

# Anti-Racism and Race Literacy: A Primer and Toolkit for Medical Educators

## Introduction

As medical educators and clinicians, we are often called upon to address race/ethnicity and to discuss the origins of health disparities while teaching and delivering care. UCSF students now engage academically with concepts such as racism and power through the Bridges curriculum in the Health and Individual and Health and Society blocks. They learn that while race is a social construct, racism affects one's lived experience in ways that have tangible consequences. Stereotyping, bias, lack of representation, and racism perpetuate false beliefs, lead to misdiagnosis, dangerously narrow clinical decision making, and perpetuate implicit bias, all of which lead to real health disparities. These forces also affect the integrity and safety of the learning climate and thus may impact the success of our learners. Therefore, as educators and clinicians, for our students and for our patients, we have a moral imperative to confront and dismantle racism.

Despite the introduction of these topics into the pre-clinical curriculum, interviews with UCSF pre-clinical educators show that many feel unprepared or uncomfortable addressing the topics of race and racism in educational materials or the learning environment. As a result, they may provide inconsistent messaging to learners and inadvertently reinforce biases and structural forces that impact patient care. This impedes the creation of an inclusive learning environment where all students can thrive. Every year that our educational approach neglects to intentionally dismantle racism and bias (or worse, perpetuates it), we undermine our students' success. Every year that we graduate students into the physician workforce who lack an understanding of the complex mechanisms, contexts, and manifestations of racism, we are perpetuating health disparities and causing harm. As educators we have a responsibility to our learners and our patients to advance understanding of the complex mechanisms and manifestations of bias and intentionally act to dismantle racism in the learning environment and in clinical medicine.

In this toolkit, we seek to provide a structured approach to equip new and existing faculty with the tools to engage learners in topics of health disparities, social justice, bias, and racism in the classroom and clinical environment. While this document focuses on race, we recognize that the depiction and treatment of other components of identity—including, but not limited to, gender, age, sexuality, ability, education, and economic status—also require thoughtfulness and skill. In fact, because identities intersect, we often need to engage with multiple identity elements simultaneously. However, we choose to center understandings of race and racism because racial inequities are deeply rooted, pervasive, and traverse all indicators of success when other aspects of identity are controlled for. Focus and specificity are necessary to drive change.

Despite the discomfort and difficulty that may arise when talking about racism and race, **examining our personal and collective experience and roles in maintaining racism is essential to the pursuit of equity, a core value here at UCSF.** The work of dismantling racism in healthcare and medical education in order to build a just, welcoming, and inclusive environment is a collective and life-long process that requires practice, commitment, and humility. While we cannot expect faculty to achieve “competence” in this work because the growth is continuous and dynamic, UCSF Medical School expects that faculty will demonstrate a commitment to the self-reflection, humble inquiry, learning, and resilience necessary to engage learners, colleagues, and community in creating a welcoming and inclusive environment for all learners, especially those who have historically been excluded. We acknowledge that neither one’s race nor individual experience with racism confers comfort or expertise when discussing race and racism, especially in the complicated context (historical and current) of medical training and practice.

### **Who is this Primer and Toolkit for?**

- Pre-clinical medical educators, especially those leading small groups and developing teaching or testing materials.
- Curriculum content creators.
- Any medical educator, in any setting, working with any level of medical learner (UME, GME, and CME) who needs or wants to have a deeper understanding of race and racism. These principles can be applied across all levels of learners, in all settings.

### **Objective of the Primer and Toolkit:**

- Provide historical context, theoretical frameworks, and shared definitions for talking about race and racism in medicine so that all faculty have a basic shared understanding.
- Provide a structured approach for medical educators to evaluate their own educational materials in order to identify and eliminate bias, promote accurate and holistic representations of patients and providers, and examine the structural causes of health disparities.
- Support faculty in developing their own reflective practice around how they use race and racism in their teaching and educational materials.

### **How to use this Toolkit:**

This Toolkit is divided into 4 sections, or steps:

- Step 1: Prepare to talk about racism and race
- Step 2: Definitions and Frameworks
- Step 3: Understand racism in the historical context of healthcare and medicine
- Step 4: Implement anti-racism in medical education – A Toolkit

Each section can stand alone, but we recommend working through the Toolkit sequentially. This Primer and Toolkit are not exhaustive, but rather an entry point. Look for selected resources at the end of each section that you can use to deepen your learning and growth. Additional resources and references for all cited works are at the end of the document.

This Primer and Toolkit are living and iterative. Please direct all feedback and suggestions for additional resources to [racelit@ucsf.edu](mailto:racelit@ucsf.edu).

**Questions for self-reflection:**

- *How do you know whether your curriculum and teaching materials perpetuate or disrupt racism?*
- *What steps do you currently take to ensure an inclusive and equitable curriculum?*
- *Do you feel comfortable talking about race with learners and trainees? Why or why not?*
- *What steps would you take to address your teaching materials if you received feedback that they were biased?*

**Suggested reading:**

- Brooks, Katherine C. 2015. "A Piece of My Mind. A Silent Curriculum." *JAMA: The Journal of the American Medical Association* 313 (19): 1909–10.
- Tsai, J. "Diversity and Inclusion in Medical Schools: The Reality". *Scientific American*. July 12, 2018.
- Paul, Dereck W., Jr. 2019. "Medical Training in the Maelstrom: The Call to Physician Advocacy and Activism in Turbulent Times." *Academic Medicine: Journal of the Association of American Medical Colleges* 94 (8): 1071–73.

## Step 1: Prepare to talk about racism and race

### ***Why is talking about racism and race so difficult?***

Everyone has a different expertise and experiential background with regards to race, racism, and conversations about these topics, and brings something different to the dialogue. Consider the following as you begin or deepen your practice of dismantling racism in medicine.

**Be prepared to be uncomfortable during productive dialogue.** Racism can be an emotionally loaded topic because of our different experiential backgrounds, controversies, and contexts. People who are used to certain racial norms may be triggered by disruptions to that equilibrium that make them feel threatened or uncomfortable.<sup>1</sup> When someone identifies another's actions or words as racist, it may feel like an insult or a condemnation of that person's character and may ignite defensiveness. A common impulse is to focus on defending one's intention—on reinforcing one's "goodness"—rather than focusing on the impact of the words or deed. This is an understandable response for people who have learned (and believe) that racism is morally wrong, but who have not also been taught the complex ways racism operates. Good people live in a racist society (like fish in water). Just because someone identifies your words or actions as racist doesn't mean you are a bad person. Defending your "goodness" forestalls productive conversation by centering the dialogue on the defense of intentions and character rather than on the way words and actions impact another person or reinforce inequitable *systems*. Inability to tolerate one's own discomfort thwarts productive dialogue. Trust your ability to navigate this discomfort. When discomfort arises from a place of *unfamiliarity* with a new idea or another's experience, attempt to tolerate it and tap into humility and accountability.

**Cultivate a culture of trust, humility, and accountability when talking about race.** Sometimes discomfort arises from a place of *familiarity*. For people of color who routinely experience racism, dialogue may be greeted with trepidation due to an informed concern about psychological, professional, or physical safety. Dialogue may also be burdensome for people of color who are disproportionately asked to prove their experience of racism, or to educate others about racism, because society positions the white experience as normative (default). Practicing humility, empathy, and personal accountability can cultivate a culture of trust and safety, and give space for colleagues to engage despite their past negative experiences. For those who experience the discomfort of familiarity, setting boundaries, asking to revisit the conversation at a later time, redirecting the conversation to an ally, and seeking support from trusted colleagues may help mitigate discomfort.

**Avoid frameworks of colorblindness.** Well-intended people may try to distance themselves from racism's negative connotations by adopting an attitude of "colorblindness," or of not seeing color or race. This approach ignores the actual

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<sup>1</sup> DiAngelo, 2011

differences in the reality of people's lived experience. Our lives are shaped by how others respond to our race and by unequal social systems that determine our access to resources and opportunities. In order to engage in meaningful conversation, we must honor our divergent experiences and build authentic understanding rooted in empathy and trust of one another's stories. In other words, we must cultivate a *consciousness* about these different experiences (often called *color-consciousness*).

**Guilt and defensiveness can make talking about racism difficult. Keep trying.**

White people, and others with race privilege, may wrestle with feelings of guilt when they begin to confront the idea that their race affords them certain privileges at the expense of people of color. They may feel angry and defensive when their hard work, struggle, and success seem undermined by the suggestion that they have benefited from unearned privilege. This is a false dichotomy. One can have worked hard to achieve success, or have faced and overcome tremendous adversity, and still have benefited from a system that elevates whiteness. Emotions like guilt and defensiveness can make talking about racism difficult. If these emotions arise in you, try to identify them, tolerate the discomfort they bring, and persist in conversations with a focus on active listening and humble inquiry. If these emotions arise in someone else and conversation becomes unproductive or hostile, consider revisiting the conversation with a facilitator (eg. a Differences Matter community ambassador) after a cooling-off period.

**Racism affects all of us.** Sometimes white people and others with race privilege disengage from conversations about racism because they perceive that racism doesn't affect them. When someone does not have to think about their race every day, it usually means they do not often confront racism (this is an example of white privilege). If someone has not been affected by racism, and they do not feel that they perpetuate racism, then they may think that it is not their responsibility to address racism, and thus disengage from necessary conversations. Everyone's participation is necessary in order to dismantle racism.

***Whose responsibility is it to dismantle racism?***

*Dismantling racism is everyone's work.* Systems of inequity are experienced by everyone and can be perpetuated by anyone of any race. Sometimes white people and others with race privilege believe that dismantling racism is not their responsibility because they see themselves to be good, non-racist people who treat everyone the same, and feel that should be enough. However, this is far from true. They may be unaware of the ways in which they unintentionally reinforce structural inequality (inequitable social, political, and economic forces that offer different access and opportunities to people with different identities) because they haven't been confronted with their role in the systems that maintain inequality. Viewing anti-racism as everyone's problem requires a frame shift. Since everyone has a role in social systems, we each have a role and responsibility in dismantling the systems that perpetuate racism.

*In fact, dismantling racism is especially the work of those who hold racial/white privilege. Not only do people of color have to deal with racism, but they often shoulder the additional burden of being asked to both *prove* the veracity of their experience of racism and to serve as an expert educator for others on how racism works. Those with race privilege can take responsibility for their own education and cultivate *racial stamina*<sup>2</sup>, or resilience for doing the difficult work of dismantling racism. Developing racial stamina requires personal work, including active reflection on how we were taught to think about racism and race growing up, scrutiny of the power dynamics governing experiences across contexts, ongoing engagement and humility, and intentional practice of these skills.*

**Questions for self-reflection:**

- *How did you learn about race and racism and what were you taught?*
- *What is your relationship to your own race? In what ways has race shaped your experience in your family, communities, schools, work place?*
- *What makes you uncomfortable discussing race and racism? What assumptions and ideas underlie your discomfort?*
- *Think back to experiences when you were aware of race and experiences when you didn't have to think about race. How were the two experiences distinct?*

**Suggested reading/listening:**

- DiAngelo Robin. *White Fragility: Why It's so Hard for White People to Talk About Racism*. Boston, MA: Beacon Press; 2018.
- Lorde, Audre. "The Uses of Anger". *Women's Studies Quarterly*. 1997;25(1&2).
- *Woke WOC Docs (podcast): "Making the World Safer for Black Children Beyond Diversity Rhetoric"*. Available: <https://soundcloud.com/wokewocdocs/s2ep4-dr-rhea-boyd>.

**Suggested trainings:**

- Relationship Centered Communication for Racial Equity at [UCSF](#) and [ZSFG](#).

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<sup>2</sup> DiAngelo, 2018

## Step 2: Definitions and Frameworks

Before you can create curriculum or engage in discussion with learners about topics that address racism and race, we must have a shared understanding of common definitions and frameworks. Please review the definitions below.

### DEFINITIONS

#### **Anti-racist**

Someone who expresses and anti-racist idea or supports and anti-racist policy or action that yields racial equity.<sup>3</sup>

#### **Color-blindness**

One mainstream approach race in the United States is to insist that race is unimportant (or unseen) and does not impact a person's achievements or abilities.<sup>4</sup> However, because of racism, people of different races have different lived experiences. Espousing a colorblind ideology that race does not matter ignores the actual differences in lived experience that people have based on how others perceive and respond to them in conscious, subconscious, and systemic ways. Becoming conscious of how race affects one's experiences in the world, or becoming *color-conscious*, is an important step in addressing racism.<sup>5</sup>

#### **Implicit bias**

Implicit bias refers to unconscious attitudes, associations and beliefs towards individuals and social groups that affect one's feelings, actions, understanding, and decisions.<sup>6</sup>

#### **Ethnicity**

Ethnicity, like race, is a social construct that has been used for categorizing people based on perceived differences in appearance and behavior. Historically, race has been tied to biology and ethnicity to culture, though the definitions are fluid, have shifted over time, and the two concepts are not clearly distinct from one another. According to the American Anthropological Society, "ethnicity may be defined as the identification with population groups characterized by common ancestry, language and custom. Because of common origins and intermarriage, ethnic groups often share physical characteristics which also then become a part of their identification--by themselves and/or by others. However, populations with similar physical appearance may have different ethnic identities, and populations with different physical appearances may have a common ethnic identity."<sup>7</sup> Race and ethnicity, social constructions, are often conflated with, and used as a surrogate for, ancestry. Ancestry more specifically and accurately identifies ancestral genetic lineage than does race or ethnicity.

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<sup>3</sup> Kendi, 2019

<sup>4</sup> Flagg, 1992

<sup>5</sup> Crenshaw et al, 1995

<sup>6</sup> "Talking About Race Toolkit"

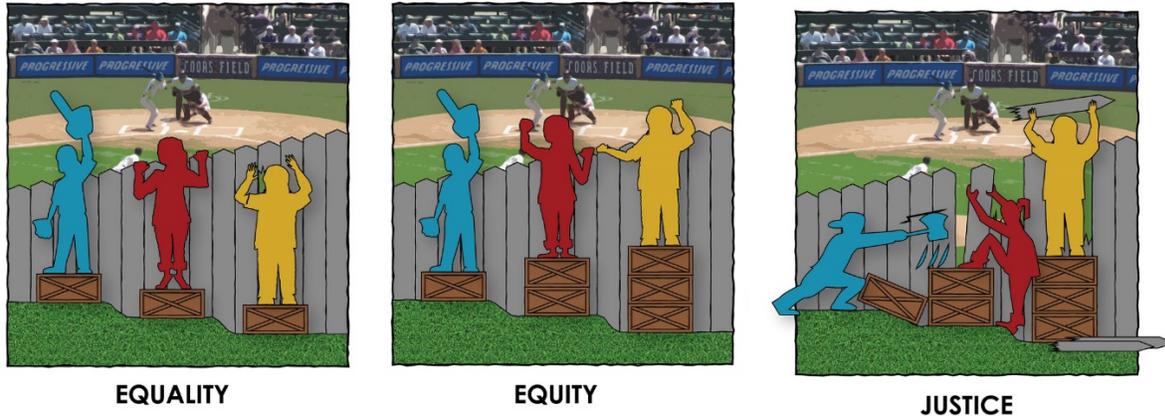
<sup>7</sup> AAA Response, 1997

## Equality

Equality is a state/outcome that is the same among different groups of people. Equality is sameness.<sup>8</sup>

## Equity

The process by which resources are distributed according to need. Equity is fairness.<sup>9</sup>



[Culturalorganizing.org](http://Culturalorganizing.org)

## Race

The concept of race was constructed as a tool to categorize people with the purpose of validating racism. Race has no biological basis. During historical projects such as colonialism and slavery, race was artificially imposed on people in different political positions to create a moral hierarchy used to justify the harm the inequitable systems inflicted.<sup>10</sup> Although the construct of race is dynamic and evolves with changing social, political, and historical norms,<sup>11</sup> the construct perpetuated the idea that there are static, innate characteristics that apply to sets of people despite diverse origins, life experiences, and genetic makeups. However, race is distinct from ancestry. Ancestry denotes people's shared traits based on the genetic similarities of their ancestors and accounts for the complexity of geographic variation and fluidity.<sup>12</sup> While race is socially constructed, the consequences of this social construct are experienced individually and collectively by communities in the form of racism. The effects of racism can be seen in differential outcomes in health, wealth, socioeconomic status, education, and social mobility in the United States.

## Race Privilege

Race privilege is a term that identifies people who may be afforded privileges over others, usually because of their race's relative historical or current proximity to whiteness when compared to another person identified as being of a different race.

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<sup>8</sup> "Visual Glossary"

<sup>9</sup> "Visual Glossary"

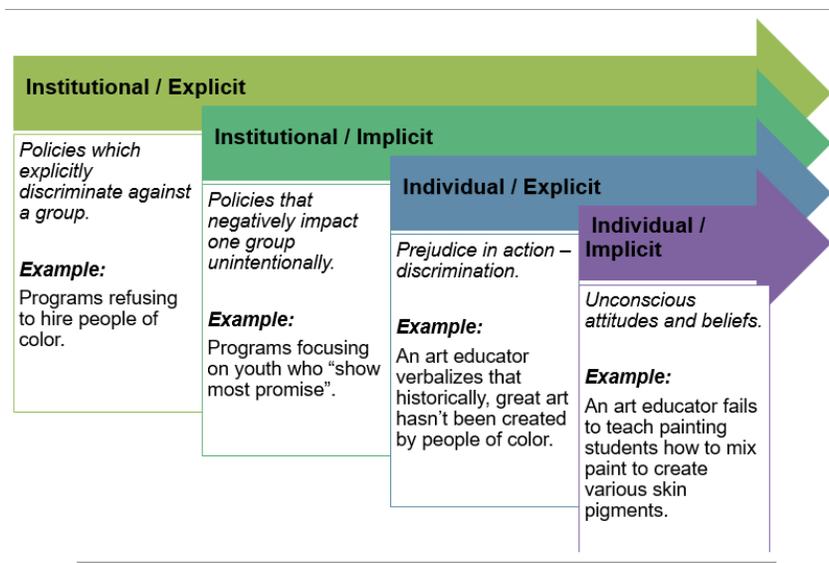
<sup>10</sup> Roberts, 2011

<sup>11</sup> Morning, 2011

<sup>12</sup> Roberts, 2011

## Racism

Geographer and social theorist Dr. Ruth Wilson Gilmore defines *racism* as “the state-sanctioned and/or legal production and exploitation of group-differentiated vulnerabilities to premature death, in distinct and yet densely interconnected political geographies.”<sup>13</sup> Importantly, her definition centers on how people of color *experience* racism, rather than focusing on how race is *imagined* or intended by white people.<sup>14</sup> Racism exists in many forms. **Institutional racism** describes the “policies, practices and procedures that work better for white people than for people of color, *regardless of intention.*”<sup>15</sup> When describing how these institutions combine across history and present day reality to create systems that negatively impact communities of color, we call this **structural racism**.<sup>16</sup> Our experiences in the world and interacting with institutions and social structures results in **internalized racism** that shapes our biases and beliefs about ourselves and others. These beliefs may manifest on an interpersonal level as **individual racism**, or the “pre-judgement, bias, or discrimination by an individual based on race”.<sup>17</sup> Although individually exercised, individual racism is internalized from racist institutions and systems. Because it exists in the context of structural racism, there is no such thing as “reverse racism” since the inequitable systems upon which racism is based are set up to benefit white people.



## White Privilege

White privilege is a term that identifies disproportionate access to opportunities, privileges, protections, head starts, or benefits (eg. absence of burdens, barriers,

<sup>13</sup> Gilmore, 261 Gilmore

<sup>14</sup> Brooks, 2006

<sup>15</sup> “Talking About Race Toolkit”.

<sup>16</sup> “Talking About Race Toolkit”.

<sup>17</sup> “Talking About Race Toolkit”.

oppression) that afford social and economic mobility that people perceived to be white enjoy that are not typically afforded to people of color. These benefits can be material, social, or psychological.<sup>18</sup>

### **White Fragility<sup>19</sup>**

Multicultural education scholar Dr. Robin DiAngelo describes white fragility as “a state in which even a minimum amount of racial stress becomes intolerable, triggering a range of defensive moves. These moves include the outward display of emotions such as anger, fear, and guilt, and behaviors such as argumentation, silence, and leaving the stress-inducing situation. These behaviors, in turn, function to reinstate white racial equilibrium. Racial stress results from an interruption to what is racially familiar.” White fragility may be a learned and is often a subconscious emotional response, resulting from white people lacking the prior experience to develop the tools for constructive engagement across racial divides. It is nefarious in that it works to protect, maintain, and reproduce white privilege by centering the emotions of white people in dialogues about racism, thus impeding discussions about racist systems that need dismantling.

### **Whiteness**

Often conversations about racism can feel personal, rather than focused on the systemic mechanisms that maintain or protect racism. In order to set the stage for productive conversations about racism at UCSF, we want to introduce the useful theoretical framework of *whiteness*. Whiteness is beyond white skin; it refers to a *systematic* prioritization that advantages white people and disadvantages people of color. The fundamental premise of the concept of whiteness is that being white is the standard and being a person of color is a deviation from this norm.<sup>20</sup> Whiteness influences everyone because it is a ubiquitous set of cultural assumptions to which we are all pressured to conform. It is, essentially, the water in which we all swim.<sup>21</sup> For example, consider what understood to be “normal” when Band-Aid describes a pale tan bandage as “skin tone”, or when a patient expresses surprise that their doctor is black, or when a person’s name is described as “unusual” when it is really just unfamiliar to someone. The normative ideals of whiteness often go unnamed, unexamined, and unquestioned. This has tangible consequences, and often violent effects, for those who do not default into the norms of whiteness. Whiteness and its consequences permeate medicine and health care in complex and nuanced ways. A discussion or critique of whiteness is not a critique of white people.

## **KEY FRAMEWORKS**

**Critical Race Theory (CRT)** emerged from legal scholarship in 1989 in response to the limited and narrow scope of how law defined and addressed racism. It offered a set of key racial equity principles and a methodology to illuminate and combat the root cause

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<sup>18</sup> McIntosh, 1998

<sup>19</sup> DiAngelo, 2011

<sup>20</sup> McLaren, 1998

<sup>21</sup> Tatum, 1997

of structural racism. This methodology has since been adapted to the field of health and medicine to help scholars attend to equity while carrying out research.<sup>22</sup> Critical race theorists recognize that racism is ingrained in the United States' historical fabric and argue we must explicitly identify and name racial power dynamics in order to address racism.<sup>23</sup> CRT challenges the fundamental assumption that science is objective because scientific activity occurs within, and is informed by, the social context in which we live, which is biased.

**Public Health Critical Race Praxis (PHCRP)** is a framework that applies CRT to health equity and public health research. PHCRP offers a semi-structured process to evaluate current and historical research, by applying a “race conscious orientation” to methods and offering tools for racial equity-informed approaches to knowledge generation. Researchers evaluate how racism (institutional and personal) informs their study design. They use these findings to refine their research and advance our understanding of how racism influences public health and disease.<sup>24</sup>

**Anti-racism** is the active process of identifying and eliminating racism by changing systems, organizational structures, policies and practices and attitudes, so that power is redistributed and shared equitably. Anti-racism examines and disrupts the power imbalances between racialized people and non-racialized (white people). In order to practice anti-racism, a person must first understand:

- How racism affects the lived experience of people of color and Indigenous people
- How racism is systemic and manifested in both individual attitudes and behaviors as well as formal policies and practices within institutions
- How both white people and people of color can, often unknowingly, participate in racism through perpetuating inequitable systems
- That dismantling racism requires dismantling systems that perpetuate inequity

Remember, these concepts are complex and these conversations can be challenging. Try to lean into the discomfort with the goal of talking about systems, and our roles in perpetuating or dismantling unjust systems, rather than attacking or defending one's character.

**Questions and exercises for self-reflection:**

- *Before engaging this toolkit, how did you know what race and racism meant? How has your definition of race and racism shifted over time?*
- *Assess your implicit biases with the [Implicit Association Test](#). What surprised you about your results? What feelings did you notice bubbling up?*
- *How does institutional racism or structural racism manifest in the criminal justice system? In your educational training? In your work place?*

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<sup>22</sup> Ford, 2010

<sup>23</sup> Crenshaw et al, 1995

<sup>24</sup> Ford & Airhinenbuwa, 2010

**Recommended reading:**

- Ford, C, et al. Critical Race Theory, Race Equity, and Public Health: Toward Antiracism Praxis. *American Journal of Public Health*, 1 Sept 2010. Vol 100 No. S1
- Kendi, Ibrham. *How to be an Antiracist*. Random House. 2019
- Lee C. “Race” and “ethnicity” in biomedical research: how do scientists construct and explain differences in health? *Soc Sci Med*.2009;68(6):1183–1190.
- McIntosh, P. (2003). White privilege: Unpacking the invisible knapsack. In S. Plous (Ed.), *Understanding prejudice and discrimination* (p. 191–196)
- Tsai, Jennifer. “The problem with cultural competency in medical education”. *KevinMD.com*. 8 Mar 2016. Available: <https://www.kevinmd.com/blog/2016/03/problem-cultural-competency-medical-education.html>

## Step 3: Understand race in the historical context of health care and medicine

Before you can create curriculum or engage in discussion with learners about topics that address racism and race in medicine, we must have a shared understanding of historical context.

### Justification of oppression

The history of medicine in the United States is intertwined with the economic and social foundations of slavery and colonization in our country. In pre-Darwinian times, the different customs, language and physical traits that European colonizers encountered were identified as products of God's creation and used to categorize and rank groups of people. Raking categorized people into races based on notions of superiority was used to justify inhumane historical projects, such as colonialism and slavery.<sup>25</sup> The subsequent rooting of the concept of race in biology and "scientific" theories of innate racial difference affirmed race's independent position in the natural order and provided justification for colonialism and the abuse of black slaves.<sup>26</sup>

### How racism invaded medicine, health, and science

The biological basis for race merged with medicine in the 18th and 19th centuries when scientific scholars attempted to explain phenotypic differences between white and black people. For example, various physician-scientists conducted experiments to prove that brain size and mental worth were dependent on race. Similarly conflating biology and race, Samuel Cartwright, a prominent antebellum physician theorized that black people had dysesthesia, a disease in which slaves experienced inadequate breathing due to insufficient decarbonization of blood in their lungs.<sup>27</sup> Cartwright invented the spirometer to measure his subjects lung capacity and used it to conclude that the brutal working conditions of slavery provided an appropriate treatment.<sup>28</sup> In 1962, scientist James Neel put forth his thrifty gene hypothesis to explain the high rates of diabetes among indigenous people and people of color, suggesting that genetic-based differences in glucose handling helped non-white populations endure times of famine. Neel later wrote in 1999 that his investigations found "no support to the notion that high frequency of [T2DM] in reservation Amerindians might be due simply to an ethnic predisposition—rather, it must predominantly reflect lifestyle changes."<sup>29</sup> Despite this, racialized notions of the genetic basis for disease persist and obfuscate the impact that historical trauma, dispossession, demoralization,<sup>30</sup> and an underfunded Indian Health Services system have on the health disparities experienced by America's indigenous people.

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<sup>25</sup> AAA Response, 1997

<sup>26</sup> Fields, 1990; Duster 2006

<sup>27</sup> Gould, 1996

<sup>28</sup> Gould, 1996; Duster, 2006; Braun et al., 2007

<sup>29</sup> Paradies et al, 2007

<sup>30</sup> Warwick, 2007

Beyond attempts to explain phenotypic difference, researchers also exploited racial hierarchies to justify experimentation on people of color. For example, the contemporary field of gynecology was established through the work of James Marion Sims, a plantation doctor. In an effort to develop a treatment for vesico-vaginal fistulas, Sims performed excruciatingly painful and dehumanizing experiments on the genitalia and reproductive organs of enslaved women.<sup>31</sup>

### Contemporary times

These examples may sound ludicrous and distant from our contemporary medical world where we actively strive to “do no harm”. However, these historical assumptions about race being biologically rooted persist in medicine and negatively impact health. For example, researchers at the University of Virginia (UVA)<sup>32</sup> found that differences in pain treatment provided to African-Americans is associated with beliefs in biological difference. Researchers presented participants with false ideas about the physiology of black patients (eg. that black people age slower than whites, their nerve endings are less sensitive, their skin is thicker) and asked participants about the extent to which statements were true or untrue. Researchers found that half of participants endorsed more than one false belief, and that the white medical trainees who endorsed these false beliefs had less accurate assessments of black patients’ pain levels.

In addition, the use of “race-based” predictions leads to missed diagnoses. A common example is seen in sickle cell anemia. In the United States, sickle cell anemia has become synonymous with black race. However, sickle cell disease is prevalent among people from South & Central America, Saudi Arabia, India, Turkey, Greece and Italy in addition to those labeled as “black” (descendants from those from Sub-Saharan Africa). This conflation of race with ancestry and genetics leads to improper and missed diagnosis.<sup>33</sup>

Lastly, in 2002 the Institute of Medicine was commissioned by Congress to uncover etiologies of our ongoing and persistent racial and ethnic disparities in health outcomes in the United States. The study, entitled *Unequal Treatment*, demonstrated that provider bias, in the form of implicit bias, has a large contribution to these unyielding differences.

### Race in medicine & health

Although race is a social construct, the consequences of racism are real and manifest in as health disparities. Race, whether self-identified or not, is a crude proxy for a shared lived history in the United States and signals risk of exposure to racism. **Race is not a biological construct, but a social one. Racism is the risk factor.** While conversation about how race and exposure to racism affect the health of racialized people in the United States is necessary, we must handle these topics in a way that avoids:

- Perpetuating false beliefs about differences in biology that directly lead to health disparities (as seen in the UVA study noted above)

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<sup>31</sup> Washington, 2012

<sup>32</sup> Hoffman et al, 2016

<sup>33</sup> Yudell et al, 2016

- Narrowing clinical decision making leading to misdiagnosis (as seen with sickle cell anemia)
- Leading to implicit racial bias

**In short, race does not equate to genetics.** Genetic data show that regardless of how racial groups are defined, people from different racial groups are as similar to each other as are people from different racial groups. The world of medicine is not isolated from our larger social history. Therefore, when we examine racism in medicine, we are scrutinizing forces that influence how we think and practice today.

**Questions for self-reflection:**

- *What were you taught about race and racism in medical school?*
- *How do you use a patient's race in your clinical practice? How do you know what their race is? How does it impact your clinical decision making?*
- *When you do include a patient's race in your notes or presentations, which patients do you mention it for? Why?*
- *If a patient says something that strikes you as racist, how do you respond? Is it different if there is a learner present or if you are alone with the patient? If so, why?*

**Recommended reading:**

- Coates, Ta-Nehisi. *The Case for Reparations*. [online] The Atlantic; 2014. Available: <http://www.theatlantic.com/magazine/archive/2014/06/the-case-for-reparations/361631/>
- Goddu, Anna P., O'Connor, Katie J., Lanzkron, Sophie. et al. "Do Words Matter? Stigmatizing Language and the Transmission of Bias in the Medical Record". *Journal of General Internal Medicine*. 2018;33: 685. <https://doi.org/10.1007/s11606-017-4289-2>
- Roberts, Dorothy. (2011). *Fatal Invention: How science, politics, and big business re-create race in the twenty-first century*. New York, NY: The New Press.
- Tsai, Jennifer. "Racial Differences in Addiction and Other Disorders Aren't Mostly Genetic: The assumption that health disparities are caused by race rather than racism permeates many organizations, including the NIH". *Scientific American*. Jan 30, 2018.

## Step 4: Implement anti-racism in medical education

In this section we outline (1) how to approach conversations on race, racism, and health and (2) how to develop anti-racist educational materials.

### Section 1 - *What are the best practices for dismantling racism in medical education?*

We acknowledge that everyone has a different expertise and experiential background with regards to race, racism, and conversations about these topics. No matter what we each bring to the table, conversation is an opportunity to learn about ourselves and each other. We invite you to join the conversation. Please consider the following:

**Approach conversations about racism with a growth mindset.** Recognize that racism has insidiously affected our frameworks and movements in this world. Blind spots and mistakes are natural consequences of this. In order for anti-racist work to be done, we must be willing to learn and grow. Many of us were not taught how to productively have different conversations about politically-charged topics. We may feel like beginners and that may be uncomfortable. However, we recognize that conversations about racism are opportunities to grow individually and together. Making mistakes is part of this process. Stay humble. If you see someone else make a well-intentioned mistake, avoid shaming them privately and publicly (avoid calling them out). If it is available to you, assume good intent, approach with compassion, and encourage them to continue to learn and grow (call them in).

**If you experience discomfort or anxiety that comes from a place of *unfamiliarity* when talking about race, approach your discomfort with inquiry.** Discomfort doing something new can signal an opportunity for growth. If you can be mindful about the context in which the discomfort arises and name it, you can mine those moments for learning. Sometimes white people and others with race-privilege feel attacked or targeted by conversations about racism. If this comes up for you, strive to distinguish whether the critique is of you as an individual, or of a system of which you are apart and from which you benefit. Realize anti-racist work is not about you, but about the higher purpose of uplifting communities of color that have been forcibly excluded, pathologized, and marginalized in medical education.

Sometimes people of color experience discomfort when talking about race and racism that arises from a place of *familiarity*. They may have past racial trauma that makes them feel unsafe or have suffered negative consequences as a result of engaging those with race privilege in conversations about racism. If this comes up for you, or you feel unsafe or threatened, disengage from conversation and seek support from those with whom you feel safe. While moving through discomfort of the unfamiliar is important, so too is safety a prerequisite for open communication.

**Distinguish intent and impact. Apologize, take ownership, and/or clarify if there is misalignment.** Intention describes the motivation, while impact describes the effect on

a person. When talking about race and racism, you can acknowledge an intention, but it is equally, if not more important, to honor another's experience of the impact. Some useful phrases include:

- *I am sorry I did that. Thank you for letting me know how that impacted you.*
- *What I am hearing from you is...*
- *My intention was...*
- *It seems that.... Is that true?*

**Take responsibility for “doing the work.”** Everyone has different levels of experience with regards to race and racism. One of the privileges of whiteness and proximity to whiteness is not being forced to confront race and the way race impacts your experience in the world (akin to how we do not notice a tailwind that helps us move forward, but notice the consistent force of a headwind that holds us back). Those with race privilege, should take the time to educate themselves, rather than turning to a person of color to do the unpaid emotional and cognitive labor to educate you. For people of color who experience the unwelcome ask to be another's teacher, consider setting a boundary for yourself and recommending a resource for self-study.

**Be an ally!** Allyship is an active process, not an identity. It is hallmarked by qualities of accountability, trust, and consistency in relationship building with marginalized communities. Allyship is not self-defined, but rather recognized by those with whom we seek to ally. You can work to be an educational ally by being a co-conspirator against racism and striving an equitable learning environment.<sup>34</sup>

- Demand anti-racism in your educational materials
- Be a champion to educate other faculty/staff
- Uplift and support students, trainees, and colleagues of color. Recognize that they may face unique experiences in the learning environment. Actively work to include and celebrate their presence and pursuit of medicine.

**Continue to read, reflect, and seek additional training!** This document establishes norms with regard to how we hope to approach conversations about racism at UCSF. While it is intended to provide a basic framework, it does not provide all answers. You can gain additional training at UCSF through:

- [Diversity, Equity, and Inclusion Champion Training](#)
- Relationship Centered Communication for Racial Equity at [UCSF](#) and [ZSFG](#)

**Questions for self-reflection:**

- *What makes you feel confident when talking about race and racism?*
- *What are some strategies you use to handle feelings of discomfort?*
- *How do you know when someone is actively listening to you?*
- *How can you repair a relationship if you have hurt a learner or colleague?*

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<sup>34</sup> Allyship

## Section 2 - *How can I develop anti-racist educational materials?*

When designing or reviewing educational materials such as lectures, student study guides, or exams, use the following guide to minimize stereotypes, and be inclusive and equitable in your approach:

1. **Take stock of representation.** Do you have people of different backgrounds represented in your case examples, images, and questions? (Consider representations of gender, age, sexual orientation, ability, as appropriate).

**No?** → Why not? What biases are you creating with your choice of representation? Can you directly address this as a learning moment in your lecture (eg. acknowledge the biases perpetuated by a historical representation in an old medical text book image you've included in your lecture)

**Yes!** → Are they respectful and positive representations with regards to image, associated language, and descriptive demographics? Are the demographics relevant to the case? If so, how? Are they reductionistic or expansive representations?

2. **If mention race, is it actually relevant?** Remember, race is a social construction, developed to stratify groups of people in order to privilege some (white people) at the expense of others (people of color). Biology-based definitions were mapped onto race to reinforce hierarchies of privilege and justify the social subjugation of groups of people. Disparities in health outcomes are often attributed to biology, but are more likely the result of social and structural inequities (eg. access to health care, poverty, etc.) and racism. Race is not the risk factor, but rather a crude proxy for the risk conferred by racism.

**No** → Consider using ancestral geographic origin rather than race since it more accurately describes human genetic variation. "Using *ancestry* can also be a way to acknowledge that individuals inherit traits from groups whose members share genetic similarities, while reserving *race* to designate a political category"<sup>35</sup>

**Yes** → Challenge yourself to avoid reinforcing that race is purely biological. When discussing race and propensity for disease, be sure to address health disparities and the social and structural factors that contribute. When discussing epidemiological data, distinguish between causation and observation. In question stems or examples, the mention of race in some cases but not all leads students to think that race is an inherent biological risk factor. If relevant to the case, consider using the language "the patient identifies as (race) " or

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<sup>35</sup> Roberts, 2011

“they are of \_\_\_\_\_ descent/ancestry” rather than “they are  
(race)”<sup>36</sup>

**3. Scan for stereotypes.** Find them, fix them! Stereotypes dehumanize and dangerously narrow clinical reasoning. They are conveyed through the physical traits, abilities, linguistic patterns, roles, experiences, behaviors, code words, and illnesses you’ve associated with race. Your ability to detect depends on your sensitivity to stereotypes and your blind spots, which we all have.

Example:

- “Andre Rodgers is a 48 year old man admitted to the ED complaining of a swollen right foot. He is a homeless, African American man with no known family who is referred to as a “frequent flyer” by several nurses and doctors” (Example from Deng and Kelly’s review of first year curriculum in 2017)
- After self-intentional scrutiny of your materials, consider asking a colleague for a second set of eyes for review.

**4. Have you addressed health disparities pertaining to your topic?** Identifying and discussing structural racism as a cause of health disparities is an important part of disrupting the impact of racism and building an equitable learning environment.

**[ ] No →** If disparities have not been rigorously investigated by the scientific community, why not? Teaching points may include funding inequalities, poor participant recruitment leading to a paucity of research across diverse populations, failure to involve impacted communities in setting research priorities.

**[ ] Yes →** What does the research show? What is the quality of the research? How does research methodology drive what we understand about disparities? Discuss the structural origins of health disparities, their impact, and strides made in correcting them. Identify opportunities for agency and change to make space for hope and possibility instead of resigning your audience to an unjust status quo.

**5. Who benefits and who is burdened by your materials?** Spend some time reflecting on the content, message, and perspectives represented. Consider the impact on learners, patients (present and future), families, communities, staff, and colleagues.

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<sup>36</sup> Deng, Kelly, 2019

**6. Invite and be receptive to feedback.** If a student or colleague identifies something as problematic, or challenges you with a question or comment during your lecture, invite and offer reflection, including on your biases and their origins. We are all learning from each other.

### **7. Need more support?**

- For small group facilitation, see Jason Satterfield's "Small Group Facilitation: Leading Discussions of Race and Culture"
- For Individual help, consult the Differences Matter Advisory Group! Visit our [wiki page](#) for details:
- To enhance your teaching, register for the UCSF [Teach for Equity and Inclusion Certificate](#), which includes a workshop on *Selecting and Creating Equitable Curriculum*
- To operationalize equity in your projects, check out the [Racial Equity Toolkit: An Opportunity to Operationalize Equity](#).

### **Recommended reading:**

- Krishnan, A., Rabinowitz, M., Ziminsky, A., Scott, S., & Chretien, K. C. (01/2019). Addressing Race, Culture, and Structural Inequality in Medical Education: A Guide for Revising Teaching Cases. *Academic Medicine: Journal of the Association of American Medical Colleges*, 1.

### ***Additional opportunities for exploration***

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<https://primarycare.hms.harvard.edu/rospod/ros-racism-and-inequity-in-healthcare-with-utibe-essien/>

*Scene on Radio Podcast*. "[Seeing White](#)" series. Center for Documentary Studies at Duke University.

### **Websites**

[Colorlines](#), A daily news site where race matters, featuring award-winning in-depth reporting, news analysis, opinion and curation.

[Systemic Racism](#). race forward|The Center for Racial Justice Innovation.

[Freedom School](#) for intersectional Medicine & Health Justice.

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***Trainings/Groups***

[White Noise Collective](#)

[UNtraining White Liberal Racism](#)

[Catalyst Project](#)

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  - Laisha Cornejo (DM DW 3)
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  - Michael Deng
  - Morgan Kelly
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- Differences Matter Action Group 3
- Differences Matter Leaders
- Rosny Daniels, MD (Medical Education Fellow and Watson Scholar)
- Jenna Lester, MD (Assistant Clinical Professor of Dermatology and Watson Scholar)
- Faculty participants in Rachel Field's study on Whiteness