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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Author 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 in 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 resources in Boston 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 and the work of peer institutions, 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, biased medical research and medical 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 a 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 the Doctoring course 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 or to 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 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 is in need of 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 curriculum. The curriculum was 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 (Listed in 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**
6. **Create a Systematic Process for Dynamic Curricular Review & Didactic Support**
7. **Community Partnerships and Resource Guide**
8. **Continue to Foster Student Engagement – see 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, 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 medical student volunteers did 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 Doctoring and Human Behavior in Medicine curricula were not reviewed in detail as they are in flux, but VIG members have offered some broad suggestions for those classes 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.

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, and see each curricular Appendix for 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 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 "risk factor" language, but it is recommended that BUSM make an effort to remove this harmful language.

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 the appendix, 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). *Breathing race into the machine: The surprising career of the spirometer from plantation to genetics*. U of Minnesota Press.) or inviting 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 on 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 findings in terms of strengths, weaknesses and opportunities, but call for further efforts to explore existing anti-racism curricula.

Broad Findings

BUSM Strengths in Discussing Race in Medicine

1. Developing History-Taking Skills to Broaden 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 the students' 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 which 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.

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."

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 Pryia 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.

Appendices B and C have been removed as they contain identifiable information.

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
- 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

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.

Creating Leadership & Education to Address Racism 104

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)

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

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 is 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 in 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

Name and Contact	About
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/BlackLivesMatterBOS/	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.

Boston Education Justice Alliance http://www.bostonedjustice.org/	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.
Boston Mobilization http://bostonmobilization.org/suburban-justice-program/	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.
The Boston Racial Justice and Equity Initiative http://www.futureboston.com/about/our-pov/you-all-should-know-about-boston-racial-justice-and-equity-initiative	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.
Boston Student Advisory Council http://www.youthonboard.org/bsac	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.
Boston Teacher Action Group www.tagboston.org	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.
The Cambridge Center for Adult Education https://ccae.org/	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 & White Women: Reconciling Our Past, Re-Defining Our Future.
Center for Teen Empowerment http://teenempowerment.org/	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.

Citizens for Juvenile Justice www.cfjj.org	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.
City Life / Vida Urbana http://www.clvu.org/	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.
Community Change, Inc. http://www.communitychangeinc.org/	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.
Criminal Justice Policy Coalition http://www.cjpc.org/	CJPC is a member-based, non-profit organization dedicated to the advancement of effective, just, and humane criminal justice policy in Massachusetts
CrossRoads: Antiracism Organizing & Training http://crossroadsantiracism.org/	CrossRoads' mission is to dismantle systemic racism and build antiracist multicultural diversity within institutions and communities implemented primarily by training institutional transformation teams.
Enroot http://www.enrooteducation.org/about-u/	Enroot empowers immigrant youth in Cambridge to achieve academic, career, and personal success through inspiring out-of-school experiences.
Haley House http://haleyhouse.org/	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.
Hard Conversations: An Introduction to Racism. http://www.37days.com/racism/	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.

Haymarket People's Fund http://www.haymarket.org/	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.
Hispanic Black Gay Coalition (HBGC) http://www.hbgc-boston.org/	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
Mass Mentoring Partnership http://massmentors.org/	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.
Massachusetts Advocates for Children http://massadvocates.org/	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.
Massachusetts Immigrant & Refugee Advocacy Coalition https://www.miracoalition.org/	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.
National Association for the Advancement of Colored People http://www.naacp.org/	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.
The National Coalition Building Institute www.ncbi.org	The National Coalition Building Institute is an international non-profit leadership development network dedicated to the elimination of racism and other forms of oppression. Rooted in an understanding of individual, community, and systemic change, NCBI leaders work with public and private organizations to further cultural competence, collaboration and partnerships, and effective relationships within and across group identities.

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.sociedadlatina.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/

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
9. Mentoring of students. Pipeline efforts.
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.

4. Glossary of Terms

About Racial Equity Tools • Racial Equity Tools. Racialequitytools.org. (2019). Retrieved 19 June 2020, from https://www.racialequitytools.org/about.

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.	*Accountability and White Anti-Racist Organizing: Stories from Our Work, Bonnie Berman Cushing with Lila Cabbil, Margery Freeman, Jeff Hitchcock and Kimberly Richards*
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.	*1) "The Dynamic System of Power, Privilege and Oppressions, OpenSource Leadership Strategies."* *2) Center for Assessment and Policy Development.*
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.	*The Movement for Black Lives https://policy.m4bl.org/glossary*

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*
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.	*Teaching for Diversity and Social Justice: A Sourcebook. Maurianne Adams, Lee Anne Bell, and Pat Griffin, editors. Routledge, 1997.*
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.	*Colonization and Racism. Film Emma LaRocque, PhD, Aboriginal Perspective, See Race and Colonialism, ed. Robert Ross https://link.springer.com/book/10.1007/978-94-009-7544-6* *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.	*"Colors of Resistance Archive" Accessed June 28 2013.*

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, ttps://policy.m4bl.org/glossary/* *What Is Decolonization and Why Does It Matter? Eric Ritskes https://intercontinentalcry.org/what-is-decolonization-and-why-does-it-matter/*
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.* *2) "Laws Enforced by EEOC" U.S. Equal Employment Opportunity Commission Accessed June 28 2013*
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* *2. Baltimore Racial Justice Action*

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."	*1. Glossary of Terms UC Berkeley Center for Equity, Inclusion and Diversity* *2. Baltimore Racial Justice Action*
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).	*Teaching for Diversity and Social Justice: A Sourcebook. Maurianne Adams, Lee Anne Bell, and Pat Griffin, editors. Routledge, 1997.*
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.	*State of the Science Implicit Bias Review 2013, Cheryl Staats, Kirwan Institute, The Ohio State University.*
INCLUSION	Authentically bringing traditionally excluded individuals and/or groups into processes, activities, and decision/policy making in a way that shares power.	*Some Working Definitions, OpenSource Leadership Strategies*
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.	*United Nations Working Group for Indigenous Peoples*

INDIGENEITY 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).	*United Nations Working Group for Indigenous Peoples*
INDIVIDUAL RACISM	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: ● Telling a racist joke, using a racial epithet, or believing in the inherent superiority of whites over other groups; ● 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"); ● Accepting things as they are (a form of collusion).	*Flipping the Script: White Privilege and Community Building. Maggie Potapchuk, Sally Leiderman, Donna Bivens and Barbara Major. 2005.*
RACISM	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: ● • 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"). ● • City sanitation department policies that concentrate trash transfer stations and other environmental hazards disproportionately in communities of color.	*Flipping the Script: White Privilege and Community Building. Maggie Potapchuk, Sally Leiderman, Donna Bivens and Barbara Major. 2005.*

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.	*Internalized Racism: A Definition, Donna Bivens, Women's Theological Center. 1995*
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	*Tools and Concepts for Strengthening Racial Equity, Presentation to School District U-46, Terry Keleher, Applied Research Center, 2011.*

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	*1. Intergroup Resources, 2012* *2. Kimberlé Williams Crenshaw https://www.them.us /story/kimberle-crenshaw-lady-phyll-intersectionality*
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. .	*"Microaggressions: More than Just Race," Derald Wing Sue, Psychology Today, November 17, 2010.*
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.	*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. Oppression = Power + Prejudice	*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.	*Race Forward, "Race Reporting Guide"*
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.	*Intergroup Resources, 2012 Alberta Civil Liberties Research Center http://www.aclrc.com/racism-and-power*
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.	*A Community Builder's Tool Kit. Institute for Democratic Renewal and Project Change Anti-Racism Initiative.*
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.	*Colors of Resistance Archive Accessed June 28, 2013.*

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: • 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.	*PBS, Race: Power of an Illusion Paul Kivel, Uprooting Racism: How White People Can Work for Racial Justice (Gabriola Island, British Columbia: New Society Publishers, 2002), p.141.*
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.	*Teaching for Diversity and Social Justice: A Sourcebook. Maurianne Adams, Lee Anne Bell, and Pat Griffin, editors. Routledge, 1997.*
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.	*Center for Assessment and Policy Development*
RACIAL HEALING	To restore to health or soundness; to repair or set right; to restore to spiritual wholeness	*Racial Equity Resource Guide, W. K. Kellogg Foundation, Michael R. Wenger, 2012*

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).	*New Perspective on Racial Identity Development: Integrating Emerging Frameworks, Charmaine L. Wijeyesinghe and Bailey W. Jackson, editors. NYU Press, 2012.*
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.	*Ibram X Kendi, How to be an Antiracist, Random House, 2019*
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."	*Calgary Anti-Racism Resources http://www.aclrc.com/racialization*
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.	*1. Race Forward* *2. Catalytic Change: Lessons Learned from the Racial Justice Grantmaking Assessment Report, Philanthropic Initiative for Racial Equity and Applied Research Center, 2009.*
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.	*Position Statement on Reconciliation, The William Winters Institute for Racial Reconciliation, 2007.*

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.	*Dismantling Racism Works Web Workbook*
RACIST	One who is supporting a racist policy through their actions or interaction or expressing a racist idea.	*Ibram X Kendi, How to be an Antiracist, Random House, 2019*
RACIST IDEAS	A racist idea is any idea that suggests one racial group is inferior or superior to another racial group in any way.	*Ibram X Kendi, How to be an Antiracist, Random House, 2019*
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	*Ibram X Kendi, How to be an Antiracist, Random House, 2019*
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.	*International Center for Transitional Justice*

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.	*The Movement for Black Lives https://policy.m4bl.org/glossary/*
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."	*Settler Fragility: Why Settler Privilege Is So Hard to Talk About, Dina Gilio-Whitaker https://www.beaconbroadside.com/broadside/2018/11/settler-fragility-why-settler-privilege-is-so-hard-to-talk-about.html*
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.	*Systems Thinking and Race Workshop Summary. John A. Powell, Connie Cagampang Heller, and Fayza Bundalli. The California Endowment, 2011.*

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.	***1.*** *Racial Justice Action Education Manual. Applied Research Center, 2003.* ***2.*** *Flipping the Script: White Privilege and Community Building. Maggie Potapchuk, Sally Leiderman, Donna Bivens and Barbara Major. 2005.*
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.	*Targeted Universalism: Policy & Practice A Primer , John A. Powell, Stephen Menendian, Wendy Ake*
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	*White Fragility, Robin DiAngelo*

WHITE PRIVILEGE	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. 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. *Interpersonal White Privilege:* Behavior between people that consciously or unconsciously reflects white superiority or entitlement. *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. *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.	***1.*** *White Privilege and Male Privilege: A Personal Account of Coming to See Correspondences Through Work in Women Studies. Peggy McIntosh. 1988.* ***2.*** *A 21st Century Leadership Capacity, CAPD, MP Associates, World Trust Educational Services, 2012Transforming White Privilege:*
WHITE SUPREMACY	White supremacy is a historically based, institutionally perpetuated system of exploitation and oppression of continents, nations and peoples of color by white peoples and nations of the European continent; for the purpose of maintaining and defending a system of wealth, power and privilege.	*Challenging White Supremacy Workshop, Sharon Martinas Fourth Revision. 1995.*

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. *Paying Attention to White Culture and Privilege: A Missing Link to Advancing Racial Equity, by Gita Gulati-Partee and Maggie Potapchuk, The Foundation Review, Vol. 6: Issue 1 (2014).* 2. *Challenging White Supremacy Workshop,Sharon Martinas Fourth Revision. 1995.*

WHITENESS	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.	*1. Race: The Power of an Illusion, PBS* *2. White Fragility, Robin DiAngelo*

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