The DRIVE Initiative:

Diversity, Representation, and Inclusion for Value in Education

Addressing **Bias** in the Curriculum

UMass Chan MEDICAL SCHOOL

UMassMemorial Health Care

DRIVE STATEMENT OF INTENT

We believe that everyone participating in DRIVE activities is committed to learning together, has valuable expertise, welcomes diversity, and is invested in improving teaching and learning across our community.

We strive to maintain confidentiality of personal details while elevating relevant topics for broader discussion.

DRIVE

Diversity, Representation and Inclusion for Value in Education

Our intent is to promote inclusive learning while avoiding bias.

If you identify opportunities for addressing bias or improving representation in this or other course content or instructional delivery, we encourage you to share them with either:

The DRIVE Initiative at DRIVE@umassmed.edu or you can scan the QR code to send feedback **anonymously** to DRIVE

We commit to apply the DRIVE goals and abide by the 'Statement of Intent'

Disclosures

We have no actual or potential conflict of interest in relation to this presentation

Learning objectives

By the end of this session, learners will be able to

- Recognize **six categories for improvement** of diversity, representation and inclusion in our teaching included in the DRIVE Appraisal tool
- **Locate** and **apply** the DRIVE Curriculum **Appraisal Tool** to teaching material in the classroom and clinic

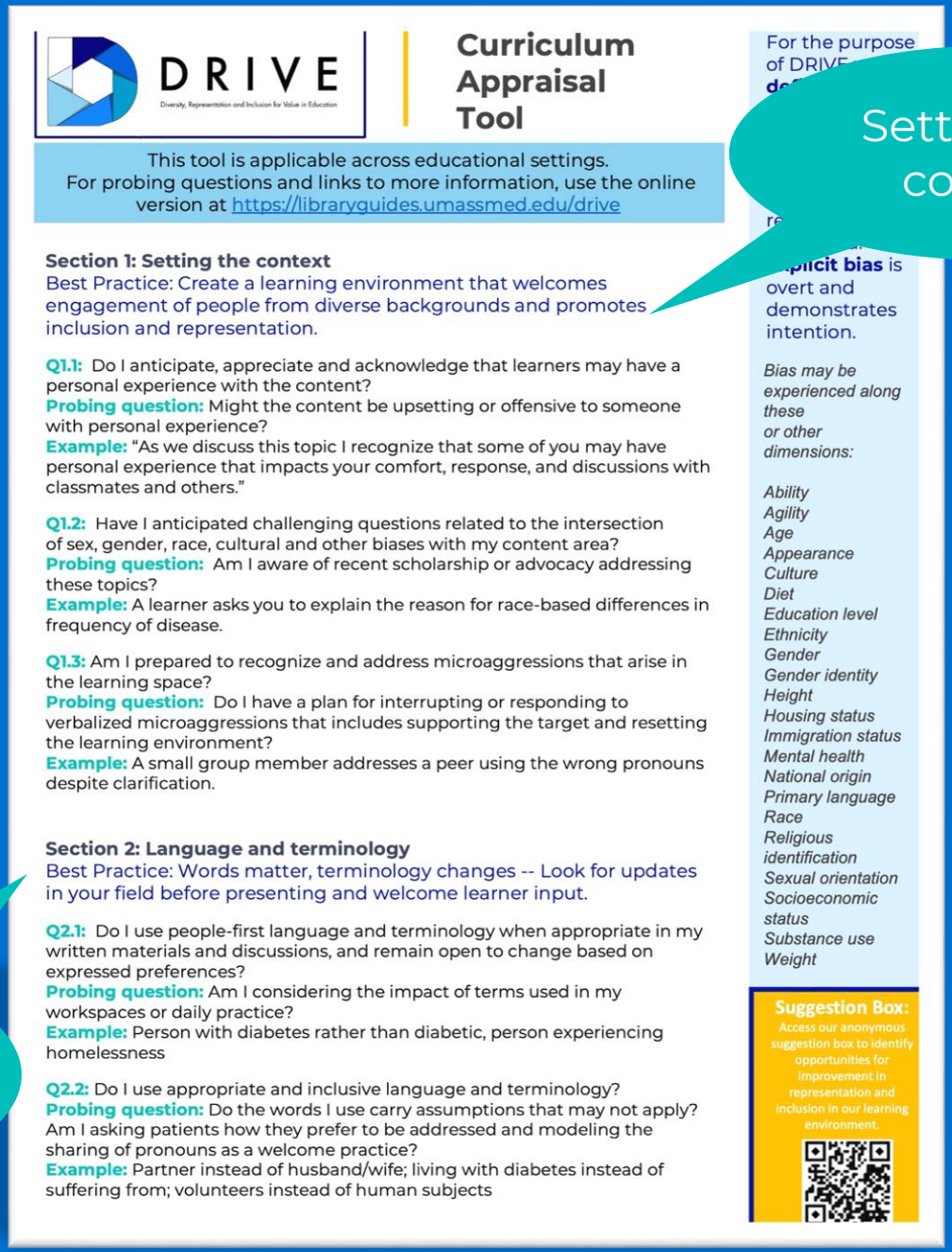
Independent Learning Module (ILM) Recap

- The DRIVE goal is to promote a representative and bias-free curriculum across our learning environments

We all have bias, and bias has many dimensions

- For the purpose of DRIVE, we define bias as a preference. Implicit bias is an unconscious response which can be recognized and mitigated.
Explicit bias is overt and demonstrates intention.

Organized into
6 sections each
with a best practice



DRIVE
Diversity, Representation and Inclusion for Value in Education

Curriculum Appraisal Tool

This tool is applicable across educational settings.
For probing questions and links to more information, use the online version at https://libraryguides.umassmed.edu/drive

Section 1: Setting the context
Best Practice: Create a learning environment that welcomes engagement of people from diverse backgrounds and promotes inclusion and representation.

Q1.1: Do I anticipate, appreciate and acknowledge that learners may have a personal experience with the content?
Probing question: Might the content be upsetting or offensive to someone with personal experience?
Example: "As we discuss this topic I recognize that some of you may have personal experience that impacts your comfort, response, and discussions with classmates and others."

Q1.2: Have I anticipated challenging questions related to the intersection of sex, gender, race, cultural and other biases with my content area?
Probing question: Am I aware of recent scholarship or advocacy addressing these topics?
Example: A learner asks you to explain the reason for race-based differences in frequency of disease.

Q1.3: Am I prepared to recognize and address microaggressions that arise in the learning space?
Probing question: Do I have a plan for interrupting or responding to verbalized microaggressions that includes supporting the target and resetting the learning environment?
Example: A small group member addresses a peer using the wrong pronouns despite clarification.

Section 2: Language and terminology
Best Practice: Words matter, terminology changes -- Look for updates in your field before presenting and welcome learner input.

Q2.1: Do I use people-first language and terminology when appropriate in my written materials and discussions, and remain open to change based on expressed preferences?
Probing question: Am I considering the impact of terms used in my workspaces or daily practice?
Example: Person with diabetes rather than diabetic, person experiencing homelessness

Q2.2: Do I use appropriate and inclusive language and terminology?
Probing question: Do the words I use carry assumptions that may not apply? Am I asking patients how they prefer to be addressed and modeling the sharing of pronouns as a welcome practice?
Example: Partner instead of husband/wife; living with diabetes instead of suffering from; volunteers instead of human subjects

For the purpose of DRIVE
de
re
plicit bias is overt and demonstrates intention.

Bias may be experienced along these or other dimensions:

Ability
Agility
Age
Appearance
Culture
Diet
Education level
Ethnicity
Gender
Gender identity
Height
Housing status
Immigration status
Mental health
National origin
Primary language
Race
Religious identification
Sexual orientation
Socioeconomic status
Substance use
Weight

Suggestion Box:
Access our anonymous suggestion box to identify opportunities for improvement in representation and inclusion in our learning environment.

Setting the context

Language and terminology

Printable 2-sided worksheet
OR
Online extended guide with resource links

Images and media

Research and references

Population and patient cases

Closing the loop

Section 3: Images & Media

Drive Best Practice: Utilize images and videos that invite connection, promote recognition and improve diagnosis across skin tones and physical features.

Q3.1: Do the images or media in my materials represent a range of characteristics?
Probing question: Have I illustrated the ways in which the condition may present differently in patients with a variety of characteristics such as skin tone, body habitus, hair?
Example: Provide more than one illustrative image.

Q3.2: Could the images or media that I am using be perceived as promoting a stereotype?
Probing question: Do I ensure that tables, graphs, and images do not reinforce unintended bias?
Example: Using multiple images when discussing specific conditions may reduce stereotypes.

Section 4: Research and References

Drive Best Practice: Select research that is inclusive in the populations being studied and the individuals directing the research.

Q4.1. Is race defined in the paper appropriately as a social construct?
Probing question: Am I able to describe the role of genetics versus socioeconomic factors?
Example: Recognition of race as a surrogate for socio/politics and not differences in biology has many rethinking the use of race in clinical calculators and the role it should play when we share demographic data.

Q4.2: Who are the researchers whose work I am citing?
Probing question: Am I including a variety of perspectives, research traditions and the full international literature on the topic? How are the people being studied represented in the research design process and authorship?
Example: Citing literature from global journals advances the state of the science, while use of local data can advance understanding.

Section 5: Population and Patient Cases

DRIVE Best Practice: Ensure that cases lead the learner to question rather than reinforce bias/ assumptions.

Q5.1: Do I include demographic characteristics (like race or ethnicity) for social context instead of as biological factors or physical findings? Am I clear on how inclusion of relevant social variables supports my learning objectives?
Probing question: Do my teaching examples encompass and normalize a range of patient characteristics similar to the mix in a diverse community like ours in Worcester?
Example: Including demographic or social data only when medically relevant may lead to over-association.

Q5.2: Do I include relative impact of cultural or socioeconomic determinants of health on case pathology?
Probing question: If I connect a demographic with a medical outcome, am I explaining the causal pathway?
Example: When presenting a case associating asthma rates with racial categories, do we explain the social and environmental factors contributing to this association? A woman of color with high blood pressure may be suffering from chronic stress from structural racism.

SECTION 6: CLOSING THE LOOP

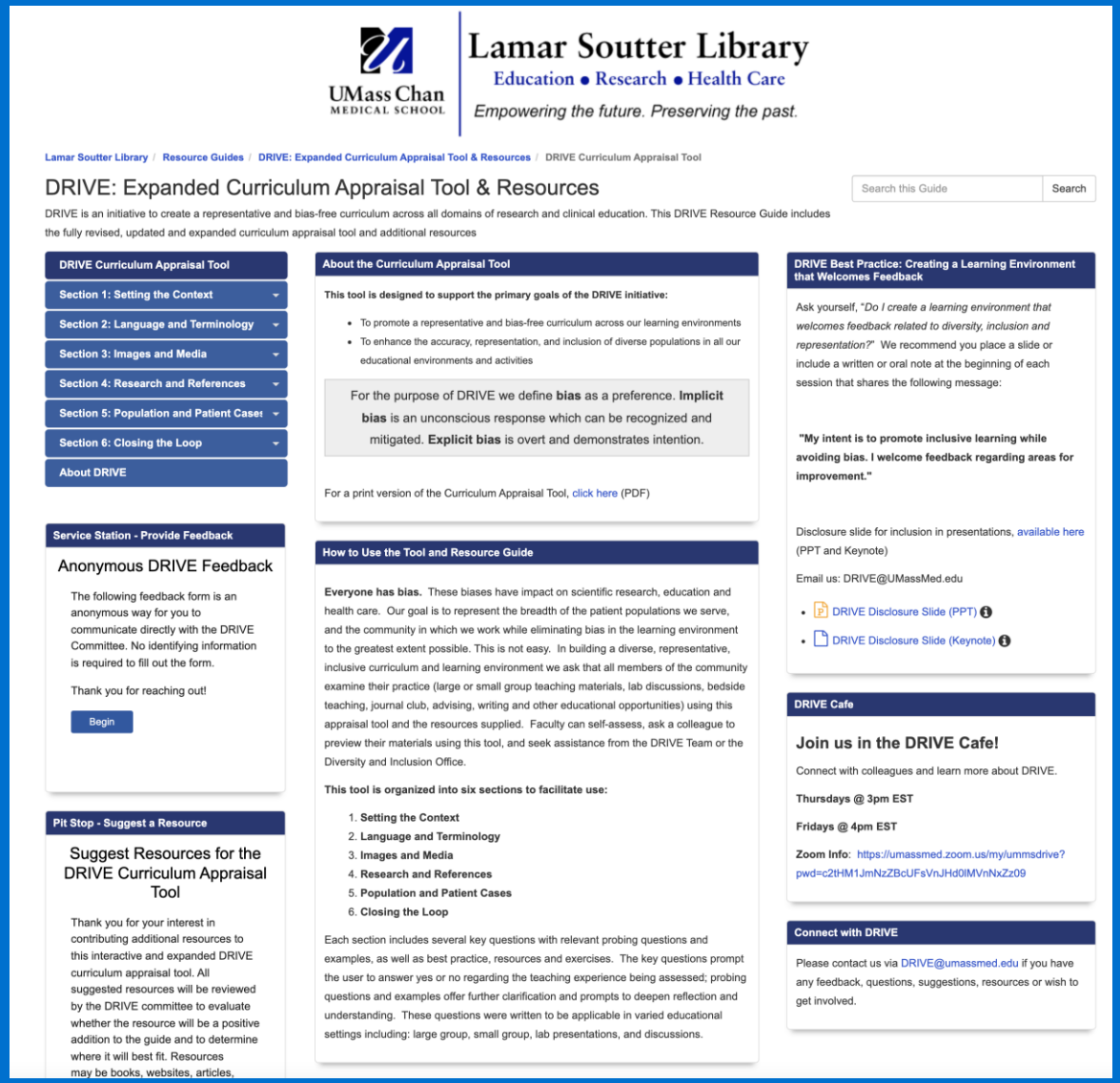
DRIVE Best Practice: Recognize that change is iterative; utilize evaluation data and feedback t drive continuous quality improvement.

Q12: Am I gathering and examining evaluation data from all sources for evidence of improvement?
Probing question: Am I aware of all the sources of feedback available to me? Reach out to DRIVE if you don't know how to address the feedback. Content experts are available to help.
Example: Contact course or program leaders to request formal evaluation data and informal feedback relevant to diversity and inclusion; incorporate feedback in ongoing development and improvement

Resources are available online

Expanded Library Guide

https://libraryguides.umassmed.edu/drive



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DRIVE: Expanded Curriculum Appraisal Tool & Resources

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DRIVE is an initiative to create a representative and bias-free curriculum across all domains of research and clinical education. This DRIVE Resource Guide includes the fully revised, updated and expanded curriculum appraisal tool and additional resources

DRIVE Curriculum Appraisal Tool

- Section 1: Setting the Context
- Section 2: Language and Terminology
- Section 3: Images and Media
- Section 4: Research and References
- Section 5: Population and Patient Cases
- Section 6: Closing the Loop
- About DRIVE

Service Station - Provide Feedback

Anonymous DRIVE Feedback

The following feedback form is an anonymous way for you to communicate directly with the DRIVE Committee. No identifying information is required to fill out the form.

Thank you for reaching out!

Begin

Pit Stop - Suggest a Resource

Suggest Resources for the DRIVE Curriculum Appraisal Tool

Thank you for your interest in contributing additional resources to this interactive and expanded DRIVE curriculum appraisal tool. All suggested resources will be reviewed by the DRIVE committee to evaluate whether the resource will be a positive addition to the guide and to determine where it will best fit. Resources may be books, websites, articles,

About the Curriculum Appraisal Tool

This tool is designed to support the primary goals of the DRIVE initiative:

- To promote a representative and bias-free curriculum across our learning environments
- To enhance the accuracy, representation, and inclusion of diverse populations in all our educational environments and activities

For the purpose of DRIVE we define **bias** as a preference. **Implicit bias** is an unconscious response which can be recognized and mitigated. **Explicit bias** is overt and demonstrates intention.

For a print version of the Curriculum Appraisal Tool, click here (PDF)

How to Use the Tool and Resource Guide

Everyone has bias. These biases have impact on scientific research, education and health care. Our goal is to represent the breadth of the patient populations we serve, and the community in which we work while eliminating bias in the learning environment to the greatest extent possible. This is not easy. In building a diverse, representative, inclusive curriculum and learning environment we ask that all members of the community examine their practice (large or small group teaching materials, lab discussions, bedside teaching, journal club, advising, writing and other educational opportunities) using this appraisal tool and the resources supplied. Faculty can self-assess, ask a colleague to preview their materials using this tool, and seek assistance from the DRIVE Team or the Diversity and Inclusion Office.

This tool is organized into six sections to facilitate use:

1. **Setting the Context**
2. **Language and Terminology**
3. **Images and Media**
4. **Research and References**
5. **Population and Patient Cases**
6. **Closing the Loop**

Each section includes several key questions with relevant probing questions and examples, as well as best practice, resources and exercises. The key questions prompt the user to answer yes or no regarding the teaching experience being assessed; probing questions and examples offer further clarification and prompts to deepen reflection and understanding. These questions were written to be applicable in varied educational settings including: large group, small group, lab presentations, and discussions.

DRIVE Best Practice: Creating a Learning Environment that Welcomes Feedback

Ask yourself, "*Do I create a learning environment that welcomes feedback related to diversity, inclusion and representation?*" We recommend you place a slide or include a written or oral note at the beginning of each session that shares the following message:

"My intent is to promote inclusive learning while avoiding bias. I welcome feedback regarding areas for improvement."

Disclosure slide for inclusion in presentations, available here (PPT and Keynote)

Email us: DRIVE@UMassMed.edu

- DRIVE Disclosure Slide (PPT)
- DRIVE Disclosure Slide (Keynote)

DRIVE Cafe

Join us in the DRIVE Cafe!

Connect with colleagues and learn more about DRIVE.

Thursdays @ 3pm EST

Fridays @ 4pm EST

Zoom Info: https://umassmed.zoom.us/my/ummsdrive?pwd=c2tHM1JmNzZBcUFsVnJHd0lMVnNxZz09

Connect with DRIVE

Please contact us via DRIVE@umassmed.edu if you have any feedback, questions, suggestions, resources or wish to get involved.

Section 1: Setting the Context

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Best Practice: Create a learning environment that welcomes engagement of people from diverse backgrounds and promotes inclusion and representation.

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Probing question: Do I have a plan for interrupting or responding to verbalized microaggressions that includes supporting the target and resetting the learning environment?
Example: A small group member addresses a peer using the wrong pronouns despite clarification.

Setting the Context: Best Practice

"Create a learning environment that welcomes engagement of people from diverse backgrounds and promotes inclusion and representation."

Setting the context questions:

Q1. Do I anticipate, appreciate and acknowledge that learners may have a personal experience with the content?

Q2. Have I anticipated challenging questions related to the intersection of sex, gender, race, cultural and other biases with my content area?

Q3. Am I prepared to recognize and address microaggressions that arise in the learning space?

Example from a UMass Chan **learner**

> “A faculty member stated in front of everyone that they weren’t even going to attempt to pronounce my name”

Discussion Prompt

Q: For an introductory class such as the GSBS SIBR course, SOM Principles 1, or GSN Societal Forces how might this sort of comment ‘set the tone’?

Example from a UMass Chan **learner**

> “I spent three years prior to med school focused on PrEP* research.
>
> When I commented on the inaccuracies presented, I was dismissed.”

Discussion Prompt

Q: How might you introduce topics in a way that allows for learners to share existing knowledge?

* Pre-exposure prophylaxis (or PrEP) is used in the prevention of HIV

Example of a Curriculum Appraisal Tool question:

> “Am I prepared to recognize and address microaggressions that arise in the learning space?”

What are ‘microaggressions’?

> “Microaggressions are the everyday verbal, nonverbal, and environmental slights, snubs, or insults, whether intentional or unintentional, which communicate hostile, derogatory, or negative messages to target persons based solely upon their marginalized group membership.”

Microaggressions in Everyday Life: Race, Gender, and Sexual Orientation - Derald Wing Sue Ph.D.

Microaggressions: Setting the context

Q: What are some of the ways you can help set the tone and space to preempt potential microaggressions and harm?

Examples:

- Give an opening statement in lectures and meetings
- DRIVE commitment slide
- Advocate for appropriate school-wide policies and procedures i.e. event and exam timing around religious holidays, ADA compliant space and access
- Further specific instruction in our break out room

Leave SPACE for all VOICES

> Ask yourself: am I leaving space for learners who are quiet, who may speak English as an additional language, or who come from cultural and ethnic backgrounds that don't encourage outgoing participation?

Ask yourself whose ideas you remember and whose you dismiss.

Section 2: Language and terminology

Section 2: Language and terminology

Best Practice: Words matter, terminology changes -- Look for updates in your field before presenting and welcome learner input.

Q2.1: Do I use people-first language and terminology when appropriate in my written materials and discussions, and remain open to change based on expressed preferences?
Probing question: Am I considering the impact of terms used in my workspaces or daily practice?
Example: Person with diabetes rather than diabetic, person experiencing homelessness

Q2.2: Do I use appropriate and inclusive language and terminology?
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Example: Partner instead of husband/wife; living with diabetes instead of suffering from; volunteers instead of human subjects

Language and Terminology: Best Practice

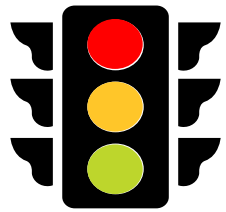
"Words matter, terminology changes -- Look for updates in your field before presenting and welcome learner input."

Language and terminology questions:

Q1. Do I use people-first language and terminology when appropriate in my written materials and discussions, and remain open to change based on expressed preferences?

Q2. Do I use appropriate and inclusive language and terminology?

- Some commonly used terms are **good-to-go**
- Some should only be used according to the **personal preference of members of that community**
- and some terms should **not be used at all**



Disabled

Person experiencing homelessness

Person with substance use disorder

Diabetic

Normal

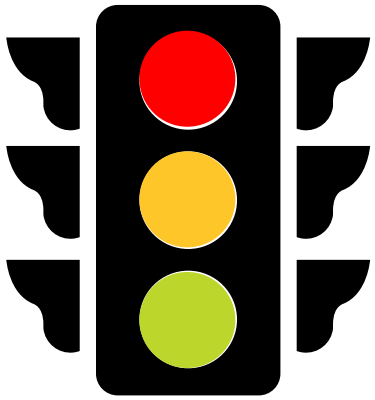
Mankind

Alcoholic

Non-Compliant

Frequent-flyer

Wheelchair bound



What ‘color’ would you make these terms?

Hearing Impaired

Differently abled

Disabled

Developmentally delayed

Stroke victim

Learning Disabled

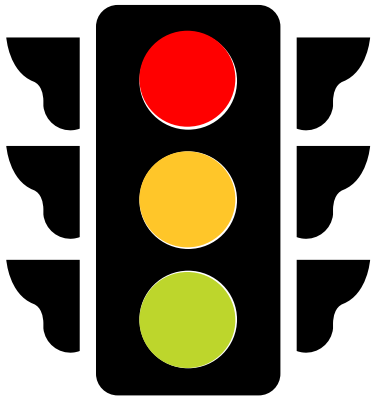
Deaf

Person with autism

Handicapped

Non-compliant

Relapsed



What ‘color’ would you make these terms?

Hearing Impaired
= Hard of Hearing

Differently abled

Disabled

Developmentally delayed

Stroke victim

Learning Disabled

Deaf

Person with autism

Handicapped

Non-compliant
= Non-Adherent

Relapsed

Example from a UMass Chan **learner**

> “Terminology is pretty inconsistent; core faculty may be using appropriate terms but then visiting lecturers don’t.”

Discussion Prompt

Q: How do I make sure my terminology is appropriate, up-to-date, and consistent with the course?

How can I address papers and text books that are ‘out-of-date’?

- We often assign readings of books and papers from seminal figures in the field, but these may contain archaic language or concepts.
- **How can we separate the scientific contribution from the era it was written in?**
  - Work to not be embarrassed discussing the issues; do not avoid
  - Utilize discussion points to provide context
  - Get comfortable with discussing the history
  - Practice acknowledging the inherent racism, sexism etc.
  - Provide examples of how the field has improved

How can I keep up-to-date?

- Create a culture of feedback to enable constructive criticism and lean in to learning opportunity
- Be open to the viewpoints of learners, colleagues, and patients.
- Consult online resources (including #medTwitter!) or peers
- Different scientific societies or groups often have updated language guidelines (i.e. UCSF – resources for care of trans individuals)
- Adopt a Growth Mindset; you will be wrong, these terms change! That is okay!

Section 3: Images & Media

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Drive Best Practice: Utilize images and videos that invite connection, promote recognition and improve diagnosis across skin tones and physical features.

Q3.1: Do the images or media in my materials represent a range of characteristics?
Probing question: Have I illustrated the ways in which the condition may present differently in patients with a variety of characteristics such as skin tone, body habitus, hair?
Example: Provide more than one illustrative image.

Q3.2: Could the images or media that I am using be perceived as promoting a stereotype?
Probing question: Do I ensure that tables, graphs, and images do not reinforce unintended bias?
Example: Using multiple images when discussing specific conditions may reduce stereotypes.

Images and Media: Best Practice

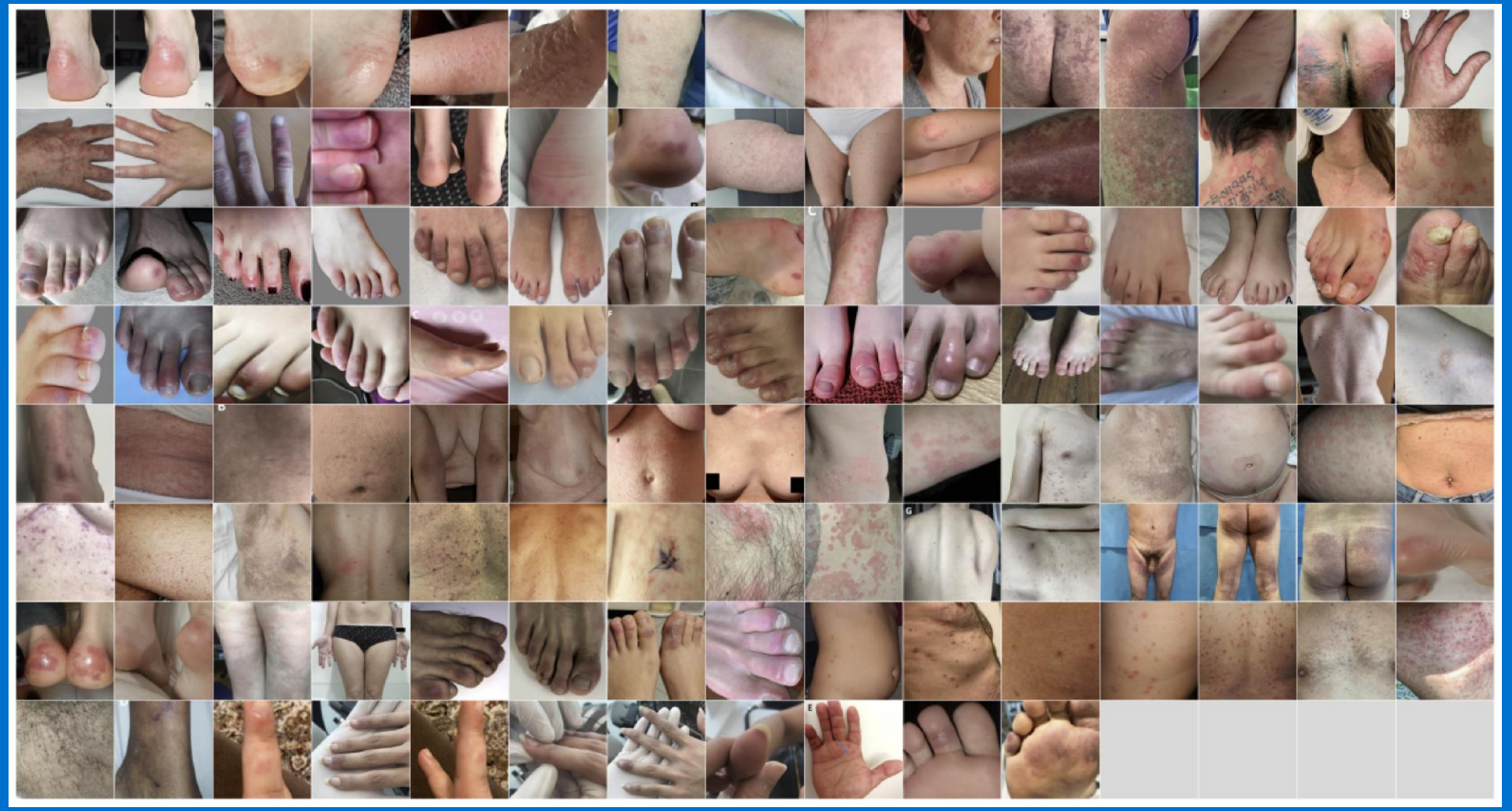
"Utilize images and videos that invite connection, promote recognition and improve diagnosis across skin tones and physical features."

Images and media questions:

Q1. Do the images or media in my materials represent a range of characteristics?

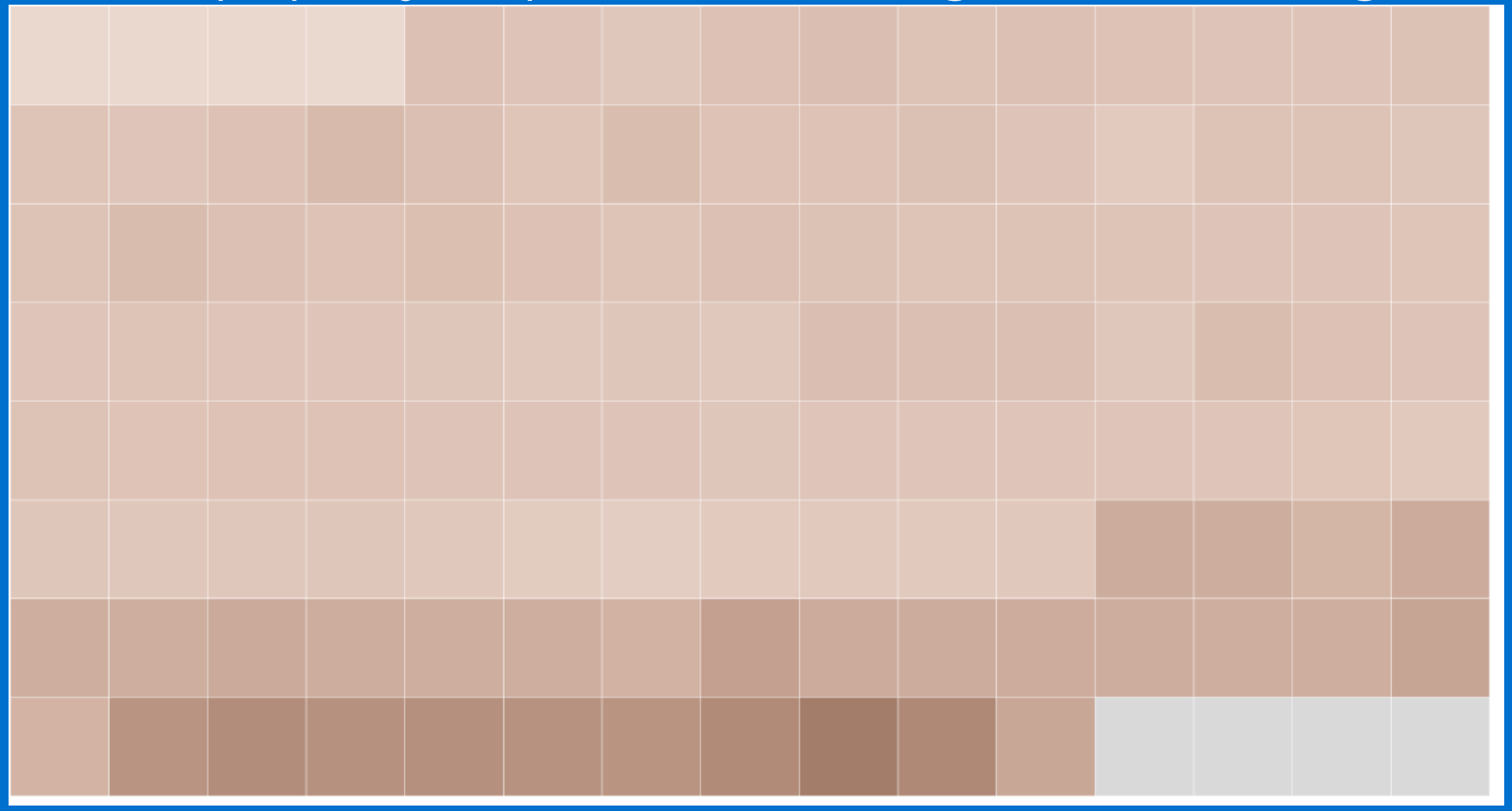
Q2. Could the images or media that I am using be perceived as promoting a stereotype?

Example: Cutaneous Manifestations of COVID-19



Lester, J. C., et al. "Absence of images of skin of colour in publications of COVID-19 skin manifestations." *The British journal of dermatology* (2020).

Q: What might be the impact of an image like this be in a paper you publish or assign as a reading?



Lester, J. C., et al. "Absence of images of skin of colour in publications of COVID-19 skin manifestations." *The British journal of dermatology* (2020).

Example from a UMass Chan **learner**

> People come in a diversity of shapes and sizes, yet when we are shown images of "healthy" people it is predominately people with a specific body shape, and when we see images of those with conditions like diabetes, we tend to see stock photos of a specific body size.
>
> It unnecessarily pathologizes larger bodies and adds to the bias that many health professionals unknowingly have towards patients of different sizes.

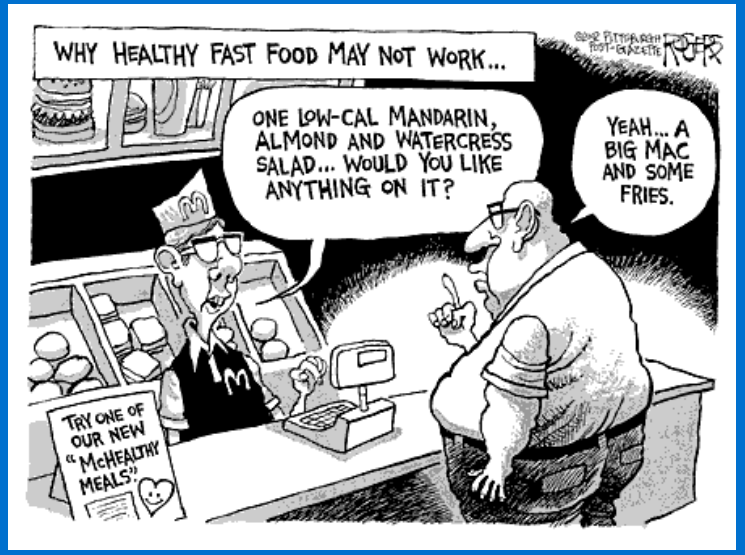
Discussion Prompt

Q: How might you address the concerns of this learner?

Image use can go beyond diagnosis and case presentations

We all use images on our posters and presentations to keep learners engaged but first ask yourself:

- Is this comic appropriate?
- Does it perpetuate a stereotype
- Could it be perceived as offensive?



Having trouble finding suitable images & videos?

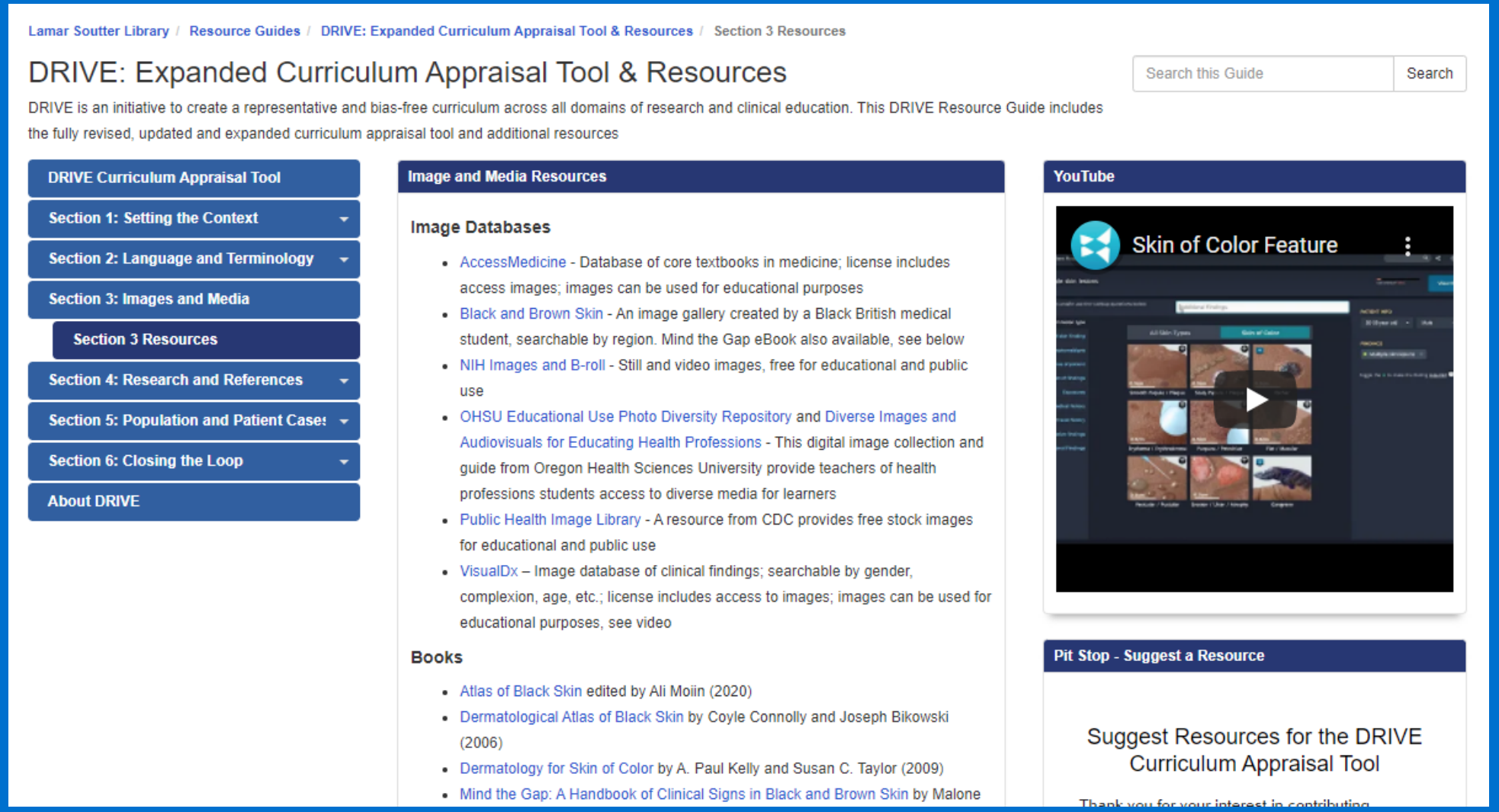


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Image and Media Resources

Image Databases

- AccessMedicine - Database of core textbooks in medicine; license includes access images; images can be used for educational purposes
- Black and Brown Skin - An image gallery created by a Black British medical student, searchable by region. Mind the Gap eBook also available, see below
- NIH Images and B-roll - Still and video images, free for educational and public use
- OHSU Educational Use Photo Diversity Repository and Diverse Images and Audiovisuals for Educating Health Professions - This digital image collection and guide from Oregon Health Sciences University provide teachers of health professions students access to diverse media for learners
- Public Health Image Library - A resource from CDC provides free stock images for educational and public use
- VisualDx – Image database of clinical findings; searchable by gender, complexion, age, etc.; license includes access to images; images can be used for educational purposes, see video

Books

- Atlas of Black Skin edited by Ali Moiin (2020)
- Dermatological Atlas of Black Skin by Coyle Connolly and Joseph Bikowski (2006)
- Dermatology for Skin of Color by A. Paul Kelly and Susan C. Taylor (2009)
- Mind the Gap: A Handbook of Clinical Signs in Black and Brown Skin by Malone

YouTube

Pit Stop - Suggest a Resource

Suggest Resources for the DRIVE Curriculum Appraisal Tool

Thank you for your interest in contributing

Consult our interactive library guide

Breakout rooms

Choose the breakout room topic based on what is most applicable to your education materials

- Room 1: **Microaggressions**
- Room 2: **Population and Patient Cases**
- Room 3: **Closing the Loop: Feedback and Evaluation**

Break out room rules

- This is a safe space
- What is said here, stays here
- Feedback is welcome, all voices are valuable

Microaggressions

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Microaggression

- Microaggressions are the everyday verbal, nonverbal, and environmental slights, snubs, or insults, whether intentional or unintentional, that communicate hostile, derogatory, or negative messages to target persons based solely upon their marginalized group membership.


Inquire
Identify

In the moment

1. ACKNOWLEDGE THE FEELINGS BEHIND THE STATEMENT.
2. SEPARATE INTENT FROM IMPACT.
3. SHARE YOUR OWN PROCESS.
4. EXPRESS YOUR FEELINGS.
5. CHALLENGE THE STEREOTYPE.
6. APPEAL TO VALUES AND PRINCIPLES.
7. PROMOTE EMPATHY

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Some approaches…

- Take a breath and take care of yourself. Avoid getting reactive, which will only increase the person's defensiveness. Consider if now is the time to respond; if not, commit yourself to when you will return to the conversation.
- Consider getting permission: "Can we talk about what just happened?" or "What just happened didn't sit right with me – are you open to talking about that?" or "Can I share a different perspective on what you said?"
- Clarify what was said to check your own assumptions. "I think I heard you say……. , is that right?"
- Draw out the speaker further to get more information: "Can you tell me more what you mean by ?" or "What led you to say / believe ?" or "What leads you to that conclusion?"
- Acknowledge the feelings the person may be having / express some empathy: "It seems like you're feeling frustrated about " or "I can understand that you'd be upset if you felt disrespected when ……."

This is hard but let's try to

1. Speak up during an event if there are inappropriate comments
2. Take a moment after an incident to acknowledge that a microaggression occurred; make time for the person who experienced the harm to reflect if they wish to do so
3. Understand support can come from those with or without shared experience.
4. Realize the care of patients from marginalized groups is impacted when providers on their care team have an outdated approach to treatment
5. Consider our involvement it's not enough to just say "I'm not racist, homophobic, ageist , antisemitic…." anymore. Being an anti-racist homophobic, ageist , antisemitic, is actively opposing these injustices and attempting to alter beliefs and policies, is the best way to promote change.

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Barriers in health care

Defensiveness: People may make comments that are inadvertently offensive, then take it personally when they receive criticism.

Solution: Try to take the feedback as a comment on your action, not a judgment on your character

Hesitation: People may not feel like they have the right background to interrupt a microaggression as it's occurring

Solution: Stepping in doesn't need to be a big, dramatic act; usually, a simple acknowledgement that something happened goes a long way

Medical hierarchy: It can be difficult for people in training to feel empowered enough to speak up, particularly if the comment comes from a supervisor

Solution: When an inappropriate comment is made, you can bring attention to it by asking a question such as "Can I ask for clarification, I think I heard you say ___

What can we do as individuals and educational leaders

- Acknowledge racism, sexism, homophobia, bias exist
- Reinforce the power of connection
- Diversify your circle
- Look for ways to support/advocate for marginalized groups
- Speak up
- Learn more about system of oppression , challenge your beliefs
- Be deliberate in our speech

Self check as an educator

What can I do

- I can be uncomfortable to make all students comfortable.
- I can understand than to be inclusive may at times challenge me and I have much to learn.
- I can acknowledge that correction and error will help me get to my goal of inclusivity.
- I can remember this is not about me and my intent.
- I can ask myself am I in a learning posture? Or defending something (what?)?

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What are your thoughts and experiences ?????

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Open Discussion

Section 5: Population and Patient Cases

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DRIVE Best Practice: Ensure that cases lead the learner to question rather than reinforce bias/ assumptions.

Q5.1: Do I include demographic characteristics (like race or ethnicity) for social context instead of as biological factors or physical findings? Am I clear on how inclusion of relevant social variables supports my learning objectives?
Probing question: Do my teaching examples encompass and normalize a range of patient characteristics similar to the mix in a diverse community like ours in Worcester?
Example: Including demographic or social data only when medically relevant may lead to over-association.

Q5.2: Do I include relative impact of cultural or socioeconomic determinants of health on case pathology?
Probing question: If I connect a demographic with a medical outcome, am I explaining the causal pathway?
Example: When presenting a case associating asthma rates with racial categories, do we explain the social and environmental factors contributing to this association? A woman of color with high blood pressure may be suffering from chronic stress from structural racism.

Population and Patient Cases: Best Practice

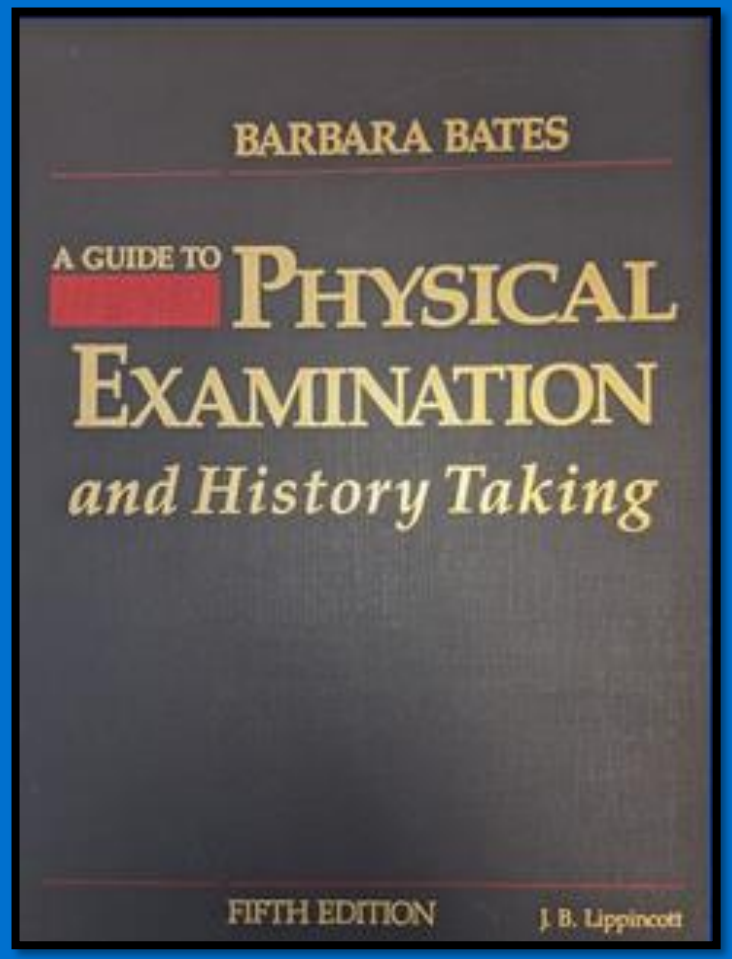
"Build cases that lead the learner to question rather than reinforce bias/ assumptions."

Population and patient cases questions:

Q1. Do I include demographic characteristics (like race or ethnicity) for social context instead of as biological factors or physical findings? Am I clear on how inclusion of relevant social variables supports my learning objectives?

Q2. Do I include relative impact of cultural or socioeconomic determinants of health on case pathology?

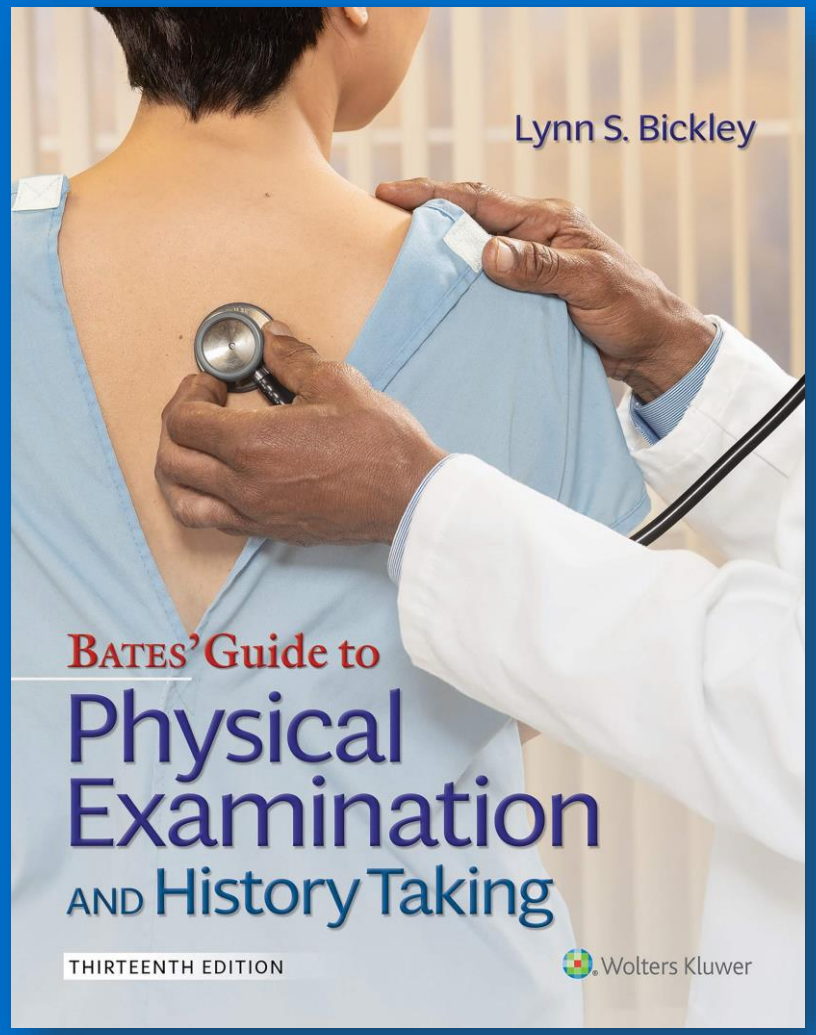
This work requires some people to UNLEARN what they were taught



Identifying data includes:

- Age
- Race
- Place of birth
- Marital status
- Occupation
- Religion

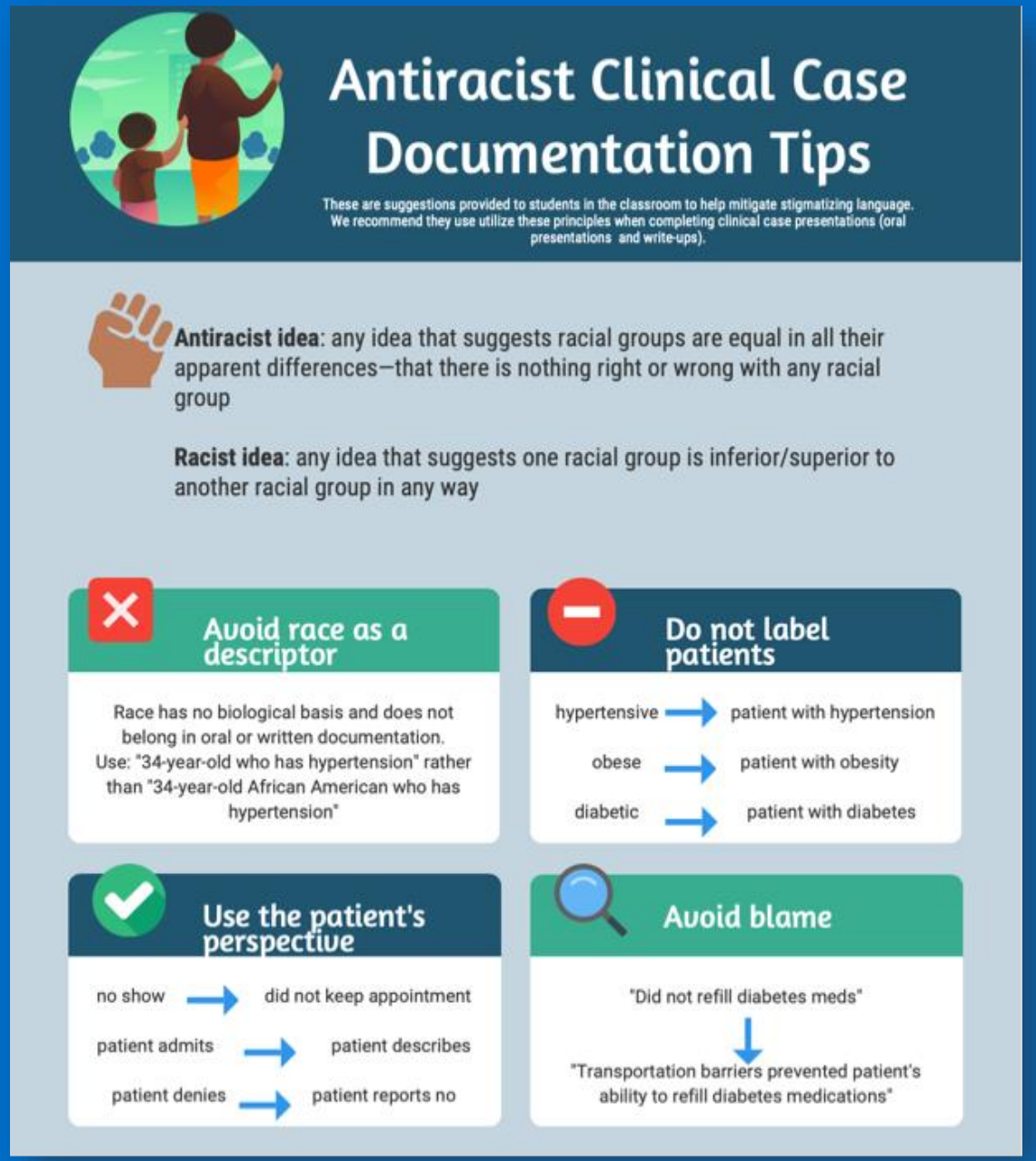
Bates 13th Edition 2020



"Opening statements for the health history documentation provide a foundation for the reader to begin to think of possible causes for the patient's condition.
This first statement should be the CC stated within the patient's clinical context [e.g., critical historical elements most related to the CC that hints to possible causes of the patient's condition)."

Some guidelines recommend the removal of race altogether from case documentation

Q: What do you think of that recommendation?



BROWN
Alpert Medical School

Example from a UMass Chan **learner**

> “Beware of encouraging stereotypes…Within the LGBTQ+ context it is common to only discuss this population when talking about STI's.”

Discussion Prompt

Q: What is likely to be the effect of this “stereotyping”?

...In Clinical Clerkships

“ I was on my family medicine clerkship and saw a patient who came in with hypertension. My supervising attending asked me, “Now if this patient were Black instead, what anti-hypertensive medications would you prescribe?” I gave him the answer that he was looking for - calcium channel blockers and thiazide diuretics - but I wish I had spoken up about how uncomfortable I felt.”

-From a UMass Chan learner

Consider the limitations of each example:

- Identifying an obese individual as having a sedentary lifestyle emphasizes personal responsibility at the expense of important genetic/epigenetic, social and structural risk factors.
- Including only minority patients in cases related to blood-borne pathogens
- Using an older adult to illustrate auditory impairments when younger people may have the condition as well (concert-goers, those who work around machinery, etc).

Open Discussion

Section 6: **Feedback and Closing the Loop**

SECTION 6: CLOSING THE LOOP

DRIVE Best Practice: Recognize that change is iterative; utilize evaluation data and feedback to drive continuous quality improvement.

Q12: Am I gathering and examining evaluation data from all sources for evidence of improvement?
Probing question: Am I aware of all the sources of feedback available to me? Reach out to DRIVE if you don't know how to address the feedback. Content experts are available to help.
Example: Contact course or program leaders to request formal evaluation data and informal feedback relevant to diversity and inclusion; incorporate feedback in ongoing development and improvement.

Closing the Loop: Best Practice

"Recognize that change is iterative; utilize evaluation data and feedback to drive continuous quality improvement."

Closing the loop question:

> “Am I gathering and examining evaluation data from all sources for evidence of improvement?”

What sources of feedback are available to me?

Conversations with Students

Peer-to-Peer

Self Evaluation

Realtime Polling

End of Course Evaluations

Class Representatives

Exam and Course Results

Zoom Chat Box

Course Director Feedback

Unsolicited Emails from Learners

Instructor Evaluation from Oasis

Discussion Prompt

You receive anonymous feedback that you feel shows the learner misunderstood what you were saying (or your beliefs/actions)

- We all experience hurt and have the urge to defend ourselves. How do we manage the emotion and move forward?
  - Try to address the issue with the learners if you interact with them again?
  - Work to make changes that demonstrate more clearly your opinions/beliefs/actions?

How do we ensure learner feedback is addressed?

What are some of the barriers?

Example from a UMass Chan **learner**

> “Honestly…what’s the point in feedback? It doesn’t seem to be anybody’s responsibility to make sure changes are made.”

Discussion Prompt

Q: How do you make learners aware of improvements?

Open Discussion

INDIVIDUAL CHARGE

- **Complete the post workshop survey**
- Select a set of your existing teaching materials: i.e. slides, syllabus, assigned readings
- Apply Curriculum Appraisal Tool:

  https://www.umassmed.edu/DRIVE
- Use online resources to dig deeper
- Engage learners – describe your changes and invite feedback
- Share successes and challenges with the DRIVE team
- Share the tool with colleagues and friends

DRIVE
Diversity, Representation and Inclusion for Value in Education

THANK YOU

for your

ENGAGEMENT!

YOUR FEEDBACK IS IMPORTANT TO US

PLEASE REMEMBER TO FILL OUT THE POST-WORKSHOP SURVEY

★★★☆