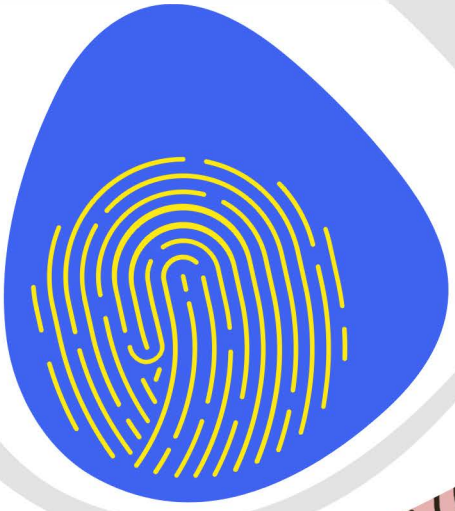
ACADEMIC HALF DAY LECTURES

TEMERTY FACULTY OF MEDICINE
UNIVERSITY OF TORONTO

GUIDELINES
FOR INCLUSIVITY



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GRATITUDE

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PRINCIPLES OF USE

We hope that others who wish to share these guidelines or use them as a building block for their own institutions and programs reflect on how they can be adapted to the unique challenges faced by their own communities.

These guidelines are intended to be an introduction to the topics of inclusivity, anti-racism, and anti-oppression and how these concepts can be practically integrated into medical education.

There is a vast body of literature, including several articles which are referenced in this document, which deserves further study to gain a deeper understanding of these complex topics.

We hope that the following principles will facilitate responsible use and dissemination of these guidelines for inclusivity.

We acknowledge that we are situated on the traditional home of nations including the Mississaugas of the Credit, the Anishinaabe, the Chippewa, the Haudenosaunee, and the Wendat peoples, and that Turtle Island continues to be the home of many diverse First Nations, Inuit, and Métis.

We acknowledge the labour of medical learners, staff, and faculty that has gone into the creation and review of this document and are grateful for their time.

PRINCIPLE 1:
Equity, Diversity & Inclusivity

Terminology and resources are included throughout these guidelines to encapsulate our diverse health care community and population. The authors aim for inclusivity and use of culturally safe terminology, while recognizing that there is no perfect way to do this and that there will be room to expand and diversify our guidelines. We have outlined suggestions for how to use these principles to foster anti-oppression in our practice.

PRINCIPLE 2:
Ease of Use

The guidelines will be available online through the Women's College Centre for Wise Practices in Indigenous Health and University of Toronto Department of Medicine and available in PDF format for ease of sharing and use.

PRINCIPLE 3:
Dissemination of Information

The authors ask that these guidelines are disseminated and shared in their original format without manipulation, unless clarified with the original authors. The authors ask that when the information is disseminated that the group's details on the cover and gratitude page are included to recognize the contributions of our authors.

PRINCIPLE 4:
Supplement & Guide to Other Teaching & Resources

The authors of this guideline recognize that there are many resources available on the topic of inclusivity in medical education and there is no one right way to share this information. This is not a prescriptive manual, rather a supplement to discussions, lectures, and other resources through training programs.

PRINCIPLE 5:

Referencing & Information Sources

The references for terminology and other content are cited via hyperlinks and with reference links in the latter pages. If referencing information within this document, we recommend citing original sources of information where factual information or terminology was obtained as well as our guidelines should content be used from here.

PRINCIPLE 6:

Document Renewal & Updating

Similar to our first principle, we recognize the limitations of our work and that there will be updates in the field of equity, diversity, and inclusion. Our Resident Interest Group in Social Advocacy (RIGSA) committee members plan to update this document on an ongoing basis with The Centre for Wise Practices in Indigenous Health, as community feedback, new ideas, practices, and beliefs surface and shape medical practice.

PRINCIPLE 7:

Transparency & Feedback

Our group is very receptive to feedback and suggestions from others and would be more than happy to receive input from others on how to improve our guidelines. Please contact us should you feel there are other additions that would be beneficial for users or readers: rigsa.utoronto@gmail.com

WCIHI CWP INDIGENOUS HEALTH

is dedicated to supporting these principles in their immediate publication and longitudinal goals of accountability, ease of use and dissemination to supplement teaching resources.

RELEVANCE & AIM

In keeping with the Temerty Faculty of Medicine strategic focus on Excellence through Equity, the purpose of these guidelines is to incorporate inclusive, anti-racist, and anti-oppression practices throughout medical education, highlighting their importance in every aspect of patient care.

CONSIDERATIONS WHEN DEVELOPING LECTURES

What are the key health inequities in your specialty?

What biases/assumptions exist and are perpetuated in your specialty?

Which populations are not reflected in the large studies in your specialty?

Who is prioritized in your specialty; do these prioritizations have any non-inclusive tendencies?

What assumptions do you have that might be reflected in the language used in your presentation? (e.g., that most people who use IV drugs are without a fixed address, that people with diabetes do not take steps to lose weight/take care of their health, etc.).

Are your case-based examples reflective of the diversity of patients in Canada?

How accessible are your suggestions for treatment (pharmacologic/non-pharmacologic)? Do these therapies work differently in various patient populations?

Are epidemiologic figures presented in a way that promote premature diagnostic closure or generalizations? Is there data exploring why these disparities exist? (e.g., populations disproportionately affected by TB/HIV, alcohol use).

Consider integrating a land acknowledgement and linking to colonization and current health inequities facing Indigenous populations.

TAKE TIME TO REFLECT:

Your own implicit biases (i.e., **subconscious behaviours** or **stereotypes that affect our interactions** with others).

Your prior experiences and how they shape your practice (e.g., did you train in Canada? Have you worked elsewhere? Have you seen or experienced certain things that might influence the "knowledge pearls" that you share?).

Your value system and how it influences your clinical decision making.

CHECK-IN

Does my attempt to be inclusive reinforce stereotypes or tokenize the represented population?

Try to avoid exclusively using examples that may reinforce negative stereotypes about particular groups (i.e., consistently using examples of a man who has sex with men to teach about sexual transmitted infections or HIV, consistently using examples of people living with homelessness to teach about substance use disorders, or consistently using examples of South Asian people to teach about diabetes).

Examples Of Topics in Different Specialties That Incorporate Inclusivity:

- Dermatologic signs/rashes in non-white skin
- Hypertension management in Black barbershops
- Use of race in measurement of renal function
- Racism and sickle cell disease
- Ageism and inclusion in care decisions
- Access to medications (e.g., drug coverage, access to a refrigeration, health literacy, etc.).
- Language barriers, variable access to translation, and importance of effective communication

CREATING AN INCLUSIVE LEARNING ENVIRONMENT

DO'S	DON'TS
Recognize not all identities of patients or students are visible or known (Iceberg of Identities).	Don't assume an identity group being discussed is not represented in the room.
Recognize that most people are not experts on any experiences beyond their own and are not capable of speaking for their entire group (or others) for which they identify.	Don't assume a member of group can or is willing to speak on the group's behalf.
Work to create a safe space for all identities.	Don't lock eyes with a student who you think represents a group you are discussing. This action assumes their identities and opinions, potentially "outs" them, and puts them on the spot.

LANGUAGE

INSTEAD OF THIS...	TRY THIS
Addict, user, alcoholic	Patient with substance use disorder, people who use drugs, patient who drinks alcohol
Handicapped, handi-capable	People who are disabled, person with a disability, distinguish 'functional limitation'
Obese, obese person, that person is obese	Person with obesity, patient has obesity, Patient with 'X weight' or 'body mass index of X'
Reducing the person with a condition to the condition itself (Ex. Diabetic, vasculopath)	Person with diabetes, person with CAD/PVD
Suffers from... [illness]	Living with [illness] unless the person identifies the illness as 'suffering'
Patient is wearing a 'diaper' or 'bib'	'Brief' or 'apron/protective clothing'
Resistant	'Isn't ready for' or 'not open to' or explain why
'Frequent flyer' or 'bounce back'	'Patient returning to hospital'
Non-compliant, non-adherent	'Declining X because Y'; identify barriers or underlying reasons
'Failure to cope' or 'acopic'	Functional decline, or more specific diagnosis

SUGGESTIONS FOR REFORMATTING EXISTING CASES *click text or image to access citation*

Section 3. Description of patients' histories, health beliefs, and practices should direct attention to unique patient circumstances and social and structural determinants of health (SSDOH), as opposed to racial/cultural stereotypes.

Does your case include:

[ ] A patient of color and/or minority culture?

[ ] Attribution of a patient's health belief or practice to cultural values, beliefs or practices?

[ ] Guidance on how to approach minority patients (based on their "unique belief systems" as a group)?

Suggested case edits:

[ ] Cases should be written such that minority patients are not automatically assumed to be "the other" (racially/culturally different from the case author, physician or medical student):

- Consider how a physician from the same racial/cultural background as the patient might interact with this patient.
- Explore whether the case might be written differently from that point of view. (Consider language like "we," "they," etc.)

[ ] Avoid use of patient's racial/cultural identity as a harbinger of pathology covered later in the case:

- Mentioning relevant SSDOH and health disparities for certain pathologies is important, but strive to include a variety of different portrayals of minority patients (not always giving them pathologies classically associated with their race/culture).
- Good example: A black child is found to have leukemia, instead of sickle cell disease.
- Good example: A trans woman is found to have meningitis, instead of HIV/AIDS.

[ ] Exercise caution and restraint when offering instructions on how to approach patients based solely on their racial/cultural identity:

- Ask patients about their beliefs, instead of assuming that because they are Latino, they believe in *fatalismo* (fatalism), for instance. A Latino patient may still report a belief in *fatalismo*, but the physician must model how to inquire about each patient's belief system, regardless of patient's race/culture.
- If instructions are offered, provide evidence that this assumption-based approach improves patient care/outcomes.
  - Good example: A patient self-identifies as a queer female teenager, so the physician asks for the patient's preferred gender pronouns. Then, evidence is provided that asking this question improves care for LGBTQ teens.
- All patients, rather than exclusively minority patients, should be asked about their belief systems when relevant.

[ ] Patients of color and/or minority culture should exhibit a broad variety of healthy and unhealthy behaviors, avoiding exclusively unhealthy, stereotypical behaviors for minority patients:

- While racial/ethnic health disparities are important to understand, patients of color should not exclusively be depicted with obesity, under-insured status, diabetes, poverty, etc., as this reinforces implicit biases and worsens health outcomes.[1]
- Good example: A Latino couple brings their 7yo daughter in for DKA. By history, parents are middle-class, born and raised in the U.S., speak only English, exercise, and eat healthy. 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 adding diversity to our portrayal of Latino families. Furthermore, the didactic content on DKA is not impacted by this revision (revised from Pediatrics, case 16).

[ ] Foster critical consciousness whenever assumptions are made about patients based on racial/cultural identity:

- Good example: Medical student interviews RR, a black female with obesity. In his oral presentation, he suggests helping RR get food stamps so that she can afford healthier food. The physician challenges the student to talk more with RR about her barriers to weight loss, and he learns that instead of access to healthy food (as he had assumed), RR's biggest barrier to weight loss is her long work hours as a bank executive sitting at a desk.

[ ] 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.

[ ] Provide the evidence:

- Literature is cited for health disparities that do exist for pathologies discussed in the case, regardless of this particular patient's race/culture, with brief discussion of structural/upstream factors.
- Links/references are offered to evidence the potential for medical harm that arises when assumptions are made about patients based on their perceived race/culture.

Rationale and evidence for case edits:

- 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.[2]
- 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.
- Race in and of itself is not necessarily a biological risk factor. However, 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 and cultures.[3]
- 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).[4]

References

1. Acquaviva KD, Mintz M. Perspective: Are we teaching racial profiling? The dangers of subjective determinations of race and ethnicity in case presentations. Acad Med. 2010;85:702–705.
2. Kumas-Tan Z, Beagan B, Loppie C, MacLeod A, Frank B. Measures of cultural competence: Examining hidden assumptions. Acad Med. 2007;82:548–557.
3. Metzl JM, Roberts DE. Structural competency meets structural racism: Race, politics, and the structure of medical knowledge. Virtual Mentor. 2014;16:674–690.
4. Wear D. Insurgent multiculturalism: Rethinking how and why we teach culture in medical education. Acad Med. 2003;78:549–554.

Abbreviations: LGBTQ indicates lesbian, gay, bisexual, transgender, queer or questioning; yo, year-old; DKA, diabetic ketoacidosis; HPI, history of present illness.

[a]The race and culture guide is based on virtual patient teaching cases from Aquifer's internal medicine, family medicine, and pediatrics courses as of August 2017. The full race and culture guide is available as Supplemental Digital Appendix 1 (http://links.lww.com/ACADMED/A628).