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Author: Ona Fernando F. PhD, MPH, MSW, MDiv; Amutah-Onukagha Ndidiamaka N. PhD, MPH; Asemamaw Rina MSc; Schlaff Anthony L. MD, MPH

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Struggles and Tensions in Anti-Racism Education in Medical School: Lessons Learned

Fernando F. Ona, PhD, MPH, MSW, MDiv, Ndidiama N. Amutah-Onukagha, PhD, MPH, Rina Asemamaw, MSc, and Anthony L. Schlaff, MD, MPH

F.F. Ona is clinical associate professor, Department of Public Health and Community Medicine, Tufts University, Boston, Massachusetts.

N.N. Amutah-Onukagha is associate professor, Department of Public Health and Community Medicine, Tufts University, Boston, Massachusetts.

R. Asemamaw is DrPH candidate, Department of Public Health and Community Medicine, Tufts University, Boston, Massachusetts.

A.L. Schlaff is professor, Department of Public Health and Community Medicine, Tufts University, Boston, Massachusetts.

Correspondence should be addressed to Anthony L. Schlaff, Tufts University School of Medicine, Department of Public Health and Community Medicine, DPHCM – M&V 124, 136 Harrison Avenue, Boston, MA 02111; telephone: (617) 636-6584; email: anthony.schlaff@tufts.edu.

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Abstract

Purpose

Faculty from different racial and ethnic backgrounds developed and piloted an anti-racism curriculum initially designed to help medical students work more effectively with patients of color. Learning objectives included developing stronger therapeutic relationships, addressing the effects of structural racism in the lives of patients, and mitigating racism in the medical encounter.

Method

The anti-racism curriculum was delivered and evaluated in 2019 through focus groups and written input before and after each module. The process and outcome evaluation utilized a grounded theory approach.

Results

Three emergent themes reflect how medical students experienced the anti-racism curriculum and inform recommendations for integrating an anti-racism curriculum into future medical education. The themes are: 1) the differential needs and experiences of persons of color and Whites; 2) the need to address issues of racism within medical education as well as in medical care; 3) the need for structures of accountability in medical education.

Conclusions

Medical educators must address racism in medical education before seeking to direct students to address it in medical practice.

The COVID-19 pandemic is highlighting and amplifying the historical, cultural, and social determinants of health that led to the disproportionate health burdens experienced by communities of color in the United States. At the same time, the highly publicized killings of Ahmaud Arbery, Breonna Taylor, George Floyd, Tony McDade, and Rayshard Brooks are highlighting and amplifying the prevalence of racism in the United States. There is overwhelming evidence that social, economic, and political factors dramatically influence rates of disease as well as how and when they reveal themselves in clinical practice. Furthermore, failure to address these structural issues contributes to poor health outcomes for patients of color.¹⁻³ Many physician scholars have shown how racism, microaggressions, and discrimination persist in medicine and cause harm.⁴⁻⁶

Neff and colleagues⁷ note that many American medical schools have not effectively integrated social determinants of health frameworks into curriculum consistently, let alone sociocultural challenges such as discrimination, racism, and implicit bias. These authors suggest that structural competency frameworks are essential to “recognize, analyze, ameliorate, and hopefully alter these harmful inequities.”⁸ Medical students themselves, however, may not recognize the need to include teaching about racism and discrimination in the medical school curriculum.⁹

Physicians in the United States receive little or no training on structural racism during their medical careers and are unprepared to work constructively with racially diverse communities, either individually as clinicians or collectively through advocacy, to address the health problems caused or worsened by racism. In response, scholars developed an anti-oppression curriculum in post-medical training for health professionals to mitigate health care disparities and address provider biases.¹⁰ Such efforts need to occur earlier and more broadly. Students must learn about structural racism, including its historical and continuing manifestations through power, privilege,

and policy, and the social epidemiology that links it to health outcomes.^{11,12} Racism is deeply embedded in all aspects of U.S. society. Physicians need to understand this in order to form more trusting relationships with patients and avoid victim blaming by acknowledging and addressing structural racism during the patient visit.

To address this problem, we developed and piloted an anti-racism curriculum for medical students.

Method

Pilot curriculum

The development of the anti-racism curriculum involved a literature review, three pre-implementation semi-structured focus groups with medical students not part of the pilot, and faculty with prior experience teaching about racism implementing a flipped classroom model with small-group sessions. The initial pilot culminated in a 7.5-hour curriculum delivered over three sessions. Institutional Review Board (IRB) approval was granted by the Tufts University IRB. A process and outcome evaluation design included pre- and post-knowledge and attitude survey, as well as semi-structured focus groups with students who participated in the pilot. The attitude tool surveying students' knowledge about racism in medicine, the social determinants of health, and health equity generated descriptive statistics, but due to the small sample size did not provide generalizable data.

The original curriculum was designed to balance didactic teaching regarding the history and effects of racism with skills to address it. Medical cases were developed to provide students with opportunities to practice skills related both to addressing racism that the students themselves experienced or perceived in medical care and to addressing racism that patients experienced in their lives, affecting their health.

The first session included norm-setting, concepts and terms, and a discussion on micro-aggressions. The second session included didactic material on both the history of racism in the United States and a discussion of implicit bias and health inequities with clinical case exercises to identify and address racism. The final session included an exercise in understanding systems of oppression; case studies of racism in medical education and in clinical care; and a “toolkit for hope,” intended both to give students resources and skills to continue anti-racism work after the course and to demonstrate the lead faculty’s accountability to them.

Medical students were recruited by sending an invitation email through the dean’s office, which requested volunteers from each medical class to participate in the anti-racism curriculum. A convenience sample of medical students was recruited to participate in the three-module curriculum, and a total of 26 medical students volunteered to enroll into the three sessions of three hours each. Twenty-two students completed the curriculum. The final sample included 16 second-year and 6 fourth-year medical students. Thirteen students self-identified as White, 3 identified as Asian, 3 as African American, and 3 as two or more racial groups. Six semi-structured post-session focus groups were conducted, and participating medical students were separated into two self-identified groups: (1) White/Caucasian, and (2) Black/African American, Latinx, and Asian American. The authors facilitated these focus groups and the authors of color were matched to the students of color focus group and the White author facilitated the White focus groups. Participants were compensated up to \$75.

Evaluation

Semi-structured focus groups were transcribed and coded using nVivo 12 (QSR International Inc, Burlington, Vermont) and procedures outlined by Saldaña¹³ and Evans.¹⁴ A classic Grounded Theory (CGT) framework was used to identify emergent themes specifically focused

on Glaser and Strauss' approach to fit, understandability, generalizability, and control.¹⁴⁻²⁰

Therefore, the CGT framework informed an open and substantive coding approach. This approach engaged with a constant comparative process that followed incident to incident codes for the emergence of concepts culminating in an emergent theoretical integration through theoretical coding.^{14,18} These were triangulated within and between semi-structured focus groups, descriptive results from the attitude survey, and confirmed with the students through member checking. Qualitative saturation focused on meaning saturation within semi-structured focus group data, and conceptual depth was achieved during the triangulation within and between semi-structured focus groups throughout the anti-racism curriculum.²¹ All names and descriptions of students in this paper are pseudonyms as per the IRB protocol.

Results

The process of implementing the curriculum created an opportunity to integrate an iterative pedagogical design. Although a formal 3-session curriculum was designed in advance, input from students and ongoing formative evaluation necessitated and allowed for changes in the design of subsequent sessions

Process data

Each part of the course implementation involved students needing to reflect, respond, and have their say regarding the content presented, the pedagogy employed, and their emotional response to the material.

A clear distinction emerged between the needs/wants of students of color and White students, with students of color expressing the frustration that some of the curriculum seemed designed to help White students understand racism without properly considering the needs of students of color. In the actual delivery of the curriculum, students repeatedly focused on the challenges they

were facing as students, and a great deal of time was spent addressing their immediate experiences and needs. During the first module, students described numerous experiences of micro-aggressions by faculty, faculty failures to explain social determinants of health disparities, and faculty reliance on scientifically unsound beliefs in the biological validity of racial categories. They also related multiple attempts to bring concerns about these experiences to school leadership and their sense that their complaints, even when acknowledged, were not being acted upon.

In the second session, as faculty sought to respond to and teach from these experiences, a spirited disagreement among the faculty about how realistic it was to expect changes in medical education surfaced. Could meaningful anti-racist teaching be fit into a crowded curriculum given the necessity of focusing on accreditation and given institutional resistance? The nature of the disagreement reflected the challenges of making major structural changes to an inflexible curriculum. The students witnessed and then participated in this discussion and later described it as an important and useful window into the struggle that faculty who are engaged in anti-racism themselves face. The disagreement was also a window into the tensions that can develop between faculty of color and White allies seeking to support an anti-racist agenda. The discussions on racism in medical education that took place in this session were intense, emotional, and time consuming. This reduced and crowded out much of the time scheduled to discuss cases of racism in the context of the health and medical care of patients.

The exercise in building a historical timeline of racism was generally well received, but students of color noted that it elicited an emotional reaction that they felt faculty could have better anticipated and managed. In response to the clearly different needs of White students and

students of color, affinity group debriefing was added at the end of each session, where self-identified homogeneous racial groups debriefed each session separately.

In the final session, time was allocated for the system of oppression case, turning it into a theater of the oppressed exercise leveraging theatrical techniques^{22,23} that allowed students to more freely express their emotional response to the material. This was well received as was the discussion of the toolkit of hope, a curated collection of print and web-based resources by the authors to promote awareness of implicit biases and develop ways to address these in personal life and professional practice. There was no time for the case vignettes on racism in medical education.

Outcome data

Three key themes emerged from our work with students: (1) the differential needs and experiences of persons of color and Whites; (2) the need to address issues of racism within medical education as well as in medical care; and (3) accountability. Further, theme 3, accountability, is characterized by sub-themes: the need to address structural problems in medical education; the need to address hierarchy and systems of oppression more broadly; and the need to build a trusted and sustainable system of leadership, resources, and support.

Theme 1: The differential needs and experiences of persons of color and whites. A dynamic tension between White students and students of color focused on positions of privilege in learning and medical school educational settings. A sub-theme focused on the experiences of racism. It was noted that White students had the privilege of “not being aware” regarding issues about race and had the “luxury” of learning about racism. Students of color often remarked that they felt that they were consistently in a reality of “surviving” and felt challenged in thriving because they had to be aware of racism in their everyday lives and how this informed their

experiences in medical school. Students of color shared that they did not have the privilege of refining their knowledge around race and racism and often reflected the frustrations or anxieties of “being held back” or “staying back” or painfully “going back” that triggered feelings of being “less than” or having to do more to “prove themselves” within medical school.

Kaylyn, a White fourth-year medical student reflected:

I haven't experienced it [in medical school]. I heard of another person in our class who had some difficult encounters with attendings and residents during her surgery rotation because she's Hispanic. And she wasn't with them wanting to call her by a shortened version of her name, she wasn't with them making inappropriate jokes.

Several White students shared their realization about how the medical school experience was for their fellow classmates. Benjamin, a fourth-year White student, stated:

I learned most about the deep pain that many students of color are currently feeling at [our medical school]. While I understood that [our medical school] is not a perfect institution by any means, I did not fully understand how negatively the administration and curriculum had deeply harmed students and staff.

Grady, a second-year student of color, said:

It often feels like people who have experienced things have the extra work of explaining it to others who haven't, or how you deal with these things. And I think by having it in the [medical school] curriculum is kind of taking the burden away from people who have had to do that. Because I don't have those conversations happen that often with people who haven't experienced those things.

As Joe, a second-year student of color, shared:

It's like when another student [at our medical school] tells me that affirmative action shouldn't exist and all this other stuff and then asked me my thoughts on affirmative action. It was very uncomfortable...how do you take in these questions, like, 'What is racism?' versus ignorance versus someone who truly wants to understand a situation better?

Another area of difference between White students and students of color focused on learning and attending to the emotional and cognitive dimensions of racism. This was reflected in a second sub-theme regarding processes for understanding racism in relationship to content, skills, and strategies to deal with racism within the medical encounter. While White students were eager for more content and skills training, students of color at times expressed frustration with this and articulated a need to spend more time addressing the emotional burden they experienced in teaching and talking about racism.

Calla, a fourth-year White student, reflected:

I think more skills [in the anti-racism pilot curriculum] would have been great, although it is difficult to do that without having everyone on the same page and with some unifying foundation of knowledge and perspective. As for specific skills, it may have been helpful to role-play how we might react to someone in authority doing something problematic while we're on the wards, or to learn more about how individual physicians can make a difference in the larger structures of racism...as we talked about, sometimes it can be overwhelming!

Sophia, a fourth-year student of color, mentioned that:

You might be at a place where you're the only student [of color in medical school], one of two, one of eight, but it's never more than one of eight. And then for family medicine, you're on your own. There're all these times where you don't even have the space to debrief what you're going through.

Theme 2: Need to address issues of racism within medical education as well as in medical care. Throughout the sessions, students needed to focus on their immediate experiences with racism in medical education. Data illustrate how these experiences within the institution and curricula are apparent in their academic experiences. Additionally, data indicate a running sub-theme that efforts to create anti-racist curricula need to match ongoing work to establish anti-racist institutions.

Mary, a second-year student of color, stated:

And I think we experience racism in our day to day lives so I don't expect that to be different when I get here [to this medical school]. But I think the disappointing thing is that there is no effort on the part of the school to stem that.

Lenora, a second-year student of color, reflected:

You can't just show a movie, say about Black Chicago, and basically say all Black communities are like this and reinforce this idea without going back in history of how they even ended up there or why communities are like this. You can't just show us a video [in a medical school class] and not give us the historical context of it.

Another student, Jude, a second-year White student, shared:

How behind [our medical school] is in addressing structural racism; the lack of understanding and a sense of urgency in adopting anti-racist curriculum; how much room

for improvement [at our medical school] as regarding understanding and internalizing and fighting against structural racism.

Georgia, a second-year White student, stated:

Through the process of trying to figure out how to teach about systemic racism [in this anti-racism curriculum], I learned that our existing educational frameworks do not really allow for the necessary work to do this, anti-racism is a lifestyle that cannot be taught simply through didactics, rather there has to be development of deep trust between classmates and a curriculum that allows us to examine and change the way we operate in existing racist structures, rather than looking at events of the past from a great emotional distance.

Theme 3: Accountability. Semi-structured focus group discussions indicated that those implementing an anti-racism curriculum need to recognize that being anti-racist takes time and often involves unlearning deep-seated or long-held beliefs. These challenges of beliefs and culture are, as one medical student of color remarked, “baked into” the medical curriculum and perpetuated by the institution and its members in several ways. Students expressed a desire to find strategies to hold the institution and its members accountable for these challenges.

Sub-theme 3A: Need to address structural problems in medical education. Students expressed the challenges of learning so much content in medical school that learning about racism feels like an “add on” or that this content knowledge, albeit important, could get lost or so embedded in the curriculum that it ends up “watered down.” Students emphasized that learning how to address racism in medicine is just as important as medical-based content and that learning the content would take time, well beyond medical school. Some students also felt that this content and

process of anti-racism education needs to be addressed before students even entered medical school.

As Marla, a second-year student of color, stated:

And that was overlooked, . . . the professor didn't talk about the types of racialized determinism [in this medical school class] . . . the lectures were really theoretical. We didn't talk about the types of stresses different ethnic groups experience. We didn't talk about how to address them as physicians. I left feeling like I had no tools to address them, health disparities, that we're gonna have to deal with daily.

Sub-theme 3B: The need to address hierarchy and systems of oppression more broadly. Students expressed how racism must be systematically and more carefully addressed in order to expose the raw edges, nuanced aggressions, and insidious ways racism creates cognitive distortions, even among physicians. Focus group discussions emphasized how students and patients of color can fade away from White people's view, as well as the surveillance of institutional structures. However, as many students of color noted: "If you make racism its own thing, it isolates people of color more," meaning that it can make them easy targets or the focus of frustration, dismissal, or even more aggression. Overall, students reflected that they desired to talk about structures of power and oppression in relationship to agency.

As, Jane, a second-year student of color, stated:

I do wish we talked more about practical ways to be anti-racist from within strict hierarchical structures [in medical school], as in medicine, where we take huge risks by pointing out racism by superiors.

Diane, a second-year student of color, shared that:

[T]here's no structure [at our medical school] built into where it should be practiced holding those accountable for the things that they say and the things that we bring up. So, I think that's important. I don't know if that's, that's probably not a curriculum thing, but more of an institutional policy type thing.

Sub-theme 3C: Need to build a trusted and sustainable system of leadership, resources, and support. Students across all races reflected on the roles and responsibilities of medical educators and their obligations to provide rigorous and robust educational support on anti-racism. Students also shared concerns about their trust of leadership and commitment of the medical school to dedicate resources and support for an anti-racism curriculum. Students emphasized the need to build trust among students within and across all years, but also reflected upon the need to do this between students and administration, educators, and attendings during clinical rotations.

Fourth-year medical student of color, Matthew, shared:

We're told before third year or whatever, this is who you go to report [a racist issue in medical school]. Even if you don't think that it's reportable, just come to us and we'll talk about it. But yeah, at the point, you haven't had a lot of interaction with the deans and you're in this situation where you're like, "Alright, I'm starting to think about residency and that you might write me a letter, and I'm gonna be that person that met you because this thing happened to me."

Helen, a second-year white student, noted:

I think one of the things that I've been frustrated by [in our medical school] and elsewhere, is just that I feel like, sometimes, race gets talked about as, like, a one and done. Like you can do a workshop on race and medicine and then that will de-racist you and then you'll be an anti-racist clinician.

Discussion

Medical students in this pilot curriculum experienced the content in many ways. Overall, White students often wanted to understand the necessary content around racism in order to mitigate implicit bias in their future medical encounters. Additionally, White students shared their collective experiences of privileges while discussing racism since many do not encounter discrimination or racism in their everyday lives.

On the other hand, students of color noted that they often have to wrestle with the burden of racist encounters in their everyday lives, not just within medical school. These experiences leave them emotionally drained; consistently worried, anxious, or hypervigilant; and continually distracts them from their medical studies. Students of color shared the emotional and spiritual toll that the role of racism has in their medical education. These differences affect what they want from the university and how they experience the curriculum.

Several lessons emerge from each of the focus group themes and subthemes.

Lesson 1: Respecting polyvocality and multiple struggles

The medical students' experiences reflect the importance of sharing, recognizing, comprehending, and "doing something," as one student of color stated, about the different and disproportionate experiences of racism between medical students within and outside of medical education. The entire medical school curriculum, including those portions of it explicitly designed to teach about racism and other systems and structures that create health inequities, must consider the different needs of students of color. While honoring students' agency and capacity for resilience, schools must reduce the micro-aggressions students of color are subjected to and must seek to provide remedial education to White students about the presence of and

effects of racism in society, in medicine, and in medical education without subjecting students of color to experiences that put them under a racialized spotlight.

One way medical schools could start addressing this is through meaningful participatory forums and processes that take seriously medical student and faculty feedback and actively incorporate this into the ongoing work of the medical education curriculum committees. Further, medical school deans and administrators need to create strong policy guidelines that explicitly include mechanisms to provide remedial education to White students. Medical schools also need to better resource and integrate anti-racism task forces with academic committees responsible for admissions, curriculum, recruitment, retention, and faculty climate to not only promote an anti-racist culture but ensure that policies, rules, regulations, curricula, and processes encourage racial discourse, address racial bias and discrimination throughout the medical school, and aspire toward a more inclusive and diverse community.

Furthermore, teaching about racism cannot be rushed; it must be done over the entire course of the medical curriculum, must occur in small enough groups to allow for trust and safe sharing, and must provide opportunities for students to reflect on their emotional experiences.

Lesson 2: Addressing structures of power

Stated simply, medical educators must practice what they preach. If we are to teach students to understand and address structures of power and how they are experienced as violence and oppression, then we must bring those lessons into the work we do as leaders in our own organizations. The question thus becomes, how do medical educators address this systematically and proactively within medical education? In speaking to higher educational and institutional structures of violence and oppression, Squires, Williams, and Tuitt state, “Certainly, the best way to deconstruct and dismantle a racist institution is to, in fact, deconstruct it and reconstruct anti-

racist institutions.”²⁴ Yet, as students witnessed and shared, this is profoundly challenging given the embedded nature of racism in these structures of power and privilege.

Medical educators can build on the intrinsic strengths of our discipline to imbed anti-racism throughout the curriculum. Curiosity and empathy must be encouraged so students are constantly helped to see the essential and complex humanity of every patient. Respect for science must be used to recognize and address implicit bias and to exclude anti-scientific notions of race.

Reflective time must become an essential feature of medical education to allow students to understand their own and others’ reactions to racism and other structures that dehumanize.

Finally, and leading to the final theme of accountability, anti-racist work must not simply be taught in the educational setting, it must be applied to that same setting.

Lesson 3: Mechanisms of accountability

Perhaps, the biggest challenge is to call out, address, and repair the damages of racism within medical education. How do we build meaningful, effective, and appropriate anti-racist medical education structures? As one student shared during the focus group, “When we see an attending during a clinical rotation do something racist over and over again, and it’s been reported before, what do you do?” Medical schools must hold faculty, clinical preceptors, and administrators who engage in racist acts accountable through such mechanisms as more resources for education and more pro-active reporting policies and processes for incident reviews and sanctions. Thus, medical educators must not only dismantle racist structures, but also work at taking seriously and effectively responding to a spectrum of racists and discriminatory practices.²⁵ Racist attitudes and actions on the part of faculty can be mitigated by linking, in both administrative and faculty development settings, how science and compassion demand anti-racist language, teaching,

processes, and structures. Building anti-racist processes and mechanisms takes time that involves an iterative, transparent, and extraordinary effort all levels of a medical school community.

Collectively, we must hold ourselves accountable to how we as medical educators *transparently* address racism, discrimination, and oppression in our curriculum. Collectively, we must build active mechanisms, strategies, and tactics for trust and transparency to ensure that processes, procedures, and strategies are in place to transform our educational practices and institutions. Only by creating such mechanisms of accountability within medical education can we prepare clinicians who will be consistently curious and want “to do something” about racism, and thus be capable of supporting the health and well-being of all people, especially those disproportionately burdened by disease morbidity and mortality.

Conclusions

Students need to be educated about structural racism to more effectively care for patients and communities of color. To do so effectively, faculty developing and implementing curricula to address this must keep in mind the differential needs of students of color and White students, the struggles that students have facing racism within medical education itself, and the need to support words with deeds by developing systems of accountability for anti-racist work within their educational institutions. Medical schools must provide leadership and support for faculty development, curricular reforms, and institutional change if medical education and medical practice are to become anti-racist. Our own institution has started on this work. Leaders are listening to the voices of faculty of color as well as our growing number of students of color, conversations are underway regarding incorporating our pilot into the required curriculum, and a new assistant dean for multicultural affairs and an anti-racism committee have started to more comprehensively review the curriculum and climate of the school.

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