UC DAVIS HEALTH | SCHOOL OF MEDICINE

Inclusive Education

Guidelines for Teaching Excellence in Diversity, Equity, and Inclusion in School of Medicine Education

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Introduction

The purpose of *inclusive medical education* is "to demonstrate how including diverse perspectives in general medical education scholarship could prompt reconsideration of basic concepts and the development of richer, more nuanced, and practicable understanding of who medical learners are."[1] To that end, the following document contains guidelines to help support faculty in using a more inclusive medical education approach, including adopting more inclusive language in teaching.

However, it is important to understand that true skill and expertise in teaching more inclusively comes from ongoing exploration and reading about these concepts, and committing to a cultural and structural humility[2] framework – a lifelong process of seeking to understand and grow in the knowledge of these topics.[3] For each of these suggested practices in this document, there is an extensive body of literature that helps to inform these recommendations. Additional information is provided in the *Resources* section of this document, but even the resource list is simply a starting point for expanding one's knowledge and skill in this area.

Effective use of these guidelines involves increasing one's knowledge about important concepts, including othering, which is "a set of dynamics, processes, and structures that engender marginality and persistent inequality across any of the full range of human differences based on group identities."[4] These guidelines seek to minimize othering and promote inclusion and equity in teaching. Similarly, educators should seek to understand the concept of intersectionality, which describes "how different social group categorizations are interconnected, creating overlapping systems of oppression."[5]

Please note that in considering these guidelines, it is not helpful to learn specific rules for referring to groups that are traditionally marginalized and oppressed. Inclusive education involves changing the perspective-taking of the educator. It means moving beyond the consideration of cisgender white men as normative and all other groups as specialized and requiring shortcuts to greater understanding. Therefore, these guidelines are not to be considered as rules, but as entry points for ongoing dialogue and reflection.

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[1] Maduakolam E, Madden B, Kelley T, Cianciolo AT. Beyond diversity: envisioning inclusion in medical education research and practice. Teaching and Learning in Medicine. 2020 Nov 20;32(5):459-65.

[2] Metzl JM, Hansen H. Structural competency: theorizing a new medical engagement with stigma and inequality. Social science & medicine. 2014 Feb 1;103:126-33.

[3] Tervalon M, Murray-Garcia J. Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. Journal of health care for the poor and underserved. 1998; 9(2):117-25.

[4] powell ja, Menendian S. The problem of othering. In Othering and Belonging: Expanding the Circle of Human Concern. Berkeley, CA, Haas Institute, 2016.

[5] Crenshaw K. Mapping the margins: intersectionality, identity politics, and violence against women of color. Stanford Law Review. 1990 43: 1241-1299.

Finally, an additional note on terminology – while these guidelines aim to provide the most up-to-date terminology, we recognize that acceptable terminology is always changing. It is the responsibility of the educator to continually learn the most acceptable terminology. Groups that are traditionally oppressed have limited power; therefore, defining how they name themselves is a way to exert some control. Thus, the most acceptable terminology to use is the terminology that members of these groups choose to define themselves, with a recognition that these terms can change and evolve. We encourage educators to use these guidelines as a starting point, but to recognize that one must seek ongoing feedback regularly to ensure the terminology they are using is most accurate, often on a case-by-case basis when individualizing patient care.

Examples of Inclusive Educational Practices

- When introducing yourself to others, include the pronouns you use and encourage learners to introduce themselves with their pronouns (see Resources section for more information about pronouns).

- When presenting data about race and ethnicity, it is helpful to acknowledge the limitations and imprecision of this data. This includes stating that race is a social construct that cannot be accurately biologically or genetically categorized, and that this limits the conclusions that we can make based on these data (see Resources section for more information about the historical imprecision of race and ethnicity in medicine).
    - *Example – "There are significant differences in outcomes by race and ethnicity for chronic kidney disease. I am going to present these data, but it is important to acknowledge that race is a social construct, and that our racial classifications are imprecise because racial definitions vary across cultures."*

- When presenting data about differences/disparities in incidence, prevalence, or outcomes of diseases by race, ethnicity, gender, gender identity, or other demographic groups, it is important to provide a plausible explanation for these differences. In many cases, structural discrimination is a traceable cause of health inequities between population groups. Please note that genetic or biological causes are not acceptable explanations. If the causes of differences/disparities are not well understood, it is acceptable to state this.
    - *Example – "In the US, Black patients with sarcoidosis have more severe pulmonary disease, more multiorgan involvement, and higher rates of hospitalization and mortality than white patients. While the exact causes for these differences are not entirely well understood, recent studies have suggested that social determinants of health, including lack of access to*

health insurance, socioeconomic status, and implicit bias of providers all play a role in these differences."

- Race is not equivalent to genetic ancestry, and genetics is not equivalent to race or ancestry. When presenting information on single-gene diseases, they should not be equated or associated with race. Aspects of genetic ancestry can be discussed in the limited context of the specific disease and should specify the specific population within the geographic area, when applicable.
    - *Example* – Instead of saying "African Americans have higher rates of sickle cell disease," it is more accurate to say*, "People with West African ancestry are more likely to carry the sickle cell allele. This may include some who identify as African American."*

- When presenting published guidelines that reference race or other factors that are not biologically based, it is helpful to acknowledge that medical guidelines are not yet fully up to date on their understanding that race is not a biological risk factor, and that increased risk associated with race is most often a result of structural inequities. Educators should remind students that they are responsible for learning the current content as that will enable them to better critique and improve this content in the future.

- When using clinical images or pictures, make sure to include many different skin colors and skin tones. Examples of images are widely available via NIH Image Banks, VisualDx, etc. It is not acceptable just to present white skin tones and apologize for not showing other skin tones.

- When presenting vignettes, make sure to include patients with varying gender identities, sexual orientation, racial identities, and other personal descriptors. To reinforce these components of identity as important social context rather than buzzwords for clinical diagnoses, students should have regular exposure to patients whose identities are not directly related to their diagnoses.

- When presenting vignettes, avoid using race, sexuality, or other personal descriptors in the initial description of the patient. Because racism and other forms of discrimination are important social determinants of health, it is relevant when discussing the social history of a patient, but often triggers bias and stereotypes when presented in an initial description of a patient. Racial, sexual, and other identities should be listed in the social history using language such as, "Patient identifies as…" or "Patient describes their [racial/sexual/gender/other] identity as…" Importantly, do not omit descriptions of race and ethnicity when discussing white people and only identify race and ethnicity when discussing people of color. Similarly, do not omit descriptions of sexual orientation only for

heterosexual patients and only identify sexuality when discussing LGBTQ+ people.

- In case discussion or case vignettes, always describe patients by their gender identity, pronouns, and lived name (rather than sex assigned at birth or given/legal name). Sex assigned at birth should only be included in the vignette or discussion if it is relevant to patient care (e.g., the patient is receiving gender affirming medical services or experiencing discrimination because of their gender identity as trans* or gender expansive). When reporting on race and ethnicity, make sure to use the proper terminology. Although racial classifications are imprecise and poorly defined, it is important to make an effort to use those terms currently considered most acceptable. Do not use “Caucasian” when referring to white people, as this term is not considered accurate or precise (except when referring specifically to people that are from the geographic region of Caucasia). Also, avoid referring generally to “racial and ethnic minority groups” as it is helpful to be more specific about the groups you are referring to.
    - *Examples of currently acceptable terminology:* Black, Latino/a/x/e, Native American/Indigenous, White, and Asian.
    - Whenever possible, try to be as specific when describing racial and ethnic groups (e.g., Vietnamese person, Mexican American person, Choctaw person).
    - It is helpful to mirror the language a patient uses to describe themselves.

- Please be aware of when you are mentioning body size (e.g., weight, BMI, "obese") and why you are mentioning it. Remind students that you cannot infer anything about a person's health by looking at their size. Most of the data we have linking weight and size to health are correlative, so a reminder that correlation does not equal causation can be helpful. Include information about how trauma, food insecurity, and living in food deserts contribute to one’s weight and utilize a “Health at Every Size” approach to discussing weight with patients (website included in Resources section). Consider discussing how provider bias about a patient’s weight can contribute to poor communication, avoidance and delay of health services, and patient mistrust.

- When discussing sexuality, distinguish between sexual orientation (which is a predictor of how a patient may experience discrimination, social exclusion, and related trauma/mental health problems) and sexual behavior (which influences sexual health needs such as STI testing). One’s sexual identity does not determine one’s sexual practices. For example, many people who participate in “same-sex” sexual behavior do not identify as members of the LGBTQ+ community.

- Use organ-specific language rather than gendered language to refer to sexual or reproductive health systems. For example, use gynecologic and urologic health versus women's and men's health. Similarly, use words like penis and vagina rather than "male" or "female" genitalia. Do not assume what kind of anatomy one has based on their gender identity.

- Use non-judgmental language when discussing patient behavior, especially sexual behavior. For example, diagnoses such as "high-risk sexual encounter" are much more stigmatizing and patient shaming than diagnoses that cover the same medical procedures or medications such as "encounter with HIV" or "screening for STI."

- Use person-first (centered) language in all situations, but be especially vigilant when describing any populations that are associated with high levels of stigma and oppression.

    - *Examples – "a person who is unhoused"* instead of a homeless person, *"a person with diabetes"* instead of a diabetic, *"a person with a substance use disorder*" instead of an addict, *"a person who uses drugs"* instead of a drug abuser, *"a person with a mental illness"* instead of a mentally ill person, *"a person who is incarcerated*" instead of an inmate, *or "a person with a disability"* instead of a disabled person

- Replace stigmatizing language with less morally charged language.

    - *Examples* – "*drug use"* instead of drug abuse, "*died by suicide"* instead of committed suicide, "*sex worker"* instead of prostitute, or "*undocumented person"* instead of illegal immigrant

- When possible, use assistive methods to amplify voices when speaking, regardless of room size, to facilitate ease of hearing for all.

- Use easily legible font on slides and handouts.

- Describe images in presentations in narrative form or use alt-text.

- When possible, use closed captioning for audio material.

- Offer transcripts of presentations and interviews after presentations.

- Ensure that seating in the presentation space accommodates as many body types as possible.

Practices to Avoid

- Avoid relying on inaccurate stereotypes when describing or speaking about race, ethnicity, sexual orientation, or other demographic factors.
    - *Examples of what **not** to say* – “Latinx people have higher rates of diabetes because they eat a lot of tortillas,” or “Gay men have a lot of STDs because they are promiscuous.”

- Do not advance theories of *biological determinism* – the theory that there are biological or genetic differences between races and ethnicities. This theory has been thoroughly debunked, as races of people do not have separate physical characteristics.
    - *Example of what **not** to say* – “On average, Black people have greater muscle mass than white people.”

- Do not advance theories of *cultural determinism* – the theory that cultural differences are responsible for differences in health outcomes.
    - *Examples of what **not** to say* – “Asian people have lower rates of depression because their culture emphasizes collectivism rather than individualism,” or “Gay men have higher rates of STDs because gay culture encourages promiscuity.”

- Avoid advancing cultural deprivation theories – the idea that certain cultural groups (or races and ethnicities) have differences in health outcomes because of a lack of environmental stimuli and support in society. There is a close line between identifying the social determinants of health and implying that some cultural groups are inferior because of negative generalizations about their environments.
    - *Example of what **not** to say* – “Racial and ethnic minorities are more likely to somaticize mental health symptoms because they come from cultures that utilize more primitive coping mechanisms.”

Resources

Websites:

https://lgbtqia.ucdavis.edu/educated/pronouns-inclusive-language

https://www.lgbtqiahealtheducation.org/resources/

https://lgbt.ucsf.edu/glossary-terms

https://www.ohsu.edu/sites/default/files/2021-03/OHSU%20Inclusive%20Language%20Guide_031521.pdf
https://www.cdc.gov/healthcommunication/Preferred_Terms.html

https://asdah.org/health-at-every-size-haes-approach/

Articles and Books:

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Chokshi DA, Foote MMK, Morse ME. How to Act Upon Racism—not Race—as a Risk Factor. *JAMA Health Forum.* 2022;3(2):e220548. Doi:10.1001/jamahealthforum.2022.0548. Available at: https://jamanetwork.com/journals/jama-health-forum/fullarticle/2789583

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Alberga AS, Edache IY, Forhan M, Russell-Mayhew S. Weight bias and health care utilization: a scoping review. Prim Health Care Res Dev. 2019;20:e116. Published 2019 Jul 22. Available at: https://onlinelibrary.wiley.com/doi/pdf/10.1111/cob.12147?casa_token=Z_COLcaV25oAAAAA:ee3MtHmz4YhihhS-2RSbDvHFwPqw9nBIzbGYKTI7mGFe2T2OLoM4wCM4wD3no31dyLTAiVOFxq8f_m7M

Chang SC, Singh AA, dickey lm. A clinician's guide to gender-affirming care: Working with transgender and gender nonconforming clients. New Harbinger Publications, 2018. Available at: https://www.newharbinger.com/9781684030521/a-clinicians-guide-to-gender-affirming-care/

Courses and Online Trainings:

UC Davis Learning Center E-course: “Race and Medicine in Clinical Practice” (from UC Learning Center home page click on “Find a Course” then type course name in search field)

Anti-Racism and Cultural Humility (ARC) Fellowship and Academy: https://health.ucdavis.edu/diversity-inclusion/events/ARC-fellowship-index.html

Structural Racism Revealed: https://health.ucdavis.edu/pmr/news/headlines/structural-racism-revealed-program-to-begin-soon/2022/05