# Faculty guide for an anti-racist and social justice approach to medical education

**When writing clinical cases or exam questions:**

* A patient’s demographic description should not include racial qualifier unless this is intentional and very pertinent to the case and teaching points, such as a case that teaches about implicit bias or Ashkenazi Jewish genetic diseases…
* Description of patients’ histories, health beliefs, and practices should direct attention to unique patient circumstances and social and structural determinants of health, as opposed to racial/cultural stereotypes.1
* *Example: Miguel is a 16-year-old boy who presented to the ED with a left thigh laceration from fighting at school…(better to use a generic first name in this case)*
* *Example: A 38-year-old woman G6P5015, presented with abdominal pain…social history: she is unemployed, has SNAP benefits and Medicaid insurance*…INCLUDE DETAILS THAT PROVIDE ADDITIONAL PERSPECTIVES SUCH AS...*she used to work as a legal aid for a law firm but had to quit to care for her last born with developmental disability*
* Exercise caution and restraint when offering instructions on how to approach patients based solely on their racial/cultural identity. Model how physician should inquire about each patient’s beliefs, regardless of patients’ race/culture.
* Avoid attributing etiologies of disease as due solely to behaviors without any social context such as *racial disparities in adolescent obesity are attributed to “increased consumption of processed foods.”* Ask why do some individuals preferably consume processed or fast foods?
* Avoid portraying a sense of futility in addressing social and structural causes of disease and illness (*Mr. S repeatedly presented to the ED with alcohol intoxication…prior efforts to get him rehabilitation…ADD he is very motivated to quit drinking at this visit…)*
* Use names and photos that portray minority identities among patients, students and physicians that reflect the current US population. Patients of color and/or minority culture should exhibit a broad variety of healthy and unhealthy behaviors.
	+ *A trans man and his girlfriend returned from a boating trip and developed URI symptoms…*
* Avoid using a patient’s racial/cultural identity as a harbinger of pathology covered later in the case; similarly, avoid using race in exam questions as a clue for determining the “best” diagnosis without needing to pay attention to other details.
* Find opportunities to incorporate social needs or social determinants into a case (incorporate neighborhood, pollution, food insecurity, transportation, housing instability, etc. as well as more proximal determinants such as insurance status, healthcare access, navigation and cost of treatment.
* Highlight racism and social disadvantage as a source of chronic stress and disparities in health outcomes.
	+ The neuroendocrine and immune processes are involved in the stress response, and chronic exposure to stress can result in poor health and premature deaths.

**When discussing or including studies or publications in reading/assignments:**

* When highlighting studies that show **racial disparities in risk, diagnosis or treatment outcomes**:
	+ Encourage students to question the true relationship between race and disease, question whether the observed “genetic” differences are due to external factors such as social inequalities and/or institutional racism.
	+ If authors mentioned “unknown or unmeasured genetic or biological factors,” point out that this analytical framing ignores racism as the mechanism by which racial categorizations have biological consequences. Sometimes authors mentioned societal factors but the term “racism” was never mentioned. Racism, not race, is a risk factor.
	+ Be vigilant or critical of work that suggests or espouses biological race or provides a genetic basis for racial differences in health outcomes.
	+ If authors mentioned “**patient mistrust**” as a driver of disparities, point out that this framing obscures other etiologies of racial health inequities and essentially blames affected patients for their problems and suffering. Mistrust is often the result of mistreatment and negative interactions with the healthcare system.
	+ If authors mentioned “**nonadherence or noncompliance**,” discuss root causes of nonadherence such as cost, fear, miscommunication, complexity of regimen, etc., and it is not a personal failing or irresponsibility.
	+ Discuss rationale for using race in the experimental design or as an epidemiological risk factor. Faculty must be intentional when including race as a risk factor for disease and must include relevant literature to support these assertions.

**When suggesting clinical algorithm in patient care:**

* Re-examine the use of race in prediction algorithms and artificial intelligence
* Critically review an algorithm’s inputs and outputs as well as objective function
* For a list of race adjusted algorithms, click [here](https://www.nejm.org/doi/full/10.1056/NEJMms2004740)2
* If any of these is mentioned in a syllabus, provide a qualified statement/rationale for continued use

**When implicit bias or racism arises in discussion**:

* Refrain from racism-evasive rhetoric by using our own experiences, such as overcoming adversity growing up, community activism, travel to “Africa,” inter-racial marriage, etc. to justify your anti-racist credentials or liberal progressiveness.
* Don’t try to dissipate racial tension during these conversations; embrace discomfort and dialogue as these moments are potentially powerful learning opportunities for all involved
* Do not imply that communication skills and cultural competency among others can be mastered like some knowledge; teaching in this area suffers from lack of curricular time, space for reflection and dialogue as well as the difficulties of assessing learning in this area
* Also acknowledge that we will not end inequities by only focusing on clinicians’ implicit bias or unconscious beliefs; we should also confront explicit practices that perpetuate systemic inequities. Lastly, acknowledge that the evidentiary basis for effective strategies to attain racial equity is still in its infancy. More work needs to be done!

References

1. Krishnan A, Rabinowitz, M, Ziminsky A, Scott SM, Chretien KC. Addressing Race, Culture, and Structural Inequality in Medicine Education: A Guide for Revising Teaching Cases. Acad Med 2019; 94:550-555
2. Vyas DA, Eisenstein LG, Jones DS. Hidden in Plain Sight—Reconsidering the Use of Race Correction in Clinical Algorithms. NEJM 2020.