



**School of Medicine
and Public Health**
UNIVERSITY OF WISCONSIN-MADISON

**University of Wisconsin School of Medicine and Public Health
Presenter's Guide**

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in collaboration with student representatives from:

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PRIDE in Healthcare

Latino Medical Student Association

Student National Medical Association

Asian Pacific American Medical Student Association

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Health Equity Activation Team

UW SMPH Academic Planning Council

UW SMPH Building Community Steering Committee

Reflection Questions

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

1. How do you foster a learning environment that actively seeks to promote inclusivity and reduce micro-aggressions (indirect, subtle or unintentional discrimination)?
2. When organizing a patient panel or writing clinical scenarios, do you attempt to represent a variety of individuals affected by the condition? (age, race, ethnicity, gender, sexual orientation, socioeconomic status, etc.)
3. How do you identify implicit and explicit bias as patients are presented and treated?
4. When highlighting variation in disease prevalence between 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?
5. When discussing health inequities, do you include how physicians and others might contribute to promoting health equity and/or reducing inequities?
6. When you discuss guidelines, do you actively call out homophobia, sexism, racism, or other forms of bias and discrimination?

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

Gender and LGBTQ+

Information

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+ identities is rapidly changing, and so it is always important to acknowledge the way each patient chooses to identify.

Sex (male, female, intersex) 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. **Gender** (man, woman, agender, gender-fluid, gender-queer, two-spirit, non-binary, etc.) refers to the ideas and identities assigned to the sexes. **Gender identity** refers to a person's perception of their own gender. People who identify with the gender they were assigned at birth are described as cisgender. People who identify as transgender or non-binary identify with a gender other than that which they were assigned at birth, while those who identify as agender do not feel a connection to any particular gender. **Gender expression** (masculine, feminine, gender-nonconforming, etc.) is 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. **Sexual orientation**, or **sexuality** (heterosexual, gay, bisexual, pansexual, queer, asexual), describes the gender(s) of the individuals that a person may be sexually attracted to. It is worth noting that the LGBTQ+ community includes many more sexual identities than are listed above. 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.

Student Suggestions and Examples

1. Avoid gendered language.

This can be particularly difficult, as 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.

“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.
- 3. When restating a student question for lecture capture, do not assume the student’s gender, but rather refer to them as “they”**
“So the question she asked was” ⇒ “So the question they asked was”
- 4. When discussing anatomy or physiology of the human body, use sex based language such as female or male. When referring to the person or patient, use man or woman.**
- 5. Avoid using “normal” to describe body size and shape or using “normal” to describe heterosexual individuals or cis individuals. An appropriate replacement term is “typical”.**
- 6. When discussing transgender patients, refer to them as a transgender man, transgender woman, or transgender person. Transgender is an adjective, not a noun.**
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”
- 7. 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 (<https://lgbt.ucsf.edu/glossary-terms>) for definitions on these terms as well as other related terms.
- 8. Demonstrate that a person’s gender, sex, and/or 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+.

Race and Ethnicity

Information

Race is a 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 lead to the differential treatment of certain groups of people on the basis of these traits. Descriptions of race are fluid; they vary across people and societies and change over time. In many cases, there is as much genetic and physiologic variation among individuals within a racial group as there is between racial groups. **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** 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. It can be easy to mix the concepts, particularly when discussing health disparities. However, it is important to take into account 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 not an independent risk factor for morbidity or mortality; however, experiencing racism is.** 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 discussion of racism and its impact on the social determinants of health. **Racism** can be defined as 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 (i.e. African Americans, Native Americans) that contribute to the disparities we see today.

It is also important to note how multiple identities may intersect in a person’s experience. **Intersectionality** is the concept that everyone has multiple identities (i.e. racial identity, gender, sexuality, ability status), and this combination of identities impacts their perspective on the world and the way society treats them. 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. 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.

Student Suggestions and Examples

- 1. Discuss why disparities exist across racial groups from a systems perspective rather than individuals 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 Americans. 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."

- 2. Use geographic ancestry rather than race when describing at risk populations for genetic disorders.**

"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."

- 3. Ensure that there is fair and responsible representation of the 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 of dermatologic conditions in people with different skin tones.

- 4. Acknowledge intersectionality in clinical scenarios.**

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

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

- 6. In diseases with known genetic causes, identify ancestry as a risk factor rather than race.**

Abilities and Disabilities

Information

Disability, like most aspects of an individual's identity, falls on a spectrum and includes a wide range of physical, intellectual, emotional, and psychological conditions. Societal and cultural definitions of what is considered a "disability" constantly changes with time and often depends on the context within which it is 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, as described by Dr. Joel Michael Reynolds in the AMA Journal of Ethics, "refers to the assumption that the 'normal' able body is better than abnormal bodily forms and to the social ramifications of that assumption". Dr. Reynolds continues to discuss two common but counterproductive and harmful biases held by clinicians:

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

Over the past several years, countless studies have supported 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 mischaracterization of the condition and a negative portrayal of "disability" that prevents patients from adapting and thriving in their new circumstances.

Misconception Two: 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".

Student Suggestions and Examples

1. Anytime you would use the word “handicap”, use “accessible”.

“Handicapped Parking Space” ⇒ “Accessible Parking Space”

2. Avoid the term “mental retardation” and replace it with “intellectual disability”.

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

3. Be wary about the use of “normal”, especially when referencing development, psychological conditions, or bodily forms. An appropriate replacement term is “typical”.

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 typical BMI is...”

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

Person-first language (i.e. “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 in autism, individuals who accept their condition as a part of their identity may prefer the opposite language (i.e. “I am autistic”).

Socioeconomic Status

Information

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.

Student Suggestions and Examples

1. 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."

2. 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.

3. Remember that 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.

4. 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.

5. 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

1. Cal State Diversity Style Guide
<https://www2.calstate.edu/csu-system/csu-branding-standards/editorial-style-guide/Pages/diversity-style-guide.aspx>
2. UW-Madison School of Medicine and Public Health (UW SMPH) Diversity Statement
<https://www.med.wisc.edu/about-us/diversity/>
3. UW SMPH HEAT Lens and Equity in Every Case
4. Stanford Gendered Innovations
<http://genderedinnovations.stanford.edu/terms/race.html>
5. Journal of Ethics, Information about Disabilities for Clinicians
<https://journalofethics.ama-assn.org/article/three-things-clinicians-should-know-about-disability/2018-12>
6. UCSF LGBT Resource Center General Definitions
<https://lgbt.ucsf.edu/glossary-terms>
7. White Coat For Black Lives
<https://whitecoats4blacklives.org>