Is race a risk factor?
Creating Leadership and Education to Address Racism: An Analytical Review of Best Practices for BUSM Implementation

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Limitations

The pedagogy of race at BUSM is largely Afrocentric, and thus the scope of the Vertical Integration Group and the themes represented in the resulting report are similarly limited. In addition, due to extensive redesigning of the Doctoring and Human Behavior in Medicine courses in recent years, the topics in these courses were omitted from our review. While the curricular content of racism in medicine programming modeled at twelve universities (detailed in Appendix D) was analyzed, the approaches of other institutions have not been explored here.

Medicine is a conglomerate of psychology, socioeconomic theory, politics, legislation, and other topics, and there is no authoritative resource that brings all these together. Although the research was as extensive and inclusive as possible, there is insufficient literature published in this arena to provide definitive recommendations on implementation strategies and faculty development techniques. With this in mind, Appendix E was created with a set of Boston resources and training sessions that will take place at Boston University School of Medicine to serve as reference for continuing efforts in curricular reform.
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Executive Summary
Executive Summary

On May 9, 2019, the Boston University School of Medicine’s (BUSM) Medical Education Committee (MEC) commissioned the formation of a Vertical Integration Group composed of students, faculty, and staff to assess how systemic racism has impacted the internal climate and curriculum at BUSM. The Racism in Medicine Vertical Integration Group (VIG) was commissioned to support the Medical Education Office (MEO) in the ongoing work of deconstructing racism in medicine through the development of a longitudinal curriculum. This report endeavors to establish a historical understanding of how racism impacts the institution of medicine and medical training, share the results from an internal assessment of the current BUSM curriculum on matters of race and racism, summarize the current literature on race and racism in medical curricula, highlight the work of peer institutions as a model for BUSM, provide a thorough list of tools and resources, and propose a set of key recommendations. It is with this disposition and with these objectives that this report has been drafted. The goal of this document is twofold:

1. To bear witness to the history of racism within the institution of medicine and its impact on trainees, physicians, and patients.
   
   The act of bearing witness is an intentional act of recognizing those who struggle to move within a system that causes harm. Moreover, it empowers individuals to bring forth tangible change to positively impact those who come after.

2. To partner with BUSM’s Medical Education Office in the creation of an intentional and longitudinal curriculum to dismantle the impact of racism in medical education and medical practice.
Historical Perspective

The institution of medicine has been shaped by the belief of racial inferiority. This theory was affirmed in the late twentieth century by prominent physicians who thus codified a belief system of inequity and propelled the forward system of disenfranchisement (Bryd & Clayton, 2001). The theory of racial inferiority continues to have a significant impact on the healthcare system (Nelson et al., 2001). This tacit mindset fosters patient and physician stereotypes, poor patient outcomes, and biased medical research and education (Bryd & Clayton, 2001; Kovel, 1984; Tsai et al., 2016). The systemic infiltration of this belief has allowed for the sociological conception of race to be misconstrued as a risk factor and for a hidden curriculum to emerge within medical education (Osman et al., 2019; Osseo-Asare et al., 2018; Shapiro, 2002; Tsai, 2018). Even with the explicit denouncement of the theory of racial inferiority by the institution of medicine, this theory is subversively affirmed through current racialized medical pedagogy.

BUSM Internal Curricular Assessment

Pre-Clerkship Curriculum

Members of the VIG as well as additional medical student volunteers conducted a systematic review to examine how BUSM addresses race throughout the curriculum. For the pre-clerkship curriculum, the didactic material was reviewed via an in-depth assessment of the syllabi, slides, practice questions, and clinical vignettes for how race and the topic of racism was covered in this material. All pre-clerkship courses were reviewed excluding the Human Behavior in Medicine and Doctoring courses as their curriculum is in flux. The key findings are found below:

1. Strengths

   a. Highlighting Racial Health Disparities through Population Health Data and Patient Narratives
   b. Foundation for Appropriate Discussion about Race and Medicine
   c. Historical Perspective of Race in the Context of Research Ethics

2. Weaknesses

   a. The Use of Race as a Risk Factor for Pathology
   b. Consequences of the Explicit and Implicit Representation of Race as Biological and/or Genetic
   c. Lack of Images of Patients of Different Skin Types

3. Opportunities for Expansion and Growth

   a. Naming Racism
   b. Expanding on Prevalence & The Critical Examination of Evidence Promoting Race-Based Medicine
   c. Questioning Use of Race in Clinical Vignettes
   d. Standardized Approach Throughout the Curriculum
Clerkship Curriculum
Assessment of the clerkship curriculum consisted of an in-depth review of didactic lecture slides for all clerkships other than the Emergency Medicine, Ambulatory Medicine and the Surgical Subspecialties courses. Of note, the Radiology clerkship did not have any mention of race. In addition to reviewing the didactic material, 3rd and 4th year students met and discussed their personal experiences and those of their colleagues throughout the clerkship curricula, specifically examining the utility of mentions of race, the extent of medical knowledge about an association between race and disease and, most importantly and most difficult to pinpoint, what was left out in terms of an anti-racism curriculum. The key findings are found below:

1. **Strengths**
   a. Developing History-Taking Skills to Broaden Treatment Options
   b. Abandoning a Culture of Stigmatization and Patient-Blaming

2. **Weaknesses**
   a. Lack of Images of Patients of Different Skin Types
   b. Imprecise Wording to Describe Patient Demographics
   c. Incorrect Association of Race with Disease

3. **Opportunities for Expansion and Growth**
   a. Further Understanding Legacies of Racism and Systemic Oppression
   b. Promote Bystander Training
   c. Opportunities for Reflection and Continued Conversations About Racism
   d. Case-Based Learning on Informed Consent

Pre-Clerkship & Clerkship Curriculum Key Recommendations
1. Standardize terminology and framing across modules
2. Remove the use of race as a risk factor for pathology
3. Critically examine why race is being used in the clinical vignettes and exam questions
4. Diversify clipart and images to include a broad range of skin tones
5. Use the most specific data for a given population and discuss the limits of the data to prevent the use of racially motivated epidemiological reporting
6. Critically examine the strength of evidence when promoting race-based medicine
7. Ensure culturally sensitive and appropriate language is used to describe patient demographics
8. Create additional opportunities for students, faculty, and staff to develop the skills to become allies to communities of color
9. Equip faculty to teach how the historical and structural background of racism has shaped the institution of medicine and created health disparities
10. Create additional opportunities for students, faculty, and staff to reflect on how racism has impacted their lives
BUSM External Assessment

In alignment with the Boston University School of Medicine’s (BUSM) mission to train physicians and physician-scientists to have an “active understanding and commitment to social justice,” and in recognition that America’s diversity remains on the rise, with census data projecting that the nation will become majority non-White by 2045, society needs medical professionals who are equipped to properly respond to this rapidly changing demographic. Moreover, research has shown that intentional exposure to minority healthcare and health disparities in the medical curriculum leads to better patient rapport with minority patients (Phelan, 2019). Towards that end, the Racism in Medicine VIG researched aspirational institutions and programs to survey best practices for how to incorporate a longitudinal racism in medicine curriculum.

The external assessment was conducted by members of the VIG and other BUSM students who reviewed curricula from 12 American medical schools and conducted a literature review assessing racism focused curricula. The curricula were reviewed via a combination of work published online, email and phone correspondence with students and faculty, and in-person interviews. The findings were synthesized into a core group of values that were deemed to be fundamental for enhancing medical students’ education. The desired outcome is to develop physicians who will be knowledgeable of and sensitive to matters related to racism in the medical field. The core values chosen by this taskforce were the following:

- Framing the Impact of Racism in Medicine
- Curricular Review
- Central Endorsement
- Faculty Development
- Community Engagement
Legacy

This report is as timely as it is purposeful. This report comes at an opportune moment as BUSM is in the midst of a comprehensive instructional redesign. This redesign provides an opportunity to incorporate the recommendations of this report and when this endeavor is successful, BUSM will transform millions of patient interactions.

1 BUSM Class (160 students) x 20 patients per day x 300 working days x 30 year career = 28.8 million patient interactions

Proposal

The Racism in Medicine VIG proposes the following eight initiatives for implementation of an intentional and longitudinal curriculum to address racism in medicine. These recommendations are grounded in a review of best practices at American medical schools, in the findings of our internal assessment, and in collaboration with institutional experts and stakeholders.

The initiatives are as follows:

1. Establish a curriculum throughout the four-year medical curriculum based on overarching equity and specific racially focused equity competencies (Appendix A)
2. Increase Central Endorsement to Create Collaborative Buy-In
3. Name and Frame the Impact of Racism as A Structural Inequity
4. Challenge the Biological Framework of Race
5. Increase Faculty Development
7. Community Partnerships and Resource Guide
8. Continue to Foster Student Engagement (i.e. Appendix D - CLEAR Enrichment Series)
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Full Report
Racism in Medicine VIG: Full Report

This report outlines findings of a student and faculty assembled VIG commissioned to identify methods and curricular content aimed to educate Boston University School of Medicine (BUSM) students about the continuous challenge of racism in medicine. The goal of this report is to provide research indicating how topics in racism in medicine are currently taught in medical education, to highlight findings specific to BUSM curriculum, and to build a framework of competencies for the MEO to review. Additional Boston area resources, such as organizations with a priority of racial justice, are included to aid in the development of community building that is essential for addition in a curriculum specific to BUSM.

Historical Perspective

The institution of medicine was central to the creation of the theory of racial inferiority and thus it is distinctively positioned to continue the work of dismantling it. In the 1800s, well known physicians and medical scientists including Samuel Morton, Josiah Nott, and Paul Broca affirmed the theory of racial inferiority (Byrd & Clayton, 2001). This foundational affirmation has forged an inextricable tie between modern medicine and the “creation and promulgation of a racially oriented, inequitable, medical-social culture and health delivery system” (Byrd & Clayton, 2001). Racism in America has evolved from a paternalistic and explicit expression to a competitive, systematic, and implicit manifestation. Psychiatrist Joel Kovel defines this evolution as instituting a “metaracism” which has created a systematic, policy driven social structure that moves independent of any singular factor (Kovel, 1984). Recognizing this evolution is fundamental for appreciating how race and racism saliently impact every aspect of society and medicine.

Systemic racism has allowed for the experimentation and generational disenfranchisement of people of color by the US government and medical community. Even with the scientific and social advancements of the late 20th century, which disavowed these foundational beliefs, the ongoing practice of racism in medicine is integral to health outcomes still seen today.

Throughout medical training, race is used as a risk factor despite the understanding that race is a socially-derived concept based on pigmentation and power (Tsai, 2018). This misuse creates an improper connection between race, genetics, and sociological racial disparities which perpetuates the theory of biologically-derived racial differences (Tsai, 2016). Tsai et al. state that this practice “employs race as a definitive medical category without context, which may… increase bias among student–doctors, and ultimately contribute to worse patient outcomes” (2016). Secondly, it has been well documented that there are significant racial healthcare and health outcome disparities. Nelson states that “racial and ethnic minorities tend to receive a lower quality of healthcare than non-minorities, even when access-related factors, such as patients’ insurance status and income, are controlled” (Nelson et al, 2001). This inequity manifests in the disproportionate burden of disease seen in people of color. The two previous points converge in
the experience of trainees and physicians of color who, despite being a member of the institution of medicine, are still subject to the social injustices of racism. These experiences are most aptly seen through the explicit and hidden curriculum about race in undergraduate and graduate medical education, the lack of representation, and the implicit and explicit bias from colleagues and patients (Osseo-Asare, 2018).
Internal BUSM Assessment

Pre-Clerkship Curriculum

Methods

From September 2019-January 2020, student VIG members as well as additional BUSM medical student volunteers conducted a systematic review of the pre-clerkship curriculum to examine how BUSM addresses race. Each lecture in Principles Integrating Science and Medicine (PriSM), Disease and Therapy (DRx), and Essentials of Public Health (EPH) were reviewed to assess where and how the curriculum discusses topics of race. The curricula for the Doctoring and Human Behavior in Medicine courses were not reviewed in detail as they are in flux. However, the VIG members have offered some broad suggestions for those courses as well. An Instruction and Tip Sheet, adapted from a similar tip-sheet created at Alpert Medical School at Brown University, was created to facilitate a systematic data mining process (Green, 2018). A team of students representing all years went through each lecture and used the instructions and tip sheet to assess the lectures for how race is discussed and to identify opportunities for growth. Findings were entered into respective course spreadsheets and categorized into three sections: strengths, weaknesses, and opportunities for expansion and growth. The broad findings are listed below with top resources and recommendations, and the detailed findings can be found in Appendix B.

Broad Findings

BUSM Strengths in Discussing Race in Medicine

1. Highlighting Racial Health Disparities through Population Health Data and Patient Narratives

Throughout the pre-clerkship curriculum, there is a focus on highlighting racial/ethnic health disparities. BUSM has an overarching commitment to teach students about conditions that affect racial/ethnic minorities in preparation for patient care at a regional safety-net hospital serving patients from minority communities. BUSM actively demonstrates an understanding of the specific needs and conditions affecting the patient population seen at BMC. A major strength of the BUSM curriculum is its focus on pathology that significantly affects the BMC population and the epidemiological lens employed by lecturers to highlight differences in health outcomes between racial groups. Important examples of this are found in the DRx Reproduction module, where trends in incidence and mortality rates of gynecological and breast cancers are examined. By presenting data of diagnosis and treatment rates of breast and ovarian cancers in the context of advances in testing and treatment, these lectures suggest that race is a placeholder for unequal access to care and possibly imply genetic differences that determine effectiveness of treatment. While stating the prevalence of a disease in certain groups is useful to highlight population health disparities, it does not explain why the disparities exist. Providing data of structural systems of oppression, as in the above examples, tasks students with finding solutions to reduce racial health disparities. Other instances in this module include lectures on contraception and
abortion which present data of rates of contraception use and abortion rates by race within a framing of reproductive justice to highlight the barriers faced by women of color. Similarly, EPH discusses racial health disparities with the goal of understanding why disparities exist. See below for EPH’s important naming of racism and structural barriers. Furthermore, each course’s curricular appendix, found within Appendix B, has further examples of racial disparities discussed in the pre-clerkship curriculum.

Additionally, the BUSM pre-clerkship curriculum highlights racial health disparities by offering students many opportunities to hear the stories and experiences of patients of diverse racial and ethnic backgrounds. This exposure allows students to learn from a multitude of perspectives and prepare them for the diversity that is to come on the wards. It emphasizes that patient experiences are not monolithic and that disease presentation is unique to each individual. The focus on diverse patient representation in the pre-clerkship curriculum as well as the emphasis on BUSM’s commitment to training physicians invested in serving diverse populations creates a learning environment conducive for continued conversations about racial health disparities.

2. PrISM Genomic Medicine: Foundation for Appropriate Discussion about Race and Medicine

An exemplary example of creating a clear foundation for students to understand the intersection of genetics, race, and racism in medicine is the PrISM Genomic Medicine module. The PrISM Genomic Medicine module introduces first year students to topics in genetics, race, and racism in medicine. The module is exemplary in providing clear definitions for these different concepts and illustrative examples of differences between them. For example, when discussing the prevalence of sickle cell disease, Dr. Dasgupta presents a map of alleles for the disease to show genetic distribution. By avoiding stating prevalence by race or geographic distribution, students are taught not to expect to see the disease in a singular racial group, but rather in a particular genotype. This is essential to point out the importance of disentangling geographic origin from race. This allele is not inherent to a race; rather, there is more prevalence of the allele in certain specific areas of the world.

The Genomic Medicine module’s definitions of terms such as ancestry and race have the potential to be compiled into a glossary of terms that could be standardized across all modules and aid in dispelling the myth that race is genetic. The module’s approach of focusing on descent and ancestry, rather than race, is successful in laying a foundation for appropriate clinical workup of a genetic disease such as sickle cell, rather than promoting differential medical treatment based on a patient’s phenotypic appearance.

Additionally, Dr. Dasgupta highlights the need for more genetic research in diverse populations, with a specific focus on diverse ancestries. For example, the genetic mutations in both breast cancer and cystic fibrosis often vary across ancestral groups, but there is not as much data on these “Variants of Uncertain Significance” that present in patients with diverse ancestry. The course highlights healthcare access inequities, racism, and warranted distrust of the medical
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system as contributing factors to the lack of research and genetic testing skewed towards known gene polymorphisms found at a higher rate in individuals with European ancestry. This landscape is important for medical students to know before they enter the wards in order to understand the limits of current testing guidelines and research and to be part of expanding and challenging them.

3. Discussion of Race in the Context of Research Ethics

Providing students the historical context of how racism has impacted medical research is essential for framing the impact of biased and/or unethical research on society, medical practice, and patient outcomes. Within multiple courses in the PrISM curriculum, landmark cases are explored to assess unjust practices against people of color and/or biased research that leads to potentially differential treatment protocols. This practice is essential for framing for students why there is mistrust of the medical community by people of color and that medical research must be critically assessed for non-discriminatory findings.

In both the PrISM Genomic Medicine Module as well as EPH, students experience a deep dive into research ethics as the subject intersects with race. In Genomic Medicine, first-year students learn about the Tuskegee syphilis experiment. In EPH, students learn about Henrietta Lacks in lecture and are assigned independent reading outside of class to understand how her cancer cells were and continue to be used without her consent.

An important example that the Genomic Medicine module offers about race in the context of research ethics as well as the dangers of genetic assumptions about race is the module’s discussion of the drug BiDil. BiDil is a drug that was used in the treatment of heart failure in Black patients despite the misleading evidence to prove that it works better in Black individuals. Furthermore, the original study used self-identified race as an independent variable in a very small sample size (Tsai, et al., 2018). The Genomic Medicine Module elaborates on the history of BiDil and highlights that these assumptions about genetics in this case led to potentially damaging differential treatment for heart failure based on race. For more information on BiDil, see this additional appendix on its important history and racialized context.

Presenting these ethical issues is critical to the education of future physicians, as learning science without historical context is problematic. Historical framing of information influences the impact on society, medical practice, and health outcomes. The next step of the inclusion of these topics is to integrate them into their PrISM and DRx counterpart lectures, to be discussed below. These topics should not be presented as separate from or unrelated to the science curriculum, as often science has progressed by virtue of racist practices and policies.

Weaknesses

1. The Use of Race as a Risk Factor for Pathology

Throughout almost the entirety of the preclinical curriculum, race is explicitly listed as a risk factor for various health conditions in both the syllabi and lecture slides. While this seems
like a harmless inclusion, it can lead to dangerous assumptions about patients based on race. Additionally, it implies that there is something inherent about a certain race that can lead to a particular pathology. In her article in *Scientific American*, Jennifer Tsai, MD, writes that “rather than a risk factor that predicts disease or disability because of genetic susceptibility, race is better conceptualized as a risk marker—of vulnerability, bias or systemic disadvantage” (Tsai, 2018). When race is stated as a risk factor, it is often being conflated with social determinants of health. Furthermore, when race is identified as a risk factor, it implies that race is genetic and/or biological. This implication changes approach to treatment, as students learn that genetically based pathology is approached differently than acquired pathology. When structural barriers to healthcare are not examined, blame is often placed on individuals from marginalized racial groups for their health outcomes, and further research and action to remove structural barriers stagnates (Villarosa, 2019).

Another pitfall of listing race as a risk factor for certain diseases is that it stunts clinical thinking and may lead students to prematurely discount diseases not usually associated with a certain perceived population, for example, in the cases of non-White individuals with cystic fibrosis or osteoporosis. Alpert Medical School at Brown University has created a video that displays how to challenge the notion of race as a risk factor and incorporate those changes into lectures (Green, 2018). It provides tools to indicate prevalence without conflating prevalence with genetic/biological differences as well as how to discuss race and pathology without stating it as a risk factor. With permission from Alpert Medical School at Brown University, we recommend the use of this video for faculty development (Green, 2018). We recognize the reality of medical licensing exams' continued use of race as a risk factor, but it is recommended that BUSM remove this harmful language internally as well as challenge this terminology in national licensure exams.

2. **Consequences of the Explicit and Implicit Representation of Race as Biological and/or Genetic**

The use of race as a differential marker for treatment, screening protocols (i.e. GFR, spirometry), and disease etiology perpetuates the inaccurate false equivalency of biological risk groups and origin of race. While this practice is pervasive throughout all of medicine and undergirds many foundational pieces of medical research, it must be challenged to protect patients and prevent students from propagating systemic racism. It is imperative that faculty acknowledge these flaws and alert students to the shortcomings of the existing research and detrimental consequences of these beliefs. For example, the current American Heart Association guidelines discuss differential treatments for hypertension, heart failure, and other cardiac conditions based on race. However, these guidelines are a direct result of a medical system that is often complicit in and endorses institutionalized racism. These guidelines are based in faulty and unsubstantiated research that falsely identifies race as a proxy for biology/genetics, rather than as the social construct we know it to be. Continuing to teach this institutionalized race-based ideology implicitly
and explicitly perpetuates racist ideas about inherent differences in racial groups, ideas that have been time and time again proven to worsen health outcomes for patients of color. It is our charge to address this cycle of racism in medicine head on as to not propagate these health disparities.

Identifying race as a risk factor is one significant example of how the pre-clerkship curriculum implies that race is biological and/or genetic. The statement that race is biologically constructed directly contradicts what is taught in the Human Behavior in Medicine and Genomic Medicine courses, in which students are explicitly taught that race is socially constructed. Oftentimes in class, professors refer to racial health disparities to be due to “genetic differences in race.” In 2016, a study was published that showed that many medical students still believe in biological differences between races. An example of a consequence of this is the belief that Black skin is thicker with few nerve endings, leading to increased pain tolerance (Hoffman et al, 2016). Clinically, this leads to differential treatment of pain and decreased pain management for Black individuals (Green et al, 2003). Students continuing to believe a biological basis for race sets the stage for them to perpetuate health inequities as future providers.

Three examples, among several others listed in Appendix B, are important to address immediately in the curriculum: the “race correction” button on the spirometer, perceived differences in estimates of Glomerular Filtration Rate (GFR) by race, and the notion of the conditions of slave transport across the Atlantic Ocean being the reason for racial disparities in hypertension.

Pulmonary curriculum: In the case of the spirometer, perceived differences in lung function was used as a justification for slavery and, unfortunately, this perceived difference has led the race correction to persist on the spirometer. The consequences of this have been far-reaching and deadly, as the race correction is built into disability estimates, pre-employment physicals, and clinical diagnoses (Shaban, H., 2014). It is recommended to incorporate Lundy Braun’s Breathing Race into the Machine into the curriculum (Braun, L., 2014) or to invite her to speak in DRx Pulmonology module to address this history, as she is the leading expert on this issue.

Renal curriculum: On the topic of perceived differences in GFR by race, the idea persists due to a belief that Blacks have more muscle mass than those of other races (Eneanya et al, 2019). Hospitals such as Beth Israel Deaconess Medical Center and Zuckerberg San Francisco General have started to remove the GFR race correction as it can affect listing for kidney transplant, participation in clinical trials, and nephrology referral (Morris et al, 2020). BUSM students need to be aware of the dangers of this race correction and should be encouraged to challenge the greater medical community around it, in order to avoid contributing to the racism entrenched within the correction.

Cardiology curriculum: On the subject of hypertension, the salt slavery hypothesis posits that salt scarcity in West Africa, on the ships of the Middle Passage slave trade, and under conditions of slavery in the United States caused selective pressure on slaves such that those with better salt retention had greater reproductive success (Wilson, 1991). This theory was discussed
in a peer-reviewed paper only once in 1991 and proposed without the input of historians of West Africa and the slave trade, who dispute the occurrence of any salt scarcity (Curtin, 1992). Furthermore, the wide diversity of new conditions under slavery in the United States would have likely encouraged genetic variation among slaves, and the physiology of salt response is governed by multiple genes that would not be the basis of an evolutionary bottleneck to cause a trait that would last two hundred years (Jackson, 1991). Such traits, such as sickle cell trait for malaria protection, are governed by single genes and have taken thousands of years to develop over generations. As such, the salt slavery hypothesis is unsubstantiated and, further, ignores social factors, such as racism and poverty, that contribute to racial disparities in hypertension (Lujan, 2018). It is recommended that this false claim be explicitly refuted by the pre-clerkship curriculum.

Notably, information about racial health disparities is incompletely explored in the curriculum. For example, the disproportionate impact of sepsis on Black men is presented with an admission that the underlying causes of this disparity have not yet been identified. While this knowledge gap reflects the lack of diversity in medical research, it may imply to students that this disparity is a biological and/or genetic issue. Additionally, if lecturers posit that the reasons for differences in pathology by race are biological, they should at the very least cite their claim and explain the biological underpinnings for this theory. For example, when a lecturer states that lung cancer is more prevalent in Black individuals than White despite lower instances of tobacco use due to differences in metabolism, it is paramount that sources are provided. Giving unsubstantiated information about race may have the unfortunate unintended consequence of being detrimental to medical education and future patients. Even when these claims provide any evidence, the evidence is typically demonstrated to inappropriately use race a proxy.

In regard to genetic mutations based on race, there is research that suggests that assumptions about certain diseases and race-based genetics lead to later diagnoses in those who are not White. This is the case in cystic fibrosis; there are later diagnoses in Black individuals and thus more progressive disease (Schrijver, I. et al., 2016). In this instance, the fact that race is used as proxy for genetics has led to the failure to understand actual genetic variations based on ancestry, not race (Schrijver, I. et al., 2016). In order to address health disparities based on genetic diseases, there must be a focus on ancestry, as ancestry has a role in genetics, and race, as it is socially constructed, does not.

These notions are essential to challenge. If they are not challenged, they have the potential to lead BUSM students to perpetuate systemic racial inequities themselves, which is not the intention of individuals at BUSM nor BUSM as an institution.

3. Images and Clipart of Light Skin
Throughout the preclinical curriculum, many of the lectures display images and clipart that display individuals with light skin only. A disservice is done to future physicians if they are shown images of individuals with light skin, presumably White skin, the majority of the time.
Continuing to show students images primarily of light-skinned patients and healthcare professionals reinforces power dynamics of White skin as the default in both groups. There is a critical need to diversify images of pathology, as well as stock images, to prepare students to diagnose with greater accuracy and to challenge associations and assumptions about both patients and providers. This is particularly important in the context of our affiliation to BMC, which has a racially diverse patient and provider population. Additionally, it is harmful when lecturers assert that it is easier to first learn dermatological conditions as they present on White skin first, as it perpetuates the idea that darker skin is difficult, problematic, or undesirable.

**Opportunities for Expansion and Growth**

1. **Naming Racism**
   
   A concrete way to challenge the notion that there is something inherent to one’s race that leads to health disparities is to explicitly name racism. Outside of the racism lecture in the Human Behavior in Medicine class in the first year, the only preclinical course that has been documented after extensive review to name racism is EPH. In EPH, discussions are held about racism and other structural barriers to achieving positive health outcomes for marginalized communities. It is recommended that other course directors adopt Dr. McSweeney’s approach to explicitly link racism to health disparities. Instead of using race as a risk factor, it is more accurate to link the impact of racism as a risk factor for disease (Krieger, 1990). For example, instead of claiming race is a risk factor for hypertension, there is strong evidence suggesting that *racism* is a risk factor for hypertension (Krieger, 1990). Nancy Krieger’s study showed that an internalized response to unfair racial treatment may contribute to increased rates of high blood pressure among Black women.

   If the curriculum does not name racism, there is too much focus on biomedical pathology that lacks evidence rather than focusing on the structural barriers such as racism that can be elucidated by population data and social policies. The aforementioned video from Alpert Medical School at Brown University presents a clear way to begin to move from using race as a risk factor to naming racism (Green, 2018). Additionally, frequently naming structural racism in addition to interpersonal racism may make students feel less individual blame for the inequities that exist and instead bring more focus on addressing needed structural change.

2. **Expanding on Prevalence**

   Expanding the concept of prevalence beyond listing occurrence by racial group allows for discussions about specific ancestries that have a genetic disposition to a particular pathology and the structural issues which may have caused the differential prevalence. There is certainly a place for listing prevalence by racial group when it comes to pathology, as it highlights disparities and frequencies. However, when discussing prevalence, there is an opportunity to, if applicable, indicate specific ancestry and posit why there are differences in prevalence. There is an opportunity to point out structural issues. When thinking about why “we don’t know why” certain diseases
occur in certain populations more than others, there is an opportunity to unpack why and if race is used as a proxy for concepts that are ill-defined as of yet. Differences in prevalence are not always because of racism and discrimination, but it is important to think about these things as potential issues and indicate ancestry rather than race when appropriate. When a population is mentioned, it is imperative to use the most specific data of a given population or to discuss the limits of the data (for example, presenting national statistics obscures regional variations). Additionally, oftentimes prevalence is described as only consisting of Black and White people. Rarely do students learn about the prevalence of conditions in other racial and/or groups nor are they equipped to apply testing and treatment guidelines to individuals of mixed descent. This dichotomy has the potential to erase other communities from health narratives and limit students’ ability to apply clinical reasoning appropriately. Growth in this area will provide students the tools to refine their clinical reasoning and to have a more accurate understanding of the epidemiological factors influencing pathological prevalence.

3. Questioning Use of Race in Clinical Vignettes

Often students receive cases in lecture and small group sessions that mention race as part of the clinical vignette. Employing race in a clinical vignette that is detached from a person reinforces pattern recognition of diseases associated with race, which may lead to bias in delivery of care. When writing clinical vignettes for case-based learning and practice questions, it is essential to consider why race is being used in a case and to parse out if it adds value.

4. Critically Examining Strength of Evidence Promoting Race-Based Medicine

A previously mentioned example explored in the Genomic Medicine module of race-based medicine is of the drug BiDil, FDA approved for use in Black patients with heart failure. There is a lot to learn from the BiDil example, including the degree of trust that should be put into clinical guidelines (the original V-Heft I Trial published results based on an initial subject group of 180 Black males) and the financial incentives at play in marketing of a drug that has poorly defined evidence to prove that it works better in specific racial groups (Sankar et al 2005; Callier et al, 2018; Tsai et al, 2018). The V-HeFT study was done to evaluate the effectiveness of BiDil, but was rejected by the FDA in 1997 because the data did not meet regulatory standards for approval. Several years later, faced with a rapidly expiring patent and still no FDA approval, there began a post-hoc analysis of the V-HeFT trial. This kind of post-hoc “data dredging” is widely considered a bad statistical technique and is not accepted as evidence for drug approval by the FDA. The claims made by these trials supports the need for lecturers to baseline review studies before citing them in their lecture. Additionally, if lectures are going to make any claims about racial groups whatsoever, it is critical that there is a strong evidence-basis for these claims. For example, if there are going to be claims made in lectures about diet likely causing higher cancer rates in specific racial groups, there should be data presented with substantiated citations. For more information on BiDil and its racist history, see this brief appendix.
5. Standardized Approach throughout the Curriculum

There exists an important opportunity for communication across modules to standardize the discussion around racism in medicine as well as to reinforce what students are learning about racism in Doctoring courses. For example, when discussing syphilis, it is important to at least mention the Tuskegee syphilis experiment as it is essential historical context. When students learn about antibodies in rheumatology and the HeLa cell line is mentioned, it is useful to briefly mention that these cells originated from Henrietta Lacks. In the Pulmonary module, there is an opportunity to discuss the history of the spirometer that is entrenched in racism. Additionally, as definitions of race vary across modules, it is important for there to be standardization so that modules do not directly contradict each other. It is recommended at the beginning of the first year for students to learn about race as a social construct and receive an introduction about how to navigate race, racism, biology, and genetics during the curriculum over the next four years. Having standardization will equip faculty with a guide to help facilitate productive and informative conversations.

Clerkship Curriculum

Methods

Four 4th-year students analyzed core clerkships from the third and fourth year clerkship curricula. Given that much of the learning during the clinical years is site- and preceptor-dependent, we examined didactic lecture slides to understand the content that was provided to all students. Our methods were as above, consistent with the review of the pre-clerkship modules, using the Instruction and Tip Sheet to analyze didactic lecture slides and recording findings in a separate document. Of note, there were no didactic lectures for the Emergency Medicine, Ambulatory Medicine and Surgical Subspecialties courses. Further, Radiology was examined but did not have any mentions of race. Following analysis of all of the clerkships, the students met to discuss findings. Through our discussion, we asked ourselves about the utility of mentions of race, the extent of medical knowledge about an association between race and disease and, most importantly and most difficult to pinpoint, what was left out in terms of an anti-racism curriculum. We exchanged personal experiences working with clinicians who informally shared historical data on racism in medicine, which we did not see come through in the formal curriculum. We have outlined, as with the pre-clerkship curriculum, our broad findings in terms of strengths, weaknesses and opportunities, but call for further efforts to explore existing anti-racism curricula. The detailed curricula findings are listed in Appendix C.
**Broad Findings**

**BUSM Strengths in Discussing Race in Medicine**

1. **Developing History-Taking Skills to Broadan Treatment Options**

   Multiple clerkships focus on developing student’s ability to support marginalized populations and throughout their didactic materials. This approach reinforces a big picture view of the healthcare system and prompts students to screen patients for different social determinants of health in the clinic setting.

   In didactic lectures during the clinical clerkships, students are presented with information about vulnerable groups to prompt them to ask further history from their patients once back in clinic or on the wards. An example of this includes the HIV lecture in the Medicine clerkship where students are presented with demographic data of new transmissions, showing how HIV disproportionately affects Black men who have sex with men (MSM) and differences in rates of transmission based on sexual practice. This is a departure from blanket epidemiological data as it offers students information to counsel patients on sexual practices as well as treatment options such as PrEP.

   Another example (from a student’s personal experience in Ambulatory Medicine), is a lecture on caring for patients with a history of incarceration, where students were asked how they would go about taking a legal history and what clinical decisions might be driven by this type of information. This responds to the known high risks of the period immediately after release from prison/jail when individuals are at risk for suicide, drug overdose, and discontinuous care. The Ob/Gyn clerkship also includes content on differences in care based on race of the patient through required reading about prenatal aspirin and student involvement in a QI project for patient education about the treatment. This is highly relevant with respect to the timely concern of Black maternal mortality, often driven by lack of care in the prenatal and immediate postpartum periods.

   A last example of formal instruction in racial disparities includes the Overview of Family Medicine lecture in the Family Medicine clerkship. This lecture presents population data of health outcomes demonstrating racial disparities. The lecture is dedicated to exploring which social determinants of health are behind racial disparities, including access to primary care, education, etc. This approach, inherent to primary care, offers a big picture view of the healthcare system and, as it is given at the beginning of the clerkship, hopefully prompts students to screen patients for different social determinants of health in the clinic. Perhaps this approach could be taken when introducing the preclinical curriculum in first year.

2. **Abandoning a Culture of Stigmatization and Patient-Blaming**

   An area of particular strength within the BUSM clerkship curriculum comes from the culture on the wards destigmatizing substance use disorder and screening for barriers to care in instances of non-adherence to treatment and pain medication ‘seeking’ for patients with sickle cell disease. While these areas are still subject to preceptor lead in setting the tone for the clinical
team and are dependent on whether an individual student is part of the care team of a patient confronted by one of these challenges, it is found much more often than not that preceptors acknowledge historical abandonment of vulnerable populations by the medical system.

Weaknesses

1. **Lack of Images of Patients of Different Skin Types**

   Lack of diversity of skin types in images has been recognized not only at the medical school level, but at further training levels (Ebede et al, 2006). Images need to become representative of different skin types, particularly to aid students with performing improved physical exams. Lecture slides should be reviewed for inclusion of images of different skin types, both in images of pathology and normal skin.

2. **Imprecise Wording to Describe Patient Demographics**

   It is important to question whether race provides pertinent information for a given case and to determine whether the correct terms are used. For example, the patient chart of the Theresa patient in the Family Medicine clerkship describes her as a 44-year-old Hispanic female. The term Hispanic denotes an individual with Spanish heritage, which is not clinically relevant. It is recommended that “Hispanic” is replaced by “Spanish-speaking” because the language that a patient speaks has an impact on clinical management. “Hispanic” groups are very heterogeneous in terms of ancestry, thus making any biological meaning of this even less sound. Analysis of didactic slides also revealed some instances of coded terms, such as “urban poor” as a patient descriptor, which is recommended to avoid entirely.

3. **Incorrect Association of Race with Disease**

   The clerkship years offer students experiences to replace detrimental patterns associating race with a given disease that students often build for purposes of preparation for Step 1. Some notable associations that are emphasized include Caucasian race with multiple sclerosis and cystic fibrosis and Black race with sickle cell disease, lupus and keloid formation. In the Neurology lecture on multiple sclerosis, the lecturer posits that an environmental association or trigger may exist, leading to greater burden of disease in Caucasians of northern European ancestry. While there is an attempt to describe genetic vulnerability to the disease, the slide is still titled “Race and MS.” It is recommended that clerkship lectures also adopt “ancestry” and “genetic inheritance” where studies have shown a genetic linkage, rather than “race” since it is a social construct.

   Other mentions of race as a risk factor for disease include: Caucasian race as a risk factor for suicide, discussed in the Suicide Screening lecture, and African American race as a risk factor for vascular dementia in the Neurocognitive Disorders lecture, both in the Psychiatry clerkship. In all of these cases, it is recommended that the patient’s race is not described as a risk factor, but rather as a risk marker and explicitly stated as not a proxy for genetics.
Opportunities for Expansion and Growth

1. Further Understanding Legacies of Racism and Systemic Oppression

   There exists the opportunity to study important legacies of racism in more depth in the clinical curriculum. On the wards, this may include exploring differences in clinical tools such as spirometry, race correction factors in the evaluation of lung and renal function, and risk assessment calculators that include race. Formal didactics could include more information on racist practices in the provision of family planning care and in the treatment of psychosis. An overview of racist and eugenic motivations in the development of birth control pills is well outlined in Jonathan Eig’s book “The Birth of The Pill.”

2. Promote Bystander Training

   While the beginning of medical school exposes students to the concept of implicit bias in a standard fashion, there is no place in the curriculum to go beyond understanding one’s own implicit biases, or to re-evaluate changing biases. Often on the wards, racism is perpetrated not by staff or faculty, but rather by patients, and students are not equipped to advocate for themselves or for their peers or other patients. While reporting mechanisms exist through the Appropriate Treatment in Medicine committee to address racism from staff and faculty, students have no tools for addressing other situations. Bystander training should be provided to faculty and students alike and modeled by team leaders who are able to call attention to microaggressions or overt instances of racism in order to promote an inclusive learning and healing environment in all clinical settings (Nelson et al, 2010).

3. Opportunities for Reflection and Continued Conversations about Racism

   It is difficult to initiate conversation about racism, yet critical to our formation as future physicians. Students would benefit from a longitudinal curriculum focused on racism in health care that includes opportunities for reflection of personal biases, group sharing of experiences on wards and in clinics, and ideas for reducing racist practices still embedded in the health care system.

4. Case-Based Learning on Informed Consent

   A time when patients from underrepresented backgrounds or with limited English proficiency are especially vulnerable is during the informed consent process. This is also a time when providers can proactively build trust with their patients if done thoroughly. It is recommended that lecture time for case-based learning or a formal evaluation (OSCE) should be dedicated to training students to appropriately counsel a patient awaiting a procedure (Brooks et al, 2016).
External Review of Aspirational Institutions and Programs

Identifying Curricular Components of Education Focused on Racism in Medicine

Students at BUSM receive their training at the largest safety net hospital in New England, which serves a patient population that is 57% underserved and 32% non-native English speakers. This is a unique opportunity for students to encounter populations who have historically been negatively impacted by the healthcare system due to race. Given this opportunity, it is the role of medical education to prepare students to work with and advocate for patients from various backgrounds. In a longitudinal study of students at 49 US medical schools, it was concluded that students had increased intentionality to care for minority patients when exposed to a curriculum focused on minority health/disparities and improved perceived skill at developing relationships with minority patients (Phelan, 2019). After reviewing curriculum offered at 12 medical colleges and universities across the United States, a core group of values have been identified that will enhance the understanding and education of students in an effort to develop physicians who will be knowledgeable of and sensitive to matters related to racism in the medical field. The core values chosen by this taskforce were the following:

1. Framing the Impact of Racism in Medicine
2. Curricular Review
3. Community Engagement
4. Faculty Development

Methods

Fourth and second year medical students identified 12 universities with published curricular content in areas aligned with racism in medicine. These areas include, but are not limited to, genetics as it relates to race, framing the impact of racism as a public health crisis, allyship, and intersectionality. The following universities were identified: Johns Hopkins University School of Medicine, Perelman School of Medicine at the University of Pennsylvania, Yale School of Medicine, David Geffen School of Medicine at UCLA, Alpert Medical School at Brown University, Geisel School of Medicine at Dartmouth, Icahn School of Medicine at Mount Sinai, University of California San Francisco (UCSF) School of Medicine, University of North Carolina School of Medicine, Florida State University College of Medicine, Northwestern University Feinberg School of Medicine, and the University of Minnesota Medical School. Information from each university was collected through a combination of work published online, email and phone correspondence with students and faculty, and in-person interviews. In addition to findings from the 12 universities, a literature review using keywords “racism”, “medicine”, and “curriculum” was performed and included in this report. The essential racism in medicine curricular framework desired for BUSM was designed from these research findings and is outlined below.
Essentials to a BUSM-Tailored Racism in Medicine Curricular Framework

In order to start a conversation about racism, it is imperative that its impact is framed appropriately to facilitate discussion that is productive, thought provoking, and that creates a safe space for individuals of color. Racism impacts medicine through patient interactions, research practices, peer engagement, and medical education. As an example, in medical education, the concept of race is embedded in passive discussions due to its addition in clinical vignettes, usage as a proxy for genetics, and its ability to designate otherness. Framing the impact of direct and indirect racism begins with a common language on which to build discussion. When building their diversity-focused Differences Matter curriculum, UCSF introduced a glossary of terms to provide access to language, now shared amongst its community, in an effort to produce a foundation on which discourse could flourish. When equipped with a proper understanding of words such as ethnicity, diversity, equity, race, racism, and culture, learning is enriched with an authenticity that may otherwise be fabricated in an effort to engage with foreign concepts.

Findings at the University of Washington School of Public Health identified the necessity of a common language to create a safe environment that enables conversation about racism and systems of oppression (Hagopian, 2018).

In addition to framing racism with a shared language, continual curricular review is a necessary process to ensure the concept of racism is appropriate and relevant throughout the curriculum. Universities that dedicated resources to building a curriculum that highlights racism in medicine included an intensive review of their existing curriculum to establish an accurate baseline and identify areas for improvement. A thorough review includes, but is not limited to, identifying and analyzing all instances of race-based information in slides, cases, practice and exam questions, and syllabi for clinical and pre-clinical material. This is especially important for the clinical curriculum, where clinical learning becomes more variable.

Standardized didactics that dedicate enrichment to the issues of racism in medicine will ensure all clinical students are equipped with the understanding and tools needed to be successful in a practice that encounters patients of a wide spectrum of races, ethnicities, and backgrounds. In anticipation of its new curriculum integrating racial disparities education, faculty at Dartmouth found an opportunity to engage clinical students in the curriculum as there is a significant decline in coverage of racial disparities early in medical education (White, 2019). Lastly, faculty at Alpert Medical School at Brown University have access to a video and document with tips for how to appropriately discuss and present topics around race in lecture material (Green, 2018). This includes ways to structure slide material so that when race is mentioned, the context is appropriate and relevant to learning.

The work required to build a curriculum centered around racism in medicine is benefited immensely by a central endorsement from faculty. The institutions garnering the most success in securing longitudinal curricular content included Mount Sinai, UCSF, and Dartmouth, where the
initiatives were spearheaded by faculty interest and collaboration. Additionally, Alpert Medical School at Brown University hosts an administration supported fellowship for faculty, residents, and students who wish to engage further in issues around racism in medicine (Garcia-Sampson, 2018). Support from administration gives credence to an endeavor that will benefit every student who is fortunate to take part in the curriculum and aids in faculty buy-in.

Importance given to a topic is often underscored by the level of commitment and passion required to succeed, and a racism in medicine curricular development is no different. Students pay more attention when sessions are mandatory as the course directors have denoted an increased level of importance to those topics. With a larger audience, lecturers are more enthusiastic and engaged in sharing what they prepared for the current topic. The LCME has designated cultural competency as a requirement to be included in some aspect of medical education affirming its indispensability in medical education. Likewise, content highlighting the patient and provider experience with racism must be required for all BUSM students to ensure readiness when facing these issues in a clinical setting.

A common theme, and the largest undertaking, of successful institutions is faculty development. It is not expected that faculty members are experts in teaching about the nuances of race and its significance in medical spaces. However, it is paramount that those educating on sensitive topics such as race and racism are equipped with the language and understanding to do so in an effort to ensure meaningful dialogue and guidance. Faculty development is institution-specific and may take many forms. At one institution, day-long optional training courses are given once a month with a tally kept to identify which department has the most participation. This style may not work for BUSM; however, emphasis on continued training by administration is a key component for success moving forward. Identifying figures in each department as faculty advocates to contribute their perspective and expertise provides a continuous presence of support.

The city of Boston is rife with resources for BUSM to utilize when adapting the new curriculum. Racism is not a new topic of discussion and neither is its intersection within and surrounding medicine. An essential tenet of a racism in medicine curriculum at BUSM begins by sourcing Boston area organizations and professionals who are dedicated to this work and can consult on what this curriculum should include. The city itself is rich with a historical racial divide that is felt in everyday life. Students, who will be caring for patients who have lived their entire lives within the normalcy of this division, must appreciate the history of race and racism in Boston to be able to meet patients with a level of understanding they may not obtain from their lives before Boston. The fear of racism is entrenched in the psyche of many patients and it is difficult for an unaware student to navigate through a precedent of distrust without the proper context of historical systematic racism. Redlining shaped the social makeup of Boston; and though it may not seem to have a direct correlation to medicine, social, political, and economic
racism serve as foundations, along with outright medical racism, for mistrust of the medical community. A starting point could be to enhance the relationship with the School of Public Health to forge a partnership that fosters greater collaboration. The public health approach was adopted by the University of Minnesota when creating their medical school racism curriculum. By enacting a two-phase system wherein they developed content with individuals solely from minority groups followed by the addition of White counterparts, it was concluded that employing a public health methodology allowed for new insights on what it means to discuss racism with varying groups (Hardeman, 2018). As it stands, the current BUSM public health and human behavior coursework lends itself to additions of this material and can serve as a tool for introduction into a more comprehensive curriculum.

Finally, all learning must be measurable and practical. Introducing content into the curriculum necessitates a metric by which evaluation is concrete. Outlined in the report, this VIG proposes measurable competencies for students to be evaluated that are specific to racism in medicine and in congruence with a greater equity Medical Education Program Objectives. Each identifies a key concept in which graduates from BUSM must master in order to equip them for racially tactful patient-centered care and colleague interactions. Faculty development, common language to discuss key factors, and integrative practice models are all important when addressing racism and the implications of racism on patient outcomes. It is recommended that BUSM adopt an inclusive anti-racist model for the new curriculum.
Creating Leadership & Education to Address Racism

Legacy

This work has been a labor of love and desperation. We believe that BUSM has the leadership and commitment to help dismantle the aforementioned historical vestiges of racism and simultaneously endeavor to eliminate healthcare disparities. The historic and present reality of racism in America has impacted each of us and propelled us forward to create a better future for our patients, our colleagues, and ourselves. Our passion is echoed by the current AMA CEO, James L. Madara, M.D., who reiterates the sentiments included in this report by stating that the AMA “aspire(s) to advance our mission by reducing disparities and increasing health equity to improve the health of all populations.” (American Medical Association, 2019).

Moreover, this report comes at an opportune moment as BUSM is in the midst of a comprehensive instructional redesign. This redesign provides an opportunity to incorporate the recommendations of this report and implement a curriculum that equips and empowers every BUSM graduate to have the knowledge and skills to address health inequities through their training and beyond. When this endeavor is successful, BUSM will transform millions of patient interactions.

1 BUSM Class (160 students) x 20 patients per day x 300 working days x 30 year career = 28.8 million patient interactions
Appendix A - Equity Competencies

The BUSM Medical Education Office (MEO) has endeavored, under the leadership of Priya Garg, MD, to develop a longitudinal equity curriculum. This work, in partnership with avid student advocacy, has culminated in the commissioning of three equity taskforces (Racism in Medicine, Gender and Sexual Diversity and Spectrum of Physician Advocacy) to assess the state of BUSM curriculum, research national models of equity curricula and develop evidence based curricular recommendations for the advancement of faculty, staff, and students to address the health inequities experienced by marginalized populations. These taskforces have unanimously proposed that a longitudinal and integrative equity curriculum be developed for the institution. Therefore, spurred from the MEO’s vision and the taskforce’s recommendation, Kaye-Alese Green’ 23, composed the following Overarching and Racism in Medicine specific BUSM Equity Competencies.

Central Equity Competencies

Derived from: The work of the BUSM Racism in Medicine, Gender and Sexual Diversity, and Advocacy Training taskforces

The BUSM graduate...
Recognizes instances and systems of inequity, comprehends the historical context and current drivers of inequity, reflects on their personal biases and privilege, analyzes medical literature through the lens of structural inequity, exhibits the medical knowledge to understand the physiologic response to inequity, recognizes the implications of inequity on health outcomes, and possesses the knowledge and practical skills to be an advocate for a more equitable environment in any health care setting.

1. Recognizes instances and systems of inequity & comprehends the historical context and current drivers
   a. Demonstrates an understanding of the historical and current sociopolitical factors affecting health equity for marginalized patient populations
   b. Demonstrates an understanding of the trust/mistrust of the healthcare system and the current structural factors that propagate inequity for marginalized populations

2. Reflects on their personal biases and privilege
   a. Demonstrates an awareness of personal bias and privilege and how it impacts patient care, health outcomes and interprofessional relationships

3. Analyzes medical literature through the lens of structural inequity
   a. Exhibits the ability to critically examine the medical literature’s use of sociopolitical categorizations (i.e. race, refugee, etc.) and disease states

4. Exhibits the medical knowledge to understand the physiologic response to inequity
   a. Exhibits the medical knowledge of how inequity influences the development of pathology at the physiologic, neurocognitive and epigenetic level
5. **Recognizes the implications of inequality on health outcome**
   a. Recognizes medical and sociopolitical inequities and how they impact patient care and health outcomes.
   b. Recognizes how stigmatizing language negatively impacts patient care and professional relationships
   c. Recognizes and comprehends how medical and sociopolitical inequities impact their colleagues personally and professionally.

6. **Possesses the knowledge and practical skill to be an advocate for a more equitable environment in any health care setting.**
   a. Demonstrates the ability to employ evidence-based strategies to advocate for creating equitable health care for marginalized populations

*The BUSM graduates will be specifically adept in the following topics: racism, gender and sexual diversity, refugee and immigrant health, and social determinants of health.*

**Racism in Medicine Specific Equity Competencies**

*Derived from: Health Equity Rounds: An Interdisciplinary Case Conference to Address Implicit Bias and Structural Racism for Faculty and Trainees (Perdomo et al., 2019)*

**The BUSM graduate...**

1. Recognizes the historical context and current manifestations of structural racism and its impact on the health care system.
2. Employs evidence-based tools to recognize and mitigate the effects of personally held implicit racial biases.
3. Identifies and analyzes the effects of implicit racial bias and structural racism in clinical scenarios and health outcomes.
4. Exhibits the scientific acumen to understand the difference between genetic variation, ancestry, and sociologically-derived (race and racism) risk factors.
5. Exhibits the knowledge of how racial social inequity influences physiological pathology.
6. Analyzes medical literature with the historical understanding of racial inequity, identifies gaps in the medical literature, and is able to delineate where race is used or not used appropriately.
7. Employs evidence-based strategies to address structural racism at the individual and institutional level to reduce the negative impact of implicit racial bias on patient care and interprofessional relationships.
Appendix B

BUSM Internal Assessment – Pre-Clerkship Curriculum In-Depth Review

The following section is a compilation of findings identified upon complete review of BUSM curricular materials, including lecture recordings, syllabi, and presentation slides. This resource was created to serve as a foundation to inform future curricular reform and promote our collective growth as an institution, documenting both explicit mentions of race and opportunities to add thoughtful discussions of race and racism. It is not intended to criticize any individual involved with the creation or dissemination of these materials. Rather, it is intended to provide concrete and accessible recommendations to promote diversity, inclusion, and antiracism across all four years of medical education based on the overarching themes discussed in the body of this report.

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<td>Dermatology</td>
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<td>Reproduction</td>
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<td>Endocrinology and Nutrition</td>
<td>72</td>
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<td>Neurology</td>
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<td>Psychiatry</td>
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<td>Oncology</td>
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<td>Hematology</td>
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<td>EPH</td>
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PrISMe

Molecular Foundations of Medicine

- **Lecture 2: Protein Structures**
  - Slide 24
    - "New patient Oliver is a 2.5-yo male of Northern European descent in for his well-child visit"
      - **Appropriate Use**: Talks about race in terms of descent by geography.
      - **Needs Improvement**: Add note/details about allele prevalence in different areas to avoid racial association with CF.

- **Lecture 17: Protein Synthesis and Trafficking**
  - Syllabus Page 8, Paragraph 2
    - "Approximately 10% of African Americans are carriers of these mutations" (in regard to sickle cell disease)
      - **Needs Improvement**: Detail mutation, mutation prevalence in African countries as well as other places (i.e. Mediterranean areas) that have dealt with malaria historically.

- **Lecture 23: Techniques in Molecular Medicine**
  - Slide 4
    - "Emmanuel and Rose, an African-American couple in their mid-20s come to a genetic counselor before planning to start a family. They both came to the US from Nigeria as children…"
      - **Needs Improvement**: Detail mutation, mutation prevalence in African countries as well as other places (i.e. Mediterranean areas) that have dealt with malaria historically.

- **Lecture 24: Clinical Correlations**
  - Multiple slides
    - Image use
      - **Appropriate Use**: Used a variety of skin colors in images to show examples of the various conditions.

- **Lecture 25: Cancer Genetics**
  - Slide 64
    - Case of cancer with first pap smear in "55 y.o. Latina, immigrant" used as an example of increased risk of cervical cancer in some countries
      - **Needs Improvement**: A more nuanced approach to the important subject of cancer screening. The case is written to associate immigrants coming to the U.S. from any number of countries with poor healthcare. Replace “Latina” with specific country of origin to avoid stereotyping large groups of people. Consider addition of a map used to show incidence of cervical cancer in the U.S. to compare incidence rates to other countries.

  - Syllabus Page 8, Paragraph 2
    - "Three of these mutations are found at an elevated frequency among individuals of Ashkenazi Jewish ancestry, allowing for the possibility of a targeted genetic testing strategy for individuals of Ashkenazi Jewish descent.”
      - **Needs Improvement**: A more detailed explanation as to what is known about the incidence of this mutation.
Cellular Foundations of Medicine

- **Lecture 7A: Peripheral Blood: Leukocytes**
  - Slide 5
    - “Hematocrit (packed cell volume) 44%, but depends on sex, age, race, etc.”
      - Needs Improvement: Add explanation on why hematocrit depends on these factors. Remove reference to race or replace with a term like “genetics” unless evidence-based explanation can be provided for variance based on race.

- **Lecture 7B: Peripheral Blood: Red Blood Cells**
  - Syllabus Page 4, Paragraph 1
    - “This defect is prevalent in some ethnic subgroups, particularly those of Mediterranean and African descent.”
      - Needs Improvement: Misleadingly equates ethnicity and ancestry; add precision to explanation as to why this is the case.
  - Syllabus Page 11, Paragraph 5
    - “A 38-year-old White female suffers a disorder that leads to the prompt hemolysis of many red cells in her circulation. In the following days you would expect to observe:”
      - Needs Improvement: Remove reference to race.

- **Lecture 11: Histology of Connective Tissue**
  - Syllabus Page 11, Paragraph 14
    - “It is not known why keloids form, but they are seen much more commonly in people of African as compared to European descent.”
      - Needs Improvement: Explain why it is more prevalent and how the data was gathered. Detail the region/populations the data gathered was from, e.g. America, Africa, etc.

Body Structures 1

- **Lecture 2: Introduction to Anatomical Terminology**
  - Slide 36
    - “Arthritis is more common among women (24.3%) than men (18.7%) in every age group, and it affects members of all racial and ethnic groups.” (Image that follows of a White-passing individual.)
      - Appropriate Use: Mentions that arthritis occurs in all racial and ethnic groups.
      - Needs Improvement: Provide images of arthritis on diverse skin tones.

- **Lecture 8: Axillary and UE Blood Supply**
  - Slide 14
    - “Slide is image of Allen Test for Collateral circulation, meant to illustrate what impaired and healthy refill is.”
      - Needs Improvement: Only set of images provided are on light-colored skin; change may be subtler in individuals with darker complexion.

- **Lecture 14: Forearm and Wrist**
  - Slide 29
    - Topic of Duputreyn’s contracture. Lecturer: “It seems to have some genetic component and it’s most prevalent in males of Welsh and Irish and English heritage. so the hand clinic at Mass General the Duputreyn's patients come in and the list in
Michael O’Brien, O’Leary. There is some correlation with that ancestry, it hasn't been worked out but there is a correlation with these patients…”

- **Needs Improvement:** Provide details and cite studies for condition’s link to ancestry/geography. If studies have not been completed in diverse regions/backgrounds, it is advised to remove reference to Welsh, Irish, and English heritage and remove association with MGH to avoid false impression that it may not be seen in a patient at BMC.

**Body Structures 2**
- **Lecture 17: Anatomical Basis for Cancer Metastasis**
  - Slide 5

  ⇒ Lecture recording: "...if you are an African American male you have about twice the risk of dying of prostate cancer as Whites. Latinas and Asian Pacific Islanders...they're the lowest...have even a lower rate than Whites and Blacks...it's thought that the Latin population eats a lot more vegetables than the White and Black population...there may be other factors as well”

- **Needs Improvement:** Provide justification/cite studies for further information on there may be racial disparities in prostate cancer mortality; i.e., possible underdiagnoses, lack of access to screening, etc.

**Body Structures 3**
- **Lecture 3: Triangles & Fascia of the Neck**
  - Slides 2, 3, 7, 9, 10, 14, 15, 26, 29, 37, 38, 42
  - Model photographs

  ⇒ **Needs Improvement:** Improve the diversity photos used to demonstrate muscles in this lecture.

- **Lecture 4: Face and Superficial Head**
  - Slides 10, 17-18, 36
  - Photographs of facial expressions

  ⇒ **Appropriate Use:** Diverse model subjects to demonstrate use of facial expressions.
Neurosciences

- Lecture 15: Autonomic Nervous System
  - Slide 4
    ⇒ Familial dysautonomia “in Ashkenazi Jews”
      o **Needs Improvement**: More specific language would improve this discussion, i.e. "people of Ashkenazi descent,” as well as a note to the mechanisms and inherited gene behind the disorder.
  - Slide 10
    ⇒ Curare used on the tips in Peruvian blow guns
      o **Needs Improvement**: Attributing this cultural practice to people of a nationality/country defined by politics and borders (i.e. Peru) versus a specific culture of indigenous peoples. Also, an acknowledgement that the practice of using poison-tipped arrows is widespread throughout many cultures of the world and in Paleolithic human history.

- Lecture 25: Taste and Smell
  - Syllabus Page 4, heading Amino Acids
    ⇒ "The only amino acid that has been studied extensively in mammals is L-glutamate, believed to elicit the unique umami sensations, well known from some Asian restaurants."
      o **Needs Improvement**: While this does not specifically state inappropriate use of race, the close association of the word Umami, which is a Japanese word, with Asian restaurants and MSG is a reinforcement of the negative stereotype that Asian restaurants use MSG in their food and that MSG is bad. This stereotype has origins in racist myths about East Asians, specifically Chinese. There is an opportunity to explain what responsible scientific research looks like with regards to these populations and communities and describe the research correctly without essentializing these identities.

Genomic Medicine

- Lecture 2: Single Gene Disorders and the Molecular Basis of Disease
  - Slide 10
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1. **Prevalence of sickle cell allele**
   - Appropriate Use: Stated as prevalence. Rather than listing a country, continent or race, the prevalence of the allele was given on a map to give the most precise picture of the occurrence of the allele.

   Syllabus Page 4, Paragraph 1
   - “As a result, the HbS allele is present at a high frequency (1 in 250 affected individuals) in areas where malaria is endemic. Therefore, this condition is highly prevalent in African American populations (although somewhat less so than in African populations themselves).”
   - Appropriate Use: Provides allelic frequency in precise numbers, relates allelic frequency to known association with regions where malaria is endemic.

2. **Splice junction mutations: β–Thalassemia**
   - Needs Improvement: Only dark skin was displayed on the image for beta thalassemia. Consider including more images of diverse skin colors.

   Slide 31:
   - “Routine screening of newborns: incidence among Caucasian Americans is 1 in 8000”
   - Appropriate Use: Stated as incidence, gives precise numbers.
Creating Leadership & Education to Address Racism

- **Needs Improvement**: Only Caucasian Americans is listed – further explanation needed for mention of race on this slide (e.g. extremely low prevalence in other populations? Not studied in other populations?).

  ➢ Slide 48

  ![PAH: Phenylalanine Hydroxylase](image)

  ➢ **Appropriate Use**: graphic use is helpful in describing number and name of alleles given different regions.

- **Lecture 8: Testing for Genetic Susceptibility**
  ➢ Slide 2
  ➢ “Case presentation "Your patient is an 8-year-old, tall and slender Hispanic male with a history of scoliosis. When you perform a physical exam, you also notice he has a highly arched palate, significant joint laxity, and long limbs. He has never had any cardiac imaging. His parents are both present at this visit. You notice that the patient’s father has a similar appearance as the patient and has not visited a physician in many years. The father was adopted, and his family history is unknown."

  - **Appropriate Use**: Includes diversity in clinical scenarios.

  - **Needs Improvement**: Consider including prevalence by ancestry for Marfan syndrome to avoid association of Hispanic to this disease process. Consider removing “patient has not visited a physician in many years” to avoid association of Hispanic with lack of healthcare.

- **Lecture 9: Population and Prenatal Screening**
  ➢ Slide 10
  ➢ "Connexin-26 (GJB2) mutations account for: • 50-80% non-syndromic AR deafness in Caucasians • 1 in 31 individuals of European descent are carriers – 35delG common mutation in 90% of affected Caucasians; V37I in affected Asians – 167delT founder mutation carried by 1 in 25 AJs"

  - **Appropriate Use**: Breaks down genetics hearing loss by specific known carrier mutations.

  ➢ Slide 15
Creating Leadership & Education to Address Racism

Higher Carrier Frequencies

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>Disorder</th>
<th>Carrier Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caucasian</td>
<td>Cystic fibrosis</td>
<td>1/25</td>
</tr>
<tr>
<td>African American</td>
<td>Sickle Cell</td>
<td>1/12</td>
</tr>
<tr>
<td>Mediterranean</td>
<td>Beta-thalassemia</td>
<td>1/70</td>
</tr>
<tr>
<td>East Asian / Southeast Asian</td>
<td>Alpha-thalassemia</td>
<td>1/30 [variable]</td>
</tr>
<tr>
<td>French Canadian</td>
<td>Tay-Sachs disease</td>
<td>1/30</td>
</tr>
<tr>
<td>Ashkenazi Jewish</td>
<td>Tay-Sachs disease and more</td>
<td>1/25</td>
</tr>
</tbody>
</table>

- **Appropriate Use**: States by specific carrier frequency number by ethnic group. States as "higher" and not as an absolute.

- **Syllabus Page 5, Paragraph 3**
  - “Sickle cell anemia is most common in the African population, with the thalassemias being most common in the Mediterranean and Asian populations. Interestingly, there are no published recommendations for screening for those of Hispanic background, yet people from countries on the Atlantic Coast of South America have very high carrier rates for sickle cell anemia due to ancestral mixing during the slave trade era.”
  - **Appropriate Use**: States as most common rather than an absolute. Adds doubt to thinking about these diseases in solely race-based schemas.

- **Slide 16**
  - “PAN-ethnic panel of 23 common mutations • 90% sensitive for Caucasians (deltaF508-70%) • All mutations with an allele frequency of 0.1% in the general US population • Gene sequencing is also available – Important for partners of confirmed carriers – Initially offered to Caucasian or Ashkenazi Jewish people – “Should also be available to other ethnic groups” - now available to all”
  - **Appropriate Use**: Presents testing information in diverse populations.

- **Slide 18**
  - "There are no published recommendations for carrier screening in the Hispanic population. Carrier frequencies for sickle cell anemia affected by slave trade prevalence”
  - **Appropriate Use**: Adds doubt to thinking about these diseases in solely race-based schemas.

- **Slide 19**
  - “ACMG Screening Committee 2008–Discussed laboratory guidelines for 9 diseases – Proposed criteria for panel • Serious and well described • Sensitivity >90% or carrier freq > 1 in 100 • Testing available ACOG Guidelines 2009 Carrier screening for Tay-Sachs Disease, Canavan disease, cystic fibrosis, and familial dysautonomia should be offered to Ashkenazi Jewish individuals ACOG set cut off carrier rate of 1 in 40 Carrier screening is available for 5 other diseases and can be offered”
  - **Appropriate Use**: Provides screening guidelines with sensitivity and specificity.

- **Slide 20**
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⇒ “– Carrier rate of 1/25 in AJs and French Canadians • 1 in 4000 affected births
   (~60/year) – Other ethnic backgrounds closer to 1/300 • 1 in 360,000”
   o **Appropriate Use:** Provides carrier rate for populations with greater prevalence
     AND for other ethnic backgrounds. Precise information used

➢ Slide 24
⇒ “Carrier freq. is 1:41 in Caucasians; ACOG Practice Guideline (2017) recommended
   that SMA carrier screening be offered to all pregnant couples after many years of
   controversy”
   o **Appropriate Use:** Provides precise carrier frequency for Caucasians, provides
     ACOG guideline to offer to all couples.

● Lecture 12: Genetic Testing in Diverse Patient Populations
➢ Slides 12-33
⇒ Uses a case study of a women of African descent to discuss genetic testing strategies
   for BRCA Mutations
   o **Appropriate Use:** Thoughtful case discussion on genetic screening based on ethnic
     groups and how the results can be affected based on ancestry.

➢ Syllabus Page 2, Paragraph 1
⇒ "Traditional racial concepts of Asian, European (or Caucasian), and African “races”
   give an inaccurate picture of human variation. Because Africa is thought to be the
   birthplace of humankind, it is also the population with the highest observed degree of
   genetic variation. As mankind migrated out of Africa, a subset of individuals from the
   original gene pool seeded new populations in various regions throughout the world.
   In fact, because of these human migration patterns, genetic variation observed in
   individuals of European and Asian ancestry is actually a subset of the variation
   observed in the African population. Put another way, there is more genetic variation
   within an ancestral group than there is between groups; the main observed differences
   have to do with frequency of variants rather than presence or absence of variants in
   the groups. Population genetics and the determination of allele and genotype
   frequency have clinical importance as they form the basis of genetic counseling and
   the estimation of the risk calculations of having a disease or having children with a
   disease."
   o **Appropriate Use:** Provides an excellent overview of what "race" is. Consider
     expanding discussion to what this means for medicine and research. Consider
     moving this discussion to an earlier part of PrISM to give a framework for other
     coursework.

➢ Syllabus Page 2, Paragraph 2
⇒ "Genetic research has recently focused on the migration of ancestral human
   populations into different geographic areas. Advances in DNA sequencing have made
   it possible to catalogue human genetic variation observed in modern populations and
   to use this to confirm migration history previously constructed through archaeological
   and anthropological studies. Group endogamy (marrying within a specific group)
   causes allele frequencies to often cluster around specific regions or ancestries,
   particularly when those regions are geographically isolated. An important example of
   the heterogeneity in geographic ancestry exists in the different populations of the
   Indian sub- continent. India possesses a staggering amount of human diversity; 15
   languages alone are found on its printed currency. In a recent study (Nature 461: 489-
Reich et al. examined 560,000 single nucleotide polymorphisms (SNPs) of 125 individuals from 25 social, linguistic, and geographic groups in India and the Andaman Islands in the Bay of Bengal. They found that Indian populations bear the genetic imprint of European, Asian, and even African genomes and that genetic diversity in India is 3 times greater than in Europe. The groups also determined that most Indian populations have a 39-71% mixture of variation from ancestral North India (ANI) and ancestral South India (ASI) across all caste and tribal groups.

**Appropriate Use:** An excellent broad overview of geography’s relation to genomics. Consider expanding discussion to what this means for medicine and research. Consider moving this discussion to earlier part of PrISM to give a framework for other coursework.

- **Lecture 15: Sickle Cell Trait and Sickle Cell Disease, Case Study**
  - Entire Case Study
    - **Appropriate Use:** Thoughtful discussion based on a real case considering ancestral descent and hemoglobinopathies.

- **Lecture 16: Ethics and Genomic Medicine**
  - Entire Lecture Notes
    - **Appropriate Use:** Discussion of ethical considerations in biomedical research. Brings up critically important topics relating to race and medicine such as BiDil and the Tuskegee Study. Consider moving this to an earlier part of the course/PrISM to give a good foundation for the other coursework. Consider a discussion on how these broad categories of race are used in medicine currently and why that may be problematic.

**Practice Questions:**

- **Practice Exam Problems, Question 11**
  ⇒ "Ancestry-based carrier detection tests are available for all of the following EXCEPT: a. Cystic fibrosis b. Familial dysautonomia c. Tay-Sachs disease d. Thalassemia e. Marfan syndrome." Answer explanation: “The answer is e. Familial dysautonomia and Tay-Sachs are more prevalent in Ashkenazi Jewish populations; cystic fibrosis is elevated in Caucasian and Ashkenazi Jewish individuals; and alpha- and beta-thalassemias in East Asian or African American or Mediterranean individuals respectively. Marfan syndrome is a disorder due to a mutation in the fibrillin-1 gene, and it does not display a particular association with any ethnicity."
    - **Appropriate Use:** Discusses disease in relation to ancestry. Gives a full answer explanation that discusses the disease process by elevated prevalence.

**Medical Immunology**

- **Lecture 13: Hypersensitivity**
  - Slide 30 (labeled as 22)
    ⇒ Photograph showing serum sickness rash appearance on light skin tones only
      - **Needs Improvement:** Serum sickness is a serious iatrogenic reaction that is important to recognize in a patient of any skin tone.
  - Slide 38 (labeled as 28)
    ⇒ Photograph showing poison ivy rash appearance on light skin tones only
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- Needs Improvement: For slides with images, consider including multiple pictures, making sure to include the rash's presentation on a wide range of skin tones.
  - Slide 39 (labeled as 29)
    - Photographs of tuberculin skin test on light skin only
  - Needs Improvement: For slides with images, consider including multiple pictures, making sure to include the rash's presentation on a wide range of skin tones.

- Lecture 18: Immunology of Sepsis
  - Slide 9 (labeled as 6)
    - "[Sepsis] mortality is greatest among Black men"
    - Lecturer: “For reasons unrelated to socioeconomic status, mortality is highest among Black males. And sort of the reinforce this point, New York Times reporter Michael Feeney died in 2016 from a staph infection. So a Black male dying of a gram-positive infection. I can tell you the definitive answer--we don't know. They've looked into it and specifically looked at whether it was due to less access to health care and it was not due to less access to health care..."
  - Appropriate Use: It is important to point out these disparities, as there is often no discussion of disparities that occur in very acute/emergent disease settings.
  - Needs Improvement: This is a discussion of racial disparities without pertinent discussion of the context behind it. When underlying causes are not discussed, race is perceived to be a biological phenomenon rather than a social construct.

Cardiovascular System
- Lecture 18: Circulation
  - Slide 32
    - Image: Graph comparing mean systolic and diastolic blood pressures by age and race/ethnicity for men and women in the US
    - Needs Improvement: Add note that race was self-identified in this study. Consider changing graph since race is not the lecturer’s point of discussion for this slide; a more appropriate/up-to-date image showing age vs. blood pressure would be appropriate.

- Lecture 27-29: Cholesterol, Lipoproteins and Cardiovascular Disease
  - Slide 30 (labeled as 22)
    - “Ava S. is a 5-year-old Hispanic female with multiple cutaneous xanthomas on her hands, feet, elbows, and knees...”
    - Appropriate Use: Different ethnic backgrounds used for clinical scenarios.
    - Needs Improvement: The clinical scenario is used as the only example tied to familial hypercholesterolemia (FH). FH prevalence statistics should be added so as not to confuse students when talking about rare diseases to avoid a false association between Hispanic individuals and FH. Race can be removed here and also provide the same teaching point.
Respiratory System

• Lecture 11: Hemoglobin Pathology
  ➢ Syllabus Page 2, Paragraph 1-3
    ⇒ “One of the most prevalent hemoglobin variants (~1 in 250 African Americans) is sickle cell disease (SCD), so called because it causes red blood cells (RBCs) to become elongated and sickle shaped in low oxygen and acidic environments...Ten percent of African Americans have only one of the two beta hemoglobin genes for Hbs and are carriers (sickle cell trait).”
    o **Appropriate Use:** Precise numbers of incidence statistics were used.
    o **Needs Improvement:** Only providing statistics for one population may give students the false impression that only Black people can get sickle cell disease. Consider adding reference back to Genomic Medicine where heterozygote advantage resulted in increased SCD incidence among people who come from Hispanic, southern European, Middle Eastern, or Asian Indian backgrounds.
  ➢ Syllabus Page 4, Paragraph 2
    ⇒ “Thalassemia affecting production of alpha or beta chains, affects approximately 4.4 of every 10,000 live births throughout the world. As of 2013, thalassemia occurred in 208 million people, 4.7 million with severe disease. It is most common among people of Italian, Greek, Middle Eastern, South Asian and African descent.”
    o **Appropriate Use:** All of the most common regions of descent were listed
  ➢ Syllabus Page 4, Paragraph 6
    ⇒ “Hemoglobin E is very common among people of Southeast Asian, Northeast Indian, Sri Lankan and Bangladeshi descent.”
    o **Appropriate Use:** Most common regions of descent were listed
    o **Needs Improvement:** “Very common” qualitative descriptor of incidence could be replaced or supplemented with precise incidence of the trait in those populations.
  ➢ Syllabus Page 7, Paragraph 3
    ⇒ “This defect is prevalent in some ethnic subgroups, particularly those of Mediterranean and African descent.”
    o **Appropriate Use:** Two regions were listed for highest prevalence.
    o **Needs Improvement:** Specific regional incidences can be provided. Consider a graphic/map.

Renal System

• Lecture 9: Glomerular Filtration and Clearance Physiology Discussion
  ➢ Case 1
    ⇒ “Peter G. is a 19-year-old Hispanic student...On physical examination the physician noted edema of his extremities... [serum values and 24-hour urine sample led to diagnosis of minimal change disease].”
    o **Appropriate Use:** Different ethnic backgrounds used for clinical scenarios
    o **Needs Improvement:** The key information in context of this diagnosis is the age of the patient. Mention of race can be removed. If race is used, prevalence statistics should be added to avoid a false association between Hispanic individuals and minimal change disease.
Gastrointestinal System and Nutrition

- Lecture 6: Oral Cavity Histology
  - Throughout Slides
    ➢ Clipart used only includes light skin.
      - Needs Improvement: Diversify clipart.
- Lecture 8: Oral Cavity
  - Throughout Slides
    ➢ Clipart used only includes light skin.
      - Needs Improvement: Diversify clipart.
- Lecture 15: PPP and Gluconeogenesis
  - Slide 16
    ➢ “G6PD Deficiency • Typically X-linked • Seen in Mediterranean populations, Africa, Middle East • Neonatal jaundice or acute hemolytic episodes • Hemolysis is induced by medications • Favism = oxidative stress from fava bean products”
      - Needs Improvement: Add specific prevalence statistics for these populations and discuss in terms of ancestry.
- Lecture 20: Lipid Digestion
  - Slide 10
    ➢ “Some factors that lead to gallstone formation • Excess cholesterol relative to bile salts and lecithin • Excess reabsorption of water and electrolytes • Stasis • Genetic (higher prevalence among Native-Americans, Mexican-Americans, Asians and women)”
      - Needs Improvement: Race is not genetic. Higher prevalence should be listed separately by regional ancestry.
- Lecture 21: Weight Loss Surgery
  - Slide 17
    ➢ “28-year-old Caucasian female with longstanding history of morbid obesity”
      - Needs Improvement: Remove reference to race.
- Lecture 32: Heme, Bilirubin and Porphyria
  - Throughout Slides
    ➢ Images on light skin only
      - Needs Improvement: More diverse images necessary, especially because jaundice is discussed.
- Practice Questions
  - Practice Questions Final, Question 10
    ➢ “You see a 3-day old Caucasian infant in the ER who is brought by her parents with a one-day history of failure to feed. The infant is in obvious distress and will not stop crying. Her skin is notably yellow and blood tests reveal unconjugated bilirubin levels of 25 mg/dL. You treat the infant with 400 nm light and assure the parents that the condition is only temporary. Her condition results from a developmental delay in the expression of: A. beta-Glucuronidase B. Heme oxygenase C. Biliverdin reductase D. Bilirubin glucuronyl transferase E. Cytochrome P-450”
Endocrinology and Reproductive Systems

- Lecture 13: Appetite Regulation
  - Syllabus Page 8, Paragraph 1-2
    - “The interplay between genetic and environmental factors is illustrated in landmark studies (National Institute of Diabetes and Digestive Diseases) of the Pima, indigenous Americans who are genetically predisposed to obesity and T2DM. There are two genetically identical Pima populations, one which settled in the southern Arizona desert and the other in a relatively remote region of Mexico. The study found that as a group, the U.S. Pima had more sedentary lifestyles and easier access to higher-calorie processed foods than the Mexican Pima, who exhibited higher activity levels and consumed lower-fat, traditional foods. For this latter population, obesity was uncommon and the prevalence of T2DM was comparable to the U.S. population as a whole. However, strikingly, nearly half of the U.S. Pima population had T2DM, the highest prevalence of the disease in the world. Approximately 95% of those with diabetes were overweight. These findings support the “thrifty gene” hypothesis, i.e. the idea that the genetic ability to accumulate and retain stores of fat is adaptive in times of famine; unfortunately, it may also be maladaptive when food is plentiful. Whether this hypothesis is borne out by further research, these important studies of the Pima clearly demonstrate the primary influence of environmental factors on the genetic predisposition to obesity and T2DM. Epidemiological studies show that certain ethnic groups are at increased risk for insulin resistance and T2DM. In addition to the Pima, other Native Americans as well as African or Asian Americans, Latinos, and Alaskan or Pacific Islanders show increased risk. In addition to ethnicity, risk factors for T2DM include family history; obesity, particularly central; inactivity; impaired glucose tolerance (pre-diabetes), gestational diabetes or giving birth to a baby weighing greater than 9 pounds; age greater than 45 years, and metabolic syndrome (see below).”

- Needs Improvement: Clarify wording that the two populations of Pima Indians are "genetically identical", add a note about genetic diversity (genetic admixture) if generalizing to broad "ethnic groups.” Consider note similar to the following “…insulin resistance and acute insulin response were shown to vary as a function of genetic markers (acting as surrogates for proportion African admixture). This approach has also been used to study type 2 diabetes in Pima Indians and type 1 diabetes in African Americans. The intriguing findings reported from these studies sometimes suggest powerful genetic differences across races/ethnicities; but extreme caution is needed in interpretation. Analyses that pool a minimally admixed group, e.g., European Americans or Asian Americans, with a group with greater levels of admixture (e.g., African Americans or Latino Americans) may yield distorted conclusions because the large group of non-admixed individuals exerts a powerful leveraging effect on the regression analysis. It is more appropriate to restrict admixture studies only to the admixed group (e.g., African Americans and Latino Americans) when associating levels of admixture and disease phenotype. Another shortcoming in admixture studies is that non-genetic factors (e.g., diet and SES) may co-vari with admixture as well, and without
thorough adjustment for these environmental factors, residual confounding could bias estimates of the genetic effect." ([https://care.diabetesjournals.org/content/26/7/2189](https://care.diabetesjournals.org/content/26/7/2189))

- There is also a significant ethical issue with these studies, and it warrants mention in discussion of the findings. Informed consent of this vulnerable community was not conducted properly; if this isn’t mentioned, it suggests that the ends justify the means and that the wishes of this ethnic group are not important. ([https://www.nytimes.com/2010/04/22/us/22dna.html](https://www.nytimes.com/2010/04/22/us/22dna.html)), ([https://www.nature.com/articles/nn0710-777](https://www.nature.com/articles/nn0710-777)), ([https://www.theatlantic.com/science/archive/2015/10/indigenising-genomics/412096/](https://www.theatlantic.com/science/archive/2015/10/indigenising-genomics/412096/))

- **Lecture 14: Diabetes Discussion**
  - **Case 1, Answers**
    - “Major risk factors associated with type 2 diabetes include: ...Certain ethnicities -- African-Americans, Latinos, and Native Americans all have high rates of diabetes.”
  - **Needs Improvement:** Ethnicity as a risk factor for diabetes reinforces the incorrect idea that race is biological. Failure to separate race from other socioeconomic and behavioral characteristics as risk factors for certain diseases may contribute to the misdiagnosis of patients and interfere with efforts to identify and remove causes of health disparities. If race/ethnicity and diabetes prevalence is to be discussed, a more substantive explanation in the corresponding syllabus section is recommended.
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DRx

Foundations
- Lectures 1&2: Principles of Pharmacokinetics, Drug Transport, Absorption, Distribution, and Elimination
  - Slide 81
    ⇒ “Genetic polymorphisms in enzymes of biotransformation – Generally result in prolonged half-life – Frequency depends on enzyme and ethnicity”
    - Needs Improvement: Discuss diverse prevalence based on ancestry, not ethnicity, list the specific polymorphisms, and cite study
  - Syllabus Page 44
    ⇒ “Genetics: Level of enzyme activity shows greater concordance among identical than fraternal twins; many enzymes of biotransformation exhibit genetic polymorphisms of clinical significance in which case drug substrate clearances are distributed bi- or trimodal depending upon the frequency of gene mutation in the population of patients; the frequency of polymorphisms tends to vary with ethnicity.”
    - Needs Improvement: Discuss polymorphisms in terms of prevalence based on ancestry.
- Lecture 3: Pharmacokinetics and Multiple Dosing
  - Throughout Lecture
    ⇒ Only light skinned images used
    - Needs Improvement: Consider adding more diverse images.
- Lectures 8&9: Cholinergic Agonists and Antagonists
  - Slide 51
    ⇒ “A White male, age 21, presents at an emergency room in North Carolina complaining of severe headache, weakness, dizziness, abdominal cramps, nausea and vomiting. He is perspiring heavily. He states that he is a worker employed harvesting tobacco. He reports that he is a nonsmoker.”
    - Needs Improvement: Remove reference to race. Race is not pertinent to this case.
- Lecture 15: Adaption, Injury, and Cell Death
  - Throughout Lecture
    ⇒ Only light skinned images used
    - Needs Improvement: Consider adding more diverse images.
  - Slide 71
    ⇒ “Keloid formation is a genetic predisposition that is common in African Americans. It tends to affect the earlobes, face, neck, sternum, and forearms, and it may produce large tumor-like scars extending beyond the injury site. There is excess production of collagen that is predominantly type III.”
    - Needs Improvement: Cite genetic predisposition study. Consider changing discussion based on skin color rather than race, as dermatologists do.
- Lecture 17: Acute Inflammation
  - Throughout Lecture
    ⇒ Only light skinned images used
    - Needs Improvement: Consider adding more diverse images.
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- **Lecture 18: Chronic and Granulomatous Inflammation**
  - Throughout Lecture
    - Only light skinned images used
      - **Needs Improvement:** Consider adding more diverse images.

- **Lectures 20&21: Anti-inflammatory and Immunosuppressive Agents**
  - Throughout Lecture
    - Only light skinned images used
      - **Needs Improvement:** Consider adding more diverse images.

- **Lectures 23&24: Opioid Pharmacology**
  - Slide 53
    - “OPRM-1 Polymorphism • Most frequent mutation is A118G – Asn to Asp substitution at position 40 – Frequency 10-20% in Caucasian, Hispanic – May be as high as 35-50% in Asians!”
      - **Needs Improvement:** Discuss prevalence of polymorphism by ancestry, cite study.
  - Syllabus Page 192
    - “Opioid metabolism and sensitivity are subject to genetic polymorphisms, and these may influence clinical effects. • Codeine is demethylated by CYP2D6 to its active metabolite, morphine. “Poor metabolizers” (many Caucasians) do not get expected analgesic effect from codeine, but “ultra rapid metabolizers” (many N. Africans) may have multiple gene copies and get toxicity.”
      - **Needs Improvement:** Discuss prevalence of genetic variance by ancestry, change qualitative descriptor (many) to precise value for incidence, describe various example genotypes corresponding to poor/intermediate/normal/ultra rapid metabolizers, and cite study.

- **Lecture 25&26: Developmental and Genetic Disease**
  - Slide 31
    - “Cystic Fibrosis: Most common lethal genetic disease that affects Caucasian populations.”
      - **Needs Improvement:** State that this is prevalence, and not of Caucasians but instead within populations of European ancestry. State that mutations in CF have been significantly understudied in other populations of different ancestry. State that you have to look for CF in all patients as there is research done to show that late and misdiagnosis and thus early death in other populations; consider removing CF from this lecture as it is covered with attention to these nuances in PrISM: Genomic Medicine.
  - Syllabus Page 195
    - “Cystic fibrosis is an autosomal recessive disease considered the most common lethal genetic disease that affects Caucasian populations”
      - **Needs Improvement:** Implies that CF only affects Caucasian populations.
  - Syllabus Page 199
    - “- carrier rate in Jewish people of Eastern European ancestry is 1:10”
      - **Appropriate Use:** Discussed in terms of ancestry of a specific region.
      - **Needs Improvement:** Discuss how “Jewish” was defined in this study.
Syllabus Page 199
⇒ “Type 1: (Classic) - Adult type, non-neurotropic, storage cells in spleen and bone, 80% cases occur in Jews of Eastern European ancestry, reduced but detectable level of enzyme, longevity is shortened but not markedly.”
  ○ **Appropriate Use:** Discussed in terms of ancestry of a specific region.
  ○ **Needs Improvement:** Discuss how “Jewish” was defined in this study.

- **Lecture 27: Cell Injury Case**
  ⇒ Throughout Lecture
  ⇒ Only light skinned images used
  ○ **Needs Improvement:** Consider adding more diverse images.

- **Lecture 28: Environmental Pathology**
  ⇒ Throughout Lecture
  ⇒ Mostly light skinned images used
  ○ **Needs Improvement:** Consider adding more diverse images.

- **Slide 27**
  ⇒ “Alcohol Toxicity: Genetic variations: variants of the ADH and ALDH enzymes in different individuals determine the acetaldehyde level and hence the level of ‘tolerance’ to alcohol. Fast ADH and/or slow ALDH protect against alcoholism (e.g., slow ALDH variant in 50% of Asians).
  ○ **Needs Improvement:** More precise language needed. Discuss what Asian populations were studied, rephrase in terms of ancestry and add prevalence data with study cited. Consider removing reference to race.

- **Syllabus Page 208**
  ⇒ “50% of Asians have a slow ALDH variant and, therefore, low alcohol tolerance.”
  ○ **Needs Improvement:** More precise language needed. Discuss what Asian populations were studied, rephrase in terms of ancestry and add prevalence data with study cited. Consider removing reference to race.

- **Lectures 34&35: Introduction to Bacteria**
  ⇒ Throughout Lecture
  ⇒ Only light skinned clipart used
  ○ **Needs Improvement:** Consider adding more diverse images.

- **Lecture 38: Microbiome**
  ⇒ Throughout Lecture
  ⇒ Only light skinned clipart used
  ○ **Needs Improvement:** Consider adding more diverse images.

- **Lecture 40: Mechanisms of Bacterial Pathogenesis**
  ⇒ Throughout Lecture
  ⇒ Mostly light skinned images used
  ○ **Needs Improvement:** Consider adding more diverse images.

- **Lecture 43: Integrated Case Discussion 2**
  ⇒ Throughout Lecture
  ⇒ Only light skinned images used
  ○ **Needs Improvement:** Consider adding more diverse images.
Practice Questions:
- Pharmacology Set 2, Question 17
  ⇒ “A clinically important characteristic of CYP450 enzymes is that: A. Deficiency results in prolonged paralysis by succinylcholine. B. Reduced drug clearance by this mechanism is more likely to be observed in patients with renal disease than in those with hepatic disease. C. Transcription rates are constant and not affected by exposure to drugs or chemicals in the diet. D. Genetic polymorphisms contribute to the variability among patients in drug clearance by this mechanism. E. Ethnicity is not a factor that contributes to variability in drug clearance by this mechanism.”
  o Needs Improvement: This question reinforces a false association between ethnicity and genetics.

Infectious Diseases
- Lecture 7: Chlamydia and Legionella
  ➢ Throughout Lecture
  ⇒ Only light skinned clipart used
  o Needs Improvement: Consider adding more diverse images.
  ➢ Syllabus Page 90
  ⇒ “Risk factors: non-White race, multiple sexual partners, <19 y.o., poor socioeconomic conditions, single marital status, non-barrier or no contraceptive use”
  o Needs Improvement: Remove reference to race as a risk factor. If discussion of race is important, discuss in terms of precise numbers of prevalence and explain possible reasons to explain racial disparities (e.g. testing and reporting differences).
- Lecture 8: Antibacterial Agents 1, 2, 3/Antifungal
  ➢ Throughout Lecture
  ⇒ Only light skinned clipart used
  o Needs Improvement: Consider adding more diverse images.
- Lecture 14: Syphilis and Chancroid
  ➢ Selection of Images throughout lecture
  ⇒ The only people of color were represented by their genitalia. Other manifestations of syphilis were represented as White.
  o Needs Improvement: More diverse images with care to not stigmatize this disease process.
  ➢ Topic of Tuskegee Study
  ⇒ Racist history of Tuskegee study was not mentioned
  o Needs Improvement: Add information on the history of this study which contributed to much of the knowledge of the disease process that we have today. This need not be a deep dive on the topic as it was discussed at length in EPH and mentioned in Genomic Medicine, but it should not be completely ignored either.
- Lecture 16: Antibacterial Agents 1,2,3/Antifungal
  ➢ Throughout Lecture
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⇒ Only light skinned clipart used
  o Needs Improvement: Consider adding more diverse images.

• Lecture 19: Malaria and Babesia
  ➢ Slide 1
    ⇒ Image of Black child with malaria
      o Needs Improvement: Consider removing due to stigmatizing nature or consider adding multiple children of various ancestries.

• Lecture 20: The Pharmacology of Anti-Malarial Agents
  ➢ Throughout Lecture
    ⇒ Only light skinned images used
      o Needs Improvement: Consider adding more diverse images.

• Lecture 24: HIV and AIDS
  ➢ Throughout Lecture
    ⇒ Only light skinned images used
      o Needs Improvement: Consider adding more diverse images.
  ➢ Slide 13
    ⇒
      o Appropriate Use: Discusses overrepresentation in data.
      o Needs Improvement: Consider adding discussion for reasons why this might be the case.
  ➢ Syllabus Page 261
    ⇒ “HIV infection in the US disproportionately affects minority populations”
      o Appropriate Use: Does not state as a risk factor.
      o Needs Improvement: Consider adding a discussion as to the factors that may be causing the disparity.

• Lecture 25&26: Herpes Viruses 1 and 2
  ➢ Syllabus Page 275
    ⇒ “Epstein Barr Virus: Nasopharyngeal carcinoma (NPC): epithelial cell tumor found primarily in Asian adult populations. EBV associated with some cases.”
      o Needs Improvement: Clarify specific Asian populations, provide precise incidence/prevalence statistics and cite study.
  ➢ Slide 38
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⇒ Diverse images and specific mention of diverse images: "I wanted you to be able to see the rash on different skin colors"
  o **Appropriate Use:** Important intentional placement of varying pictures with children with different skin colors with chickenpox.

- **Lecture 27: Poxviruses and Papillomaviruses**
  ➢ Throughout Lecture
  ⇒ Diverse images used.
    o **Appropriate Use:** Diverse images.
- **Lecture 28: Adenoviruses**
  ➢ Throughout Lecture
  ⇒ Only light skinned images used
    o **Needs Improvement:** Consider adding more diverse images.

**Pulmonary**
- **Lecture 2: Introduction to PFTs**
  ➢ Slides 6, 7
  ⇒ NHANES Data that uses race to identify normal values of lung function and was specifically used in a case study for a White male for predicted values. "NHANES III Caucasian dataset"
    o **Needs Improvement:** Consider adding commentary on how NHANES data is not always used in clinical settings. Consider inclusion of history of racism and spirometry.
- **Lecture 3: Case Studies of PFT**
  ➢ Slides 12, 52
  ⇒ NHANES Data that uses race to identify normal values of lung function and was specifically used in a case study for a White male for predicted values. "NHANES III Caucasian dataset"
    o **Needs Improvement:** Consider adding commentary on how NHANES data is not always used in clinical settings. Consider inclusion of history of racism and spirometry.
- **Lecture 6: Asthma**
  ➢ Opportunity to Supplement Lecture
  ⇒ Asthma and Social Determinants of Health
    o **Needs Improvement:** Opportunity to discuss social factors that influence asthma, discussion of social determinants of health.
- **Lecture 10: Interstitial Lung Disease Pathology**
  ➢ Slide 29
  ⇒ Image discussing sarcoidosis worldwide
    o **Appropriate Use:** Very informative infographic regarding incidence of sarcoidosis across the world.
    o **Needs Improvement:** Add discussion on information from image, as it would have been interesting to note that highest incidence of sarcoidosis is in Scandinavia.
- **Lecture 16: Sarcoidosis, Hypersensitivity, Pneumonitis, Silicosis, Asbestosis**
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- Slide 18
  ⇒ Racial Differences of Sarcoidosis in USA
  o **Needs Improvement**: Add discussion of data on possible contributing factors for higher incidence by race.

- Slide 5, 19, 39
  ⇒ Use of race in cases: “25 y.o. African American Female,” “African American Female,” “29 y.o. African American Male”
  o **Needs Improvement**: The case discussion leads students to incorporate African American into the illness script for sarcoidosis. The discussion would be benefitted with information on incidence of Sarcoidosis in various populations.

- Slide 49
  ⇒ “Predictors of chronic of progressive Sarcoid: - Previous steroid therapy - Black Race - Lupus Pernio, Nasal or Bone disease - Cardiac or Neurological Disease - Progressive Respiratory Disease - Low socioeconomic status”
  o **Needs Improvement**: Remove reference to race as a risk factor as it implies genetics and biological ideas of race. If there is an ancestral basis, it should be stated in that way. If there are specific genetic polymorphisms by ancestral group, they should be listed. If there are multiple contributing factors such as environmental and socioeconomic factors or other social determinants of health, they should be detailed.

- Lecture 20: Tuberculosis
  - Slide 8
  ⇒ “Non-US Born: Blacks, Asians, and Hispanics – 20, 25, and 10/100,000 vs 0.4/100,000 in US born Whites – Among US-born, Blacks = 6.5x Whites”
  o **Appropriate Use**: Stated in epidemiological terms.
  o **Needs Improvement**: Consider including discussion as to possible reasons for these disparities.

- Lecture 30: Sleep Disordered Breathing
  - Slide 9
  ⇒ “Risk factors for OSA: African American, East Asian, Pacific Islander”
  o **Needs Improvement**: Remove reference to race as a risk factor as it implies genetics and biological ideas of race. If there is an ancestral basis, it should be stated in that way. If there are specific genetic polymorphisms by ancestral group, they should be listed. If there are multiple contributing factors such as environmental and socioeconomic factors or other social determinants of health, they should be detailed.

**Cardiovascular**
- Lecture 1&2: Atherosclerosis and Ischemic Heart Disease
  - Slide 9
⇒ Infographic: "Heart Disease is the leading cause of death in African Americans, Hispanics and Whites.", "For Asian American or Pacific Islanders or American Indians or Alaska Natives, heart disease is second only to cancer"
  o Needs Improvement: Consider removing these statistics as they do not aid in diagnosis or improve patient care.

● Lecture 3: Hypertension and Its Treatments
  ➢ Slide 38, Racial and Ethnic Considerations
  ⇒ “In Black adults with hypertension but without HF or CKD, including those with DM, initial antihypertensive treatment should include a thiazide-type diuretic or CCB. Two or more antihypertensive medications are recommended to achieve a BP target of less than 130/80 mm Hg in most adults with hypertension, especially in Black adults with hypertension.”
  o Needs Improvement: Reference should be made to the original research that was done or the reasoning that derived this recommendation. Consider adding information to help students understand why this recommendation was made.

● Lecture 4: Drugs Affecting the Renin Angiotensin System
  ➢ Slide 26
  ⇒ Graph about racial differences in response to hypertension, Lecturer: “Blacks do not respond to ACE Inhibitors"
  o Needs Improvement: Remove false statement or amend to provide accurate information regarding ancestry and genetic link, if known, and provide data and cite studies that allow for this conclusion.

● Lecture 17: Peripheral Vascular Disease
  ➢ Syllabus Page 5
  ⇒ Risk Factors for Abdominal Aortic Aneurysm: “major risk factors are....and genetics (more common in White patients and those with 1st degree relatives)."
  o Needs Improvement: Remove association with race as a risk factor as it leads to confounding of race as biology.

● Lecture 18: Epidemiology of Coronary Artery Disease
  ➢ Slide 9
  ⇒ Graph separating White, Black, and Hispanic women
  o Needs Improvement: State how race/ethnicity was identified in the studies cited for the figures in the slides; acknowledge limitations of the Framingham Heart Study cohort lacking diversity.
  ➢ Slide 30
  ⇒ Graph showing smoking prevalence separated by race/ethnicity
  o Needs Improvement: Acknowledge that SES is one of the greatest predictors for this rather than just attributing differences to race
  ➢ Slide 44
  ⇒ “Blacks” listed as a bullet point for risk factor
  o Needs Improvement: Remove association with race as a risk factor as it leads to confounding of race as biology.
  ➢ Slide 49
  ⇒ Graph showing HTN awareness, treatment, control by race/ethnicity
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- Needs Improvement: Acknowledge the impact of access to healthcare and other SES factors.

- Slide 51
  ⇒ Graph showing physical activity levels by race/ethnicity
  - Needs Improvement: Acknowledge the impact of access to healthcare and other SES factors.

- Slide 59
  ⇒ Graph DM prevalence by race/ethnicity
  - Needs Improvement: Acknowledge the impact of access to healthcare and other SES factors.

- Slide 73:
  ⇒ Reducing Racial/Ethnic Disparities in Risk Factors
  - Appropriate Use: Acknowledges the separation of race from other factors, with race not being a risk factor in itself. Syllabus does a great job of focusing on specific risk factors rather than race.

- Lectures 19, 24&25, 26
  ⇒ Throughout lectures
  - Discussion of risk factors.
  - Appropriate Use: Race not provided in the patient presentations nor mentioned as a risk factor in the answer key. Specific risk factors were examined without being given a race label. Did not encourage the use of race as a proxy for other risk factors.

- Lecture 31: Heart Failure
  ⇒ Syllabus Pages 22 and 36
  - 22: "Blacks have higher hospitalization rates and mortality compared with Whites."
  - Needs Improvement: No explanation given as to why this health disparity exists. No discussion of how race is identified here.

  - 36: "The combination of hydralazine and long-acting nitrates has been shown to improve survival in self-described Black patients by 36% (V-Heft trial)." and "This medication should be started in Black patients and patients of any race who cannot tolerate an ACE-I or ARB (patients with bilateral renal artery stenosis, etc.)."
  - Needs Improvement: This statement fails to discuss the controversy over the use of BiDil and the V-Heft trial. This statement is also not in line with the ACC guidelines (https://www.ahajournals.org/doi/full/10.1161/cir.0b013e31829e8776); which specify that hydralazine and nitrates should only be initiated in "patients with HFrEF who "remain symptomatic despite concomitant use of ACE-inhibitors, beta blockers, and aldosterone antagonists.” The first-line therapy regimen is the same for all patients regardless of race.

  - Needs Improvement: This statement indicates a brief appendix on the important contextual history BiDil, its history, and the research surrounding it:
    (https://docs.google.com/document/d/1htKMzDr-9-TveElShKoaU7VK_VHJOwDlSemiU6psFv8c/edit?usp=sharing)

- Lectures 32&33: Drugs for Heart Failure 1&2
In addition, hydralazine (combined with a nitrate) is specifically indicated for treatment of symptomatic heart failure in African American patients, based on the A-HEFT trial which demonstrated a marked reduction in mortality in African Americans with systolic heart failure."

- **Needs Improvement:** Statement is misleading and conflates race with genetics. Replace information with current ACC guidelines (i.e. first-line therapy is the same for all patients regardless of race. Nitrates are not first-line treatment for African-Americans (nor are they first-line for renal artery stenosis patients), ACC guidelines: "7.3.2.6.1. Hydralazine and Isosorbide Dinitrate: Selection of Patients. The combination of hydralazine and isosorbide dinitrate is recommended for African Americans with HFrEF who remain symptomatic despite concomitant use of ACE inhibitors, beta blockers, and aldosterone antagonists. Whether this benefit is evident in non–African Americans with HFrEF remains to be investigated. The combination of hydralazine and isosorbide dinitrate should not be used for the treatment of HFrEF in patients who have no prior use of standard neurohumoral antagonist therapy and should not be substituted for ACE inhibitor or ARB therapy in patients who are tolerating therapy without difficulty. Despite the lack of data with the vasodilator combination in patients who are intolerant of ACE inhibitors or ARBs, the combined use of hydralazine and isosorbide dinitrate may be considered as a therapeutic option in such patients.”

- **Slide 91**
  - Nitrates are "Second line behind ACEi/ARBs" but "First line if: African-Americans; Intolerant of ACEi; Renal artery stenosis; Chronic renal failure"
  - **Needs Improvement:** Statement is misleading and conflates race with genetics. Replace information with current ACC guidelines (i.e. first-line therapy is the same for all patients regardless of race. Nitrates are not first-line treatment for African-Americans (nor are they first-line for renal artery stenosis patients), ACC guidelines: "7.3.2.6.1. Hydralazine and Isosorbide Dinitrate: Selection of Patients. The combination of hydralazine and isosorbide dinitrate is recommended for African Americans with HFrEF who remain symptomatic despite concomitant use of ACE inhibitors, beta blockers, and aldosterone antagonists. Whether this benefit is evident in non–African Americans with HFrEF remains to be investigated. The combination of hydralazine and isosorbide dinitrate should not be used for the treatment of HFrEF in patients who have no prior use of standard neurohumoral antagonist therapy and should not be substituted for ACE inhibitor or ARB therapy in patients who are tolerating therapy without difficulty. Despite the lack of data with the vasodilator combination in patients who are intolerant of ACE inhibitors or ARBs, the combined use of hydralazine and isosorbide dinitrate may be considered as a therapeutic option in such patients.”
  - [https://www.ahajournals.org/doi/full/10.1161/cir.0b013e31829e8776](https://www.ahajournals.org/doi/full/10.1161/cir.0b013e31829e8776); Brief history of these guidelines: see this document.

- **Slide 94**
  - Graph of survival from V-HEFT I trial distinguishing survival by "Non-African Americans" vs "African Americans"
Needs Improvement: Statement is misleading and conflates race with genetics. Replace information with current ACC guidelines (i.e. first-line therapy is the same for all patients regardless of race. Nitrates are not first-line treatment for African-Americans (nor are they first-line for renal artery stenosis patients), ACC guidelines: "7.3.2.6.1. Hydralazine and Isosorbide Dinitrate: Selection of Patients. The combination of hydralazine and isosorbide dinitrate is recommended for African Americans with HFrEF who remain symptomatic despite concomitant use of ACE inhibitors, beta blockers, and aldosterone antagonists. Whether this benefit is evident in non–African Americans with HFrEF remains to be investigated. The combination of hydralazine and isosorbide dinitrate should not be used for the treatment of HFrEF in patients who have no prior use of standard neurohumoral antagonist therapy and should not be substituted for ACE inhibitor or ARB therapy in patients who are tolerating therapy without difficulty. Despite the lack of data with the vasodilator combination in patients who are intolerant of ACE inhibitors or ARBs, the combined use of hydralazine and isosorbide dinitrate may be considered as a therapeutic option in such patients.”

Further information about the problematic history of the V-HEFT trial and its impact on racism today: see this document.

Slide 109

“Current Drug Treatment for Chronic Systolic Heart Failure (2015)...

Needs Improvement: Statement is misleading and conflates race with genetics. Replace information with current ACC guidelines (i.e. first-line therapy is the same for all patients regardless of race. Nitrates are not first-line treatment for African-Americans (nor are they first-line for renal artery stenosis patients), ACC guidelines: "7.3.2.6.1. Hydralazine and Isosorbide Dinitrate: Selection of Patients. The combination of hydralazine and isosorbide dinitrate is recommended for African Americans with HFrEF who remain symptomatic despite concomitant use of ACE inhibitors, beta blockers, and aldosterone antagonists. Whether this benefit is evident in non–African Americans with HFrEF remains to be investigated. The combination of hydralazine and isosorbide dinitrate should not be used for the treatment of HFrEF in patients who have no prior use of standard neurohumoral antagonist therapy and should not be substituted for ACE inhibitor or ARB therapy in patients who are tolerating therapy without difficulty. Despite the lack of data with the vasodilator combination in patients who are intolerant of ACE inhibitors or ARBs, the combined use of hydralazine and isosorbide dinitrate may be considered as a therapeutic option in such patients.”

History of guidelines: this document

Lecture 34: Cardiomyopathies

Syllabus Page 5

"Hydralazine/nitrates in self-described Black patients can be added for afterload and preload reduction."

Appropriate Use: Characterizes race as self-identified/social rather than biological/genetic
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- **Needs Improvement**: Describes differential treatment based on race without explanation.

- **Lecture 35: Pathology Independent Study**
  - Slide 2
  - Race (White male) included in case
  - **Needs Improvement**: Remove reference to race.

- **Lecture 37: Heart Failure and Valve Disease Cases**
  - Case 2, Page 4
  - Case 2 describes a "Cape Verdean woman". In the answer key: "Questions to ask include her past medical history and current medications, as well as adherence to her medication regimen. We must also focus on barriers she may face in taking her medications and barriers to adhering to a low salt diet (food insecurity, for example)."
  - **Needs Improvement**: Remove reference to patient’s ethnicity unless specifically related to their diagnosis or care. Rewrite case to avoid stereotyping certain ethnicities as being more or less adherent to medical therapy or facing food insecurity.

- **Lecture 38: Hyperlipidemias**
  - Throughout Lecture
  - Only light skinned images used for xanthelasmas.
  - **Needs Improvement**: Consider adding more diverse images.

- **Lecture 40: Pharmacology of Drugs for Hyperlipoproteinemias, Cases**
  - Slides 3&4
  - "Race: African American" or "Other" is included as a risk factor in the ACC/AHA Pooled Cohort Estimate tool.
  - **Needs Improvement**: Since this tool and slide were not developed at BU, it would be hard to change the tool itself. However, the Framingham Risk Calculator (also used in this lecture), does not include race as a risk factor and could be used as a tool instead.

- **Exam Review: Clinical**
  - Slide 24
  - Graph of age-adjusted death rates for Black and White females, indicating higher cardiovascular deaths in Black females.
  - **Needs Improvement**: State how race was identified in this study. Use this slide as an opportunity to mention how disparities in health outcomes by race are related to the effects of racism (lower SES, access to food, increased chronic stress, etc.) rather than race as a standalone item.

- **Exam Review Pharmacology**
  - Slide 41
  - "ACEIs in Black patients" given as a wrong answer choice to the question "Which drug class is among the first choices for treating stage 1 hypertension (BP >130/80mm Hg) in the absence of other compelling indications?"
  - **Needs Improvement**: While it is true that the ACC 2017 guidelines do not indicate ACE-I as first-line monotherapy in AA individuals, using this as a wrong answer choice perpetuates the idea that ACE-I are not effective in Black patients, which they are. When teaching about ACE-I in Black patients and the ACC guidelines, it is critical to mention that "A reinterpretation of published data from these same
clinical trials suggests that: (1) the majority of African-Americans have meaningful BP responses to ACE inhibitors, albeit at a higher average dose than in Whites; and (2) high levels of dietary sodium intake appear to explain a significant portion of the racial differences in BP response at the lower doses of ACE inhibitors. Thus, ACE inhibitors can effectively lower BP in African-Americans." (Flack, J. M., Mensah, G. A., & Ferrario, C. M. (2000). Using angiotensin converting enzyme inhibitors in African-American hypertensives: a new approach to treating hypertension and preventing target-organ damage. Current medical research and opinion, 16(2), 66-79.)

- Practice Questions
  - Pharmacology Set 1, Question 7
    ⇒ “A 66-year-old man African American is diagnosed with systolic heart failure. Which of the following therapies is optimal for the chronic management of symptoms of congestive heart failure in this patient? A. Nifedipine B. Lisinopril and losartan in combination C. Hydralazine and isosorbide dinitrate D. Verapamil”
    o Needs Improvement: Race included in patient presentation without relevance.
  - Pharmacology Set 1, Question 19
    ⇒ “A 75-year-old African American male with ischemic cardiomyopathy, congestive heart failure, and prior myocardial infarction presents to your office with symptomatic, refractory atrial fibrillation. Which of the following antiarrhythmic drugs would appropriate for suppression of further atrial arrhythmias in the outpatient setting, but requires patient monitoring for side effects pulmonary toxicity?: Amiodarone, Lidocaine, Dofetilide, Procainamide, Flecainide”
    o Needs Improvement: Race included in patient presentation without relevance.
  - Pharmacology Set 2, Question 9
    ⇒ “A 67-year White female with known systolic heart failure presents to the emergency ward with a 2-week history of increasing shortness of breath and leg swelling. On examination, respirations are rapid and labored, blood pressure is 120/70 mmHg and the heart rate is 85 beats/min. There is jugular venous distention, bibasilar rales, and severe bilateral pedal edema. Which of the following is the appropriate initial treatment to rapidly relieve her dyspnea? A. The diuretic furosemide IV B. Spironolactone PO C. Digoxin PO D. Diltiazem E. Metoprolol”
    o Needs Improvement: Race included in patient presentation without relevance.
  - Pharmacology Set 2, Question 10
    ⇒ “A 52-year-old African American male with known systolic heart failure is seen in the cardiomyopathy clinic. He is doing well with regard to symptoms and functional capacity. He is taking a thiazide diuretic, a beta-blocker and spironolactone. Addition of which of the following medications would be most likely to increase his chances of survival? A. Nitroglycerin B. The loop diuretic furosemide C. Hydralazine and a nitrate D. Digoxin E. Hydralazine”
    o Needs Improvement: Race included in patient presentation without relevance.
  - Pharmacology Set 2, Question 14
“Angiotensin II receptor antagonists are useful in patients with: A. Low blood pressure B. Hypertension during pregnancy C. Cough from an ACE inhibitor D. Hypertension; efficacy is greater in African-Americans than Caucasians E. Hyperkalemia”
- Needs Improvement: Race included in patient presentation without relevance.

### Rheumatology
- **Lecture 0: Introduction to Rheumatology Module**
  - Slides 15-37
  - Images of various rheumatologic conditions on light skin tones.
  - Needs Improvement: Consider adding more diverse images.
- **Lecture 1: Scleroderma**
  - Slides 6, Syllabus Page 3
  - Syllabus: "There appear to be no clear racial or ethnic differences with the exception of a severe phenotype in young African American women"
  - Lecturer: “Our belief is that most likely due to the passage of African American slaves to the new world there was some genetic bottleneck that passed along genes, unfortunately, that predisposed more severe disease in scleroderma as opposed to Caucasians. It is fairly evident that African Americans have a very different genetic profile of scleroderma than Caucasians do based on some of our European colleagues that do their own cohorts.”
  - Needs Improvement: Add a note that the study cited used demographic data from medical records, which is likely either self-reported or entered by the healthcare team based on how the patient looked to them. Using the social category of race to explain differences in disease severity misrepresents the data as biology. The study does not provide any explanation for the differences observed, while the explanation in the course equates race and genetics. The genetic explanation is also flawed as there is no specific evolutionary selection that would select for this complex trait in a single generation (i.e. the time needed to travel under slave trade conditions to the US), nor was there a bottleneck event where only a small number of founders were responsible for all the slaves living in the US. Remove the suggestion that all people who identify/or are identified as African American are descendants of slaves.
  - Slides 24, 25, 31
  - Images of Raynaud's Phenomenon, nail fold capillary changes, and other skin features of scleroderma displayed on light skin.
  - Needs Improvement: Consider adding more diverse images.
- **Lecture 2: Rheumatoid Arthritis**
  - Throughout the presentation.
  - Images of body parts represented with light skin.
  - Needs Improvement: Consider adding more diverse images.
- **Lecture 3: Systemic Lupus Erythematosus (SLE): Clinical Aspects**
  - Slide 4, Syllabus Page 2
⇒ Slides: "Ethnic variability: White women ~1:1500, African-American women ~1:500"
⇒ Syllabus: “Increased incidence (~3 fold) in certain African-American Groups.”
  o **Appropriate Use:** The lecture recognized that the biases that can form in our mind based on epidemiological data on race and gender can cause us to miss diagnoses when it is not presenting in the "stereotypical patient."
  o **Needs Improvement:** Comparison of incidence of SLE among different racial groups without context could imply race is the causative factor in these differences. Include specific data regarding ancestry if available, and add note that the differences observed are multifactorial.

⇒ Slides 17-23
⇒ Images of skin manifestations of lupus
  o **Needs Improvement:** Consider adding more diverse images.

● **Lecture 4: Pathology Independent Study Case – SLE**
  ➢ Slide 3, 4
    ⇒ Image of malar rash
    o **Needs Improvement:** Consider adding more diverse images.

● **Lecture 5: Spondyloarthritis**
  ➢ Slide 9
    ⇒ “SpA is the most commonly associated systemic disease in North America and Europe (Ddx: Behcet’s, sarcoid, viral)”
    o **Appropriate Use:** Appropriately describes prevalence in geographic regions without equating it to race
  ➢ Slide 19
    ⇒ “95% are HLA B27+ HLA B27+ in ~5-10% of Caucasian populations”
    o **Needs Improvement:** If the data is available, it would be better to present the prevalence among people of different ancestries/geographic regions as opposed to using a racial category.
  ➢ Syllabus Page 5
    ⇒ "However, the prevalence varies by ethnic group due to difference in the prevalence of genetic factors such as HLA-B27”
    o **Appropriate Use:** Use of “ethnic group,” though ill-defined, is preferred to race in this context, given that ethnic groups are often defined based on the assumption of shared ancestry.
  ➢ Slides 8-12, 15, 39-40, 51
    ⇒ Images of extra-articular features of spondyloarthitis, psoriatic arthritis and reactive arthritis: all of the images, except that of circinate balanitis on slide 50, are only shown on light skin
    o **Needs Improvement:** Consider adding more diverse images.

● **Lecture 6: Lower Back Pain**
  ➢ Syllabus Page 3
    ⇒ "Risk factors for osteoporosis are....and Caucasian or Asian race"
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- **Needs Improvement:** Remove reference to race as a risk factor. If included, add note that risk is not race but another undetermined factor for which race is a surrogate marker. Provide causes of risk if known/research available.

- **Lecture 7: The Pharmacology of Immunosuppressive Agents**
  - Slide 9
  - "Hemolytic anemia – Risk increased by G-6-PD deficiency – Prevalence >1% in Mediterranean region, India, middle Africa, south China"
  - **Appropriate Use:** This appropriately describes prevalence in different geographic regions without equating it to race.
  - Syllabus Page 4
  - "about 0.3% of Caucasians are homozygous for mutant alleles and have markedly deficient TPMT activity"
  - **Needs Improvement:** If the data is available, it would be better to present the prevalence among people of different ancestries or geographic regions.

- **Syllabus Page 5**
  - "Randomized double-blind studies have shown mycophenolate to be effective as cyclophosphamide in patients with lupus nephritis, and perhaps better in African-American patients"
  - **Needs Improvement:** If the mechanism of differential treatment response is unknown, remove reference to race, as this statement otherwise implies race is biologic.

- **Lecture 8: Pathology of Systemic Autoimmune Disease**
  - Slides 14, 18
  - Image of peripheral cutaneous vasculitis, image of sclerotic skin on face
  - **Needs Improvement:** Consider adding more diverse images.

- **Lecture 9: Immunology of Autoimmune Disease**
  - Slide 12
  - Image of pemphigus vulgaris
  - **Needs Improvement:** Consider adding more diverse images.

- **Lecture 10: Pediatric Rheumatology**
  - Throughout presentation
  - All images of body parts
  - **Needs Improvement:** Consider adding more diverse images.

- **Lecture 12: Soft Tissue Rheumatism**
  - **Syllabus Page 4**
  - "Associations exist between [Dupuytren's contracture] ...and Northern European Ancestry"
  - **Appropriate Use:** Appropriately uses ancestry as a risk factor for a given condition

- **Lecture 13: Crystal Arthritis**
  - Slide 32
  - Image of tophi
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- **Needs Improvement:** Consider adding more diverse images.

- **Lecture 15: Vasculitis**
  - Slides 3, 13
    - Images of purpura
      - **Needs Improvement:** Consider adding more diverse images.

- **Syllabus Page 8**
  - “Although TAK is more prevalent in people of Asian descent, this disorder is seen world-wide...”
    - **Appropriate Use:** Good to make sure that we don't limit our idea of who is at risk for this disease
    - **Needs Improvement:** If data is available, provide specific ancestries within "Asian" descent that have higher prevalence of TAK.

- **Syllabus Page 10**
  - “Bechet’s disease occurs with markedly increased prevalence among certain populations stemming from countries bordering the Mediterranean Sea. It is thought that there was a genetic predisposition to this disease in the people who traveled along the ancient silk route, and thus the geographic distribution of Bechet’s disease reflects this migration. Turkey has a particularly high prevalence of the disease as do other neighboring countries including Iran and Iraq....Also markedly increased prevalence in Japan”
    - **Appropriate Use:** When talking about risk and demographics, this is a great level of specificity that should be strived for – specific ancestries or geographies are used.

- **Lecture 16: Osteoarthritis**
  - Slide 16, Syllabus Page 7
    - Slides: "Systemic Factors Affecting Joint Vulnerability: Age, Gender, Race, Genetic Susceptibility"
    - Syllabus: among systemic factors are age, female gender after age 50, genetic susceptibility and possibly racial or ethnic factors"
      - **Needs Improvement:** Race is likely a risk marker for some other unidentified factor that is confounded by the social categorization of race, and it should not be presented as a risk factor.

- **Lecture 18: Joint anatomy, Physical Exam, and Synovial Fluid Analysis**
  - Throughout presentation
    - While there were some images of people with dark skin in these slides, all of the images of skin specific manifestations of disease were shown on light skin;
      - **Needs Improvement:** Consider adding more diverse images.

- **Lecture 21: Infectious Arthritis**
  - Slides 17-18, 36, 44, 48, 57
    - Images of skin findings in disseminated gonococcal infection, image of erythema migrans, image of Fifth disease, image of rubella rash, image of erythema marginatum
      - **Needs Improvement:** Consider adding more diverse images.

- **Lecture 22: Myositis/Myalgia**
  - Slides 14-16, 19
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⇒ Images of Gottron's sign, image of shawl sign
  • Needs Improvement: Consider adding more diverse images.

➤ Syllabus Page 3
⇒ “Inclusion Body Myositis (IBM): Predominantly affects White males over age of 50”
  • Needs Improvement: Add note that epidemiologic observations that involve race do not suggest a biological mechanism in the same way that sex and age might.

Renal
• Lecture 9: Chronic Kidney Disney
  ➤ Page 3 Syllabus
⇒ “MDRD GFR = 186 x [Pcr]-1.154 x [age]-.203 x [0.742 if female] x [1.212 if patient is Black]”
  • Needs Improvement: Further studies yielded a different calculation for Black individuals and explain the repercussions of African American patients being ascribed higher GFRs solely based on their race (e.g. transplantation cutoffs).

➤ Slide 12
⇒ Differential creatinine production in people of different muscle mass – higher among Black vs White, with accompanying contrasting image
  • Needs Improvement: The statement generalizing muscle mass and resultant creatinine clearance is higher among "Blacks" is not accurate across all groups who identify as Black. This type of thinking leads to implicit biases about certain patients. Picture should be replaced or not affiliated with the slide stating that "Blacks have more muscle mass than Whites."

• Lecture 15-17: Glomerular Disease
  ➤ Page 14 of Syllabus
⇒ “Idiopathic FSGS- Common cause of adult nephrotic syndrome esp. among Blacks”
  • Needs Improvement: Caution not to ascribe prevalence of a disease amongst a racial group based on genetic differences, as this implies a genetic basis for race.

➤ Slide 35
⇒ “Collapsing glomerulopathy (African ancestry + APOL1 SNPs)”
  • Needs Improvement: Caution not to ascribe prevalence of a disease amongst a racial group based on genetic differences, as this implies a genetic basis for race.

➤ Slide 58
⇒ “IgA nephropathy- Highest prevalence in Asia”
  • Appropriate Use: Stated in terms of prevalence.
  • Needs Improvement: More precise information on the ancestry/geographical region with increased prevalence within Asia.

Gastrointestinal
• Lecture 3: Pathology of Upper GI Disease
  ➤ Syllabus Page 3, Paragraph 4
⇒ "[Squamous carcinoma] is >3 times more prevalent in African-American than in Caucasian males in contrast to adenocarcinoma which is several fold more frequent among Whites."
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- Needs Improvement: Consider removing statistic. If included, a brief explanation of factors that may contribute to increased prevalence in Black men is necessary.

- Slide 31
  ⇒ “Squamous Carcinoma Esophagus: "Black males at >risk"
  - Needs Improvement: Consider removing statistic. If included, a brief explanation of factors that may contribute to increased risk in Black men is necessary.

- Lecture 5: Inflammatory Bowel Disease
  - Syllabus Page 1, Paragraph 2
    ⇒ “IBD is more common in Caucasians, but the incidence in Asians, Hispanics and African Americans are all increasing. Crohn’s Disease is three to eight times and ulcerative colitis two to four times more common in patients of Jewish descent than in non-Jews.”
    - Needs Improvement: More information needed for prevalence information, if available. Why do we think IBD incidence is rising in Asians, Hispanics and African Americans? By how much? Over what period of time? Is incidence of IBD disproportionately rising in these populations or is it increasing in all populations?

- Slide 23
  ⇒ Images of perianal Crohn's disease
  - Needs Improvement: Consider adding more diverse images.

- Lecture 7: Malabsorptive Disorders
  - Syllabus Page 6, Paragraph 5
    ⇒ "Different ethnic groups have a variable prevalence of lactase deficiency: Northern European 5-15%, African-American 45-80%, Asian >90%"
    - Needs Improvement: Cite source of data and how groups were determined.

- Slide 23
  ⇒ Pictures of common findings of various vitamin deficiencies
  - Needs Improvement: Consider adding more diverse images.

- Lecture 9: Clostridium and Bacillus
  - Throughout presentation
    - Needs Improvement: Consider adding more diverse images.

- Lecture 21: Case Discussions
  - Syllabus Page 1, Paragraph 1
    ⇒ On exam the patient is a thin White man in no acute distress
    - Needs Improvement: Consider removing race from this case.

- Lecture 24: Bile and Gallstones
  - Slide 27
    ⇒ Gallstone disease: “More common is western Caucasian, Hispanic, and Native American populations”
    - Needs Improvement: No comparison or explanation for this statement is provided.

- Lecture 25: Evaluation of Liver Disease
  - Slide 6
    ⇒ Pictures of liver disease symptoms
    - Needs Improvement: Consider adding more diverse images.

- Lecture 27: Gallbladder and Biliary Disease
Syllabus Page 5, Paragraph 2
⇒ “Gallstone disease occurs in epidemic proportions in American Indian populations, with prevalence rates of approximately 30% and 64% in men and women, respectively. In general, gallstone disease is more common in western Caucasian, Hispanic and Native American populations, and less common in eastern European, African American, and Asian populations.”
  o **Needs Improvement:** Consider adding a more detailed explanation for regional variations and increased rates in some populations.

- **Lecture 30: Pancreatic Disorders**
  - Syllabus Page 6, Paragraph 1
    ⇒ “Incidence [of CF] for Caucasians in US is 1 in 2,000 live births, among African Americans 1 in 14,000”
    o **Appropriate Use:** Provides precise values for incidence, and provides incidence for more than just Caucasian populations.

- **Lecture 31: Trematodes/Cestodes**
  - Slide 16
    ⇒ Photos of cercarial dermatitis
    o **Needs Improvement:** Consider adding more diverse images.

- **Lecture 32: Nematodes**
  - Syllabus Page 15
    ⇒ “Epidemiology of onchocerca volvulus: Endemic to much of western Sub-Saharan Africa especially Congo and Volta river basins. Low level endemicity in Central and South America, Brazil.”
    o **Appropriate Use:** Use of specific regions/countries, most precise information used.
  - Slides 28, 30, 33
    ⇒ Photos of darker skinned individuals with various parasitic diseases
    o **Needs Improvement:** Consider the stigmatizing effect of photos chosen for this presentation. Consider removing images as they are not necessary or beneficial for instruction on serious and debilitating diseases.
  - Slide 37
    ⇒ Photos of cutaneous larva migrans
    o **Needs Improvement:** Consider adding more diverse images.

- **Lecture 34: Hepatitis B and D Viruses**
  - Syllabus Page 1
    ⇒ “Over 257 million people are estimated to be chronically infected with HBV, mostly in Asia and Africa (est. 862,000 in the U.S., 1700 deaths/yr)”
    o **Needs Improvement:** More information needed for this statistic, with more specific regional information if available.

- **Lecture 35&36: Viral Hepatitis and HCV Drugs**
  - Slide 27
    ⇒ HEV case: "24-year-old Chinese student", Lecturer “usually from Southeast Asia or Africa”
    o **Needs Improvement:** Add precise information on the epidemiology and prevalence of this disease. Remove race from case.
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- Slide 30
  - HBV case: "41-year-old Chinese researcher"
    - Needs Improvement: Add precise information on the epidemiology and prevalence of this disease. Remove race from case.

**Dermatology**

- **Lecture 1: Dermatology Lexicon**
  - Throughout presentation
  - Images
    - Appropriate Use: Diverse images were used throughout the slide deck. The importance of seeing the conditions on multiple skin tones was discussed.
- **Lecture 2: Common Neoplasms of the Skin**
  - Throughout presentation
  - Images
    - Needs Improvement: Consider adding more diverse images.
- **Lecture 4: Dermatologic Emergencies**
  - Throughout presentation
  - Images
    - Needs Improvement: Consider adding more diverse images.
- **Lecture 7: Non-Melanoma Skin Cancers: Basal Cell and Squamous Cell Carcinomas**
  - Throughout presentation
  - Images
    - Needs Improvement: Consider adding more diverse images.
- **Lecture 13: Infectious Disease Dermatology: Common infectious Diseases of the Skin**
  - Slide 16
    - Mongolian Spots - "Less frequently seen in in Black infants"
      - Needs Improvement: Important to clarify reasons if known/current theories.
- **Lecture 17: Pigmented Lesions – From Moles to Melanoma**
  - Slide 44
    - "Acral Lentiginous Melanoma- most common subtype in darkly-pigmented people (Asians, African Americans, Hispanics) ... associated with Kit mutation"
      - Needs Improvement: Important to clarify reasons if known/current theories.

**Reproduction**

- **Lecture 3: Abortion**
  - Slides 6, 7
    - US abortion patients and rates by race and ethnicity
      - Appropriate Use: Names the proximal causes (health insurance/access to care, racism, discrimination) that are responsible for disparities in abortion rates
- **Lecture 5: Congenital Abnormalities**
  - Slide 42
    - Guevedoces of the Dominican Republic
      - Needs Improvement: Requires further explanation. Clarify if information is included as an example of what it is called in some places or if 5 alpha reductase deficiency is more prevalent in certain countries or ancestry groups.
• Lecture 6: Acquired Abnormalities
  ➢ Slide 17
  ⇒ “Uterine fibroids 2-3 fold higher in Black women than White women, familial predisposition - twin studies, pathophysiology unclear”
    o Needs Improvement: Specify that familial predisposition does not mean that this disparity can be fully explained by biological processes, especially since pathophysiology and risk factors are unclear.

• Lecture 7: Gyn Malignancies 1
  ➢ Slide 14
  ⇒ Uterine cancer incidence/death rates, by racial/ethnic group, United States 1999-2015
    o Appropriate Use: Discussion of disparities with data.
  ➢ Slide 16
  ⇒ Type II endometrial cancer disproportionately Black, risk factors not well characterized
    o Appropriate Use: Acknowledges that risk factors are not well characterized rather than substituting race as a risk factor.
  ➢ Slide 30
  ⇒ Black women 2x more likely to die from uterine cancer
    o Needs Improvement: Although reasons may be unknown, some discussion of what might be contributing to this disparity is warranted. Positioning after differential risk for type I and type II endometrial cancer implies that this is a large part of it – specify whether this is the case or if there are other contributing factors.

• Lecture 8: Gyn Malignancies 2
  ➢ Slide 2
  ⇒ “67 y.o. Haitian female, G6P6005, LMP “many years ago” presents with intermittent vaginal bleeding over the past 6 month”
    o Needs Improvement: Specify that the patient is an immigrant and how the risk factor is being from a country without a cervical cancer screening program rather than Haitian ancestry.
  ➢ Slide 6
  ⇒ “[Cervical cancer] Incidence and mortality in US higher among minorities • RR ~1.8 for Hispanic women • RR ~1.5 for African-American women”
    o Needs Improvement: Connect racial disparities to risk factors, how much do SES and smoking account for the racial disparities in both incidence and mortality.
  ➢ Slide 16
  ⇒ “Risk Factors for Cervical Cancer • Low socioeconomic status • cervical cancer incidence was higher in women who lived in communities with higher poverty levels Smoking (squamous cell only)”
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- **Appropriate Use**: Potential proximal causes that contribute to racial disparities in Cervical cancer.

- **Lecture 9: Overview of Diseases of the Prostate**
  - Slide 18
    - “African American men have higher risk and more progression [BPH]”
    - **Needs Improvement**: Discussion of what the higher risk is or whether there is a higher incidence and the contributing factors are unknown.
  - Slide 35
    - “Prostate cancer risk factors - Race (African American), HPC1 Gene”
    - **Needs Improvement**: Adjust wording to remove race as a risk factor. Clarify if the gene is more common in people of African ancestry and if that factor fully explains increased risk. If not, add a note about other contributing factors if known, or state that reasons for increased incidence is unknown.

- **Lecture 10: Male Sexual Dysfunction**
  - Throughout presentation
    - Penile condyloma images all lighter skin tones.
    - **Needs Improvement**: Include examples of what lesions look like on a variety of skin tones

- **Lecture 16: Gynecologic Pathology**
  - Slide 38
    - “[Hydatidiform Mole] Asia, Latin America, Middle East”
    - **Needs Improvement**: Specify whether these are regions where hydatidiform moles are more prevalent - perhaps comment on any evidence on whether this is purely regional or related to other factors.

- **Lectures 18 & 19: Abnormal Pregnancy 1 & 2**
  - Throughout lectures
    - **Needs Improvement**: There is an opportunity for discussion of the factors contributing to racial disparities in birth outcomes. Consider discussing studies that have shown impact of stress of racism and racist treatment by medical providers to emphasize that disparities are not the result of biological differences. Discuss any efforts/initiatives that have addressed these disparities such as the California Maternal Quality Care Collaborative.

- **Lecture 24: Menopause and Female Sexual Dysfunction**
  - Slide 13
    - “[Menopause Epidemiology] Earlier among Latina women and later in Japanese-American women”
    - **Needs Improvement**: Expand on what might be contributing to these trends or whether it is unknown (e.g. tracking with other countries, difference in mean parity, SES).
  - Slide 31
    - “Osteoporosis - White women who reach 50 years of age have a 1:3 lifetime risk of vertebral fracture and 1:6 risk of hip fracture Solomon GC, NEJM 2002; 346:642”
    - **Appropriate Use**: Specific study was cited.
    - **Needs Improvement**: Clarify why the study made a claim specifically about White women. Specify how race was identified in this study.
Endocrinology and Nutrition

● Lecture 1: Pediatrics – Growth
  ➢ Slide 13
    ⇒ WHO growth charts: "multiethnic/international"
      o **Appropriate Use:** Some examination of the diversity of the population from which data was taken to create commonly used growth charts (WHO vs. CDC)
      o **Needs Improvement:** Clarify relevance/importance of using "multiethnic" growth chart (syllabus explains more). More precise language if talking about biological differences in height based on ancestry.
  ➢ Throughout presentation
    ⇒ All images appear to be of White people except one (Simone Biles)
      o **Needs Improvement:** Consider adding more diverse images.
  ➢ Syllabus Page 2
    ⇒ “The National Center for Health Statistics (NCHS) growth charts were updated by the NCHS and the Centers for Disease Control and Prevention (CDC) in 2000. The old charts (1977) were based on data collected in a private Ohio study and reflected growth patterns of White, middle-income children. The updated growth charts are based on data gathered through 1994 from five national health examination surveys and five supplementary data sources. These data are racially and ethnically diverse and are growth references showing how children actually grew”
      o **Appropriate Use:** Explains how race was used in the datasets behind commonly used growth charts and cites sources.
      o **Needs Improvement:** Consider adding these explanations to slides.
  ➢ Syllabus Page 2
    ⇒ “More recently, the World Health Organization (WHO) used a multiethnic international design to create a single international standard reflective of the global community and tested the strong likelihood that infants and young children from diverse ethnic backgrounds grow very similarly for the first five years of life when their nutritional needs are met.”
      o **Appropriate Use:** Explains importance of data from diverse populations and debunks idea of biological ethnic differences in growth rates.

● Lecture 3: Anterior Pituitary
  ➢ Throughout presentation
    ⇒ Most images appear to be of White people
      o **Needs Improvement:** Consider adding more diverse images.

● Lecture 5: Adrenal Excess and Deficiency
  ➢ Throughout presentations
    ⇒ Relatively diverse images, still majority lighter skinned people
      o **Needs Improvement:** Consider adding more diverse images.

● Lecture 7: Adrenal Incidentaloma
  ➢ Slide 22
    ⇒ Patient with "ruddy complexion" in hypercortisolism case
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- **Needs Improvement**: Potentially reinforces thinking only of fairer-skinned patients when picturing someone with hypercortisolism. If appropriate, add equivalent vocabulary for darker skinned individuals.

  - **Slide 32**
    - Iodine deficiency "worldwide problem in 3rd world countries" with picture of dark-skinned kids in minimal/"traditional" clothing
    - **Needs Improvement**: Consider discussing more specifically about worldwide vs. US prevalence of iodine deficiency, regions where it is most common. Replace “3rd world” with “low-middle-income countries.” Consider the stigmatizing nature of images.

  - **Throughout presentation**
    - All images are of light-skinned people except for the one associated with iodine deficiency in "third world countries"
    - **Needs Improvement**: Consider adding more diverse images.

- **Lecture 9: Hypothyroidism**

  - **Slide 32**
    - “Iodine Deficiency: A severe, worldwide problem in many underdeveloped countries, but non-existent in the U.S. and Canada”
    - **Needs Improvement**: Consider providing statistics on prevalence worldwide, in US/Canada, and particular regions where iodine deficiency is common rather than verbiage of "under developed countries.”

  - **Throughout presentation**
    - Some diversity of images, still mostly light-skinned people
    - **Needs Improvement**: Consider adding more diverse images.

- **Syllabus Page 3**

  - “Iodine Deficiency: A severe, worldwide problem in many underdeveloped countries, but non-existent in the U.S. and Canada:
    - **Needs Improvement**: Consider providing statistics on prevalence worldwide, in US/Canada, and particular regions where iodine deficiency is common rather than verbiage of "under developed countries.”

- **Lecture 10: Hyperthyroidism**

  - **Throughout presentation**
    - Some diversity of images, still mostly light-skinned people
    - **Needs Improvement**: Consider adding more diverse images.

- **Lecture 14&15: Vitamin D/Calcium**

  - **Throughout presentation**
    - Almost all images of light-skinned people except one of rickets
    - **Needs Improvement**: Consider adding more diverse images.

  - **Syllabus Page 4**
    - “Melanin pigmentation acts as a neutral filter and competes with provitamin D3 for solar radiation that is responsible for previtamin D3 production. As a result, increased pigmentation will decrease the capacity of the skin to produce vitamin D3”
    - **Appropriate Use**: Talks specifically about skin pigmentation rather than using racial language.

- **Lecture 16: Osteoporosis**
Slide 41
⇒ “Paget's disease most common in people of Northern European descent”
  o Appropriate Use: Talks specifically about ancestry and cites source

Throughout presentation
⇒ All images of light-skinned people
  o Needs Improvement: Consider adding more diverse images.

Syllabus Page 1
⇒ “It has been estimated that 1 out of every 2 Caucasian women will have an osteoporotic fracture in her lifetime.”
  o Needs Improvement: Discuss more specifically about data behind this estimate – is it based on ancestry or self-identified race/ethnicity? Also consider whether there is value in giving this data in addition to the overall US prevalence data. Are osteoporotic fractures more common in women of particular ancestry? If the goal is only to emphasize that osteoporosis is common in US women, the overall prevalence statistics given before this statement are sufficient.

Syllabus Page 2
⇒ “Caucasian and Asian ethnicity are associated with lower bone mass”
  o Needs Improvement: Use more specific language to clarify where data comes from, whether discussing specific ancestry or self-identified race/ethnicity.

Syllabus Page 8
⇒ “Caucasian race listed as non-modifiable risk factor for fractures”
  o Needs Improvement: Talk more specifically about underlying data – differences in ancestry, self-identified race, etc.

Lecture 18: Pediatrics – Puberty

Syllabus Page 1-2
⇒ “This same difference in secular trend downwards in the age of puberty is reflected in differences seen between developed countries and underdeveloped countries. For example, an immigrant mother from west Africa (menarche at age 15, still normal in parts of West Africa) will show serious concern when her American born daughter starts to exhibit signs of pubertal development at age 10 years (normal in the US) ...More recently (1997) Herman-Giddens, et al, sought to redefine the onset of puberty to encompass even younger age range, after a survey of 17,077 girls in pediatric offices. The study showed variation based on ethnicity, race, and geographic location. This idea has not achieved widespread consensus.”
  o Needs Improvement: Add clarity on differences in the age of puberty landmarks attributed to biological vs. social factors. Use precise language to separate racial vs. geographic differences.

Slide 11
⇒ Notes data on puberty landmarks is from study of White British girls
  o Appropriate Use: Good explanation of lack of diversity in data used to guide assumptions of what is normal puberty.

Slide 12, 20, Syllabus Page 1-2
⇒ Statistics about age of puberty landmarks in White vs. Black or African American girls
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- **Needs improvement**: Specifically discuss underlying data – if based on self-identified race, state explicitly. Discuss potential factors underlying earlier puberty in Black/African American girls – are there genetic differences based on ancestry? Social factors based on structural racism? What about other groups besides White and Black?

  - Slide 35
    - “What about the new adopted girl from a third world country, trying to be an American and having to deal with puberty”
      - **Needs Improvement**: Remove statement. If the intent is to say that going through puberty early creates additional stress for children already dealing with other stressors (like immigration to a new country), that would suffice, and list immigration as one of the possible stressors.

- **Lecture 21: Pathology of Diabetes Mellitus**
  - Slide 7, Syllabus Page 2
    - Lists racial and ethnic differences in diagnosed diabetes (non-Hispanic Whites, Asian Americans, Hispanics/Latinos, non-Hispanic Blacks)
      - **Appropriate Use**: Good to note significant racial disparities in diabetes prevalence in the US.
      - **Needs Improvement**: Clarify if discussing ancestry or self-identified race. Discuss potential underlying causes of disparities including structural racism.

- **Lecture 22: Type 1 Diabetes**
  - Slide 7, 29, 32
    - Discusses incidence of different types of diabetes in different countries, mentions potential environmental influences behind rates of type 1 diabetes, specifically talks about ancestry contributing to MODY rates
      - **Appropriate Use**: Talks about specific geographic variation, not broad racial/ethnic differences. Relatively clear when talking about ancestry vs. environmental influences.

- **Lecture 23: Type 2 Diabetes**
  - Slides 3-4, 25, Syllabus Page 1
    - Notes increased prevalence of type 2 diabetes in certain ethnic groups, lower education and SES. Gives prevalence statistics by race/ethnicity (AI/AN, Asian Black non-Hispanic, Hispanic, White non-Hispanic). Same for metabolic syndrome prevalence (non-Hispanic White, non-Hispanic Black, Mexican American)
      - **Appropriate Use**: Good to note significant racial/ethnic disparities in diabetes prevalence in the US.
      - **Needs Improvement**: Clarify if discussing ancestry or self-identified race. Discuss potential underlying causes of disparities (e.g. race as a surrogate for the educational/socioeconomic disparities mentioned, structural racism as an independent risk factor).

  - Syllabus Page 6
    - Discusses increases in obesity in South and East Asia, North Africa, the Middle East, Sub-Saharan Africa, and Latin America due to increase in global availability of cheap vegetable oils and fats
      - **Appropriate Use**: Clear identification of distinct geographic regions and environmental cause of increased rates of obesity in particular populations
Syllabus Page 10

- Different definitions of excessive waist circumference based upon “racial characteristics and geography”
  - **Needs Improvement**: Clarify data behind these distinctions, whether they are based on ancestry, environment, or both.

- **Lecture 25: Hyperglycemic Crises**
  - Slide 35
    - “30-yo previously healthy obese Afro-Caribbean man”
    - **Needs Improvement**: Remove race/ethnicity as it does not seem relevant to case.

- **Lecture 27: Treatment of Diabetes Mellitus with Insulin**
  - Throughout presentation
    - All images of light-skinned people
    - **Needs Improvement**: Consider adding more diverse images.

- **Lecture 29: Complications in Diabetes**
  - Slide 41, Syllabus Page 10
    - “Racial disparities are seen in the rate of ESRD associated with diabetes which is higher in African Americans compared to Whites.”
    - **Appropriate Use**: Good to note disparity.

- **Lecture 30: Starvation and Nutrition Support**
  - Throughout presentation
    - All pictures of malnourished children are people of color.
    - **Needs Improvement**: Consider adding more diverse images.

- **Lecture 32: Diabetes Cases**
  - Throughout presentation
    - "First 3 cases list the race/ethnicity of the patient. Case 3 (Hispanic patient) mentions ethnicity as risk factor for diabetes and says insulin resistance is a prominent component of T2DM in Hispanics and Latinos”
    - **Appropriate Use**: Diverse patient cases (White, African American, Hispanic). Mentions disparities.
    - **Needs Improvement**: Potentially omit race/ethnicity. Clarify biological vs. social factors. Cite source for claim about insulin resistance.

- **Lecture 33: Nutritional Pathology**
  - Slide 20
    - Under pernicious anemia: Northern European - blue eyes, blond hair
    - **Appropriate Use**: Talks about ancestry, specific geographic region.
  - Syllabus Page 2
    - PA is more prevalent in Northern Europeans (blue eyes, blond) but occurs in all races
    - **Appropriate Use**: Talks about ancestry and specific geographic region. Clarifies that it can also occur in people other than those of Northern European descent
    - **Needs Improvement**: Conflates ancestry with race by adding “but occurs in all races.”
Neurology

- Lecture 2-3: Neuroanatomy
  - Throughout presentation
  - Few images but all of light-skinned people
  - Syllabus Page 8
    - “Despite worldwide efforts to eradicate poliomyelitis through universal immunization, the disease does occur in many parts of Africa and Asia”

- Lecture 4: Headache
  - Throughout presentation
  - Few images but all of light-skinned people
  - Needs Improvement: Consider adding more diverse images.

- Lecture 5: Spinal Cord
  - Throughout presentation
  - Few images but all of light-skinned people
  - Needs Improvement: Consider adding more diverse images.

- Lecture 7: Nerve Injuries
  - Throughout presentation
  - Few images but all of light-skinned people
  - Needs Improvement: Consider adding more diverse images.

- Lecture 8: CNS Development
  - Slide 12, Syllabus Page 4
    - "Anencephaly more common in Whites, female offspring, and Irish/English"
    - Appropriate Use: Mentions specific ancestry (Irish/English).
    - Needs Improved: Specifically discuss ancestry – if it is more prevalent in people from other regions besides Ireland/England, include information.
  - Throughout presentation
  - Few images but all of light-skinned people
  - Needs Improvement: Consider adding more diverse images.

- Lecture 9: Stroke
  - Slide 12
    - Race listed as a non-modifiable risk factor for stroke (no further explanation)
    - Needs Improvement: Clarify the disparities discussed and remove race as a risk factor. If based on self-identified race, discuss underlying factors for disparities.
  - Syllabus Page 17
    - SAH occurs most commonly during middle age (40-60) and is more frequent in women (1.6x) and African Americans (10x).
    - Needs Improvement: Explicitly state what group African Americans are compared to. If talking about ancestry, be specific. If talking about self-identified race/ethnicity, discuss underlying causes for disparity, including structural racism
  - Syllabus Page 2
    - Race, ethnic background, and heredity all listed as risk factors for stroke
    - Needs Improvement: Be explicit about disparities and underlying causes. Remove race as a risk factor.

- Lecture 11: Neuroophthalmology
  - Throughout presentation
Images mostly of light-skinned people
- **Needs Improvement**: Consider adding more diverse images.

- **Lecture 15: Epilepsy Medications**
  - **Slide 21**
  - **Implies**: Risk of SJS 10x higher in Asian ancestry
  - **Appropriate Use**: Specific about ancestry, not race.
  - **Needs Improvement**: Specify precise regions of Asia if possible

- **Lecture 17: Multiple Sclerosis**
  - **Slide 9, Syllabus Page 17**
  - "Traditionally thought more common in Caucasians of northern European ancestry (worldwide) • Incidence data at Kaiser Permanente Southern California 2013 • highest in AA 10.2, Caucasians 6.9, Hispanics 2.9, Asians 1.4; AA had 47% increased risk of MS compared with Caucasians • This difference was most pronounced amongst women: AA women had a higher risk of MS (risk ratio 1.59) whereas AA men had a similar risk of MS (risk ratio 1.04) compared to Caucasians."
  - **Appropriate Use**: Slide mentions high rates in African Americans in contrast with conventional wisdom
  - **Needs Improvement**: Be specific about ancestry vs. race vs. ethnicity, talk about underlying reasons for differences.
  - **Slide 12, Syllabus Page 3**
  - "Race and MS: Low-risk of MS in Japan, which is same latitude as areas of high prevalence in Europe. Almost no cases in the Inuit population."
  - **Needs Improvement**: Be specific about ancestry vs. race vs. geographic differences.

- **Lecture 20: Neuropathology**
  - **Slide 28**
  - "MS: geographic and migration studies suggest an environmental etiologic agent: incidence is greatest in North America, northern Europe, southeast Australia and New Zealand • family, twin, racial and HLA studies indicate that genetic factors play a role."
  - **Needs Improvement**: Clarify what "racial studies" means

- **Lecture 21: Dementia**
  - **Slide 75**
  - "Mini-Mental State Examination: Adjustments for age, education and race may be necessary"
  - **Needs Improvement**: Clarify why a clinician would adjust for race and provide data that guides the decision to make an adjustment.
  - **Syllabus Page 2**
  - Hispanics and African Americans seem to have a higher risk of developing AD than Whites.
  - **Appropriate Use**: Mentions racial disparities.
  - **Needs Improvement**: Clarify whether talking about race vs. ethnicity vs. ancestry and address underlying reasons for disparities.
  - **Syllabus Page 1**
It is also unclear if non-European races, low- and middle-income countries have a similar decline [in age-specific dementia rates]

- Needs Improvement: Clarify wording – race vs ancestry, and provide more information on these studies.

**Psychiatry**

- Lecture 2: Unipolar and Bipolar Mood Disorders
  - Slide 49
  - Elderly White males at highest risk for suicide
  - Needs Improvement: Consider adding further information for why this may be the case.

- Lecture 3: Ethical Issues in Medicine and Psychiatry
  - Slide 10
  - "• Tuskegee syphilis experiment • U.S. Public Health Service, 1932-1972, observed the natural progression of syphilis in untreated rural African-American men in Alabama. • The men were never informed of their diagnosis, and never offered treatment with penicillin, which had become the standard of care by 1947. • Uncovered by a whistle blower in 1972, the experiment was widely recognized as grossly unethical. • The 1979 Belmont Report was an outgrowth, leading to the development of Institutional Review Boards for research with patients."
  - Appropriate Use: Important to cover topic and mention the role of race.
  - Needs Improvement: Consider adding a discussion on the role of structural racism in medicine, and the legacy of mistrust of the medical establishment among African Americans. Can also refer to prior discussion of this topic in EPH.

- Lecture 12: Alcohols and Cannabinoids
  - Syllabus Page 6
  - "Alcohol dehydrogenase: This polymorphism is seen in 30-45% of Chinese, Japanese, and Koreans, less than 10% of most Europeans, but in 50-90% of Russians and Jews. It is associated with a lower risk for heavy drinking and ethanol-related problems. A second polymorphism for ADH1B, ADH1B*3, has a 30-fold higher Vmax. ADH1B*3 is seen in about 30% of Africans and also is associated with lower risk."
  - Appropriate Use: Specific about ancestry, not conflating it with race.
  - Needs Improvement: Ideally be more specific about ancestry within "Africans."
  - Syllabus Page 6
  - "Aldehyde dehydrogenase: Homozygotes with a nonfunctional ALDH2*2 occur in 5-10% of Japanese, Chinese, and Korean individuals, for whom severe adverse reactions occur after consumption of one drink or less, which gives them an almost null risk for heavy drinking (same mechanism as disulfiram). Heterozygotes for this polymorphism (ALDH2*2, 2*1) make up 30-40% of Asian individuals who, after
consuming ethanol experience a facial flush and an enhanced sensitivity to beverage alcohol, not necessarily an overall adverse response"
  - Appropriate Use: Specific about ancestry, not conflating it with race.
  - Needs Improvement: Ideally, add more specifics about ancestry within "Asians."

- **Lecture 13: Substance Use Disorders**
  - Throughout presentation
    - Lack of information on drug policy
      - Needs Improvement: Opportunity to include racist history of drug policy.

- **Lecture 16: PTSD**
  - Slide 9
    - ACE study’s participants were 17,000 mostly White, middle and upper-middle class college educated San Diegans with good jobs and great health care
      - Appropriate Use: Good to specify non-diverse study participants.
  - Slide 26
    - Elevated rates of PTSD in racial and ethnic minorities
      - Appropriate Use: Good to point out disparity.
      - Needs Improvement: Could be more specific about which minorities. Does not address potential underlying causes including structural racism.

- **Lecture 18: Suicide and Violence**
  - Slide 34
    - Graph of suicide rates by age, race, and gender (White and Black)
      - Appropriate Use: Good to note high rates in elderly White males.
      - Needs Improvement: Does not include other racial groups or discuss reasons for differences.

- **Lecture 19&20: Psychiatric Manifestations of Medical Illnesses**
  - Slides 4, 9, 27
    - 50-year-old Hispanic male, 20-year-old healthy Caucasian female, 60-year-old African-American man in cases
      - Appropriate Use: Diverse patients in cases.
      - Needs Improvement: Race/ethnicity does not seem relevant to cases.

- **Lecture 23: Disorders of Adolescence**
  - Slide 6
    - Prevalence of MDD by race (Hispanic, White, Black, Asian, 2 or more)
      - Needs Improvement: Clarify source of data (e.g. self-identified race), discuss potential contributors to different rates by race.

**Oncology**
- **Lecture 1: Epidemiology of Cancer**
  - Slides 26-30
    - Graphs from national cancer institute on cancer incidence and mortality rate by race including a chart showing lower survival rates in Black patients compared to White in all cancers by site of cancer.
      - Appropriate Use: Discussion of disparities.
  - Slide 42
⇒ Closing gap in incidence and death rate of lung cancer between racial groups up to 2005
  o **Appropriate Use:** Discussion of disparities.
⇒ Slide 53
  ⇒ Lists "African American" under the header "Causes of Prostate Cancer"
  o **Needs Improvement:** Remove reference to race or discuss epidemiology separately to avoid conflation of race and biology.

● Lecture 3: Intro to Rad/Onc
  ➢ Throughout presentation
    ⇒ Images of mostly lighter-skinned individuals.
    o **Needs Improvement:** Consider adding more diverse images.

● Lecture 5: Breast Cancer
  ➢ Syllabus Page 1-2, 7
    ⇒ “Breast cancer disparities are a well-known problem. Using data from population-based cancer registries affiliated with the National Program of Cancer Registries and SEER, 2009-2013, the rate of newly diagnosed breast cancer (per 100,000 women) was 128 and 125 for White and Black women, respectively. Despite this, Black women more commonly presented with regional or advanced disease (45 versus 35 percent) and had a 41 percent higher breast cancer specific mortality rate (32 versus 22 deaths per 100,000 women). This breast cancer disparity is attributable to many factors including biology of the disease (more triple negative breast cancers), more advanced stage at diagnosis (with subsequent higher stage-specific mortality), lifestyle (e.g., body mass index [BMI], reproductive patterns) and access to healthcare/socio-economic challenges.”
    ⇒ “Race and ethnicity- In the US, breast cancer is the most common cancer among women of every major ethnic group, although there are interracial differences. Data from the American Cancer Society, 2009-2013, the highest rates occur in Whites (128 cases per 100,000 women). The rates are lower in Blacks (125 per 100,000), Asian Americans/Pacific Islanders (89 per 100,000), Hispanic/Latina women (92 per 100,000), and American Indians/Alaska natives (98 per 100,000).”
    ⇒ “Despite this, most breast cancer deaths are from ER-positive, HER2-negative disease, and racial disparity in outcome is particularly found in this subset.”
      o **Appropriate Use:** Discussion of disparities.

● Lecture 8: Lung Cancer
  ➢ Syllabus Page 2
    ⇒ “Black Americans more susceptible to lung cancer than Whites, while Japanese Americans and Latinos are less susceptible…Likely related to polymorphisms in genes involved in metabolism of toxic components of cigarettes, DNA repair genes, cell cycle checkpoint genes, and caspase 9,”
      o **Needs Improvement:** Passage suggests race is biological. Rewrite section to include information on disparities and add note on multi-factorial contributors to racial and ethnic differences.
  ➢ Syllabus Page 11
    ⇒ "ROS-1 rearrangements are more commonly seen in patients of Asian ethnicity, young age, female sex, never-smokers, and adenocarcinoma histology.”
Creating Leadership & Education to Address Racism

- Needs Improvement: Add information on prevalence in different populations, rather than singling out “Asian ethnicity.”

- Lecture 9: Pancreatic Cancer and Hepatocellular Carcinoma
  - Syllabus Page 2, Slide 26:
    - "More common in African Americans than Whites."
    - Needs Improvement: Add precise prevalence data.
  - Syllabus Page 6:
    - "Hepatitis B patients: - Asian Men > 40 yrs. old - Asian Women > 50 yrs. old - Africans and North Americans of African descent > 20 yrs. old"
    - Needs Improvement: Further discussion of differential screening recommendations based on race.

- Lecture 15: Testicular Cancer
  - Slide 7
    - “Ethnicity: more common in Caucasian populations- lower risk in African Americans but increased risk of mortality compared with non-Hispanic Whites"
    - Needs Improvement: Present prevalence data. Remove reference to race as a risk factor, as it implies race is biological.

- Lecture 20: Esophageal and Gastric Cancer
  - Throughout presentation
    - References to race in cases.
    - Needs improvement: Remove reference to patient race as it is not relevant to case discussion.

Hematology
- Lecture 3: Disorders of Iron
  - Slide 13
    - “- Paper, Corn starch (amylophagia) - more common in African American population - Clay/dirt - more common in Africa”
    - Needs Improvement: Discuss factors contributing to this difference.

- Lecture 4: Hemolytic Anemia
  - Slide 17
    - “Frequency of D antigen - 85% Caucasians, 92% Blacks, 99% Asians”
    - Needs Improvement: Provide more specific prevalence data.

- Lectures 6&7: Understanding Hemoglobinopathies and Thalassemia
  - Slides 25-26
    - “b thalassemia is a global disease, but is most prevalent in southern China, southeast and south Asia, the Middle East and Mediterranean countries; the disorder is becoming increasingly common in Europe and North America due to population migration - a thalassemia common in southern China and southeast Asia”
    - Appropriate Use: Use of specific regions, discussed in terms of prevalence.
    - Needs Improvement: Add precise prevalence statistics.
  - Slide 5
    - Geographic distribution of common disorders of hemoglobin
Creating Leadership & Education to Address Racism

- **Appropriate Use:** Provides distribution by geography rather than race.

  - Slide 33
    - “Alpha thalassemia: African/afrocarribean ("trans") - Asian families, mainly SE Asia - more likely "cis"”
    - **Needs Improvement:** Provide more specific prevalence data.

  - Slide 35
    - **Needs Improvement:** Provide more specific prevalence data.

- **Lecture 20: Large Group Case Discussion**
  - Slide 11
    - “32 y.o. African American woman comes to the ER complaining of: episodic orbital headaches - difficulty moving her tongue - difficulty speaking - intermittent numbness of her extremities for the last week.”
    - **Needs Improvement:** Remove reference to race.

- **Lecture 27: Board Prep Session**
  - Slide 39
    - “48yo Black man presents to the emergency department for evaluation of severe fatigue. He has been HIV positive for several years. He reports that his last known CD4+ T cell count was "around 100". The patient is receiving drugs for prophylaxis against PCP. He was in his usual state of moderate health until 2 days ago. His only complaints are severe fatigue and some dyspnea on exertion. He denies having fever, chills, cough, abdominal pain, or dysuria. He states that his doctor recently changed his "PCP pill" because of a persistent rash…”
    - **Needs Improvement:** Remove reference to race.

- **Lecture 31: Acute Leukemia**
  - Slide 24
    - “APML more common (arguably) in Hispanics, less common in African Americans”
    - **Needs Improvement:** More information needed on data, with studies cited.

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**EPH**

- Essentials of Public Health Medical Education Program Objectives
  - Syllabus Page 3, B.4
    - “Demonstrate sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.”
    - **Appropriate Use:** Specifically talks about the need to be sensitive and responsive to diverse patient populations in terms of race.

- **Exam 1 Take Homes**
  - Slide 33: HIV
    - “Highest prevalence of HIV is in Sub-Saharan Africa”
    - **Needs Improvement:** State which countries in Sub-Saharan Africa.
  
  - Slide 34: HIV
Graph that states new HIV diagnoses as of 2017 in the US for the most-affected subpopulations, shows that Black male to male sexual contact is disproportionately higher on the graph.
  * **Needs Improvement:** Verbal comment/discussion during lecture addressing this disparity.

- **Slide 9: Introduction, Factors that Affect Health**
  - Socioeconomic factors as the thing that impacts health the most, listening inequity as one of the facets of socioeconomic factors
    * **Needs Improvement:** Could list discrimination/bias/racism as a part of inequity, i.e. Connecting inequity to more than socioeconomic inequity.

- **Slide 35: Henrietta Lacks**
  - Slide mentions Henrietta Lacks case as part of examples of violations of research ethics, mentions plans to limit access to her cells in future
    * **Appropriate Use:** It is great that this is part of a discussion on research ethics.

- **Slide 36: Tuskegee Syphilis Study**
  - Slide mentions Tuskegee Syphilis as part of examples of violations of research ethics
    * **Appropriate Use:** It is great that this is part of a discussion on research ethics.

- **Exam 2 Take Homes**
  - **Slide 19: Stress**
    * “Bias has an impact on health/health care. When health care providers are more stressed it’s easier for implicit biases to affect decisions. Recognize the likelihood of bias when in a stressful or time-sensitive situation—and slow down. Make the default equity (checklists, blinding, a systematic approach every time)”
      * **Appropriate Use:** It is great that bias is mentioned in terms of experiences with healthcare as well as bias by providers.
      * **Needs Improvement:** Could specifically name the bias of racism, as racism is a huge source of stress.

  - **Slide 29: Preconception/Prenatal**
    * Non-modifiable risk factors: prior history, multiple gestation, uterine anatomical anomaly, family history, age, race/ethnicity
      * **Needs Improvement:** Race/ethnicity is not a risk factor. Stating this, implies that there is something inherent to race that increases risk, when race is not biological – race here is essentially a proxy for racism, stress, etc. This is problematic because it can lead to dangerous generalizations made about patients as well as explaining something that is structurally based in racism as biological. Perhaps racism/stress can be listed under modifiable risk factors.

- **HIV**
  - **Slide 12**
    * Graph showing rates of diagnoses of HIV infection among White adults and adolescents, then Hispanic/Latino, then Black/African American in 2017
    * Lecturer stated: “Observe where the dark states are, mostly in the South and California. In every map I am going to show you, the high end of the bad range will always apply to Washington DC. I want you to observe how the colors change but more importantly how does the total rate change as we talk about different ethnic groups and keep an eye on this number (DC). Within Detroit, if you go to Grosse
Pointe and then two blocks, rates of HIV are significantly different.” Lecturer states that the overall rates have increased for Blacks and Latinos.

- **Appropriate Use:** Good to mention disparities and to indicate that it varies by neighborhood location etc., good to use specific examples
- **Needs Improvement:** Could talk about more about why these disparities exist—could mention racism, discrimination, lack of access to sex education etc.

- **Throughout presentation**
  - Mentions of Africa and countries within Africa with highest HIV prevalence
    - **Appropriate Use:** It is good that it is specific regions and often specific countries and that there is mention of virus diversity in Central Africa.
    - **Needs Improvement:** It could be even more country specific--yes "Africa was hit the hardest," but it could create an “us vs them” paradigm.

- **Cost Control**
  - **Slide 16**
    - Image of “Choosing Wisely” shows all light skin clip art
      - **Needs Improvement:** Either remove graphics or add more such that there is not a sole depiction of light-colored skin.

- **Vaccination**
  - **Slide 37**
    - Race/Ethnicity as risk factors for vaccine hesitancy
      - **Needs Improvement:** Race is not a risk factor. Maybe could put cultural practices/traditions, distrust of the medical system.

- **QI Methodology: Stakeholder Analysis and Cause and Effect Diagrams**
  - **Slide 19**
    - “What causes readmission rates at BMC? Socioeconomic status, race, age, health literacy, history of trauma, degree of comorbid illness, code status and polypharmacy...and likely many more!”
      - **Needs Improvement:** Race is not a risk factor and thus is not a causal independent variable. Add note about alternative of readmission that race is a proxy for, e.g. disenfranchisement, discrimination caused by racism, etc.

- **Slide 11**
  - Image of sources of infection: all light-colored skin
    - **Needs Improvement:** Either remove graphics or not just have individuals with only light-colored skin in them.
  - Image of a Black man with a chain. This is on a slide with information about readmissions
    - **Needs Improvement:** Remove image as this is an image that can be interpreted as related to Black men in prison or during slavery.

- **Slide 14**
  - Image of all people with light-colored skin
    - **Needs Improvement:** Diversify imagery.

- **Introduction to Quality Improvement Methodology**
  - **Slide 27**
“It is important to understand that Whiteness is not a race. It is a system of privilege. The essence of Whiteness is never having to think about race. To be White in America is to be able to expect respect in school, at the bank, on the street and in stores. White providers need to be aware of their implicit privilege in order to be able to promote inclusion and diversity. Catherine Walker CNM MPH”

- **Appropriate Use:** Important to center race when we think about equity and specifically call out Whiteness and privilege.

- **Throughout**
  - **Diverse Imagery**
    - **Appropriate Use:** Good use of images of individuals with diverse skin tones.

- **Ethics: Resource Allocation**
  - **Slide 21**
    - “Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity. The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.”
    - **Appropriate Use:** Mentions race.
    - **Needs Improvement:** Could call out racism in medicine and could call out working toward this definition of health.
  - **Slide 18**
    - Image of all people with light-colored skin on a slide about equity
    - **Needs Improvement:** Diversify imagery.
  - **Throughout presentation**
    - No mention of race as part of ethics/resource allocation
    - **Needs Improvement:** It would be good if this lecture and the interactive ethics discussion could specifically name racism and race and how it complicates kidney transplant lists.

- **Massachusetts and the ACA**
  - **Throughout the presentation.**
    - “Medicaid Expansion: Require enhanced collection and reporting of data on race, ethnicity, sex, primary language, disability status, and for underserved rural and frontier populations, access and treatment data for people with disabilities”
    - **Appropriate Use:** Good to mention expansion’s focus on diversity.
  - **Slide 20**
    - Graph that shows prevalence of uninsured among nonelderly adults in Massachusetts, by population characteristics, 2010 Lecturer stated, "Who in the state has higher rates of uninsurance--thinking about factors in terms of race/ethnicity/country of origin and poverty level"
    - **Appropriate Use:** Good to mention disparities.
    - **Needs Improvement:** Could mention why disparities are important/why they exist.

- **Research Ethics**
  - **Slide 27**
    - Graph that shows mistrust of the medical system by Black vs White patients: Lecturer stated “[The] mistrust of research and medical care that have been intertwined over time, there is a legacy of research, they are working toward making research
representative. White patients and Black patients have distrust of research—you can see the difference between the two groups, the fact that it is really high for both races. There are studies about what makes a difference in terms of dealing with mistrust.”
- **Appropriate Use**: Good to mention differences in trust
- **Needs Improvement**: Need to mention why there are differences in trust by race, this needs to be in historical context of racism

- **Slide 4**
  - Tuskegee Syphilis Study (1932-1972) by US Public Health Service (CDC): Hundreds of African-American males untreated for syphilis to study the natural history of disease
  - **Appropriate Use**: Good to mention Tuskegee syphilis study as violation of research ethics.

- **Slide 9**
  - Belmont Report (1978) from Commission formed by National Research Act - In part in response to Tuskegee
  - **Appropriate Use**: Good for Belmont report to be listed in response to Tuskegee.

- **Slide 18**
  - Henrietta Lacks: Henrietta Lacks was treated in the “colored ward” of JHU. The cells from her tumor were originally removed during biopsy for culturing, and additional samples were procured from her body in the morgue. Her cells went on to become the first cell line propagated in a lab. Work involving her cells has contributed to >70,000 papers in PubMed. Ms. Lacks or her family were not initially approached for permission to grow her cells.
  - **Appropriate Use**: Good to spark a discussion on Henrietta Lacks, equipoise and informed consent.

- **Long Term Care of the Elderly**
  - **Slide 3**
    - “Mr. Harris, a 72-year-old African American man with hypertension and diabetes, is ‘found down’ at the local grocery store in Dudley Square. According to a witness, he is in the produce section when he bends over and holds onto the edge of the produce bin. He then pitches forward onto the floor, hitting his head on a shopping cart and losing consciousness.”
    - **Needs Improvement**: Why was race mentioned here? If it is mentioned, indicate why. Why is the specific neighborhood chosen? The sole choice of Dudley Square may limit student’s perception of where African Americans in Boston live.

- **Reducing Hospital Readmission**
  - **Throughout the presentation**.
    - **Diverse Imagery**
      - **Appropriate Use**: Good use of images of individuals with diverse skin tones.

- **Patient-Centered Medical Home**
  - Image of all people with light-colored skin
  - **Needs Improvement**: Diversify imagery.

- **Boston: A City of Neighborhoods**
  - **Slides 39-49**
    - Lecturer states, “If part of that [Racial Segregation] is racism, how does that impact all of the opportunities you have and how does that impact health outcomes” Then
lecturer shows video about structural racism that has shaped what cities look like: “Unnatural Causes”
  o **Appropriate Use:** Name racism and then show a whole video on racism. Use “Unnatural Causes” potentially at the start of school-year for students to get on the same page.

- **Slide 52**
  ⇒ Graph that shows Parents/Caregivers who felt child was unsafe in neighborhood, based on race, lecturer states “Thinking about exercise and getting out and being able to use your environment we talked a little bit about if there are sidewalks, if you feel like your neighborhood is unsafe for your kids, you aren't going to let them exercise”
  o **Appropriate Use:** Mentions racial disparities in exercise access and safety impacting health

- **Social Determinants of Health: Screening and Intervention**
  - **Slide 32**
    ⇒ 53 y/o Hispanic male at BMC-based primary care
    o **Needs Improvement:** In mentioning race, state why or remove the mention.
  - **Throughout the presentation.**
    ⇒ Diverse Imagery
    o **Appropriate Use:** Good use of images of individuals with diverse skin tones.

- **Food**
  - **Slide 33**
    ⇒ Graph of Food Insecurity by race/ethnicity, lecturer states “If you look here, the trends vary by race and ethnicity you can see that there are disparities”
    o **Appropriate Use:** Good to state disparities.
    o **Needs Improvement:** Could state what those disparities are and why.
  - **Slide 39**
    ⇒ Diverse Graphic of WIC process
    o **Appropriate Use:** Good use of images of individuals with diverse skin tones.

- **Environmental Health**
  - **Slide 12**
    ⇒ Graph of Asthma ER Visits by Race, Lecturer states "Looking at ER visits broken down by race and ethnicity over the years you can see the trend there in terms of health inequity between people of different race and ethnicity part of which is based on neighborhood factor part of which has other factors that are impacting "
    o **Appropriate Use:** States racial inequities.
    o **Needs Improvement:** Could name racism as one of the “other factors” and also state more explicitly what the disparities are.

- **EPH Community Health Cases 1-3**
  ⇒ “Matteo is a five-year-old Latino boy who was diagnosed with asthma after repeated visits to the emergency room when he was 4.5 years old. In the last 9 months, he has been seen in the emergency room four times with a history of wheezing and cough with the last visit requiring hospitalization in the setting of RSV (respiratory syncytial virus) bronchiolitis.”
  ⇒ Izaiah is a 15-year old African American male with severe, persistent asthma who comes into the clinic with three days of cough, runny nose and one day of wheezing not controlled by using his home as needed medication (albuterol MDI). The front
desk staff member gets the nurse who initially sees him and then informs a medical provider “he doesn’t look so good, someone ought to see him now.” The medical resident provider see’s the patient and Izaiah is given a nebulizer treatment in the office.

Sharon is a 61-year-old Caucasian female with a history of hypertension, gastro-esophageal reflux disease, depression and moderate persistent asthma. Her asthma symptoms of cough and difficulty breathing are typically worse in the fall season, with exercise, exposure to cold air, and with upper respiratory viral illness. She was last admitted to the hospital with an exacerbation in January and was treated with steroids which helped improve her symptoms, her prior admission was in November. She reports her cough has occurred pretty much daily for the last year and several days a week her cough and chest tightness wake her up at night. She is constantly tired and comes to see you in the clinic stating her asthma “has really affected my quality of life.”

- **Needs Improvement:** Mention race in the context of Boston and racism. There needs to be a statement made here to indicate why race is relevant here. Otherwise it can and likely will be falsely interpreted as biological.

- **Stress**
  - **Slide 18**
    - Lecturer states, “Racism and the impact on someone’s health: There is more data from your health of Boston report that all of you are hopefully familiar with—they also looked into people who felt like they had experienced race related mistreatment in the last 30 days and looked at it based on race and ethnicity and you can see the numbers here for Boston.”
    - **Appropriate Use:** Name Racism.
  - **Slide 19**
    - Lecturer states “Looking at perceived treatment with health indicators—the ones that are significant here are persistent anxiety and persistent sadness. Thinking about that idea of the experience of bias in this case race related mistreatment can really have an impact on a person in the moment in terms of what they are picking up here and we think that that can be a marker of chronic stress and can have an impact.”
    - **Appropriate Use:** Shows mental health impact of racism.
  - **Slide 24**
    - Implicit Bias: Schulman 1999: videos of people with chest pain, women and African Americans less likely to be referred for cardiac catheterization. Provision of pain medication varied by race and gender—of physician and pt. Also, knee replacement (2008), diagnosis COPD (2011). Green 2007: no explicit bias but implicit White positive bias on IAT correlated with increased likelihood to treat White patients with thrombolysis for acute coronary syndrome and not treat Black patients
    - Lecturer states “The one from 1999 they showed people videos of patients with chest pain, and women and African Americans were less likely to be referred for cardiac catheterization. It is even more worrisome if you don’t have explicit bias but you carry implicit bias that you may not be aware of it influences your likelihood to treat patients of a certain race, implicit White positive bias made them more likely to treat White patients with TPA rather than Black patients
    - **Appropriate Use:** Good to cite instances of racial bias.
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- Needs Improvement: Name racism.

- Slide 21
  - Microaggressions: a subtle but offensive comment or action directed at a minority or other nondominant group that is often unintentional or unconsciously reinforces a stereotype verbal vs nonverbal. Lecturer states, “whether microaggression is intentional or not can still cause stress for someone”
  - Appropriate Use: Good to include insidiousness and good that it follows immediately after discussion of racism in medicine.

- Slide 22
  - Implicit Bias: The attitudes or stereotypes that affect our understanding, actions, and decisions in an unconscious manner. Activated involuntarily, without awareness or intentional control. Can be either positive or negative. Everyone is susceptible. “Implicit biases are fascinating because they produce behavior that diverges from someone’s endorsed principles and beliefs.” Professor Phil Stinson
  - Lecturer states, “You are supposed to pick out all of these factors about people when we give you a history, we are supposed to pick out and form these illness scripts, when a patient has these things, that's what they have. We don't want you to overlook the broader possibly out there and generalize too much. You are in a place in medical school where this matters and being aware of this and thinking about ways to overcome these biases--this can impact the care you provide. You might not be aware of it, but it can impact what you do.”
  - Appropriate Use: State the nuances and complexities of how to reconcile our biases with how we are taught in medical school.

- Slide 29
  - Make the default equity: checklists, blinded, going through the exercise of a full differential diagnosis
  - Lecturer states, “there are good studies that show if people know the race/ethnicity of the applicant there is a differential hiring that occurs--blinding to that is one way that people try to address that to make it so that it cannot be a factor--for you in medicine, going through exercise of full differential diagnosis--this is the script I’ve been given and I’m supposed to be thinking about this but taking that step to really go through full differential diagnosis in terms of thinking about what else could it be to try to be guided by what you are seeing by also not entirely biased by what you are seeing--having the idea when you can of being able to slow down, being able to be mindful and questioning what your actions are, having more reserves on board like sleep”
  - Appropriate Use: State the nuances and complexities of how to reconcile our biases with how we are taught in medical school.

- Specific Curriculum on Racism
  - Appropriate Use: It is great there is a specific training/workshop devoted to talking about racism

- How to Give a Great Presentation
  - Throughout
    - Image of all people with light-colored skin
      - Needs Improvement: Diversify imagery

- Gun Violence
  - Slide 3
⇒ It affects people of all ages, races/ethnicities, classes. 1 in 3 people know someone who has been shot.
  ○ Needs Improvement: Should mention the disparities in race despite it affecting everyone.

➢ Slide 9
⇒ Who is most at risk of suicide attempts? American Indians and Alaska Natives
⇒ Lecturer states, “People in any of these categories--it is important to think about your risk assessment of patients that some of these might prompt to ask a little bit more when you are asking questions about depression for example, these are the folks who are most at risk”
  ○ Needs Improvement: Race is not a risk factor – this slide implies that there is something inherent rather than something structural like racism.

● Introduction to Maternal-Child Health
➢ Slide 20
⇒ “Disparities in US maternal mortality: 12.4 deaths per 100,000 live births for White women, 40.0 deaths per 100,000 live births for Black women, 17.8 deaths per 100,000 live births for women of other races. Why?”
⇒ Lecturer states, “There are disparities in maternal mortality in terms of what happens in the US--so the number of deaths for White women is less than for Black women and also less than those for other races-one of our questions needs to be why this is--and thinking about where you can have an impact.”
  ○ Appropriate Use: Good to think about why and state disparities.
  ○ Needs Improvement: Could actually state why or at least posit why, racism as a potential cause should be listed.

● Preconception and Prenatal Care
➢ Slide 29
⇒ Lecturer states "Wear and tear on the body due to exposure to stress, early life events plus cumulative allostatic load--contributes to disparities and outcomes. The "weathering hypothesis"-- she was looking at a population of African-American women and infants looking at idea that these factors, load over life time can really be a piece of this deterioration in terms of physical consequences coming overtime from a number of different injuries which may continue down for generations"
  ○ Needs improvement: Could talk about the significance here of racism and race.
➢ Slide 52
⇒ Race is listed as a risk factor for preterm birth
  ○ Needs Improvement: Race is not a risk factor--this slide implies that there is something inherent rather than something structural like racism going on.

➢ Throughout
⇒ Diverse Imagery
  ○ Appropriate Use: Good use of images of individuals with diverse skin tones

● Birth and Newborn Care
➢ Slides 10 and 18
⇒ States that being Black is a higher risk group and that being White is a lower risk group
⇒ Home Births: Demographics: more White, older, not first child, married
  o Needs Improvement: Implies that there intrinsic about being Black that is "higher risk" Leads to generalizations. There is nothing inherently or biologically riskier about “being Black.” In addition, states that lower risk people have home-births and those people are White but doesn’t posit racism being one of these reasons. Again, can lead to harmful generalizations.
  
  ➢ Throughout
  ⇒ Diverse Imagery
    o Appropriate Use: Good use of images of individuals with diverse skin tones

• Well Child Care
  ➢ Throughout
    ⇒ Diverse Imagery
      o Appropriate Use: Good use of images of individuals with diverse skin tones

• Biostatistics
  ➢ Slides 63-66
    ⇒ Shows race association with low birth weight--we can say Black infants weigh less compared to White infants but that is not statistically significant.
    o Needs Improvement: This slide should state: if this study is hypothetical or not; how race was reported (self-identified or not), and how to address multi-racial individuals This has the potential to imply a genetic cause for difference. A non-racialized example should be used to illustrate the intended biostatistics concept.
Appendix C

BUSM Internal Assessment – Clerkship Curriculum In-depth Review

The following section is a compilation of findings identified upon complete review of BUSM curricular materials, including lecture recordings, syllabi, and presentation slides. This resource was created to serve as a foundation to inform future curricular reform and promote our collective growth as an institution, documenting both explicit mentions of race and opportunities to add thoughtful discussions of race and racism. It is not intended to criticize any individual involved with the creation or dissemination of these materials. Rather, it is intended to provide concrete and accessible recommendations to promote diversity, inclusion, and antiracism across all four years of medical education based on the overarching themes discussed in the body of this report.

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**Medicine**
- HIV lecture
  - Slide 33 - New HIV Infections 2010
    - Demographic info of race/sexual orientation groups w/ infections diagnosed in 2010
      - **Appropriate Use:** Next slide shows relative risk of contracting infection based on sex practice and transmission method.
- Anemia lecture
  - Slides 13 & 21
    - Photos are all of light pigmented people.
      - **Needs Improvement:** It would be very helpful to see a variety of skin colors for detecting anemia on physical exam.

**Family Medicine**
- MSK Exam Workshops
  - Exam Videos
    - Of the 5 physical exam videos, 5/5 of the healthcare professionals are light-skinned, and 4/5 of the patients are light-skinned.
      - **Needs Improvement:** Improve the diversity of the healthcare professionals and the patients in these physical exam videos.
- Overview of Family Medicine
  - Slide 20
      - **Needs Improvement:** Discuss the reasons behind these disparities.
  - Slide 39
    - Many racial and ethnic minorities have higher mortality rates from chronic diseases such as cancer, diabetes, and cardiovascular disease than non-Hispanic Whites. Racial and ethnic minorities and lower incomes are associated with more barriers to care and poorer quality care.
      - **Appropriate use:** Addresses some underlying reasons behind disparities.
  - Slide 41
    - The association of primary care with decreased mortality is greater in the African-American population than in the White population.
      - **Needs Improvement:** Discuss the underlying reasons behind this.
- Teresa patient chart
  - Page 2
    - This is an acute care visit for this 44-year-old Hispanic female who presents with a complaint of five days of vaginal discharge.
      - **Needs Improvement:** Only include information about her race/ethnicity that is relevant to the case (e.g., if she is Spanish-speaking or any information about her immigration status or experience).
  - Page 3
⇒ This is the first Family Medicine visit for this 44-year-old Hispanic female.
  o **Needs Improvement**: Only include information about her race/ethnicity that is relevant to the case (e.g., if she is Spanish-speaking or any information about her immigration status or experience).

- **Dermatology module**
  - Slide 19
    ⇒ A 35-year-old African American woman presents to your office because of large tissue accumulation at the site of her previous C-section scar and on her leg where she had a skin lesion previously removed. What are these lesions?
      o **Needs Improvement**: It would be helpful to provide more information about the link between keloid formation and African-American patients rather than just teaching students to associate the two. Is there data on a biological mechanism that makes keloids more common in people of particular ancestry or with darker skin pigmentation?
  - **Images**
    ⇒ Of the >35 pictures in these slides, only 3 pictures depict persons of color.
      o **Needs Improvement**: Include more diverse images.

- **Derm Glossary**
  - **Images**
    ⇒ 17/18 pictures depict light-colored/White individuals
      o **Needs Improvement**: Include more diverse images.

**Radiology**
No mention of race in didactics.

**Neurology**
- **Epilepsy videos**
  - **Sample videos**
    ⇒ These are relatively low-resolution images, but it appears that the sample videos are all of light-skinned individuals.
      o **Needs Improvement**: Include more diverse images.
- **Multiple sclerosis lecture**
  - **Slide 9**
    ⇒ "More common in Caucasians of northern European ancestry"
      o **Appropriate Use**: Talks specifically about ancestry.
  - **Slides 13-15**
    ⇒ Slide 13 is titled "Race and MS" though content is about the disease prevalence in certain populations thought to be related to environmental trigger
      o **Appropriate Use**: Overall nuanced discussion about genetic and environmental influences on disease prevalence.
      o **Needs Improvement**: The title of slide 13 should be changed to reflect the nuance of the rest of the content and refer to ancestry/geographic location rather than race.
- **Neuro Bootcamp**
  - **Slides 18-19**
Pattern recognition for MS in young Caucasian female
  - Needs Improvement: We are taught through many cases in medical school to associate MS with young Caucasian females. Including some more diverse examples of patients with MS in clinical cases could help ensure that this diagnosis isn’t overlooked in other patients.

Emergency Medicine
No didactics for this clerkship.

Pediatrics
- Adolescent and LGBT Lecture
  - Page 1/Slide 1
    - Adolescence. Shaped by race, ethnicity, religion, socioeconomic status, family/peers
      - Needs Improvement: Provide more information on what is meant by differences based on race and ethnicity.
  - Page 3/Slide 4
    - Variation in timing of puberty: - genetics (≥50%), ethnicity
      - Needs Improvement: Clarify why ethnicity is mentioned separately from genetics.
  - Page 4/Slide 4
    - Ethnic differences in secondary sexual characteristics. Observed racial/ethnic difference in pubertal development not due to social economic factors, such as family size, rural/urban residency, and poverty/income ratio.
      - Needs Improvement: More discussion of underlying reasons for these differences
- Step 2 CK Review
  - Slides 12-13
    - "A 2-year-old Black child presents with anemia and painful swelling of the hands and feet. The most likely diagnosis is:"
      - Needs Improvement: Reinforces pattern recognition of associating sickle cell disease with Black patients. Including more diversity of patients in these questions could help ensure that the diagnosis is not missed in non-Black patients. Race is unnecessary to include here for these reasons.
- IEP Male NEW GU
  - Slide 12
    - There is a slight difference in image among races and presentation of stage of puberty due to variation in hair distribution and thickness.
      - Appropriate Use: Good to include diverse images.
      - Needs Improvement: Stages of puberty should be comparable in images of patients of different races.
- Cases for anemia lecture
  - Page 6
    - Family from Indian subcontinent
      - Needs Improvement: Only need to include ancestry if it is relevant to the case. If it is relevant, should explain how.
- Common external newborn physical exam findings
  - Case presentations
    - Many cases introduced with “patient is a [Caucasian or African-American] infant
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- **Needs Improvement:** Do not need to include race/ethnicity of patient unless it is relevant to the case. If it is relevant, should explain how.

- **Slide 7**
  - Darker pigmented children tend to have a higher incidence (Black children 5%, Caucasian children 0.3%)
    - **Appropriate Use:** Good specification of skin pigmentation as the relevant difference.
    - **Needs Improvement:** Use of “Black” and “Caucasian” as examples of differences in incidence conflates race, ethnicity, and skin pigmentation as sources of difference.

- **Slide 22**
  - They tend to be more common in certain ethnic groups such as Asian, Native American, Hispanic and Black infants.
    - **Needs Improvement:** Conflates ancestry with socially constructed race. Be clear about the relevant difference in incidence and whether it is related to ancestry, skin pigmentation, etc.

- **Slide 31**
  - More commonly seen in Black infants and it is presumed to be an autosomal dominant trait. Polydactyly is less frequently diagnosed in White infants, and it is thought to be an autosomal recessive trait and associated with other syndromes.
    - **Needs Improvement:** Conflates ancestry and race. Use specific language to discuss what the relevant differences are.

- **Introduction to neonatology**
  - **Images throughout presentation**
    - **Needs Improvement:** Include more diverse images.

- **Pediatric hematology jeopardy**
  - **Slides 3, 6, 12**
    - An 18 mo. Hispanic girl is brought to your office for routine evaluation.
      - **Needs Improvement:** Only need to specify race/ethnicity if it is directly relevant to case. If it is, explain how. Define the term Hispanic; Latinx is likely more inclusive language here.

- **Thrombocytopenia lecture**
  - **Images throughout presentation**
    - **Needs Improvement:** Include more diverse images.

- **Physical abuse lecture**
  - **Images throughout presentation**
    - Images are all of non-White children
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- Needs Improvement: Reinforces stereotypes of non-White children as more vulnerable to child abuse. Include more diverse images, including White children.

**Surgery**

- Anorectal disease lecture
  - Images
  - All images of pale bottoms
  - Needs Improvement: Greater diversity of images.

- Breast cancer lecture
  - Breast Clinic - Chapter 40 Small document
    - The lifetime risk of developing breast cancer was 1 in 13 during the 1970s. It is now 1 in 9 for White American women. The incidence of breast cancer in American women of Black and Hispanic descent is lower than that of White American women, but in recent years, the rate of increase among Black and Hispanic women has been increasing significantly. That of African-American women may soon approach the same level of occurrence as is found in White women. - pg. 478
  - Needs Improvement: Discussion of underlying reasons for racial/ethnic differences in breast cancer incidence, such as racism.
    - Slides 14-15
      - Four pictures of breasts, ¼ darker skin
      - Needs Improvement: Greater diversity of images.

- Fluids and electrolytes lecture
  - Slide 90
    - A 9-month-old girl is brought to the BMC ER by her middle eastern immigrant parents, with an episode of twitching of her extremities.
      - Needs Improvement: No need to mention that her parents are Middle Eastern immigrants unless it is directly relevant to the case. If so, explain how it is relevant.

- Colorectal cancer lecture
  - Slide 7
    - USA - declining, lifetime incidence >5%, higher in African Americans, lower in Hispanics, overall survival: 66% Whites, 55% African Americans
      - Needs Improvement: Discuss underlying reasons behind disparities.
  - Slide 20
    - Guidelines differ for African Americans with otherwise average risk of colorectal cancer: - screening should begin at age 45 years, incidence is higher compared to other groups, more likely to present at later stages.
      - Needs Improvement: Discuss reasons for racial difference in guidelines. Is the higher incidence and likelihood of presenting at a later stage due to higher genetic risk, less access/lower quality of health care, or something else?

- PAD lecture
  - Images
    - All pictures of pale lower extremities
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- **Needs Improvement:** Greater diversity of images.

**OB/GYN**
- **Routine prenatal care case study**
  - Maria is a 17 y.o. Hispanic woman who comes to see you at the office today for her 1st prenatal visit. As you introduce yourself and engage in conversation, you notice that she seems anxious, nervous (biting her nails) and a little bit teary eyed.
  - ⇒ **Needs Improvement:** Only include mention of race/ethnicity if it is directly relevant to the case. If it is, explain how.

- **Contraception student handout**
  - Andel T. is a 37-year-old G3P0 Black woman with BMI > 30 who shows up for her routine annual exam. During her consultation she states that she is not currently with a steady partner, but she does date men and will occasionally use condoms. The last time she had any sexual activity was 9 months ago. She does not want children at this time, but she states if the right man comes around she might want to have a child one day. She is afraid to use hormones because she heard “those things cause cancer.”
  - ⇒ **Needs Improvement:** No role for race in this case. May reinforce harmful stereotypes of Black women.

- **Article on prenatal ASA**
  - There is medication to stop preterm births but many women don't get it -- article by Dr. Abbott re: ASA
  - ⇒ **Appropriate Use:** Calls attention to relevant racial disparities in care.

- **Preterm labor**
  - An 18-year-old African-American, G2P0101 woman who is 12 weeks pregnant, presents to your prenatal clinic for a new patient visit. Before you walk into the room to see the patient, you look through her records and note that she delivered her last pregnancy just 12 months ago.
  - ⇒ **Needs Improvement:** No role for race in this case. May reinforce harmful stereotypes of African-American women.

**Psychiatry**
- **Suicide screening lecture**
  - Slide 8
  - ⇒ Being Caucasian listed as a risk factor for suicide
    - o **Needs Improvement:** Provide more information about reasons for this increased risk if available.

- **Psychosis and schizophrenia**
  - Slide 39
  - ⇒ Highest incidence among the urban poor
    - o **Needs Improvement:** Doesn’t directly mention race but “urban poor” is racially coded language. Should address racist history of diagnosing schizophrenia and discuss how schizophrenia/psychosis can lead to poverty.

- **Alcoholism**
  - Slide 15
  - ⇒ Acknowledges oversampling of Blacks, Latinos, young adults
    - o **Appropriate Use:** Provides context about source of the data.
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- **Psychopharmacology**
  - Slide 39
    - SJ/TEN a/w HLA-B*1502 allele (high prevalence in Asians)
      - **Needs Improvement:** Would be good to be more specific than the broad category of “Asians” if we have data.

- **PTSD**
  - Slide 3
    - Juan, a Hispanic 60-year-old man, had a road traffic accident on the motorway 3 months before presenting for assessment.
  - Slide 15
    - Elevated rates of PTSD in "racial and ethnic minorities"
  - Slide 22
    - Addresses social stress "minority stressors: discrimination, violence, expected/actual rejection, internalized stigma"
      - **Appropriate Use:** Acknowledges racism as a contributor to PTSD.

- **Psych disorder due to general medical condition**
  - Slide 33
    - On MS: "Primarily affects women of Northern European descent of child-bear age"
      - **Appropriate Use:** Talks specifically about differences in incidence by ancestry.

- **Psychiatric emergencies**
  - Slides 3 and 4
    - Protective factor against suicide: "Positive cultural, ethnic or racial identification"
      - **Needs Improvement:** Would be good to expand on what the lecturer means by this.

- **Neurocognitive disorders**
  - Slide 16
    - On vascular dementia: "The prevalence of VaD is relatively high in African Americans, hypertensive persons, and patients with diabetes."
      - **Needs Improvement:** Clarify whether race/ethnicity is really an independent risk factor for vascular dementia apart from higher incidence of diabetes and hypertension in African-Americans.

- **Depression in children and adolescents**
  - Slide 4
    - Case: "Hasan is a 16-year-old West Indian male who obtains his primary care at a health center in Roxbury."
      - **Needs Improvement:** Clarify whether ancestry is relevant to case. It could make sense to include if discussing cultural perceptions of depression, particularly if this is a real case. If not relevant, don’t need to include it.

- **Geriatrics**
  - **Fatigue case**
    - Page 3
      - From Ecuador, Spanish primary language but speaks English. Moved to the United States 20 years ago.
      - **Appropriate Use:** Seems like an appropriate part of the social history.
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● Oral health
  ➢ Images throughout presentation
    ⇒ Diversity of images
    o Appropriate Use: Good diversity of images.

  ➢ Slide 43
    ⇒ Born and lived in Haiti until late 2005...speaks only Haitian Creole
    o Appropriate Use: Seems appropriate in the context of the social history.

● Pressure injury
  ➢ Images
    ⇒ Most images are of light-skinned patients, with some exceptions
    o Needs Improvement: Greater diversity of images.

  ➢ Slide 9
    ⇒ "Dark-skinned patients may not have visible blanching or erythema"
    o Appropriate Use: Clinically relevant difference, talks specifically about skin color (which is what is relevant here).
    o Needs Improvement: Would be helpful to include an image of dark skin with stage 1 pressure injury on this slide.

● Delirium case 1
  ➢ Page 1
    ⇒ Grew up in Puerto Rico, worked as a seamstress. She moved from PR to NYC about 20 years ago. She went back to PR with her husband and just recently returned to the US to live near their daughter because of her husband's declining health.
    o Appropriate Use: Seems appropriate in context of the social history.

● Low vision/OT module
  ➢ Images
    ⇒ Almost all images are of light-skinned people.
    Needs Improvement: Greater diversity of images.
Appendix D

External Review Of Aspirational Institutions And Programs

Alpert Medical School at Brown University

The work Alpert Medical School at Brown University is currently engaged in surrounds the med school's student created diversity and inclusion action plan (DIAP) of Spring 2016. After the DIAP was written, each medical school department was tasked to write their own. The medical school was integral in leading the hospital to write their own plan as well. Brown hosts a Race in Medicine Panel for M2 students, content on how to create an inclusive community, faculty development surrounding how to talk about race in lectures, and a Social Change and Equity Fellowship.

Interview Highlights

Major Highlights and Programmatic Implementations

- Brown put together a mini video and a set of guidelines on how race should be talked about in lectures and received feedback from the Committee on Diverse and Inclusive Teaching.
- Summer Reading before M2: Fatal Invention by Dorothy Roberts, JD
- An M2 doctoring panel is hosted where the question is asked, “What is structural Racism and How do you bring it into your practice?” Students then had small group discussions reflecting on the panel.
- A second M2 panel with the topic of intersectionality is hosted later in the year. During the subsequent small group discussion, students were encouraged to take a deep dive into the meaning of intersectionality and how patients’ lives are affected by the intersections with which they reside.
- Dr. Lundy Braun gives a lecture on the racist history of the spirometer to the M2 class in their pulmonology block.
- M1 students are tasked to discuss structural racism after engaging in community outreach during orientation.

Summary of Major Content Areas Covered

- Faculty development
- Health disparities
- Bias in practice and research
- Contemporary controversy surrounding race and genetics
- Interdisciplinary leadership
- Language choice
- Structural racism
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Tangible Resources

Faculty Training Video: Alpert Medical School Program in Educational Faculty Development, email Emily_Green@Brown.edu with any questions

Creating Inclusive Curricula: Alpert Medical School Program in Educational Faculty Development, email Emily_Green@Brown.edu with any questions

- Final Paper on Radhika Rajan Diversity Fellow Work: Radhika Rajan, MD, email Radhika_Rajan@brown.edu with any questions
- Brown Advocates for Social Change and Equity Fellowship Syllabus: Gabryel Garcia-Sampson, MD, MPH, and Radhika Rajan, MD
- Alpert Medical School at Brown University Diversity and Inclusion Plan

Dartmouth

As of the 2019 school year, the school will be including a Race and Health Equity Longitudinal Curriculum with the goal that graduating students will be equipped with the confidence to treat a diverse patient population.

Summary of Major Content Areas Covered

- Address health disparities
- Socioeconomic ties to race
- Implicit bias and how it relates to health outcomes
- Historical context of race and how it impacts patient and population health
- Differences in presentation and outcomes for patients of different races

FSU

FSU’s largest initiative to discuss racism in medicine is through RAW Week: Racism Awareness Week which is open to their medical school community with the hopes of bringing awareness to racism centered in the medical field. The week of workshops is overseen by both faculty and students. There is also a Council on Diversity and Inclusion that is supported by deans and student groups.

Interview Highlights

Talk about how to ease into addressing racism in medicine, beginning with implicit Bias. Have someone come in as a lecturer like a Black PhD, PA to talk from their experiences and have students ask questions. Address scenarios when the patient exhibits racist behavior and how to work through as a professional. Difficult Conversations - Vision: Questions you ask and assumptions you make. When leadership shows up it sends a message, so it is beneficial to have faculty present. Dr. Mary O’Connor is an orthopedic surgeon in Boston and may be useful to reach. In the final report, include studies showing individuals with similar experiences are treated disparately based on their race.
Summary of Major Content Areas Covered

- Power and privilege
- Family separation and effects of toxic stress on children
- Implicit bias
- The role of student activism in racial justice and health equity and comparison to the civil rights movement
- Discussing racism with peers and authority
- Privilege

Tangible Resources

- Racism Awareness Week Agenda
- Flyer

Hopkins

The racism in medicine focused initiative is event based. As an example, Hopkins has held a showing of The Deadliest Disease in America, a documentary that highlights differential treatment individuals of different races receive in the context of medical treatment. In conjunction with the film, workshops have been held to assess ways improvements can be made in relation to health equity and access to care.

Summary of Major Content Areas Covered

- Provider attitudes and their contribution of health disparities
- Healthcare access
- Racism as a disease (figuratively)

Mt. Sinai

There is a faculty led committee that reviews all course material specifically looking for its use of race in the pre-clerkship years. The review findings are given back to the course directors with supplemental material to help course directors use race appropriately. The supplemental material includes: information on when the use of race is inappropriate and actually propagates racial inequities, up to date information on how to explain the true biological/genetic basis for disease prevalence as opposed to race, and addresses the potential deleterious impact of using traditional racial groups to describe disease.

Summary of Major Content Areas Covered

- Curriculum reviews
- Comprehensive programmatic development

Tangible Resources

- Course Material Review Criteria and Example
- Outline of the Mt. Sinai process around Racism in Medicine thus Far
- Racism and Bias Initiative Overview
- Scheduled RiM Focused Events (Chats for Change)
Creating Leadership & Education to Address Racism

Northwestern

The curriculum of Northwestern has a sector that is dedicated to Health and Society. Students understand and participate in healthcare delivery from a personal, patient and community perspective, and work with 21 diverse communities. A curricular thread that follows this is *Health Equity and Advocacy.*

**Summary of Major Content Areas Covered**

- Systemic factors that influence health
- Intersection between individual, community, and policies and how they affect health outcomes
- Community engagement

UCLA

Through the Center for the Study of Racism, Social Justice, and Health, UCLA focuses on racism as a public health concern and conducts research in racial disparities, health equity, and social justice. UCLA has partnered with Charles Drew University of Medicine and Science, an HBCU, to build a curriculum where students complete a project focusing on health disparities, learn to be leaders in underserved communities, and have the option to take part in a program to practice primary care in Watts, California.

**Summary of Major Content Areas Covered**

- Racism as a public health issue
- Interdisciplinary approaches to studying racism and health equity
- Social justice
- Community engagement

UCSF

UCSF has completely overhauled the way they view education surrounding diversity and inclusion. The Differences Matter initiative swept in a phase of curricular change with a focus on diversity and inclusion throughout the medical education process. It is a little unclear as to how the mission of the initiative has been implemented into the core curriculum; however, faculty and staff development seems to be a high priority. UCSF offers Diversity, Equity, and Inclusion Champion training for faculty and staff. In an effort to engage their students early on, during orientation, students attend YMCAs in multiple locations around San Francisco. Once the students reconvene, they discuss the different experiences the children face at YMCAs in wealthy neighborhoods as compared to those in less affluent ones.

**Summary of Major Content Areas Covered**

- Bias
- Health equity
- Faculty development
- Community engagement
Creating Leadership & Education to Address Racism 106

Tangible Resources

- Differences Matter content integrated into existing curriculum
- UCSF’s “VIG” work login with BU ID under Differences Matter (DM) Group 3

University of Minnesota School of Medicine

The school has utilized public health practices to develop a curriculum on racism. This was done by using Public Health Critical Race Praxis (PHCRP) methodology [which encourages participants to systematically assess and address racism-related factors that may influence research and practice] to set up monthly 2-hour meetings for 1 year in 2 phases: 1 phase with Underrepresented Minorities in Medicine participants and a 2nd phase with mixed group that included 5 White male participants. It was concluded that there is a different meaning behind discussing race with those from different groups and the voices from phase 1 became less prominent with the addition of the White male participants.

Summary of Major Content Areas Covered

- Structural racism
- Implicit bias
- Intersectionality
- History of racism in America
- Defining racism
- Recognizing racism
- Shifting viewpoints to the marginalized group rather than majority

University of North Carolina (UNC SOM)

A faculty directed and administered student elective has been created in order to facilitate a space to engage students to participate in anti-racist work at UNC SOM. This elective is run similarly to the student run electives except that it is faculty directed and has dedicated outcomes. The course encourages participation from students, faculty, practicing physicians, and community members to facilitate discussion from various perspectives. The content created by students throughout the course is used as research to implement into the core curriculum and address the issues identified in current courses.

Interview Highlights

The course was born out of an incident at the University Missouri in conjunction with the Silent Sam confederate statue at UNC. There was a lot of student unrest and push for anti-racism training for faculty. Alongside this effort the racial equity course was created to help second year medical students understand system-based racism. -- In addition to the course the new strategic plan for UNC SOM has listed racial equity and diversity as key goals. The addition of central support has helped move the effort forward. Lastly, another major highlight of the course is a two-day training from the Racial Equity Institute. The current elective course director said (as someone who has studied racial equity and health outcomes across diverse populations for years) “it was life changing”. He went on to say that this course helped illuminate the far reaching impact of racism on all aspects of life. This training was also attended by faculty outside of the course and by community members (which was highlighted as a benefit because it added a
richness to the discussion that would have been lost if only one group was present.). The hope is that all students and faculty at UNC SOM will have to take this course (this will take a financial commitment from the SOM because the workshop is not free). Overall the work of this course and the student projects has been well-received.

**Summary of Major Content Areas Covered**

- Intersectionality
- UNC specific history and targeted improvements
- Health disparities
- Student driven anti-racism projects
- Improving racial equity in medicine
- Race based medicine
- Incarceration

**Tangible Resources**

- [Racism in Medicine Elective Syllabus](#)

**UPENN**

UPenn students put together an annual conference on racism in medicine for medical students, nursing students and social work students.

**Summary of Major Content Areas Covered**

- The impact of racism on individual health
- Codeswitching
- Racial justice
- Racialized clinical decision making
- Immigration

**Tangible Resources**

- [Article with Racism in Medicine Conference Workshop Titles](#)

**Yale**

There is currently a push by the medical education office to hire someone to integrate health equity and anti-racism content into the curriculum.

**Summary of Major Content Areas Covered**

- Curriculum review
- Health equity
Appendix E

Additional Resource Guide

1. Creating Leadership and Education to Address Racism (CLEAR): A BUSM Extracurricular Enrichment Experience

In fall 2019, CLEAR piloted a 6-week enrichment series on Racism in Medicine featuring sessions spanning the history of racism in medicine, anti-racism 101, racism and genetics, critical race theory, racism on the wards, and clinical cases.

The mission of CLEAR is to provide medical students with a hands-on opportunity to deepen their knowledge and understanding of race and racism and how they impact patients, providers, and medicine as an institution. Grounded in a robust historical context, CLEAR aims to give students the tools to begin to address racism in medicine in both the classroom as well as in the clinic. CLEAR partners with faculty and administration to address the issue of racism in medicine in the formal four-year medical school curriculum as well as provides a 6-week enrichment opportunity for students to engage further.

The goals for CLEAR are to engage students in a focused and extended dialogue around racism in medicine, introduce mentors, organizations, and thought leaders in this field to interested students and begin to develop student leaders in this area, give students the tools to create a more equitable healthcare environment, and pilot topics focused on racism in medicine for future BUSM curricular integration.

The vision for BUSM students is to develop an increased awareness and understanding of how a history of and continued racial injustices affect health outcomes and health care in Boston and beyond, skills for intra and interprofessional communication about race, racism, health inequity, and medicine, and tools to build intentionally anti-racist relationships with future patients and clinicians.

Students who participated in the pilot semester of this course were surveyed before and after the course, and consistently throughout the questions and situations surveyed, students felt more comfortable in navigating situations and their knowledge after their participation in the extracurricular enrichment. Areas surveyed included confidence in knowledge about the impact of racism on patient care and outcomes, comfort in discussing with superiors ways to improve the care of patients from racially/ethnically diverse populations, confidence in ability to create a safe, comfortable, and trusting environment for patients from racially/ethnically diverse populations, and comfort in collaborating with a diverse team.
2. Racial Justice Organizations for Collaboration

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<tr>
<th>Name and Contact</th>
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| Alternatives for Community & Environment  
http://www.ace-ej.org/ | ACE builds the power of communities of color and low-income communities in Massachusetts to eradicate environmental racism and classism, create healthy, sustainable communities, and achieve environmental justice. |
| Anti-Racism Collaborative (ARC)  
Antiracismcollaborative.org | ARC is a multi-racial collective of anti-oppression educators and activists committed to the movement for racial justice. Through courses, workshops, and community building, we cultivate opportunities that provide participants with experiences along an arch of growth. Their journey in these programs will change their world view, opening them to a clear action-oriented process for directing their energy to dismantle injustices. ARC offers courses and workshops, including the 5-week courses: Confronting Systemic Racism and Racial Justice Activism |
| Belmont Against Racism (BAR)  
http://www.belmontagainstracism.org/ | BAR is a community-action, all-volunteer organization addressing issues of racism and prejudice by following the slogan, think globally, act locally. We focus on fostering awareness and educating the community about exclusionary practices, creating a welcoming community for all, and increasing diversity throughout the town. While BAR, in its first decade, mostly focused on addressing racism, its mission has broadened to include all problems of prejudice that impact the town and local community. |
| Black Lives Matter – Cambridge and Boston  
https://www.facebook.com/BlackLivesMatterBOSS/ | Black Lives Matter Cambridge/Boston is part of the movement to end structural racism both locally, nationally and internationally. |
| Black & Pink (B&P)  
www.Blackandpink.org | B&P is an open family of LGBTQ prisoners and “free world” allies who support each other. Work toward the abolition of the prison industrial complex is rooted in the experience of currently and formerly incarcerated people. We are outraged by the specific violence of the prison industrial complex against LGBTQ people, and respond through advocacy, education, direct service, and organizing. Black & Pink is a national organization with a Boston chapter. B&P Boston welcomes new volunteers to get involved and/or assist with mail processing at multiple times and locations each week. |
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<tr>
<th><strong>Organization</strong></th>
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<tr>
<td><strong>Boston Education Justice Alliance</strong>&lt;br&gt;<a href="http://www.bostonedjustice.org/">http://www.bostonedjustice.org/</a></td>
<td>The founding local chapter of the Mass Education Justice Alliance, BEJA is a coalition of students, educators, parents, school staff, and concerned community members committed to building a stronger and better public school system that is driven by community voices.</td>
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<td><strong>Boston Mobilization</strong>&lt;br&gt;<a href="http://bostonmobilization.org/suburban-justice-program/">http://bostonmobilization.org/suburban-justice-program/</a></td>
<td>Boston Mobilization’s work continues to be developing the next generation of social justice leaders, through powerful trainings, community organizing campaign work, mentorship of young leaders and transformational youth programs. Support teen leadership for action, organizing and social justice education in and out of schools in greater Boston. If one is a young person interested in racial justice, there are great ways to get involved.</td>
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<td><strong>The Boston Racial Justice and Equity Initiative</strong>&lt;br&gt;<a href="http://www.futureboston.com/about/our-pov/you-all-should-know-about-boston-racial-justice-and-equity-initiative">http://www.futureboston.com/about/our-pov/you-all-should-know-about-boston-racial-justice-and-equity-initiative</a></td>
<td>The Boston racial Justice and Equity Initiative is a group of organizations, professionals, and community members that are committed to building a healthy community by increasing racial equity in employment, education, housing, and health care, among other opportunities, and by working for racial justice.</td>
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<td><strong>Boston Student Advisory Council</strong>&lt;br&gt;<a href="http://www.youthonboard.org/bsac">http://www.youthonboard.org/bsac</a></td>
<td>BSAC advocates for and protects the voices of students in BPS by empowering the student body to express their opinions regarding education reform and ensuring that students are included in decision and policy making that impacts their lives and educational experiences.</td>
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<td><strong>Boston Teacher Action Group</strong>&lt;br&gt;<a href="http://www.tagboston.org">www.tagboston.org</a></td>
<td>TAG is a coalition of educators from greater Boston who believe education is essential to human liberation. They are committed to working alongside youth and other members of the community to dismantle oppressive practices in schools and society. TAG is part of a national coalition of grassroots teacher organizing groups. They engage in shared political education and relationship building in order to work for educational justice both nationally and in local communities.</td>
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<td><strong>The Cambridge Center for Adult Education</strong>&lt;br&gt;<a href="https://ccae.org/">https://ccae.org/</a></td>
<td>The Cambridge Center for Adult Education provides high-quality educational opportunities for the diverse adults of Greater Boston including such courses as White People Challenging Racism and Black &amp; White Women: Reconciling Our Past, Re-Defining Our Future.</td>
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<tr>
<td><strong>Center for Teen Empowerment</strong>&lt;br&gt;<a href="http://teenempowerment.org/">http://teenempowerment.org/</a></td>
<td>Youth organizing and social change program that has sites in Roxbury, Dorchester, and Somerville, MA, and in Rochester, NY. At each site, Teen Empowerment hires a group of youth, ages 14-21, and trains them as community organizers, providing them with the support, resources, and ongoing training they need to organize initiatives that involve both youth and adults in addressing community issues.</td>
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<td>Organization</td>
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<td>Citizens for Juvenile Justice</td>
<td>The only independent, non-profit, statewide organization working exclusively to improve the juvenile justice system in Massachusetts. CfJJ advocates, convenes, conducts research, and educates the public on important juvenile justice issues.</td>
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<td>City Life / Vida Urbana</td>
<td>A 40-year-old bilingual, community organization whose mission is to fight for racial, social and economic justice and gender equality by building working class power through direct action, coalition building, education and advocacy. Currently working against evictions, CL/VU views the current displacement crisis as an issue of racial equity, as well as economic and housing justice.</td>
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<td>Community Change, Inc.</td>
<td>Since 1968, Community Change Inc. has served as a community for White people and their multiracial allies to come together to learn about systemic racism and to fight against it. Now Black-led under the leadership of Shay Stewart-Bouley, CCI is shifting into the role of a legacy organization supporting the work of emerging White anti-racist activists as well as established groups organizing within the greater Boston area.</td>
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<td>Criminal Justice Policy Coalition</td>
<td>CJPC is a member-based, non-profit organization dedicated to the advancement of effective, just, and humane criminal justice policy in Massachusetts.</td>
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<td>CrossRoads: Antiracism Organizing &amp; Training</td>
<td>CrossRoads’ mission is to dismantle systemic racism and build antiracist multicultural diversity within institutions and communities implemented primarily by training institutional transformation teams.</td>
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<td>Enroot</td>
<td>Enroot empowers immigrant youth in Cambridge to achieve academic, career, and personal success through inspiring out-of-school experiences.</td>
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<td>Haley House</td>
<td>Haley House uses food and the power of community to break down barriers between people, transfer new skills, and revitalize neighborhoods. It believes in radical solutions: solving problems at their root by challenging attitudes that perpetuate suffering and by building alternative models.</td>
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<tr>
<td>Hard Conversations: An Introduction to Racism.</td>
<td>Hard Conversations is a month-long online seminar program hosted by authors, speakers, and social justice activists Patti Digh and Victor Lee Lewis, who was featured in the documentary film, The Color of Fear, with help from a community of people who want and are willing to help us understand the reality of racism by telling their stories and sharing their resources.</td>
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<td>Haymarket People’s Fund</td>
<td>Haymarket People’s Fund is an anti-racist and multi-cultural foundation that is committed to strengthening the movement for social justice in New England. Through grant making, fundraising and capacity building, they support grassroots organizations that address the root causes of injustice. Haymarket also organizes to increase sustainable community philanthropy throughout the region.</td>
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<td>Hispanic Black Gay Coalition (HBGC)</td>
<td>HBCG is one of few non-profit organizations in Boston dedicated to the unique and complex needs of the Black, Hispanic and Latinx LGBTQ community. Founded in 2009, it works to inspire and empower Latinx, Hispanic and Black LGBTQ individuals to improve their livelihood through activism, education, community outreach, and counseling.</td>
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<td>Mass Mentoring Partnership</td>
<td>Based in Boston, MMP is fueling the movement to expand empowering youth-adult relationships across Massachusetts. MMP serves more than 250 mentoring and youth development programs statewide supporting more than 33,000 youth in mentoring relationships.</td>
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<td>Massachusetts Advocates for Children</td>
<td>MAC is dedicated to being an independent and effective voice for children who face significant barriers to equal educational and life opportunities. MAC works to overcome these barriers by changing conditions for many children, while also helping one child at a time.</td>
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<tr>
<td>Massachusetts Immigrant &amp; Refugee Advocacy Coalition</td>
<td>The largest organization in New England promoting the rights and integration of immigrants and refugees. MIRA serves the Commonwealth's one million foreign-born residents with policy analysis and advocacy, institutional organizing, training and leadership development, strategic communications, citizenship assistance.</td>
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<tr>
<td>National Association for the Advancement of Colored People</td>
<td>The mission of the National Association for the Advancement of Colored People (NAACP) is to ensure the political, educational, social, and economic equality of rights of all persons and to eliminate race-based discrimination. The vision of the National Association for the Advancement of Colored People is to ensure a society in which all individuals have equal rights without discrimination based on race.</td>
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| **The People’s Institute for Survival and Beyond**  
http://www.pisab.org/ | The People’s Institute for Survival and Beyond focuses on understanding what racism is, where it comes from, how it functions, why it persists and how it can be undone. Workshops utilize a systemic approach that emphasizes learning from history, developing leadership, maintaining accountability to communities, creating networks, undoing internalized racial oppression and understanding the role of organizational gate keeping as a mechanism for perpetuating racism. |
|---|---|
| **Posse Foundation**  
https://www.possefoundation.org/ | Rooted in the belief that a small, diverse group of talented students—a Posse—carefully selected and trained, can serve as a catalyst for increased individual and community development in an increasingly multicultural society. |
| **Prison Policy Initiative**  
http://www.prisonpolicy.org/ | The Prison Policy Initiative produces cutting edge research to expose the broader harm of mass criminalization, and then sparks advocacy campaigns to create a more just society. |
| **Resist**  
www.resist.org | Resist is a foundation that supports people's movements for justice and liberation. We redistribute resources back to frontline communities at the forefront of change while amplifying their stories of building a better world. |
| **Roca**  
http://rocainc.org/ | Founded in 1988, Roca is an outcomes-driven organization dedicated to transforming the lives of the most high-risk young people ages 17-24 (street, court, and gang-involved; drop-outs; young parents). Roca combines relentless outreach with data-driven evaluation to produce consistent, positive outcomes for young people in the Greater Boston area, including the communities of Chelsea, Revere, Everett, Boston, and East Boston, as well as Springfield. |
| **Rootstrong**  
http://www.rootstrong.org/ | Rootstrong is an organization focused on excellence in multicultural leadership education and development. Mission is to provide resources, experiences, and development opportunities to promote equity, social justice and excellence through leadership. Having derived great strength, guidance and inspiration from one’s family, community, and/or personal history. |
| **Sociedad Latina**  
http://www.sociedadalatina.org/ | Sociedad Latina is a citywide organization that focuses on supporting the unmet needs of youth and families from Boston’s Latino and Mission Hill/Roxbury communities. Since 1968, Sociedad Latina has worked in partnership with youth and families to create the next generation of Latino leaders who are confident, competent, self-sustaining and proud of their cultural heritage. |
| **SURJ Boston**  
**Showing Up For Racial Justice**  
http://www.surjboston.org/ | SURJ is a national network of groups and individuals organizing White people for racial justice. Through community organizing, mobilizing, and education, SURJ moves White people to act as part of a multi-racial majority for justice with passion and accountability. We work to connect people across the country while supporting and collaborating with local and national racial justice organizations. |
|---|---|
| **UTEC**  
https://www.utec-lowell.org/ | UTEC’s mission and promise is to ignite and nurture the ambition of Lowell’s most disconnected young people to trade violence and poverty for social and economic success. UTEC is the result of an organizing movement driven by young people to develop their own teen center in response to gang violence. UTEC serves young people from both Lowell and Lawrence, MA. |
| **White People Challenging Racism: Moving from Talk to Action (WPCR)**  
www.wpcr-boston.org/ | WPCR brings people together to examine White privilege and racism in order to galvanize them to anti-racist action. Our mission is to provide people with tools and resources to challenge and change attitudes and actions that perpetuate racism. While our focus is on White people’s role in dismantling racism, our courses are open to everyone who is committed to achieving racial justice. It is a five-part workshop which consists of weekly two-hour meetings over the course of five weeks. Other time configurations are being developed. WPCR is a program of Community Change Inc. |
| **Wholeness Beyond Whiteness**  
http://bit.ly/29vYOy9 | Wholeness Beyond Whiteness seeks to create a space for White people in racial justice work to deepen their sense of rootedness in the work. Goal is to help enable White people to get past the fears of risk that hold us back from full commitment to racial justice by focusing on how shame functions as a tool of White supremacy and thus how shame resilience is necessary for White racial justice organizers, as well as the ways that perception fundamentally shapes the way we come into racial justice organizing spaces. |
| **YouthBuild Boston**  
http://youthbuildboston.org/aboutus/ | YouthBuild empowers and assists underserved young people from the Boston area with the essential social, vocational, academic, and life skills necessary to navigate a positive pathway to self-sufficiency and neighborhood responsibility. YouthBuild uses entrepreneurship and experiential learning to ignite the potential of youth in under-resourced communities and equip them for high school, college and career success. |
3. **Boston University School of Public Health (BUSPH)**

BUSPH has continually been a role model in taking concrete steps to address racism in the medical and public health fields. In 2017, BUSPH created an 11-point plan towards excellence on diversity and inclusion: [https://www.bu.edu/sph/announcement/diversity-and-inclusion-at-sph-3/](https://www.bu.edu/sph/announcement/diversity-and-inclusion-at-sph-3/)

**11 Point Plan-Major Topics**

1. Targeted teachings.
2. Effective teaching strategies to promote inclusion in the classroom.
3. Diversity and Inclusion Seminar Series
4. SPH Reads.
5. Language of Inclusion.
6. Affinity Groups.
7. Cultural events.
8. Online discussion space
10. Underrepresented faculty/faculty development.

It is critical that BUSM continue to partner and learn from BUSPH, especially as BUSPH is on the same campus as BUSM. It is recommended that BUSM delve deeper into the work of BUSPH around racism in order to implement change on our own campus.
### Glossary of Terms

**ACCOUNTABILITY**

In the context of racial equity work, accountability refers to the ways in which individuals and communities hold themselves to their goals and actions and acknowledge the values and groups to which they are responsible.

To be accountable, one must be visible, with a transparent agenda and process. Invisibility defies examination; it is, in fact, employed in order to avoid detection and examination. Accountability demands commitment. It might be defined as “what kicks in when convenience runs out.” Accountability requires some sense of urgency and becoming a true stakeholder in the outcome. Accountability can be externally imposed (legal or organizational requirements), or internally applied (moral, relational, faith-based, or recognized as some combination of the two) on a continuum from the institutional and organizational level to the individual level.

From a relational point of view, accountability is not always doing it right. Sometimes it’s really about what happens after it’s done wrong.

**ALLY**

1) Someone who makes the commitment and effort to recognize their privilege (based on gender, class, race, sexual identity, etc.) and work in solidarity with oppressed groups in the struggle for justice. Allies understand that it is in their own interest to end all forms of oppression, even those from which they may benefit in concrete ways.

2) Allies commit to reducing their own complicity or collusion in oppression of those groups and invest in strengthening their own knowledge and awareness of oppression. Allies commit to reducing their own complicity or collusion in oppression of those groups and invest in strengthening their own knowledge and awareness of oppression.

**ANTI-BLACK**

The Council for Democratizing Education defines anti-Blackness as being a two-part formation that both voids Blackness of value, while systematically marginalizing Black people and their issues. The first form of anti-Blackness is overt racism. Beneath this anti-Black racism is the covert structural and systemic racism which categorically predetermines the socioeconomic status of Blacks in this country. The structure is held in place by anti-Black policies, institutions, and ideologies.

The second form of anti-Blackness is the unethical disregard for anti-Black institutions and policies. This disregard is the product of class, race, and/or gender privilege certain individuals experience due to anti-Black institutions and policies. This form of anti-Blackness is protected by the first form of overt racism.
| **ANTI-RACISM** | Anti-Racism is defined as the work of actively opposing racism by advocating for changes in political, economic, and social life. Anti-racism tends to be an individualized approach and set up in opposition to individual racist behaviors and impacts. | *Race Forward* |
| **ANTI-RACIST** | An anti-racist is someone who is supporting an antiracist policy through their actions or expressing antiracist ideas. This includes the expression or ideas that racial groups are equals and none needs developing, and is supporting policy that reduces racial inequity. | *Ibram X Kendi, How to be Antiracist, Random House, 2019* |
| **ANTI-RACIST IDEAS** | An antiracist idea is any idea that suggests the racial groups are equal in all of their apparent differences and that there is nothing wrong with any racial group. Antiracists argue that racist policies are the cause of racial injustices. | *Ibram X Kendi, How to be an Antiracist, Random House, 2019* |
| **ASSIMILATIONIST** | One who is expressing the racist idea that a racial group is culturally or behaviorally inferior and is supporting cultural or behavioral enrichment programs to develop that racial group. | *Ibram X Kendi, How to be an Antiracist, Random House, 2019* |
| **BIGOTRY** | Intolerant prejudice that glorifies one’s own group and denigrates members of other groups. | *National Conference for Community and Justice - St. Louis Region. unpublished handout used in the Dismantling Racism Institute program.* |
| **BLACK LIVES MATTER** | A political movement to address systemic and state violence against African Americans. Per the Black Lives Matter organizers: “In 2013, three radical Black organizers—Alicia Garza, Patrisse Cullors, and Opal Tometi—created a Black-centered political will and movement building project called #BlackLivesMatter. It was in response to the acquittal of Trayvon Martin’s murderer, George Zimmerman. The project is now a member-led global network of more than 40 chapters. [Black Lives Matter] members organize and build local power to intervene in violence inflicted on Black communities by the state and vigilantes. Black Lives Matter is an ideological and political intervention in a world where Black lives are systematically and intentionally targeted for demise. It is an affirmation of Black folks’ humanity, our contributions to this society, and our resilience in the face of deadly oppression.” | *Black Lives Matter, “Herstory”, accessed 10/7/19* |
### CAUCUS (Affinity Groups)

White people and people of color each have work to do separately and together. Caucuses provide spaces for people to work within their own racial/ethnic groups. For White people, a caucus provides time and space to work explicitly and intentionally on understanding White culture and White privilege, and to increase one’s critical analysis around these concepts. A White caucus also puts the onus on White people to teach each other about these ideas, rather than relying on people of color to teach them (as often occurs in integrated spaces). For people of color, a caucus is a place to work with their peers on their experiences of internalized racism, for healing and to work on liberation.

[www.racialequitytools.org](http://www.racialequitytools.org)

### COLLUSION

When people act to perpetuate oppression or prevent others from working to eliminate oppression. Example: Able-bodied people who object to strategies for making buildings accessible because of the expense.


### COLONIZATION

Colonization can be defined as some form of invasion, dispossession and subjugation of a people. The invasion need not be military; it can begin—or continue—as geographical intrusion in the form of agricultural, urban or industrial encroachments. The result of such incursion is the dispossession of vast amounts of lands from the original inhabitants. This is often legalized after the fact. The long-term result of such massive dispossession is institutionalized inequality. The colonizer/colonized relationship is by nature an unequal one that benefits the colonizer at the expense of the colonized. Ongoing and legacy Colonialism impact power relations in most of the world today.


[Indigeneity, Settler Colonialism, White Supremacy Andrea Smith](#)

### CRITICAL RACE THEORY

The Critical Race Theory movement considers many of the same issues that conventional civil rights and ethnic studies take up but places them in a broader perspective that includes economics, history, and even feelings and the unconscious. Unlike traditional civil rights, which embraces incrementalism and step by step progress, critical race theory questions the very foundations of the liberal order, including equality theory, legal reasoning, Enlightenment rationalism and principles of constitutional law.

[Critical Race Theory: An Introduction by Richard Delgado, Jean Stefancic. NYU Press, 2001](#)

### CULTURAL APPROPRIATION

Theft of cultural elements for one’s own use, commodification, or profit — including symbols, art, language, customs, etc. — often without understanding, acknowledgement, or respect for its value in the original culture. Results from the assumption of a dominant (i.e. White) culture’s right to take other cultural elements.

| **CULTURAL MISAPPROPRIATION** | Cultural misappropriation distinguishes itself from the neutrality of cultural exchange, appreciation, and appropriation because of the instance of colonialism and capitalism; cultural misappropriation occurs when a cultural fixture of a marginalized culture/community is copied, mimicked, or recreated by the dominant culture against the will of the original community and, above all else, commodified. *One can understand the* use of “misappropriation” *as a distinguishing tool because it assumes that there are 1) instances of neutral appropriation, 2) the specifically referenced instance is non-neutral and problematic, even if benevolent in intention, 3) some act of theft or dishonest attribution has taken place, and 4) moral judgement of the act of appropriation is subjective to the specific culture from which is being engaged.* | What ‘Cultural Appropriation’ Is and Isn’t, Devyn Springer, Medium.com. accessed 10/7/19 |
| **CULTURAL RACISM** | Cultural racism refers to representations, messages and stories conveying the idea that behaviors and values associated with White people or “Whiteness” are automatically “better” or more “normal” than those associated with other racially defined groups. Cultural racism shows up in advertising, movies, history books, definitions of patriotism, and in policies and laws. Cultural racism is also a powerful force in maintaining systems of internalized supremacy and internalized racism. It does that by influencing collective beliefs about what constitutes appropriate behavior, what is seen as beautiful, and the value placed on various forms of expression. All of these cultural norms and values in the U.S. have explicitly or implicitly racialized ideals and assumptions (for example, what “nude” means as a color, which facial features and body types are considered beautiful, which child-rearing practices are considered appropriate.) | www.racialequitytools.org |
| **CULTURE** | A social system of meaning and custom that is developed by a group of people to assure its adaptation and survival. These groups are distinguished by a set of unspoken rules that shape values, beliefs, habits, patterns of thinking, behaviors and styles of communication. | A Community Builder's Tool Kit. Institute for Democratic Renewal and Project Change |
| **DECOLONIZATION** | Decolonization may be defined as the active resistance against colonial powers, and a shifting of power towards political, economic, educational, cultural, psychic independence and power that originate from a colonized nations’ own indigenous culture. This process occurs politically and also applies to personal and societal psychic, cultural, political, agricultural, and educational deconstruction of colonial oppression. Per Eve Tuck and K. Wayne Yang: “Decolonization doesn’t have a synonym”; it is not a substitute for ‘human rights’ or ‘social justice’, though undoubtedly, they are connected in various ways. Decolonization demands an Indigenous framework and a centering of Indigenous land, Indigenous sovereignty, and Indigenous ways of thinking. |  | The Movement for Black Lives, https://policy.m4bl.org/glossary/  
| **DIASPORA** | Diaspora is "the voluntary or forcible movement of peoples from their homelands into new regions...a common element in all forms of diaspora; these are people who live outside their natal (or imagined natal) territories and recognize that their traditional homelands are reflected deeply in the languages they speak, religions they adopt, and the cultures they produce. | “The Culture of Diasporas in the Postcolonial Web” Leong Yew  |
| **DISCRIMINATION** | 1) The unequal treatment of members of various groups based on race, gender, social class, sexual orientation, physical ability, religion and other categories.  

2) [In the United States] the law makes it illegal to discriminate against someone on the basis of race, color, religion, national origin, or sex. The law also makes it illegal to retaliate against a person because the person complained about discrimination, filed a charge of discrimination, or participated in an employment discrimination investigation or lawsuit. The law also requires that employers reasonably accommodate applicants' and employees' sincerely held religious practices, unless doing so would impose an undue hardship on the operation of the employer's business. | 1) A Community Builder's Tool Kit. Institute for Democratic Renewal and Project Change Anti-Racism Initiative.  
| **DIVERSITY** | 1. Diversity includes all the ways in which people differ, and it encompasses all the different characteristics that make one individual or group different from another. It is all-inclusive and recognizes everyone and every group as part of the diversity that should be valued. A broad definition includes not only race, ethnicity, and gender — the groups that most often come to mind when the term “diversity” is used — but also age, national origin, religion, disability, sexual orientation, socioeconomic status, education, marital status, language, and physical appearance. It also involves different ideas, perspectives, and values. . | 1. Glossary of Terms :UC Berkeley Center for Equity, Inclusion and Diversity  |
| **DIVERSITY cont.** | 2. It is important to note that many activists and thinkers critique diversity alone as a strategy. For instance, Baltimore Racial Justice Action states: “Diversity is silent on the subject of equity. In an anti-oppression context, therefore, the issue is not diversity, but rather equity. Often when people talk about diversity, they are thinking only of the “non-dominant” groups.” |
| **ETHNICITY** | A social construct that divides people into smaller social groups based on characteristics such as shared sense of group membership, values, behavioral patterns, language, political and economic interests, history and ancestral geographical base. Examples of different ethnic groups are: Cape Verdean, Haitian, African American (Black); Chinese, Korean, Vietnamese (Asian); Cherokee, Mohawk, Navaho (Native American); Cuban, Mexican, Puerto Rican (Latino); Polish, Irish, and Swedish (White). |
| **IMPLICIT BIAS** | Also known as unconscious or hidden bias, implicit biases are negative associations that people unknowingly hold. They are expressed automatically, without conscious awareness. Many studies have indicated that implicit biases affect individuals’ attitudes and actions, thus creating real-world implications, even though individuals may not even be aware that those biases exist within themselves. Notably, implicit biases have been shown to trump individuals’ stated commitments to equality and fairness, thereby producing behavior that diverges from the explicit attitudes that many people profess. The Implicit Association Test (IAT) is often used to measure implicit biases with regard to race, gender, sexual orientation, age, religion, and other topics. |
| **INCLUSION** | Authentically bringing traditionally excluded individuals and/or groups into processes, activities, and decision/policy making in a way that shares power. |
| **INDIGENEITY** | Indigenous populations are composed of the existing descendants of the peoples who inhabited the present territory of a country wholly or partially at the time when persons of a different culture or ethnic origin arrived there from other parts of the world, overcame them, by conquest, settlement or other means and reduced them to a non-dominant or colonial condition; who today live more in conformity with their particular social, economic and cultural customs and traditions than with the institutions of the country of which they now form part, under a state structure which incorporates mainly national, social and cultural characteristics of other segments of the population which are predominant. |


*State of the Science Implicit Bias Review 2013, Cheryl Staats, Kirwan Institute, The Ohio State University.*

*Some Working Definitions, OpenSource Leadership Strategies*

*United Nations Working Group for Indigenous Peoples*
### INDIGENITY cont.

(Example: Maori in territory now defined as New Zealand; Mexicans in territory now defined as Texas, California, New Mexico, Arizona, Utah, Nevada and parts of Colorado, Wyoming, Kansas, and Oklahoma; Native American tribes in territory now defined as the United States).

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<table>
<thead>
<tr>
<th>INDIVIDUAL RACISM</th>
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<tbody>
<tr>
<td>Individual racism refers to the beliefs, attitudes, and actions of individuals that support or perpetuate racism. Individual racism can be deliberate, or the individual may act to perpetuate or support racism without knowing that is what he or she is doing. Examples:</td>
</tr>
<tr>
<td>- Telling a racist joke, using a racial epithet, or believing in the inherent superiority of Whites over other groups;</td>
</tr>
<tr>
<td>- Avoiding people of color whom you do not know personally, but not Whites whom you do not know personally (e.g., White people crossing the street to avoid a group of Latino/a young people; locking their doors when they see African American families sitting on their doorsteps in a city neighborhood; or not hiring a person of color because “something doesn’t feel right”);</td>
</tr>
<tr>
<td>- Accepting things as they are (a form of collusion).</td>
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<thead>
<tr>
<th>INSTITUTIONAL RACISM</th>
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<tbody>
<tr>
<td>Institutional racism refers specifically to the ways in which institutional policies and practices create different outcomes for different racial groups. The institutional policies may never mention any racial group, but their effect is to create advantages for Whites and oppression and disadvantage for people from groups classified as people of color. Examples:</td>
</tr>
<tr>
<td>- Government policies that explicitly restricted the ability of people to get loans to buy or improve their homes in neighborhoods with high concentrations of African Americans (also known as “red-lining”).</td>
</tr>
<tr>
<td>- City sanitation department policies that concentrate trash transfer stations and other environmental hazards disproportionately in communities of color.</td>
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</tbody>
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United Nations Working Group for Indigenous Peoples
| INTERNALIZED RACISM | Internalized racism is the situation that occurs in a racist system when a racial group oppressed by racism supports the supremacy and dominance of the dominating group by maintaining or participating in the set of attitudes, behaviors, social structures and ideologies that undergird the dominating group’s power. It involves four essential and interconnected elements:

**Decision-Making** - Due to racism, people of color do not have the ultimate decision-making power over the decisions that control our lives and resources. As a result, on a personal level, we may think White people know more about what needs to be done for us than we do. On an interpersonal level, we may not support each other's authority and power—especially if it is in opposition to the dominating racial group. Structurally, there is a system in place that rewards people of color who support White supremacy and power and coerces or punishes those who do not.

**Resources** - Resources, broadly defined (e.g. money, time, etc.), are unequally in the hands and under the control of White people. Internalized racism is the system in place that makes it difficult for people of color to get access to resources for our own communities and to control the resources of our community. We learn to believe that serving and using resources for ourselves and our particular community is not serving "everybody."

**Standards** - With internalized racism, the standards for what is appropriate or "normal" that people of color accept are White people's or Eurocentric standards. We have difficulty naming, communicating and living up to our deepest standards and values, and holding ourselves and each other accountable to them.

**Naming the problem** - There is a system in place that misnames the problem of racism as a problem of or caused by people of color and blames the disease - emotional, economic, political, etc. - on people of color. With internalized racism, people of color might, for example, believe we are more violent than White people and not consider state-sanctioned political violence or the hidden or privatized violence of White people and the systems they put in place and support.

| INTERPERSONAL RACISM | Interpersonal racism occurs between individuals. Once we bring our private beliefs into our interaction with others, racism is now in the interpersonal realm. Examples: public expressions of racial prejudice, hate, bias and bigotry between individuals.

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Internalized Racism: A Definition, Donna Bivens, Women's Theological Center. 1995

### INTERSECTIONALITY

1. Exposing [one’s] multiple identities can help clarify they ways in which a person can simultaneously experience privilege and oppression. For example, a Black woman in America does not experience gender inequalities in exactly the same way as a White woman, nor racial oppression identical to that experienced by a Black man. Each race and gender intersection produce a qualitatively distinct life.

2. Intersectionality is simply a prism to see the interactive effects of various forms of discrimination and disempowerment. It looks at the way that racism, many times, interacts with patriarchy, heterosexism, classism, xenophobia — seeing that the overlapping vulnerabilities created by these systems actually create specific kinds of challenges. “Intersectionality 102,” then, is to say that these distinct problems create challenges for movements that are only organized around these problems as separate and individual. So when racial justice doesn’t have a critique of patriarchy and homophobia, the particular way that racism is experienced and exacerbated by heterosexism, classism etc., falls outside of our political organizing. It means that significant numbers of people in our communities aren’t being served by social justice frames because they don’t address

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1. *Intergroup Resources*, 2012

### MICROAGGRESSION

The everyday verbal, nonverbal, and environmental slights, snubs, or insults, whether intentional or unintentional, which communicate hostile, derogatory, or negative messages to target persons based solely upon their marginalized group membership.

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### MODEL MINORITY

A term created by sociologist William Peterson to describe the Japanese community, whom he saw as being able to overcome oppression because of their cultural values. While individuals employing the Model Minority trope may think they are being complimentary, in fact the term is related to colorism and its root, anti-Blackness. The model minority myth creates an understanding of ethnic groups, including Asian Americans, as a monolith, or as a mass whose parts cannot be distinguished from each other. The model minority myth can be understood as a tool that White supremacy uses to pit people of color against each other in order to protect its status.

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*Asian American Activism: The Continuing Struggle*
| MOVEMENT BUILDING | Movement Building is the effort of social change agents to engage power holders and the broader society in addressing a systemic problem or injustice while promoting an alternative vision or solution. Movement building requires a range of intersecting approaches through a set of distinct stages over a long-term period of time. Through movement building, organizers can:  
- Propose solutions to the root causes of social problems;  
- Enable people to exercise their collective power;  
- Humanize groups that have been denied basic human rights and improve conditions for the groups affected;  
- Create structural change by building something larger than a particular organization or campaign; and  
- Promote visions and values for society based on fairness, justice and democracy.  

*Roots: Building the Power of Communities of Color to Challenge Structural Racism. Akonadi Foundation, 2010. (Definition from the Movement Strategy Center.)* |
| --- | --- |
| MULTICULTURAL COMPETENCY | A process of learning about and becoming allies with people from other cultures, thereby broadening our own understanding and ability to participate in a multicultural process. The key element to becoming more culturally competent is respect for the ways that others live in and organize the world and an openness to learn from them.  

*Multicultural Competence, Paul Kivel, 2007.* |
| OPPRESSION | The systematic subjugation of one social group by a more powerful social group for the social, economic, and political benefit of the more powerful social group. Rita Hardiman and Bailey Jackson state that oppression exists when the following 4 conditions are found:  
- the oppressor group has the power to define reality for themselves and others,  
- the target groups take in and internalize the negative messages about them and end up cooperating with the oppressors (thinking and acting like them),  
- genocide, harassment, and discrimination are systematic and institutionalized, so that individuals are not necessary to keep it going, and,  
- members of both the oppressor and target groups are socialized to play their roles as normal and correct.  

*Dismantling Racism Works web workbook.* |
| **PEOPLE OF COLOR** | Often the preferred collective term for referring to non-White racial groups. Racial justice advocates have been using the term “people of color” (not to be confused with the pejorative “colored people”) since the late 1970s as an inclusive and unifying frame across different racial groups that are not White, to address racial inequities. While “people of color” can be a politically useful term, and describes people with their own attributes (as opposed to what they are not, e.g., “non-White”), it is also important whenever possible to identify people through their own racial/ethnic group, as each has its own distinct experience and meaning and may be more appropriate. |

| **POWER** | Power is unequally distributed globally and in U.S. society; some individuals or groups wield greater power than others, thereby allowing them greater access and control over resources. Wealth, Whiteness, citizenship, patriarchy, heterosexism, and education are a few key social mechanisms through which power operates. Although power is often conceptualized as power over other individuals or groups, other variations are power with (used in the context of building collective strength) and power within (which references an individual’s internal strength). Learning to “see” and understand relations of power is vital to organizing for progressive social change. Power may also be understood as the ability to influence others and impose one’s beliefs. All power is relational, and the different relationships either reinforce or disrupt one another. The importance of the concept of power to anti-racism is clear: racism cannot be understood without understanding that power is not only an individual relationship but a cultural one, and that power relationships are shifting constantly. Power can be used malignantly and intentionally, but need not be, and individuals within a culture may benefit from power of which they are unaware. |

| **PREJUDICE** | A pre-judgment or unjustifiable, and usually negative, attitude of one type of individual or groups toward another group and its members. Such negative attitudes are typically based on unsupported generalizations (or stereotypes) that deny the right of individual members of certain groups to be recognized and treated as individuals with individual characteristics. |

| **PRIVILEGE** | Unearned social power accorded by the formal and informal institutions of society to ALL members of a dominant group (e.g. White privilege, male privilege, etc.). Privilege is usually invisible to those who have it because we’re taught not to see it, but nevertheless it puts them at an advantage over those who do not have it. |
### RACE

For many people, it comes as a surprise that racial categorization schemes were invented by scientists to support worldviews that viewed some groups of people as superior and some as inferior. There are three important concepts linked to this fact:

- For many people, it comes as a surprise that racial categorization schemes were invented by scientists to support worldviews that viewed some groups of people as superior and some as inferior. There are three important concepts linked to this fact:
  - Race is a made-up social construct, and not an actual biological fact
  - Race designations have changed over time. Some groups that are considered “White” in the United States today were considered “non-White” in previous eras, in U.S. Census data and in mass media and popular culture (for example, Irish, Italian and Jewish people).
  - The way in which racial categorizations are enforced (the shape of racism) has also changed over time. For example, the racial designation of Asian American and Pacific Islander changed four times in the 19th century. That is, they were defined at times as White and at other times as not White. Asian Americans and Pacific Islanders, as designated groups, have been used by Whites at different times in history to compete with African American labor.

### RACIAL AND ETHNIC IDENTITY

An individual’s awareness and experience of being a member of a racial and ethnic group; the racial and ethnic categories that an individual chooses to describe him or herself based on such factors as biological heritage, physical appearance, cultural affiliation, early socialization, and personal experience.

### RACIAL EQUITY

Racial equity is the condition that would be achieved if one's racial identity no longer predicted, in a statistical sense, how one fares. When we use the term, we are thinking about racial equity as one part of racial justice, and thus we also include work to address root causes of inequities not just their manifestation. This includes elimination of policies, practices, attitudes and cultural messages that reinforce differential outcomes by race or fail to eliminate them.

### RACIAL HEALING

To restore to health or soundness; to repair or set right; to restore to spiritual wholeness

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**Teaching for Diversity and Social Justice: A Sourcebook, Maurianne Adams, Lee Anne Bell, and Pat Griffin, editors. Routledge, 1997.**

**Center for Assessment and Policy Development**

| **RACIAL IDENTITY DEVELOPMENT THEORY** | Racial Identity Development Theory discusses how people in various racial groups and with multiracial identities form their particular self-concept. It also describes some typical phases in remaking that identity based on learning and awareness of systems of privilege and structural racism, cultural and historical meanings attached to racial categories, and factors operating in the larger socio-historical level (e.g. globalization, technology, immigration, and increasing multiracial population). |
| **RACIAL INEQUITY** | Racial inequity is when two or more racial groups are not standing on approximately equal footing, such as percentages of each ethnic group in terms of dropout rates, single family home ownership, access to healthcare, etc. |
| **RACIALIZATION** | Racialization is the very complex and contradictory process through which groups come to be designated as being of a particular “race” and on that basis subjected to differential and/or unequal treatment. Put simply, “racialization [is] the process of manufacturing and utilizing the notion of race in any capacity” (Dalal, 2002, p. 27). While White people are also racialized, this process is often rendered invisible or normative to those designated as White. As a result, White people may not see themselves as part of a race but still maintain the authority to name and racialize "others." |
| **RACIAL JUSTICE** | 1. The systematic fair treatment of people of all races, resulting in equitable opportunities and outcomes for all. Racial justice—or racial equity—goes beyond “anti-racism.” It is not just the absence of discrimination and inequities, but also the presence of deliberate systems and supports to achieve and sustain racial equity through proactive and preventative measures.

2. Racial Justice [is defined] as the proactive reinforcement of policies, practices, attitudes and actions that produce equitable power, access, opportunities, treatment, impacts and outcomes for all. |
| **RACIAL RECONCILIATION** | Reconciliation involves three ideas. First, it recognizes that racism in America is both systemic and institutionalized, with far-reaching effects on both political engagement and economic opportunities for minorities. Second, reconciliation is engendered by empowering local communities through relationship-building and truth-telling. Lastly, justice is the essential component of the conciliatory process—justice that is best termed as restorative rather than retributive, while still maintaining its vital punitive character. |


**Ibram X Kendi, How to be an Antiracist,** Random House, 2019

**Calgary Anti-Racism Resources** [http://www.aclrc.com/racialization](http://www.aclrc.com/racialization)

**1. Race Forward**


| RACISM | ● Racism = race prejudice + social and institutional power  
       | ● Racism = a system of advantage based on race  
       | ● Racism = a system of oppression based on race  
       | ● Racism = a White supremacy system Racism is different from racial prejudice, hatred, or discrimination.  
       | ● Racism involves one group having the power to carry out systematic discrimination through the institutional policies and practices of the society and by shaping the cultural beliefs and values that support those racist policies and practices. |
| RACIST | One who is supporting a racist policy through their actions or interaction or expressing a racist idea. |
| RACIST IDEAS | A racist idea is any idea that suggests one racial group is inferior or superior to another racial group in any way. |
| RACIST POLICIES | A racist policy is any measure that produces or sustains racial inequity between or among racial groups. Policies are written and unwritten laws, rules, procedures, processes, regulations and guidelines that govern people. There is no such thing as a nonracist or race-neutral policy. Every policy in every institution in every community in every nation is producing or sustaining either racial inequity or equity between racial groups. Racist policies are also express through other terms such as “structural racism” or “systemic racism”. Racism itself is institutional, structural, and systemic |
| REPARATIONS | States have a legal duty to acknowledge and address widespread or systematic human rights violations, in cases where the state caused the violations or did not seriously try to prevent them. Reparations initiatives seek to address the harms caused by these violations. They can take the form of compensating for the losses suffered, which helps overcome some of the consequences of abuse. They can also be future oriented—providing rehabilitation and a better life to victims—and help to change the underlying causes of abuse. Reparations publicly affirm that victims are rights-holders entitled to redress. |
| RESTORATIVE JUSTICE | Restorative Justice is a theory of justice that emphasizes repairing the harm caused by crime and conflict. It places decisions in the hands of those who have been most affected by wrongdoing, and gives equal concern to the victim, the offender, and the surrounding community. Restorative responses are meant to repair harm, heal broken relationships, and address the underlying reasons for the offense. Restorative Justice emphasizes individual and collective accountability. Crime and conflict generate opportunities to build community and increase grassroots power when restorative practices are employed. |
| SETTLER COLONIALISM | Settler colonialism refers to colonization in which colonizing powers create permanent or long-term settlement on land owned and/or occupied by other peoples, often by force. This contrasts with colonialism where colonizer’s focus only on extracting resources back to their countries of origin, for example. Settler Colonialism typically includes oppressive governance, dismantling of indigenous cultural forms, and enforcement of codes of superiority (such as White supremacy). Examples include White European occupations of land in what is now the United States, Spain’s settlements throughout Latin America, and the Apartheid government established by White Europeans in South Africa. Per Dino Gillio-Whitaker, “Settler Colonialism may be said to be a structure, not an historic event, whose endgame is always the elimination of the Natives in order to acquire their land, which it does in countless seen and unseen ways. These techniques are woven throughout the US’s national discourse at all levels of society. Manifest Destiny—that is, the US’s divinely sanctioned inevitability—is like a computer program always operating unnoticeably in the background. In this program, genocide and land dispossession are continually both justified and denied.” |
| STRUCTURAL RACIALIZATION | Structural racialization connotes the dynamic process that creates cumulative and durable inequalities based on race. Interactions between individuals are shaped by and reflect underlying and often hidden structures that shape biases and create disparate outcomes even in the absence of racist actors or racist intentions. The presence of structural racialization is evidenced by consistent differences in outcomes in education attainment, family wealth and even life span. |

The Movement for Black Lives [https://policy.m4bl.org/glossary/](https://policy.m4bl.org/glossary/)


### Structural Racism

1. The normalization and legitimization of an array of dynamics – historical, cultural, institutional and interpersonal – that routinely advantage Whites while producing cumulative and chronic adverse outcomes for people of color. Structural racism encompasses the entire system of White domination, diffused and infused in all aspects of society including its history, culture, politics, economics and entire social fabric. Structural racism is more difficult to locate in a particular institution because it involves the reinforcing effects of multiple institutions and cultural norms, past and present, continually reproducing old and producing new forms of racism. Structural racism is the most profound and pervasive form of racism – all other forms of racism emerge from structural racism.

2. For example, we can see structural racism in the many institutional, cultural and structural factors that contribute to lower life expectancy for African American and Native American men, compared to White men. These include higher exposure to environmental toxins, dangerous jobs and unhealthy housing stock, higher exposure to and more lethal consequences for reacting to violence, stress and racism, lower rates of health care coverage, access and quality of care and systematic refusal by the nation to fix these things.

### Targeted Universalism

Targeted universalism means setting universal goals pursued by targeted processes to achieve those goals. Within a targeted universalism framework, universal goals are established for all groups concerned. The strategies developed to achieve those goals are targeted, based upon how different groups are situated within structures, culture, and across geographies to obtain the universal goal. Targeted universalism is goal oriented, and the processes are directed in service of the explicit, universal goal.

### White Fragility

“A state in which even a minimum amount of racial stress becomes intolerable [for White people], 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” 30 31


3. *White Fragility, Robin DiAngelo*
<table>
<thead>
<tr>
<th><strong>WHITE PRIVILEGE</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Refers to the unquestioned and unearned set of advantages, entitlements, benefits and choices bestowed on people solely because they are White. Generally White people who experience such privilege do so without being conscious of it.</td>
</tr>
<tr>
<td>2. Structural White Privilege: A system of White domination that creates and maintains belief systems that make current racial advantages and disadvantages seem normal. The system includes powerful incentives for maintaining White privilege and its consequences, and powerful negative consequences for trying to interrupt White privilege or reduce its consequences in meaningful ways. The system includes internal and external manifestations at the individual, interpersonal, cultural and institutional levels. The accumulated and interrelated advantages and disadvantages of White privilege that are reflected in racial/ethnic inequities in life-expectancy and other health outcomes, income and wealth and other outcomes, in part through different access to opportunities and resources. These differences are maintained in part by denying that these advantages and disadvantages exist at the structural, institutional, cultural, interpersonal and individual levels and by refusing to redress them or eliminate the systems, policies, practices, cultural norms and other behaviors and assumptions that maintain them.</td>
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<tr>
<td>Interpersonal White Privilege: Behavior between people that consciously or unconsciously reflects White superiority or entitlement.</td>
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<tr>
<td>Cultural White Privilege: A set of dominant cultural assumptions about what is good, normal or appropriate that reflects Western European White world views and dismisses or demonizes other worldviews.</td>
</tr>
<tr>
<td>Institutional White Privilege: Policies, practices and behaviors of institutions -- such as schools, banks, non-profits or the Supreme Court -- that have the effect of maintaining or increasing accumulated advantages for those groups currently defined as White, and maintaining or increasing disadvantages for those racial or ethnic groups not defined as White. The ability of institutions to survive and thrive even when their policies, practices and behaviors maintain, expand or fail to redress accumulated disadvantages and/or inequitable outcomes for people of color.</td>
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<tr>
<td>WHITE SUPREMACY</td>
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<td>-----------------</td>
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</tbody>
</table>
| WHITE SUPREMACY CULTURE | 1. White Supremacy Culture refers to the dominant, unquestioned standards of behavior and ways of functioning embodied by the vast majority of institutions in the United States. These standards may be seen as mainstream, dominant cultural practices; they have evolved from the United States’ history of White supremacy. Because it is so normalized it can be hard to see, which only adds to its powerful hold. In many ways, it is indistinguishable from what we might call U.S. culture or norms – a focus on individuals over groups, for example, or an emphasis on the written word as a form of professional communication. But it operates in even more subtle ways, by actually defining what “normal” is – and likewise, what “professional,” “effective,” or even “good” is. In turn, White culture also defines what is not good, “at risk,” or “unsustainable.” White culture values some ways – ways that are more familiar and come more naturally to those from a White, western tradition – of thinking, behaving, deciding, and knowing, while devaluing or rendering invisible other ways. And it does this without ever having to explicitly say so...

2. White supremacy culture is an artificial, historically constructed culture which expresses, justifies and binds together the United States White supremacy system. It is the glue that binds together White-controlled institutions into systems and White-controlled systems into the global White supremacy system. |

1. The term White, referring to people, was created by Virginia slave owners and colonial rules in the 17th century. It replaced terms like Christian and Englishman to distinguish European colonists from Africans and indigenous peoples. European colonial powers established Whiteness as a legal concept after Bacon’s Rebellion in 1676, during which indentured servants of European and African descent had united against the colonial elite. The legal distinction of White separated the servant class on the basis of skin color and continental origin. The creation of ‘Whiteness’ meant giving privileges to some, while denying them to others with the justification of biological and social inferiority.

2. Whiteness itself refers to the specific dimensions of racism that serve to elevate White people over people of color. This definition counters the dominant representation of racism in mainstream education as isolated in discrete behaviors that some individuals may or may not demonstrate, and goes beyond naming specific privileges (McIntosh, 1988). Whites are theorized as actively shaped, affected, defined, and elevated through their racialization and the individual and collective consciousness formed with it (Whiteness is thus conceptualized as a constellation of processes and practices rather than as a discrete entity (i.e. skin color alone). Whiteness is dynamic, relational, and operating at all times and my myriad levels. These processes and practices include basic rights, values, beliefs, perspectives and experiences purported to be commonly shared by all, but which are actually only consistently afforded to White people.

<table>
<thead>
<tr>
<th>WHITENESS</th>
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<tbody>
<tr>
<td>1. Race: The Power of an Illusion, PBS</td>
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<td>2. White Fragility, Robin DiAngelo</td>
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