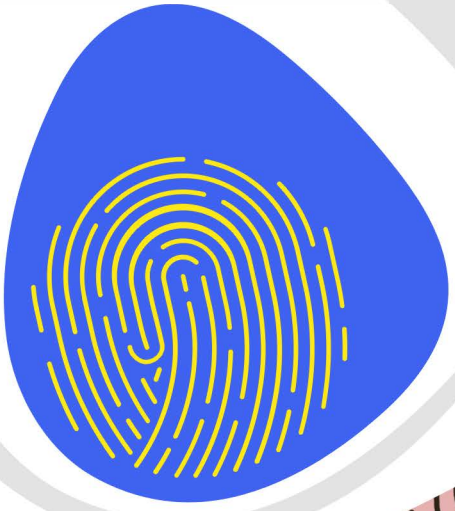
ACADEMIC HALF DAY LECTURES

TEMERTY FACULTY OF MEDICINE
UNIVERSITY OF TORONTO

GUIDELINES
FOR INCLUSIVITY



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RESIDENT INTEREST GROUP IN SOCIAL ADVOCACY
INTERNAL MEDICINE PROGRAM

GRATITUDE

For their expertise & contributions

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CONTENTS

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).

GENERAL TERMINOLOGY

For citations, please click the defined term to access hyperlink

ALLYSHIP

"There are many different definitions and descriptions of what it means to be an ally...To be an ally is to unite oneself with another to promote a common interest...Being an ally is more than being sympathetic towards those who experience discrimination. It is more than simply believing in equality. Being an ally means being willing to act with and for others in pursuit of ending oppression and creating equality."

CULTURE

"While definitions of culture vary, most agree that, at minimum, culture constitutes a set of behaviors and guidelines that individuals use to understand the world and how to live in it."

CULTURAL SAFETY

Includes "those actions that recognize and respect the cultural identity of others and take into consideration their needs and rights. Wood and Schwass developed their model on cultural safety in terms of:

3 Ds (DIMINISH, DEMEAN, DISEMPOWER)

3 Rs (RECOGNIZE, RESPECT, RIGHTS)

The 'Ds' define culturally unsafe practices and the 'Rs' define culturally safe ones, which are applicable to all cultures."

GENERAL TERMS CONT'D

For citations, please click the defined term to open hyperlink

DIVERSITY

Defined as a set of conscience practices that involve:

"Understanding and appreciating interdependence of humanity, cultures, and the natural environment.

Practicing mutual respect for qualities and experiences that are different from our own.

Understanding that diversity includes not only ways of being but also ways of knowing;

Recognizing that personal, cultural, and institutionalized discrimination creates and sustains privileges for some while creating and sustaining disadvantages for others;

Building alliances across differences so that we can work together to eradicate all forms of discrimination."

EQUITY

"Treating each individual according to his or her abilities and needs. This notion of equity, encompasses both providing the same resources to people with the same needs and giving more resources to people with more needs."

EQUALITY

"Equality, in contrast, aims to ensure that everyone gets the same things in order to enjoy full, healthy lives. Like equity, equality aims to promote fairness and justice, but it can only work if everyone starts from the same place and needs the same things."

EXPLICIT BIAS

"In the case of explicit or conscious [bias], the person is very clear about his or her feelings and attitudes, and related behaviors are conducted with intent. This type of bias is processed neurologically at a conscious level as declarative, semantic memory, and in words. Conscious bias in its extreme is characterized by overt negative behavior that can be expressed through physical and verbal harassment or through more subtle means such as exclusion."

GENERAL TERMS CONT'D

For citations, please click the defined term to open hyperlink

IMPLICIT BIAS

"The attitudes or stereotypes that affect our understanding, actions, and decisions in an unconscious manner. These biases, which encompass both favorable and unfavorable assessments, are activated involuntarily and without an individual's awareness or intentional control."

INTERSECTIONALITY

Theoretic tool and framework developed by scholar Kimberlé Crenshaw:
"Intersectionality is a lens through which you can see where power comes and collides, where it interlocks and intersects."

"Intersectionality involves the study of how race, gender, disability, sexuality, class, and other social categories are mutually shaped and interrelated with broader historical and global forces such as colonialism, neoliberalism, geopolitics, and cultural configurations to produce shifting relations of power and oppression (Hobbs & Rice, 2011; Hobbs & Rice, 2018.)"

ANOTHER DEFINITION FOR INTERSECTIONALITY

"Examining mutually constituted identities through historical, political, social and cultural lenses - being mindful of their ever-changing nature - thus enabling us to gain a deeper understanding of 'the process by which they are produced, experienced, reproduced and resisted in everyday life.'" **(McCall L, 2005; Monrouxe L V, 2015).**

MARGINALIZED GROUPS

Including but not limited to distinguished groups based on ethnicity, sex, gender identity, sexual orientation, socioeconomic status, incarceration, drug use, religion or belief, health status, education, geography.

MICROAGGRESSIONS

"Brief and commonplace daily verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults towards people of color." **(Sue DW, et al, 2007).**
Ontario Human Rights Code (OHRC)

GENERAL TERMS CONT'D

For citations, please click the defined term to access hyperlink

DISCRIMINATION

"Treating someone unfairly by either imposing a burden on them, or denying them a privilege, benefit or opportunity enjoyed by others, because of their race, citizenship, family status, disability, sex or other personal characteristics."

HARASSMENT

"The Code defines harassment as 'engaging in a course of vexatious [annoying or provoking] comment or conduct which is known or ought reasonably to be known to be unwelcome. It can involve words or actions that are known or should be known to be offensive, embarrassing, humiliating, demeaning or unwelcome.'"

OPPRESSION

"When an agent group, whether knowingly or unknowingly, abuses a target group. This pervasive system is rooted historically and maintained through individual and institutional/systematic discrimination, personal bias, bigotry, and social prejudice, resulting in a condition of privilege for the agent group at the expense of the target group."

DISCRIMINATION & SOCIAL POWER  **OPPRESSION**

RACISM  THIS IS ONE OF MANY DEFINITIONS OF RACISM

RACISM  **RACIAL PREJUDICE & POWER**

GENERAL TERMS CONT'D

For citations, please click the defined term to open hyperlink

By Racial Prejudice We Mean: a set of discriminatory or derogatory attitudes based on assumptions deriving from perceptions about race/skin colour.

By Power We Mean: the authority granted through social structures and conventions—possibly supported by force or the threat of force—and access to means of communications and resources, to reinforce racial prejudice, regardless of the falsity of the underlying prejudiced assumption. Basically, all power is relational, and the different relationships either reinforce or disrupt one another.

REFLEXIVITY

"Ability to understand how one's own social locations and experiences of advantage or disadvantage have shaped the way one understands the world and produces knowledge"

STRUCTURAL RACISM

"Structural racism is defined as the macro-level systems, social forces, institutions, ideologies, and processes that interact with one another to generate and reinforce inequities among racial and ethnic groups (Powell 2008). The term structural racism emphasizes the most influential socioecological levels at which racism may affect racial and ethnic health inequities."

RESOURCES

Office of Inclusion and Diversity, Faculty of Medicine

IMPLICIT BIAS

- 2016 State of the Science: Implicit Bias Review
- The Harvard Implicit Association Test is frequently used and linked here. It is noted to have low test-retest reliability. A commentary on the strengths and weaknesses of the test is also included here.

EXAMPLES OF STUDIES DISCUSSING HEALTH INEQUITIES

Health Inequities for Black Canadians

- Black, White, Black, and White: Mixed Race and Health in Canada
- Black-White Health Inequalities in Canada

Health Inequities for First Nations, Inuit & Métis

- Royal College of Physicians and Surgeons of Canada Indigenous Health Primer
- Unmet health needs and discrimination from healthcare providers
- The mental health of Indigenous peoples in Canada: A critical review of research
- Socioeconomic and health inequalities in indigenous peoples living off reserve in Canada

GIM/Geriatrics

- Ageism and Autonomy
- Failure to cope
- Effect of socioeconomic disparities on incidence of dementia among biracial adults

Hematology

- Racism and Sickle Cell Disease

Cardiology

- Sex Differences in Acute Coronary Syndrome Symptom Presentation in Young Patients
- Reporting and representation of ethnic minorities in cardiovascular trials: a systematic review
- Cardiovascular disease and Homelessness

RESOURCES CONT'D

Dermatology/Rheumatology

- Under-representation of skin of colour in dermatology images: not just an educational issue

Nephrology

- Race in measurement of renal function

Endocrinology

- Cross-sex Hormones and Acute Cardiovascular Events in Transgender Persons

Infectious Diseases

- HIV disparities in Black and other MSM in Canada, USA, and the UK

Gastroenterology

- Race and SES in IBD management

Respirology

- Tuberculosis in Indigenous peoples

Toxicology

- SES and drug overdose

Teaching & Inclusivity:

- Addressing Microaggressions in the Classroom
- Addressing Race, Culture, and Structural Inequality in Medical Education
- Beyond Cultural Competence: Critical Consciousness, Social Justice, and Multicultural Education
- Reducing Implicit Bias Through Curricular Interventions
- Reducing Racial Bias Among Health Care Providers
- UW (University of Washington) Medicine Centre for Health Equity, Diversity and Inclusion: Implicit Bias in the Clinical Setting and Learning Environment

RESOURCES CONT'D

Patient Care

- Approach to Anti-Oppressive Assessment & Care

Person-Centred Language:

- Inclusive Language in Media
- Alzheimer Society
- Failure to Cope
- Sexual and Gender Identity terminology
- Re:searching for LGBTQ Health: What Community Means to Us
- Pronouns Matter
- Support Gender Pronouns
- Know Your Gender Pronouns
- Respectful Disability Language
- Putting People First in Obesity

Equity, Intersectionality, Culture

- When I say... intersectionality in medical education research
- The complexity of intersectionality
- When I say... equity
- Gender, identities, and intersectionality in medical education research
- Beyond Cultural Competence: Critical Consciousness, Social Justice, and Multicultural Education
- "Rewriting" cultural safety within the postcolonial and post national feminist project: toward new epistemologies of healing