Anti-racism: A Toolkit for Medical Educators

INTRODUCTION

As medical educators and clinicians, we are often called upon to address race/ethnicity and to discuss the origins of health disparities while teaching and delivering care. UCSF students now engage academically with concepts such as racism and power through the new Bridges curriculum in Health and Individual/Health and Society. They learn that while race is a social construct, it affects their patient's health 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, which are "the epidemic of our time" as Vice Dean for Education Catherine Lucey starkly identified. These forces also affect the integrity and safety of the learning climate and the success of our learners. As educators and clinicians, for our students and our patients, we have a moral imperative to confront and dismantle racism. Every year that we graduate students into the physician workforce that lack an understanding of the complex mechanisms and manifestations of racism, we are perpetuating disparities and causing harm.

In this toolkit, we seek to provide a structured approach to ensure that new and existing faculty cultivate deep competency and comfort addressing and discussing 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 components of a person's or group's identity--including, but not limited to, gender identity, 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, the goal of this toolkit is to provide the space and time to focus on racism since our country's deeply ingrained unease with the topic often means it gets pushed aside.

Despite the discomfort that may arise when talking about racism and race, engaging together to examine our personal and collective experience and roles in maintaining racism is essential to the pursuit of ***equity, a core value here at UCSF.***

HOW TO USE THIS TOOLKIT:

This toolkit is divided into 4 sections.

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

Each section can stand alone, but we recommend working through the toolkit sequentially to cultivate a shared understanding. This toolkit is not exhaustive, but rather an entry point and a springboard. Look for resources at the end of each section that you can use to deepen your learning and growth. References for all cited works is at the end of the document.

Opportunities for exploration:

Articles:

Denise, Marte. “Can women of color trust medical education?” *Academic Medicine*. Accepted 2019 Feb 26 DOI: 10.1097/ACM.0000000000002680

Tsai, Jennifer. “Diversity and Inclusion in Medical Schools: The Reality”. *Scientific American*. July 12, 2018.

Step 1: Prepare to talk about racism and race

Why is talking about racism and race so difficult?

Racism can be an emotionally loaded topic. When someone identifies another's actions or words as racist, it may feel like an insult or a condemnation of the person and their character. A common impulse is to focus on defending their intention--on their "goodness"--rather than on the impact of their words or deed. Too often this defense forestalls productive conversation by centering the dialogue on defense of intentions and character rather than on the way words and actions impact another person or reinforce inequitable systems.

Well-intended people may try to distance themselves from racism's negative connotations by adopting an attitude of "colorblindness," or not seeing color. This approach, too, forestalls conversation since it 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 create space to hear and honor our 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*).

Emotions like guilt and defensiveness can make talking about racism difficult. White people, and others with race privilege, may wrestle with feelings of guilt when they begin to confront the idea that their race affords them certain privileges at expense of people of color. They may feel angry that their hard work 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.

Sometimes white people and others with race privilege disengage from conversations about racism because they think that racism doesn't affect them. When someone does not have to think about their race every day, it usually means they are in a position where they do not often confront racism (this is an example of white privilege). If someone has not been affected by racism, and they do not feel that they perpetuate racism, then they may think that it is not their responsibility to address racism, and thus disengage from necessary conversations.

Whose responsibility is it to dismantle racism?

Dismantling racism cannot be done alone. Sometimes white people and others with race privilege believe that dismantling racism is not their responsibility because they feel they do not have the knowledge or expertise gained by experiencing racism themselves. However, this is far from true. They may be unaware of the ways in which they unintentionally reinforce structural inequality (inequitable social, political, and economic forces that offer different access and opportunities to people with different identities) because they haven't had to think critically about their role in the systems that maintain inequality. Viewing anti-racism as everyone's problem requires a frame shift. Since everyone has a role in social systems, we each have a role and responsibility in dismantling the systems that perpetuate racism.

Doing the work. Not only do people of color have to deal with racism, but they often shoulder the additional burden of being asked to both *prove* the veracity of their experience of racism and to serve as an expert educator for others (white people or people with race privilege) on how racism works. Those with race privilege can take responsibility for their own education by cultivating *racial stamina*[1], or resilience for doing the difficult work of dismantling racism. Gaining racial stamina requires personal work, including active reflection on how we were taught to think about racism and race growing up. It requires intentional practice to identify the power dynamics that exist in our classrooms, exam rooms, and our larger professional and community spaces. It requires ongoing engagement, scrutiny, and humility.

Opportunities for exploration:

Books

- DiAngelo Robin. *White Fragility: Why It's so Hard for White People to Talk About Racism*. Boston, MA: Beacon Press; 2018.
- *White Fragility* Readers Guide

Articles

- Acosta, David & Ackerman-Barger, Kupiri. "Breaking the silence: Time to talk about race and racism". *Academic Medicine*. 2017;92(3):285-288. doi:10.1097/ACM.0000000000001416
- Crosley-Corcoran, Gina. "Explaining White Privilege to a Broke White Person." *Huffington Post.* 8 May 2014.
- Lorde, Audre. "The Uses of Anger". *Women's Studies Quarterly*. 1997;25(1&2).

Trainings/Groups

- White Noise Collective: https://www.conspireforchange.org/
- UNtraining White Liberal Racism: http://untraining.org/
- Catalyst Project: https://collectiveliberation.org/resources/training-programs/
- Relationship Centered Communication for Anti-Racism at ZSFG/DPH

Podcasts

- *Interchangeable White Ladies Podcast. "Episode 41:*An Interview with Robin DiAngelo", March 7, 2019.
- *On Being with Krista Tippett*. "Claudia Rankine: How can I say this so we can stay in this car together?" January 10, 2019.

[1] DiAngelo, 2018

Step 2: Definitions and Frameworks

Before you can create curriculum or engage in discussion with learners about topics that address racism and race, please familiarize yourself with the following definitions and frameworks.

DEFINITIONS

Racism

Racism typically refers to prejudice, discrimination, antagonism against a person or group of people based on their race. Racism reinforces systems of power and privilege. Racism can be overt or subtle. It can be personal (between people), and it can be structural (inequitable systems including laws, markets, institutions, etc.). Racism may be intentional or motivated by fear, greed, malice, or belief in one's own superiority; it may be unintentional, born out of inexperience, ignorance, or unconscious biases that have been shaped by a lifetime of experiences and internalized cultural messages.[2]

Race

Race is a social construct and categorizing tool that emerges from 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.[3] The boundaries of what constitute race are murky and shift with changing social norms.[4] The construct of race was used to perpetuate the idea that there are fixed, innate characteristics that apply to sets of people with diverse origins, life experiences, and genetic makeups. However, race is distinct from ancestry. Ancestry denotes people's shared traits based the genetic similarities of their ancestors and accounts for the complexity of geographic variation and fluidity.[5] While race is socially constructed, the consequences of this social construct are experienced individually, and collectively by communities, in the form of racism, and its effects can be seen in differential outcomes in health, wealth, socioeconomic status, education, and social mobility in the United States.

Whiteness

Often conversations about racism can feel personal, rather than focused on the systemic mechanisms that maintain or protect racism. In order to set the stage for productive conversations about racism at UCSF, we want to introduce the useful theoretical framework of *whiteness*. Whiteness is the *systematic* prioritization that advantages white people and disadvantages people of color. The fundamental premise of whiteness is that being white is the standard and being a person of color is a deviation from this norm.[6] Whiteness influences everyone because it is a ubiquitous set of cultural assumptions to which we are all pressured to conform. It is, essentially, the water in which we all swim.[7] As such, the ideals of whiteness become normative and often go unnamed and unquestioned. This has tangible consequences, and often violent effects, for those who do not default into the norms of whiteness. Whiteness and its consequences permeate medicine and health care in complex and nuanced ways.

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[2] Jones, 2000
[3] Roberts, 2011
[4] Morning, 2011
[5] Roberts, 2011
[6] McLaren, 1998
[7] Tatum, 1997

White Privilege
White privilege is a term that identifies opportunities, privileges, protections, head starts, or benefits that people perceived to be white enjoy that are not typically afforded to people of color. These benefits can be material, social, or psychological.[8]

Race privilege
Race privilege is a term that identifies people who may be afforded privileges over others, usually because of race and relative proximity to whiteness when compared to another person identified as being of a different race.

White fragility
White fragility is a term used to describe an emotional response that white people may experience when discussing racism. It is characterized by emotions such as shame, defensiveness, anger, withdrawal, and guilt, and often results from feeling personally attacked in discussion about race and racism, even when the focus of the discussion is about a system. While white fragility may be a learned and often a subconscious emotional response, 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.

Color-blindness
One mainstream and often culturally acceptable way to approach race in the United States is to insist that race is unimportant (or unseen) and does not impact a person's achievements or abilities.[9] However, because of racism, people of different races have different lived experience. Espousing a colorblind ideology that race does not matter ignores the actual differences in lived experience that people have based on how others perceive and respond to them, in conscious, subconscious, and systemic ways. Becoming conscious of how race affects one's experiences in the world, or becoming *color-conscious*, is an important step in addressing racism.[10]

KEY FRAMEWORKS

Critical Race Theory (CRT) emerged from legal scholarship in response to the limited and narrow scope of how law defined and addressed racism. Critical race theorists recognize that racism is ingrained in the United States' historical fabric and argue we must explicitly identify and name racial power dynamics in order to address racism.[11]

Public Health Critical Race Praxis (PHCRP) is a framework that uses the core tenant of CRT and applies it to health equity and public health research. PHCRP offers a framework to both evaluate current and historical research that inadvertently reinforce social racial hierarchies and offers tools for racial equity approaches to knowledge production.[12]

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

[8] McIntosh, 1998
[9] Flagg, 1992
[10] Crenshaw et al, 1995
[11] Crenshaw et al, 1995
[12] Ford & Airhinhenbuwa, 2010

shared equitably. Anti-racism examines the power imbalances between racialized people and non-racialized (ie white people). A person who practices anti-racism is someone who works to understand:

- How racism affects the lived experience of people of color and Indigenous people
- How racism is systemic and be manifested in both individual attitudes and behaviors as well as formal policies and practices within institution
- How white people can, often unknowingly, participate, in racism
- That dismantling racism requires dismantling systems that perpetuate inequity

Remember, these concepts are complex and these conversations will be challenging. They may feel personal at times. As you experience your own discomfort, remember those who consistently experience racism's discomfort. Lean into the discomfort with the goal of talking about systems, and our roles in perpetuating or dismantling unjust systems, rather than attacking or defending one's character.

Opportunities for exploration:

Books

- Irvin Painter, Nell. *The History of White People.* W. W. Norton & Company, 2010.
- Thandeka. *Learning to be White: Money, race, and God in America.* Continuum, 1999.

Articles

- McIntosh, Peggy. "White Privilege and Male Privilege: A personal account of coming to see correspondences through work in women's studies". *World Trust.* 1998. https://www.racialequitytools.org/resourcefiles/mcintosh.pdf
- Tsai, Jennifer. "The problem with cultural competency in medical education". 8 Mar 2016. https://www.kevinmd.com/blog/2016/03/problem-cultural-competency-medical-education.html

Podcast

- "Seeing White" series*. Scene on Radio.* Center for Documentary Studies at Duke University. http://www.sceneonradio.org/seeing-white/

TED Talk

- Kang, Jerry, JD. "Immaculate Perception: Jerry Kang at TEDxSanDiego 2013." *re:THINK TEDxSanDiego*. YouTube; 2014. https://www.youtube.com/watch?v=9VGbwNI6Ssk

Step 3. Historical Context: Understanding race in the context of health care and medicine

Justification of oppression

The history of medicine in the United States is intertwined with the economic and social foundations of slavery and colonization in our country. While racism in medicine has historically and continues to harm people of color from various backgrounds, we focus on how medicine contributes to anti-blackness to provide one clear example. As the founding fathers were establishing democracy on the principles of natural rights and liberty, race was simultaneously used as an organizing tool to rationalize the enslavements of Africans. Rooting the concept of race in biology and scientific theories of innate racial difference asserted race's independent position in the natural order and provided justification for the abuse of black slaves.[13]

How racism invaded medicine, health, and science

The biologic basis for race was further codified by scientific scholars throughout the 18th and 19th century who attempted to explain phenotypic differences between white and black people. For example, the physician-scientist Samuel George Morton argued that brain size depended on race while Dr. Robert Bennett Bean plotted races in a linear hierarchy with regard to their mental worth. Samuel Cartwright, a prominent Southern physician theorized that black people had dysesthesia, a disease in which slaves experienced inadequate breathing due to insufficient decarbonization of blood in their lungs.[14] Cartwright concluded that the brutal working conditions of slavery provided an appropriate treatment for black peoples' inferior lung capacity.[15] Similarly conflating biology and race, in 1962 scientist James Neel put forth his thrifty gene hypothesis to explain the high rates of 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 wrote in 1999 that his investigations found "no support to the notion that high frequency of [T2DM] in reservation Amerindians might be due simply to an ethnic predisposition—rather, it must predominantly reflect lifestyle changes."[16] Despite this, racialized notions of genetic basis for disease persist and function to obfuscate the impact of historical trauma, dispossession, demoralization,[17] and an underfunded Indian Health Services system on health disparities experienced by America's indigenous people.

Beyond attempts to explain phenotypic difference, researchers also exploited racial hierarchies to justify experimentation on people of color. For example, the contemporary field of gynecology was established through the work of James Marion Sims, a plantation doctor. In an effort to develop a treatment for vesico-vaginal fistulas, Sims performed excruciatingly painful and dehumanizing experiments on the genitalia and reproductive organs of enslaved women.[18]

Contemporary Times

These examples may sound ludicrous and distant from our contemporary medical world where we actively strive to "do no harm". However, these historical assumptions about race being biologically rooted persist in medicine and negatively impact health. For example, researchers

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[13] Fields, 1990; Duster 2006
[14] Gould, 1996
[15] Gould, 1996; Duster, 2006; Braun et al., 2007
[16] Paradies et al, 2007
[17] Warwick, 2007
[18] Washington, 2012

at the University of Virginia (UVA)[19] found that differences in pain treatment for African-Americans is associated with beliefs in biological difference. They presented false beliefs about the physiology of black patients, such as the idea that black people age slower than whites, their blood coagulates more quickly, and their skin is thicker. This UVA study found that as white medical trainees more strongly endorsed these false beliefs, the accuracy in their assessment of black patients' pain levels decreased.

In addition, the use of "race-based" predictions leads to missed diagnoses. A common example is seen in sickle cell anemia. In the United States, sickle cell anemia has become synonymous with black race. However, sickle cell disease is prevalent among people from South & Central America, Saudi Arabia, India, Turkey, Greece and Italy in addition to those labeled as "black" (descendants from those from Sub-Saharan Africa). This conflation of race with ancestry and genetics leads to improper and missed diagnosis.[20]

Lastly, in 2002 the Institute of Medicine was commissioned by congress to uncover etiologies of our ongoing and persistent racial and ethnic disparities in health outcomes in the United States. The study, entitled *Unequal Treatment,* demonstrated that provider bias, in the form of implicit bias, has a large contribution to these unyielding differences.

Race in medicine & health

Although race is a social construct, the consequences of racism are real and manifest in the form of, among other things, health disparities. Race, whether it is self-identified or not, is a crude proxy for a shared lived history in the United States. **Race is not a biological construct, but a social one.** While it is necessary to discuss how race, specifically racism, has affected the health of racialized people in the United States we need to be careful on how it is used so that it does not:

- Perpetuate false beliefs about differences in biology that directly lead to health disparities (as seen in the UVA study noted above)
- Lead to common misdiagnosis (as seen with sickle cell anemia)
- Lead to implicit racial bias

In short, genetics is real, however race does not equate to genetics. The world of medicine is embedded in our larger society. Therefore, when we examine racism in medicine, we are scrutinizing forces that influence how we think and practice today.

[19] Hoffman et al, 2016
[20] Yudell et al, 2016

Opportunities for Exploration:

Articles

- Braun, Lundy; Fausto-Sterlin, Anne, Fullwiley, Duana,…Shields, Alexandra E. "Racial Categories in Medical Practice: How useful are they?" *PLoS Medicine.* October 2007. DOI: 10.1371/journal.pmed.0040271.
- Tsai, Jennifer. "What role should race play in medicine?" *Scientific American*. 2018 Sept 12. https://blogs.scientificamerican.com/voices/what-role-should-race-play-in-medicine/
- Coates, Ta-Nehisi. *The Case for Reparations*. [online] The Atlantic; 2014. Available: http://www.theatlantic.com/magazine/archive/2014/06/the-case-for-reparations/361631/
- Tsai, Jennifer. "How racism makes us sick". 15 April 2015. Available: https://www.kevinmd".com/blog/2015/04/how-racism-makes-us-sick-the-medical-repercussions-of-segregation.html
- 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.
- Duster, Troy. "Lessons from History: Why Race and Ethnicity Have Played a Major Role in Biomedical Research". *Journal of Law, Medicine, and Ethics*. 2006;34(3):487-96.
- Goddu, Anna P., O'Conor, Katie J., Lanzkron, Sophie. et al. "Do Words Matter? Stigmatizing Language and the Transmission of Bias in the Medical Record". *Journal of General Internal Medicine*. 2018;33: 685. https://doi.org/10.1007/s11606-017-4289-2

Books

- Kendi, Ibrham. *Stamped from the Beginning: The definitive history of racist ideas in America*. Random House; 2017.
- Roberts, Dorothy. (2011). *Fatal Invention: How science, politics, and big business re-create race in the twenty-first century.* New York, NY: The New Press.
- Green, Laurie B., Mckiernan-González, John, & Summers, Martin, eds. *Precarious Prescriptions: Contested Histories of Race and Health in North America*. University of Minnesota Press, 2014.

Podcasts

- *RoS Racism and Inequity in Healthcare with Utibe Essien.* https://primarycare.hms.harvard.edu/rospod/ros-racism-and-inequity-in-healthcare-with-utibe-essien/
- Bichelle, Rae Ellen. "Scientists Start To Tease Out The Subtler Ways Racism Hurts Health". NPR. 2017 Nov 11. https://www.npr.org/sections/health-shots/2017/11/11/562623815/scientists-start-to-tease-out-the-subtler-ways-racism-hurts-health

TED Talks

- Dorothy Roberts: The Problem with Race Based Medicine. TEDMED 2015. https://www.ted.com/talks/dorothy_roberts_the_problem_with_race_based_medicine

Step 4. Implement anti-racism in medical education

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

Section 1 - *What are the best practices for engaging in discussions about race and racism?*

Approach conversations about racism with a growth mindset. Many of us were not taught how to productively have different conversations about politically-charged topics. We may feel like beginners and that may be uncomfortable. However, we recognize that conversations about racism are opportunities to grow individually and together. Making mistakes is part of this process. Stay humble.

Approach your discomfort with inquiry. Discomfort is a signal that we have an opportunity for growth. If you can be mindful about the circumstances and context in which discomfort arises and name it, we can mine those moments for learning.

Distinguish the individual from the system. An individual's relationship to systems of oppression is complex and may evolve. One may benefit from a system, be oppressed by it, actively or passively reinforce it, or subvert it. If you find yourself feeling guilty or attacked, try to remember that critiques of a system are not necessarily critiques of your person. Is the attack on you, or on a system that benefits you?

Distinguish intention and impact. Intention describes the motivation, while impact describes the effect on a person. When talking about race and racism, you can acknowledge an intention, but it is equally, if not more important, to honor another's experience of the impact.

Take responsibility for "doing the work". Everyone has different levels of experience and expertise with regards to race and racism. One of the privileges of whiteness is not being forced to confront your race and the way it 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). Take the time to educate yourself rather than always turning to a person of color to educate you.

Be an ally! Allyship is a process, not an identity. It is hallmarked by qualities of accountability, trust, and consistency in relationship building with marginalized communities. Allyship is not self-defined, but rather recognized by those with whom we seek to ally. You can work to be an educational ally by striving for an anti-racist learning environment.

Continue to 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.

Section 2 - *How can I develop anti-racist educational materials?*

When designing or reviewing educational materials such as lectures, student study guides, or exams, use the following guide to minimize stereotypes, and be inclusive and equitable in your approach:

1. **Take stock of representation.** Do you have people of different backgrounds represented in your case examples, images, and questions? (Should also consider representations of gender, age, sexual orientation, ability, as appropriate).

    No? → Why not? What biases are you creating with your choice of representation? Can you directly address this as a learning moment in your lecture (eg. acknowledge the biases perpetuated by a historical representation in an old medical text book image you've included in your lecture)

    Yes! → Are they respectful and positive representations with regards to image, associated language, and descriptive demographics? Are the demographics relevant to the case? If so, how? Are they reductionistic or expansive representations?

2. **If you are talking about race, is it actually relevant?** Remember**,** race is a social construction, developed to stratify groups of people in order privilege some (white people) at the expense of others (people of color). Biology-based definitions were mapped onto race to reinforce hierarchies of privilege and justify the social subjugation of groups of people. Disparities in health outcomes are often attributed to biology, but are more likely the result of social inequities (eg. access to health care, poverty, etc.) and racism. Race is not the risk factor, but rather a crude proxy for the risk conferred by racism.

    No → Consider using ancestral geographic origin rather than race since it more accurately describes human genetic variation. "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"[21]

    Yes → Challenge yourself to avoid reinforcing that race is purely biological. When discussing race and propensity for disease, be sure to address health disparities and the social and structural factors that contribute. When discussing epidemiological data, distinguish between causation and observation. In question stems or examples, the mention of race in some cases but not all leads students to think that race is an inherent biological risk factor. If relevant to the case, consider using the language "the patient identifies as_(race)_" or "they are of _____ descent/ancestry" rather than "they are _(race)_"[22]

[21] Roberts, 2011
[22] Deng, Kelly, 2019

3. **Scan for stereotypes.** Find them, fix them! Your ability to do this will depend on your sensitivity to stereotypes and your "blind spots," which we all have. After intentional scrutiny of your materials, consider asking a colleague for a second set of eyes for review.

- Examples:
  - "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 M. Deng and M. Kelly's review of first year curriculum)

4. **If race is applicable to your topic, have you addressed health disparities pertaining to your topic?** Identifying and discussing health disparities is an important part of building an equitable learning environment.

No → 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 in the area, disparate research priorities.

Yes → What does the research show? What is the quality of the research? How does research methodology drive what we understand about disparities? What structural causes contributed to the findings?

5. **Be receptive to feedback.** If a student or colleague identifies something as problematic, or challenges you with a question or comment during your lecture, invite reflection! We are all learning from each other.

6. **Need more support?**

- Additional resources → See Jason Satterfield's "Small Group Facilitation: Leading Discussions of Race and Culture"
- Individual help → Consult the Differences Matter Advisory Group! Visit our wiki page for details: https://wiki.library.ucsf.edu/pages/viewpage.action?spaceKey=DMI&title=DM+-+Action+Group+3

Opportunities for growth:

Article:

- Tsai, Jennifer. "What role should race play in medicine?" *Scientific American.* 2018 Sept 12. Available: https://blogs.scientificamerican.com/voices/what-role-should-race-play-in-medicine/
- Gehl, Lynn. "Ally Bill of Responsibilities." Accessed 29 March 2019. http://www.lynngehl.com/uploads/5/0/0/4/5004954/ally_bill_of_responsibilities_poster.pdf

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Fields, BJ. Slavery, race and ideology in the United States of America. *New Left Review*. 1990;1(181), 95-118.

Flagg B. "'Was Blind, But Now I See': White Race consciousness and the requirement of discriminatory intent". *Michigan Law Review.*1993;91:953-1017.

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Hoffman KM, Trawalter S, Axt JR, Oliver MN. Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites. Proceedings of the National Academy of Sciences. 2016;113(16), 4296–4301. http://doi.org/10.1073/pnas.1516047113

Kelly, M., Deng, M. *Recommendations for Faculty: Use of Race/Ethnicity/Geographic Origin in Patient Case.* Handout. 2018 Dec 12.

Jones CP. Levels of Racism: A theoretical framework and a gardener's tale. Am J Public Health. 2000 August;90(8): 1212–1215.

McLaren P. Whiteness is. . . the struggle for postcolonial hybridity. In J. Kincheloe, S. Steinberg, N. Rodriguez, and R. Chennault (Eds.). *White Reign*. New York: St. Martin's Griffin; 1998.

McIntosh P. *White Privilege and Male Privilege: A personal account of coming to see correspondences through work in women's studies.* Wellesley, MA: Wellesley College, Center for Research on Women; 1988.

Paradies Y, Montoya M. "Racialized Genetics and the Study of Complex Diseases: the thrifty genotype revisited" *Perspectives in Biology and Medicine*, volume 50, number 2 p 203–27. Johns Hopkins University Press; 2007

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