Addressing Race, Culture, & Structural Inequality in Medical Education:

A Guide for Revising Teaching Cases

Remove -

Unnecessary content which may promote stereotypes.

Replace -

E.g replace some slides of white skin with more representative slides of many skin colors, replacing outdated or offensive terminology with more appropriate language.

Add / Contextualize -

Include women and people of color in a lecture on the history of medicine, discussing why a race-based disease association might exist.

Acknowledge -

Or attach a disclosure for the content. For example: Acknowledge that race based GFR corrections are not based in science but may appear in standardized tests.

UCF MED
Office of Diversity, Equity & Inclusion

Adapted from "Creating diverse, equitable and inclusive content in health in medical education." (International Association of Medical Science Educators Spring Webinar Series, 4 March 2021)

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Background

Studies demonstrate that educators and cultural competency-based curricula, although well-intentioned, may inadvertently reinforce stereotypes. Racial or cultural profiling and stereotyping of patients by providers can result in delayed or missed diagnoses and contribute to poorer patient outcomes.

Toolkit Goals

- Provide a practical guide for medical educators to use to revise existing teaching cases
- Improve the delivery of critical concepts surrounding race and culture in medical education

Strategies for Revising Teaching Case

Questions to ask when preparing a vignette:

1. Is the information within this vignette/question stem at risk for bias?
    a. In what ways does this bias affect learners?
    b. Does this vignette include a social identifier for the patient, physician, or other subjects?
2. What are the learning objectives for this vignette or question stem?
    a. Should the learning objectives be changed in order to prevent bias? if so, how?

When reviewing the details of a case study or vignette, think about how it would affect learners if every patient with that condition was presented as being of a particular race, ethnicity, sexual orientation, etc.

RACE

Cases should be written such that when patients from historically marginalized groups are incorporated into a test question or case, they are not automatically assumed to be racially and/or culturally different from the case author, physician, or medical student

- When constructing a question around a patient from a historically marginalized group, try and consider how a physician from the same racial and/or cultural background as the patient might interact with this patient.
    - Such as the use of language like “we,” “they,” etc.

Avoid using a patient’s race, cultural identity, and/ or sexual identity as a harbinger of pathology in cases when possible.
For example, A 22-year-old Black male with a past medical history of sickle cell anemia presents with lower extremity pain.

A 42-year-old *homosexual* man who has been active with multiple partners without taking precautions experiences fever and persistent headaches for about a month.

Include a variety of different portrayals of minority patients when developing questions. Try to avoid the frequent use of minority patients with pathologies classically associated with their race/culture.

- Although health disparities exist for many historically marginalized groups with respect to certain diseases, strive to develop questions that include these groups across all diseases and conditions.
- For example,
    - A black child is found to have leukemia instead of sickle cell disease
    - A trans woman is found to have meningitis instead of HIV/AIDS.

Patients from historically marginalized groups should exhibit a broad variety of healthy and unhealthy behaviors, avoiding exclusively unhealthy, stereotypical behaviors for minority patients:

- While racial and/or ethnic health disparities are important to understand, patients of color should not exclusively be depicted with obesity, underinsured status, diabetes, poverty, etc., as this reinforces implicit biases and worsens health outcomes.
- For example, A Latino couple brings their 7-year-old daughter in for DKA. By history, parents are middle-class, born and raised in the U.S., speak only English, exercise, and eat healthily. Health disparities related to DKA are discussed later in the case, but this patient's HPI does not fall back on cultural stereotypes/implicit biases, instead of adding diversity to our portrayal of Latino families. Furthermore, the didactic content on DKA is not impacted by this revision.

A strategy for incorporating health equity into cases is to elaborate on structural factors that may influence a patient's and/or a patient's family's actions or decisions.

- An African American 5 yo female patient presents to the emergency department 10 days after laceration repair to her right hand with a wound infection. The patient's family was informed to return 5 days after laceration repair for reevaluation and suture removal however failed**.**
    - As opposed to ending your scenario here, elaborate on the factors that may have prevented timely patient follow-up.
        - No reliable transportation
        - Family not able to obtain time off of work due to fear of getting fired
        - No reliable option for primary care follow-up

DIVERSE IMAGES

Case images/photos: Consider any implicit messages that images convey; does the depiction of a patient of color serve as a hint at what is to come later in the case (e.g.,

that a certain pathology will be discussed, or that a stereotypical set of SSDOH will be encountered)?

- Consider re-shooting photographs with a more diverse group of providers/patients/students or finding more diverse open-source Google images.

Rationale and evidence for case revisions:

- Students must be exposed to alternative portrayals of minority patients that move beyond reductionist views and exemplify the diversity within minority groups.
- Medical education must minimize essentialism.
    - the practice of regarding something (such as a presumed human trait) as having innate existence or universal validity rather than as being a social, ideological, or intellectual construct
- Structural competency skills are best learned when demonstrated in practice. The structural context in which patients live should be incorporated into the disease narrative as this may expose a modifiable risk factor different from those associated with the patient's stereotype.
- Ancestral origin can be related to disease prevalence in a very limited number of conditions. However, race in and of itself is not a biological risk factor; rather, the social context of racism can be a risk factor, which has led to certain health behaviors, disease prevalence, and health outcomes being commonly associated with certain races/ethnicities and cultures.
- While it is critical to learn how to understand, model empathy, and effectively communicate with people of different races and cultures, these provider-patient communication tactics should be taught and practiced because they are medically relevant and lead to improved health outcomes, not because a patient is a member of a racial/cultural group for which stereotypes exist (i.e., the same questions regarding patients' health beliefs can and should theoretically be used for minority and non-minority races and cultures)

Four ways to change content:

- *Remove* – unnecessary content which may promote stereotypes.
- *Replace* – e.g, replace some slides of white skin with more representative slides of many skin colors, replacing outdated or offensive terminology with more appropriate language.
- *Add/Contextualize* – include women and people of color in a lecture on the history of medicine, discussing why a race-based disease association might exist.
- *Apologize* – or attach a disclosure for the content. Acknowledge that race-based GFR corrections are not based in science but may appear in standardized tests.

CHECKLIST

Consider the questions listed below when reviewing your teaching cases. These questions may help you identify inequities within your cases and empower you to lean on the content and strategies discussed within this toolkit.

Race & Ethnicity
Does the case include any mention of race, ethnicity, gender, sex, or sexual orientation?
If yes, is it epidemiologically or diagnostically pertinent based on evidence? ***If yes – keep*** ***If no – remove***
Do social/ structural determinants of health also contribute to the difference? ***If yes – contextualize*** ***If no – keep but show evidence-based work up and management.***
Are biological differences between racial or ethnic groups present based on previously used or established racially separated scoring systems for disease? Do they still appear on standardized tests and thus are necessary to mention? ***If yes – add disclosure acknowledging this***
Could this be a case where a positive representation of minority populations can be exhibited? ***If yes – consider adding more diverse patient identities in questions and images.***
Using Diverse Images
Does the image(s) you have incorporated into your case add value to the case based on current evidence? ***If yes – keep*** ***If no – remove/change***
Does the image(s) encourage stereotypes or promote bias? ***If yes – remove/change*** ***If no – keep***
Are the pictures of people depicted within the case racially and ethnically diverse? ***If yes – keep*** ***If no – consider adding if reasonable***

Do the person(s) represent the full spectrum of skin tones or other physical features? ***If yes – keep*** ***If no – consider adding if reasonable***
Does the case include any mention of sexual behavior, sexuality, or sexual orientation? ***If yes – is it positively represented?*** ***If no – would the case benefit from mentioning it?***

Sex and Gender
Are all sexes, genders, and/or sexual orientations appropriately represented? ***If yes – keep*** ***If no – consider adding if reasonable***
If biological sex is presented in a binary fashion, is it appropriate? ***If yes – keep*** ***If no – consider adding if reasonable***
Is gender presented as part of a spectrum, rather than a binary concept? ***If yes – keep*** ***If no – consider adding if reasonable***
Is the medical student or physician always a "he"? Is the nurse always a "she"? ***If yes – remove/change*** ***If no – keep***
Could the content be perceived as promoting stereotypes, bias, shame, or stigma? ***If yes – remove/change*** ***If no – keep***
Immigration status
Is the patient's immigration status a learning point for access to care? ***If yes – contextualize*** ***If no – remove***
Is this case an opportunity for teaching cultural competency? ***If yes – contextualize*** ***If no – add education on it if appropriate***