



UW SCHOOL OF MEDICINE
AND PUBLIC HEALTH

PRESENTER'S GUIDE

Published by the
Health Equity Activation Team

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2024

Biennial Review:
Education Policy & Curriculum Committee (EPCC)
Curriculum & Assessment Subcommittee (CAS)
Medical Student Association's Equity and Diversity
Subcommittee
in collaboration with student representatives from:
Medical Students for Minority Concerns
PRIDE in Healthcare
Latino Medical Student Association
Student National Medical Association
Asian Pacific American Medical Student Association

Dear Presenters,

We, as students, are incredibly appreciative of the time you donate to our education as well as the energy and passion you put into teaching us. We also acknowledge that language is constantly changing and that there are a lot of questions that can come up regarding best practices to teach and discuss race, sexuality, socioeconomic status, disabilities, gender, and other complex topics. With support from the Deans and the Health Equity Activation Team, and input from classmates in student organizations, such as PRIDE in Healthcare, Medical Students for Minority Concerns, Latino Medical Student Association, Student National Medical Association, and Asian Pacific American Medical Student Association, we wrote this presenter's guide with suggestions and reflections of how to talk about underrepresented identities in medicine. As lecturers, facilitators, and attending physicians, you have significant influence on our education, and it is our hope that you can help us create an inclusive learning environment for students of all backgrounds.

In this guide, you can expect to find a set of questions to consider as you create lecture slides or student activities. We have then highlighted some common identities and/or social issues. For each topic, we have provided information about why we believe they require careful thought and attention. We follow this with a list of suggestions and examples to facilitate more sensitive discussion regarding these topics. They will be presented in the following order:

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Students and patients may identify with one or multiple of the populations we discuss. However, these topics are by no means all-encompassing. Thus, we strongly encourage you to be mindful of your audience. This document is meant to provide an overview and should be supplemented by other resources. We hope that this guide will help facilitate culturally sensitive conversations with the diverse communities that you may encounter.

We intend for future student classes to modify this guide as appropriate. We also encourage you to ask questions and make suggestions as well. We are all constantly learning, and we hope to be able to work together to promote a more inclusive environment for everyone.

Sincerely,

The Health Equity Activation Team

KEY TERMINOLOGY

Sex	<p>refers to the genetics, anatomy, and biological characteristics of males and females. People who are described as intersex have genitals, gonads, and/or chromosome patterns that do not fit a binary notion of male and female bodies.</p> <p>Terms: male, female, intersex</p>
Gender	<p>refers to the ideas and identities assigned to the sexes.</p> <p>Sample terms: man, woman, agender, gender-fluid, genderqueer, two-spirit, non-binary, etc.</p>
Gender Identity	<p>refers to a person's perception of their own gender.</p> <ul style="list-style-type: none">• cisgender: people who identify with the gender they were assigned at birth• Non-binary or transgender: identify with a gender other than that which they were assigned at birth• Agender: people who do not feel a connection to any particular gender.
Gender Expression	<p>Defined as how people express their gender, including their dress, behavior, and mannerisms. For example, some people dress or behave with characteristics that are typically described as feminine but still identify as agender or as a man.</p> <p>Sample terms: masculine, feminine, gender-nonconforming, etc.</p>
Sexual Orientation	<p>Describes the gender(s) of the individuals that a person may be sexually attracted to. The term homosexual is no longer an acceptable term according to the LGBTQ+ community, and it is not inclusive of all sexualities other than heterosexual.</p> <p>Sample terms: heterosexual, gay, bisexual, pansexual, queer, asexual</p>
Race	<p>A fluid social construct that is deeply rooted in a system of slavery and oppression. It categorizes people based on physical traits that are deemed "socially significant," and leads to the differential treatment of certain groups of people based on these traits. Race is often used as a proxy in discussions about racism, but this is inaccurate, non-reproducible, and harmful to patients</p>
Geographic Ancestry	<p>The geographic origins of our ancestry, and the divergence from our ancestral geographic regions may account for the genetic variation that we see among humans.</p>
Ethnicity	<p>a descriptor that captures the shared identity-based ancestry, language, culture, traditions, religion, and beliefs of a group of people.</p>
Racism	<p>the subordination of a racial group politically, socially, and economically by individual people, groups and systems (including health systems), and policies and practices. It is the structural inequities and the years of disinvestment in certain communities (e.g., African Americans, Native Americans) that contribute to the disparities we see today.</p>
Intersectionality	<p>The concept that everyone has multiple identities (e.g., racial identity, gender, sexuality, ability status), and this combination of identities impacts their perspective on the world and the way society treats them.</p>
Ableism	<p>Refers to the assumption that the 'normal' able body is better than abnormal bodily forms and to the social ramifications of that assumption." Individuals of all body types can find success and happiness despite the disability they may be facing.</p>
Disability	<p>Falls on a spectrum and includes a wide range of physical, intellectual, emotional, and psychological conditions. Disability is not synonymous with disease; having a disability does not always mean that an individual is suffering or their condition needs to be corrected.</p>



REFLECTION QUESTIONS

When designing lectures or activities, we ask that you reflect on the following questions:

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- How do you foster a learning environment that actively seeks to promote inclusivity and reduce micro-aggressions (indirect, subtle, or unintentional discrimination)?
 - Are you open to feedback regarding some sensitive topics and willing to acknowledge and correct your missteps even when unintentional?
 - When organizing a patient panel or writing clinical scenarios, do you attempt to represent a variety of individuals affected by the condition? (e.g., age, race, ethnicity, gender, sexual orientation, socioeconomic status, disabilities, etc.)
 - How do you identify implicit and explicit bias as patients are presented and treated?
 - When highlighting variation in disease prevalence among populations, do you explain why? Do you distinguish biological differences from inequities that could have been prevented by addressing differences across groups in living conditions or the drivers of those conditions?
 - When discussing health inequities, do you include how physicians and others might contribute to promoting health equity and/or reducing inequities?
 - When discussing differences in health behaviors, do you introduce historical and current factors that have impacted these differences?
 - When you discuss guidelines, do you actively call out homophobia, sexism, racism, or other forms of bias and discrimination?
 - When using patient identifying information in case-based learning, are you soliciting consultation from relevant stakeholders of those demographics being referenced?

(Adapted from UW SMPH's Health Lens and Equity in Every Case)

Gender & LGBTQ Identities

Gender and sexuality include a spectrum of identities. Traditionally, society has placed people in binary categories such as man or woman, straight or gay; however future physicians are going to meet patients with experiences along and outside of this binary. It is important to represent these experiences and validate them, as it has been reported patients that identify as LGBTQ+ feel less comfortable in healthcare settings due to discrimination by medical professionals. We have included a few definitions of words and identities that are common, but the terms and language surrounding LGBTQ+ identifiers are rapidly changing, so it is always important to acknowledge the way each patient chooses to identify. **See key terminology for definitions of sex, gender, gender-identity, gender expression, and sexual orientation.**

1 Avoid gendered language

We use many words that are gendered without realizing it. Gendered language also tends to center around men and maleness. Being aware of how gendered words might affect students, especially those who identify as a woman or as LGBTQ+, is important. Some examples include:

- "Chairman" or "spokesman" ⇒ "Chairperson" or "spokesperson"
- "Latino" or "Filipino" ⇒ "Latinx" or "Filipinx"
- "He or she" (when a patient's gender is unknown) ⇒ "they"

2 Acknowledge different pathological presentations in females

An example of sex-based differences is in heart attacks. Female patients tend to have different symptoms than males do when presenting with a heart attack. Consider discussing wide ranges of symptoms in addition to what is described as "classical" presentation. Also consider challenging the history behind labeling "classical" conditions and the context in how these were defined.

3 Do not assume student gender

When restating a student question for lecture capture, do not assume the student's gender, but rather refer to them as "they". Example: "So, the question she asked was" ⇒ "So the question they asked was"

4 Avoid using "normal"

Avoid using "normal" to describe body size and shape or using "normal" to describe heterosexual individuals or cis individuals.

5 Refer to patients as a transgender person

When discussing transgender patients, refer to them as a transgender man, transgender woman, or transgender person. Transgender, or trans, is an adjective - not a noun. Also avoid using "transgendered" as an adjective, for the same reasons a patient would not be described as "Italianed." "A transgender" or "transgenders" ⇒ "a trans woman," "transgender people"

6 Be inclusive to the full spectrum

Include identities outside of gay and straight such as bisexual, pansexual, asexual, intersex, or transgender in clinical scenarios. Please refer to UCSF's LGBT Resource Center for definitions on these terms as well as other related terms.
(<https://lgbt.ucsf.edu/glossary-terms>)

7 Gender, sex, and sexual orientation can be complex, fluid, and dynamic

For example, no matter the age, a patient's sexuality can change from a previous visit, so it is best to consider all possibilities when asking questions about sexual and overall health. Another thing to consider is that not all people who engage in same-sex behavior (i.e., MSM, WSW, etc.) identify as LGBTQ+.

8 Ask about pronouns

Ask people what their pronouns are and give yours when you introduce yourself.

9 Use sex based language when discussing anatomy/physiology and man or woman when referring to the person or patient. Default to gender-neutral pronouns.

When discussing sex and gender, be intentional with the terms "sex" versus "gender" and accordingly, sex-based terminology and gender-based terminology. For example, "risk of aortic aneurysm rupture is higher among women" => "risk of aortic aneurysm rupture is higher in the female sex." If the data is available, qualify these relationships. For example, "female sex is a risk factor for breast cancer" => "estrogen exposure is a risk factor for breast cancer, estrogen exposure may be increased among patients with female sex, early menarche, late menopause, obesity..."

Race and Ethnicity

These terms are these are important to understand guidelines for appropriate terminology in medical education

Race

Race categorizes people based on physical traits that are deemed “socially significant,” and leads to the differential treatment of certain groups of people based on these traits. Descriptions of race are fluid; they vary across people and societies and change over time.

Geographic Ancestry

Geographic ancestry can be defined as the geographic origins of our ancestry, and the divergence from our ancestral geographic regions may account for the genetic variation that we see among humans.

Ethnicity

Ethnicity is a descriptor that captures the shared identity-based ancestry, language, culture, traditions, religion, and beliefs of a group of people.

AS AN EXAMPLE, INDIVIDUALS IN THE UNITED STATES MAY BE GEOGRAPHICALLY FROM CHINA, IDENTIFY ETHNICALLY AS VIETNAMESE, AND RACIALLY AS ASIAN.

Intersectionality

It is also important to note how multiple identities may intersect in a person’s experience (intersectionality). For example, a Black woman will experience the same events or interactions differently than either a Black man or a white woman, since their experiences are shaped by their race and gender, to name a few identities.

Race is not an independent risk factor for morbidity or mortality; however, experiencing racism is.

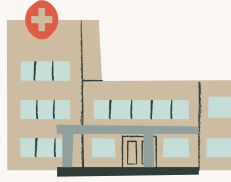
It can be easy to mix the concepts, particularly when discussing health disparities. However, it is important to consider the cultural differences between ethnic groups and the consequences of racial classifications in order to understand the biological manifestations that create health disparities, especially in diseases that are not caused by genetic patterns. We must consider the intertwined relationship of race and racism and how they influence an individual’s experiences. Race is often used as a proxy in discussions about racism, but this is inaccurate, non-reproducible, and harmful to patients. One cannot talk about race without a discussion of racism and its impact on the social determinants of health.



Understanding systemic racism and discriminatory practices can provide insight into how healthcare and the field of medicine uphold systems of oppression and why disparities between racial groups exist. It can also guide our actions to be anti-racist, including using appropriate terminology and enacting policies that actively dismantle these structures and systems of oppression.



Race and Ethnicity Best Practices



Discuss why disparities exist across racial groups from a systems perspective

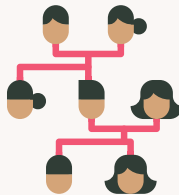
Rather than an individual's perspective. Acknowledge the role of systemic racism and discriminatory practices in creating health disparities. One's ethnicity may also contribute to health disparities.

"Hypertension is more common among African Americans" ⇒
"Hypertension is more common among African American. The disparity can likely be attributed to social determinants, such as environment, access to health care, and financial stability, rather than biological or genetic difference."



Ensure fair and responsible representation of patients affected by conditions or illnesses

Ensure that there is a variety of individuals affected by specific conditions or illnesses. Avoid stereotypes. When discussing malnutrition, keep in mind that malnutrition unfortunately occurs in people from all over the world, even in Madison, WI. Use images that represent the diverse people affected by malnutrition. Present images and descriptions of conditions, particularly dermatologic, in people with different skin tones.



Use geographic ancestry rather than race

Use geographic ancestry when describing populations at risk for genetic disorders. In diseases with known genetic causes, identify ancestry as a risk factor.

"Sickle cell disease is more common in Black people" ⇒ "Sickle cell disease is more common in people with ancestors from Africa, India, the Middle East, and the Mediterranean. The disparity exists not due to race, but rather can be traced to geographic origin."



Avoid the term "illegal" or "alien"

When referring to immigrant populations, avoid the term "illegal" or "alien".

Consider also that immigrants come from various countries from varying ancestries such as European countries.



Acknowledge intersectionality

Acknowledge intersectionality in clinical scenarios.



Use person-first language

Center the person rather than an identifier. Use person-first language.

"Blacks" ⇒ "Black people," "people who are Black," "people who identify as Black"

ABILITIES AND DISABILITIES



Disability

Societal and cultural definitions of what is considered a “disability” constantly change with time and often depend on the context within which they are discussed (medical, legal, educational, etc.). This flux in interpretations of the term introduces a great amount of confusion within the medical community that often leads to negative health outcomes and poorer patient interactions and communication.

Ableism

See key terminology for the definition of ableism, as defined by Dr. Joel Michael Reynolds in the AMA Journal of Ethics. Dr. Reynolds discusses two common, but counterproductive and harmful biases held by clinicians:

Misconception #1

Individuals with disabilities have a lower quality of life than typically-bodied individuals.

Over the past several years, countless studies have supported the idea that individuals of all body types can find success and happiness despite the disability they may be facing. However, personal biases held by physicians about how a disability may affect one’s life can lead to a mischaracterization of the condition and a negative portrayal of “disability” that prevents patients from adapting and thriving in their new circumstances.

Misconception #2

Disability is associated with the same amount of “pain, suffering, and disadvantage” as an illness or disease.

Disability is not synonymous with disease; having a disability does not always mean that an individual is suffering or is in constant pain, or that their condition is meant to be corrected.

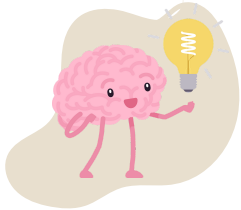
This especially applies to those with developmental or intellectual disabilities and those with mental health conditions. While some view their condition as something that does not define them and something that requires treatment, others take pride in their status and believe that their circumstances are simply different, not to be cured or removed. The latter group may not even consider their conditions as “disabilities” because they are not “disabling.” How an individual defines their disability identity is, Reynolds states, “as complex and contextual as any other significant facet of human identity such as race, ethnicity, sexuality, gender, and so on.”

Abilities and Disabilities



01 - Use “accessible” instead of handicap

Anytime you would use the word “handicap,” instead use “accessible.”
“Handicapped Parking Space” ⇒ “Accessible Parking Space”



02- Use “intellectual disability” in place of “mental retardation”

“Mental retardation” is an outdated term that, over the past several years, has been slowly eradicated from literature and clinical practice. The phrase carries with it a heavy social stigma that contributes to the discrimination this population continues to experience today, one that incurs an emotional burden on the affected patient and their family.



03- Use “typical” in place of “normal”, especially when referencing development, psychological conditions, or bodily forms.

Be wary about the use of “normal.” We recognize that the use of “normal”/“abnormal” is heavily ingrained in clinical practice, such as when referencing lab values. However, in some cases, labeling aspects of a patient as “normal”/“abnormal” may be isolating, or even offensive, to certain patient populations. “Normal” also carries social connotations that can perpetuate stigma.

For example, labeling a two-month delay in speech development as “abnormal” may incite more patient alarm or concern than stating that it is “different from what we typically see.”

“In the normal population...” ⇒ “In typically-developing individuals...”

“A normal BMI is...” ⇒ “A BMI most associated with reduced risk of metabolic disease is...”. When discussing weight in the context of BMI, “normal BMI” and “typical BMI” are not synonymous. While normal BMI is defined as 18.5 – 24.9, typical U.S. BMI varies by the geographic location e.g. ~ 67% of Wisconsin adult BMI is ≥ 25 .



04 - Acknowledge the complexities of disability identity and make decisions about nomenclature on a patient-by-patient basis.

Person-first language (e.g., “an individual with Down syndrome” or “an individual facing depression”) is often the “safest,” most respectful way to refer to patients in this population. In certain groups, such as autism, deafness, and blindness individuals who accept their condition as a part of their identity may prefer the opposite language (e.g., “I am autistic”, “I am deaf”).

05 - Acknowledge neurodivergence as an identity.

Some will identify their neurodivergence as a disability and others will not.



06 - Avoid stigmatizing mental health language and acknowledge variation in how people identify their concerns

Avoid stigmatizing language surrounding mental illness such as insane or crazy. OCD is not an adjective. Some people will identify their mental health concerns as a short-term or long-term disability, and some will not.

07 - Invisible Identities -Acknowledge that there are students within the lecture that likely identify as disabled and/or neurodivergent.

08 - Do not use the term morbidly obese when discussing BMI.

09 - Avoid the term “wheelchair-bound”.

Wheel-chair user is a more active and accurate term to describe those who use wheelchairs to achieve mobility and independence therefore inclusion in their homes and communities.



SOCIOECONOMIC STATUS

Best Practices

With nearly 90 million Americans living below 200% of the federal poverty level, it is important to approach the topic of poverty with compassion, inclusion, and sensitivity. It is important to point out that there are certain biases that underlie the federal poverty line, and that a living wage in one city may not necessarily be considered "livable" in a different city. It is also important to consider the lack of economic security as an experience that can intersect with other identities and provide more barriers to physical, emotional, or financial support. Furthermore, it is important to be aware of societally constructed stigmas and shame that are attached to having a low socioeconomic status. These individuals are typically ascribed as lacking motivation, drive, or the strength to persist. It is important to acknowledge that poverty is not an individual problem, but rather a series of systemic issues that have maintained the cyclic dependence of different communities for the benefit of others.



01 - Do not use words such as "poverty-ridden/stricken."

These words are vague and demeaning. They often rely on stereotypes and make statements susceptible to unconscious bias. Instead, consider the word "under-resourced" or consider using specific statements backed by concrete statistics rather than anecdotes.

"Asthma is typically more common in poverty-ridden neighborhoods." ⇒ "Asthma is typically more common in under-resourced neighborhoods because of x, y, and z (environmental contaminants, access to safe housing, job safety risks)."



03- Your audience includes people experiencing economic hardships beyond the burdens of medical school loans.

Ensure students understand that they are not alone, and that this is not a personal problem. Ensure that audiences understand that people living in poverty are multidimensional, as are their experiences.



02- Be wary of assumptions about poverty and do NOT blame the individual.

Do not sensationalize poverty nor represent the people experiencing poverty as: the victim, the criminal, or the exception. There are various reasons why any given individual could be experiencing poverty that are beyond their control. Do not encourage the perception of "hand-outs," "working the system" to get free government assistance. Do not make broad statements about what "everyone" thinks or does, especially when those statements likely do not apply to individuals of all income levels.



04 - Racism and low SES have a bidirectional relationship.

SES and racism are intimately associated with each other. Racism causes restricted socioeconomic attainment for many members of minority groups, whereas SES has facilitated the pervasive effects of racism. Racial disparities in SES, in part, reflect the successful implementation of discriminatory policies.

For example, lower SES is indirectly and inversely correlated with access to healthcare. Ergo, addressing differences in social class is critical to an examination of racial disparities in healthcare.



05 - Carefully consider how you approach a story and the messaging/stereotypes that photographs, and stories might perpetuate.

Ensure that photos or anecdotes do not disproportionately portray poverty as an isolated experience within a specific population. If a specific neighborhood or community is experiencing poverty, make sure that there is sufficient background and clarifications on systemic issues that have created this environment.

References



Cal State Diversity Style Guide

<https://www2.calstate.edu/csu-system/csu-branding-standards/editorial-style-guide/Pages/diversity-style-guide.aspx>

01



UW-Madison School of Medicine and Public Health (UW SMPH) Diversity Statement

<https://www.med.wisc.edu/about-us/diversity/>

02



UW SMPH HEAT Lens and Equity in Every Case

03



Stanford Gendered Innovations

<http://genderedinnovations.stanford.edu/terms/race.html>

04

Journal of Ethics, Information about Disabilities for Clinicians

<https://journalofethics.ama-assn.org/article/three-things-clinicians-should-know-about-disability/2018-12>

05

UCSF LGBT Resource Center General Definitions

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

06

White Coat For Black Lives

<https://whitecoats4blacklives.org>

07

FACILITATOR GUIDE KEY TAKEAWAYS

GENDER & LGBTQ

DO'S

- Acknowledge different pathological presentations in females.
- Use "they" pronouns if re-stating questions for lecture capture
- Use sex-based language for anatomy or physiology (male or female)
- Use man or women when referring to the person or patient
- Use gender neutral terms or ask people about their pronouns, give yours with your introduction
- Refer to transgender patients as a transgender man, transgender woman, or transgender person.
- Include identities outside of gay and straight such as bisexual, pansexual, asexual, intersex, or transgender in clinical scenarios.
- Demonstrate that a person's gender, sex, and/or sexual orientation can be complex, fluid, and dynamic.

DON'TS

- ·Use gendered-language
- ·Assume student or patient gender-identity
- ·Use "normal" to describe body size and shape or to describe heterosexual or cis individuals
- ·Use transgender as a noun, it is an adjective

Gender and sexuality include a spectrum of identities. It is important to represent these experiences and validate them, as it has been reported patients that identify as LGBTQ+ feel less comfortable in healthcare settings due to discrimination by medical professionals.

RACE AND ETHNICITY

DO'S

- ·Discuss why disparities exist across racial groups from a systems perspective
- ·Acknowledge the role of systemic racism and discriminatory practices in creating health disparities.
- ·Acknowledge one's ethnicity may also contribute to health disparities.
- ·Use geographic ancestry when describing populations at risk for genetic disorders.
- ·Ensure that there is fair and responsible representation of the variety of individuals affected by specific conditions or illnesses.
- ·Acknowledge intersectionality in clinical scenarios.
- Center the person rather than an identifier. Use person-first language.

DON'TS

- Focus on individual perspective when discussing disparities across racial groups
- Associate genetic risk with race as a factor
- Use the term "illegal" or "alien" when referring to immigrant populations
- ·Rely on or use stereotypes

Race is a social construct that is deeply rooted in a system of slavery and oppression. We must consider the intertwined relationship of race and racism. Race is not an independent risk factor for morbidity or mortality; however, experiencing racism is.

ABILITIES AND DISABILITIES

DO'S

- Use the term accessible
- Replace mental retardation with intellectual disability
- An appropriate replacement term for "normal" is "typical"
- Acknowledge the complexities of disability identity and make decisions about nomenclature on a patient-by-patient basis.
- Acknowledge neurodivergence as an identity.
- Acknowledge some people will identify their neurodivergence or mental health conditions as a disability, others may not
- Invisible Identities -Acknowledge that there are students within the lecture that likely identify as disabled and/or neurodivergent.

DON'TS

- Use the word handicap.
- ·Use the term mental retardation.
- Use the term "normal" when referencing development, psychological conditions, or bodily forms.
- Use stigmatizing language surrounding mental illness (ex: insane or crazy)
- Do not use the term morbidly obese when discussing BMI.
- Do not use the term "wheelchair-bound".

Societal and cultural definitions of what is considered a "disability" constantly change with time and often depend on the context within which they are discussed (medical, legal, educational, etc.). Many may not even consider their conditions as "disabilities" because they are not "disabling." How an individual defines their disability identity is complex and contextual

SOCIO-ECONOMIC STATUS

DO'S

- Be wary of assumptions about poverty
- Remember that your audience includes people experiencing economic hardships beyond the burdens of medical school loans.
- Be aware racism and low SES have a bidirectional relationship.
- Carefully consider how you approach a story and the messaging/stereotypes that photographs, and stories might perpetuate.

DON'TS

- Do not use words such as "poverty-ridden/stricken."
- Do NOT blame the individual.

It is important to approach the topic of poverty with compassion, inclusion, and sensitivity. It is important to point out that there are certain biases that underlie the federal poverty line, and that a living wage in one city may not necessarily be considered "livable" in a different city.