Original Report: Training the Next Generation

Developing a Medical School Curriculum on Racism: Multidisciplinary, Multiracial Conversations Informed by Public Health Critical Race Praxis (PHCRP)

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Background: To fight racism and its potential influence on health, health care professionals must recognize, name, understand and talk about racism. These conversations are difficult, particularly when stakes feel high—in the workplace and in interracial groups. We convened a multidisciplinary, multi-racial group of professionals in two phases of this exploratory project to develop and pilot an intervention to promote effective dialogues on racism for first year medical students at the University of Minnesota Medical School.

Methods: Informed by a Public Health Critical Race Praxis (PHCRP) methodology in Phase I, initial content was developed by a group of seven women primarily from racial and ethnic minority groups. In a later phase, they joined with five White (primarily male) colleagues to discuss racism and race. Participants met monthly for 12 months from Jan 2016-Dec 2016. All participants were recruited by study PI. An inductive approach was used to analyze meeting notes and post intervention reflections to describe lessons learned from the process of employing a PHCRP methodology to develop the aforementioned curriculum with a multidisciplinary and multi-racial group of professionals dedicated to advancing conversations on racial equity.

Results: Participants from Phase I described the early meetings as "powerful," allowing them to "bring their full selves" to a project that convened individuals who are often marginalized in their professional environments. In Phase II, which included White colleagues, the dynamics shifted: "…the voices from Phase I became quieter…"; "I had to put on my armor and fight in those later meetings…"

Conclusions: The process of employing PHCRP in the development of an intervention about racism led to new insights on what it means to discuss racism among those marginalized and those with privilege. Conversations in each phase yielded new insights and strategies to advance a conversation about racism in health care. *Ethn Dis*. 2018;28(Suppl 1):271-278; doi:10.18865/ed.28.S1.271.

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Introduction

Recent calls for clinicians, health care professionals and researchers to play a role in dismantling structural racism suggest that health care professionals have an obligation and opportunity to advance health equity through antiracist practices in clinical care and research.[1,2] To fight racism and its inextricable link to health, health care professionals must recognize, name, understand and talk about racism competently.[1,3,4] Unfortunately, most Americans have very little experience discussing racism.[5] These conversations can be difficult to have. When the stakes feel high (eg, in the workplace and in interracial groups), they can generate negative emotions and unwittingly replicate dominant structures of power that marginalize the voices of people of color.[6]

People experience a range of emotions when discussing race and rac-

ism.[7] Whites often fear making a mistake that might offend others or expose ignorance.[8] Conversations can become uncomfortable and destabilizing for many Whites when the norms that hold racial inequality in place are challenged.[8,9] Often people of color attempt to lessen that discomfort for Whites by softening their critiques of individual choices or social systems. However, this may help to maintain the racial status quo[9] and lead to frustration or anger among people of color whose concerns are once again marginalized.[9]

> *To fight racism and its inextricable link to health, health care professionals must recognize, name, understand and talk about racism competently.*[1,3,4]

These actions also reproduce dominant power relations. While people of color may sit at the tables of power, they often have difficulty being heard.[10] To counter this tendency to discount Black voices, a positive communicative climate is necessary.[11] Public Health Critical Race Praxis (PHCRP) methodology represents a salient way to achieve this when conducting research.[12,13] PHCRP seeks to dismantle group power relations and to systematically promote and sustain interracial dialogue in a professional setting by encouraging participants to systematically assess and address racism-related factors that may influence research and practice.[12,13]

In September 2015, the University of Minnesota held a Convergence Colloquia, a multidisciplinary gathering aimed at advancing cutting-edge research to develop innovative solutions to address critical problems.[14] One participant in the Colloquia urged the others to "come step in it" and be willing to have uncomfortable conversations about racism in the professional setting. As a participant in the colloquia, the author and the principal investigator (PI) of this study seized the opportunity to "come step in it," convening a group to develop and pilot a curriculum to teach first year medical students about race and racism. The overarching aim of the project was to develop a curriculum to teach and promote critical conversations about race and racism among medical students. This article describes lessons learned employing a PHCRP methodology to develop this curriculum with a multidisciplinary and multi-racial group of professionals dedicated to advancing conversations on racial equity.

Methods

A Public Health Critical Race Praxis (PHCRP) methodology was selected for this exploratory study.[12,13,15] A detailed explanation of PHCRP has been published elsewhere.[13,15]

Sample

We convened a multidisciplinary, multi-racial group of professionals in two phases to develop and pilot an intervention to promote effective dialogues on racism for first year medical students at the University of Minnesota Medical School (UMN). We divided the group into three groups of participants.

Core Group

The Core Group was led by the PI and comprised five co-PIs, all women, who were selected by the PI to participate because of their knowledge of racism, health and wellbeing. Drawing on PHCRP methodology of centering at the margins,[13,15] the Core Group primarily comprised women of color (eg, African American, American Indian). The Core Group members all held positions in public health or medicine, ranging from faculty positions to leadership roles in community health and community research centers.

Two graduate students in public health and organizational management, with interests in race and racism, served as research assistants and were tasked with taking detailed notes during each meeting.

Extended Core

The core group was extended by inviting people of color in community organizations to participate. Only one member of the Extended Core remained involved for the duration of the project. We included this participant as part of the Core Group.

Expanded Group

The Expanded Group comprised four White male physicians and/or researchers and one White female researcher, all medical school faculty.

Process

"Come Step in It" consisted of three-phases: Phase I: content development with the Core Group; Phase II: content refinement with the Core and the Expanded Group; and Phase III: pilot testing with first year medical students. In this article, we describe the group processes employed during Phase I and Phase II. This was an iterative process, which included 12 monthly, two-hour meetings from Jan 2016-Dec 2016. The agenda for each meeting was designed to advance the conversation from the previous meeting. All meetings were facilitated by the PI.

Phase I

The objective of Phase I conversations was to exchange thoughts, feelings, and experiences, in order to map out the problem. These conversations were designed to draw equally on knowledge of the literature and lived experience in a process of reflective and mutual learning. Conversations led by the PI began by identifying barriers to advancing conversations on race and racism. We held nine meetings in nine months during Phase I.

In this project, we centered in the margins[13]—that is, we actively sought to move voices typically on the margins of academic research to the center. As a core tenant of Public Health Critical Race Praxis methodology, the PI intentionally selected women of color and/or women whose identity(s) and, in many cases, their academic work were on the margins. Indeed, many of the Phase I participants would describe themselves as "outsiders within their respective disciplines."[13,15] This centering allowed for the project to be grounded in the lived experiences and perspectives of women and women of color and for the intervention to be shaped early on by academics and experts who belong to historically stigmatized racial groups.

Phase II

In Phase II, the Expanded Group joined with the Core Group to engage in authentic and honest interracial discussions. The overarching goal of Phase II was to obtain input from White allies who taught medical students, and whose own racialized identities could provide greater insight into White students' reactions. Although the hope was that White colleagues would react positively to the proposed content, there was also a real risk that, because of different worldviews and experiences, there would be disagreement. For example, we recognized that White colleagues who were "pragmatists" might want to gingerly introduce content to audiences that they expect to resist ideas of race-based privilege. However, people of color might want to risk alienating some in order to introduce subjects that they view as high stakes. There were three meetings during Phase II. The content of these meetings changed each month as the curriculum development moved forward. Participants remained consistent across the meetings.

PHCRP Methodology

Our process draws in part from each of the four focuses of PHCRP (Table 1).[15] Focus one, contemporary patterns of racial relations led us to focus our early discussions in Phase I on how racism operates in contemporary health care delivery systems.[15] By centering at the margins, the women of color in our group could describe their lived experiences of racism in health care delivery systems. The stories each Core Group participant told either of themselves or a family member certainly were important for the process of developing the intervention. Focus 1 also led us to consider the mechanisms by which racism operates and resulted in a Core Group decision to focus on structural racism rather than implicit racial bias. PHCRP methodology Focus 2 is knowledge production.[15] In Phase I, we were all well aware of how our respective discipline's norms and conventions help to reinforce existing racial interactions and hierarchies. This focus also created a comfort to allow our own personal subjectivities to shape the work. We used the social construction of knowledge[15]—an important principle of Focus 2 as the basis for our conversations in deconstructing what is currently taught to medical students about racism. This too, led us to the conclusion that sturcutral racism (vs implicit bias) should be the primary focus of the intervention. The concept of intersectionality, which comes from Focus 3, conceptualization and measurement,[15] was employed in that the PI considered the interlocking nature of race and gender when centering at the margins and selecting the participants for the Core Group. Finally, we used Focus 4, action, in an effort to use our newly acquired knowledge around the processes of multidisciplinary, multiracial conversations on race

Table 1: Public Health Critical Race Praxis focus areas and select examples of how they play out in the process of using multidisciplinary and multiracial conversations on race and racism to teach medical students about racism

Focus	Relevant principle(s)	Example
Contemporary patterns of racial relations	Structural determinism ("…the tendency of dominant group members and institutions to make decisions or take actions that preserve existing power hierarchies…")[15]	**Phase I:** Intentional centering in the margins explicitly to prevent dominant group members (eg, White males) from making decisions or taking actions. **Phase II:** A loss of some structural determinism: "I too saw a shift in the 'voices' from Phase I to II. I could now see and understand the dynamics that marginalize and shut down voices from the community. I was now part of the group being shut out."
Knowledge production	Social construction of knowledge ("…established knowledge within a discipline can be re-evaluated using antiracism modes of analysis") [15]	"…to implement the intervention with medical students, we needed to both work within the system AND resist the system.
Conceptualization and measurement	Intersectionality (the intersecting of social categories) [15]	**Phase I:** Race and gender intersect in the social identities of Phase I Core Group participants. **Phase II:** Intersectional identities explored for different identities. "I'm not sure if it's White male doctor privilege or just the mere fact that they [the White male physicians] had a deeper knowledge of what could feasibly be changed in the medical school curriculum but either way it was frustrating to constantly push back against this…ego of sorts."
Action	Voice (prioritizing the perspectives of marginalized persons; Privileging the experiential knowledge of outsiders within) [15]	**Phase I:** "In the beginning it was all women and mainly women of color…the conversation was wonderful." **Phase II:** Many in the Core Group described the voices of the Expanded Group as "louder and more prominent."

and racism to help disrupt racism. This article represents our first action step—we are telling the story of the process that led to the creation of a curriculum to teach first year medical students about racism. We seek to expand the practice of studying race relations through a PHCRP lens.

Data Sources

Meeting Notes

The two graduate research assistants took detailed (nearly verbatim) meeting notes in all meetings in order to document the conversations and group dynamics. The meetings were not recorded.

Post Intervention Reflections

A post-intervention meeting was held for all participants to reflect on the entire process. Research assistants also took detailed notes at this meeting.

Analysis of Data

An inductive approach was used to allow the frequent and dominant themes to emerge. This allowed for ground-up development of codes and identification of recurrent unifying concepts that characterized the experiences of participants. Coding was done by the lead author and codes and dominant themes were shared with a sub-set of participants for confirmation and feedback. Overall, coding was grounded in the lead author's synthesis of the materials as a participant in the project and her personal perspective based in part on the experience of being a Black woman in academia. It is important to acknowledge this positionality as PHCRP calls us to recognize the role that our identities may play in the research.[12,13,15] As a Black woman whose lived experience is that of frequent marginalization, the unique details and issues that are shared through the analyses reflected this lived experience. These details and issues also reflected the experience of being a Black female academic in a predominately White institution (PWI). While we do not suggest that the author speaks for all Black female academics, we do, however, believe that there is likely a common lens and experience by which many Black female academics view race and racism and navigate discussions of the topic, particularly with colleagues at a PWI.[16] This perspective and positionality also made drawing on some of the principles of PHCRP straight-

forward. Race consciousness, for example, the backbone of PHCRP methodology requires explicit attention to racial dynamics in one's personal world.[15] This deep awareness of one's racial position certainly contributed to an ability to view the project and this article from the lens of someone who has experienced racism. The disciplinary self-critique principle of PHCRP was self-affirming in that those on the margins often have critically examined their discipline's norms and are often actively working outside of that or to dismantle it or to create new ones. This work was a chance to do that. Voice was also important. In a space (PWI) where White voices are routinely privileged, Phase I was an opportunity to be in an environment that was predominantly women of color and, in many ways, speaking truth to power.

Results

Phase I

Powerful

Core Group participants described the Phase I meetings as powerful, allowing them to "bring their full selves" to a project that convened individuals who are often marginalized in their professional environments. Reflections from the Core Group members included comments such as: "In the beginning, it was all women and mainly women of color…the conversation was wonderful." Most Core Group members expressed comfort with one another and described a safe space: "I felt that our sessions were about letting our armor down… We weren't always in agreement but we were in support." Another explained, "We could disagree, have different viewpoints and still end up getting things done."

Mutual Respect and Support

In Phase I, the Core Group built respect for one another's professional roles. Core Group members noted that there was no professional hierarchy present. The Core Group's commitment to supporting career advancement of the PI and co-PI as Black junior faculty was apparent. Meeting notes reflected several discussions as to how to support "Come Step In It" in a way that would promote academic success for the junior faculty. Simultaneously, there was a deep understanding of the weight of advocacy for the marginalized communities the Core Group sought to serve. "I am sitting here and I am moved. I do recognize that sometimes I look at it as I am moving the boulder up hill."

Centered

The PI's efforts to center at the margins were evident from the racial and ethnic makeup of the Core Group that she assembled. This effort did not go unnoticed by Core Group members. Many reflected on how refreshing and safe it felt to be in a space with individuals from historically marginalized communities. "It was energizing and inspiring, I really felt like I was building something important and impactful." Another explained, "As a Black woman, it's rare to have the opportunity to sit in a professional meeting with other Black women." While the women possessed varying perspectives, the commonality of being marginalized seemed to offer a level of comfort. One member summed it up as "…we may be different but we all come from similar experiences of having been ignored or overlooked. There is an unwritten rule that we understand each other and that we work together."

Phase II

Power Dynamics

Post-intervention reflections from the Core Group suggest that the dynamics shifted significantly with the addition of the Expanded Group. One Core Group member noted, "… the voices from Phase I became quieter…" Some of the Core Group were not surprised by this, explaining, "… We are used to being marginalized and dealing with power structures..." Power differentials between Core and Expanded Group members created conflict for Core Group members: "I had to put on my armor and fight in those later meetings…" Others reflected on a feeling of "going to battle." One Core Group member went on to explain that, "As the group changed I felt like I constantly had to speak up and explain to them [the Expanded Group], the reasoning behind the decisions that were made early on...."

Quieter Voices

While some Core Group members were vocal, others became quiet. Indeed, even the one White woman from the Core Group noted the shift stating: "I too saw a shift in the 'voices' from Phase I to II. I could now see and understand the dynamics that marginalize and shut down voices

from the community. I was now part of the group being shut out." Many in the Core Group described the voices of the Expanded Group as "louder and more prominent." Expanded Group members expressed in post project reflections that they "…didn't have a clue…" as to how the group dynamics impacted the Core Group. For example, one Expanded Group member explained: "I was completely oblivious to this. It hadn't occurred to me that some of the original group were no longer speaking their mind." Another Expanded Group member said: "I wish they [Core Group] would have [spoken their mind] … The last thing I wanted was for the original members to feel marginalized within their own project!" He continued: "It's ironic that even within a group of individuals educated on this topic [racism], we demonstrated the insidious strength of these social patterns." Some Core Group members reflected on which identity most perpetuated dominant social patterns (race, gender, professional status): "I too felt silenced in Phase II but that was not because there were Whites present, it was because they were traditionally prepared male physicians who did not listen." Another stated: "I'm not sure if it's White male doctor privilege or just the mere fact that they [the White male physicians] had a deeper knowledge of what could feasibly be changed in the medical school curriculum but either way it was frustrating to constantly push back against this…ego of sorts."

Good Intentions

The perspective from the Expanded Group was slightly different. As one physician explained, "I recall thinking I had to walk the line between criticizing something and continuing to prove, "Hey, I'm a good guy" – I'm well-intentioned and not completely ignorant about these things (but still somewhat ignorant)." One member of the Expanded Group was particularly vocal about the intervention, its contents and feasibility. He explained in post project reflections: "I felt like I was frequently bringing in the constraints of the course, the medical school, and the traditional types of content and structures we use in the school. So whether it's race or ivory tower traditionalism (or both), I felt myself frequently coming back to what I believed was realistic within the existing structure." He continued by stating: "I definitely recognized myself as the 'White pragmatist'." Stereotype threat (feeling at risk of conforming to stereotypes about one's social group) also emerged in post project reflections among Expanded Group members: "So, it was awkward to be asked to come in and criticize others' work – especially given the gender, race, and social power dynamics. I was definitely feeling some gender/race stereotype threat – that the White male doctor is going to tell us what we're doing wrong and think he knows best. Believe it or not, I held back some because of that!"

A Shift in Norms

Group norms and the trust that existed in Phase I was lost. "Early on, when I came in I saw how different this space was from spaces I had been in. Norms were self-created. With the [Expanded Group], the norms didn't translate. How do you translate that to a space where that wasn't natural?" Another Core Group member reflected on the norms as they related to a shift in power dynamics: "Our norm in the beginning was to bring our full selves. When White people show up in the room we don't know where they stand even if they say the right things. I need to know who you are. I did get quiet and it's because I'm used to being marginalized... So I sat and learned how to navigate."

Roles and Motivations

In addition to concerns with the shift in norms, some Core Group members questioned the motivations of the Expanded Group: "I am not sure that all of the new folks [Expanded Group members] believed this work has an impact on their [own] success as faculty, researchers and clinicians. The respect for [PI] and [co-PIs] and the need for them to have buy-in from the new members silenced some of the questions." Finally, post meeting memos written by the research assistants during Phase II also reflect the power of the "medical institution" more broadly. This is to say, it's not just the individuals from the Expanded Core who may be shifting the power dynamics but that the group overall was tasked with working to create an intervention around racism within a system that might not be accepting of it: "…to implement the intervention with medical students, we needed to both work within the system AND resist the system. This is hard to do!" Nevertheless, there was agreement among both groups that the project was a success. The Core Group offered that this success came

on two levels. First, the intervention was successfully piloted among first year medical students. Second was the recognition of the unique role that a group of women from marginalized communities played in its success. A Core Group member summed it up when stating: "I believe that folks who are marginalized learn to work like water and move undetected to have impact that is long lasting."

Discussion

The process of employing PHCRP methodology in this exploratory study that uses interracial dialogues to develop an intervention about racism for medical students led to new insights about the dynamics of discussing racism in interracial setting and how to employ the principles of PHCRP methodology specifically in doing so (Table 1). It is common for people of color to serve on the margins of projects, as partners, assistants, and perhaps most commonly as study participants.[7-10] We aimed to focus those voices and flatten the traditional hierarchies found in conventional modes of scientific inquiry. That meant flattening hierarchies between academics and non-academics, physicians and non-physicians, and Whites and people of color. This was challenging, yet essential in our process of identifying meaningful content and authentic interracial engagement. An important take away from our efforts to center in the margins is that even when you do so, ensuring that marginalized voices are heard is challenging. Phase I proactively moved those on the margins to the center. However, it was clear that these efforts were slightly obscured in Phase II. At the heart of Phase I was an understanding that the project was not simply teaching medical students about racism—but a project steeped in a deep history of oppression. A space was created in Phase I that affirmed and nurtured this. Not only did we successfully center at the margins but we were centered around a broader more insidious and pervasive issue than simply the task at hand. It is unclear if this connection to the work could be taught to those who cannot identify with it through their lived experience. Future efforts in this vein may consider exploring this more deeply as previous work suggests that one of the primary issues with anti-racism work is that it often has a very different meaning for oppressed groups themselves than their White allies.[17] Employing more explicitly, the critical approaches of PHCRP Focus two and four, which calls for researchers to critically reflect on their biases and develop a comprehensive understanding of them, would help to unpack these different meanings. Additionally, going beyond the assumption of a shared concept and directly revisiting biases consistently throughout the project might allow researchers (participants) to clarify, unpack and discuss them on an ongoing basis. This may be uncomfortable; thus, a willingness to "come step in it" must be present.

PHCRP requires explicit attention to the racial dynamics in one's personal life and broader society.[12,13,15] The intervention was certainly developed through a race-conscious lens, in that there was explicit agreement and awareness of racial stratification processes. However, the group perhaps failed to apply this race-conscious lens to their interactions with each other. This would have required participants to explicitly clarify their racial biases perhaps in a discussion early on in Phase II. Future projects of this nature might require that members of the interracial group stop to answer the question collectively: "how is racism operating here?"[3] making explicit the shifting dynamics. The dominant societal power structures that appeared in Phase II were not anticipated, as the Core Group had worked to set parameters around the involvement and integration of the Expanded Core. It was also unexpected in that the Expanded Core members were all considered to be "woke"—individuals known to care deeply about and understand racial inequality. What we see in this process is that even among racially aware allies, racialized and socialized roles can easily dominate, resulting in the perpetuation and replication of power structures in spaces where the intent to avoid doing so is quite explicit.

Limitations

Our study findings must be understood within the context of their limitations. First, this project was conducted at a single medical school and therefore findings may not be generalizable beyond those involved. Additionally, this study is limited by its small sample size. Future studies that explore these dynamics at multiple sites or institutions will be important. We also did not record meetings; however, having two well-trained note takers

in each meeting allowed for very detailed and nearly verbatim notes for each meeting. What one note taker did not capture, the other likely did. Finally, this project was exploratory in nature and part of a larger study with the goal of piloting a racism curriculum with first year medical students. Learnings from this project may guide future replication of this work across multiple sites allowing for an even deeper understanding of what happens when a multidisciplinary group of health professionals is convened to "come step in it."

Conclusion

Future work drawing on intersectionality as an analytic lens within the health care setting might help to highlight the nature of multiple individual identities (eg, class, gender, race, profession) and how varying combinations differentially positioned each individual. Particularly, there must be a focus on unpacking structural racism in medical institutions through the lens of White male privilege. Participants described the struggle between disentangling the power of the White male voice and their content expertise. Articulating the intersection of these identities is important and has the potential to contribute to a new understanding and knowledge of how structural racism continues to be perpetuated in medical institutions and medical education.[1]

Overall, using a PHCRP approach to interracial discussions about racism illuminated a unique process where professionals dedicated to health equity worked among themselves while preparing to implement the work among medical students. The conflicts both implicit and explicit that arose in Phase II are a profound example of what "stepping in it" really means.

Conflict of Interest

No conflicts of interest to report.

Author Contributions

Research concept and design: Cunningham, Hardeman, Potter, Zulu-Gillespie, Apolinario-Wilcoxon, Nielsen; Acquisition of data: Hardeman, Burgess, Murphy, Satin, Nielsen, Potter, Karbeah, Zulu-Gillespie, Apolinario-Wilcoxon, Reif, Cunningham; Data analysis and interpretation: Hardeman, Burgess, Murphy, Satin, Nielsen, Potter, Karbeah, Zulu-Gillespie, Apolinario-Wilcoxon, Reif, Cunningham; Manuscript draft: Hardeman, Burgess, Cunningham; Acquisition of funding: Cunningham, Hardeman; Administrative: Karbeah, Murphy; Supervision: Cunningham, Hardeman

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