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Assistant Professor, Department of Community Health and Epidemiology

O-Week 2022

The complexities of medical practice in 2022 – introducing anti-oppressive practice

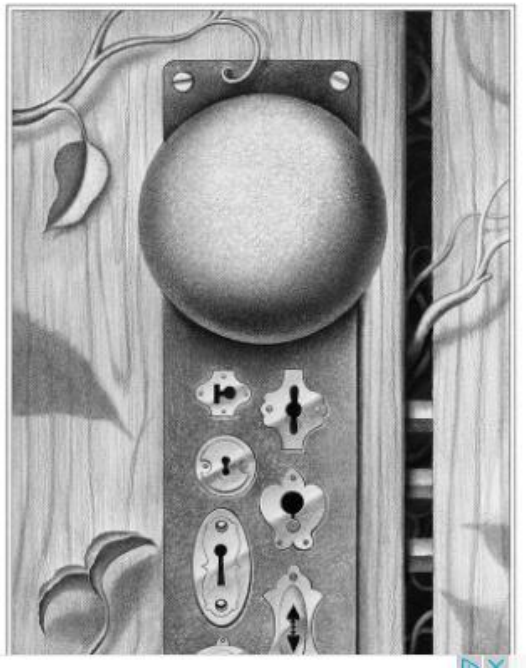
DALHOUSIE UNIVERSITY

FACULTY OF MEDICINE

SCIENCE | MARCH 31, 2022

Why Have Female Animals Evolved Such Wild Genitals?

From ducks to dolphins, females have developed sex organs that help them deter undesirable suitors and derive pleasure from non-reproductive behavior



“We don’t see the world the way it is – we see it the way we are..”

- Anais Nin quoting the Talmud, 1961

Objectives and Outline

- By the end of this session participants will:
- Be introduced to the concept of anti-oppressive practice
- Be aware of the ways in which the practice and profession of medicine has complicit in upholding forms of oppression, using racism as the primary example.
- Have reflected on the biases we are left with and how we react with fragility when they are exposed.
- Have considered approaches for dealing with complex societal (health) issues.
- Be aware of the language and terminology that is being used by the Dalhousie Faculty of Medicine to better describe the complex and dynamic approaches to equity, diversity, inclusion, and accessibility in 2022.

Disclosures

- I have no financial or other material conflicts of interest related to this topic.
- I am not a member of a speakers' bureau.
- Photos have been taken from sources labelled as creative commons licenced.

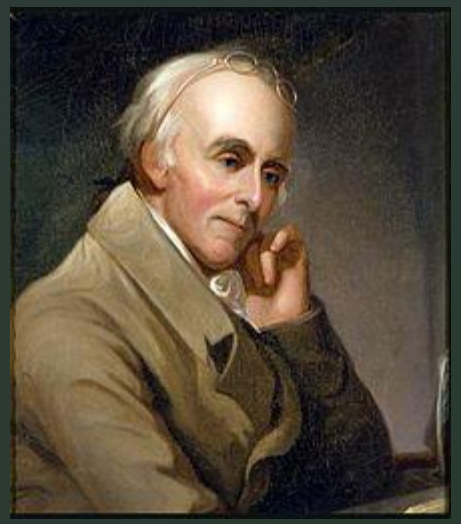
Disclosures

- I am neither critical race theorist nor lawyer nor ethicist nor anthropologist nor historian. All of what I say today has been said before me by others who have carried the struggle of anti-racism work for decades.
- I am a fierce advocate for the collection of race-based population-level data related to health and social outcomes.
- There are myriad ways to present the content I am about to share with you. The central concept – of race as a social construct – remains indisputable.
- Some of what I share with you today will be deeply challenging for some of you.
- I am learning every day. Still.

The damage done by the artificial construct of *race* has been immense.

Sadly, medicine has not been immune.
In fact, physicians were the key developers of these racist ideas in the 1700s.

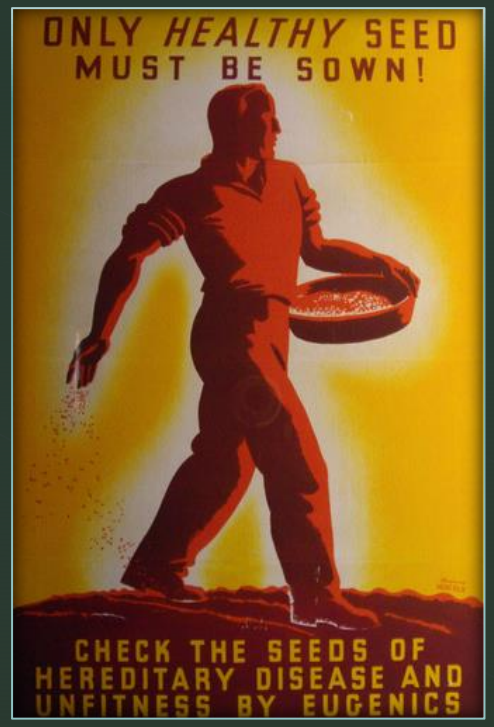
Dr. Benjamin Rush, Founding Father of the United States of America

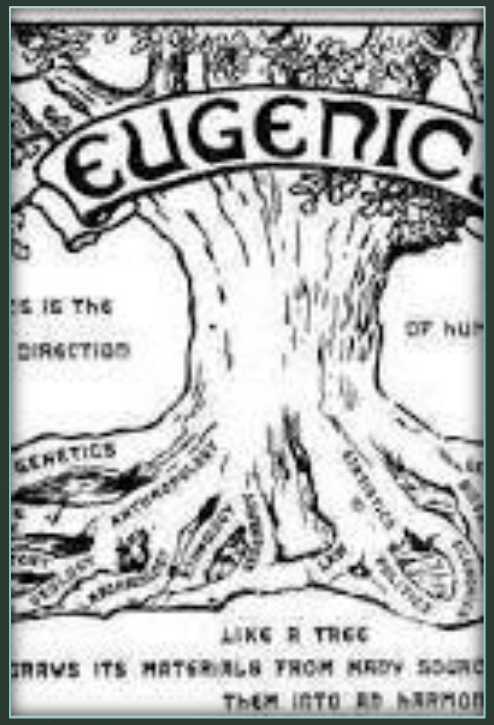


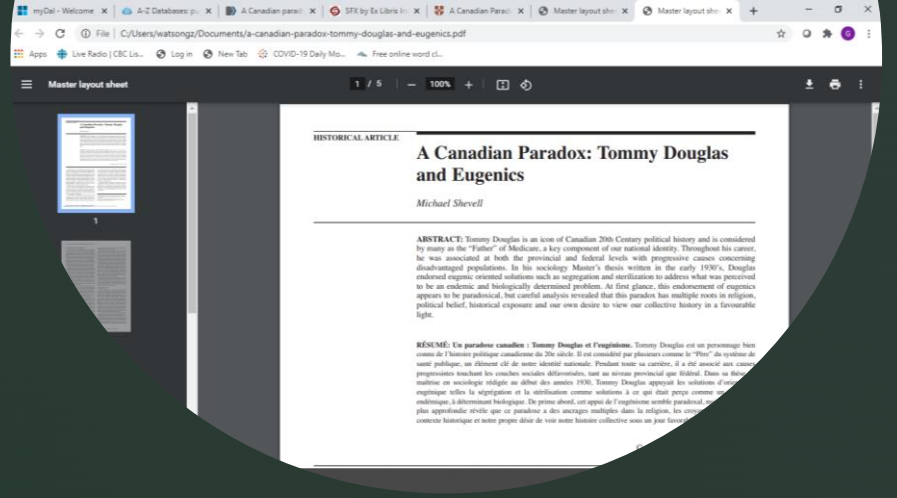
- Taught his medical students that Blackness was a disease like leprosy. And so should be cured. In favour of whiteness.
- “Racial Scientists” existed in the US in the 1800s

Scientific racism extended to medicine…

- Eugenics: “good breeding” – popularized in Europe and North America in the 1920s and 1930s. Discredited in 1940s post WWII.

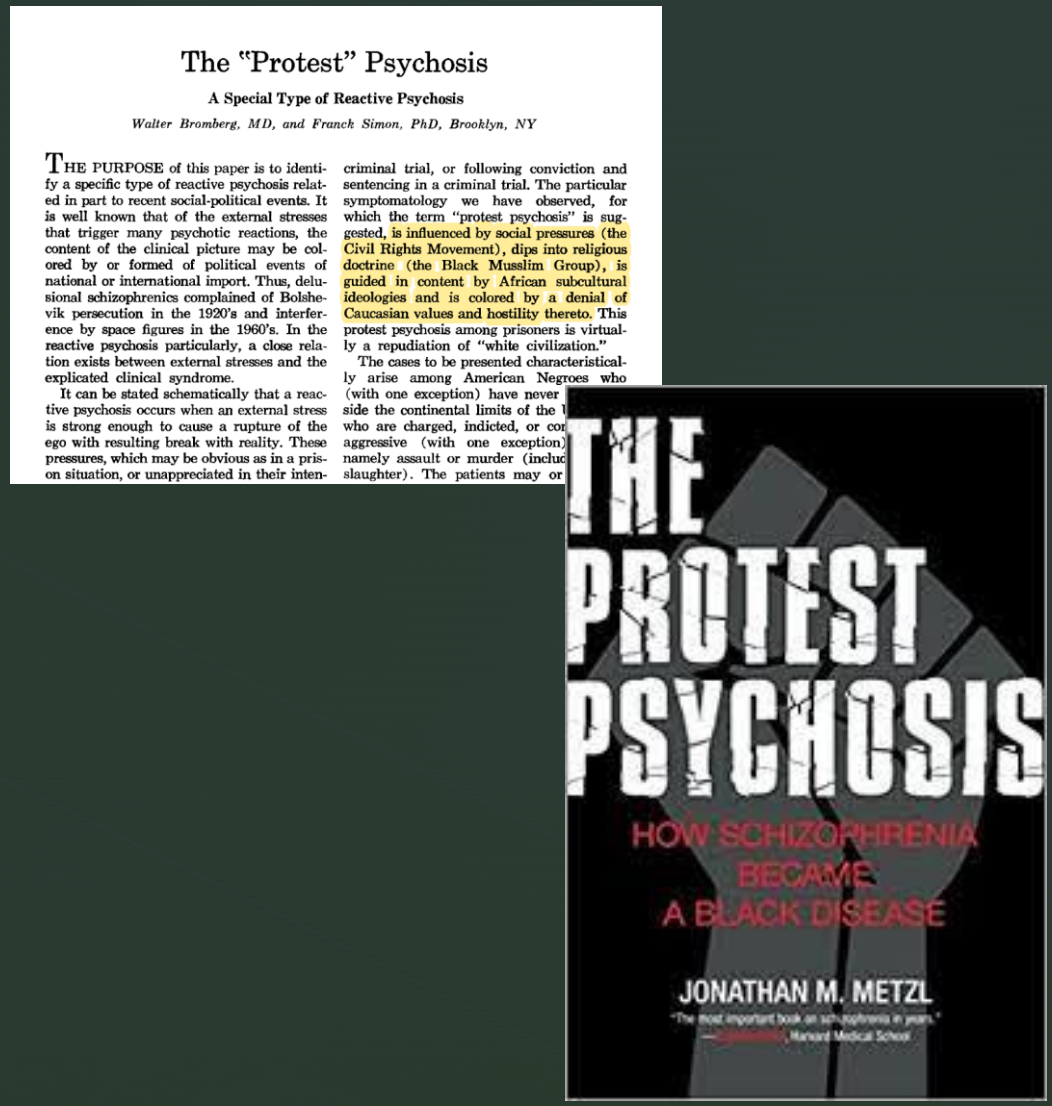






Eugenics had some very popular proponents.

Race was used to “explain away” the very necessary and appropriate anger felt and expressed by Black men during the civil rights movement in the 1960s.



The “Protest” Psychosis

A Special Type of Reactive Psychosis

Walter Bromberg, MD, and Franck Simon, PhD, Brooklyn, NY

THE PURPOSE of this paper is to identify a specific type of reactive psychosis related in part to recent social-political events. It is well known that of the external stresses that trigger many psychotic reactions, the content of the clinical picture may be colored by or formed of political events of national or international import. Thus, delusional schizophrenics complained of Bolshevik persecution in the 1920's and interference by space figures in the 1960's. In the reactive psychosis particularly, a close relation exists between external stresses and the explicated clinical syndrome.

It can be stated schematically that a reactive psychosis occurs when an external stress is strong enough to cause a rupture of the ego with resulting break with reality. These pressures, which may be obvious as in a prison situation, or unappreciated in their intencriminal trial, or following conviction and sentencing in a criminal trial. The particular symptomatology we have observed, for which the term “protest psychosis” is suggested, is influenced by social pressures (the Civil Rights Movement), dips into religious doctrine (the Black Musslim Group), is guided in content by African subcultural ideologies and is colored by a denial of Caucasian values and hostility thereto. This protest psychosis among prisoners is virtually a repudiation of “white civilization.”

The cases to be presented characteristically arise among American Negroes who (with one exception) have never
side the continental limits of the
who are charged, indicted, or co
aggressive (with one exception)
namely assault or murder (includ
slaughter). The patients may or

THE PROTEST PSYCHOSIS

HOW SCHIZOPHRENIA BECAME A BLACK DISEASE

JONATHAN M. METZL

“The most important book on schizophrenia in years.”
—, Harvard Medical School

Includes human rights violations in Canada up until recently…and ongoing.

North

Indigenous women come forward with accounts of forced sterilization, says lawyer

Lawyer says sterilization without informed consent has been performed as recently as 2018 in Saskatchewan

Avery Zingel · CBC News · Posted: Apr 18, 2019 7:48 AM CT | Last Updated: April 18, 2019

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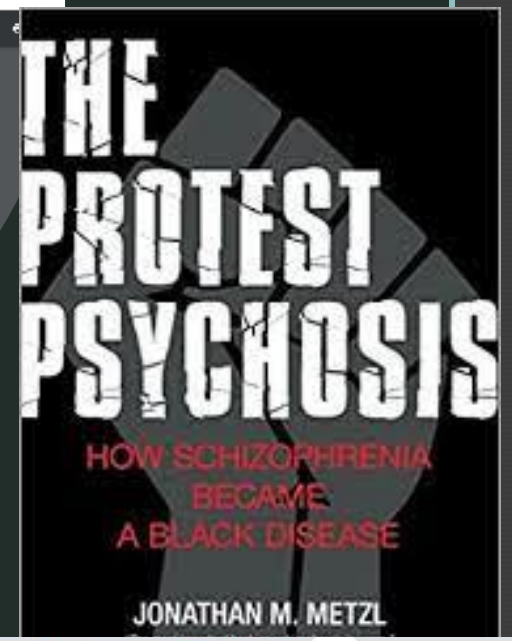
Race Based Medicine

Race is a social construct that is used to group people based on physical characteristics, behavioral patterns, and geographic location. Racial categories are broad, poorly defined, vary by country and change over time. People who are assigned to the same racial category do not necessarily share the same genetic ancestry; therefore, there are no underlying genetic or biological factors that unite people within the same racial category. By using race as a biological marker for disease states or as a variable in medical diagnosis and treatment, the true health status of a patient may not be accurately assessed, which can lead to racial health disparities.

The American Academy of Family Physicians (AAFP) opposes the use of race as a proxy for biology or genetics in clinical evaluation and management and in research. The AAFP encourages clinicians and researchers to investigate alternative indicators to race to stratify medical risk factors for disease states. (July 2020 BOD) (2020 COD



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aamc.org/news-insights/how-we-fail-black-patients-pain

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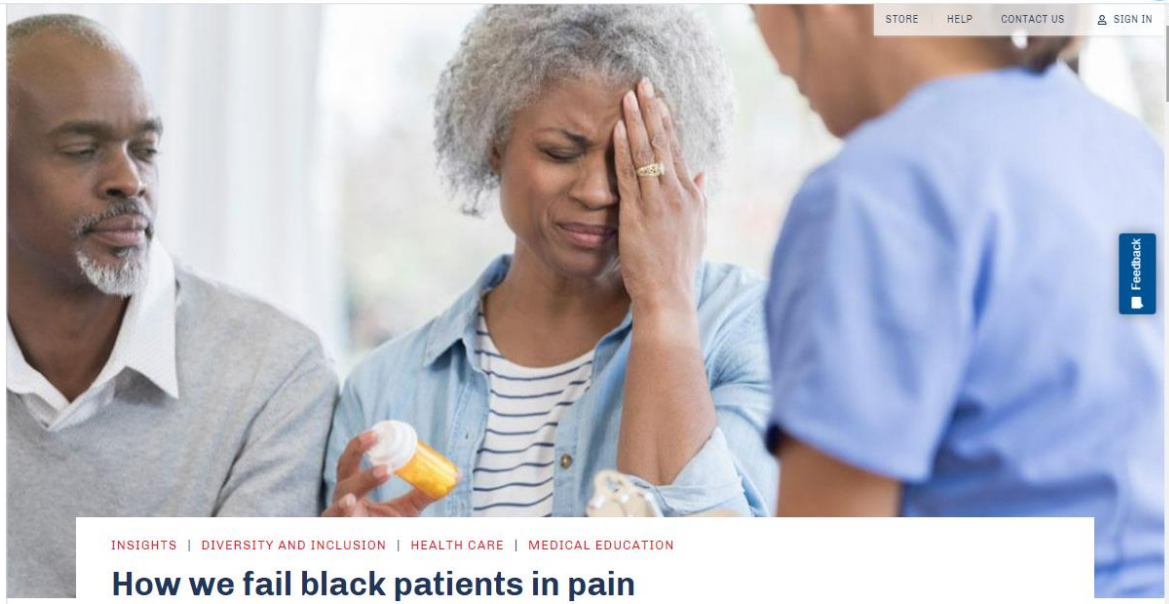

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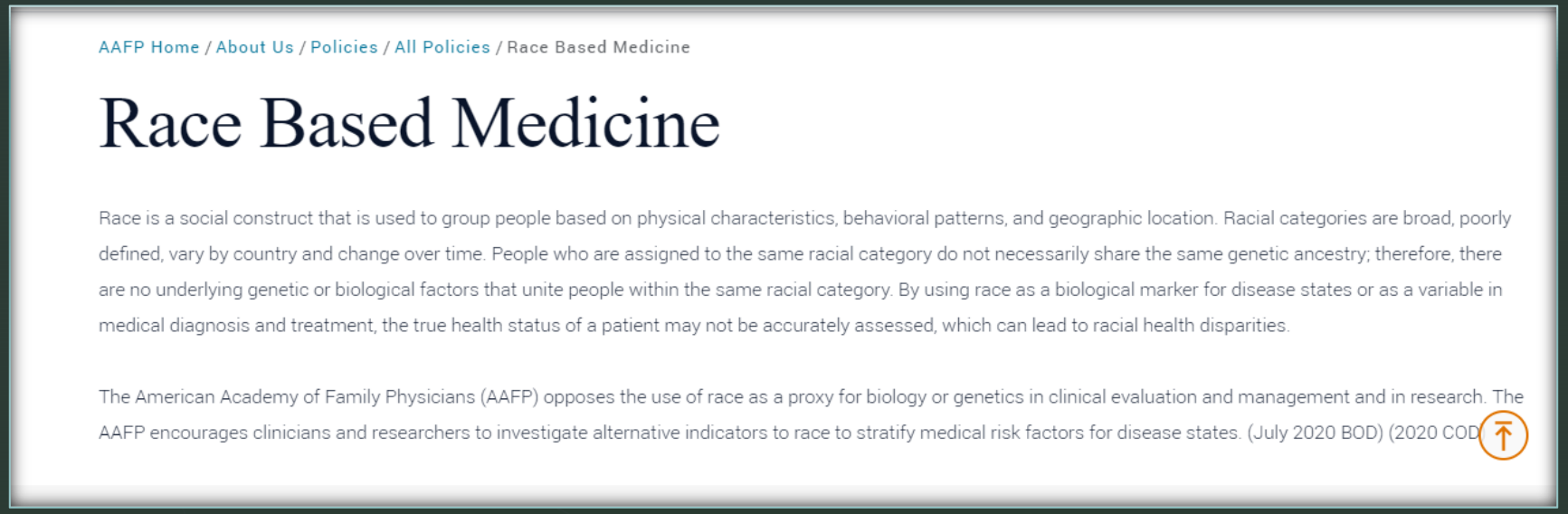
How we fail black patients in pain

Janice A. Sabin, PhD, MSW

Feedback



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The notion of race as a biological and genetically important entity has been persistent in medicine despite being repeatedly debunked…

NIH National Human Genome Research Institute

The NEW ENGLAND JOURNAL of MEDICINE

MEDICINE AND SOCIETY

Debra Malina, Ph.D., *Editor*

Hidden in Plain Sight — Reconsidering the Use of Race Correction in Clinical Algorithms

Darshali A. Vyas, M.D., Leo G. Eisenstein, M.D., and David S. Jones, M.D., Ph.D.

Physicians still lack consensus on the meaning of race. When the *Journal* took up the topic in 2003 with a debate about the role of race in medicine, one side argued that racial and ethnic categories reflected underlying population genetics and could be clinically useful.[1] Others held that any small benefit was outweighed by potential harms that arose from the long, rotten history of racism in medicine.[2] Weighing the two sides, the accompanying Perspective article concluded that though the concept of race was "fraught with sensitivities and fueled by past abuses and the potential for future abuses," race-based medicine still had potential: "it seems unwise to abandon the practice of recording race when we have barely begun to understand the architecture of the human genome."[3]

The next year, a randomized trial showed that a combination of hydralazine and isosorbide

subtle insertion of race into medicine involves diagnostic algorithms and practice guidelines that adjust or "correct" their outputs on the basis of a patient's race or ethnicity. Physicians use these algorithms to individualize risk assessment and guide clinical decisions. By embedding race into the basic data and decisions of health care, these algorithms propagate race-based medicine. Many of these race-adjusted algorithms guide decisions in ways that may direct more attention or resources to white patients than to members of racial and ethnic minorities.

To illustrate the potential dangers of such practices, we have compiled a partial list of race-adjusted algorithms (Table 1). We explore several of them in detail here. Given their potential to perpetuate or even amplify race-based health inequities, they merit thorough scrutiny.

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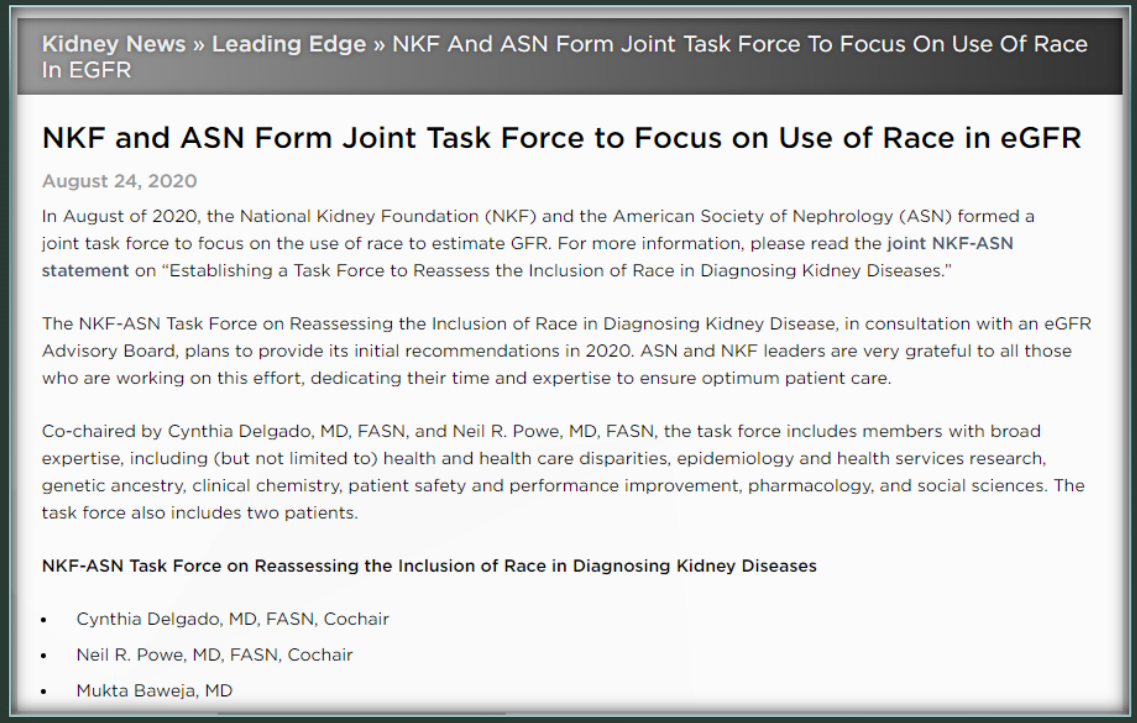
Advocating for a Shift From Race-based to Race-conscious Medicine

October 08, 2020 by Abigail Roth

Update!

- As of mid-2021 the race-modifier previously used to calculate eGFR in Black patients in the US was removed (ASN-NKF 2021).



Kidney News » Leading Edge » NKF And ASN Form Joint Task Force To Focus On Use Of Race In EGFR

NKF and ASN Form Joint Task Force to Focus on Use of Race in eGFR

August 24, 2020

In August of 2020, the National Kidney Foundation (NKF) and the American Society of Nephrology (ASN) formed a joint task force to focus on the use of race to estimate GFR. For more information, please read the **joint NKF-ASN statement** on "Establishing a Task Force to Reassess the Inclusion of Race in Diagnosing Kidney Diseases."

The NKF-ASN Task Force on Reassessing the Inclusion of Race in Diagnosing Kidney Disease, in consultation with an eGFR Advisory Board, plans to provide its initial recommendations in 2020. ASN and NKF leaders are very grateful to all those who are working on this effort, dedicating their time and expertise to ensure optimum patient care.

Co-chaired by Cynthia Delgado, MD, FASN, and Neil R. Powe, MD, FASN, the task force includes members with broad expertise, including (but not limited to) health and health care disparities, epidemiology and health services research, genetic ancestry, clinical chemistry, patient safety and performance improvement, pharmacology, and social sciences. The task force also includes two patients.

NKF-ASN Task Force on Reassessing the Inclusion of Race in Diagnosing Kidney Diseases

- Cynthia Delgado, MD, FASN, Cochair
- Neil R. Powe, MD, FASN, Cochair
- Mukta Baweja, MD

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Commentary

Elimination of race in estimates of kidney function to provide unbiased clinical management in Canada

Rulan S. Parekh, Jeffrey Perl, Bourne Auguste and Manish M. Sood
CMAJ March 21, 2022 194 (11) E421-E423; DOI: https://doi.org/10.1503/cmaj.210838

Article Responses Metrics PDF

KEY POINTS

- For many years, the universally used Chronic Kidney Disease Epidemiology Collaboration equation (CKD-EPI) for estimating kidney disease function has included an adjustment for Black race that resulted in an upward correction in estimated glomerular filtration rate (eGFR).
- In 2021, new equations that omit race but include other factors were developed and found to be more accurate in estimating eGFR.

In This Issue

CMAJ

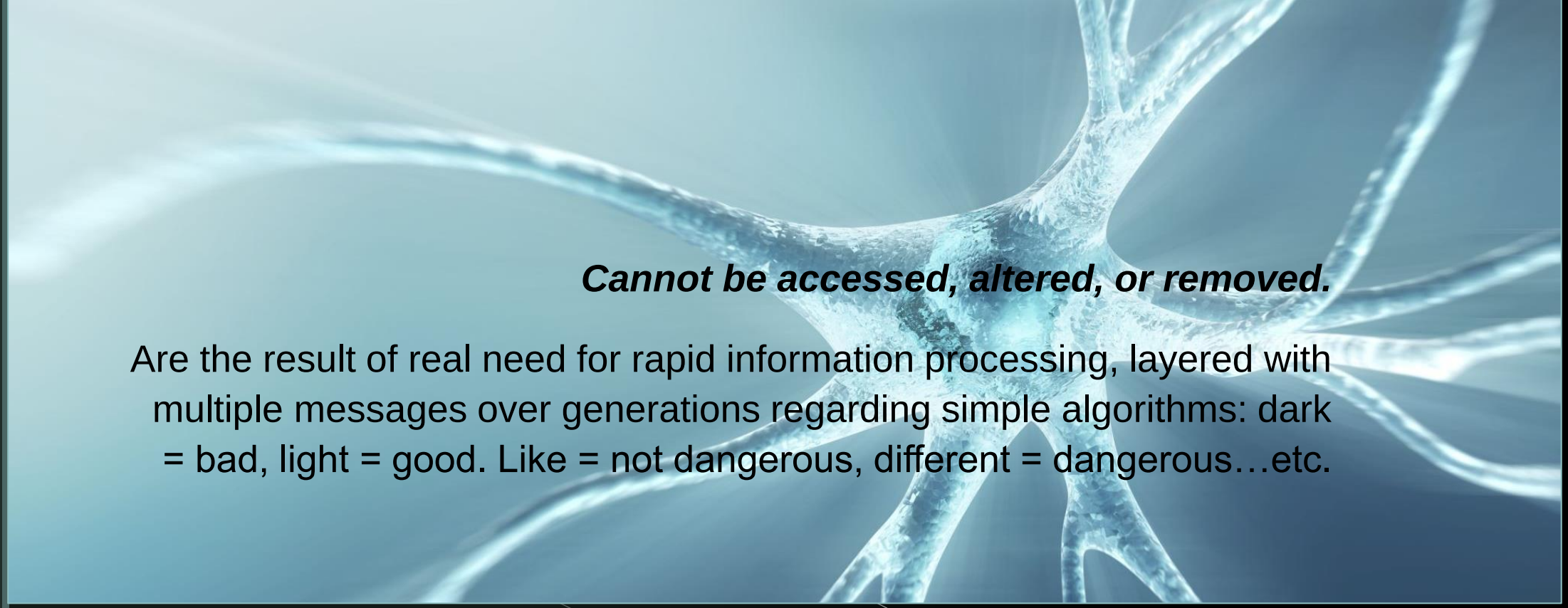
The challenge is that the concept of race has our attention, as a profession, but for the *wrong reasons.* It has *no* biological utility, and undermines our attempts at "evidence-based medicine".

This critically changes how we teach epidemiology and genetics.

Prison populations
High school graduation rates
Children in “custody of the state”
Chronic disease statistics
Premature death rates
Poverty rates
Chronic pain statistics

When racism has set up the institutional structures that support ***life*** to preference and privilege opportunity to those of a certain skin colour – and often without any of our understanding or awareness – ***then how can life ever succeed?***

The damage done by this artificial construct has been immense.



Cannot be accessed, altered, or removed.

Are the result of real need for rapid information processing, layered with multiple messages over generations regarding simple algorithms: dark = bad, light = good. Like = not dangerous, different = dangerous…etc.

(Implicit) biases are rooted in the unconscious.

The concept of race has so insidiously and completely penetrated our every institution that it very nearly has become part of the air we breathe.

It also manifests in such a way that we forget, regularly and repeatedly, that *structural white supremacy* is the organizing framework from which racism arises.

COMMENTARY ■ VULNERABLE POPULATIONS

Healing racism in Canadian health care

Yvonne Boyer JD LLD

■ Cite as: *CMAJ* 2017 November 20;189:E1408-9. doi: 10.1503/cmaj.171234

KEY POINTS

- Indigenous peoples face systemic racism and discrimination in the Canadian health care system, as identified by two recent reports.
- The health care system is set up to ignore the colonial history facing Indigenous patients.
- Structural changes to the current system are urgently needed to address these failures.

Racism in the Canadian health care system is endemic. Recent reports[1,2] have highlighted its preponderance in central Canada, where Indigenous women have been coerced into sterilization and Indigenous men have been ignored in emergency departments, left to suffer and, in at least one tragic case, to die. Canada's current model of delivering health care fails either to show an understanding of or to address the subset of health determinants that affect Indigenous patients. Ingrained problems of racism and discrimination will not be solved until the system is changed so that health care is delivered in a way that is culturally competent and inclusive of an Indigenous model.

In July 2017, the Saskatoon Health Region commissioned an external review in response to media reports of Aboriginal women being coerced into tubal ligation immediately after childbirth in a Saskatoon Health Region hospital; the review found several structural problems.[1]

Sixteen Aboriginal women contacted the reviewers and seven interviews were completed. All of the women felt coerced into having a tubal ligation postdelivery in the Saskatoon Health Region, most believing it to be reversible as a type of birth control. The women shared that nurses, social workers and physicians pressured them while they were at their most vulnerable, either in the throes of labour or immediately postdelivery. They stated they felt powerless to resist the coercion and have suffered immensely as a result of having tubal ligation.

The report concluded that the Saskatoon Health Region promotes racist and discriminatory health care for Indigenous women. It suggested structural change that is inclusive of culturally relevant health care, and that health professionals be educated and made sensitive to Indigenous history and the unique health care requirements of the people they serve.

An interim report released in September 2017 after a multidisciplinary inquest into the death of Brian Sinclair[2] — a 45-year-old First Nations man who died of a treatable bladder infection in 2008, after being ignored for 34 hours in the emergency department of the Health Sciences Hospital in Winnipeg — detailed systemic failures at many levels.

When evaluating the circumstances of his death, the working group identified a sequence of racist events that had occurred. For instance, Sinclair was visible to the emergency department staff, who ignored him because they assumed he was homeless or intoxicated or just hanging around. The staff did not question why he remained in the waiting room at any point during the 34-hour interval after he wheeled himself in. Even when he began vomiting and slumping further in his wheelchair, the staff did not consider him to be in distress. When the public intervened, the staff quickly quelled their concern by insisting that Sinclair was either sleeping or intoxicated and not sick at all. The working group report suggested that an antiracist policy be implemented immediately, with a monitoring mechanism to evaluate its ongoing effectiveness.

Systemic racism in health care is not unique to Canada. It is also pervasive in other countries, as outlined in a recent report from the College of Family Physicians of Canada.[3] In New Zealand and Australia, for example, Indigenous peoples are unlikely to get timely access to coronary angiography or revascularization following acute myocardial infarction in spite of high rates of cardiovascular disease. Maori patients reported health care issues similar to those of Indigenous people in Canada, including gaps in understanding of the patient experience and beliefs that the patients are responsible for their own poor health status. The report noted, however, that when providers of health care for the Maori were made aware of these findings, they were motivated to change their behaviour and made efforts to increase their understanding of Maori culture. These are but a few of the examples of "interpersonal or relational racism" that can lead to suboptimal medical treatment, but that may also be addressed through effective interventions.

In Canada, Indigenous peoples carry the intergenerational trauma of the residential school system, and its myriad tentacles of physical and sexual abuse. Such policies were rooted in racism

COMMENTARY

Time to dismantle systemic anti-Black racism in medicine in Canada

OmiSoore Dryden PhD, Onye Nnorom MD MPH

■ Cite as: *CMAJ* 2021 January 11;193:E55-7. doi: 10.1503/cmaj.201579

KEY POINTS

- Anti-Black racism is a specific form of racism, rooted in the history and experience of enslavement, that is targeted against Black people.
- Disparities between Black people and other groups with respect to medical conditions and risk factors are not explained by biological differences between "races."
- The field of medicine can no longer deny or overlook the existence of systemic anti-Black racism in Canada and how it affects the health of Black people and communities.
- We can address, confront and interrupt anti-Black racism in medicine by taking direction from leading experts both within and outside our profession. An easy step is to pay attention to the conversations Black people are having in our communities, including patients and health care professionals.

On May 25, 2020, George Floyd, an unarmed Black man, was murdered in the United States by White police officer Derek Chauvin who, in the course of arresting Mr. Floyd for allegedly using a counterfeit 20-dollar bill, knelt on his neck for almost 9 minutes. Mr. Floyd repeatedly said, "I can't breathe" (www.nytimes.com/2020/05/31/us/george-floyd-investigation.html). The video of this event, released on social media the next day, started a new chapter in history, sparking protests worldwide that demanded justice and an end to anti-Black racism. In response, the Toronto Board of Health declared anti-Black racism a public health crisis (www.cbc.ca/news/canada/toronto/board-of-health-anti-black-racism-1.5603383), and several public health units in Ontario followed suit, acknowledging that race-based health inequities disproportionately affect Black and racialized communities. We consider the health impacts of anti-Black racism and discuss what the field of medicine must do to dismantle systemic racism in its structures and institutions.

Black people comprise 3.5% of Canada's total population and about 43% of Black people in Canada are Canadian born.[1] In Nova Scotia, there are large, centuries-old communities, including descendants of people who were enslaved in Canada. Although slavery was abolished in what was to become Canada in 1831, it was a foundational institution in the building of the nation.[2,3] Black Canadians also represent diverse immigrant communities.

Systemic racism (also referred to as structural or institutionalized racism) refers to "the processes of racism that are embedded in laws (local, state, and federal), policies, and practices of society and its institutions that provide advantages to racial groups deemed as superior, while differentially oppressing, disadvantaging, or otherwise neglecting racial groups viewed as inferior."[4] Anti-Black racism is a specific form of racism, rooted in the history and experience of enslavement, that is targeted against Black people, people of African descent. Myths and stereotypes were created and used to justify slavery and the torture of enslaved African people, including the idea that Black people were biologically different or subhuman, less intelligent, had a greater tolerance for pain and were not to be trusted, among many others.[2]

Although many Canadians may believe that racism is an issue only south of the border, Black Canadians have been raising awareness about anti-Black racism for centuries. In 2017, the United Nations expressed its deep concern at "the structural racism that lies at the core of many Canadian institutions and the systemic anti-Black racism that continues to have a negative impact on the human rights situation of African Canadians."[5] The United Nations Working Group of Experts on People of African Descent noted that "across the country, many people of African descent continue to live in poverty and poor health, have low educational attainment and are overrepresented in the criminal justice system" and that systemic anti-Black racism is an upstream factor contributing to these outcomes.[5] A 2011 study showed that, on average, Black Canadians earn 75.6 cents for every dollar a white person earns, even after controlling for age, education and immigration status.[6] An analysis of Canadian Census data from 1996 to 2006 showed that 13.4% of Black people with a graduate degree in Montreal were unemployed, a rate comparable with that of non-Black people who had not completed high school (12%).[7]

The stress of racism drives multiple upstream societal factors that perpetuate racial inequities in health for nondominant racial groups around the world, including both mental

Politics

Health care system was designed to subject Indigenous people to systemic racism: Hajdu

Federal minister met with provinces, Indigenous leadership, medical professionals to talk racism in healthcare

Peter Zimonjic · CBC News · Posted: Oct 15, 2020 11:55 PM ET | Last Updated: October 16, 2020

Indigenous Services Minister Marc Miller pauses as he responds to a question during a news conference in June in Ottawa. On Friday, Miller and other federal officials will meet Indigenous leaders to discuss racism in the health-care system. (Adrian Wyld/The Canadian Press)

- "Sadly this is not shocking to me," Hajdu said. "Racism is not an accident. The system is not broken. It was created this way. And the people in the system are incentivized to stay the same."

- Minister Patty Hadju, October 2020

What does it all mean?

- “decolonizing” medical curriculum – means **acknowledging that medical education often arises from a dominant world view which clouds our capacity to see the world as it is** – clouds our capacity to see and realize diverse realities and their causes (Bhandal, CMEJ 2018)

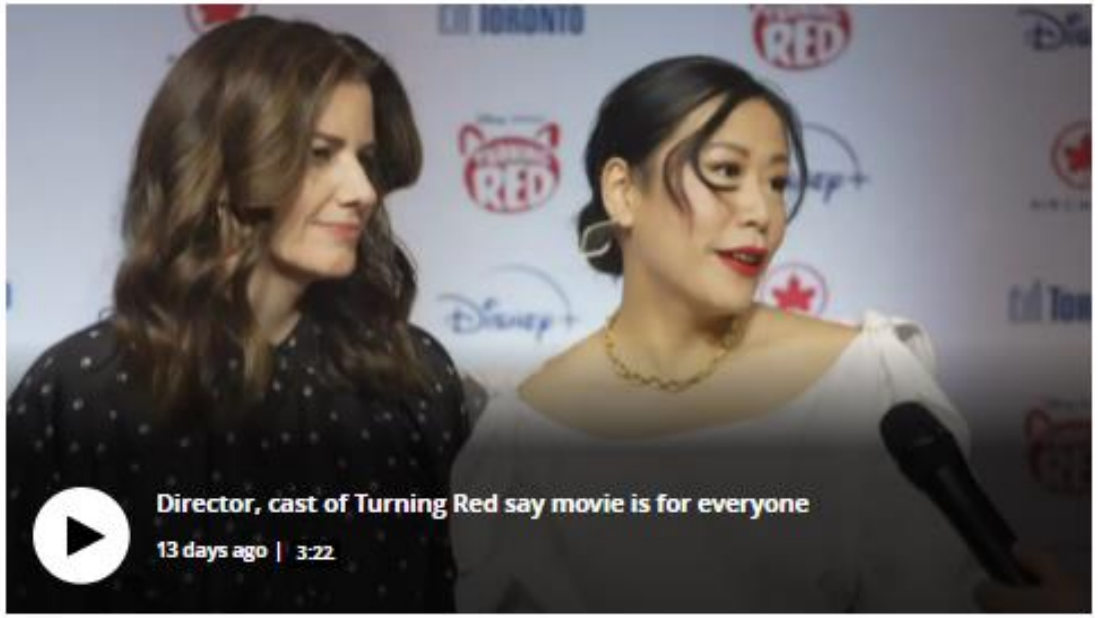
  - Who wrote our text books? Who chose them? How do they truly represent “universal” as opposed to “white-centric?” “hetero-centric?” “able-centric?”

Who defines the “universal” story?

Turning Red is for everyone, cast says after review calls film about Chinese-Canadian girl unrelatable

'We failed to properly edit this review, and it never should have gone up,' wrote CinemaBlend editor-in-chief

Jackson Weaver · CBC News · Posted: Mar 08, 2022 8:04 PM ET | Last Updated: March 14



Turning Red's director, Domee Shi, producer Lindsey Collins, Canadian actor Maitreyi Ramakrishnan and star Rosalie Chiang respond to criticism saying the film is not relatable. 3:22

75 comments

A review posted on website CinemaBlend of Disney-Pixar's new animated film *Turning Red* was

- Often the question is framed as “how do we ‘add diversity’ to discussion of cases?”
  - What types of diversity
  - What happens if we miss “groups”
  - What happen if our representation is wrong?
  - How will we know if we got it right?

How do you deconstruct something that is so perfectly constructed as to undermine every attempt to remove it????

- What if the question is, instead:
- How do we remove “hegemony” from our cases – ***dominant sociopolitical narratives, colonial narratives,*** from our educational and practice content?

John Sylliboy, Mi’kmaw Educator, at IKEA Halifax, 2021

- “A lot of people often misunderstand that we are building Mi’kmaq symbols and art into an IKEA space, when really it’s the other way around. It’s IKEA integrating into a space of Mi’kmaq.”

The specifics triggers and traps of language:

- Part of the trap of racism and other constructs is that they attempt to cloak many oppressive activities in either extremes or softenings of language, including through language (and history of language) omissions:

- Examples:
- “Structural white supremacy”
- “Microaggression”
- “Caucasian”
- Absence of “white” from discourses on race!

The absence of the impact of whiteness from the discourse on racism extends the perverse way in which whiteness defines racism.

Introducing “White Fragility Clinic” at the FoM

- “Safe Spaces for White Questions” – Dr. Ajay Parasram (Fernwood Publishing)
- Our discomfort with language will interfere with our capacity for meaningful and enriching dialogue.
  - This is practice space!

A word on narrative – a tale of three definitions

- Anti-Racist (differs from ‘not racist’ (active vs passive))
- Anti-Discrimination
- **Anti-Oppression** – the attempt to remove multiple and overlapping forms of oppression from a system, institution, or individual experience. Anti-oppression recognizes *that people hold multiple identities* at once, any or all of which may have them subjected to compounding forms of oppression (or privilege). Anti-Oppressive Practice (or Care) then looks at the dynamics of power at play when oppression is occurring, and seeks instead to replace power imbalance with equity, empowerment, affirmation, and inclusion (see Burke and Harrison).
  - Rel – cultural safety, cultural humility, cultural competency, cultural blindness, etc etc. (see AFMC Primer) – care is taken, in culturally safe or humble care, to acknowledge and remedy the power differentials attendant in the multiple identities of the patient and provider

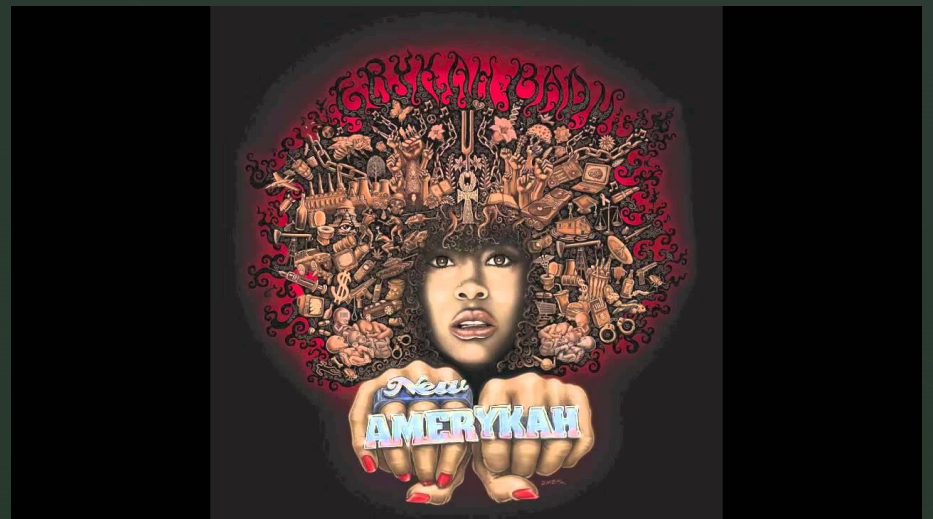
More on narrative and language

- Changes about every five years! (Dr. Lynette Reid)
  - Each change is (usually) an attempt to come empirically closer to an accurate description of the phenomena at change
- See the *Language Matters g*uide published by the Student Diversity and Inclusion Committee (2022) for tips…

https://cdn.dal.ca/content/dam/dalhousie/pdf/faculty/medicine/departments/core-units/cpd/FacDev/LanguageMattersSDIC2022.pdf

More on narrative and language:

WOKE



A word about “backlash” – another manifestation of white fragility - the “***anti-woke medicine***” movement

The WASHINGTON FREE BEACON

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LIBERTY

Raising Concerns About ‘Woke’ Medicine

by Mitch Kokai
Senior Political Analyst, John Locke Foundation

May 24, 2022

Christine Rosen writes for the Washington Free Beacon about a dangerous development in American medicine.

> *It is a popular sport among those on the progressive left to dismiss conservatives’ concerns about the spread of “woke” ideology (such as Critical Race Theory and “antiracism” training) in public education and corporate culture. Parents are scolded for suggesting that seeing the world through the “lens of CRT” or the factually challenged posturing of the 1619 Project might be harmful to their children’s education, and employees are chastised for questioning the effectiveness of new mandates on Diversity, Equity, and Inclusion. The implication is that only a racist would resist the new “antiracism.”*
>
> *And yet, there is one arena in which woke thinking is not merely politically polarizing, but deadly. As Dr. Stanley Goldfarb, a nephrologist*

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Medicine is getting major injections of woke ideology

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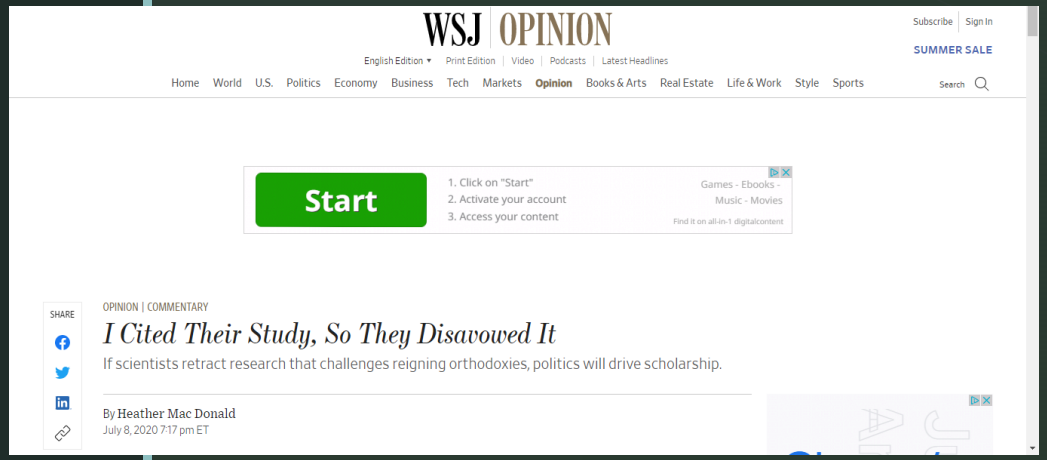
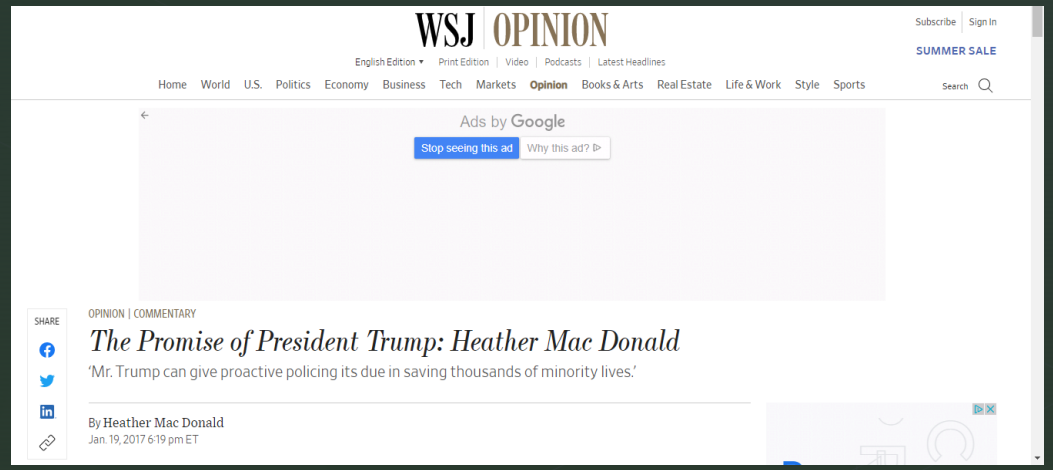
If physicians are trained to combat 'systemic racism,' their ability to treat disease will suffer.

By Heather Mac Donald

Aug. 5, 2022 3:20 pm ET





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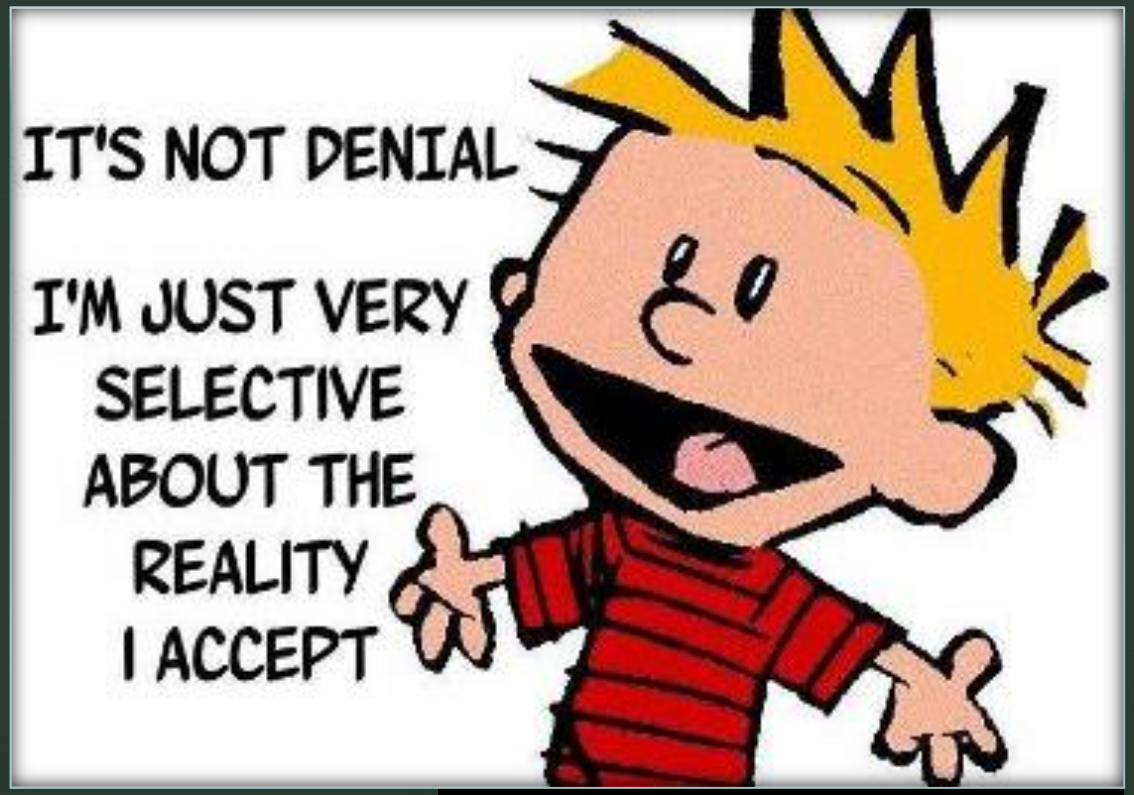
The tactics used by the “anti-woke medicine” movement are identical to those used by the anti-vaxx, anti-fluoride, and climate-change-denial movements:

- Reframing of language - eg “inclusion for all” to suggest that anything that is not “equal” is “reverse racism”
- Claims that medicine is “lowering the standard” rather than acknowledging a) that the standard was biased from the beginning and b) that “different” and “lower” are not the same thing!
- Betrays a fundamental misunderstanding of “equal” versus “equitable” treatment – basic health promotion concepts
- (Note that the teaching of critical appraisal skills in medicine may need to be amended to incorporate these 21st century phenomena regarding misinformation)



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We are a diverse group of physicians, healthcare professionals, medical students, patients, and policymakers united by a moral mission: Protect healthcare from a radical, divisive, and discriminatory ideology. We believe in making healthcare better for all – not undermining it in pursuit of a political agenda.

Leadership

Dr. Stanley Goldfarb

Board Chair

Dr. Goldfarb, a board-certified kidney specialist, is a former Professor and Associate Dean for Curriculum at the University of Pennsylvania School of Medicine. He has been widely published in medical journals, as well as The Wall Street Journal.

Kristina Rasmussen

Executive Director

Kristina is a grassroots and advocacy expert. She previously served as the president of a major state think tank, chief of staff to a governor, and as an advocate for federal government reform.

Benita Cotton-Orr

Senior Fellow

Benita, who immigrated from South Africa in 1988, is a policy analyst with a background in journalism. Her outspoken opposition to racially based and discriminatory policies is rooted in personal experience and the discrimination and inequities her family, friends and colleagues suffered under apartheid.

Laura Morgan

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Laura is a Registered Nurse with a background in critical care, research, and clinical education. She advocates for medical professionalism and the highest standards of individual care.

Mark J. Perry, Ph.D.

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Mark is professor emeritus at the University of Michigan and senior fellow emeritus at the American Enterprise Institute. In recent years, he has been a full-time civil rights advocate and has challenged nearly 800 U.S colleges and universities for

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Doctor who chairs woke 'antiracist' organization accuses five medical schools of unfairly discriminating against WHITE applicants by only offering scholarships for minorities

- Dr. Stanley Goldfarb is the board chair of antiracist group Do No Harm, whose raison d'etre is to combat racism and discrimination in the world of medicine

=true&redir=https%3A%2F%2Frtb-us-e... lleging five U.S. medical schools of actively pushir

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91 Comments

OPINION

Top med school putting wokeism ahead of giving America good doctors

By Dr. Stanley Goldfarb and Laura L. Morgan

September 2, 2022 | 4:54pm | Updated

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PSOM Response to Goldfarb Message

UMELT has received your messages of concern in response to former Professor of Medicine and Associate Dean for Curriculum Stanley Goldfarb's response to this recent article published in Academic Medicine, tweeting "could it be they were just less good at being residents." We are disheartened that our institution and our anti-racist efforts could be overshadowed by such divisive statements. We would like to share this statement shared by Dean Jameson, as the institutional response to Dr. Goldfarb's message.

Such comments, and thinking, on the part of Dr. Goldfarb are harmful and damaging to our URiM students. We are here to be a resource and source of support for our students in the community who feel negatively impacted by this recent messaging. As an anti-racist medical school, we will continue to do the work necessary to maintain that standard as

We must be myth busters

- Many of us actually have NOT been exposed to these concepts in our previous studies/careers
  - We/I/they believe they know what is “true” based on what they have “heard”
  - Our new understanding of race/racism will challenge us to look differently at every institution we hold dear.
  - Similar challenge must be offered against constructs of gender, ability, and age.

Examples of action…

1) Engage specifically with anti-Black and anti-Indigenous Racism

- Dr. Brent Young, Academic Director, Indigenous Health
- Dr. OmiSoore Dryden, JRJ Chair in Black Canadian Studies.
- Dr. Leah Jones recently hired as the Academic Director, Black Health!

2) Normalize

- Normalize a variety of realities by adding labels to ***all*** cases, not only those that are “non-white, non-cisgendered, non able-bodied”
  - “Joe Briggs is a 56 yo white able-bodied person who identifies as male and presents with right-sided weakness of 2 days duration.”
  - “Rihanna Tyndall is a 22 yo Indigenous able-bodied person who identifies as two-spirited and presents with a cough that has persisted for 6 months.”
- By presenting in a normalized and routine way as many realities as possible, we present all realities as valid, and avoid the presumption of one narrative being dominant over others.
- The labels should describe characteristics that may be important in how a patient is initially greeted/met, but nothing more (eg income and education levels not necessary!).

“Race-neutrality” is not a thing!

- Even when we think we are being “race neutral”, if we claim neutrality by failing to acknowledge the “credential of whiteness” and the role it plays, then we are already racially active/complicit/biased (Tiako et al, JGIM 2021).

JGIM

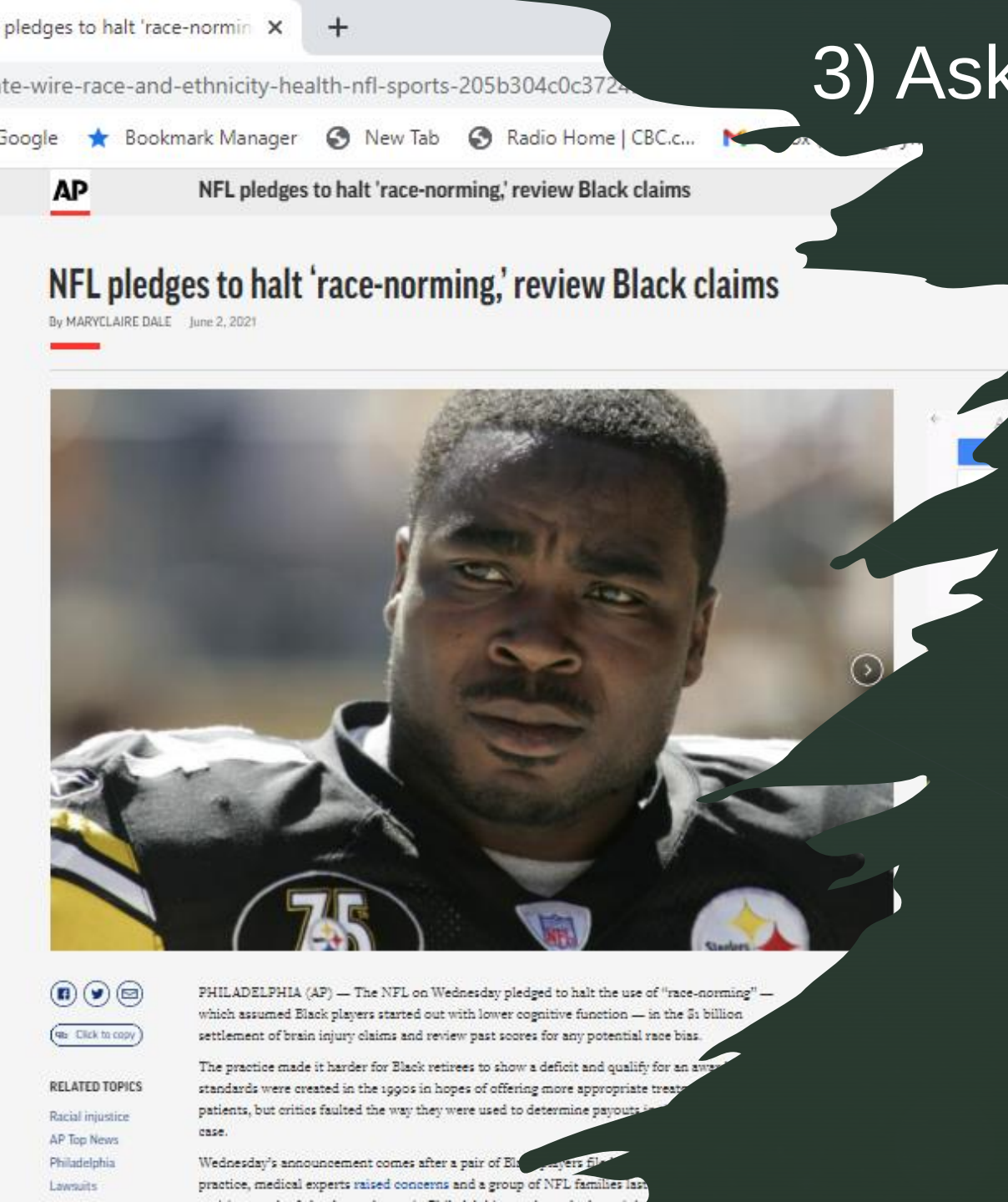
REVIEWS

Medical Schools as Racialized Organizations: How Race-Neutral Structures Sustain Racial Inequality in Medical Education—a Narrative Review

Max Jordan Nguemeni Tiako, MD, MS[1,2,3], Victor Ray, PhD[4], and Eugenia C. South, MD, MS[3,5]

[1]Department of Medicine, Brigham and Women’s Hospital, Boston, MA, USA; [2]Harvard Medical School, Boston, MA, USA; [3]Urban Health Lab, Perelman School of Medicine at the University of Pennsylvania, Philadelphia, PA, USA; [4]Department of Sociology, University of Iowa, Iowa City, IA, USA; [5]Department of Emergency Medicine, University of Pennsylvania, Philadelphia, PA, USA.

3) Ask critical questions. Critique!


pledges to halt 'race-norm

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AP NFL pledges to halt 'race-norming,' review Black claims

NFL pledges to halt 'race-norming,' review Black claims

By MARYCLAIRE DALE June 2, 2021

PHILADELPHIA (AP) — The NFL on Wednesday pledged to halt the use of "race-norming" — which assumed Black players started out with lower cognitive function — in the $1 billion settlement of brain injury claims and review past scores for any potential race bias.

The practice made it harder for Black retirees to show a deficit and qualify for an awa

standards were created in the 1990s in hopes of offering more appropriate treat

patients, but critics faulted the way they were used to determine payouts i

case.

Wednesday's announcement comes after a pair of Bl players fil

practice, medical experts raised concerns and a group of NFL families las

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- Who got to decide this?
- Why isn't there more outrage?
- Why didn't AP offer more critique of the illegitimacy of the underlying assumption? Why didn't they name explicitly that race is understood to not have any biological basis?
- Where were the NFLs own medical professionals during this? What have they been doing to debunk these falsehoods?

Same.
Questions.

Nova Scotia

Pride breaks with Halifax libraries after controversial book kept on shelves

'This book is definitely debating the existence of trans people': Halifax Pride

Haley Ryan · CBC News · Posted: May 30, 2021 2:39 PM AT | Last Updated: May 31

4) Hone in on a key issue – "Microaggressions"

- Microaggression/microinvalidation – versus "macroagressions"(ie those which are obvious)
- "Things that make you go…'hmmmm'"
- Susan Francis is a 46 yo able-bodied person who identifies as female and mixed race (Chinese and African). She is in your office today for immunizations related to an upcoming trip. She is having a pleasant conversation with your secretary when you come to the waiting room to get her. As you walk up, you hear your secretary, who is white, say to her, "I just can't get over how curly your hair is. Don't you find it difficult to manage?" "No, not at all," says Susan, with a smile.
- Discuss. ☺

Microaggressions happen when…

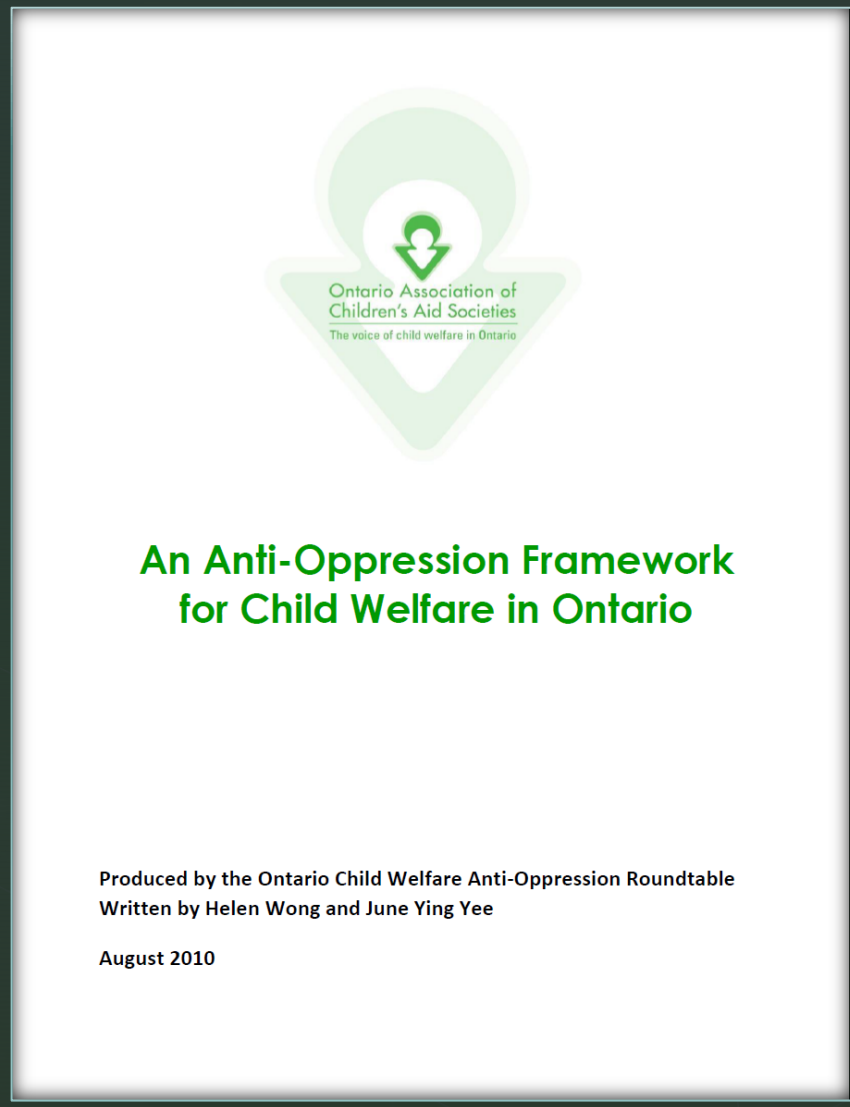
- When something gets said, even without intent, and ***has the effect of reminding the recipient that they are not part of the "dominant" culture***.
  - "Black curly hair = difficult. Black + Curly + Difficult = bad? Bad = White (hair?) is much better? Better = **I would be <u>better</u> if I was white/<u>things would be better if I was white</u>**?"
- This is the wondering that starts when a microaggression is experienced.
  - "Where are you from?" ("Can I not just be from here, like everyone else?")
  - Your English is so good! ("I know you just tried to compliment me, but, uh, I don't know any other languages?")
  - You are so normal for a gay person! ("!!!!!!!!!!!!" "So...'straight' is normal and everyone else is – not?????")

5) Time out to talk

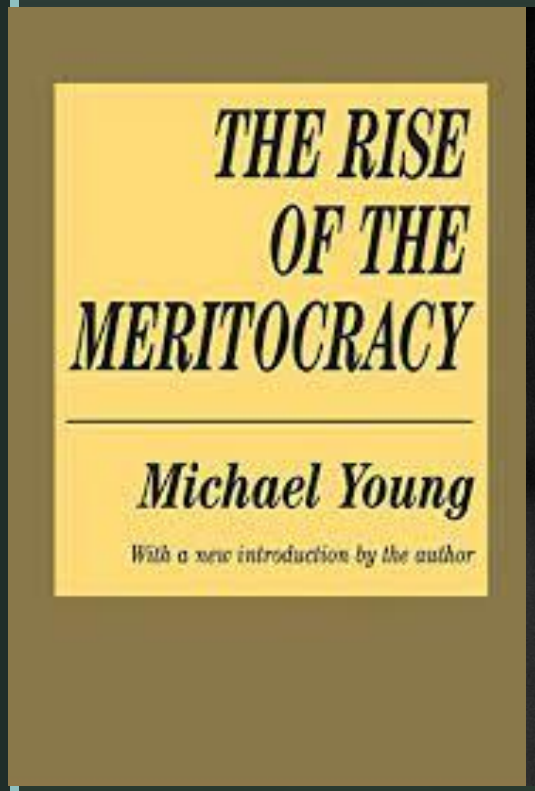
- Discuss issues of diversity in a format **deliberately intended** to get to the heart of diversity and inclusion issues and the dominant narratives that shape them.
- “safe spaces” concept – discussion leaders have to be comfortable to invite a diversity of viewpoints and experiences here.
- Acknowledge – “white fragility”; “weaponization” of race, and other difficult but important experiences
- **Be an ally** to minority students in this setting.
- Take a critical perspective. “Are we sure we treated this patient according to *their* own reality and not *ours*?”

Reflexive questions for Anti-Oppressive Practice:

1. In all interactions/situations, have I thought about power, privilege, and social location and how it impacts my actions?
    - Who got to decide? Who gets to decide? Who's voice is the loudest here? Is it my patient's? My own? The system's?
2. Have I questioned/challenged dominant ways of thinking to transform power towards equity?
3. Have I ensured the actions I have taken are equitable, collaborative and power sharing?
4. How can I promote anti-oppressive actions at an institutional or systemic level?



6) Challenge Meritocracy



Michael Young, author of The Rise of the Meritocracy. Photograph: Charles Hewitt/Picture Post/Getty Images; courtesy of the Guardian, October 2018

Definition (Merriam-Webster): a system, organization, or society in which people are chosen and moved into positions of success, power, and influence on the basis of their demonstrated abilities and merit

7) RETHINK CLINICAL ALGORITHMS

Woah. This is big.

8) Don’t gaslight. Ever.

This is a hideous way to treat people.

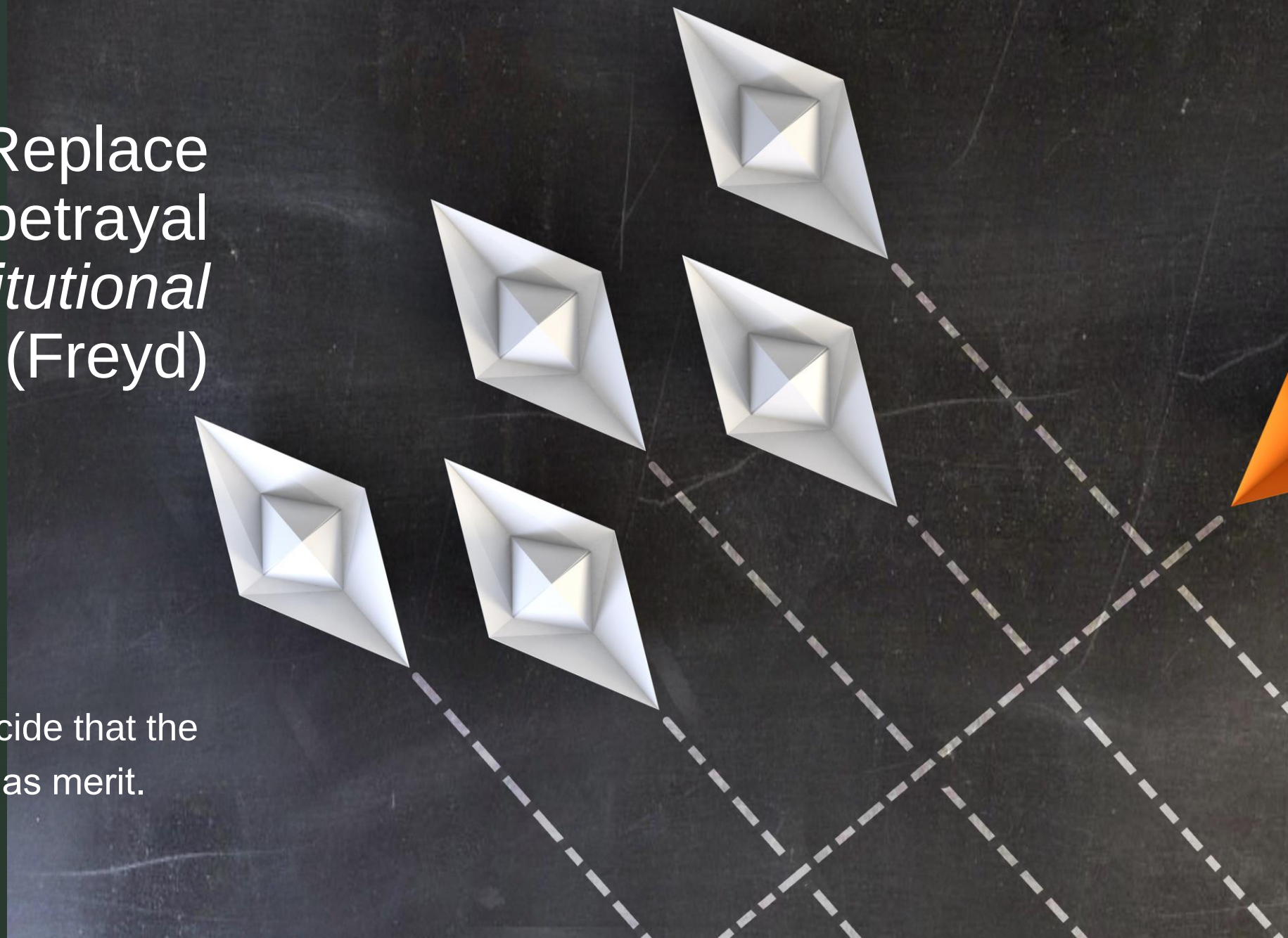
Institutional betrayal as a threat to EDI work

Institutional betrayal is the term used to describe the negative experiences of members of an organization when the organization fails to act according to its stated values or rules. (Freyd)

Related to white fragility.

- Disorientation – cognitive dissonance associated with continuing to want to believe that the organization will do the right thing, while experiencing harm at the hands of the same organization
- Self-doubt – about their capacity to understand negative occurrences that might be happening to them
- Loss of confidence related to self doubt.
- Anxiety – about work performance and about being in the work environment.
- Depression
- Suicide

Replace institutional betrayal with *institutional courage* (Freyd)



Fundamentally decide that the individual's story has merit.

Treat every individual's story as though it has merit.

The tropes of institutional betrayal:

- "There's two sides to every story."
  - Yes. But they are not always equal.
- "This seems like a case of 'he-said-she-said',"
  - Or is it a case of "she said and no one cared?"
- "Yes, but you know how they are."
  - Yes – but that doesn't mean that they are wrong.

9) How we **welcome** people into our spaces and encounters might – *might* – change

everything.

How can we create welcome?

The ‘catch’.

The question is also a **promise**. A promise of protection.

You have to mean it.

If we did not create this reality, we have inherited.

- Be ***real*** and informed about what it is.
- Your work is not necessarily to become an expert in these fields. Your work is to simply **be deeply awake** to the impact of these concepts and also your unique impact on those around you.

THANK YOU for your attention!

gwatson@dal.ca

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