MGUH Equity Forward Faculty Workshop: Ensuring Equity, Inclusion & Diversity in Education & Research: Correct Use of Race and Ethnicity (IEM)

Activity Information

Original Release Date October 1, 2025
Termination Date April 30, 2028

Target Audience Physicians, Nurses

Speaker Names:
Karey M. Sutton, PhD | Sarah Kureshi, MD, MPH | Jessica Galarraga, MD, MPH, AVP

Speaker Disclosure Information: No relevant financial relationships to report.

Learning Objectives

- Explain the constructs of race and ethnicity and how they have been used incorrectly in medical education and research
- Discuss best practices on the use of race and ethnicity in the learning environment and in health sciences research
- Learn the fundamental tenets of composing curriculum and research manuscripts with inclusive language and interpretations in alignment with advancing health equity
- Develop skills to analyze the fidelity of conclusions in medical literature with a health equity lens

Evaluation Information
You must complete an online evaluation at the end of this course to receive continuing education credit.

After completing the evaluation, your CE credits will be available on your MedStar Health CE transcript on CloudCME™ **on the next business day**.

No commercial support has been provided.

The following Planning Committee members have reported no relevant financial relationships:
Mun Chun Chan, PhD | Sneha Daya, MD | Vicki Girard, JD | Aniket Kini, MBBS, MPH | Sarah Kureshi, MD, MPH | Michelle A. Roett, MD, MPH | Lois Wessel, DNP, FNP-BC

Accreditation

JOINTLY ACCREDITED PROVIDER™ INTERPROFESSIONAL CONTINUING EDUCATION

In support of improving patient care, MedStar Health is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC) to provide continuing education for the healthcare team.

Credit Designation

IPCE CREDIT™

This activity was planned by and for the healthcare team, and learners will receive **0.75** Interprofessional Continuing Education (IPCE) credits for learning and change.

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Credits Available for this Activity

Nurses: This activity is approved for **0.75** ANCC contact hours. Nurses should claim only the credit commensurate with the extent of their participation in the activity.

Physicians: MedStar Health designates this enduring material for a maximum of **0.75** *AMA PRA Category 1 Credits*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

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Bibliographic Resources

- Lett E, Asabor E, Beltrán S, Cannon AM, Arah OA. Conceptualizing, Contextualizing, and Operationalizing Race in Quantitative Health Sciences Research. *The Annals of Family Medicine*. 2022;20(2):157-163. doi:https://doi.org/10.1370/afm.2792
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- Powe NR, Yearby R, Wilson MR. Race and Ethnicity in Biomedical Research: Changing Course and Improving Accountability. *JAMA.* 2025;333(11):935–936. doi:10.1001/jama.2024.28390
- Advancing Health Equity: A Guide to Language, Narrative and Concepts. Center For Health Justice. Published 2025. https://www.aamchealthjustice.org/key-topics/trustworthiness/narrative-guide
- Equity Forward - Center for Health Equity. Center for Health Equity. Published February 11, 2025. Accessed September 18, 2025. https://centerforhealthequity.georgetown.edu/equity-forward-faculty-campaign/
- Gannon M. Race Is a Social Construct, Scientists Argue. Scientific American. Published February 5, 2016. https://www.scientificamerican.com/article/race-is-a-social-construct-scientists-argue/
- Tong M, Artiga S. Use of Race in Clinical Diagnosis and Decision Making: Overview and Implications | KFF. KFF. Published December 9, 2021. https://www.kff.org/racial-equity-and-health-policy/use-of-race-in-clinical-diagnosis-and-decision-making-overview-and-implications/
- AAPA Statement on Race & Racism. Physanth.org. Published 2019. https://physanth.org/about/position-statements/aapa-statement-race-and-racism-2019/

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Bibliographic Resources (Cont.)

- Skerrett P. Substituting genetic ancestry for race in research? Not so fast. STAT. Published May 2, 2022. https://www.statnews.com/2022/05/02/substituting-genetic-ancestry-for-race-in-research-not-so-fast/
- Cerdeña JP, Plaisime MV, Tsai J. From race-based to race-conscious medicine: how anti-racist uprisings call us to act. *The Lancet*. 2020;396(10257):1125-1128. doi:https://doi.org/10.1016/S0140-6736(20)32076-6
- Amutah C, Greenidge K, Mante A, et al. Misrepresenting Race — The Role of Medical Schools in Propagating Physician Bias. Malina D, ed. New England Journal of Medicine. 2021;384(9). doi:https://doi.org/10.1056/nejmms2025768
- Benoit LJ, Travis C, Swan Sein A, Quiah SC, Amiel J, Gowda D. Toward a Bias-Free and Inclusive Medical Curriculum: Development and Implementation of Student-Initiated Guidelines and Monitoring Mechanisms at One Institution. *Academic Medicine*. 2020;95(12S):S145-S149. doi:https://doi.org/10.1097/acm.0000000000003701

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Evaluation and Transcript

You must complete an online evaluation at the end of this course within 30 days to receive continuing education credit.

After completing the evaluation, your CE credits will be available in your MedStar Health CE transcript on CloudCME™ on the **next business day**. CloudCME™ is a web-based continuing education portal where users can access their transcript anywhere, anytime, as well as register for MedStar Health conferences. Healthcare provider demographic information from all MedStar entities has been uploaded to CloudCME™ to facilitate a single sign-on system.

To access your transcript via CloudCME:

- Choose one of the two login options below.
  1. **MedStar Health Associates:** From your SiTELMS account under the Main Menu, select **CloudCME**. This will automatically log you in to your CloudCME account.
  2. **Non-MedStar Health Learners:** From your browser, go to **https://medstar.cloud-cme.com**, select **Sign in**, select "I am Not a MedStar Associate," and log in with your credentials.
- Select **My CE** (yellow button in the navigation menu).
- Select **Transcript**.
- On the left side, adjust the **Filter by Date** fields to the desired time period.
- On the right side, select **Download Transcript** to save your transcript, or select **Email Transcript** to email your transcript to yourself or someone else.

For questions about accessing CloudCME™, please contact:
SiTEL Help Desk at 855-745-1861, Monday through Friday from 8 a.m. to 5 p.m. Eastern time, or at medstarceapplications@email.sitel.org.

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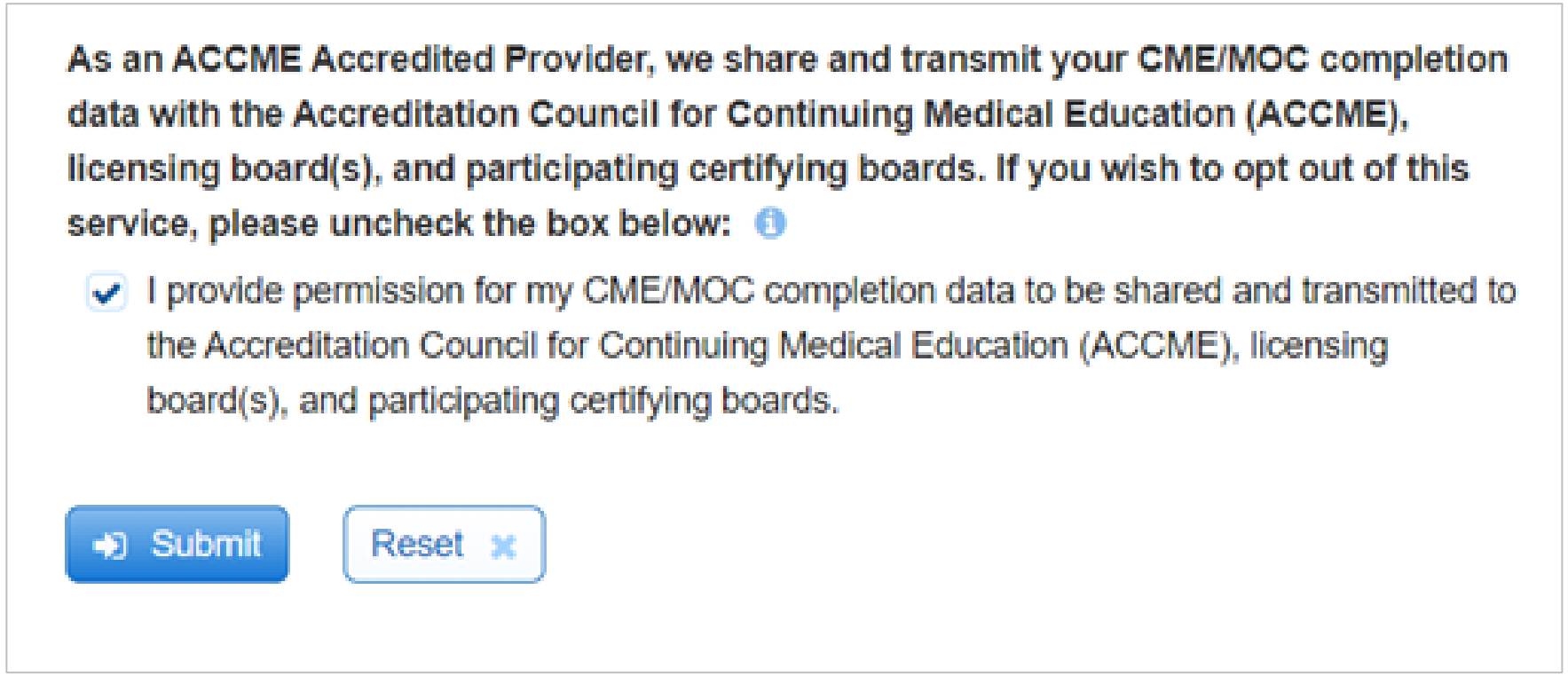
Attention Physician Learners

To ensure accurate CME credit data reporting to participating state medical licensing boards/certifying boards, please log into **CloudCME™** and click on **My CE / Profile** to review and update your profile with the following details: **your full name, state of licensure (including number and expiration date), and your birth month and day.** Here is the direct link to the CloudCME™ website: https://medstar.cloud-cme.com.

Additionally, please remember to check the box at the bottom of the profile screen to grant permission for us to report your completion data to ACCME and participating licensing/certifying boards. Questions? Email medstarceapplications@email.sitel.org.



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You have successfully reviewed the interprofessional continuing education credit information for this activity.

Click “Save & Exit” in the upper right to complete.

Reminder: **You must complete an online evaluation at the end of this course to receive continuing education credit.** After completing the evaluation, your CE credits will be available on your MedStar Health CE transcript on CloudCME™ **on the next business day**.

It’s how we treat people.

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It's how we treat people.

July 23, 2025

Ensuring Equity, Inclusion & Diversity in Education & Research: Correct Use of Race and Ethnicity

Karey M. Sutton, PhD, Scientific Director, Health Equity Research, MedStar Health Research Institute
Sarah Kureshi, MD, MPH, Associate Professor and Vice Chair for Education, Dept of Family Medicine
Jessica Galarraga, MD, MPH, AVP Health Equity

GEORGETOWN UNIVERSITY

Agenda

Presentation	Duration
Welcome and Learning Objectives Karey Sutton	5-min
EI&D Principles in the Medical Education and Research Environment Sarah Kureshi	8-min
The Social Construction of Race & Ethnicity Karey Sutton	10-min
Race & Ethnicity in Medical Education and Research Sarah Kureshi	10-min
Best Practices on the Use of Race & Ethnicity and Inclusive Language Karey Sutton & Sarah Kureshi	12-min
Applying Lessons into Practice Group Activity	10-min
Discussion All	5-min

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What is Health Equity?

*Health equity is the state in which everyone has a **fair and just opportunity** to attain their highest level of health*

(Centers for Disease Control and Prevention)

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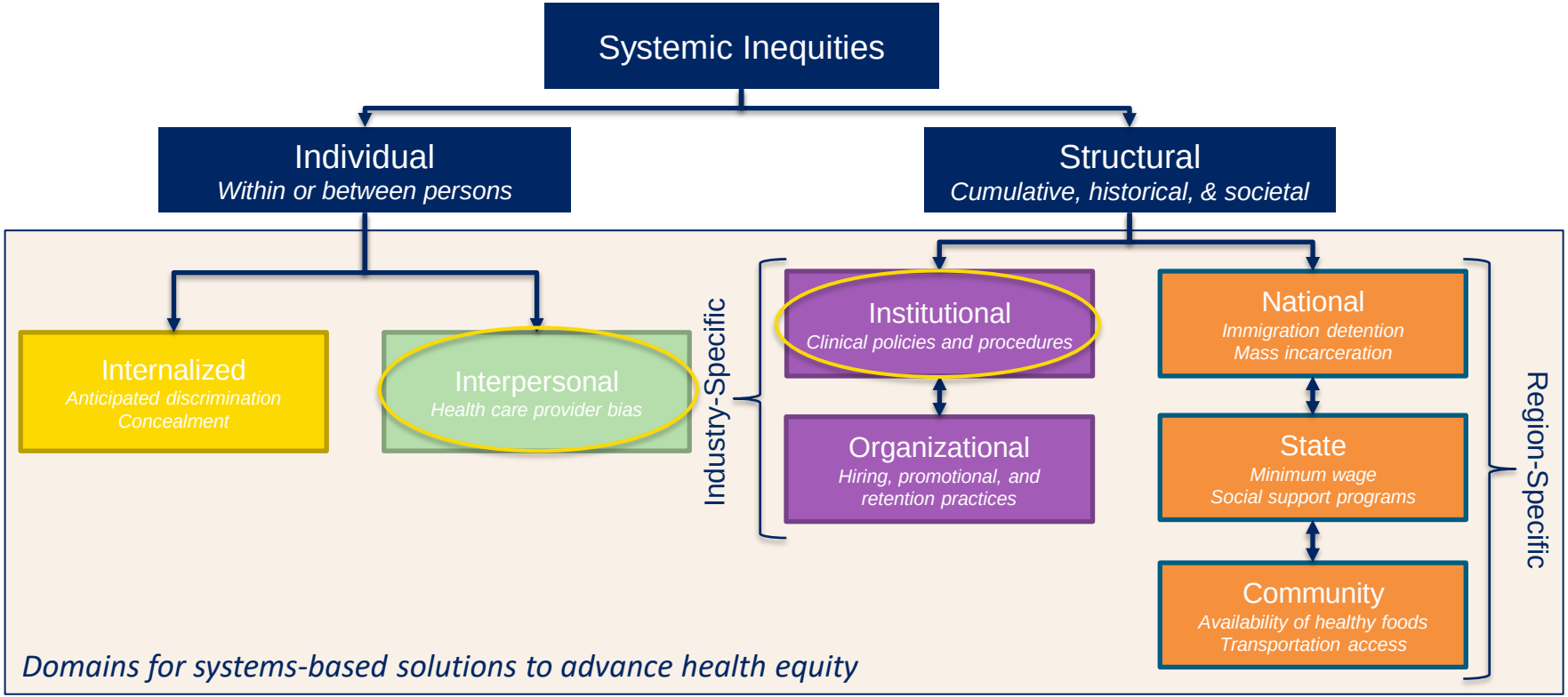
Key Elements Driving Health Inequities



Adapted from Lett et al. Conceptualizing, Contextualizing, and Operationalizing Race in Quantitative Health Sciences Research. Ann Fam Med. 2022 Mar-Apr;20(2):157-163

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EI&D Principles in the Medical Education and Research Environment

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Vulnerability, Honesty, & Willingness to Learn

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Fair access, opportunity, and support

EQUITY

Genuine sense of belonging and value

INCLUSION

Presence of differences

DIVERSITY

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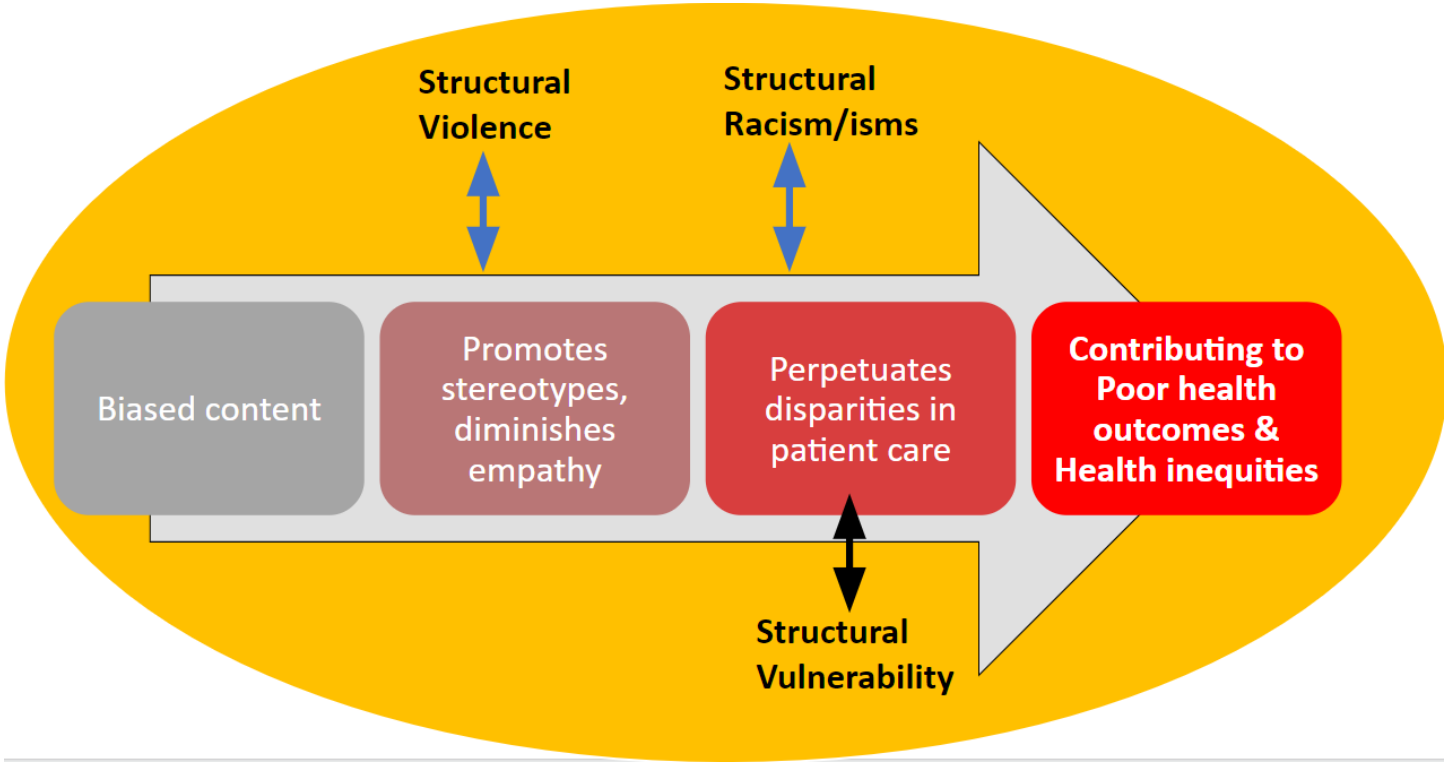
https://www.aafp.org/news/health-of-the-public/health-equity-framework.html



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slido

Reflect on a time where you experienced or observed bias or exclusion in the learning environment or in health sciences research. Please share here.

ⓘ Start presenting to display the poll results on this slide.

How to Emerge as an Equity Minded Academic Health Center (AHC)

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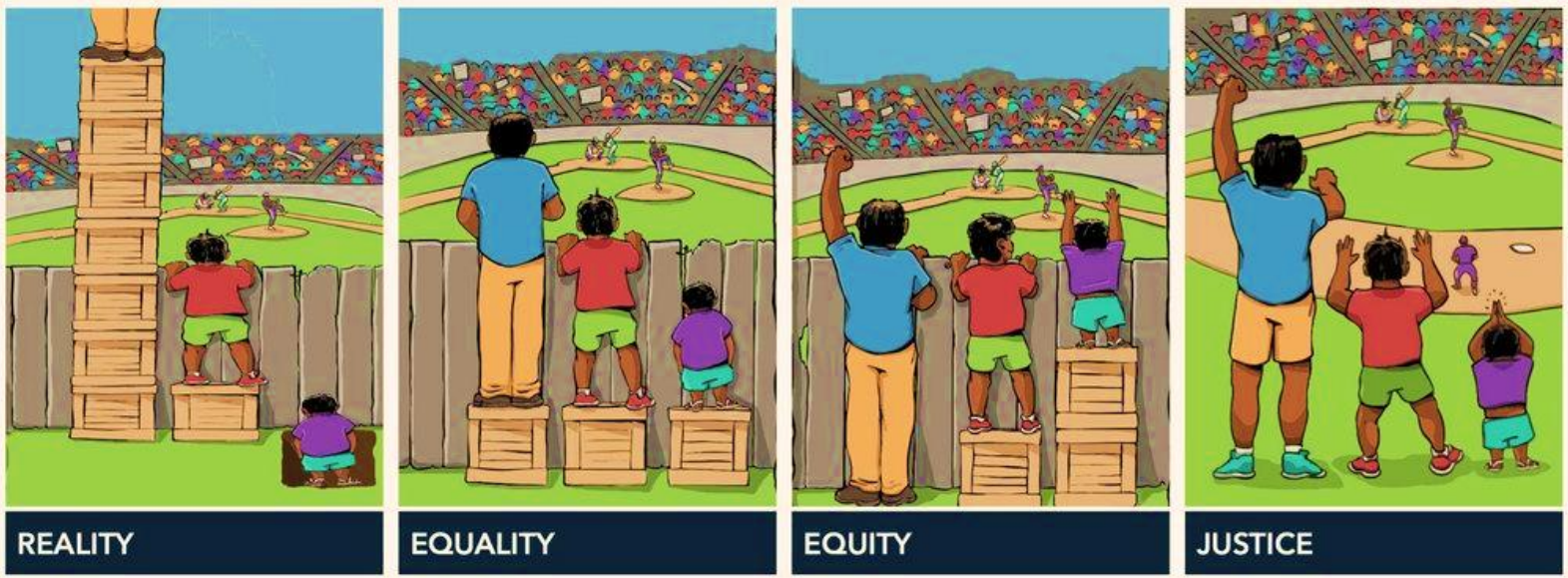
Illustrated are the three dimensions (diversity, inclusion, equity), including their documented benefits, needed for an academic health center to achieve excellence.
https://www.aamc.org/news/achieving-excellence-through-equity-diversity-and-inclusion

Equality vs. Equity vs. Justice



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The Social Construction of Race & Ethnicity

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Understanding the Concept of Race

- An abundance of research has unequivocally demonstrated that race is not a biological construct and is not a reliable proxy for genetic differences.

- Race is a **social construct.** It is a human-invented classification system.

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Human Genome Project

- In 2003, scientists completed the Human Genome Project. A major scientific milestone which sequenced the full human genome.
- The project found that there is ***more genetic variation within races than between them***.

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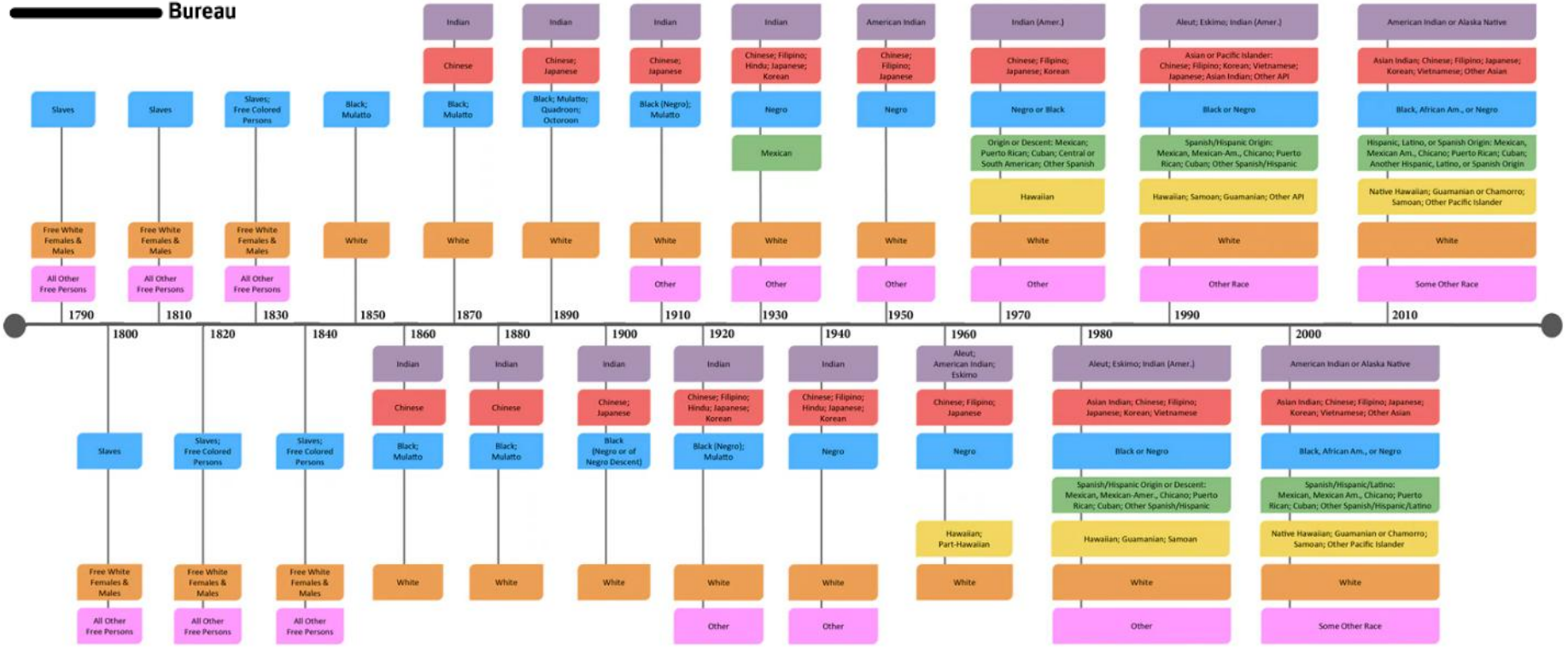
United States® Census Bureau

Measuring Race and Ethnicity Across the Decades: 1790–2010

Mapped to 1997 U.S. Office of Management and Budget Classification Standards



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Race as a Social Construct

Though race does not have intrinsic biological meaning, the social construction of race still affects the daily lived experiences of individuals and can impact health outcomes.

SCIENTIFIC AMERICAN

"Rather than a risk *factor* that predicts disease or disability because of genetic susceptibility, race is better conceptualized as a risk *marker*—of vulnerability, bias or systemic disadvantage."
– Jennifer Tsai, MD

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Gaps in Translating Evidence into Practice

- Despite the evidence and consensus among biological and social scientists that race is a social construct...
  - Race is often still misused as a biological construct, in research, in medical education, and in clinical practice

- This practice of “Racial Essentialism” perpetuates and exacerbates inequities in health care experienced among racial and ethnic minorities.

Explanations of observed racial/ethnic differences in health outcomes as biological

Racial variations in COVID-19 deaths may be due to androgen receptor genetic variants associated with prostate cancer and androgenetic alopecia. Are anti-androgens a potential treatment for COVID-19?

John McCoy [1], Carlos G Wambier [2], Sergio Vano-Galvan [3], Jerry Shapiro [4], Rodney Sinclair [5], Paulo Müller Ramos [6], Kenneth Washenik [7], Murilo Andrade [8], Sabina Herrera [9], Andy Goren [1] [10]

Affiliations + expand

PMID: 32333494 PMCID: PMC7267367 DOI: 10.1111/jocd.13455

Free PMC article

J Cosmet Dermatol. 2020 Jul;19(7):1542-1543.

Race is associated with differences in airway inflammation in patients with asthma

Sharmilee M Nyenhuis [1], Jerry A Krishnan [2], Alalia Berry [3], William J Calhoun [4], Vernon M Chinchilli [5], Linda Engle [5], Nicole Grossman [6], Fernando Holguin [7], Elliot Israel [6], Rick A Kittles [8], Monica Kraft [8], Stephen C Lazarus [9], Erik B Lehman [5], David T Mauger [5], James N Moy [10], Stephen P Peters [11], Wanda Phipatanakul [12], Lewis J Smith [13], Kaharu Sumino [14], Stanley J Szefler [15], Michael E Wechsler [16], Sally Wenzel [7], Steven R White [17], Steven J Ackerman [18]

Affiliations + expand

PMID: 28069248 PMCID: PMC5494010 DOI: 10.1016/j.jaci.2016.10.024

Free PMC article

J Allergy Clin Immunol. 2017 Jul;140(1):257-265.e11.

Racial differences in birth health risk: a quantitative genetic approach

E J van den Oord [1], D C Rowe

Affiliations + expand

PMID: 10953804

Demography. 2000 Aug;37(3):285-98.

Racial/Ethnic Variation in Nasal Gene Expression of Transmembrane Serine Protease 2 (*TMPRSS2*)

Supinda Bunyavanich, MD, MPH, MPhil[1]; Chantal Grant, MD[2]; Alfin Vicencio, MD[2]

» Author Affiliations | Article Information

JAMA. 2020;324(15):1567-1568. doi:10.1001/jama.2020.17386

COVID-19 Resource Center

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Bias Rooted in the Use of Race as a Biological Construct

PNAS

Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites

Kelly M. Hoffman[a,1], Sophie Trawalter[a], Jordan R. Axt[a], and M. Norman Oliver[b,c]

[a]Department of Psychology, University of Virginia, Charlottesville, VA 22904; [b]Department of Family Medicine, University of Virginia, Charlottesville, VA 22908; and [c]Department of Public Health Sciences, University of Virginia, Charlottesville, VA 22908

Edited by Susan T. Fiske, Princeton University, Princeton, NJ, and approved March 1, 2016 (received for review August 18, 2015)

The NEW ENGLAND JOURNAL of MEDICINE

The NEW ENGLAND JOURNAL of MEDICINE

MEDICINE AND SOCIETY

Debra Malina, Ph.D., *Editor*

Hidden in Plain Sight — Reconsidering the Use of Race Correction in Clinical Algorithms

Darshali A. Vyas, M.D., Leo G. Eisenstein, M.D., and David S. Jones, M.D., Ph.D.

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The Use of Race & Ethnicity in Medical Education and Research

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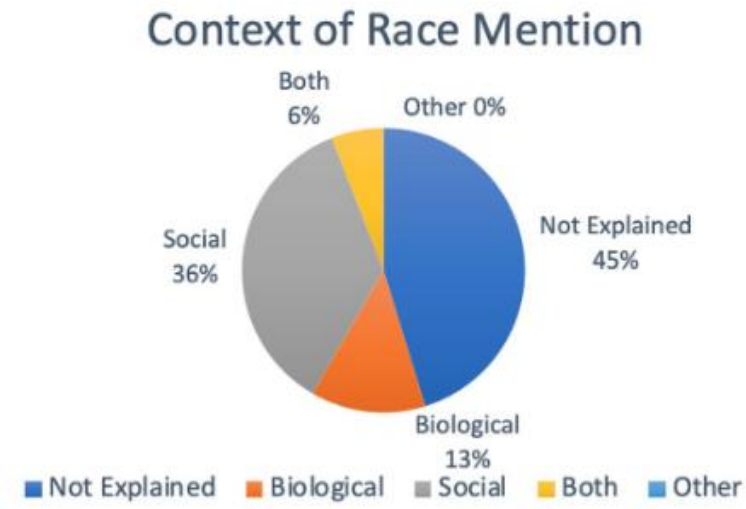
GUSOM Curriculum Analysis and Surveys



Ibrahim Z, Brown C, Crow B, Roumimper H, Kureshi S. The Propagation of Race and Racial Differences as Biological in Preclinical Education. Med.Sci.Educ. (2022) 32:209-219.

Survey Results

- The majority of students and faculty (>80%) believe there is at least a small biological or genetic basis for race
- 36% of students and 37% of faculty believe Somewhat or more that racial health disparities are due to biological differences

"Two Different Campuses"

Q8b: How conducive is the academic environment at GUSOM to having open discussion on race in medicine?

- Faculty and students identifying as **White** are statistically more likely to indicate that GUSOM is **Moderately to Extremely conducive (P<0.05)**
- Faculty and students identifying as **African American or Black** are statistically more likely to indicate that GUSOM is **Not at all conducive (P<0.05)**

Sample Quotes Pulled From Lectures

"Mr. Jones is a 58 year old Hispanic male...came in for chest pressure."

"ACE Inhibitors (eg captopril) are not as effective for Blacks, especially older Blacks, but CCBs (eg diltiazem) and thiazide diuretics (eg HCTZ) have much better effects in African Americans. However, if you combine ACE Inhibitors or ARBs with thiazide diuretics or CCBs in the clinic, you will get the same results for African Americans or Whites."

"Asthma is higher in Black people...also have worse outcomes, especially in Black women."

"Many factors go into increased maternal mortality of Black women in the US, including perceptions of their pain, access to resources, and systemic racism. Generations of Black women born in this country to mothers born outside of the US have increased rates of maternal mortality compared to their mothers."

"Celiac disease is due to the movement of cultivating wheat. It started in the Middle East and spread to North Africa and Europe...so we actually see celiacs everywhere in the world. Africa has one of the highest prevalence rates, specifically the Serawe tribe, because the UN sends them food (crackers and bread, which are not gluten-free)...Celiac disease is not present where the wheat movement did not happen--these tend to be rice-based countries such as East and South Asia."

GEORGETOWN UNIVERSITY
School of Medicine

GUSOM Inclusive Curriculum Feedback Form

If you note an example of bias within materials or resources used in the curriculum or any other venue at the school of medicine, please submit your comment below and document with an uploaded photo or attachment of the biased example. Concerns may include, but are not limited to biases (racial/ethnic/cultural/sexual/gender or other) stated in written text or photos/visual representations contained within assigned textbooks, presentation powerpoints, or recorded lecture capture audio.

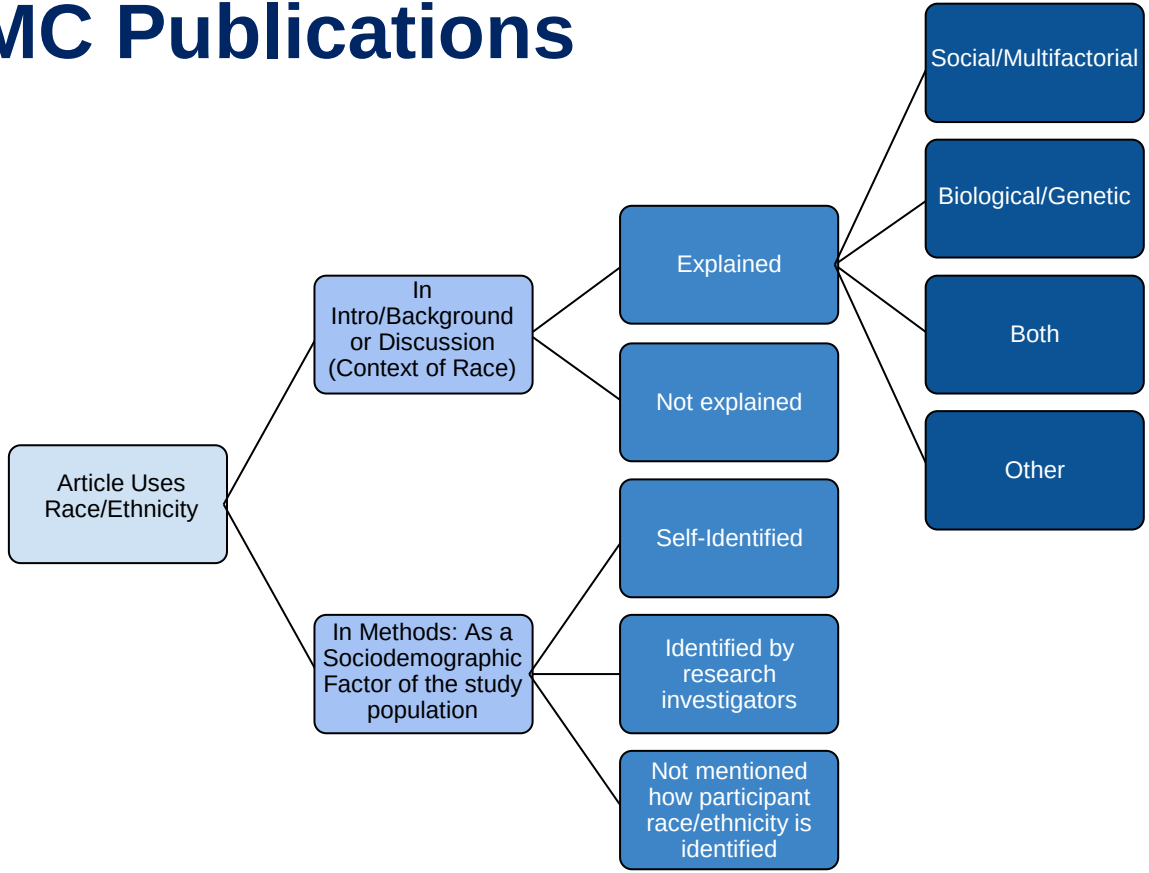
When submitting feedback, you may decide to do so anonymously or to provide your name. This form will be reviewed by the GUSOM Office of Student Affairs, The Office of Medical Education, and The Office of Diversity & Inclusion. Upon review, a course of action will be determined and actions including a follow-up from the faculty involved which addresses the incident or reporting the action to the publisher of the content will be pursued. Support will also be offered to faculty to help make curriculum more inclusive.

Every effort will be made to follow-up with the requests in a timely manner. Retaliatory conduct is prohibited.

Additional Information
This form is not to report mistreatment or discrimination based on protected class. Please report mistreatment in your learning environment here: https://som.georgetown.edu/studentservices/mslac/howtoreport/

	Year 1 (2021)	Year 2 (2022)
Reports Received	12 (2 of same incident, just different students reporting)	9 (2 of same incident, just different students reporting)
Race/Ethnicity Bias	75%	56%
Ability Bias	8%	22%
Sexuality Bias	0%	11%
Specialty Disrespect Bias	0%	11%
Gender/Sexism Bias	17%	0%
Preclinical (lecture, small groups, Grand Rounds, Scholar Research Projects)	83%	78%
Clinical (rotations, clerkship)	17%	11%
Research Day Registration Form	0%	11%
Common Concerns	•References to race as a biological factor in medicine •Microaggressions in academic, work environment •Selected visual images/representations •Homophobic slur used in a teaching video •Negative racial stereotypes regarding immigrant populations	•Microaggressions in academic, work environment •References to race as a biological factor in medicine •Selected visual images/representations

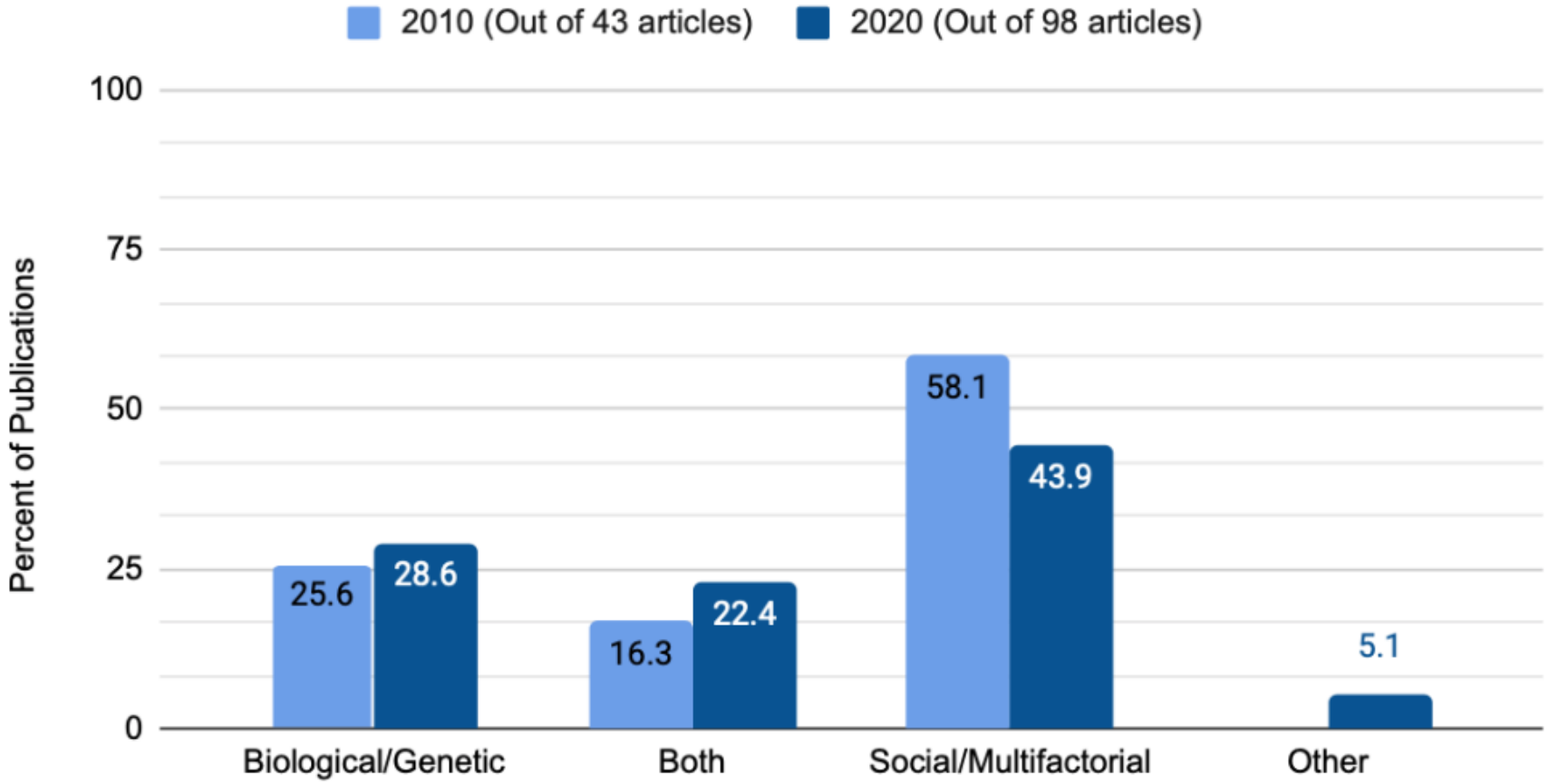
An Analysis of the Use of Race and Ethnicity in GUMC Publications



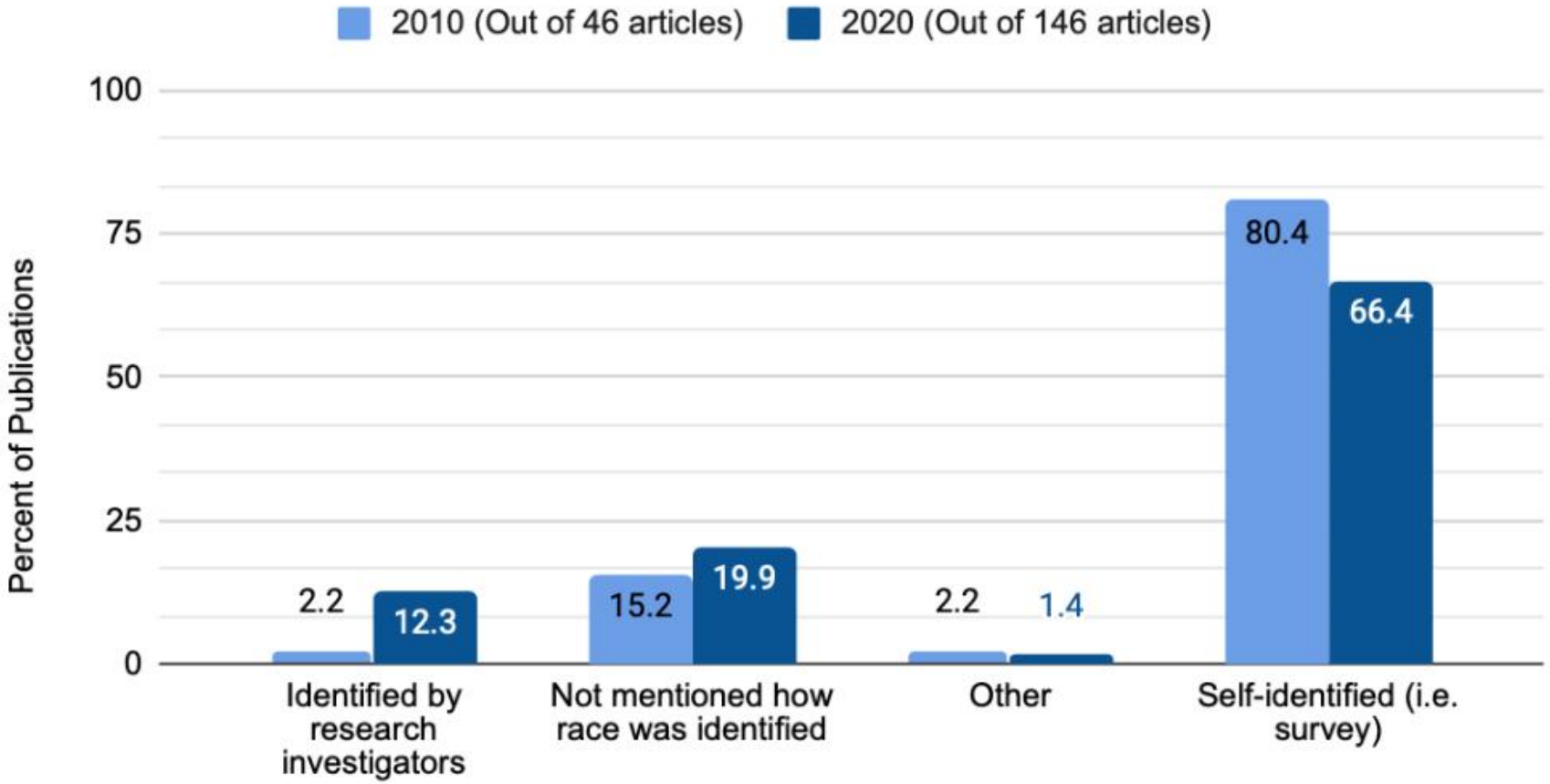
Examples of Explanations/Context for Race

Biological/Genetic	Social/Multifactorial	Both
“Multivariable analysis also demonstrated the persistent effects of black race, hypertension, diabetes…”	“These increased obesity and diabetes rates among Native Americans have occurred alongside a ‘nutrition transition’ from traditional foods; typically from diets that were high in fiber and lean meats and daily life that was highly active, to one that is increasingly dependent on processed foods high in sugar, fat, and meat products.”	“The mechanisms underlying observed racial differences have not been elucidated, however, variations in genes regulating sympathetic activity as well as differences in endothelial homeostasis have been described.” “AA overall have more in-hospital complications; however, the differences are driven by racial disparities in demographics, comorbidities, and socio-economic factors.”

If the contextual mention of race was explained, in what manner was that explanation?



If the mention of race was as a sociodemographic factor, how was race identified in the study?



Conclusions

- Even though publications in 2020 referenced race more, they primarily used race as a demographic factor and provided no context in the background or discussion. **This finding was statistically significant.**
- Over ten years, we expected the discussion around race to shift from a biological to more of a multifactorial construct – instead we saw two trends
  - **Race continues to be contextualized as biological 27% of the time**
  - There was a **decrease in the social/multifactorial use of race from 2010 to 2020**
- Self-identification of race in the methodology also decreased over time.

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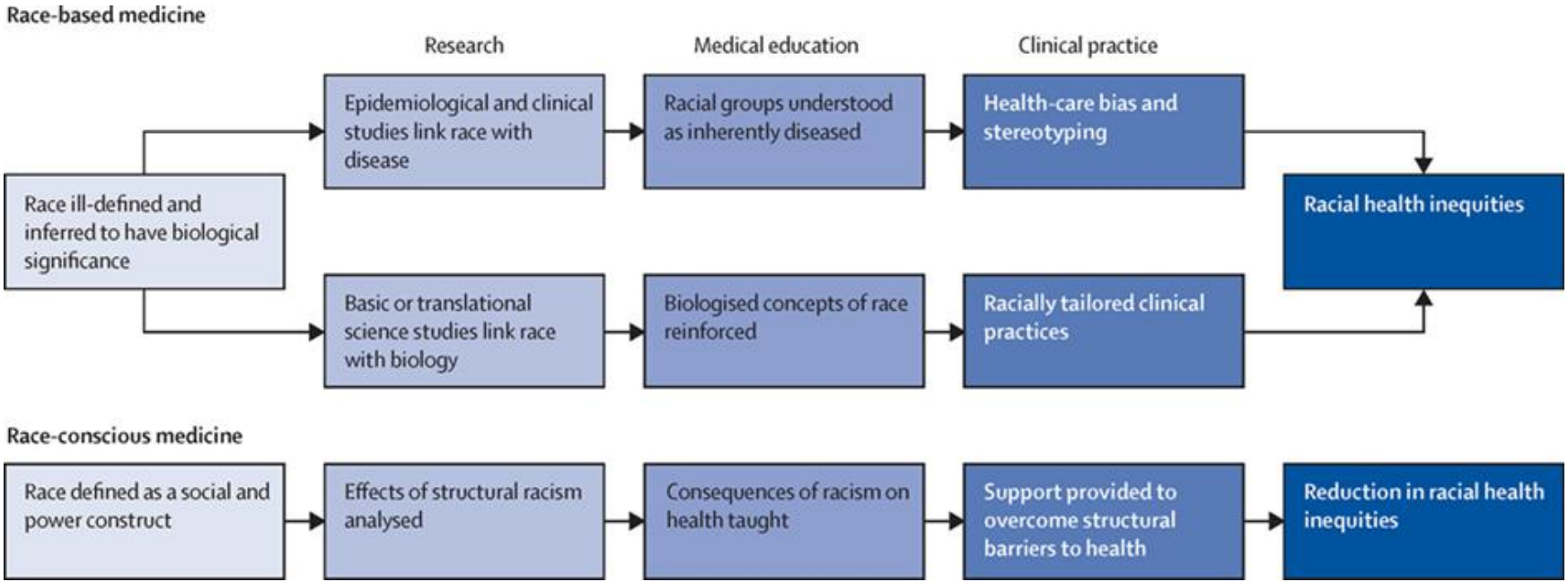
Race-Based vs. Race-Conscious Medicine



From race-based to race-conscious medicine: how anti-racist uprisings call us to act. Jessica P Cerdeña, MPhil, Marie V Plaisime, MPH, Jennifer Tsai, MD. The Lancet Volume 396 Issue 10257 Pages 1125-1128 (October 2020). DOI: 10.1016/S0140-6736(20)32076-6

Best Practices on the Use of Race & Ethnicity in Research and Education

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Best Practices

These guidelines describe:

1. Important considerations of how race and ethnicity are contextualized in research studies and in learning environments
2. Methodological strategies for high-quality health equity research and curriculum
3. Tips for inclusive language in the reporting of race and ethnicity in scientific journals and in curriculum

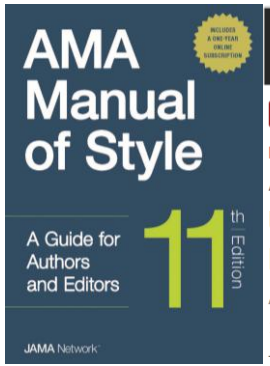
Resources on Research Best Practices

ANNALS OF FAMILY MEDICINE

Conceptualizing, Contextualizing, and Operationalizing Race in Quantitative Health Sciences Research

Elle Lett, Emmanuella Asabor, Sourik Beltrán, Ashley Michelle Cannon and Onyebuchi A. Arah

The Annals of Family Medicine January 2022, 2792; DOI: https://doi.org/10.1370/afm.2792



JAMA Network

Editorial

August 17, 2021

Updated Guidance on the Reporting of Race and Ethnicity in Medical and Science Journals

Annette Flanagin, RN, MA[1]; Tracy Frey, BA[2]; Stacy L. Christiansen, MA[3]; et al

» Author Affiliations | Article Information

JAMA. 2021;326(7):621-627. doi:10.1001/jama.2021.13304

Viewpoint

February 10, 2025

Race and Ethnicity in Biomedical Research
Changing Course and Improving Accountability

Neil R. Powe, MD, MPH, MBA[1]; Ruqaiijah Yearby, JD, MPH[2]; M. Roy Wilson, MD, MS[3]

» Author Affiliations | Article Information

JAMA. 2025;333(11):935-936. doi:10.1001/jama.2024.28390

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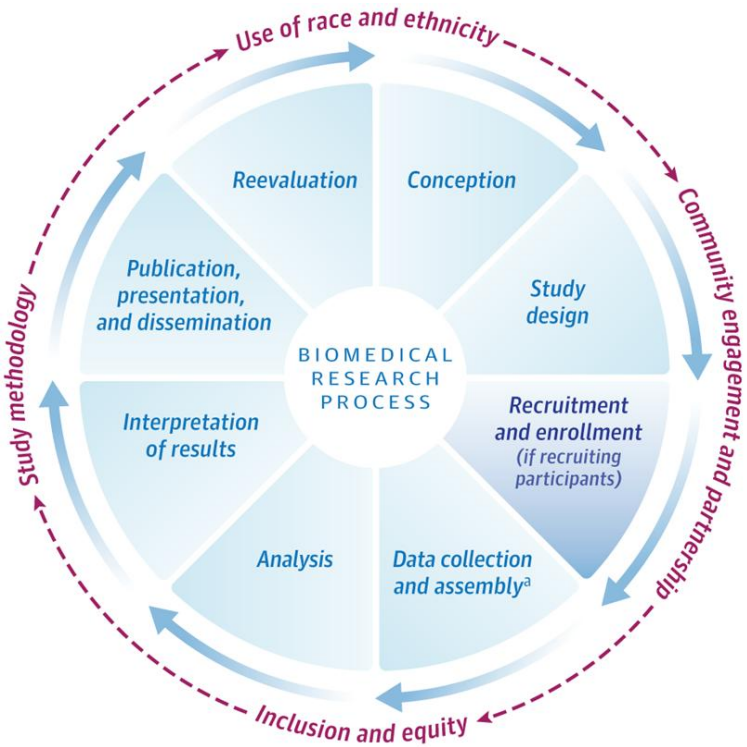
Considerations for Use of Race and Ethnicity in Research



FOR ALL STUDIES CONSIDER AT EVERY RESEARCH STAGE

Use of race and ethnicity
- Disaggregate race and ethnicity
- Define concepts and measurements
- Disclose limitations

Community engagement and partnership
- Build trust
- Sustain community partnerships
- Ensure transparency
- Respect data sovereignty
- Form interdisciplinary study teams including community members

Inclusion and equity
- Account for time for outreach
- Ensure equitable benefit sharing with the community
- Incorporate multiracial and multiethnic individuals

Study methodology
- Collect more granular data
- Use appropriate categories and measurements for analysis
- Disclose limitations of legacy datasets

*Above considerations may not apply if no **recruitment and enrollment** stage*

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Powe NR, Yearby R, Wilson MR. Race and Ethnicity in Biomedical Research: Changing Course and Improving Accountability. *JAMA.* 2025;333(11):935–936.

Best Practice Recommendations for Research

Use of Race & Ethnicity

- The reporting of race and ethnicity ***should not be considered in isolation***.
  - It should be accompanied by reporting other sociodemographic factors that can provide context to observed differences.

Inclusion & Equity

- ***Transparency, community partnerships, and cultural humility are key for trust-building*** with communities for recruitment

Community Engagement & Partnership

- Form interdisciplinary study teams that ***include community members***
  - They are experts of their own experience and an essential resource for high-quality research on their communities

Study Methodology

- Collect more ***granular racial and ethnic data***, e.g. ancestry categories
- ***Include direct measures of systemic inequities***, where possible, rather than race or ethnicity as a proxy

  Existing data sources can estimate contextual factors:
  - American Community Survey (US Census Bureau)
  - Behavioral Risk Factor Surveillance System (CDC)
  - National Health and Nutrition Examination Survey
- If race and ethnicity data were collected in a study, describe the rationale for their collection, who identified the participant's race and ethnicity (e.g., self-report, investigator observation, database, EHR, survey), and the source of the classification system used (e.g., OMB, HHS)

Key Guiding Principle for Manuscripts

Always explain observed differences in outcomes stratified by race or ethnicity.

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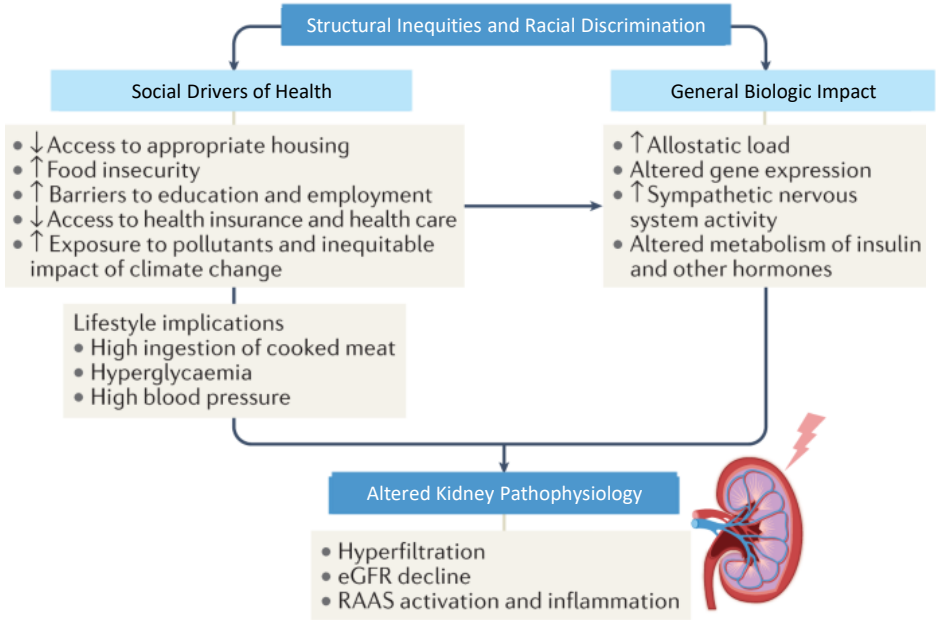
Racial and Ethnic Disparities in Kidney Disease

An ***intersectional approach to data*** when identifying contributing factors to disparities.



Eneanya, N.D., Boulware, L.E., Tsai, J. *et al.* Health inequities and the inappropriate use of race in nephrology. *Nat Rev Nephrol* **18**, 84–94 (2022). https://doi.org/10.1038/s41581-021-00501-8

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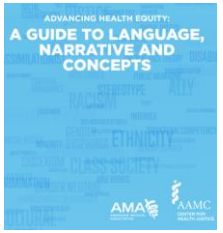
Guidance on Inclusive Language



Race & Ethnicity Categories

- Specific racial and ethnic categories are preferred over collective terms
- Categories included in groups labeled as “other” should be defined.
- Use racial and ethnic designations with awareness of the relevance of geographic origin and regionalization associated with the term.
  - For example, African-American is used to refer to Black Americans who are descendants of enslaved Africans

Formatting Considerations

- Categories should be listed in alphabetical order in text and tables
- Capitalize the names of races, ethnicities, and tribes
- Racial and ethnic terms should not be used in noun form (e.g., avoid *Asians*, *Blacks*, *Hispanics*, or *Whites*) with the adjectival form preferred (e.g., *Asian women, Black patients*, *Hispanic children*, or *White participants*)
- Abbreviations of categories for race and ethnicity should be avoided unless necessary.
  - If used, clearly explain abbreviations parenthetically in text or in table and figure footnotes or legends.

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AAMC/AMA – A Guide to Language, Narrative, and Concepts

Best Practice Recommendations for Education

Use of Race & Ethnicity

- Use race and ethnicity to illuminate health inequities, **not as biological risk factors**
- Avoid using race as a proxy for genetics or behavior
- Prioritize self-identified race and ethnicity
- Acknowledge the **limitations and fluidity of racial and ethnic categories**

Structural and Social Context

- Contextualize race and ethnicity within **structural, social, and historical factors**
- Clearly define and justify their use in teaching materials

Equity-Centered Curriculum Design

- Incorporate **antiracist and equity-focused frameworks** in curriculum development
- Engage **diverse stakeholders** in content creation and review

Ongoing Content Review and Improvement

- Review and revise educational content to **correct racial biases and stereotypes**
- Regularly evaluate materials for alignment with equity principles

Key Guiding Principle for Education

Always emphasize that racial health disparities are rooted in social and structural factors, not biology

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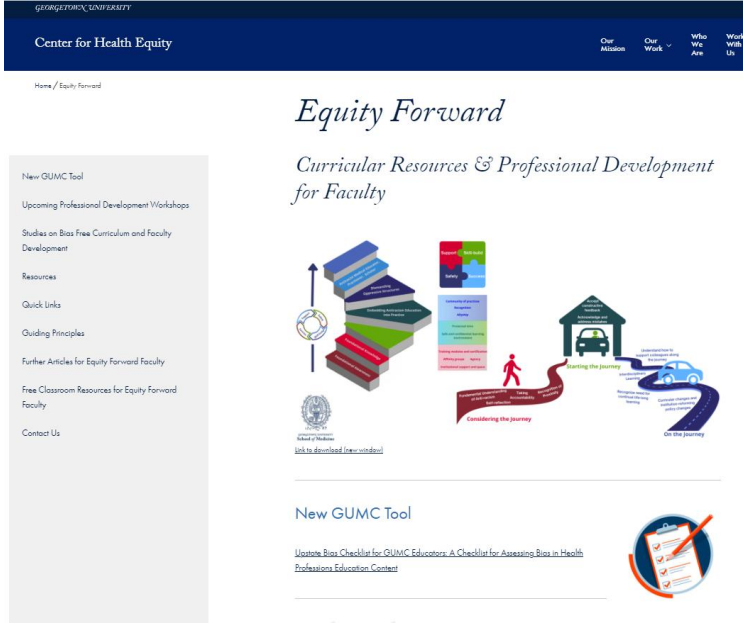
Curriculum Resources

Date & Time	Workshop Title
May 6, 2025 12:00 PM ET	**Trauma Informed Pedagogy**
May 21, 2025 5:30 PM ET	**Language Access Services and Health Equity**
Jun 3, 2025 5:30 PM ET	**History of DC and Health Inequities**
Jun 18, 2025 12:00 PM ET	**Strategies for Managing Bias and Discrimination in the Classroom**
Jun 26, 2025 12:00 PM ET	**Medical-Legal Partnership: Using Law & Policy to Advance Health Equity & Expand Interprofessional Learning**
July 8, 2025 12:00 PM ET	**Strategies for Equity in Assessment in Narrative Comments**
July 23, 2025 12:00 PM ET	**Ensuring Equity, Inclusion & Diversity in Education & Research: Correct Use of Race and Ethnicity**
Aug 5, 2025 12:00 PM ET	**Equitable Global Health Engagement**
Aug 20, 2025 5:30 PM ET	**Foundational Principles for Equity in Assessment in Health Professions Education**



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https://centerforhealthequity.georgetown.edu/equity-forward-faculty-campaign/

Table 2. Recommendations for Improving the Use of Race in Medicine.*

Recommendation	Key Suggestions for Improvement	Resources
Standardize language used to describe race/ethnicity.	Use granular ethnicity or ancestry (e.g., country of origin) to discuss genetic predisposition to disease. Avoid using imprecise language to approximate ancestry, such as "Asian" or "African American," when discussing genetic predisposition to disease. Use categories that reflect societal norms for defining populations in discussing unequal treatment or unequal burden of disease attributable to bias and structural racism. Use combined race/ethnicity rather than just race. The responses to the recommended 1-question format that combines race and ethnicity are Native American or Alaska Native; Asian; Black or African American; Hispanic or Latino; Native Hawaiian or Other Pacific Islander; White; and Multi (select multiple options above). Avoid the use of outdated terms, such as "Caucasian," that do not reflect current societal norms in defining race or approximate ancestry.	National Academy of Medicine (Institute of Medicine)[22]: Template of Granular Ethnicity Category Lists and Coding Schemes with Rollup to the OMB Race and Hispanic Ethnicity Categories, and OMB Race and Hispanic Ethnicity Categories according to a one- and two-question format
Appropriately contextualize racial/ethnic differences in disease burden.	Carefully consider whether the population categories used in a study or lecture represent true genetic differences due to ancestry. When discussing genetic susceptibility, avoid the use of race as the sole reason for differences in disease burden between populations. To approximate ancestry, instead use granular ethnicity (e.g., country of origin). Always consider structural and social determinants of disease when discussing the causes of unequal disease burden. Consider the socioeconomic and political differences between population categories and trends over time of the disease burden in the context of historical insults such as slavery and residential segregation, as well as the environmental influences of migration.	Stonington et al.[12]; Bailey et al.[23]
Generate and impart evidence-based medical knowledge when it comes to race.	Incorporate best practices regarding the use and interpretation of race/ethnicity in human subjects training programs, such as CITI. Involve funding agencies and medical journals in reinforcing these best practices. Reform board examinations (e.g., USMLE) to avoid testing students on race-based clinical guidelines and racial heuristics.	Ripp and Braun[24]; Vyas et al.[1]

* OMB denotes Office of Management and Budget, CITI Collaborative Institutional Training Initiative, and USMLE U.S. Medical Licensing Examination.

Amatuah, et al. (2021). NEJM
DOI: 10.1056/NEJMms2025768

	How race is used	Rationale for race-based management	Potential harm	Race-conscious approach
eGFR[6]	eGFR for Black patients is multiplied by 1·16–1·21 the eGFR for White patients, depending on the equation used	Black patients are presumed to have higher muscle mass and creatinine generation rate than patients of other races	Black patients might experience delayed dialysis and transplant referral[8,9]	Use eGFR equations that do not adjust for race (eg, CKD-EPI Cystatin C)[10]
BMI risk for diabetes[7]	Asian patients considered at risk for diabetes at BMI ≥23 vs 25 for patients of other races	Asian patients are presumed to develop more visceral than peripheral adiposity than patients of other races at similar BMI levels, increasing risk for insulin resistance[7]	Asian patients screened for diabetes despite absence of other risk factors might experience increased stigma and distrust of medical providers[10]	Screen patients with lower BMIs on the basis of indications of increased body fat (eg, body roundness,[11] body fat percentage), not based on race
FRAX[11]	Probability of fracture is adjusted according to geography or minority status, or both	Different geographical and ethnic minority populations are presumed to have varied relative risks for fracture on the basis of epidemiological data	Some populations, including Black women, might be less likely to be screened for osteoporosis than other populations[12]	Screen patients for osteoporosis on the basis of clinical risk criteria, rather than race; counteract existing biases that place Black patients at risk because of racial essentialist beliefs about variation in bone density[13]
PFT[14]	Reference values for pulmonary function are adjusted for race and ethnicity	Racial and ethnic minority groups are presumed to have varied lung function on the basis of epidemiological data	Black patients might experience increased difficulty obtaining disability support for pulmonary disease[15]	Use unadjusted measures of lung function for all patients; counteract existing biases that harm Black patients because of racial essentialist beliefs about variation in lung capacity[16]
JNC 8 Hypertension Guidelines[18]	Treatment algorithm provides alternate pathways for Black and non-Black patients	ACE-inhibitor use associated with higher risk of stroke and poorer control of blood pressure in Black patients than in patients of other races	Black patients might be less likely to achieve hypertension control and require multiple antihypertensive agents[19]	Consider all antihypertensive options for blood pressure control in Black patients; adjust as needed to achieve goals and manage adverse effects
Paediatric UTI diagnosis[20]	White race in girls and non-Black race in boys are considered independent risk factors for UTI	Study of febrile children in the emergency department found highest prevalence of UTI among White girls and non-Black boys[20]	Experimental data suggests that these guidelines could affect management of UTI by race[21]	Treat UTI in children on the basis of clinical presentation, regardless of race
ASCVD risk estimation	Race-specific equations included to estimate ASCVD risk	ASCVD events higher for Black patients than patients of other races with otherwise equivalent risk burden[24]	Black patients might experience more adverse effects from recommended statin therapy, including persistent muscle damage[25]	Recommend preventive therapy on the basis of clinical metrics and comorbidities; consider pathways by which structural racism might increase cardiovascular risk among Black patients and promote resources to reduce racial stress and trauma[26]
Eltrombopag dosing	East Asian patients receive half the starting dose compared with non-east Asian patients	Limited pharmacokinetic studies suggest reduced metabolism of eltrombopag in patients of East Asian descent[27]	Some East Asian patients might receive inappropriate dosing[28]	Initiate same starting dose for all patients, regardless of race, and adjust as needed on the basis of platelet response

Examples of race-based medicine were chosen to represent multiple racial groups (eg, White, Black, Asian) and domains in which race is essentialised as biological (eg, pharmacokinetics, bone density, lung capacity). ACE=angiotensin-converting enzyme. ASCVD=atherosclerotic cardiovascular disease. BMI=body-mass index. CKD-EPI=Chronic Kidney Disease Epidemiologic Collaboration equation. eGFR=estimated glomerular filtration rate. FRAX=fracture risk assessment score. JNC 8=Eighth Joint National Committee. PFT=pulmonary function test. UTI=urinary tract infection.

Table: Examples of race-based medicine, the potential harm to patients, and race-conscious alternatives

Cerdena, et al. (2020). Lancet. DOI: 10.1016/S0140-6736(20)32076-6

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Guidelines for Educators to Promote a Bias-Free Curriculum

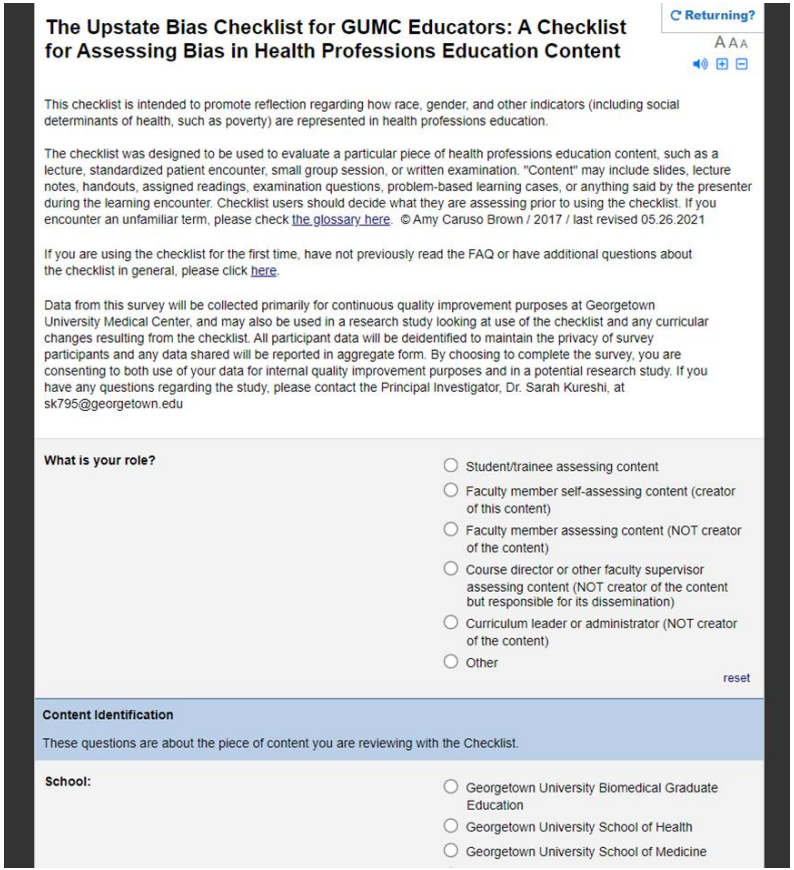
Guideline	Example	Proposed solution
Be inclusive in representations of healthy/normal	A textbook may describe healthy gums as being "coral pink" in color, but healthy gums of persons of color may be pigmented. Such a limited description of normal may not prepare students to work with a diverse patient population and also risks communicating to some students that they are not "normal."	When describing human structure, function, or behavior, consider whether a representation applies universally or whether more broad descriptions are needed. An educator teaching the example material may present images of gums of different normal pigmentations. In addition, teachers can strive to craft cases for class discussion, simulation, or examination that are inclusive with regard to race, religion, sex and gender, and other domains of identity.
Be inclusive in representations of pathology	Hyperbilirubinemia can present clinically as jaundiced skin. However, in darker-skinned persons, jaundiced skin may be clinically difficult to appreciate.	An educator may first consider whether the clinical presentation of a disease may vary across populations and discuss those differences with students. In the example above, the educator can discuss the challenges of identifying skin color changes in persons with darker skin and might discuss how one can look at palms and sclera for clinical clues in these patients. Alternatively, in a case where the descriptors used for pathology are consistent across groups, such as peau d'orange to refer to the dimpled appearance of cutaneous lymphatic edema, the educator could be explicit about the universality of the trait.
Avoid stereotypes in representations of pathology	A discussion on sexually transmitted infections (STIs) may use "typical" case examples to illustrate disease pathology and epidemiology (e.g., men who have sex with men or young people). We may be inadvertently teaching students to think that these are the only kinds of persons who are at risk for STIs. Similarly, we risk suggesting that all or most individuals in a particular group have STIs. This type of stereotypical representation is particularly problematic for conditions associated with social stigma.	Consider using a diverse set of case examples that illustrate both the typical populations at risk for certain diseases (guided by evidence-based knowledge of population prevalence) while avoiding the impression that only those populations are at risk. For instance, a teacher may discuss a geriatric or pediatric patient who develops an STI or a case that focuses on the sexual health of a woman who has sex with women. Another example of teaching that disrupts stereotypes and biases in clinical thinking might be to craft a case of a man who has sex with men who presents with a fever and turns out not to have HIV or an STI, but rather has a common infectious process that any immunocompetent person might develop.
Acknowledge limitations of research	It is common to encounter studies in the medical literature that disproportionately enroll men or people of Caucasian descent. In certain situations, we may find that the generalizability of those findings to women, persons of color, or other underrepresented populations may be limited or problematic.	Educators who are sharing evidence from the literature should be aware of the limitations of that evidence, including the selection methods for the population under study. If underrepresentation in study subjects by gender identity, sex, race, socioeconomic status, or another meaningful variable may limit its generalizability to other populations, this should be disclosed and serve as a point of conversation with the students. Critically examining published evidence in this way encourages a more sophisticated appraisal of the literature. This practice also consciously considers the challenges in applying research findings to diverse populations and promotes a mindfulness of diversity itself. Dialogue could be encouraged even when study subjects across groups appear represented, because the categories are often poorly defined and might not be as generalizable as the study suggests (e.g., using a sample of a Yoruba population in Nigeria to compare "Africans" or "Blacks" with Caucasian Americans).
Explore differences in health outcomes and responses to treatment	The medical literature now describes many examples of health care disparities by race, socioeconomic status, and other variables. However, the mediators of those disparities are not always known and, even if known, are not always discussed. This may leave some students with a misguided impression that genetic or intrinsic differences drive all such disparities.	Though the factors that mediate the health care disparities are often not fully elucidated, it can be worthwhile for educators to foster a discussion surrounding what may be driving disparities. Such conversations will help some students move from a misguided notion that genetic differences drive all such health care disparities to developing a more nuanced understanding of how race, socioeconomic status, unconscious bias, and other factors impact health care. Furthermore, students may develop an increased understanding of structural inequalities that may be driving many of the disparities seen.
Consider informal attitudes and behaviors	Humor is often a useful tool when teaching. However, while some may find a particular joke to be a useful mnemonic device or an engaging part of the teaching experience, others might be offended or feel excluded. The teacher risks alienating the learner or distracting the learner from the teaching point, particularly if the joke comes at the expense of a particular identity group.	Educational research indicates that informal attitudes and behavior in the educational setting powerfully affect the student experience. For instance, while educators are encouraged to use humor in their teaching, they should remain cognizant of whether a particular group is being targeted as a result of the joke, or whether the joke is directed to certain audience members, excluding others. In this case, the joke should either be modified or avoided altogether.

ACADEMIC MEDICINE

Benoit, et al. (2020). Acad Med. DOI: 10.1097/ACM.0000000000003701

OUTDATED TERM	WHY IS IT HARMFUL?	ALTERNATIVE TERM
Buffalo Hump	Derogatory towards overweight individuals.	Supraclavicular and/or dorsocervical fat pad
Mongolian Spot	Historicallly, individuals with these skin findings were stigmatized to be racially inferior; term originated with the incorrect belief that it was most common in Mongolian populations (1,2).	Slate grey nevus, congenital dermal melanosis
Dwarfism	Linked to the root meaning 'to deceive,' implying an inherent moral defect in individuals with short stature (3). Also, historically been linked to intellectual disability which is inaccurate.	Individual with short stature, little person
Cretinism	Derogatory slang term for someone perceived as foolish or incompetent; historically used to mean "human being" as a reminder that individuals with this condition were humans and not beasts (3,5).	Congenital iodine deficiency syndrome, congenital hypothyroidism
Leprosy	Historically used as a metaphor for "all that is impure, immoral, and dreadful" (9).	Hansen's Disease
Moon face or facies	Slur used for Asians and Pacific Islanders (10).	Swelling or puffing of face
Red man syndrome	Slur used for Indigenous people (11, 12).	Vancomycin-flushing Syndrome
Wegener's Granulomatosis	Named after a member of the Nazi party (13).	Granulomatosis with Polyangiitis
Reiter's arthritis	Named after a member of the Nazi party (14).	Reactive Arthritis
Asperger's Syndrome	Named after a member of the Nazi party (15).	Autism Spectrum Disorder

OHSU School of Medicine: https://www.ohsu.edu/sites/default/files/2023-01/OutdatedMedTerminology_2023Updated.pdf



The Upstate Bias Checklist for GUMC Educators: A Checklist for Assessing Bias in Health Professions Education Content

Returning?

AAA

This checklist is intended to promote reflection regarding how race, gender, and other indicators (including social determinants of health, such as poverty) are represented in health professions education.

The checklist was designed to be used to evaluate a particular piece of health professions education content, such as a lecture, standardized patient encounter, small group session, or written examination. "Content" may include slides, lecture notes, handouts, assigned readings, examination questions, problem-based learning cases, or anything said by the presenter during the learning encounter. Checklist users should decide what they are assessing prior to using the checklist. If you encounter an unfamiliar term, please check the glossary here. © Amy Caruso Brown / 2017 / last revised 05.26.2021

If you are using the checklist for the first time, have not previously read the FAQ or have additional questions about the checklist in general, please click here.

Data from this survey will be collected primarily for continuous quality improvement purposes at Georgetown University Medical Center, and may also be used in a research study looking at use of the checklist and any curricular changes resulting from the checklist. All participant data will be deidentified to maintain the privacy of survey participants and any data shared will be reported in aggregate form. By choosing to complete the survey, you are consenting to both use of your data for internal quality improvement purposes and in a potential research study. If you have any questions regarding the study, please contact the Principal Investigator, Dr. Sarah Kureshi, at sk795@georgetown.edu

What is your role?

- ○ Student/trainee assessing content
- ○ Faculty member self-assessing content (creator of this content)
- ○ Faculty member assessing content (NOT creator of the content)
- ○ Course director or other faculty supervisor assessing content (NOT creator of the content but responsible for its dissemination)
- ○ Curriculum leader or administrator (NOT creator of the content)
- ○ Other

reset

Content Identification

These questions are about the piece of content you are reviewing with the Checklist.

School:

- ○ Georgetown University Biomedical Graduate Education
- ○ Georgetown University School of Health
- ○ Georgetown University School of Medicine

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https://redcap.link/gumcbiaschecklist

Applying Lessons into Practice

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Using Race & Ethnicity More Thoughtfully

Example	Better Wording or Better Description
“Mr. Jones is a 58yo homeless Hispanic male who came in for Chest Pressure”	
“In this study, 375 participants (75%) were white and 125 participants (25%) were non-white…. Results showed that white participants were more likely to take their medications than those who were non-white."	
“Black males are at higher risk for hypertension and ACE inhibitors are not as effective for blacks…”	

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Points of Reflection

- Inclusivity of Language Used
- Contextualization of Race & Ethnicity in the Description of Findings
- Quality of Data Sources and Research Design to Examine Racial & Ethnic Disparities

slido

What is one change you plan to make in your teaching, research, or clinical practice as a result of what you've learned today

ⓘ Start presenting to display the poll results on this slide.

Questions?

Please feel free to reach to us at:

karey.m.sutton@medstar.net
sk795@georgetown.edu

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GEORGETOWN UNIVERSITY

References

- Conceptualizing, Contextualizing, and Operationalizing Race in Quantitative Health Sciences Research (annfammed.org)
- Updated Guidance on the Reporting of Race and Ethnicity in Medical and Science Journals | Medical Journals and Publishing | JAMA | JAMA Network
- Race and Ethnicity in Biomedical Research: Changing Course and Improving Accountability
- AAMC/AMA – A Guide to Language, Narrative, and Concepts
- GUMC Center for Health Equity: Equity Forward Faculty Campaign
- Race Is a Social Construct, Scientists Argue - Scientific American
- Use of Race in Clinical Diagnosis and Decision Making: Overview and Implications | KFF
- AABA Statement on Race & Racism (physanth.org)
- Substituting genetic ancestry for race in research? Not so fast - STAT (statnews.com)
- From race-based to race-conscious medicine: how anti-racist uprisings call us to act
- Misrepresenting Race — The Role of Medical Schools in Propagating Physician Bias
- Toward a Bias-Free and Inclusive Medical Curriculum: Development and Implementation of Student-Initiated Guidelines and Monitoring Mechanisms at One Institution
- The Upstate Bias Checklist for GUMC Educators: A Checklist for Assessing Bias in Health Professions Education Content