Authors: The University of Arizona Anti-Racism in Medicine Curriculum Committee 4/20/2021
A Guide to Creating Inclusive Lectures
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This content was adapted from an Academic Medicine article (Krishnan A et al*) to assist faculty in evaluating lectures and revising material that unintentionally reproduces racism and white privilege.[i] Problematic content includes discussing racial categories as if they index biological difference,[ii] "blaming" minoritized groups for poor health outcomes,[iii] and/or uses the white population as a reference group. Understanding cultural processes[iv] (without falling into reductionist[v] or essentialist[vi] traps) can help faculty discuss differential health outcomes and behaviors that are meaningful for learners, minimize bias,[vii] and encourage critical thinking/consciousness.[viii] This guide provides background, evidence and rationales for revising curriculum in which race/ethnicity[ix] is unintentionally reinforcing erroneous connections about genetics/race or biases or in which race/ethnicity (or other difference) is absent.

This guide includes **3 KEY POINTS** to consider:

KEY POINT #1: Racial and ethnic health disparities are caused by social and structural determinants of health (SSDOH) and not based in genetics or biology.

Does your content include references to race and/or ethnicity as risk factors for disease?

□ Yes. *If yes, see suggested edits.*

□ No

Suggested edits:
□ *Provide brief explanation for racial and/or ethnic health disparities when mentioned*:
  ● Explanations should be included for "Risk factors"
□ *Provide the evidence:*
  ● A literature search will show that for many diseases, a racial disparity in outcomes exists in the US. This should be highlighted, but the reason for the disparity must be clearly identified as a result of structural and social determinants of health (SSDOH) (e.g., housing, jobs, etc.).
  ● Include the latest data on racial and ethnic health disparities for common diseases and health status indicators (e.g., breast cancer, cervical cancer, colorectal cancer, breastfeeding rates, etc.) in both cases with and without patients of color
□ *Be specific:*
  ● Race is an unscientific taxonomy that is very poorly defined. For scientific purposes, greater levels of specificity are required when discussing populations
  ● For example, if trying to describe genetic predisposition for a particular disease among a particular group, do not simply use racial groupings like "Black", "White", "Asian", or "non-White." "Non-White" in particular collapses most of the world's population into a single grouping. Refer to specific populations from particular regions preferably smaller than a continent, for whom there is evidence that the gene pool is confined by either geography or specific reproductive practices such as high rates of intragroup marriage. Only in these specific cases would there be sufficient reason to believe that intergroup genetic variation might explain different genetic predisposition to a particular disease as it is well documented that there is generally greater genetic variation within socially-defined racial groups than there is between such groups.[5]

EXAMPLE: "Diabetes screening is indicated for Native American, African-American, Hispanic American, Asian/South Pacific Islander race," as per USPSTF, American Diabetes Association and American Association of Clinical Endocrinology guidelines, based on the fact that there is higher prevalence of DM within these populations. This may be because these populations are disproportionately exposed to SSDOH which increase the risk for development of DM.

Rationale and evidence for edits:

- When the cause of a racial/ethnic health disparity is not known, we must be careful not to attribute these disparities to genetics/biology as evidence points to social/structural determinants having a greater impact on disparities than genetics.[1, 2, 3]
- If there is a lack of diverse representation in your field or the current research lacks diversity, consider making a learning point about the lack of information available today. Consider mentioning the historic lack of representation in medicine and how that has led to a lack of data today. Highlight the need for more research.
- Social/structural risk factors are modifiable, so attributing them to race/ethnicity eliminates possibility of intervention.[4]
- Focusing solely on racial/ethnic minoritized groups as "at risk" paints an overall picture of the groups being a "problem" rather than a history of inequality as the problem.
- Race is a false surrogate for genetic/biological makeup (e.g. person who "looks white" may have one African great-grandparent and therefore 1/8 chance of inheriting that ancestor's sickle-cell mutation).[5,6,7]
- Mention that race and racial hierarchies are social constructs that influence social determinants of health (due to racism).

Key Point #1 References link

Key Point #1 Resource:

- UCSF anti-racism race and literacy toolkit:
  - https://www.facs.org/-/media/files/covid19/ucsf_antiracism_race_literacy_toolkit_medical_educators.ashx
    - For help answering student questions refer to pages 4-5 and 16-18
    - For information about the history of race in medicine and racism as a risk factor for health outcome disparities refer to pages 13-15 and 19-20
    - For more information on self-reflection and reflecting on course content refer to page 15
    - For more information on why there is a lack of data or why there might be poor adherence, poor study recruitment, and failure to involve minority and low-income communities in research refer to page 21

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KEY POINT #2: Discussions of population risk and/or depiction of disease/impairment should reflect a variety of identities that represent nationwide sociodemographic statistics.

Does your content include discussion of population risk or identities that represent nationwide sociodemographic statistics?

□ Yes. *If yes, see suggested edits.*

□ No

Suggested edits:

□ Diversity of patient images or population-based statistics should include:
- Non-white race/ethnicity
- Multiracial couples
- Religious beliefs/traditional dress
- Non-binary gender identity
- Same-sex couples
- Diversity of national origin, language fluency
- Disability
- Urban/rural
- Veteran status
- Family status/pregnancy

□ When using language or images to depict minority groups make a conscious effort for the content to be respectful and relevant

□ When using population-based statistics, attempt to state the information as patient self-identification rather than a state of being.

EXAMPLE: State "the patient identifies as African-American" rather than "the patient is African-American" or "an African-American patient"

Rationale and evidence for edits:
- Current medical texts that are commonly used across medical schools often have disproportionate racial representation, and racial minorities are still absent at this topic level or continue to portray the lack of diversity in medicine. These omissions result in racial and ethnic bias in medical care for underserved minority populations and may also have negative impacts on students of color.[1,2]
- Despite the current lack of diversity in medical schools and the physician workforce, medical school curricula should reflect the nation's diverse racial and ethnic composition as this increases the feelings of safety, inclusion acceptance and overall wellness for underrepresented minority students.[3,4]

Key Point #2 References link

KEY POINT #3: "Using race to guide clinical care is justified only if…the use confers substantial benefit."
– Eneanya et. al[1]

Does your content suggest using race to guide clinical care?
□ Yes. *If yes, see suggested edits.*

□ No

Suggested edits:
□ Always vet race-based disease information with the following heuristic: *Is this information clinically useful – that is, will this information help a physician care for the patient in front of them?*
□ Be exceedingly cautious about making the leap from using race descriptively to prescriptively (i.e., from using race to describe the way in which negative health outcomes are unfairly distributed across racial groups towards using race to prescribe different standards of care)
□ Be intentional about including a diverse representation of the American population in clinical data, but also be thoughtful when presenting that data disaggregated by race and provide a diversity of possible causal explanations that might account for differences in various racial groups' data (including socioeconomic causes)
□ When teaching students about widely-used standards of care that include race-correction factors (see examples below), provide context and encourage critical thinking about whether race should be used in this way, and if race is perhaps serving as a proxy for other more important factors such as access to care and poverty

EXAMPLE: Critically consider the use of race-correction factors in calculations for eGFR, ASCVD Risk, and vaginal birth after cesarean risk. Compare results with and without race-correction and consider which confers greatest benefit to patient.

Rationale and evidence for edits:

- Focusing on the clinical utility of race-based clinical guidance is valuable because this helps keep medical knowledge-generation and research accountable to patients
    - Often there is a tendency to fixate on epidemiological differences in disease prevalence among socially-defined racial groups in clinical education, without consideration for the reality that clinical decision-making should generally always prioritize the clinical picture above all else
- In an article by nephrologist Amaka Eneanya et al, the authors outline a useful burden of proof that should be met before race is used in shaping standard of care; they suggest "Using race to guide clinical care is justified only if
    - (1) the use confers substantial benefit;
    - (2) the benefit cannot be achieved through other feasible approaches;
    - (3) patients who reject race categorization are accommodated fairly; and
    - (4) the use of race is transparent."[1]
- Disaggregating data by race can tacitly suggest a genetic cause given the deep, inherent association between race and genetics in our minds. Although we are trained to be cautious of attributing causation to correlation in higher education, investigations of correlations like race-disease correlations can inherently imply causation unless otherwise specified because correlations are used to prove causation in science all the time with the help of statistics. Yet many correlations, even apparently significant ones, found in data sets are often spurious[2]

Key Point #3 References link

Key Concepts References
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2. Oppenheimer, GM. Paradigm lost: Race, ethnicity, and the search for a new population taxonomy. American Journal of Public Health. 2001;91(7):1049-55.
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4. Viladrich A, Loue S. Minority identity development. In: Loue S, ed. Sexualities and Identities of Minority Women. New York, NY: Springer; 2010.
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7. Newark Community Collaborative Board. Framework: Critical consciousness theory. http://newarkccb.org/framework/critical-consciousness-theory/. Published 2016. Accessed November 27, 2018.
8. Smithsonian Institute, National Museum of African American History and Culture, Talking about Race, https://nmaahc.si.edu/learn/talking-about-race/topics/whiteness

Key Point #1 References
1. Acquaviva KD, Mintz M. Perspective: Are we teaching racial profiling? The dangers of subjective determinations of race and ethnicity in case presentations. Academic Medicine. 2010;85(4):702-5.
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7. Obasogie, Osagie K. *Playing the Gene Card?: A Report on Race and Human Biotechnology*. Center for Genetics and Society, 2009. https://www.geneticsandsociety.org/sites/default/files/complete_PTGC.pdf.

Key Point #2 References
1. Louie P, Wilkes R. Representations of race and skin tone in medical textbook imagery. Soc Sci Med. 2018; 202:38- 42.
2. Karani R, Varpio L, May W, et al. Commentary: Racism and bias in health professions education: How educators, faculty developers, and researchers can make a difference. Academic Medicine. 2017;92(11S):S1-S6.
3. Saha S, Guiton G, Wimmers PF, Wilkerson L. Student body racial and ethnic composition and diversity-Related outcomes in US medical schools. JAMA. 2008;300(10):1135–1145.
4. Cooper LA, Powe NR. Disparities in Patient Experiences, Healthcare Processes, and Outcomes: The Role of Patient–Provider Racial, Ethnic and Language Concordance. Pub. no. 753. New York, NY: The Commonwealth Fund; 2004.

Key Point #3 References
1. Eneanya, Nwamaka Denise, Wei Yang, and Peter Philip Reese. "Reconsidering the consequences of using race to estimate kidney function." *Jama* 322.2 (2019): 113-114.
2. Vigen, T. (n.d.). 15 insane things that correlate with each other. Retrieved February 11, 2021, from https://www.tylervigen.com/spurious-correlations

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DEFINTIONS:

[i] **White privilege** operates as a social mechanism that grants advantages to white people, since they can navigate society both by feeling normal and being viewed as normal. Persons who identify as white rarely need to think about their racial identity because they live within a culture where whiteness has been normalized.

[ii] **Race is a socially meaningful construct and is of limited biological significance**. Conceptions of the social categories of race being based in biological and behavioral differences are based in historical processes within the United States, which justified subjugation of minoritized groups.

[iii] **Minoritized populations** are groups of people who are singled out from the others in the society in which they live for differential and unequal treatment, and thus, it implies the existence of a corresponding dominant group enjoying higher social status and greater privileges. Characteristics that have been linked to minority group identity include sex, gender, sexual orientation, disability, ethnicity, nationality, race, language, culture, and religion. The use of "minoritized" versus "minority" acknowledges the active process of marginalization by the dominant group.

[iv] **Culture** is defined as "integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. Culture can be transmitted intergenerationally. Culture in the context of health behavior has been defined as "unique shared values, beliefs, and practices that are directly associated with a health-related behavior, indirectly associated with a behavior, or influence acceptance and adoption of the health education message." (Egede 2003) Importantly, knowing someone's ethnic identity or national origin does not reliably predict beliefs and attitudes of individuals.

[v] **Reductionism** is the process by which "complex phenomena are partitioned into smaller segments that are then dealt with piecemeal." (Pillay 2005) Reducing ethnicities and cultures to a single category comprised of a checklist of items results in a single story, which creates stereotypes that may not just be untrue, but are also incomplete. This single story not only perpetuates stereotypes but also prevents delivery of adequate, necessary and equitable care.

[vi] **Essentialism** is a concept that refers to defining and classifying a person's "true and fixed essence." (Pillay 2005) In the context of culture, essentialism is the practice of categorizing groups of people within a culture, or from other cultures, according to essential qualities.

[vii] **Stereotyping and bias**: "Stereotypes are the belief that most members of a group have some characteristic. Some examples of stereotypes are the belief that women are nurturing or the belief that police officers like donuts. An explicit stereotype is the kind that you deliberately think about and report. An implicit stereotype is one that is relatively inaccessible to conscious awareness and/or control. Even if you say that men and women are equally good at math, it is possible that you associate math more strongly with men without being actively aware of it." (Harvard Project Implicit 2011)

[viii] **Critical consciousness** refers to:" The process by which individuals apply critical thinking skills to examine their current situations, develop a deeper understanding about their concrete reality, and devise, implement, and evaluate solutions to their problems. Critical consciousness is a key ingredient for positive behavior change. It is a state of understanding how power and difference shape social structure and interaction. It has two components: anti-oppressive thinking and anti-oppressive action." (Newark Community Collaborative Board, 2016)

[ix] **Ethnicity** is an attempt to further differentiate racial groups and account for diversity within the population; however, like race, it carries its own historical, political, and social baggage. A commonly used definition follows: "Common threads that may tie one to an ethnic group include skin color, religion, language, customs, ancestry, and occupational or regional features. In addition, persons belonging to the same ethnic group share a unique history different from that of other ethnic groups. Usually a combination of these features identifies an ethnic group." (Oppenheimer, 2001)

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