Remembering Freddie Gray: Medical Education for Social Justice

Delese Wear, PhD, Joseph Zarconi, MD, Julie M. Aultman, PhD, Michelle R. Chyatte, DrPH, MPH, and Arno K. Kumagai, MD

Abstract

Recent attention to racial disparities in law enforcement, highlighted by the death of Freddie Gray, raises questions about whether medical education adequately prepares physicians to care for persons particularly affected by societal inequities and injustice who present to clinics, hospitals, and emergency rooms. In this Perspective, the authors propose that medical school curricula should address such concerns through an explicit pedagogical orientation. The authors detail two specific approaches—antiracist pedagogy and the concept of structural competency—to construct a curriculum oriented toward appropriate care for patients who are victimized by extremely challenging social and economic disadvantages and who present with health concerns that arise from these disadvantages. In memory of Freddie Gray, the authors describe a curriculum, outlining specific strategies for engaging learners and naming specific resources that can be brought to bear on these strategies. The fundamental aim of such a curriculum is to help trainees and faculty understand how equitable access to skilled and respectful health care is often denied; how we and the institutions where we learn, teach, and work can be complicit in this reality; and how we can work toward eliminating the societal injustices that interfere with the delivery of appropriate health care.

On April 12, 2015, as nearly 20,000 fourth-year medical students in the United States were finishing their last electives, packing up their apartments, or beginning their summer vacations, a 25-year-old African American man in Baltimore, Maryland, named Freddie Gray, lay dying. Gray was arrested, cuffed with his hands behind his back, restrained with leg irons, and placed without proper safety restraints into a police van. On the way to the police station, Gray reportedly called out several times for medical help and said he could not breathe. He was subsequently found to be unresponsive and taken to a local hospital. Seven days later, he died. The stories of Gray's life and arrest and of the subsequent investigation into his death were captured in the 24-hour news cycle. Though the story is no longer daily front-page news, it remains tragic—emblematic of the struggles, resilience, and despair of whole communities in the United States who are not able to enjoy the benefits of an advanced industrialized society. As medical educators, we wondered how we might memorialize Freddie Gray, as well as other young black men killed prematurely and unjustly, including Trayvon Martin, Michael Brown, Eric Garner, Tamir Rice, Walter Scott, Laquan McDonald, Alton Sterling, and Philando Castile, through a renewed commitment to education for social justice. In the same spirit as the Black Lives Matter movement and its medical school version, White Coats for Black Lives, we wish to realize this commitment through action—*educational action*. The ultimate goal of this effort is to educate ourselves and our students to advocate and provide care for people who are disempowered and dispossessed, for people with no voice, for the individuals whom our new medical graduates will most surely encounter in the months ahead.

Freddie Gray's story—of his childhood, community, parents, education, health, work status, and interaction with civil authorities—is vastly different from that of most medical students. The economic profile of U.S. medical students' families is quite different from that of the mainstream, and profoundly different from that of many patients whom trainees encounter in hospital wards, clinics, and emergency departments. To illustrate, 64% of U.S. medical students come from families whose income is $100,000 or higher; 22% from families whose income is a quarter-million dollars or more. Fewer than 7% come from families with annual incomes below $25,000.[1]

Yet because most academic medical centers are located in urban settings, a majority of students learn medicine caring for patients with significant social and economic disadvantages and with profound health problems that are far beyond easy fixes. The task has fallen to us as medical educators to teach the relevant knowledge and skills needed to provide care to such economically disadvantaged and historically marginalized patients, who are often members of racial minorities, and who often live in devastatingly poor neighborhoods.

So we ask, "How are we doing?"

In her eloquent essay, then-medical student Katherine Brooks[2] tells us "not so well." The problem is not merely an *inadequate* formal curriculum, she argues, one that does little to address why disparities exist, or why, for such conditions as coronary heart disease in black patients, standards of care are still not met.[2] Rather, she believes, a *silent curriculum* exists, one that does not address the current or critical health needs of people in communities such as those where "Trayvon Martin lost his life, [where] Michael Brown was left to die in the streets …, and [where] Eric Garner was choked by officers as he repeated 11 times that he could not breathe."[2] Brooks

Please see the end of this article for information about the authors.

Correspondence should be addressed to Delese Wear, Family and Community Medicine, 4209 Rte. 44, PO Box 95, Rootstown, OH 44272-0095; telephone: (330) 325-6125; e-mail: dw@neomed.edu; Twitter: @NEOMEDedu.

Acad Med. XXXX;XX:00–00.
First published online
doi: 10.1097/ACM.0000000000001355

wonders where in the curriculum is a critical examination of these specific events, which are certainly emblematic of the health of communities; and, where, more broadly, is an examination of class bias and racism, especially as they manifest in the culture of medicine?

Of course, one would be hard pressed to find a medical curriculum that does not address health disparities in some manner. Brooks[2] writes of being "inundated with lecture PowerPoint slides that list diseases with higher rates among minorities." But the curriculum rarely focuses on the forces—from individual biases and stereotypes to the myriad societal, cultural, legal, political, and medical structures—that impact health outcomes and, in a broader context, lead to the discrimination and oppression of individuals such as Freddie Gray. How, then, can medical school and clinical faculty create learning spaces and experiences to help students see the next person who appears in the clinic or hospital ward or the emergency department as more than a set of characteristics/demographics or worse, as a social caricature created by deeply embedded stereotypes? How do medical educators create an environment that fosters practicing medicine with excellence and justice? How do faculty nurture a society that embodies such values?

The first step, we believe, is the willingness of educators to examine uncomfortable realities that are exceedingly difficult to confront: the messy landscapes that are America's legacy of racism, brutality, violence, poverty, hopelessness, and despair. Racism and other forms of bigotry have particularly deleterious effects, for they reduce human beings to objects without individuality, agency, or value, and thereby allow debasement and even destruction without moral objection. To effectively address these issues, educators must leave the relative comfort of abstraction, and instead teach and practice *fearlessness*.[3] In this Perspective, we explore theoretical frameworks as well as practical applications as means toward accomplishing this objective. The Perspective contains two major threads. First, we propose a morally just medical curriculum pedagogically oriented from two theoretical positions: antiracist pedagogy and structural competency. Next, we offer specific suggestions that would characterize a curriculum informed by the lessons of Freddie Gray's experiences and aimed at fostering a deeper understanding of societal inequities and social justice. We offer these ideas in the spirit of the #FergusonSyllabus Twitter campaign, which is designed for educators to share ideas on how to talk about Ferguson in their classrooms.[4]

Pedagogical Orientation: Making It Visible

One of the core values in medicine is objectivity. Coupled with objectivity is a reluctance to discuss events, such as the death of Freddie Gray or the shooting of Trayvon Martin, which may be deemed as "too political" for a medical school curriculum. From the basic sciences to evidence-based medicine, medical educators teach the importance of knowledge and critical reasoning; however, critical reasoning, although necessary for providing the best care possible, is by itself insufficient to address social injustice, disparities, and inequities.[5] Curricular attempts to capture issues regarding race and class through the characteristics, individual behaviors, and beliefs typically ascribed to members of particular classes or racial groups are important but, even collectively, represent a limited, and often simplistic, attempt to move students toward "cultural competency." They are simplistic because they ask little of students other than memorizing lists of characteristics of people mostly unlike themselves, or listening to the stories of *individuals*, while rarely addressing the formidable contribution of *institutions* (e.g., lending institutions, public schools) to racism, bias, and exclusion. We have previously argued for going beyond notions of "cultural competency" to consider issues of power and privilege, difference, and identity in fostering a professional self committed to fairness and justice.[6–8] Here we extend our arguments by asking students and faculty to look deeper into themselves, the culture of medicine, and the larger structural contexts in which they (and their patients) live to gain an always-incomplete yet more rigorous and difficult understanding of race and class in the United States. To foster this critical perspective, we must move beyond postures of pseudo-objectivity and adopt such strategies as applying an antiracist pedagogy or exploring structural competency. Below, we describe each strategy individually, recognizing that the two overlap substantially.

Antiracist pedagogy

Faculty who adopt the goals of antiracist pedagogy must first give up the idea of neutrality by explicitly stating that the goal of a class/discussion/group is to "move beyond their comfortable, deeply rooted views of the world."[9] This openness and surrender do not come easily. In fact, the "resistance and emotions which are likely to accompany such pedagogy"—not to mention anger and defensiveness from learners and teachers alike—are difficult for many faculty who are used to more polite, orderly classrooms, even when controversial topics are addressed.[9]

Specifically, antiracist pedagogy "seeks to provide students with the ability to critically reflect on the ways in which oppressive power relations are inscribed in their own lives, as well as the lives of others."[10] This approach stands in sharp opposition to the focus on beliefs, values, and health practices of "others," most often marginalized groups, in a depoliticized way. Such efforts in cultural competency are often accompanied by larger institutional efforts to celebrate diverse cultures without addressing inequalities. These celebrations often come to resemble "cultural safaris"[6] that involve observing the interesting characteristics of "Others" (most often people who are not white, not economically stable, not Judeo-Christian, not able-bodied, and so on) with an attitude of "tolerance," while ignoring "systems of oppression … responsible for the development and perpetuation of health disparities."[10] In contrast, antiracist pedagogy continually attempts to examine issues from multiple standpoints—including the standpoints of the providers themselves—so that systems of power, the systems that create privilege in some people and not others, are made visible.

This pedagogy, of course, necessarily involves an examination of white privilege, the clear preference for whiteness that saturates mainstream U.S. culture, providing advantages to white

people that are unearned and which make them unaware of, if not immune to, many challenges experienced by those who are not white. We note, however, that the discourse of white privilege is not without controversy due to, among other factors, conflicting meanings of whiteness, along with the potential for such discourse to be a distraction from effective action toward racial equality and fairness.[11,12] That said, considerations of how white privilege manifests itself in U.S. culture in general, and in health care in particular, could offer insights to medical students as they consider social justice in medicine. Whiteness is the prevailing racial atmosphere at nearly every medical school in the United States, and "while students of color perceive that constantly, white administrators, faculty members, and students just don't see it."[13] White privilege is, perhaps, a more difficult idea to address in the classroom where any number of white students may cite examples of social and economic struggles experienced by their families (e.g., "My grandfather came to this country with a dollar in his pocket"). Such thinking, however, misses the point entirely: to have struggles even as one has privilege is possible, but white privilege is "the lack of struggle in a very specific and profound aspect of life. It does not mean *no* struggle, just not *that* struggle."[13]

The idea of the unearned, often taken-for-granted privileges that certain groups enjoy is not new. Over a quarter-century ago, Peggy McIntosh[14] examined how her male colleagues were generally unaware of their own privilege as men (even as many of them acknowledged the disadvantages experienced by women), and realized that as a white woman she, too, had an invisible weightless knapsack of unacknowledged privileges that included "special provisions, maps, passports, codebooks, visas, clothes, tools, and blank checks." McIntosh lists 50 of these unspoken advantages from everyday experiences that white people take for granted, such as "I can go shopping most of the time, pretty well assured that I will not be followed or harassed," or "I do not have to educate my children to be aware of systemic racism for their own daily physical protection," or "I can be pretty sure that if I ask to talk to the 'person in charge,' I will be facing a person of my race." Faculty have engaged learners with her essay innumerable times in higher education classrooms across the country, yet rarely in medical education. In fact, a June 2016 PubMed search of the term "white privilege" yielded just 35 entries with only 2 in medicine/medical education, the majority found in the social sciences and nursing. As one educator, Kandaswamy,[15] has aptly noted, "students and teachers do not check their histories at the door when they enter it.… In the classroom, just as in the society in which we live, there are no blank slates or level playing fields for any of us." Antiracist pedagogies attempt to tackle the myth of the blank slate, along with the belief voiced by well-meaning students that they are "color blind" when it comes to caring for patients. Understandably, no one wants to be labeled racist, particularly students entering the medical profession, yet it is essential to design learning experiences that attempt to draw out our conscious and unconscious biases surrounding race and class which get in the way of providing effective and humane health care to all patients—especially given the compelling and consistent evidence that clinician bias is one factor among others that contributes to racial inequities in health care.[16–18]

Structural competency

The idea of "structural competency"—a play on and extension of cultural competency—"emphasizes recognition of the complex ways that matters such as rising income inequalities, decaying infrastructure, poor food distribution networks," among other social and economic factors, lead to poor health.[19,20] This model, developed in large part by Vanderbilt's Center for Medicine, Health and Society director, Jonathan Metzl, promotes looking at forces beyond the patient–doctor interaction:

> We train doctors to listen to individualized stories, not to structural ones. For instance, methods such as cultural competency or narrative analysis teach doctors to better listen to the "cross-cultural" aspects of the stories that their patients tell at moments of clinical encounter.… such approaches … do little to address the complex relationships between clinical symptoms and social, political, and economic systems. We thus argue that medical education needs to more broadly engage with knowledges and methods beyond its traditional purview if it wishes to train its practitioners to effectively address the pressing health issues of our time.[21]

However, our propensity as a culture to look to the individual as the single most important determinant of his or her health gets in the way of structural competency. Such a view suggests that "people's health status is largely within their control through their health behavior choices,"[22] and ignores the fact that social and economic status shapes a person's ability to make healthy choices regarding housing, available food, safe neighborhoods, and the like. This fallacy is the old "bootstraps" belief that individuals are capable of and responsible for simply "pulling themselves up."

A focus on structural competency, however, does not replace an awareness of cultural factors in the clinical setting but, rather, recognizes "how 'culture' and 'structure' are mutually co-implicated in producing stigma and inequality."[21] Metzl and Hansen[21] posit a number of skills and orientations leading to structural competency, including (1) identifying structures that influence clinical encounters; (2) developing understandings of structure from other disciplines such as sociology, urban planning, economics, etc.; (3) recasting case presentations to acknowledge structural barriers to health; (4) developing interventions to address health infrastructures; and, importantly, (5) nurturing a critical awareness of structural humility. The ultimate goal is producing clinicians who "are at once speakers and listeners, leaders and collaborators, experts and benighted."[21]

Below, we offer some specific ideas of how, with these pedagogical orientations in play, medical educators might develop learning experiences focused on the ubiquitous and unjust inequalities that manifest in health.

Remembering Freddie Gray: A Curriculum for Social Justice

In memory of Freddie Gray as an individual and as a symbol of the inequity, brutality, and racism in modern American society, we wish to promote curricular efforts that aspire toward social justice and equity. We provide the following suggestions in response to the injustices of Gray's experiences (and all the injustices that lead to disparities in health, income, schooling, housing, employment, and treatment by public

servants—health care professionals, the courts, and the police alike).

To these ends, antiracist pedagogy and a focus on structural competency are but two approaches to addressing bias in the classroom. Whichever strategy one adopts, it must be one that emphasizes critical reflection and dialogue—preferably in small-group settings—in which issues of power, privilege, identity, and oppression may be safely and productively explored.[6–8] The term "critical reflection" used here is synonymous with "critical consciousness" and entails a questioning of one's own values, perspectives, and assumptions, as well as those of others and of society, in an effort to uncover and address sources of injustice.[23] This approach differs from the traditional lecture-based, PowerPoint-fueled formats of traditional medical education and is meant to be deliberately provocative in order to stimulate discussion and inquiry.

Resources for teaching and learning

Although the content and skills of humanities inquiry have been extolled for nearly half a century in U.S. medical education as a means to improve the patient–physician relationship, here we call on them to "make strange"[24] taken-for-granted beliefs, assumptions, and world views in our "engagement with Otherness."[25] What follows is a brief description of resources from the humanities and bioethics that have been implemented at the Northeast Ohio Medical University (NEOMED).

Literature and written texts. Short stories, poetry, narrative nonfiction, and books are rich sources for the medical educator to examine race- and class-based bias in medicine. Toni Morrison's story "Recitatif,"[26] for example, offers readers a portrait of embodied differences such as race, class, and disability, and it illuminates how multiple identities exist in all of us, such as being white *and* being poor, or being black *and* being wealthy. Neil Calman's[27] "Out of the shadow" is an essay exploring a white inner-city physician's confrontation with his own racial prejudice. Kimberly Manning,[28] writing about the hospital setting, reveals "The Nod"—a "tiny downward head bow" shared among African American people as they pass one another, an "I see you" here in this place where just a few black people are "sprinkled." Manning's essay serves well as a companion to "Urology blues," Ugo Ezenkwele's[29] portrait of his encounters with racist patients while a medical student.

Jonathan Metzl's meticulously researched *Protest Psychosis*[30] (2009) shows how schizophrenia became the diagnostic term overwhelmingly applied to African American men in the 1960s, mirroring how racial tensions seep into medical culture and even shape disease categories. Ta-Nehisi Coates's[31] recent *Between the World and Me*, a six-chapter "letter" to his son explaining what it means to be black in the United States, examines, among many other important issues, "America's ongoing romance with its own unexamined platitudes of innocence and equality."[32]

Film. Film offers a rich source of representations of race and racism. Written and directed by Paul Haggis, *Crash* (2004) illuminates how racism arises and is enacted in multiple and contradictory ways, even in those who deny its existence in themselves. *Precious,* Lee Daniels's 2009 film, is a disturbing portrait of a young woman whose predicaments arise at the intersection of race, poverty, and violence, dispelling any mythology of a level playing field. Peter Nicks's documentary *The Waiting Room* (2012) offers viewers an intense look, over a 24-hour period, at an overstretched ER in Oakland, California, in which individuals without financial and health care resources appear routinely.

Bioethics. Bioethics inquiry is fertile ground for exploration of race- and class-based issues in health care. Discussions of narrative ethics and narrative medicine through readings such as Arthur Frank's "How can they act like that?"[33] challenge students to reflect on their own stores in relation to the stories of others. Likewise, short stories written by physicians that speak to poverty and aloneness (Jay Baruch's "Hug or ugh?"[34]) or to aversion (Irvin Yalom's "Fat lady"[35]) challenge students to feel discomfort as they confront inequities in health care, some even at the individual physician level. In addition, a bioethics curriculum, including material on eugenics, the Holocaust, and modern genetics, can address historical and contemporary examples of racism and the contributions of medicine and science to privileged systems of power.

All of the aforementioned types of teaching resources are used across the four-year course, Human Values in Medicine, at NEOMED, and are specifically applied in the reflective practice component of that course. In this component, students assemble in small groups, with clinical, social sciences, and humanities faculty preceptors, and engage in reflective writing and group discussion stimulated by assigned materials such as those described above. We have previously described the benefits of these teaching approaches: to teach and foster deep and meaningful reflection[36]; to slow down the medical education process, allowing for a richer and more productive critical self-examination and more profound professional identity development[37]; and to demonstrate the numerous ways that stories, read closely, can broaden perspectives toward others.[38] While we recognize that physicians often see the exploration of such literature as a "soft science," we agree with Kathryn Montgomery, who observes that "the profession that scorns the anecdotal is in fact up to its ears in stories, using them to educate, to suggest the uncertainty of today's fact."[39]

Clinical and community experiences

In clinical settings medical educators have vast untapped curricular options when it comes to addressing the lived realities of patients from economically disadvantaged backgrounds who are often from racial minorities and/or who often reside in overwhelmingly poor neighborhoods. Although we are careful not to conflate poverty and race, we nonetheless proceed with the knowledge that many devastatingly poor communities have high concentrations of black residents—like that of Freddie Gray, the Sandtown-Winchester neighborhood in West Baltimore, where 96.9% of the population is black.[40] Spending an afternoon or two in Freddie Gray's neighborhood clinic would hardly begin to reveal the depth and breadth of issues that bear on the patients who typically seek care there or in places like it. For many students, such drop-in visits amount to little more than a kind of "safari,"[6] a "drive-by" providing them little insight into the lives of patients whose health issues arise from myriad

factors long before they even arrive at the clinic. In fact, such visits not only fail to address structural racism, but, given "a topic so complex," such "transient exposure is unlikely to optimally prepare students" to care effectively for such patients.[41] Medical educators are beginning to realize that greater exposure is necessary, and a number of medical schools currently offer experiences that far exceed such curricular drop-ins, including urban pathways and electives embedded within core clerkships.[42,43]

NEOMED offers clinical curriculum experiences that illuminate how structures and elements outside the sterile bubble of the hospital largely influence the health of individuals and communities. With guidance, students who actively engage with people living in impoverished communities and cities begin to ascertain the predominant health problems as well as the structural impediments to good health, and they learn to "triage" resources in order to effect improvement in these settings. For example, NEOMED students, working closely with community health workers to study specific health issues, recently became focused on infant mortality. This public health issue, identified not from lectures or textbooks or preexisting community assessments but through interaction with community stakeholders, was particularly relevant in this community where the 2012 infant mortality rate for African American babies was 19.69 per 1,000 live births,[44] compared with the U.S. African American rate of 11.19, and compared with the overall U.S. infant mortality rate of 5.98.[45]

Using the Centers for Disease Control and Prevention's Racial and Ethnic Approaches to Community Health model,[46] these medical students helped to create centering pregnancy groups at two hospitals. Each group focused not only on tending to the physical health of the mother and baby but also on providing a social nucleus of support for each woman. Previous research has shown that such support systems reduce poor pregnancy outcomes and improve child health.[47–49]

The very act of placing students into communities and societies where health care disparities exist—although potentially important to the development of a critical perspective—is *by itself* insufficient. Attitudes such as the belief that one is importing "better" or "more advanced" knowledge or practices (clinical, educational, or otherwise) to "the ignorant" or "less developed" threaten to evolve into a smugness and hegemony that may lead to an "us" doing for "them" mentality that does little to foster partnerships in health.[43,50–52] Thus, taking the time to engage students in critical reflection on such issues is imperative.

Conclusions

In applying the principles of antiracist pedagogy and structural competency to medical education, faculty members must resist the temptation to avoid explicit discussion of topics that are not directly related to health care. For example, a reaction to a proposal by one of us (A.K.K.) to use the movie *Crash* for faculty development in multicultural pedagogy was met with the objection, "but this has nothing to do with health care." We would argue that, in order to understand and address the attitudes, biases, and assumptions that shape the interactions among patients and health care professionals and the health care system in which they are all immersed, exploring race relations in a larger societal context has *everything* to do with health care.

Of paramount importance to implementing a curriculum for social justice, then, is the question, "Who teaches the teachers?" Good will and good intentions alone are insufficient to meet the educational challenges inherent in confronting race, power, privilege, and identity. Good intentions must be accompanied by the skills needed to facilitate open dialogue, preserve safety, and address conflicts—not in order to achieve "conflict resolution," but in order to place one's own and others' views and assumptions into the open and to allow questioning so that all may achieve new perspectives, insights, and understanding.

We—faculty and students—are in this quest together, trying to understand how equitable access to skilled and respectful health care is often denied, how we and the institutions where we work and learn are complicit in this reality in ways known and unknown to us, and how we can work toward eliminating the injustices Freddie Gray and others like him have endured. To gain understanding and eliminate injustice is not easy; it involves difficult conversations and startling revelations. It involves cultivating cultural humility— before even talking about cultural competency. This humility is part and parcel of what Megan Boler would call a "pedagogy of discomfort," through which "we invite one another to risk 'living at the edge of our skin,' where we find the greatest hope of revisioning ourselves."[53] It is, in the words of Paulo Freire,[23] "an education for liberation"—from poverty, injustice, and oppression.

Funding/Support: None reported.

Other disclosures: None reported.

Ethical approval: Reported as not applicable.

D. Wear is professor, Family and Community Medicine, Northeast Ohio Medical University, Rootstown, Ohio.

J. Zarconi is professor and chair, Internal Medicine, Northeast Ohio Medical University, Rootstown, Ohio.

J.M. Aultman is professor, Family and Community Medicine, Northeast Ohio Medical University, Rootstown, Ohio.

M.R. Chyatte is assistant professor, Family and Community Medicine, Northeast Ohio Medical University, Rootstown, Ohio.

A.K. Kumagai is professor of medicine and vice chair for education, University of Toronto Department of Medicine, Toronto, Ontario, Canada.

References

1 Association of American Medical Colleges. Matriculating student questionnaire. 2014 all schools summary report. https://www.aamc.org/download/419782/data/msq2014report.pdf. Published December 2014. Accessed June 25, 2016.
2 Brooks KC. A silent curriculum. JAMA. 2015;313:1909–1910.
3 Wear D, Zarconi J, Dhillon N. Teaching fearlessness: A manifesto. Educ Health (Abingdon). 2011;24:668.
4 Georgetown College. The #Ferguson syllabus. http://college.georgetown.edu/Collegenews/the-ferguson-syllabus.html. Published August 27, 2014. Accessed June 25, 2016.
5 Kumagai AK. From competencies to human interests: Ways of knowing and understanding in medical education. Acad Med. 2014;89:978–983.
6 Wear D. Insurgent multiculturalism: Rethinking how and why we teach culture in medical education. Acad Med. 2003;78:549–554.
7 Kumagai AK, Lypson ML. Beyond cultural competence: Critical consciousness, social justice, and multicultural education. Acad Med. 2009;84:782–787.
8 Wear D, Kumagai AK, Varley J, Zarconi J. Cultural competency 2.0: Exploring the

concept of "difference" in engagement with the other. Acad Med. 2012;87:752–758.
9 Wagner AE. Unsettling the academy: Working through the challenges of anti-racist pedagogy. Race Ethnic Educ. 2005;8:261–275.
10 Hassouneh D. Anti-racist pedagogy: Challenges faced by faculty of color in predominantly white schools of nursing. J Nurs Educ. 2006;45:255–262.
11 Gordon LR. Critical reflections on three popular tropes in the study of whiteness. In: Yancy G, ed. What White Looks Like: African-American Philosophers on the Whiteness Question. New York, NY: Routledge; 2004.
12 Zack N. White Privilege and Black Rights: The Injustice of U.S. Police Racial Profiling and Homicide. Lanham, MD: Rowman and Littlefield; 2015.
13 Kolowich S. White like you: The challenge of getting white students to grapple with racial identity. Chron High Educ. May 29, 2015. http://chronicle.com/article/White-Like-You-The-Challenge/230509. Accessed June 25, 2016.
14 McIntosh P. White privilege: Unpacking the invisible knapsack. Peace Freedom Mag. July/August 1989. http://nationalseedproject.org/white-privilege-unpacking-the-invisible-knapsack. Accessed June 25, 2016.
15 Kandaswamy P. Beyond colorblindness and multiculturalism: Rethinking anti-racist pedagogy in the university classroom. Radical Teach. 2008;80:6–11.
16 van Ryn M, Burke J. The effect of patient race and socio-economic status on physicians' perceptions of patients. Soc Sci Med. 2000;50:813–828.
17 Fincher C, Williams JE, MacLean V, Allison JJ, Kiefe CI, Canto J. Racial disparities in coronary heart disease: A sociological view of the medical literature on physician bias. Ethn Dis. 2004;14:360–371.
18 van Ryn M, Burgess DJ, Dovidio JF, et al. The impact of racism on clinician cognition, behavior, and clinical decision making. Du Bois Rev. 2011;8:199–218.
19 Metzl J. The case for structural competency. Nashville Post. June 30, 2014. http://www.nashvillepost.com/home/article/20477276/the-case-for-structural-competency. Accessed June 25, 2016.
20 Metzl JM, Roberts DE. Structural competency meets structural racism: Race, politics, and the structure of medical knowledge. AMA J Ethics. 2014;16:674–690. http://journalofethics.ama-assn.org/2014/09/spec1-1409.html. Accessed June 25, 2016.
21 Metzl JM, Hansen H. Structural competency: Theorizing a new medical engagement with stigma and inequality. Soc Sci Med. 2014;103:126–133.
22 Niederdeppe J, Bu QL, Borah P, Kindig DA, Robert SA. Message design strategies to raise public awareness of social determinants of health and population health disparities. Milbank Q. 2008;86:481–513. http://onlinelibrary.wiley.com/doi/10.1111/j.1468-0009.2008.00530.x/full#b76. Accessed June 25, 2016.
23 Freire P. Pedagogy of the Oppressed. Ramos MB, trans. New rev 20th anniversary ed. New York, NY: Continuum; 1993.
24 Kumagai AK, Wear D. "Making strange": A role for the humanities in medical education. Acad Med. 2014;89:973–977.
25 Dalos LAP. Transformative learning for the common good. In: Mezirow J, ed. Learning as Transformation: Critical Perspectives on a Theory in Progress. San Francisco, CA: Jossey-Bass; 2000:103–123.
26 Morrison T. Recitatif. In: Baraka A (LJ), Baraka A, eds. Confirmation: An Anthology of African American Women. New York, NY: Quill; 1983:243–261.
27 Calman NS. Out of the shadow. Health Aff (Millwood). 2000;19:170–174.
28 Manning K. A piece of my mind: The nod. J Am Med Assoc. 2014;312:133–134.
29 Ezenkwele UA. Urology blues. In: Takakuwa KM, Rubashkin N, Herzig KE, eds. What I Learned in Medical School: Personal Stories of Young Doctors. Berkeley, CA: University of California Press; 2004.
30 Metzl J. The Protest Psychosis: How Schizophrenia Became a Black Disease. Boston, MA: Beacon Press; 2009.
31 Coates T-N. Between the World and Me. New York, NY: Spiegel & Grau; 2015.
32 Hamilton J. Between the world and me. Slate Book Rev. http://www.slate.com/articles/arts/books/2015/07/between_the_world_and_me_by_ta_nehisi_coates_reviewed.html. Accessed June 25, 2016.
33 Frank AW. "How can they act like that?" Clinicians and patients as characters in each other's stories. Hastings Cent Rep. 2002;32:14–22.
34 Baruch J. Hug or ugh? Hastings Cent Rep. 2010;40:7–8.
35 Yalom ID. Fat lady. In: Yalom ID. Love's Executioner and Other Tales of Psychotherapy. New York, NY: Basic Books; 1989.
36 Wear D, Zarconi J, Garden R, Jones T. Reflection in/and writing: Pedagogy and practice in medical education. Acad Med. 2012;87:603–609.
37 Wear D, Zarconi J, Kumagai A, Cole-Kelly K. Slow medical education. Acad Med. 2015;90:289–293.
38 Blackie M, Wear D. Three things to do with stories: Using literature in medical, health professions, and interprofessional education. Acad Med. 2015;90:1309–1313.
39 Hunter KM. Literature and medicine: Standards for applied literature. In: Callahan D, Caplan AL, Jennings B, eds. Applying the Humanities. Hastings-on-Hudson, NY: Hastings Center; 1985.
40 Baltimore City Health Department. 2011 neighborhood health profile: Sandtown-Winchester/Harlem Park. http://health.baltimorecity.gov/sites/default/files/47%20Sandtown.pdf. Published December 2011. Accessed June 26, 2016.
41 Doran KM, Kirley K, Barnosky AR, Williams JC, Cheng JE. Developing a novel Poverty in Healthcare curriculum for medical students at the University of Michigan Medical School. Acad Med. 2008;83:5–13.
42 Ford-Jones L, Levin L, Schneider R, Daneman D; Social Pediatrics Working Group. A new social pediatrics elective—A tool for moving to life course developmental health. J Pediatr. 2012;160:357–358.e2.
43 van den Heuvel M, Au H, Levin L, Bernstein S, Ford-Jones E, Martimianakis MA. Evaluation of a social pediatrics elective: Transforming students' perspective through reflection. Clin Pediatr (Phila). 2014;53:549–555.
44 Ohio Department of Health, Office of Vital Statistics. Neonatal, postnatal, and infant mortality, Ohio and selected counties, 2007–2012. https://www.odh.ohio.gov/~/media/ODH/ASSETS/Files/cfhs/Infant%20Mortality/collaborative/2014/2007–2012%20IM%20BY%20RACE%20%20COUNTY.pdf. Accessed July 12, 2016.
45 Matthews TJ, MacDorman MF, Thoma ME. Infant mortality statistics from the 2013 period linked birth/infant death data set. Natl Vital Stat Rep. 2015;64:1–30. http://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_09.pdf. Accessed July 12, 2016.
46 Centers for Disease Control and Prevention. Racial and ethnic approaches to community health. http://www.cdc.gov/nccdphp/dch/programs/reach/. Reviewed and updated November 4, 2015. Accessed June 25, 2016.
47 Olds DL, Kitzman H. Can home visitation improve the health of women and children at environmental risk? Pediatrics. 1990;86:108–116.
48 Penny ME, Creed-Kanashiro HM, Robert RC, Narro MR, Caulfield LE, Black RE. Effectiveness of an educational intervention delivered through the health services to improve nutrition in young children: A cluster-randomised controlled trial. Lancet. 2005;365:1863–1872.
49 Barnes-Boyd C, Fordham Norr K, Nacion KW. Promoting infant health through home visiting by a nurse-managed community worker team. Public Health Nurs. 2001;18:225–235.
50 Bleakley A, Brice J, Bligh J. Thinking the post-colonial in medical education. Med Educ. 2008;42:266–270.
51 Hodges BD, Maniate JM, Martimianakis MA, Alsuwaidan M, Segouin C. Cracks and crevices: Globalization discourse and medical education. Med Teach. 2009;31:910–917.
52 Abedini NC, Gruppen LD, Kolars JC, Kumagai AK. Understanding the effects of short-term international service-learning trips on medical students. Acad Med. 2012;87:820–828.
53 Boler M. Feeling Power: Emotions and Education. New York, NY: Routledge; 1999.