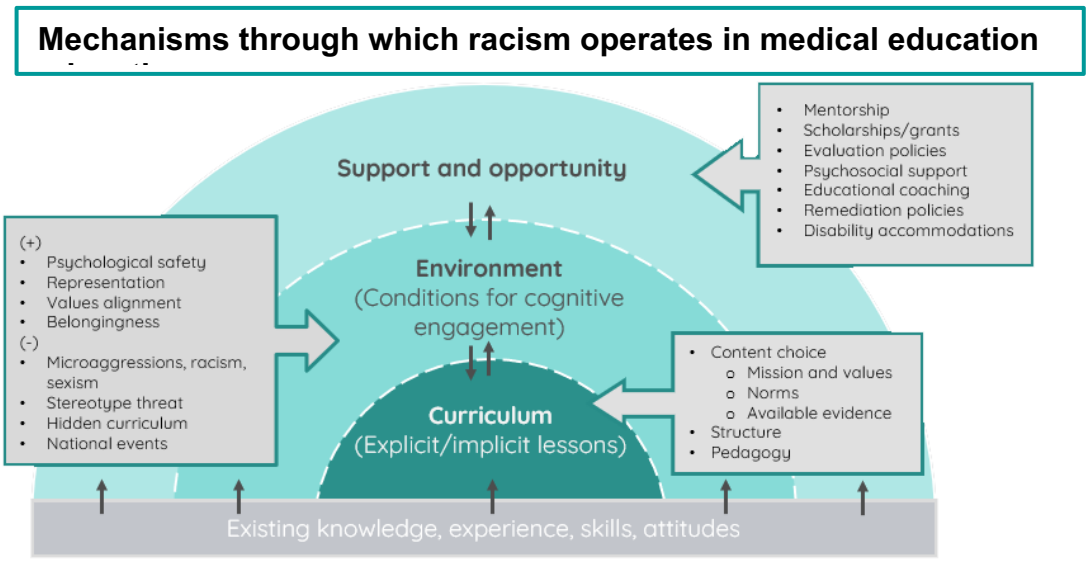
Step 4: Implement anti-racism in medical education

In this section we outline (1) how medical education propagates racism, (2) how to approach conversations on race, racism, and health and (3) how to develop anti-racist educational materials.

How does racism operate through the system of medical education?

The existence of health disparities reflects structural inequalities in multiple intersecting systems, including the medical system, whose disparities in access, quality of treatment, and outcomes have been well-documented.[48] Medical schools play a pivotal role in propagating healthcare inequities by training students to become part of and maintain the current healthcare system status quo. Students arrive with their own experience, knowledge, and biases, which medical training then shapes, imparting new knowledge, ideologies, skills, attitudes, and reasoning that impacts the clinical care they offer. Medical training also influences students' self-efficacy, sense of mission and purpose, and scholarly curiosity, which drive future scholarship and knowledge production. Disparities within medical school itself, including in evaluation[54] and experience of mistreatment,[55] among others, introduce hurdles that students from groups that have been historically excluded from medicine must contend with that their advantaged white peers do not. These educational disparities create disparities in attainment, which can cascade into disparate opportunities, which in turn shape the physician work force, impacting patients and society. Thus, the system of medical education impacts students' career trajectories and the communities they serve, whether at the bedside, through crafting policy, researching, or teaching.



Through what they teach and how they teach, medical educators play a key role in shaping students' experience of medical education. How we handle the topics of race,

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racism, and disparities in our lessons is critically important. Use of stigmatized language shapes attitudes and impacts treatment decisions.[56] How we incorporate discussion of race can impact the learning environment and students' ability to cognitively engage with the materials. For example, pathologizing or using stereotyped portrayals of racialized people, even if unintentional, may cause emotional distress, distract students, or activate stereotype threat, which in turn, increases cognitive load, impairs student performance and impedes learning.[57] Inconsistent handling of racial descriptors (e.g. identifying race more often for non-white patients), reinforces associations of race and disease which may propagate bias[58,59] and reinforce the idea that race is biological, impacting clinical reasoning. Similarly, lack of adequate representation, for example in dermatological textbooks, leaves graduates clinically unprepared to treat disease in communities of color,[60] which may contribute to health disparities.

Our handling of race, racism, and disparities also determines whether students are prepared with the skills, ability, and motivation to disrupt the cumulative and chronic inequities of medicine's structural racism. If we leave students unprepared, then we maintain racism in medicine my maintaining an unequal status quo. The psychologist, Dr. Beverly Daniel Tatum[61] describes the relationship of our behavior to the ongoing cycle of racism through an analogy of a moving walkway at the airport: active racist behavior is equivalent to walking quickly on the conveyor belt; passive racist behavior is standing still while the conveyer belt moves you to the same destination as those who are walking quickly. Unless we turn around and actively walk in the opposite direction at a faster speed than the conveyer belt, we arrive at the same destination. Thus, only by actively examining, discussing, and challenging our current perceptions and the tools we use will be able to change the system.

Questions for self-reflection:

- *How do you usually handle race and racism in your teaching?*
- *How do you assess your learners' experiences of your teaching and curriculum?*

Suggested reading:

- Freire P. *Pedagogy of the Oppressed.* New York: Continuum, 2000.
- Amutah C, Greenidge K, Mante A, et al. Misrepresenting Race — The Role of Medical Schools in Propagating Physician Bias. *N Engl J Med*. 2021. doi:10.1056/nejmms2025768
- Tervalon M, Murray-García J. Cultural humility versus cultural competence: a critical distinction in defining physician training outcomes in multicultural education. *J Health Care Poor Underserved*. 1998;9(2):117-125. doi:10.1353/hpu.2010.0233

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How can I prepare to dismantle racism in medical education?

We acknowledge that everyone has a different expertise and experiential background with regards to race, racism, and conversations about these topics. No matter what we each bring to the table, conversation is an opportunity to learn about ourselves and each other. We invite you to join the conversation. Please consider the following:

Develop structural competence. Structural competence is a trained ability to recognize that individual health outcomes represent in large part the downstream consequences of up-stream structures that produce and maintain illness and health. Structural competence allows an educator to interrogate race data that is presented without contextualization in the sociopolitical forces that contribute to the outcomes by shaping resource access, environment, and individual behavior. Identifying these structural forces is essential for decoupling false notions of race as biologically based, avoiding blaming of communities and individual behavior for poor health outcomes, and identifying solutions targeted at the structural drivers of health disparities. For example, look back at the historical discussion of Type II Diabetes incidence in Indigenous Americans in the US from Step 3. When viewed through a narrow lens, the increased incidence was attributed to "lifestyle changes"[43] (e.g. unhealthy diets, lack of exercise). A structural lens reveals the powerful factors that shape and influence individual behaviors leading to increased diabetes incidence, including lack of grocery stores in a given neighborhood or on a reservation, lack of access to spaces for exercise, both of which resulted from land dispossession, housing discrimination, and red-lining.

Discuss racism. Disambiguate race, genetics, and ancestry with nuanced and precise language. While avoiding discussions of race and racism may be more comfortable, we cannot address what we do not study, measure, or understand. To disrupt racism and begin to mitigate racial health disparities, we must identify, measure, and investigate how experiences and outcomes vary by race. Because race and biology have been historically conflated, race is often inappropriately used categorically as a proxy for genetics, despite failing to capture the complexity and gradations of human genetic variation. Ancestry more precisely captures genetic lineage, whereas race, a socially constructed and dynamic concept, better captures exposure to racism. Both genetic predisposition and social forces impacting racialized people are drivers of health and disparities, and interplay exists between the two (e.g. epigenetics, social forces that drive population migration and genetic mixing), so rigorous conceptual specificity is essential. To engage in rigorous science that has the potential to improve the health of our patients, we must be clear about which factors we are investigating, and avoid unintended hidden messages when clarity is lacking. For example, if Black race is listed as a risk factor for a given disease without explanation, we risk propagating the view that race reflects biology, obscuring underlying structural factors at play (structural racism), missing opportunities to address drivers of inequity, and reinforcing white normativity by establishing white people as having the default or 'normal' baseline risk.

When teaching and apprising literature, clearly define race and how it is used and distinguish it from genetic ancestry. Be transparent when race has been used as a

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proxy for genetic ancestry, and critique the lack of precision and problematic nature of conflating these two. Identify who benefits or is harmed from this approach. Invite students to consider a structural analysis of the findings, or a methodology that might yield more meaningful genetic insights. When studying racial disparities, use the National Academy of Medicine[62] racial and ethnic categories reflecting social norms defining populations to study disease attributable to structural bias or racism.

Broaden your influences. Many people grow up in and are socially educated in communities that reflect their culture and values, which inform our unconscious biases. Intergroup contact is a primary de-biasing force.[63] We can seek diverse perspectives in our professional and personal spheres to increase our intergroup contact. Another way to increase exposure to diverse perspectives is to harness social media by actively seeking out podcasts and following accounts that deeply engage with the topics of race and racism in ways that are new to you.

Take responsibility for "doing the work." Everyone has different levels of experience with regards to race and racism. One of the privileges of whiteness, and proximity to whiteness, is not being forced to confront race and the way race impacts your experience in the world (akin to how we do not notice a tailwind that helps us move forward, but notice the consistent force of a headwind that holds us back). Those with race privilege should take the time to educate themselves rather than turning to a person of color to do the unpaid emotional and cognitive labor to educate them, especially since conversations about race may tap into personal or generational trauma. People of color who experience an unwelcome ask to be another's teacher can set a boundary, recommend a resource for self-study, or refer the person to a white ally to continue the conversation.

Approach conversations about racism with a growth mindset. Recognize that racism has insidiously affected our frameworks and movements in this world. Blind spots and mistakes are natural consequences. For anti-racist work to be done, we must be willing to learn and grow. Many of us were not taught how to productively have conversations about emotionally-charged topics. We may feel like beginners and that may be uncomfortable, especially when we are often positioned as the most expert person in the room in traditional medical educational hierarchies. However, we recognize that conversations about racism are opportunities to grow individually and together. Making mistakes is part of this process. Stay humble. If you see someone else make a well-intentioned mistake, avoid shaming them. If it is available to you, identify the error with compassion, and encourage them to continue to learn and grow (call them in, rather than calling them out). Note, however, that there are times when calling out is the most appropriate response, for example, in cases of explicit racism.

If you experience discomfort or anxiety that comes from a place of *unfamiliarity* when talking about race, approach your discomfort with inquiry. Discomfort doing something new can signal an opportunity for growth. If you can be mindful about the context in which the discomfort arises and name it, you can mine those moments for learning. Sometimes white people and others with race-privilege feel attacked or

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targeted by conversations about racism. If this comes up for you, strive to distinguish whether the critique is of you as an individual, or of a system of which you are apart and from which you benefit. Realize anti-racist work is not about you, but about the greater purpose of uplifting communities of color that have been forcibly excluded, pathologized, and marginalized in medical education.

Sometimes people of color experience discomfort when talking about race and racism that arises from a place of *familiarity*. They may have past racial trauma that makes them feel unsafe or have suffered negative consequences as a result of engaging those with race privilege in conversations about racism. If this comes up for you, or you feel unsafe or threatened, disengage from conversation, and seek support from those with whom you feel safe. While moving through discomfort of the unfamiliar is important, so too is safety a prerequisite for open communication.

Prepare to make mistakes and actively repair. Prioritize impact over intent. If someone identifies your words or actions as problematic, apologize, take ownership, and/or clarify any misalignment. Intention describes the motivation, while impact describes the effect on another person. When talking about race and racism, explaining your intention may be experienced as explaining away your action or as an effort to assuage guilt. Prioritize honoring another's experience of the impact of your words or action. Regard feedback about racism as an opportunity to engage in self-reflection and recognize the effort and courage it took to provide you this feedback.

Some useful phrases include:

- *I am sorry I did that. Thank you for letting me know how that impacted you and for the courage it took to tell me.*
- *What I am hearing from you is…*
- *It seems that… (summarize perceived impact of actions). Is that true?*

Be a co-conspirator against racism! Anti-racist work is an active, ongoing, deliberate process hallmarked by accountability, trust, and consistency in taking action against racism, both systemic and internal. It takes deep recognition that oppression in any form dehumanizes us all, even those who benefit from it. It takes courage, effort, and action to upend the status-quo.

- Require anti-racism in your educational materials and from invited speakers.
- Develop a plan to monitor whether you equitably engage students in lectures.
- Recruit, hire, support, and competitively compensate faculty and staff of color that reflect the community we serve.
- If you are white, amplify, sponsor, cite, collaborate with, and cede power to colleagues of color.[64]
- Invite experts rigorously engaged in race theory and anti-racism to teach and train faculty, staff, and students.

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- Critically review and restructure resource allocation models, evaluation and promotion strategies, and healthcare models. Consult experts in anti-racism to inform this work.
- Develop skills to identify and intervene on microaggressions so you can be an up-stander, rather than bystander. (Microaggressions are "brief, verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative slights"[65] towards people with marginalized identities).
- Uplift and support students, trainees, and colleagues of color. Practice cultural humility by openly inviting, listening to, trusting, and validating what others offer about their experiences, social identities, and intersectional identities. Recognize that others may face unique experiences in the learning environment. Actively work to include and celebrate the presence of people of color in medicine.
- Develop a practice for self-education and reflection on racism and its personal and institutional manifestations and consequences.
- Invite, and graciously receive, feedback from colleagues and learners on biases they observe in your words and actions, teaching, research, and clinical care.
- Support, engage, and affirm the work of artists and writers of color who capture and celebrate a rich variety of perspectives and experiences, especially joy, love, and thriving.
- Encourage other faculty/staff to join you in doing the work.

Continue to read, reflect, and seek additional training! This document establishes norms with regard to how we hope to approach conversations about racism at UCSF. While it is intended to provide a basic framework, it does not provide all answers. You can gain additional training at UCSF through:

- Diversity, Equity, and Inclusion Champion Training
- Relationship Centered Communication for Racial Equity at UCSF and ZSFG
- The Diversity, Inclusion and Equity Teaching Certificate through the Center for Faculty Educators

Questions for self-reflection:

- *What makes you feel confident when talking about race and racism?*
- *What are some strategies you use to handle feelings of discomfort?*
- *How do you know when someone is actively listening to you?*
- *How can you repair a relationship if you have hurt a learner or colleague?*

Suggested reading:

- Oluo, Ijeoma. *So You Want to Talk About Race.* New York, NY, Seal Press; 2018.
- Lim, Bernadette, Carvajal, Nicole, Tokunboh, Ivie. Making the World Safer for Black Children Beyond Diversity Rhetoric. *Woke WOC Docs (podcast)*.

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How can I develop anti-racist educational materials?

> *"Formal curriculum is not an innocent bystander in the clinical learning environment, but can also be a powerful agent in the process of inclusion and alienation."*[66]

When designing or reviewing educational materials such as lectures, student study guides, panel discussions, or exams, strive to be anti-racist in your approach. Below we offer a reflection guide to use while reviewing your materials. The goal of this guide is to help the user interrupt the perceptual frames from which we teach that are internally consistent with the white normativity and structural racism in which we were trained, and which thus go unrecognized as they flow through us. We also hope this guide supports educators in reflecting on and revising their materials so they do not have to rely on the uncompensated expertise of colleagues of color, particularly women of color, to identify areas for improvement.

Guide for Developing Anti-Racist Educational Materials

1. **Are people of different races represented**? Take stock of representation in your case examples, images, questions, panel speakers, and invited lecturers. The choice of who is represented and how can reinforce associations and seed bias that impacts students' clinical reasoning, breadth of history taking, and communication, which, in turn, harms future patients. Representation may signal educators' priorities and values, which can impact the learning climate by influencing how learners view themselves and their communities, or by triggering stereotype threat. In addition to race, consider representations of other identities including gender, age, sexual orientation, ability, etc.

   [ ] No/Unsure → What biases are you creating with your choice of representation? If there are limitations to those you are able to represent, can you contextualize the lack of representation or directly address it as a learning moment in your lecture? For example, if using an old medical text book image in a lecture, acknowledge the biases perpetuated by the historical representation. Consider how your materials fit into representation throughout the arc of your curriculum, since one lecture cannot do everything.

   [ ] Yes! → Are the portrayals respectful and affirming representations with regards to image, associated language, and descriptive demographics? Are the demographics relevant to the case? If so, is it clear how? Are demographics consistently used? Are representations reductionistic or expansive?

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2. **When race is mentioned, is it contextualized and distinguished from biology/genetics?** Race is a sociopolitical construct developed to stratify groups of people in order to privilege some (white people) at the expense of others (people of color). Biology-based definitions were mapped onto race to legitimize social subjugation and exploitation along constructed racial hierarchies. While both genetic predisposition and social forces like racism contribute health outcomes, *genetic predisposition to disease cannot be inferred from one's race*[67] so racial disparities in health outcomes cannot be attributed to biology in the absence of discussion of genetic ancestry. Observed biologic differences that fall along socially constructed racial lines are more likely driven by sociopolitical and structural inequities (e.g. access to health care, poverty, discriminatory laws and policies, etc.) and racism. Thus, race is not a biological risk factor for disease, but rather a crude proxy for the risk conferred by exposure to racism.[48] Contextualize race in the social history as a social determinant of health and use ancestry to capture genetic predisposition.

[ ] No/Unsure → Challenge yourself to avoid reinforcing that race is biological. If you want to discuss genetic predisposition towards disease, "using *ancestry* can also be a way to acknowledge that individuals inherit traits from groups whose members share genetic similarities, while reserving *race* to designate a political category."[12] Consider pointing out how the lack of diversity in genetic ancestry data is a form of structural racism (exclusion and neglect) that limits the breadth, equitable access, and applicability of scientific discovery and who has access to "personalized medicine".

When race has been used as a proxy for genetic ancestry in the literature (as is often the case), point this deficit out, along with the problems this causes in our ability to rigorously understand which risk factors are truly being identified, and therefore what interventions are needed (e.g. risks from ancestry-related genetic polymorphisms have very different implications for care than risks related to the toxic exposure of racism).

The uncontextualized mention of race, especially when present in some cases but not all, implies that race itself is a risk factor for disease and reinforces pattern recognition that narrows clinical reasoning. When discussing race as a descriptor in epidemiological data, distinguish observation from causation. When discussing health disparities and race, address the structural factors driving illness.

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[ ] Yes! → Remember that even if contextualized, including race *only* when describing people of color reinforces whiteness as the default/norm. In clinical scenarios, race should be one element of an otherwise rich social history included for all patients presented. Contextualize race as it relates to resilience and thriving, in addition to considering the vulnerability or protection from racism that one's race confers. When presenting epidemiological data and associations with race, consider exploring how these associations may drive statistical discrimination,[35] or the different diagnostic and treatment decisions people of different races experience as a result of the clinician's rational application of data-driven probabilistic reasoning to individual patients in times of clinical uncertainty. When mentioning race, unlearn "the patient is [race]" and instead use the humanizing, person-first language "the patient identifies as [race]" or "they are of [geographic origin] descent/ancestry."[68]

3. **Have you eliminated inadvertent stereotypes?** Find them, fix them! Stereotypes function consciously or unconsciously as a heuristic that guides perception, interpretation, storage and retrieval of information, especially in conditions of high cognitive demand. Racialized stereotypes dehumanize and can dangerously narrow clinical reasoning by seeding bias, influencing our expectations, inferences, impressions, and limiting our ability to see others as unique individuals. Stereotypes are conveyed through the physical traits, names, abilities, linguistic patterns, roles, experiences, behaviors, code words, and illnesses you've associated with race. Your ability to detect these moments depends on your sensitivity to stereotypes and your blind spots, which we all have.

[ ] No/Unsure → Underline any race explicitly referenced, as well as any names, linguistic patterns, physical traits, or code words that could imply race. Circle role behaviors, interests, abilities, professions, experiences, and illnesses portrayed. Think about the circled descriptors, whether they are positive or negative, and whether you've seen them commonly associated with a particular race. If that race is explicitly identified or implied by the underlined descriptors, or if the descriptors are negative in tone, you may be depicting a racial stereotype. Revise or reimagine your scenario to eliminate stereotypes by adjusting descriptors or changing the race. Consider how a loved one would feel if your portrayal described them. Create dignity-driven content.

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[ ] Yes! → After intentional self-scrutiny of your materials, consider asking a colleague for a second set of eyes for review.

4. **Have you centered and contextualized health disparities pertaining to your topic?** Begin to disrupt racism by centering and prioritizing one of its consequences—health disparities.[17] Scrutinizing racism as a driver of disparities helps prepare students to address the consequences of racism and fosters an equitable learning environment. Teaching content from the lens of those most impacted (those experiencing disparities) ensures that historically neglected voices are not overlooked[58] while still allowing for discussion of pathophysiology, epidemiology, clinical presentation, treatment, etc. Avoid implying that individual behaviors are to blame for disparities. Instead, zoom out and contextualize disparities in the structural forces driving them in order to identify root causes and opportunities for intervention, broaden clinical reasoning, and uncouple race from false notions of pathology due to innate racial difference.

[ ] No/Unsure → How might siloing or deprioritizing health disparities perpetuate the forces that cause them to exist in the first place? If disparities have not been rigorously investigated by the scientific community, why not? Teaching points may include funding inequalities, poor participant recruitment leading to a paucity of research across diverse populations, failure to involve communities in setting research priorities or in sharing and critiquing results.

[ ] Yes! → Do you define race as a social construct and dismiss genetic interpretations of race by using precise language to discuss genetics and ancestry? Do you name racism as a driving force for health disparities? Do you address disparities in a meaningful, integrated way or as a one off slide, which may signal that they are unimportant? When apprising research studies, describe how the quality of the research, methodology, and handling of race drive what we understand about disparities and outcomes. Interrogate racism, policies, and other structural drivers of health inequalities.[69] Explore implications for policy and clinical practice. Make space for hope and possibility by identifying strides made and opportunities for agency/change, so as not to resign your audience to an unjust, immutable status quo. Identify and uplift groups who are actively engaged in improving equity in research in the area you are discussing.

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5. **Do your materials disrupt oppression?** Reflect on who benefits from or is burdened by the content, message, and perspectives represented in your materials.[2] Consider the immediate and downstream impact on learners, patients (present and future), families, communities, staff, and colleagues.

[ ] No/Unsure → Do your materials promote equity or merely equality? If the message, focus, and perspectives represented in your materials reinforce mainstream perspectives and an unequal status quo, they may perpetuate oppression. Leverage your educational materials and pedagogy to uplift or unburden patients, learners, and exploited communities by centering typically excluded experiences and perspectives, and matching the focus of your content and message to the named priorities of communities experiencing exploitation or oppression. Consistently invite opportunities for new perspectives throughout the learning experience, and encourage critical reflection and question asking. Role model your role as a learner as well as a teacher, and provide opportunities for students to share their expertise if they wish.

[ ] Yes! → Ask a colleague or expert for a second opinion. Be responsive to critique offered by students.

6. **Invite and be receptive to feedback.** If a student or colleague identifies something in your materials as problematic, or challenges you with a question or comment during your lecture, invite and offer humble reflection. Acknowledge the courage it took to speak up, express gratitude for the opportunity to learn and grow, affirm your priorities to disrupt racism, take time to reflect privately, and repair by seeking input from colleagues, friends, books, and articles for further self-education. Learn from students, but avoid burdening them by asking them to teach you, which may amount to a tax often experienced by minoritized students.

7. **Need more support?**

- For small group facilitation, see Jason Satterfield's "Small Group Facilitation: Leading Discussions of Race and Culture"
- To enhance your teaching, register for the UCSF Teach for Equity and Inclusion Certificate, which includes a workshop on *Selecting and Creating Equitable Curriculum*
- To operationalize equity in your projects, check out the Racial Equity Toolkit: An Opportunity to Operationalize Equity

Suggested reading:

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- Boyd, Rhea W; Lindo, Edwin G; Weeks, Lachelle D; McLemore, Monica R. On Racism: A New Standard for Publishing On Racial Health Inequities. *Health Affairs Blog*, July 2, 2020. DOI 10.1377/hblog20200630.939347/full/
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- Krishnan, Aparna; Rabinowitz, Molly; Ziminsky Ariana; Scott, Stephen M; Chretien, Katherine C. Addressing Race, Culture, and Structural Inequality in Medical Education: A Guide for Revising Teaching Cases. *Academic Medicine: J Ass Am Med Colleges*. 2019:94(4):550-555.
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Anti Racism *for* Medical Educators

Hello!

Use this tool to review your materials. Start at the top and progress down the pathway to the bottom.

Are people of different races represented?

Representation matters! Note who is represented and how in your case examples, images, and questions. Consider implicit and explicit representations of race and intersecting identities such as gender, class, etc.

yes

no

Stop, Reflect, Correct.

What biases are present in your choice of representation? Adjust representation or contextualize the lack of representation.

When mentioned, is race contextualized?

Race is a social construct often conflated with biology. However, race is not a risk factor for disease, but a proxy for the risk conferred by exposure to racism and structural inequity. Race represents a social determinant of health; it does not signal genetic predisposition to disease.

Tip! 🌟🌟🌟

When discussing race, unlearn "the patient is [race]" and use humanizing language: "they identify as [race]" or "they are of [origin] descent."

no

Stop, Reflect, Correct.

When/why is race mentioned? Distinguish race from biology, and contextualize it as a social determinant. Use geographic ancestral origin to discuss genetic risk.

yes

Have you eliminated inadvertent stereotypes?

Stereotypes dehumanize and dangerously narrow clinical reasoning. They are conveyed through the physical traits, abilities, code words, linguistic patterns, roles, experiences, behaviors, and illnesses you've associated with race.

Your sensitivity to stereotypes will depend on your experience and blindspots.

no

Stop, Reflect, Correct.

How does your portrayal sound if you swap races? How would a loved one feel if your portrayal described them? Create dignity-driven content.

yes

Have you addressed health disparities?

Identify structural racism as a cause of health disparities. Discuss their origins and impact, strides made, and opportunities for agency and change.

no

Stop, Reflect, Correct.

Are there data on structural causes of health disparities related to your topic? If not, discuss why.

yes

Do your materials disrupt oppression?

Who benefits from or is burdened by the content, message, and perspectives represented? Consider learners, patients, communities, and coworkers.

no

Stop, Reflect, Correct.

How do your materials perpetuate or undermine a racist status quo? Leverage your pedagogy to uplift/unburden patients, learners, and exploited communities.

yes

Congratulations! 🎉🎉🎉

Now, invite feedback from others!

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Differences Matter at UCSF

Developed by Meghan O'Brien MD, Rachel Fields MS, Andrea Jackson MD

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Applying the Guide for Developing Anti-Racist Educational Materials: Examples

Step 1: Are people of different races represented?

Example: You are asked to deliver a lecture on orthopedic illness prepared by a colleague. You review the lecture and notice that all clinical images are of Black patients. Your colleague who created the slide deck used images from a recent trip to an orthopedic clinic in Kenya where she spends several months working clinically each year, which she has done for the last 10 years. She is rigorous about her consent process and tells you that all patients consented to having their pictures used in her lectures. (Adapted from personal experience shared by Dr. Rosny Daniel)

Analysis: In this example, there is a lack of diversity in who is represented in case pictures. Consider how a learner might perceive this. They may be distracted wondering whether the patients consented to having their photo taken and used for educational purposes, or whether they felt exploited along power hierarchies of historical colonialist legacies, poverty/wealth, Western/local medical traditions. The slides may imply an association of orthopedic illness or trauma with Black race that impacts students' future clinical reasoning. The repeat images of Black bodies suffering with illness may trigger generational trauma and cause psychological distress.

Possible Revisions:

- ➔ Introduce the lecture by acknowledging the lack of diversity of images, explicitly describe the consent process and preemptively address concerns about exploitation. Clearly describe non-race related risk factors for orthopedic illness.

- ➔ Deliberately seek and include images of patients from other racial and ethnic groups to revise the presentation.

Step 2: When Race is mentioned, is it contextualized and distinguished from biology/genetics?

Example: Students are presented with the following clinical vignette during a lecture: "Andre Rodgers is a 48 year old man admitted to the ED complaining of a swollen right foot. He is a homeless, African American man with no known family who is referred to as a "frequent flyer" by several nurses and doctors." (Example from Deng and Kelly's review of first year curriculum in 2017)

Analysis: In this example, race is mentioned in a clinical vignette, but it is unclear how race relates to the educational lesson. Without contextualization, a learner may develop an association between race and the linked descriptors or with the clinical pathology presented. Associations of African American persons with experiences of

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homelessness/poverty and recurrent health care utilization reinforce negative stereotypes that can demoralize students, and can seed bias that impacts students' clinical reasoning, breadth of history taking, and communication patterns, which, in turn, harms future patients.

Possible Revisions:

(1) If the educational goal is to discuss social contributors to this patient's frequent presentations, provide a more dignity-driven, person-first social history and contextualize the mention of race in his experience of racism:

➔ Mr. Rogers is a 48 year old man admitted to the ED *with* a swollen right foot. *He offers the following social history: He identifies as African American and is a former construction worker who quit his job after experiencing repeated racist insults from a co-worker that went unaddressed by his manager. He is currently experiencing homelessness. He has no known family after the recent death of his only sibling, but has strong ties to his church. He has presented to the ED with increasing frequency as his health has deteriorated and he has been unable to access his primary care doctor due to a lack of stable telephone.*

(2) If the educational goal is to discuss how to assess and treat a painful, swollen foot, and mitigate risk factors for trauma, the mention of race may be unnecessary in this short clinical scenario, and additional details to inform treatment approaches are necessary.

➔ Mr. Rogers is a 48 year old man admitted to the ED *with* a swollen right foot after a fall. He has had several recent presentations for alcohol withdrawal or lacerations in the setting of acute intoxication.

Step 3: Have you eliminated inadvertent stereotypes?

Example: Students are presented with the following clinical vignette during a lecture: "Andre Rodgers is a 48 year old man admitted to the ED complaining of a swollen right foot. He is a homeless, African American man with no known family who is referred to as a "frequent flyer" by several nurses and doctors." (Example from Deng and Kelly's review of first year curriculum in 2017)

Analysis: Apply the underline/circle exercise to help identify stereotypes as follows:

"Andre Rodgers is a 48 year old man admitted to the ED complaining of a swollen right foot. He is a homeless, African American man with no known family who is referred to as a "frequent flyer" by several nurses and doctors."

Analysis: The underline/circle exercise described in the toolkit reveals that this clinical scenario depicts an African American man (implicit and explicit markers of race are underlined). Associated circled descriptions are homeless (which implies

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impoverishment and fails to use person-first language—e.g. experiencing homelessness), complaining of symptoms (as opposed to having symptoms), "frequent flyer" (which implies frequent inappropriate use of health care), which fit the common stereotype of a poor Black man seeking secondary gain. The descriptor "no known family" could reinforce the stereotype of Black men having no family ties. The presenting symptom of swollen right ankle is not typically taught as being associated with race (where as keloids, sarcoidosis, sickle cell anemia are). While Mr. Roger's race may be relevant in so far as it captures his experience of racism, which we can reasonably suspect likely contributed to his becoming homeless, this portrayal perpetuates a negative stereotype.

Possible Revisions:

(1) Revise stigmatizing/coded language to create a dignity-driven portrayal that conveys trust that he is experiencing the symptoms he reports (he has the symptom vs complains of them), that does not define his person by his living situation (is homeless vs experiencing homelessness), that removes the stigmatizing language of "frequent flier" and "no known family", and that contextualizes his recurrent presentations by including information as to why he is repeatedly presenting.

    ➔ Andre Rodgers is a 48 year old man admitted to the ED *with* a swollen right foot. *He is experiencing* homelessness, *identifies as* African American, and stays with his wife. *He has been dealing with deteriorating health and has had many recent visits to the ED to seek care.*

(2) Re-imagine the clinical scenario with a patient of a different race which is not often associated with the descriptors included to thwart stereotypes. Use dignity-driven language.

    ➔ Andre Rodgers is a 48 year old man admitted to the ED with a swollen right foot. He is experiencing homeless, identifies as white, and has no known family. He has been experiencing deteriorating health and has had many recent visits to the ED to seek care.

Step 4: Have you centered and contextualized health disparities pertaining to your topic?

Example: A pulmonologist is preparing a lecture on cystic fibrosis (CF), a disease caused by disruption in production or function of the CTFR gene that impacts chloride ion channels and disrupts electrolyte transport. She plans to review the pathophysiology of CF, clinical manifestations, screening, that the most common mutation is inherited in a predominantly autosomal recessive pattern among people with Northern European ancestry.

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Analysis: While it seems logical to focus on the most common inheritance pattern that makes CF more common among people identified as white, a quick search for racial disparities and cystic fibrosis reveals that people identified as Black and Asian develop mutations in the CTFR genes and get cystic fibrosis too, and with different distributions of mutations. Because we are taught that CF is a disease of people descended from Northern Europe who are identified as white, people of color with CF often experience misdiagnosis and delayed diagnosis, with more advanced disease at time of diagnosis. Neglecting to identify the health disparities relating to disease, and their structural drivers, perpetuates the narrow clinical reasoning that is in part responsible for delayed and missed diagnoses cases of CF in people of color.

Possible Revisions:

- ➔ Take time to review the distribution of the mutations accounting for CF among people of different ancestral lineages. Describe the structural drivers of this disparity in time to diagnosis, including different rates of complete genotyping among white vs non-white people (structural racism) and the *diagnostic* use of carrier *screening* tests which test for the most common mutations, and are thus inadequate to detect the mutations causing CF for many people of color. Identify a change in screening practices and approach to diagnosis through genotyping as a target for advocacy to improve time to diagnosis and diagnostic accuracy.

Step 5: Do your materials disrupt oppression?

Example: A pulmonologist is preparing a lecture on cystic fibrosis (CF), a disease caused by disruption in production or function of the CTFR gene that impacts chloride ion channels and disrupts electrolyte transport. She plans to review the pathophysiology, clinical manifestations, and genetics underlying CF focusing on both the most common autosomal recessive pattern among people of Northern European ancestry, as well as less common mutations that account for a greater proportion of CF diagnoses among people of color with CF. She plans to discuss structural factors driving disparities in diagnosis and opportunities for change.

Analysis: This plan does a good job covering clinical, pathophysiological, and epidemiological content, serving students with a comprehensive education. Discussion of disparities expands clinical reasoning and attunes clinical suspicion to compensate for disparities faced by patients of color with CF, which will benefit future patients. Students who are frequently presented with disparities faced by people of color may feel burdened by vicarious trauma.

Possible Revisions:

- ➔ Invite a patient of color who suffered delayed diagnosis to share their experience living with CF, cover symptoms, the experience of getting diagnoses, and their resilience. Ask them to reflect on the ways they

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sustained themselves through this ordeal, and discuss the qualities in their physicians they found especially helpful which students can strive to emulate.

Step 6: Invite and be receptive to feedback.

Example: You are lecturing students about breast cancer. Your slide deck includes a slide that mentions that screening at age 50 misses peak incidence for non-white communities who have peak breast cancer incidence in the 40s vs. 60s for whites, which you touch on briefly, before reviewing current screening guidelines. After class, a student emails you that glossing over the impact of breast cancer screening guidelines on non-white communities was jarring. (Adapted from personal experience shared by student Diane Qi on twitter and is used with permission)

Analysis: Many factors may have contributed to the student feeling jarred by the lecture, including time pressures lecturers face to cover a lot of material resulting in rushing, misunderstanding of the lecture content, and failure to adequately address disparities or impact of screening guidelines on communities of color. The student may have also perceived the lack of discussion of cause of differences in age of peak incidence (e.g. ancestry, environmental/exposure related, chronic stress exposure, food access, etc.) as reinforcing that non-white communities are pathologized, or inherently more diseased.

Possible Response:

➔ Thank the student for emailing and identifying how the lecture impacted him, apologize for the impact, and express gratitude for the opportunity to clarify or elaborate and improve your lecture for next time. Reiterate that the impact of screening policies on communities facing structural racism is especially important. Clarify any misunderstandings, or offer a critique the screening guidelines based on your expertise. Discuss what is known about the drivers for difference in peak incidence. Share this information with the class in a follow-up email so that all students benefit from ongoing discussion and information sharing.

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Additional Resources for Exploration

Articles

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Join the conversation on Twitter with academics and thought leaders who focus on Health Equity and Race

@aasewell
@AliciamoMD
@ARCHDrNguyen
@bernielim
@dereckwpaul
@doczo1
@DorothRERoberts
@DrAyanaJordan
@dribram
@DrKeishaRay
@DrOniBee
@DrRupaMarya
@EdwinLindo
@ElaineKhoong
@gradydoctor
@jbullockruns
@KBibbinsDomingo
@kellyrayknight
@Kelseycpriest
@kemidoll
@Lachelle_Dawn
@LashNolen
@LundyBraun
@MarleneMartinMD
@mclemoremr
@mguyblueMD
@MKushel
@MonicaHahnMD
@RheaBoydMD
@rosnydaniel
@ryan_huerto
@RxDrAvant
@shreyakangovi
@Srijeeva
@suenlw
@TamorahLewisMD
@thenephrologist
@tomasrdiaz
@tony_jack
@tsaiduck77
@Uche_Blackstock
@UREssien
@UrmimalaSarkar
@vashti133

Websites

Colorlines, A daily news site where race matters, featuring aware winning in-depth reporting, news analysis, opinion, and curation.

Systemic Racism. race forward | The Center for Racial Justice Innovation.

Freedom School for intersectional Medicine & Health Justice.

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Local and Regional Government Alliance on Race and Equity.
http://www.racialequityalliance.org

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Trainings/Groups

Catalyst Project

UNtraining White Liberal Racism

White Noise Collective

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