Practical Lessons for Teaching About Race and Racism: Successfully Leading Free, Frank, and Fearless Discussions
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Abstract
Successfully teaching race and racism requires a careful balance of emotional safety and honest truth-telling. Creating such environments where all learners can thrive and grow together is a challenge, but a consistently doable one. This article describes 12 lessons learned within 4 main themes: ground rules; language and communication; concepts of social constructs, intersectionality, and bidirectional biases; and structural racism, solutions, and advocacy. The authors’ recommendations for how to successfully teach health professions students about race and racism come from their collective experience of over 60 years of instruction, research, and practice. Proficiency in discussing race and addressing racism will become increasingly relevant as health care institutions strive to address the social needs of patients (e.g., food insecurity, housing instability) that contribute to poor health and are largely driven by structural inequities. Having interprofessional team-based care, with teams better able to understand and counteract their own biases, will be critical to addressing the social and structural determinants of health for marginalized patients. Recognizing that implicit biases about race impact both patients and health professions students from underrepresented racial/ethnic backgrounds is a critical step toward building robust curricula about race and health equity that will improve the learning environment for trainees and reduce health disparities.

Effectively teaching health professions students about race and racism is critically important and difficult. Implicit bias and discrimination toward patients of color has direct, and indirect, impact on their mental and physical health. An overwhelming body of evidence documents that implicit bias is an important contributor to health disparities among racial/ethnic minorities in the United States.1–3

Introduction
Understanding race and racism is important for all health professions students and has heightened stakes for racial/ethnic minority students who may experience implicit bias and discrimination from instructors and peers. Racial/ethnic minority students may experience a less supportive learning environment and may be subject to negative implicit biases when they are evaluated.4–6 In addition, research has shown that minority students who experience stereotype threat and imposter syndrome perform less well on standardized examinations.7 Stereotype threat occurs when members of a stigmatized group find themselves in a situation where negative stereotypes may be a possible interpretation of their behavior or performance, and the risk of being judged in light of those stereotypes can cause a disruptive state that undermines the very performance being evaluated.8 Imposter syndrome is a psychological term that refers to a pattern of behavior wherein people, even those with adequate external evidence of success, doubt their abilities and have a persistent fear of being exposed as a fraud.9

For students in high-stakes programs, such as health professions schools, negative implicit biases and unsafe learning environments could have significant implications for students’ career trajectories, including whether or not they complete their training at all.10,11 Black and Latinx trainees have been less likely to complete residency programs, and constitute nearly 20%–25% of lost residents in some specialties.12 Minority health professions students are also at potential risk from patients’ discriminatory words and behaviors, which can cause psychosocial trauma to students that impacts their academic pathways, especially if the discriminatory behavior is not addressed by professors and administrative leaders at the institution.13,14

Racial discrimination is present in most aspects of society; thus, ripple effects from a single discriminatory encounter have wide effects, including for health and health care, patients and providers, students and teachers, and administrators and staff. It is important that we conceptualize race within the larger context of social identity, structural inequities, and power. Race is but one of the social identities that each of us has, along with gender and gender identity, sexual orientation, age, ability/disability, language, and many others. Each identity is associated with relative power in comparison to others within the same category. For example, heterosexual identity, in mainstream culture, has more social power than other sexual identities (e.g., bisexual, homosexual, pansexual). Male gender, in general, has more social power than female gender. It is the context of the larger society (e.g., U.S. sociocultural norms), microsocieties (e.g., African American organizations), and places (e.g., college campuses, women’s clinics) that determines which identities have contextually more social power.

Structural inequities—that is, systemic differences in access to goods and
services, such as education, housing, and employment—marginalize those with lower-power social identities and favor those with higher-power social identities. Structural inequities based on race, or structural racism, have been the most powerful determinant of socioeconomic status, health, and well-being in the United States. Patients, health professionals, and health professions trainees bring all of their social identities to every clinical encounter. The relative power dynamics between health professional and patient differ depending upon the 2 specific individuals. For example, it is possible that the marginalized race of minority health professions students (compared with the race of patients) can be outweighed by their privileged identity as a member of the health care team or other privileged identities (e.g., gender, sexual orientation).

Because of the significance of race/ethnicity as a social identity in the United States, it is essential that we have tools for discussing and teaching about race in health care settings. A health professional workforce with a deeper understanding of race and stronger ability to dismantle racism can improve the care of individual racial/ethnic minority patients and reduce health disparities in the population. Instructors, students, and institutions with more sophisticated knowledge of bias and racism could reduce discrimination of racial/ethnic minority trainees and improve interpersonal relations and operational dynamics in diverse interprofessional care teams.

Yet there are many barriers and challenges to teaching about race and racism. First, discussing race inevitably leads to necessary, yet often uncomfortable, examinations of the role of structural racism and interpersonal racism in creating disparate health outcomes between Whites and people of color. These conversations can be uncomfortable for Whites, who may carry feelings of guilt about historical and/or contemporary events for which they have had no direct contribution. These feelings of guilt and discomfort can manifest as anger, frustration, and/or withdrawal, all of which are counterproductive to meaningful conversations about race. This heightened sensitivity to discussions about race has been termed “White fragility” and has been increasingly recognized as a substantial barrier to national discussions about the root causes of, and potential solutions for, social inequity. At most medical schools, racial and ethnic minority students will be underrepresented in the classroom and may feel an added burden to represent, defend, and/or answer for an entire race or ethnicity. Racial/ethnic minority students, however, can also feel uncomfortable discussing race in public forums, where they may feel shame and stigma by discourse that highlights how their racial/ethnic group has been victimized and dehumanized over time. The physical environment of the academic setting can also hamper discussions about race and privilege. Many academic institutions have lecture halls and hallways filled with portraits of White male faculty, which can create implicit assumptions about who is supposed to be there, and exacerbate experiences of stereotype threat and imposter syndrome.

Thus, discussions about race are always potentially high-stakes conversations with long-standing consequences for the climate in the room and for future interpersonal relationships of those engaged—and the health care environment is one that increases the stakes. Increasingly, health care education and delivery have moved to an interdisciplinary team-based approach. Having a strong sense of support, commitment, and collegiality among members is critical to the functioning of the team. Discussions about race, racism, and racial equity are ones that, if done poorly, can undermine the goals of team-based learning and care delivery. However, if done well, these discussions have the potential to strengthen powerful, lasting bonds between learners and facilitate the creation of future diverse teams, united in the purpose of providing high-quality health care to patients that is sensitive to the needs of their social identities.

In this article, we provide lessons learned from our combined experience of over 60 years of teaching about race within the larger context of health disparities, patient/provider communication, and shared decision making. We have taught health professionals at various stages in their training, including health professions students, postgraduate trainees, and physicians and other health professionals. We have given one-time lectures, discussed racism on hospital rounds and in clinics, and taught longitudinal courses. As a result of these experiences, we have 12 key lessons to share across 4 topics: ground rules; language and communication; concepts of social constructs, intersectionality, and bidirectional biases; and structural racism, solutions, and advocacy.

Lessons Learned

Ground rules

Lesson 1: Create a psychologically safe learning space. The single most important action is to create an emotionally safe space for learners. This means, for instructors, using both words (i.e., actually verbalizing that this is a “safe space”) and actions (e.g., modeling kindness, empathy, intellectual curiosity). We recommend Smith and Foronda’s 10 Classroom Ground Rules Based on Cultural Humility, which includes affirmations such as “I will focus on others’ feelings and experiences as well as my own” to set the tone for the learners. As the instructor, use warmth and social bonding to engender trust with you (as their leader on this journey) and among participants (on their journey together). It is also important to humanize learners for each other, with the goal being to transition participants from “clinicians” back to “people.” This is more easily done with health professions students who have not yet become as rigidly identified with their professional role as established clinicians. Similarly, it is crucial to view patients as people. Professionalization helps build ethical, responsible behavior in trainees, but overmedicalization can strip trainees of some of their own humanity and their natural reflex to see patients as people, a particular risk when caring for patients from different backgrounds. Using ice breakers, narrative, and even forms of theater can help the class learn about each other and their patients, and begin to build a sense of community and trust that will help during the difficult conversations to come.

Lesson 2: Create expectations for civil discourse. We recommend establishing clear ground rules for classroom participation that can create an emotionally safe learning space.

Academic Medicine, Vol. 95, No. 12 / December 2020 Supplement
Let participants know that this will be interactive; all minds and hearts need to be present in the room. The rules for civil discourse are ones that everyone should agree on before the discussion begins. We recommend global, accessible ground rules such as the following:

1. Respect each other’s opinions, even if you disagree;
2. Allow everyone to speak, and do not interrupt;
3. Turn off or silence electronic devices;
4. Be generous, trust each other’s intentions, and ask clarifying questions to understand further;
5. Speak from your own experience, rather than attempting to represent the entire community (e.g., race, gender) that you are a part of; and
6. Limit the people in the room to class participants to enhance accountability and trust.

Instructors and facilitators would benefit from training in negotiating conflict and maintaining classroom civility.

Lesson 3: Reward those that lean into the conversation. We have found that the most successful classes are ones that are interactive conversations, rather than didactic lectures. It can be intimidating for health professions students, accustomed to relying on data and data gathering, to initially engage in honest, compassionate dialogue about charged issues such as race and racism. It is important to verbally encourage and reward those that do and to provide outlets for continued conversations outside of the classroom. On the other hand, there will likely be learners who are reticent to engage in the classroom dialogue. If the circumstances permit (e.g., longitudinal courses), engaging those students outside of the class, to better understand their beliefs, fears, and/or attitudes, may be a helpful strategy to safely bring them into the learning circle.

Lesson 4: Avoid curricular violence; do not traumatize the participants. Discussions about race and racism can be traumatizing for participants (both White and those of color). Traumatizing dialogue and interactions may encourage participants to disengage or shut down, and they can have ripple effects within the community of learners. Traumatization can be limited by Lessons 1 and 2 (above) and by Lessons 5, 7, 9, and 12 (below). Monitor the participants for disruptive behaviors indicative of high stress and work to desensitize behaviors. Potential warning signs include focusing on the validity of the data being presented or the credentials of the facilitator, and not following the rules of civil discourse. It may be time to take a break and speak directly to that individual learner’s concerns.

Lesson 5: Take the individual blame out of the conversation about bias and racism. We have found it important to discuss the universality of implicit bias as part of our discussions about race and racism. According to social science theory, everyone uses the strategy of social categorization (e.g., by race or gender) in an attempt to understand and process new information. Unfortunately, this process can lead to exaggeration of negative intergroup differences (e.g., stereotypes) and an overgeneralization of them (e.g., subconscious bias, prejudice). Thus, implicit bias is an evolutionary cognitive shortcut for helping our brains process large amounts of incoming data about the world in which we live. We can measure these biases, or cognitive shortcuts, about race and other social identities, using tests such as the Implicit Association Test, which compares the speed at which our brains process information through the conscious, regular neural pathways compared with the subconscious, faster neural pathways. We all have a collective responsibility to check our biases, particularly the powerful ones that perpetuate race and ensure that we are truly seeing the individuals in front of us, in all of their humanity, and not the stereotyped, biased versions of them that our brains have programmed us to see. Regarding structural racism, instructors should stress that while we did not create these systems, it is important to acknowledge that we operate and sometimes benefit from these systems, and must all work to disrupt those systems that perpetuate racism.

Language and communication

Lesson 6: Be precise and consistent with language. Language is important and words are powerful. Everyone should be using the same terminology to refer to the same constructs, which can be challenging to achieve in a classroom setting. Core terms should be well defined (and well discussed, if time permits) at the beginning of the class. Use a glossary of terms with references, core required readings that specifically address terminology, and/or other didactic tools. We recommend using Dr. Camara Jones’ framework for understanding the 3 levels of racism because it is conceptually clear yet comprehensive, and because she provides a number of engaging tools and allegories that can be safe and transformative for adult learners. Dr. Jones describes institutional racism (i.e., structural racism) as differential access to goods, services, and opportunities by race, including differential access to health insurance and health care; personally mediated racism (i.e., interpersonal racism) as both prejudice (differential assumptions about the abilities, motives, and intentions of others according to their race) and discrimination (differential actions toward others according to their race); and internalized racism as the acceptance by members of stigmatized races of negative messages about their abilities and intrinsic worth.

Lesson 7: Start with stories, not numbers. Numbers may give a signal that the teaching session may be purely didactic (versus interactive) and learners may mentally check out early in the class. In contrast, stories are moving and all learners have them. We have found that sharing the lived experience of the instructor, leading by example, is important for success of the class. Subsequently leveraging a variety of individual narratives and stories from class participants will further engage the group and underscore that marginalized social identities and vulnerable experiences are something that we all may have, not just racial/ethnic minorities. Personal stories help to build solidarity of experience within the group before tackling the potentially divisive issue of race and racism. Finally, representation matters. As often as possible, racial and ethnic minority instructors who are experts in these issues should be recruited to teach and facilitate these discussions. The lived experiences of an Asian American instructor when addressing the racism faced by Asian American students and patients during the COVID-19 pandemic, for example, would be invaluable. The identity of the presenters should include, although not
Concepts: Social constructs, intersectionality, and bidirectional biases

Lesson 8: Talk about race as a social construct before talking about racism. It is important to recognize race as a nongenetic, nonbiological construct among health professions students and health professionals, given the primary educational exposure to race as a biological variant in disease prevalence (e.g., sickle cell disease). Increasingly, scientists are calling into question the current use of race in clinical medicine based on factually inaccurate historical assumptions about biological differences among races. For example, adjusting for Black race is problematic in calculations for renal function via glomerular function rates and lung function via spirometry. The U.S. Census has significantly changed how racial groups have been defined over time, and how racial groups are defined varies widely between countries. By demonstrating that the definition of race itself has varied by time and by place, it helps students to understand that race is primarily a social construct created for sociopolitical purposes, and can empower them to think more boldly about how to address social inequities created by racism.

Lesson 9: Explain that race/racism is part of a larger framework of understanding marginalized social identities: Intersectional identities and systems of oppression matter. As discussed earlier, it is important for health professions students to understand that race is but one of many social identities, and that every identity can be marginalized. This understanding reduces the isolation and potential retraumatization of racial minorities in the class by the discussion about racism itself. It is also important for students to understand the term “intersectionality,” that is, how living at the intersection of multiple marginalized identities (e.g., race, sexual orientation, class) can magnify the detrimental impact on one’s mental and physical health. Intersectionality also underscores the structural factors (e.g., structural racism, structural heterosexism) that intersect to harm persons with multiple marginalized identities (e.g., Black transgender persons). At The University of Chicago Pritzker School of Medicine, our required health disparities course for first-year medical students includes a session on intersectionality, using the example of race/ethnicity, sexual orientation, and gender identity. Appreciation for intersectional identities also shines light on the heterogeneity within racial/ethnic groups. For example, significant numbers of Southeast Asians are at high risk for poor health outcomes because of major social challenges, such as poorer economic status and lower rates of insurance coverage and language fluency. Some Asian American health professions students have experienced xenophobia and racism from a devaluation of their Asian cultures in a dominant White society.

Lesson 10: Recognize that bias and discrimination are bidirectional: Health professionals have biases toward patients, and patients have biases toward specific health professionals. Most cultural competency courses focus on the implicit biases health professionals have toward patients. The reality is more complex. To aid in shared decision making with diverse patients, including people of color who are also lesbian, gay, bisexual, transgender, queer, or intersex, we have developed a conceptual model that acknowledges the bidirectional nature of the spoken dialogue and of unspoken perceptions and implicit biases between clinician and patient. Failure to discuss and prepare learners for this complex dynamic can place further stress on racial/ethnic minority students who may frequently deal with negative patient biases. These bidirectional biases are also present between trainee and teacher/supervisor/evaluator.

Structural racism, solutions, and advocacy

Lesson 11: Engage in “free, frank, and fearless discussions” about structural racism, colonialism, and White privilege; teach about systems, not just interpersonal cultural humility. It is important that discussions about race and racism not be ahistorical, nor focus exclusively on interpersonal interactions rather than systemic, structural drivers of discrimination and inequities. The past is critical prologue for the present. For racial/ethnic minority students, it is important that their ancestral stories not begin in the classroom as enslaved or conquered peoples. Understanding the complete history of racism in the United States must include a discussion about the sociopolitical and economic drivers of colonialism, the persistence of structural racism and White privilege, and how they impact the current daily lives and well-being of Blacks and other minorities in the United States. This is where the conversations can become especially difficult. But if we have done our due diligence with the rest of the lessons, the class can embrace the issues head on together as a community and engage in open dialogue that seeks to explore, understand, heal, and problem solve. We have found it helpful to specifically talk about how structural racism has included health care institutions—medical schools, hospitals, and professional medical societies—and directly contributed to health disparities among minority populations. For example, we have included the history of Abraham Flexner recommending closure of African American medical schools, exclusion of African American physicians from the American Medical Association, patient segregation within hospitals, harmful research without consent conducted on racial minorities, and more. Of course, this must be paired with stories of courage and accomplishment despite these obstacles. Stories of the development of Black hospitals and teaching institutions, pioneering researchers (e.g., Dr. Daniel Hale Williams, Dr. William E. Bowman), and the National Medical Association have been particularly instructional.

Lesson 12: Teach about solutions and how to be a leader and advocate. A focus on problems and deficits alone is deflating and disempowering. Our experience has been that students’ passion for tackling racism and health disparities can be extinguished if the curriculum does not also cover interventions and how they can be advocates for their patients. Solutions for reducing health disparities and advancing health equity go beyond cultural humility training. Great progress has been made in the research evidence...
base about how health care professionals and health care organizations can provide more equitable care tailored to their patients and communities, addressing medical and social factors impacting health outcomes.51 Roadmaps exist for how health care organizations can address structural racism and reduce health disparities, with a key tenet to intentionally design systems of care to address the needs of racial/ethnic minority and other patients at high risk for poor outcomes.52–57 We teach what health care professionals, health care organizations, communities, and policymakers can do to address racism and structural inequities,46,56,59 and, in fact, the title of the required Pritzker School of Medicine course is “Health Disparities: Equity and Advocacy.”60

Summary and Conclusions

In summary, successfully teaching about race and racism requires a careful balance of emotional safety and honest truth-telling. Creating such environments where all learners can thrive and grow together is a challenge, but a consistently doable one. Having health professions students cognitively and emotionally trained to meet the challenges of racism in the classroom will make them more prepared to address real-world issues as they arise in patient care delivery and in interprofessional settings. Moreover, in some cases, health professions students may have a more sophisticated understanding of racism than their supervisors when they do their clinical rotations. These students should be trained in how to advocate for themselves and others, such as through bystander intervention training,11,62 while a culture of equity and institutional competency in addressing racism develop in the health care system. It should not be the responsibility of racial/ethnic minority students to fix the system. Academic medical centers need to address interpersonal and structural racism a priority; be accountable; and speak with their actions, not only words.63 Competence in discussing race and addressing racism will become increasingly relevant as health care institutions strive to address the social needs of patients (e.g., food insecurity, housing instability) that contribute to poor health and are largely driven by structural inequities.29,57,62 COVID-19 has made the public painfully aware of the inadequacy of our current health care system for meeting patients’ medical and social needs, and highlighted the importance of addressing systemic drivers of health inequities such as structural racism.46,65 Having interprofessional team-based care, with teams better able to understand and counteract their own biases, will be critical to addressing the social and structural determinants of health for marginalized patients. Teaching health professions students about race and racism is critical to countering the “silent curriculum” that perpetuates inequities, and should be done early in the curriculum.66 Recognizing that implicit biases about race impact both patients and racial/ethnic health professions students is a critical step toward building robust curricula about race and health equity that will improve the learning environment for trainees and reduce health disparities.

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Academic Medicine, Vol. 95, No. 12 / December 2020 Supplement
Curricular Interventions


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