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Self-Awareness and Cultural Identity as an Effort to Reduce Bias in Medicine

Augustus A White III[1] · Heather J. Logghe[2] · Dan A. Goodenough[1] · Linda L. Barnes[3] · Anne Hallward[4] · Irving M. Allen[5] · David W. Green[6] · Edward Krupat[1] · Roxana Llerena-Quinn[1,7]

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Abstract In response to persistently documented health disparities based on race and other demographic factors, medical schools have implemented "cultural competency" coursework. While many of these courses have focused on strategies for treating patients of different cultural backgrounds, very few have addressed the impact of the physician's own cultural background and offered methods to overcome his or her own unconscious biases. In hopes of training physicians to contextualize the impact of their own cultural background on their ability to provide optimal patient care, the authors created a 14-session course on culture, self-reflection, and medicine. After completing the course, students reported an increased awareness of their blind spots and that providing equitable care and treatment would require lifelong reflection and attention to these biases. In this article, the authors describe the formation and implementation of a novel medical school course on self-awareness and cultural identity designed to reduce unconscious bias in medicine. Finally, we discuss our observations and lessons learned after more than 10 years of experience teaching the course.

✉ Augustus A White, III
Augustus_White@hms.harvard.edu

[1] Harvard Medical School, Boston, MA, USA

[2] Allies for Health, Reno, NV, USA

[3] Boston University School of Medicine and Boston University, Boston, MA, USA

[4] Tufts University School of Medicine, Portland, ME, USA

[5] Harvard University Health Service, Cambridge, MA, USA

[6] Brookside Community Health Center AND Brigham and Women's Hospital, Boston, MA, USA

[7] Boston Children's Hospital, Boston, MA, USA

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Introduction

Differences in healthcare outcomes based on gender, race, ethnicity, income, and other social indicators are well documented and persistent over time [1–6]. Substantial evidence implicates provider's behavior as an important contributor to health disparities [1]. Decades of research in social cognitive science show that hidden biases operating largely below the scope of human consciousness influence the way we see and treat others even when we are determined to be fair and objective [7]. These biases can lead to unwanted disparities in every possible realm of human life and have been documented in the law, education, housing, employment, and more [8–11]. Medicine is no exception [1].

Evidence shows health practitioners are not immune from harboring stereotypes and bias toward patients—and even colleagues—with backgrounds similar or different from their own. In 2003, the Institute of Medicine's seminal report, Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care, noted the existence of racial and ethnic bias among healthcare providers and emphasized how these biases contribute to healthcare disparities [1]. While most physicians are not explicitly racist or prejudiced, studies show that physicians manifest the same implicit biases and stereotypes found in the general public [12–24]. While some vignette-based studies suggest such bias does not influence clinical decision-making, other studies suggest unconscious bias can lead to discordance between a physician's explicit

egalitarian beliefs and the care they provide their patients, unintentionally resulting in health inequality [25–43].

The addition of cultural competency training to medical school and continuing medical education curricula has been identified as essential to adequately prepare physicians to practice in today's diverse society and to achieve health equity [44–48]. A wide variety of programs have been implemented by accredited medical schools and residency programs in response to mandates to achieve these goals [49–60]. Most programs focus on cross-cultural communication skills and encounters, use of interpreters, alternative medicine, or culture-specific knowledge about the culture of the patient rather than the culture of the provider or implicit bias. Such cultural competence education as traditionally taught has been criticized for excessively focusing on the culture of the patient, neglecting patient and provider diversity, and decontextualizing social differences [61–63]. Many believe this approach may work against the intended goal of reducing the effects of bias and actually perpetuate stereotypes [64]. These authors have been critical of the discrete notion of "competence" as an endpoint that can be achieved. They prefer Tervalon and Murray-García's concept of "cultural humility" to acknowledge the lifelong commitment to self-reflection and self-critique necessary for appropriately redressing power imbalances and for developing mutually beneficial partnerships with patients and communities involved [65].

Beyond knowledge of specific cultures and narrow definitions of competence, many have argued that critical self-awareness and introspection are necessary for cultural competency training efforts to be effective [66–71]. Indeed, the recently revised Liaison Committee on Medical Education (LCME) 7.6 standard requires that medical curricula provide medical students with opportunities "to examine gender and culture bias in themselves, others and in the healthcare delivery system". The revised standard further links this dimension of physician education to professionalism as one of the "core professional attributes needed to provide effective care in a multidimensionally diverse society." [72] The linking of cultural competence to professionalism brings attention not just to how cultural competence is taught but to the institutional contexts in which this is learned [73]. Furthermore, the literature concerning professionalism and the hidden curriculum sheds light into how implicit biases are taught and modeled in medical education [74–76].

Regardless of one's cultural or ethnic background, all practitioners and educators inevitably treat patients and teach learners who have backgrounds different from their own. Furthermore, given the universality of bias, common social identity does not guarantee effective patient-physician interaction and therefore self-reflection and examination benefits everyone [77–79]. Until we succeed in teaching medical students, residents, and even faculty how to recognize, acknowledge, and address their unique perspective and preconceptions, unconscious bias will continue to lead to unequal treatment. The following article details the development of a self-awareness program implemented at Harvard Medical School (HMS).

Blind Spots and the Pedagogy of Self-Awareness

Blind spots are hidden biases that develop from a lifetime of experiences with social groups. Favorable or unfavorable associations to social groups develop at an early age and arise from exposure to direct or indirect messages about the value of these groups within a society. Without awareness or conscious control, such blind spots shape an individual's likes and dislikes, and even judgments about people's character and abilities based on gender, race, ethnicity, social class, religion, and other demographics [80]. Because these unconscious attitudes may be stronger predictors of behavior than explicit beliefs, preparing physicians who are well equipped to treat *all* patients equitably must include strategies to address physician' blind spots. Acknowledging recent advances in neuroscience demonstrating humans' inherent formation of bias and prejudice, it follows that awareness, self-reflection, and a process of undoing are necessary to overcome them [81–83].

The need to promote physician personal awareness of "how one's life experiences and beliefs affect one's interactions with patients, families and other professionals" has been long recognized as an important component for effective patient care in medical education. The Working Group for Promoting Physician Personal Awareness identified families of origin, gender, and sociocultural influences, including medical training, as important contexts that shape physicians' beliefs and attitudes that in turn influence patient care and their interactions with other professionals [84, 85]. The pedagogy of self-awareness focuses on the self rather than the "other." This focus on self is seen as a necessary first step in the lifelong journey toward understanding and developing accountable personal and institutional relationships with those both similar and different from oneself.

Creation of the Course

The course was developed as efforts to integrate multicultural education into the medical curriculum raised concerns about bias and stereotyping in the overt and hidden curriculum. To address these concerns, the faculty decided to capitalize on their own diversity for mutual learning, and to develop a course where they, along with students, could explore and reflect on their personal cultural identities, and to explore their own stereotypes, blind spots, and biases in a relational context. Readings on the historical cultural, political, structural, institutional, and economic imbalances of power and privilege in Western society served to provide a contextual awareness against which personal and individual biases were examined.

Thus, rather than a traditional pedagogical approach, the course took an andragogical approach in which the adult learners were encouraged to draw on their own life experiences to guide their learning in the course [86].

To create the curriculum, the team[1] engaged in months of study and discussion, undertaking the self-reflective process together, having agreed they could not ask students to do anything they themselves had not first tried. Relying on the nuanced cultural contexts they individually embodied, the faculty engaged in an intentional process to explore the ways in which these contexts touched their lives personally and professionally. Facilitators unable to participate in the faculty course were required to complete the student course prior to facilitating. Participation in the course allowed facilitators to experience firsthand the rewards and challenges associated with exploration of blind spots and the importance of the group's diversity in the process of self-discovery. Unlike traditional notions of transference and countertransference, the concepts of "blind spots" or "bias" in our course take into account the effects of these reactions in the context of real-world power imbalances resulting from perceived differences or similarities [77].

After the course was launched, the faculty instructors met after each class for substantive debrief, revision of future sessions, and feedback to develop facilitation skills. True to the commitment of lifelong learning, the course continued to evolve with student and faculty input.

The Course

The course had a voluntary structure consisting of 14, 2-h sessions, limited to 16–18 students. The course was offered to first, second, and fourth year medical students during its first iteration as a selective course in Social Medicine. When the medical curriculum changed, the course became an elective offered only to first year students. A later version was developed for faculty and allied health professional from affiliated hospitals.

The course provided an interactive, dynamic context for each participant to explore his or her own cultural background, reflect on the culture of Western medicine into which students are socialized, challenge their assumptions, and confront the effects of power and privilege in a supportive and relational environment. The course was unique in the medical school curriculum in that its primary focus was self-discovery rather than the acquisition of factual information or characterizations of the "other." The course was designed to model a lifelong commitment to self-awareness and introspection, fundamental to the process of developing healing partnerships with patients, colleagues, and relationships in general. Participants benefited from a unique opportunity of learning from their classmates as they shared their own cultural backgrounds and reflected on lived experiences arising from multiple contexts.

The stated learning goals were:

- Self-knowledge through reflection
- Contextual awareness
- Understanding the interrelationship between difference, privilege, and power
- Discovery of our blind spots
- Focus on the culture of medicine

Long-term goals included the following: (a) to improve quality of care for all patients by increased awareness of errors arising from bias and blind spots, and (b) to increase participants' comfort in realizing, addressing, and challenging their preconceived stereotypes.

The cornerstone of the course was to have each student construct a "cultural genogram" in which the students crafted a model of their histories and contexts, which had educated them about the experience and meaning of difference. The goal of this exercise was to facilitate an appreciation and understanding of the "multidimensionality of culture" and thus begin challenging one-dimensional concepts of culture that often lead to stereotyping. As Hannah and Carpenter discussed in their paper about the course, the exercise illustrated the concept of "hyperdiversity" within each of us challenging static notions of culture [87]. These genograms were developed over the period of the course, and re-visited as each of the course topics was explored. See Table 1 for specific topics selected for their association to health disparities and bias.

The sessions were adapted with student input. For example, a session on "Thin Privilege" was added to address weight bias as result of a reflection paper written by a student. Table 2 provides examples of key strategies and tools used to implement the

Table 1 Course schedule and topics

Session	Topic
Session 1.	Introduction. Course overview
Session 2.	Cultural meanings and the culture of medicine
Session 3.	The cultural genogram
Session 4.	Power and privilege
Session 5.	Gender privilege
Session 6.	Straight privilege
Session 7.	Race and levels of racism
Session 8.	Racial identity development models
Session 9.	Social inequality and social determinants of health
Session 10.	Social class and classism
Session 11.	Immigration and refugees
Session 12.	Religion and spirituality
Session 13.	Multiple identities, student project presentations
Session 14.	Closure (multiple identities) and feedback

[1] Daniel Goodnenough, Roxana Llerena-Quinn, Anne Hallward, Linda Barnes, Irving Allen.

Table 2 Key objectives and strategies

Self-reflection in context and with others	Focus on self The self-reflection in a relational context [65, 85, 88] The self is explored in multiple contexts including intersections of gender, race, sexual orientation, social class, ethnicity, and religion and by its simultaneous participation in one or more statuses that produce privilege or disadvantage
Contextual awareness	The multiple contexts that shape individuals' experience are explored at the social, historical, political, economic, cultural, family, and community levels, including the culture of medicine Societal factors (examples) Race and racism: Tools: Race: Power of an illusion (documentary) True colors (documentary), sickle cell trigger tape Class and classism: Tools: unnatural causes: The Social Determinant of Health (documentary) People like US: social class in America (documentary) Immigration: Tools: US timeline history of immigration (fact sheets) Myth and facts on immigration (fact sheets) Our immigration narratives (class reflection narratives) Family of origin and sociocultural influences Tools: Cultural genogram [89] The culture of medicine and interactions with its institutions [90–93] Tools: IOM report [1]
Understanding power, privilege	Understanding privilege Tools: Wheelchair exercise Peggy McIntosh—White Privilege [94] Growing up gay (documentary) Men privilege, class privilege, straight privilege (handouts) [95]. Understanding power and blind spots Tools: Community map exercise Universality of bias [96] Optional tools: IAT (implicit association test) [24] Bias + power = "isms" Experiential exercises and guided self-reflection to encourage critical reflection and self-discovery Small group discussions—learning from and with others Large group discussions to integrate the learning
Exploring racial/ethnic identity development models	Racial identity development models- Tools: Film: Skin deep
Engaging students as co-teachers	Students became co-teachers by sharing their cultural genograms, personal narratives, ongoing reflections, and their final paper. The class provided a learning ground no one individual could ever accomplish alone. Each student embodied a rich tapestry of experiences that could not be anticipated. Although students often start at different levels of self-awareness, this difference too added to the learning

learning objectives. An appendix has also been included with further information on course rationale and curriculum content.

The Learning Environment

The terms, "diversity" and "cultural competence" can elicit strong emotions, often triggering feelings of anger, shame, guilt, and dread. These emotions can lead to learner's resistance, promote "political correctness" and the suppression of stereotypes that perpetuate implicit bias, and result in "aversive racism" [61, 97]. Students may also demonstrate aversive racism manifesting as avoidance of interaction with other racial and ethnic groups rather than overt racism [97]. These emotions can result in learners' avoidance of authentic dialogue that is needed for mutual learning [53, 97].

The need for a safe learning environment where differences can be explored, voiced, and engaged to facilitate dialogue across differences has been documented [88, 98–100]. A safe learning environment aims to manage the intergroup anxiety that produces aversive racism and prevents self-exploration and mutual learning. However, a safe space does not imply there will be an absence of discomfort or strong emotions as navigating outside one's comfort zone is often needed for learning. Two critical factors were needed to set an appropriate tone and safe atmosphere for the course: (1) a mutually respectful environment that encourages self exploration, a curiosity about differences, asking questions, and practicing new skills; and (2) a way to minimize

the shame participants might feel in acknowledging racial, ethnic, or cultural bias and stereotypes. We accomplished this by establishing the following set of ground rules:

- Come to every class and on time to maximize the class experiential learning process
- Honor confidentiality as a safeguard for self-disclosure and trust.
- Use "I" statements to maintain a focus on self-discovery. Be curious about yourself first and about how you learned to think and feel this way.
- Participate; take a risk. Active participation enhances self-discovery and group process.
- While participation is valued, it is "ok to pass" if you need more time for reflection.
- "No blame, no shame." Rather than "blaming" others for blind spots, instead ask for elaboration: "Can you tell me more about that?" or "How did you come to believe or feel that way?" Or, be curious about yourself: Why am I feeling/reacting this way?
- Students were invited to offer additional guidelines that would promote a safe environment for them.

Since the conclusion of our course, the use of trigger warnings alerting students that a work contains writing, images, or concepts, which could be triggering of past trauma, has been hotly debated in higher education [101–104]. While the authors wish to avoid further debate of the pros and cons of trigger warnings, we acknowledge it may be argued that the delicate content of the self-awareness curriculum necessitates such warnings. However, we do not believe trigger warnings are indicated in the setting of the course given the transparency of the topics covered and the supportive environment in which the material is presented.

Methods and Exercises of Instruction

The course was facilitated by a professionally and demographically diverse team who both participated in and modeled the process. The sessions were conducted in large and small discussion groups. The principal methods of instruction relied on a set of experiential exercises designed to encourage self-reflection and self-awareness. The exercises focused on engaging the students (and faculty) to reflect on the experience and social significance associated with belonging to certain groups. Film clips and short readings were used to engage students at their individual level of racial, ethnic, or other identity awareness. Concepts were explored first in films and readings and then in the students themselves. Assignments included readings, reflection questions, journaling, writing personal narratives, and a final reflection paper.

The opening exercise, "Exploring Cultural Meanings," was designed for students to begin the exploration of self as "cultural beings." It was geared to challenge unexamined assumptions of race, ethnicity, and culture as something non-whites have or that equate culture to "race" and "ethnicity" while ignoring other social identities. Students were invited to bring an object or symbol of their culture that is meaningful to them and to come prepared to discuss "why." See Table 3 for detailed instructions and examples of items brought.

Students were not only invited to reflect upon their culture but also upon the culture of medicine to which they were being acculturated. This included the historic, yet still pervasive, use of shame as a pedagogical tool in medical education as well as the fear of appearing vulnerable or naïve. In particular, they were asked to consider how the frequent use of shame and fear of appearing incompetent may preclude honest dialogue on culture and difference and how physicians might overcome their own unconscious biases in this challenging setting.

A more nuanced understanding and appreciation for the multidimensionality of culture was encouraged through creation of a "cultural genogram." [89] In this exercise, students drew a detailed multigenerational family tree of their cultural heritage, including details of ethnicity, race, gender, education, occupation, income, immigration, religion, and sexual orientation. The goals of this exercise were (a) to challenge stereotypes dependent on single social identities, and (b) to identify the vectors of power (statuses) attributed to sociocultural differences within the family of origin. Whether students reported a mixed or homogeneous ethnicity, their culture of origin included multiple demographic and social identities, which provided contexts to explore the meaning of difference within one's family of origin.

The genogram helped students construct a narrative that answers questions such as, "Who am I?" "Where do I come from?" "Where do I belong?" "What influences have made me be who I am today?" "How have I been taught to see myself and others based on these influences?" Issues of pride, shame, status, and privilege were explored within these narratives. For example, wealth, education, and citizenship are often associated with power and status. Special attention was given to cultural differences of identity within families—e.g., what it meant to have a mother who was Jewish and a father who was a Jehovah's Witness or one family member who worked as a day laborer and another as a surgeon. For many participants, acknowledging the meaning attributed to these differences was a first step to acknowledging we are taught to make judgments about certain statuses. These concepts felt safe to explore in the context of discussing themselves and their families. In addition, by allowing participants to be authors of their own family history and narratives, participants learned about each other beyond their visible and apparent social identities.

When students shared this experience with an intimate group including other students from different heritages, complexity and

Table 3 "Exploring Cultural Meanings" exercise instructions

Exploring cultural meanings exercise
Goals:
1. To discover the cultural aspects of one's identity
2. To appreciate the multidimensionality of culture
3. To construct a definition of culture that includes all elements presented in class
Pre-session instructions: Bring an object or symbol of your culture that is meaningful to you and be prepared to discuss "[1]why"?
Going around the circle:
1. Round one: Presentation of cultural objects
a. What did you bring? Why?
2. Round two: Reflection
a. In choosing the cultural object you brought, what aspects of yourself did you find yourself addressing? Leaving out?
b. How would you define "culture" in a way that it holds all of the meanings shared in this room?
c. Where would you place your object in the culture of medicine?
Examples:
A plate that traveled West in a covered wagon and Native American shawl: a descendant of American pioneers shared objects of pride and shame associated with her ancestors' travels to the West
A broken comb: an African American student brought a broken comb that she has kept since childhood. It was presented as a symbol of her struggles with hair, and of externally imposed standards of beauty she resists
An incense stick: an incense stick was offered as a symbol of change and transformation. Burning incense growing up in a family of hippie parents in the 1960s earned a new religious meaning when her mother moved and re-married in the Middle East
A phone card: a Dominican student whose family is still in the Dominican Republic brought a phone card as a symbol of a bridge to her most important connections and losses through immigration
A rolling pin: a Mexican student brought a rolling pin as a symbol of generational connection and resistance to gender roles. Taught that a "good woman" must learn to make tortillas, she finds liberation in choosing for whom to make them and when

individuality emerged and took the place of generalizations and stereotypes. It should be noted that feelings of guilt and shame were addressed but not encouraged. Guilt often leads to inaction on the part of the learner. For example, arguments may be put forth such as, "I am not responsible for slavery", "My family came to the US after slavery…", "I have friends from all races.", "I marched on civil rights." etc. Such arguments are used to avoid the discomfort associated with perceived "blame" for historical and current oppression and inequality. What remains hidden in arguments against guilt is that by being part of a privileged group one benefits regardless of one's actions or family history. While shame-based learning has historically been central to medical education, it is a painful emotion that perpetuates unconscious bias through avoidance of honest dialogue and aversive racism. Thus, both guilt and shame were deemphasized in order to create a safe space where people felt comfortable not knowing and could open up to learn from each other.

Other exercises included a wheelchair exercise and a "community map." The wheelchair exercise was used to allow students to experience the concept of "privilege" in the context of physical disability. In preparation for this session, students were asked to imagine spending 1 day in a wheelchair, and to come prepared to discuss the experience. The "community map" was used to increase their awareness of the communities in which they had lived and been a part of and how these experiences shape their preferences and comfort zones. It also aimed to raise awareness about the communities they were unfamiliar with and how their lack of experience in these communities might shape their blind spots.

Evaluation and Outcomes

We did not collect quantitative feedback on a systematic basis; rather, we relied on qualitative reflections by students on their experience of the course via pre- and post-course questionnaires. Several themes emerged from a review of these responses. The most consistent and powerful theme was that participants felt the course "opened their eyes" to their personal biases and blind spots. A second, related theme that often accompanied the first was that providing equitable care and treatment would require lifelong reflection and attention to these biases. When asked the "the most important things you have learned about yourself?" one participant replied, "That I have negative reactions to certain groups…From talking to other students, I have gained some skills for making my practice and way of being more friendly for some target groups." And as another put it, "That I need to think about my blind spots continuously." At the end of the course, many students reported a third theme of increased awareness of the

effects of demographic "difference" both in their own life and in the delivery of healthcare.

In a published evaluation of the course, the criticism was offered that while the safe-space strategy and interactive exercises of the course were "moderately successful," that this success came at the "expense of considering the multidimensional sources of bias" and that this approach implies that "prior ignorance, not active malice, is responsible for biased actions." [87] Llerena-Quinn countered that "the 'no blame' interactional environment…does not turn a blind eye to social structures and practices that produce harm."

Numerous students requested increased engagement from the course, such as increasing the frequency and duration of the sessions. Others requested additional options for engagement, such as a journal club and Internet board. In fact, a group consisting of two faculty and five students continued to meet weekly for a year after the course, while a sixth student remained connected to the group through email. In addition, faculty instructors continue to report ways in which they have woven principles from the course into their daily teaching and clinical practices.

We were invited to engage new members of the Medical School Admissions Committee in several exercises used in the course. We found that these exercises resulted in fruitful, substantive discussion among the committee members as they explored how their own biases might influence their choice of applicants. We also offered the complete course to interested faculty and staff at our school, with some of the objectives more focused on their patient and student contact. While we experienced some pushback from some of the faculty participants, in general, the discussions were open and constructive. Based on these limited experiences, we believe that our model may be adapted to multiple group contexts.

Lessons Learned

We have seen that students and faculty can evolve substantially during their participation in the course. For example, their comfort level in discussing issues of race, ethnicity, and culture increased. The inclusion of multiple topics related to major health disparities effectively broadened the reflective process. Students who might, for example, enjoy a privileged racial identity, might also have grown up in a disenfranchised social class, have a minority sexual orientation, and be part of a religious minority. Students learned that the significance of one part of their identity took on different meanings depending on context.

In addition, it became increasingly clear that many of our students identified as multi-ethnic, exposing the limitations of more traditional cultural competence classes which often emphasize learning about specific individual cultures as if singular entities. Such awareness led to the conclusion that becoming comfortable with asking questions and revealing one's own lack of knowing were important skills in delivering culturally sensitive care.

Limitations

The heavily scheduled undergraduate medical curriculum leaves little room for electives. Initially, the HMS Department of Social Medicine allowed us to offer our course as a "selective" satisfying a requirement for one Social Medicine course. However, eventually, the HMS curriculum changed and the course was changed to an elective. Enrollment subsequently dropped dramatically, illustrating the powerful influence of the institutional curriculum. Regretfully, the course was later dropped completely. At this time, HMS is undergoing significant curriculum reform that emphasizes critical thinking and integrative learning. The proposed changes underscore the importance of collaborative learning, human relationships, self-awareness, and professionalism. Our course can offer the development of skills that are consistent with new curriculum goals not only for students but also the faculty.

While one strength of the course was its emphasis on the individual experience of culture, difference, and bias, this approach may also be a limitation; in so much as it deemphasizes historic, socio-cultural, systemic, and institutional causes of bias and oppression. Ideally, participation in the course resulted in increased awareness and attention to these inequities; however, they were not explicitly taught in course. Nor were approaches to overcoming and overturning systemic and institutional oppression.

As our course tended to attract students already committed to challenging racism and disparities in the delivery of healthcare, it could be argued we were "preaching to the converted" and not those who might benefit most. Nonetheless, given the breadth of the course, each participant encountered previously unexamined areas. Even "the converted" have unconscious biases that are painful to recognize and address.

Since the creation of the course, more awareness has been raised in regards to biases against those who do not fit into a gender dichotomy and to the nuances of sexual identity. Future iterations of this course would be improved by attention to the experience of intersex individuals and those who identify as queer, transgender, gender fluid, and asexual [105, 106]. The course may also be improved with the inclusion and exploration of the neuroscience of bias.

Finally, limitations of this report include those inherent to innovative curricula with highly subjective outcomes. Quantitative specific feedback about individual course components is difficult to obtain and to interpret, and the qualitative feedback regarding the course is similarly interpreted in light of the reader's own experiences and expectations of the course. It is presumed that many of the components of the course work synergistically, building upon one another to illuminate

different experiences and biases in different students. As such, the direct impact of novel portions of this course, such as that which might be attributed to the "cultural object" and "cultural genogram" exercises, is impossible to elicit.

Discussion

While indeed we had the luxury—though perhaps in some ways the detriment—of teaching the course to a highly motivated, self-selected group, it is possible that a less selective group would have enriched the learning and self-reflection inspired by the course. The inclusion of this course within the medical school curriculum is a debated topic that all who work on medical curriculum are likely to appreciate. Often so-called "silos" exist in which each discipline believes that its message is fundamental to becoming a physician. Thus, each is reluctant to relinquish time and space for other venues, especially "soft" topics such as self-awareness. The purpose of the course was to serve as a model for recognition and understanding of the actual clinical as well as relational consequences of hidden cultural biases. While the original course was presented within a semester, it may also be effective broken into segments and perhaps presented longitudinally. The content and objectives are indeed appropriate for "introduction to doctoring" courses, as well as courses on communication skills and continuing medical education.

As the healthcare community strives to promote a multiculturally aware and responsive system for patients, staff, faculty, and students alike, increased attention has been paid to the hidden curriculum and how multiculturalism is both "explicitly" taught and "implicitly" modeled and learned [73, 76, 98]. The literature on professionalism provides ample examples on the ways the explicit message of the "formal curriculum" in cultural competency can be undermined by implicit messages such as offhand comments about patients' weight, poverty, or ethnicity forming a "hidden curriculum" [107]. The norms and values "modeled" in the "hidden curriculum" have a profound effect in the socialization of future physicians [73–76]. Courses on self-awareness and unconscious bias provide students with techniques to counter the personal impact of the hidden curriculum.

Exploring the experiences and perceptions of bias of different cultures and groups can provide a keen awareness and insight into our common humanity. When combined with strategic self-reflection, such awareness can improve patient care by strengthening patient-doctor rapport and communications, particularly when cultural differences exist between the patient and health practitioner. The growing cultural, racial, and ethnic diversity in the USA make these issues increasingly imperative. While the last two decades have seen progress in implementing cultural competency training into medical school curricula, efforts to teach students how to be aware of their own biases have only just begun. When taught in a safe and supportive setting, self-awareness of one's biases is an essential first step toward providing compassionate and equitable care for all of one's patients, regardless of their background.

It is our sincere hope that this course may serve as a model to be replicated, adapted, implemented, and sustained at other institutions. Since the conception of our course, others have developed courses with similar frameworks [108–110]. Many highlight the importance of moving away from one-dimensional concepts of identity to an understanding of the multiplicity of cultural influences that impact our worldviews. Similar to our course, they use a series of exercises to explore the complex experience of identity in multiple contexts. From our vantage point, essential elements for successful replication of the course include faculty participation and small group discussion—it was invaluable for faculty instructors to have taken and experienced the course and small group discussion facilitated learning in an emotionally safe environment.

As was the case at our own institution, time can be a significant barrier to implementing such courses in professional school and continuing medical education curriculums. One possibility for overcoming time constraints may be longitudinal implementation of the course in the form of concise exercises distributed over the span of the 4-year medical school curriculum. Another possibility is that the content of the course may become a higher priority in the future. As the ubiquity of health disparities becomes more realized and the scientific underpinning of the unavoidability of implicit bias as part of human nature is clarified, perhaps the imperative need to find tools to overcome and manage these biases will become such a priority as to overcome the challenges of time allotment. At our own institution, we found that focusing on the shared end goal of creating better health practitioners and improving patient outcomes facilitated more of a "how can we do this?" approach than an adversarial one. The history of bias and oppression of minority groups is one that likely dates back to the beginning of humankind. Overcoming the negative effects of bias on health and healthcare will irrefutably take a multifaceted approach far beyond the scope of a single course. This course serves as a starting point for exploration of the impact—both positive and negative—of culture on the individual level.

Conclusions

We hope that sharing the background, evolution, emergence, and description of our course will show how from a scholarly environment of goodwill and real world prejudices, a thoughtful solution emerged. The solution reflected a careful consideration of numerous problematic realities in the environment and attempted to address them through the development of a

course. Our hope is that this course serves as a model for other efforts to recognize the consequences of hidden cultural biases. Furthermore, we hope this approach can serve beyond the healthcare setting as a way to universally improve self-awareness, cultural humility, and human relations.

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Dr. Robert Crowell
Culturally Competent Care Education Program, Harvard Medical School
Dr. Anthony D'Amico
Rodger L. and Gloria F. Daniels Charitable Foundation (Richard J. Hindlian, Co-Trustee)
Mr. Kevin and Mrs. Jennifer DaSilva
Mr. Michael Douvadjian
Dr. Daryll Dykes
Mr. Vincent Fath
Dr. John Feagin
Dr. Harris Gibson
J. Robert Gladden Orthopaedic Society
Mr. Fred Green
Dr. Thomas Green
Arthur and Barbara Higgins Charitable Foundation.
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Mr. Jamie Hoyte
Dr. Joseph K. Hurd, Jr. & Mrs. Jean Challenger Hurd
Dr. Jesse and Mrs. Beryl Jupiter
Mr. Wendell Knox
Dr. Melvin Law
The Macy Foundation
Massachusetts General Hospital, Department of Orthopaedic Surgery
Mr. John L. McGoldrick
McKesson Foundation
Chancellor Keith Motley
Movement is Life
Reverend Willie and Dr. Anne Naulls
Dr. Michael Parks
Dr. Bendt Petersen
Dr. Preston Phillips
Dr. Roderick Randall
Attorney Macey Russell
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Dr. Thomas P. and Cynthia D. Sculco Foundation
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Dr. Samuel Thier
Dr. Michael Watkins
The Augustus A. White, III, MD Family Trust
Dr. Willard Wong
Mr. Lloyd Wright
Zimmer Holdings Inc.

Compliance with Ethical Standards

Other Disclosures None.

Ethical Approval Ethical approval was waived by the Institutional Review Board (IRB) of the Harvard University Faculty of Medicine which determined that the research protocol is not human subjects research as defined by DHHS and FDA regulations.

Disclaimer None.

Previous Presentations Presented by the Harvard Medical School Department of Continuing Education:

"Getting to Equal: Strategies to improve care for all patients"—a course for clinicians, educators and administrators.

Held April 2–4, 2009 at the Fairmont Copley Plaza Hotel, Boston, MA.

Offered by: Culturally Competent Care Education Program at Harvard Medical School.

Under the direction of:
Augustus A. White, III, MD, PhD
Leonor Fernandez, MD.

Lecture Journey to Self-Awareness: Meeting the Requirements for LCME Educational Directive 22 (Dan Goodenough, PhD, Roxana Llerena-Quinn, PhD, David Green, MD, Irving Allen, MD, Augustus White, MD, PhD).

Workshop Understanding Dynamics of Class and Race in Doctor and Patient (Dan Goodenough, PhD, Roxana Llerena-Quinn, PhD, David Green, MD, Irving Allen, MD, Augustus White, MD, PhD)

Appendix: References provided by Roxana Llerena-Quinn, PhD

Background Material and Resources for Extensive Study

Session 1. Introduction. Course Overview

Course Rationale-

a. Institute of Medicine Report (2003). Chapter 1:"Introduction and Literature Review" in Brian D. Smedley, Adrienne Y. Stith, and Alan R. Nelson, Editors, Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care, Board on Health Sciences Policy. Unequal treatment: confronting racial and ethnic disparities in health care Washington, D.C.: The National Academies Press. http://books.nap.edu/books/030908265X/html/29.html#pagetop (provides an overview of documented health disparities that go beyond access problems)

b. US Department of Health and Human Services Agency for Healthcare Research and Quality: 2011 National Healthcare Quality Report. AHRQ Publication No. 12-0006March 2012. www.ahrq.gov/qual/qrdr11.htm
c. Physicians for human rights. The right to equal treatment. An annotated bibliography on studies on racial and ethnic disparities in healthcare, their causes and related issues. http://ignatiusbau.com/2010/09/06/physicians-for-human-rights-the-right-to-equal-treatment/ *(A resource on health disparities by specialty)
d. AAMC: cultural competence education. LCME ED 21 and 22 https://www.lcme.org/connections/connections_2013-2014/ED-21_2013-2014.htm https://www.lcme.org/connections/connections_2013-2014/ED-22_2013-2014.htm
e. Lehrman S. (uploaded on September 30, 2007) News as American as America: a report for Knight Foundation. Part 1. "Reflections on the Future," Part 2: "The Human Factor" (focusing on the media, this section explores the way our own unconscious belief systems lead to dangerous gaps in reporting and in medicine and most important why we need to change). http://www.knightfdn.org/diversity/lehrman/013_chap1.asp
f. Test on unconscious bias: research from the field of cognitive psychology shows that many forms of stereotyping occur below the level of conscious awareness. Try taking a test. It takes about 10 min. www.implicit.harvard.edu/implicit/demo/index.jsp
g. Tervalon M, Murray-Garcia J (1999) Cultural humility versus cultural competence: a critical distinction in defining physician training outcomes in multicultural education. Journal of Marital and Family Therapy 25:191–209.

Readings:

Beagan BL. (June 2003) Teaching social and cultural awareness to medical participants: "It is all very nice to talk about in theory, but ultimately it makes no difference" Academic Medicine Vol. 78 No. 6/ pp. 605–614.
Betancourt J, Ananeh-Firempong O (2004) Not me! Doctors, decisions, and disparities in health care. CVR &R. May/June 2004, pp. 105–109.
Burgess DJ, Fu SS, van Ryn M (2004). Why do providers contribute to disparities and what can be done about it? Journal of Internal Medicine; 19:1154–1159.
Burgess DJ, van Ryn M, Dovidio J, Saha S (2007). Reducing racial bias among health care providers: lessons from social-cognitive psychology. Journal of General Internal Medicine; 22:882–887.
Green A R, Carney D R, Pallin D J, Ngo L H, Raymond K L, Iezzoni L I, Banaji M R (2007). Implicit bias among physicians and its prediction of thrombolysis decisions for Black and White patients. Journal of General Internal Medicine:1–8. Readings:

Session 2. Cultural Meanings and the Culture of Medicine

Readings:

Taylor J S (2003). Confronting "culture" in medicine's "culture of no culture." Academic Medicine, Vol. 78, No.6.
Kumas-Tan S, Beagan B, Loppie C, MacLeod A, Blye F (2007). Measures of cultural competence: examining hidden assumptions. Academic Medicine, vol 82, No. 6/June.

Resources:

Definition of Culture
Helman C (1994) "Culture, health and illness" England: Butterworth-Heinnemann, pp. 2–6.
Culture of Medicine
Groopman, L C 1987 Medical internship as moral education: an essay on the system of training physicians. Culture, Medicine and Psychiatry 11:207–227
Kleinman A. What is specific to biomedicine? In Writing at the margin: discourse between anthropology and medicine. Berkeley: University of California Press, 1995, pp. 21–40
Lazare, A (1987) Shame and humiliation in the medical encounter. Arch. Intern. Med. 147:1653–1658

Session 3: The Cultural Genogram

Readings:

Hardy, K V and Laszloffy, T A (1995) The cultural genogram: key to training culturally competent family therapists. Journal of Marital and Family Therapy. 21(3) 227–237

Resources:

Keily MK, Dolbin M, Hill J, Karuppaswamy N, Liu T, Natrajan R, Poulsen S, Robbins N, Robinson P. (April 2002). The cultural genogram: experience from within marriage family therapy training program. Journal of Marital and Family Therapy. Vol.28, No.2, 165–178.

Session 4. Power and Privilege

Greene B (2007) How difference makes a difference. In Dialogues on difference: studies of diversity in the therapeutic

relationship, Washington, DC: American Psychological Association, pp. 47–63.

McIntosh, P. 1988 White privilege: unpacking the invisible knapsack. Working Paper Series No. 189 Wellesley College.

Recommended:

> Pinderhughes E. (1989) Understanding race, ethnicity, & power: the key to efficacy in clinical practice. NY: Free Press: 109–146.

Session 5. Gender Privilege

Candib L (1995) Power and relationships. In: Medicine and family: a feminist perspective. New York: Basic Books, pp. 240–74.

McGoldrick, M (1998) "Belonging and liberation: finding a place called 'home', in Re-visioning family therapy: race, culture, and gender in clinical practice, McGoldrick. New York: Guilford Press, pp. 215–18.

Mathews V. Special report: 'the biggest inequality of all: macho beliefs are just part of the problem' Independent News, March 2002.

Session 6.Straight Privilege

Harrison A E. Primary care of lesbian and gay patients: educating ourselves and our students. Fam Med. 1996; 28:10–23.

Potter, J E. Do Ask, Do Tell. Ann Intern Med 2002, 137:341–43.

http://www.annals.org/issues/v137n5/pdf/200209030-00010.pdf

Film: *Growing up gay (by Brian McNaught)*

Author, counselor and lecturer Brian McNaught, drawing from his own experience, explains the unique aspects of growing up gay in a predominantly straight world. He discusses his own experiences of growing up gay in America and examines the strictures in the Bible that are frequently quoted regarding homosexuality and put a more realistic light on what was really being said. He makes real the experience through his richly-detailed and thought-provoking guided imagery. This video can easily be used in segments as a powerful educational tool.

For more resources:

http://www.hrc.org

Session 7.Societal Factors: Race and Racism

Film: *Race: power of an illusion*

A three part series film produced by California Newsreel that investigates race in society, science and history.

Part One—*The difference between us*

Examines the contemporary science—including genetics—that challenges our common sense assumptions that human beings can be bundled into three or four fundamentally different groups according to their physical traits.

Part Two—*The story we tell*

Uncovers the roots of the race concept in North America, the nineteenth century science that legitimated it, and how it came to be held so fiercely in the Western imagination. The episode is an eye-opening tale of how race served to rationalize, even justify, American social inequalities as "natural."

Part Three—*The house we live in*

Asks, If race is not biology, what is it? This episode uncovers how race resides not in nature but in politics, economics, and culture. It reveals how our social institutions "make" race by disproportionately channeling resources, power, status, and wealth to White people.

Smedley, A. and Smedley, B.D. (2005). Race as biology is fiction, racism as a social problem is real: anthropological and historical perspectives on the social construction of race. American Psychologist (60), 1, 16–26.

Jones, C.P. (2000) Levels of racism: a theoretical framework and a gardener's tale Am. J. Pub. Health 90:1212–1215

Calman N (2000). Out of the shadow. Health Affairs 19(1):170–174

Gamble, VN 2000 Subcutaneous scars. Health Affairs 19(1):164–169

Tummala-Nara P. (2007) Skin color and the therapeutic relationship. Psychoanalytic Psychology. Vol 24, No 2, 255–270.

Session 8.Modern Racism and Levels of Racial Awareness

Take a test: implicit bias

https://implicit.harvard.edu/implicit/

Test on unconscious bias: research from the field of cognitive psychology shows that many forms of stereotyping occur below the level of conscious awareness. Try taking a test. It takes about 10 min. www.implicit.harvard.edu/implicit/demo/index.jsp

Film Resources:

> *True Colors*
>
> http://www.viewingrace.org/browse_sub.php?subject_id=40&film_id=385
>
> Subject: African Americans, race relations, racism, Whiteness
>
> Summary: to test levels of prejudice based on skin color, ABC's Prime Time host Diane Sawyer follows two friends, college-educated men in their mid-30s, one black and one white, through a variety of everyday situations. Using a hidden camera, the film explores their experiences. Pretending to be new in town, John and Glen separately try to rent an apartment, answer an ad for a job,

buy a car, and shop. The video chronicles the disturbing differences in the way they are treated in identical situations. John (white) is welcomed into the community while Glen (black) faces roadblocks of higher prices, long waits, and unfriendly salespeople. In stores, Glen finds himself either ignored or followed to make sure he does not steal. Landlords tell John that an apartment is available and tell Glen that the same apartment is not. A car dealer attempts to charge Glen $1000 more for a car than John. In the end, Glen knows that he would be reluctant to move to this city while John thinks it would be a fine place to live.
The Angry Heart. Fanlight Productions

Addresses the impact of racism on heart disease among African Americans. By Jay Fedigan

http://www.fanlight.com/catalog/films/331_ah.php

Skin Deep: a 53-min documentary film by Academy Award® nominated filmmaker, Frances Reid, tells the story of college students nationwide confronting the reality of race relations in America. The film explores what happens when culturally diverse students from colleges across the USA start talking candidly with each other about the impact of race on their experience and outlook. Brought together for a weekend retreat, the students examine their deeply held attitudes and feelings about race and ethnicity while exploring the barriers to building a society that truly respects diversity and pluralism. Scenes of their participation in group discussions, as well as personal portraits and views of their lives at home and at college, reveal why racial tension persists and suggest ways of overcoming our country's complex legacy of racial injustice, apathy, and alienation.

http://www.irisfilms.org/films/skin-deep/

Color of Fear: eight North American men, two African American, two Latinos, two Asian American, and two Caucasian were gathered by director Lee Mun Wah for a dialog about the state of race relations in America as seen through their eyes. The exchanges are sometimes dramatic, and put in plain light the pain caused by racism in North America

http://vimeo.com/40602451

Multimedia Resources—*Understanding prejudice*

http://www.understandingprejudice.org/multimedia/

Readings:

Beagan BL. Is this worth getting into a big fuss over? Everyday racism in medical school. Med Educ. 2003 Oct; 37(10):852–60

Dovidio J F, Gaertner SL, Kawakami K, Hodson G, (2002). Why can't we just get along?

Sue, D.W. et al. (2007). Racial microaggressions in everyday life: implications for clinical practice. American Psychologist (62), 4, 271–286.

McLaughlin, K.A., Hatzenbuehler, M.L., and Keyes, K.M. Responses to discrimination and psychiatric disorders among Black, Hispanic, female, and lesbian, gay, and bisexual individuals. Am J Public Health. 2010 August; 100(8): 1477–1484 doi: 10.2105/AJPH.2009.181586

Sue D W & Sue D (2008) Racial/cultural identity development in people of color: therapeutic implications in *Counseling the Culturally Diverse (5th edition)* John Wiley & Sons, Incorporated.

Sue D W & Sue D (2008) White racial identity development: therapeutic implications in *Counseling the Culturally Diverse (5th edition)* John Wiley & Sons, Incorporated.

Tatum B D. Talking about race, learning about racism: the application of racial identity development theory in the classroom. Harvard Educational Review 62, 1. Spring 1992, pp. 1–24.

Boston Globe article: they are sitting right next to us: on college campuses, students continue to struggle with ethnic tensions and racist attitudes. Dec.5, 2007

Session 9. Social Inequality and Social Determinants of Health

Readings and resources

Film:*Unnatural Causes*

Unnatural Causes is a 4-h documentary series that tackle the root causes of our alarming socio-economic and racial inequities in health. The series crisscrosses the nation uncovering startling new findings that suggest there is much more to our health than bad habits, health care, or unlucky genes. The social circumstances in which we are born, live, and work can actually get under our skin and disrupt our physiology as much as germs and viruses.

The World Health Organization (WHO). The Social Determinants of Health. http://www.who.int/social_determinants/en/

Scott J. Life at the top in America Isn't just Better, It's Longer. New York Times. May 16, 2005 http://www.nytimes.com/pages/national/class/index.html

Session 10. Classism in Medicine and Beyond

Film: *People like us: social class in America*

People Like Us looks at how class really works in America, examining how it affects our understanding of race and gender, investigating the exclusion of class from the national debate, and probing the ways in which class differences shape daily life.

The filmmakers: Louis Alvarez, Producer; Andrew Kolker, Producer

Companion multimedia site: http://www.pbs.org/peoplelikeus/about/index.html

Readings:

Beagan BL. Everyday classism in medical school: experiencing marginality and resistance. Med Educ. 2005 Aug; 39(8):777–84.

Goad J (2000) Chap. 5: Workin' hard. The redneck manifesto. Touchstone (Simon and Shuster, NY) pp.101-23

Lewis M (1978, 1993) Introduction to the Second Edition and Chapter 1: Inequality and equalitarism: the individualization of success and failure. The culture of inequality. Amherst: University of Massachusetts Press, pp. vii–xvi and 3–19.

Session 11.Immigration and Refugees

Film: *Becoming American (unnatural causes, Episode three, 29 min)*

In this segment of Unnatural Causes, we learn that recent Mexican immigrants, although poorer, tend to be healthier than the average American. They have lower rates of death, heart disease, cancer, and other illnesses, despite being less educated, earning less, and having the stress of adapting to a new country and a new language. In research circles, this is the Latino paradox. But as they are here longer, their health advantage erodes. After 5 years or more in the USA, they are 1.5 times more likely to have high blood pressure—and be obese—than when they arrived. Within one generation, their health is as poor as other Americans of similar income status. Researchers speculate about initial protective factors and reasons for its expiration date.

Readings

Aktar S (1999) Psychosocial variables associated with immigration. In Immigration and identity. Northvale, NJ: Jason Aronson Inc. chp.1, p. 5–39

Burck C (2004) Living in several languages: implications for therapy. Journal of family therapy, v.26, n.4, p.314–339

Markides KS (2001). Migration and health. International Encyclopedia of the Social & Behavioral Sciences. Elsevier Science Ltd. pp. 9799–9803

Perez Foster RM (2001) When immigration is trauma: guidelines for the individual and family clinician. American Journal of Orthopsychiatry, v.71, n.2, p.153–170

Schwartz S J, et. al. (2010) Rethinking the concept of acculturation. Implications for theory and research. American Psychologist (65), 4, 237–251

Resources:

Flores G. The impact of medical interpreter services on the quality of health care: a systemic view. Medical Care Res Rev. 2005 Jun; 62 (3):255–99

Suarez-Orozco M M (2001) Immigration and migration: cultural concerns. International Encyclopedia of the Social & Behavioral Sciences. Elsevier Science Ltd. pp. 7211–72177

U.S. Immigration history timeline http://immigration.procon.org/view.resource.php?resourceID=002690

Top 10 myths and facts about immigration http://www.immigrationforum.org/images/uploads/MythsandFacts.pdf

Session 12. Religion and Spirituality

Readings:

Wiggins Frame (2001) The spiritual genogram in training and supervision. The Family Journal, Vol. 9, No.2, 109–115

Zaal M, Salah T, Fine M (2007) The weight of the hyphen: freedom, fusion and responsibility embodied by young Muslim-American women during a time of surveillance. Applied Development Science. Vol. 11, No.3, 164–177.

Session 13. Student project presentations

Students share their semester projects with each other.

Session 14. Closure (multiple identities) and feedback

Students are given an opportunity to integrate the multiple aspects of identity they have explored during the semester focusing on lessons learned since the start of the course and next steps. Student feedback is highly valuable, as it has added complexity to the scope, depth, and processes of the course.

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14. van Ryn M, Burgess D, Malat J, Griffin J. Physicians' perceptions of patients' social and behavioral characteristics and race disparities in treatment recommendations for men with coronary artery disease. Am J Public Health. American Public Health Association. 2011;96:351–7. doi:10.2105/AJPH.2004.041806.
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