



VCU

Virginia Commonwealth University
VCU Scholars Compass

Publications from the Office of the Senior Vice
President for Health Sciences

Office of the Senior Vice President for Health
Sciences

2020

Centering Health Equity and Structural Racism in Health Sciences Curriculum

Lynn E. Pelco

Virginia Commonwealth University, lepelco@vcu.edu

Kevin A. Harris

Virginia Commonwealth University, kaharris@vcu.edu

Carolyn Watts

Virginia Commonwealth University, cwatts2@vcu.edu

Lisa B. Webb

Virginia Commonwealth University, lbwebb@vcu.edu

Follow this and additional works at: https://scholarscompass.vcu.edu/healthsciences_pubs



Part of the [Medicine and Health Sciences Commons](#)

Recommended Citation

Pelco, L. E., Harris, K.A., Watts, C. A., & Webb, L. B. (2020). Centering Health Equity and Structural Racism in Health Sciences Curriculum. Richmond, VA: Office of the Senior Vice President for Health Sciences, Virginia Commonwealth University.

This Research Report is brought to you for free and open access by the Office of the Senior Vice President for Health Sciences at VCU Scholars Compass. It has been accepted for inclusion in Publications from the Office of the Senior Vice President for Health Sciences by an authorized administrator of VCU Scholars Compass. For more information, please contact libcompass@vcu.edu.



CENTERING HEALTH EQUITY AND STRUCTURAL RACISM IN HEALTH SCIENCES CURRICULUM

A report from the VCU Office of the Senior Vice
President for Health Sciences

November 2020

Contributing Authors:

LYNN E. PELCO, PHD

Associate Vice Provost for Community Engagement
Director, Service-Learning Office
Center for Community Engagement and Impact

KEVIN A. HARRIS, PHD, MSA

Associate Vice President for Strategic Initiatives and Engagement
Office of the Senior Vice President for Health Sciences

Interim Senior Associate Dean for Diversity, Equity, and Inclusion
School of Medicine

CINDY (CAROLYN) A. WATTS, PHD

Professor, Department of Health Administration
College of Health Professions

LISA B. WEBB, EDD, CRC

Assistant Vice President for Health Sciences Education
Office of the Senior Vice President for Health Sciences

Additional Contributors:

LOGAN VETROVEC, M.ED.

Director, Campus and Community Partnerships
Director, Student Experience
Office of the Senior Vice President for Health Sciences

ANNE MASSEY, MSW

Director, Health Equity and Sponsored Projects
Office of Health Innovation

PRIYADARSHINI PATTATH, PHD

Research Assistant
Office of the Vice President for Health Sciences

Inquiries about this report can be directed to
Dr. Kevin Harris at kaharris@vcu.edu

For information on the faculty development program contact
Dr. Lisa Webb at lwebb@vcu.edu

For information on student development initiatives contact
Logan Vetovec at lavetovec@vcu.edu

CENTERING HEALTH EQUITY AND STRUCTURAL RACISM IN HEALTH SCIENCES CURRICULUM

Health professionals in the United States face two interconnected national challenges: the COVID-19 outbreak and structural racism. Understanding the relationships between these two challenges is a critical first step towards finding solutions for both. This paper presents a proposal for centering racial justice in health care through the implementation of a comprehensive plan for health equity education that engages students, faculty, staff, and the community.

In this paper, we first overview scientific evidence and some of the local history related to structural racism and health disparities. We then describe the recent demands for racial justice and curriculum transformation that have been made by VCU health sciences students, faculty and community members as well as the action steps VCU has taken to address these demands. The paper concludes by calling on VCU health sciences faculty members to take action in the following three ways: (a) by participating in professional conversations about the intersections of health equity, structural racism, and health sciences education, (b) by familiarizing themselves with available institutional resources for creating inclusive and social justice oriented curriculum and learning environments, and (c) by considering participation in new systemic racism and implicit bias faculty learning communities developed and offered by the VCU Office of the Senior Vice President for Health Sciences.

THE SCIENCE AND HISTORY OF HEALTH DISPARITIES

Structural racism, both historic and contemporary, creates and maintains racial disparities. Racial disparities directly and indirectly cause documented differences in health outcomes, including infant mortality and life expectancy. The differences in health outcomes also generate significant excess costs for the health care system, the business community, and ultimately society as a whole.

The Aspen Institute (2016) defines structural racism as “a system in which public policies, institutional practices, cultural representations, and other norms work in various, often reinforcing ways to perpetuate racial group inequity.” It is rooted in history but is still very alive in many areas of the United States. It creates and maintains environments that directly and indirectly contribute to health disparities. Residential segregation, initially fueled by discriminatory federal, state, and local banking and zoning laws, is maintained by contemporary banking practices even as laws have changed. Discriminatory mortgage lending practices common in the 1930s were outlawed by the Fair Housing Act of 1968. However, a new study demonstrates that three out of four neighborhoods that were [redlined](#) on government maps continue to struggle economically eighty years later (Jan, 2018). Further, “redlining” of minority communities persists. According to Derek Robinson, Vice President and Chief Medical Officer of

Blue Cross/Blue Shield of Illinois, for every \$1 loaned in predominantly white neighborhoods in recent years, \$0.12 was loaned in predominantly Black neighborhoods (Blue Cross, 2020). In 2020, the racial gap in home ownership, a primary source of wealth building and inter-generational wealth transfer for families, is greater than in the Jim Crow era (Glantz et al., 2018).

Anthony Iton, Senior Vice President for Healthy Communities at The California Endowment, has stated, “When it comes to health, your zip code matters more than your genetic code” (Healthy Chicago, 2020). In Chicago, for example, there is a 30-year gap in life expectancy between two communities that are nine miles apart. In predominantly white Streeterville, life expectancy is 90. Nine miles away in Englewood, a predominantly Black community, that figure is 60. While highest in Chicago, a race-related gap in life expectancy is common across the country. In Washington, DC and New York City, it is 27.5 years; in New Orleans and Buffalo, it is 25.8 years (Chicago Sun Times, 2019). Even in prosperous Northern Virginia, VCU researchers found differences in life expectancy of up to 10 years between Northern Virginia communities less than five miles apart with significantly different racial profiles. In 2015 in Richmond, life expectancy was 83 years in Westover Hills; 5.5 miles away in Gilpin, life expectancy was 20 years less at 63 years. In Swansboro, 2.8 miles from Westover Hills, life expectancy is 69 years. The researchers also found large differences in education, poverty, and health insurance (Woolf et al, 2017). Segregation of minority populations into under-resourced communities is linked to a number of conditions that foster poor health outcomes, including:

- Limited access to healthy food
- Higher rates of crime and violence
- More sources of environmental toxins
- More urban heat islands
- Fewer libraries and parks
- Under-resourced schools
- Inadequate transportation systems
- Fewer health care facilities and less resources for those that exist
- Fewer employment opportunities
- Higher rates of poverty

Documentation of racial disparities in health outcomes is abundant. The U.S. Centers for Disease Control reports pregnancy-related mortality rates three times higher for Black women than White women. Preterm births are 1.5 times more likely for Black infants, and Black infants are twice as likely to be of low birthweight (Mehra et al, 2019). While heart disease, breast cancer, and stroke mortality have been decreasing for all adults since 1990, the gap between the rates for Black and white adults had increased by 2005. Although the incidence of breast cancer was lower in Black women than in White women, the 5-year survival rate between 2009 and 2012 was 80% for Black women and 90% for White women. Racial disparities exist across other races and other diseases.

The COVID-19 pandemic has both highlighted and exacerbated racial health disparities. Members of minority populations are more likely to hold essential front-line positions in health care, food service, and retail industries where exposure and incidence is higher. These jobs are more likely to be lower paid and have fewer unemployment, sick leave, and insurance benefits. Individuals in these populations are also more likely to be reliant on public transportation and live in crowded conditions, increasing the likelihood of exposure (Centers for Disease Control, 2020). Nationally, the rate of infection in the Black population is higher than its share of the total population. In four states, it is three or more times greater (Godoy et al., 2020). In 42 states and DC, the LatinX population has been disproportionately infected by the virus. In eight states, it is four times higher than expected. The higher prevalence of obesity and other chronic conditions such as asthma as well as less physical and financial access to well-resourced health care facilities contribute to worse outcomes and higher mortality rates from the virus among minority populations. The age-adjusted mortality rate in the Black population is 3.7 times that of the white population; for Latinos, that figure is 2.8 (APM, 2020). In addition to the moral and ethical reasons why these differences matter, health disparities are expensive. Excess health care expenditures generated by racial health disparities are estimated to cost the US \$35 billion annually. Associated excess losses in productivity because of illness costs \$10 billion per year, and the cost of disparity-related premature death adds another \$200 billion per year (Ayanian, 2015).

VCU, MEDICAL EDUCATION AND HEALTH DISPARITIES

As in other parts of the country, racist practices have played a role in the history of both Richmond and VCU. Like many organizations established in the mid-1800s, the Medical College of Virginia (MCV) practiced discrimination against non-white citizens. In 1994, for example, construction workers digging the foundation for the VCU Kontos medical research building on East Marshall Street found human remains and other artifacts in what was later determined to be a well. Scientists at the Smithsonian National Museum of Natural History in Washington, D.C. identified the human remains as having belonged to people primarily of African or African American ancestry, and the well's contents are now believed to have been discarded in the 1800s by MCV medical staff (Koste, 2012). The discovery of these human remains did not receive widespread public attention until almost 20 years later when awareness of the well's history was included in Dr. Shawn Utsey's 2011 film, *Until the Well Runs Dry*, a documentary that examined the issue of grave robbing and use of illicitly-obtained black cadavers in medical education during the 19th century. Public awareness of these African and African American human remains led to a community-driven, multi-year process of identification, internment, and memorialization under the auspices of the East Marshall Street Well Project.

After the Civil War, few hospitals in Richmond provided medical treatment for Black Americans. In 1920, MCV opened [St. Philip Hospital](#) to serve Black citizens, and the hospital included a school of nursing for Black women. Overcrowding at St. Philip Hospital was common,

and a 1959 MCV report concluded, “Hospital facilities for Negro patients are not yet adequate” (Dabney, 1987).

During the Jim Crow era of the mid-20th Century, Black citizens continued to experience differential medical treatment throughout the United States. In his book, *The Organ Thieves*, author Chip Jones describes one incident that occurred at MCV in the late 1960s. In May 1968, VCU surgeons performed the first heart transplant in Virginia. Mr. Bruce Tucker, a 53-year-old African American, arrived at the MCV hospital having suffered a head injury as the result of a fall (Washington, 2020). By the time Mr. Tucker’s family arrived at the hospital, Mr. Tucker had died. The following day a funeral director notified the family that Mr. Tucker’s remains were missing both the heart and kidneys. VCU surgeons had implanted Mr. Tucker’s heart into a 54-year old white man. Virginia law during this period required a waiting period of 24 hours between the pronouncement of the death and a declaration of abandonment. VCU was in violation of this statute; however, the surgeons introduced a new concept of “brain dead” to justify their actions and meet the 24-hour waiting period. A subsequent legal proceeding found the hospital not guilty (Washington, 2020). Nevertheless, Mr. Tucker’s fate aligned with stories that had circulated among Richmond’s African American communities for decades regarding MCV’s, now VCU’s, use of African American cadavers for research (Koste, 2012).

NATIONAL, STATE AND LOCAL DEMANDS FOR RACIAL JUSTICE

Decades of structural racism, both before and since Mr. Tucker’s death, have led to organized and ongoing calls for racial justice across the country and in Richmond. The U.S. experience with racial and civil unrest reveals that African Americans and their allies have an extensive record of getting into “good, necessary trouble” on behalf of advancing racial equality. This record includes the Abolitionists Movement, the Civil Rights Movement of the 1950’s and 1960s (e.g, the 1955 Montgomery Bus Boycott, the 1963 March on Washington, the 1965 March Across the Edmond Pettus Bridge), and sentinel events across decades seeking justice in law enforcement (the 1965 Watts Riots, the 1992 Los Angeles protest of Rodney King’s beating, and the 2020 protests of the police-involved death of George Floyd). While the contextual factors of U.S. civil unrest have differed, there has been a consistent call threaded through this history for justice, equality, respect, change, and acknowledgement of a kinship in humanity.

When the 2019 novel coronavirus (2019-nCoV) reached Richmond in March 2020, it found a city and public university struggling to work together to acknowledge and confront racism and other forms of discrimination that had shaped their joint histories. Student protests during the spring of 2019 demanded that VCU leaders address discriminatory practices on campus against racial and sexual minorities. City protests called for the removal of Confederate monuments that had been erected during the Jim Crow era to intimidate African American citizens and to keep neighborhoods segregated. During the Spring and Summer of 2020, Richmond experienced multiple days and nights of primarily peaceful protests for racial justice,

although several of these protests involved physical altercations between armed police and citizen protesters and some property vandalism by protesters.

Today's protests, in Richmond and around the country, are in some ways distinct compared to the insurrections, protests, boycotts, riots, and civil disobedience of the past. The cross currents of a COVID-19 pandemic and the economic and financial uncertainties associated with that pandemic have potentially intensified pent-up demand for racial equality and justice (Amedee et al, 2020). Citizens' attention may now be more focused on current events as the pandemic has forced individuals to be less mobile. Protests around the country calling for societal change have persisted throughout the entire year with no clearly visible end in sight.

The pace and impact of equity-focused change at VCU is currently being fueled by the compelling voices of VCU students, faculty, staff, and community members who are calling for VCU to own its history of racial and other forms of discrimination. During the spring of 2020, those voices provided prescriptive treatises for advancing VCU toward a more inclusive and fair working and learning environment. One of the most compelling calls for change came in June 2020 in the form of a petition presented to the VCU School of Medicine leadership from an assembly of more than 600 co-signees self-identifying as the VCU Anti-Racism in Medicine Collective. Also in June 2020, students in the VCU School of Dentistry called for more diligence from the School of Dentistry leadership and faculty in advancing diversity and inclusion, and students in the VCU School of Nursing presented the School of Nursing administrative leadership with a letter outlining avenues for enhancing the student experience and strengthening curriculum. These petitions and letters are included in Appendix I along with recent a description of actions taken by VCU to address these calls for racial justice.

CENTERING HEALTH EQUITY AND STRUCTURAL RACISM IN HEALTH SCIENCES CURRICULUM

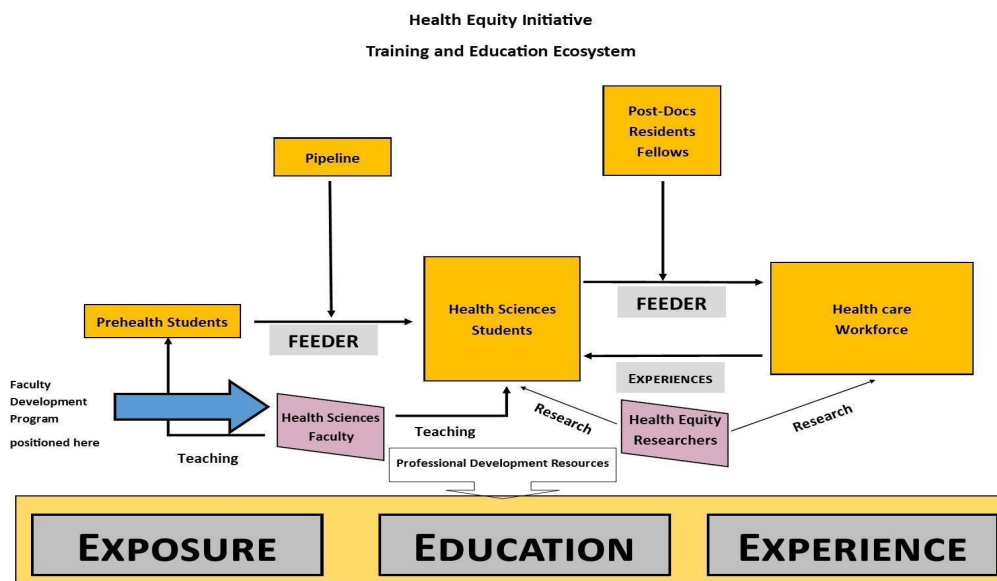
One important starting point for achieving racial equity in health outcomes is a critical examination and transformation of health sciences curricula in order to address issues of structural racism and the impact of implicit bias on content creation and delivery (Metzl et al., 2018). To prepare future health professionals for the equitable delivery of health care, universities must significantly transform their health sciences curriculum. All major accrediting bodies for health sciences education acknowledge the need for curriculum transformation in response to current social justice issues across the country and the COVID-19 pandemic. These organizations acknowledge the need to address systemic racism and the role of implicit bias in the curricula, improve education about health service delivery to diverse patient populations, and increase the diversity of health care providers graduating from health sciences programs. The [White Coats 4 Black Lives](#) movement advocates for a national curricular shift that includes specific strategies for

eliminating structural racism in the delivery of healthcare. In 2020, VCU health sciences students are advocating for these same changes.

It is important to acknowledge here that discrimination against other patient groups beyond Black Americans exists, is structural, and negatively affects health outcomes for those groups. Intersections between race and these other group identities (e.g., gender and sexuality) only deepen the impact of discrimination on health outcomes for many people. We believe that structural racism against Black community members in Richmond and at VCU provides a critical starting point for this conversation that will lead to conversations about intersectionality and structural discrimination beyond racism.

Given both national and local calls for racial justice in health sciences education, VCU has moved decisively forward with specific actions. In 2020, the Office of the Senior Vice President for Health Sciences launched an MCV Campus initiative called the *MCV Campus Diversity, Equity, and Inclusion Action Framework (DEI Action Framework)* to engage stakeholders in ongoing dialogue that leads to actionable steps for addressing individual and systemic racism on the campus and in the curriculum. A key initiative in the DEI Action Framework is the creation of a faculty development program as part of a comprehensive *Health Equity Training and Education Ecosystem* (see Figure 1). This ecosystem integrates health equity and DEI efforts to build anti-racism pedagogies across all health sciences education programs. The merger of health equity and diversity resonates intuitively, but requires intentional ideation, conceptualization, and implementation.

Figure 1: Health Equity Training and Education Ecosystem



ACTION STEPS FOR HEALTH SCIENCES FACULTY MEMBERS

FACULTY CONVERSATIONS.

This paper seeks to spark widespread conversation among VCU's health sciences faculty about the intersection of health equity, structural racism and health sciences education. Faculty members across the health professions rarely have opportunities to discuss the impact of structural racism on health outcomes. Local examples of these impacts, like the ones presented in this paper, can help connect national and global conversations with lived community experiences. The authors of this paper believe that these faculty conversations are the first step towards realizing the comprehensive health sciences curriculum revisions described in the section above.

The faculty conversations we hope this paper inspires are both public and private. Public conversations among faculty members within and across health sciences disciplines and sub-specialties can focus productively in two key areas:

- Identifying and diminishing the impact of structural racism within the discipline across time, and,
- Studying the discipline's current educational curriculum to understand how it does and does not address the history of structural racism and its resulting health outcomes disparities.

For these public conversations to remain authentic and engaging, it is important for individual faculty members to engage in ongoing self-reflection. Private introspection helps to deepen the self-awareness we need to navigate topics that, at times, can feel threatening or emotional. Private conversations with a trusted colleague can focus productively in two key areas:

- Exploring our own personal histories with and understanding of structural racism, including what we learned or experienced in the arc of our own formal education, and,
- Discovering the important spaces in our own teaching where past or current structural racism exists and affects health outcomes but is not reflected in educational content.

FACULTY LEARNING COMMUNITIES: SYSTEMIC RACISM AND IMPLICIT BIAS.

Beginning in Fall 2020, the VCU Office of the Senior Vice President for Health Sciences began hosting a 6-week learning community program for health sciences faculty members. Faculty members who participate in these learning communities will meet via Zoom for 2 hours each week. During those meetings, expert facilitators will guide participants in addressing systemic racism and implicit bias in their teaching and curriculum. During Spring 2021, each learning community will meet monthly in facilitated sessions designed to reflect on the changes implemented in their course and provide feedback and peer support to one another. New faculty

cohorts will begin in the Spring of 2021. We provide additional details related to this learning community opportunity in Appendix 2.

ADDITIONAL FACULTY RESOURCES.

A number of resources and professional development opportunities exist at VCU to assist faculty members in creating inclusive and social justice oriented curriculum and learning environments. These include, for example:

- VCU Center for Teaching and Learning Excellence (CTLE) provides a variety of resources designed to help faculty develop [inclusive teaching and learning](#) environments.
- VCU Office of the Provost offers professional development through the [Recruitment Inclusive Champions \(RIC\)](#), a program that is designed to help bring the most talented and diverse faculty to VCU. The RIC program strengthens VCU's faculty and staff recruitment efforts by building cohorts of knowledgeable champions from units across the university who have completed a comprehensive learning experience. RICs serve as consultants, resources, and advisors to the search committee and help to support the search process to ensure that a robust, diverse set of qualified candidates are being considered.
- VCU Center for Interprofessional Education and Collaborative Care offers the [Health Professions Faculty Development Initiative](#), a faculty development program designed to enhance teaching across the VCU Health Sciences campus. The program was developed in 2019 to support faculty development in teaching behaviors and to develop a model for effective teaching in an interprofessional setting.
- [VCU IExcel Education](#) is a course and program compendium that is invested in cultivating a university environment that is empowering, fair and supportive for all. IExcel courses (available upon request) help faculty increase their awareness of diversity and inclusion, learn about the impact of social identities on relationships, and improve their confidence and ability to build inclusive learning environments.

CONCLUSION

“Students need specific knowledge, skills, and attitudes in order to have the ability to influence the worlds in which they live. They need knowledge of their social, political, and economic worlds, the skills to influence their environments, and humane values that will motivate them to participate in social change to help create a more just society and world” (Banks, 1991, p. 125).

The future of health sciences education at VCU rests largely in the hands of its faculty community. In that regard, a fair question from a faculty member's perspective is whether the propositions of this paper diminish faculty autonomy or create a slippery slope toward the erosion of academic freedom. After all, faculty generally value their teaching and their courses as salient aspects of their identity. Moreover, faculty may ask to what end VCU is directing this effort. These questions are not barriers to the recommendations for transforming the curriculum

that are called for in this paper. Rather, we believe they ultimately enrich exploration of this faculty development initiative. Faculty are, in essence, learners. In sharing this kinship with students, faculty must also employ reflective practices as a part of their teaching. (Kumagai et al, 2009). The end game in doing so is no less than the establishment of legitimacy among learners and their peers and the achievement of measurable equity in health outcomes.

VCU is located in the vibrant, urban environment that once served as the capital of the confederacy: effectively VCU sits at ground zero for health equity work. We have the opportunity to deepen our institutional commitment to serving all members of our community by critically examining the impact of structural racism on health disparities. If, and when, we successfully build this health equity project, we will create a template that will not only strengthen us but will inform the national discourse. The talent and expertise that exists within the Richmond, Virginia ecosystem is vast, skillful, and rich in terms of the diverse narratives and experiences. Moreover, our health equity work is amplified by the voices of our students, our patients, and our community, that are now fueling calls for change in the diversity, equity, and inclusion space -- substantive, systemic, and sustained change. ***We must answer, now.***

REFERENCES

- Amedee, R. G., & Malone, M. (2020). Pandemic, Civil Unrest, and a Tropical Storm—What Is Next? The Locusts?? *The Ochsner Journal*, 20(2), 111.
- APM Research Lab. (2020, September). The color of coronavirus: Covid-19 deaths by race and ethnicity in the U.S. Retrieved from <https://www.apmresearchlab.org/covid/deaths-by-race>
- The Aspen Institute (2016, July). *11 Terms You Should Know to Better Understand Structural Racism*. Retrieved from <https://www.aspeninstitute.org/blog-posts/structural-racism-definition/>
- Ayanian, J. (2015). The Costs of Racial Disparities in Health Care. *Harvard Business Review*. <https://hbr.org/2015/10/the-costs-of-racial-disparities-in-health-care#:~:text=Racial%20health%20disparities%20are%20associated,%24200%20billion%20in%20premature%20deaths.>
- Banks, J. (1991). A curriculum for empowerment, action and change, in *Empowerment Through Multicultural Education*, State University of New York Press, Albany, Ny., p. 125 – 142.
- Blue Cross Blue Shield (2020, May). *How Health Equity Gaps Affect COVID-19 Impact*. Retrieved from <https://www.bcbsil.com/newsroom/category/collaborative-care/covid-19-health-disparities>.
- Centers for Disease Control. (2020, July). *Health Equity Considerations and Racial and Ethnic Minority Groups*. Retrieved from <https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/race-ethnicity.html>
- Chicago Sun Times Editorial Board (2019, June). Chicago’s shameful life expectancy gap. *Chicago Sun Times*. Retrieved from <https://chicago.suntimes.com/2019/6/7/18656669/life-expectancy-chicago-segregation-streeterville-englewood-health-care>
- Dabney, V. (1987) Virginia Commonwealth University: A Sesquicentennial History (Charlottesville: University Press of Virginia, 1987), 122; *Bulletin, Medical College of Virginia Annual Report Issue 1958-59*, 21.
- Glantz, A. and Martinez, E. (2018, February). Modern-day redlining: How banks block people of color from homeownership. *The Chicago Tribune*. Retrieved from <https://www.chicagotribune.com/business/ct-biz-modern-day-redlining-20180215-story.html>
- Godoy, M. and Wood, D. (2020, May). What do coronavirus racial disparities look like state by state? Retrieved from <https://www.npr.org/sections/health-shots/2020/05/30/865413079/what-do-coronavirus-racial-disparities-look-like-state-by-state>
- Godoy, M. (2020, November). In U.S. cities, the health effects of past housing discrimination are plain to see. Retrieved from <https://www.npr.org/sections/health-shots/2020/11/19/911909187/in-u-s-cities-the-health-effects-of-past-housing-discrimination-are-plain-to-see>
- Healthy Chicago 2.0: Partnering to Improve Health Equity, 2016 – 2020. Retrieved from https://www.chicago.gov/content/dam/city/depts/cdph/CDPH/HC2.0Plan_3252016.pdf
- Jan, Tracy, (2018, March). Redlining was banned 50 years ago. It’s still hurting minorities today. *The Washington Post*. Retrieved from <https://www.washingtonpost.com/news/wonk/wp/2018/03/28/redlining-was-banned-50-years-ago-its-still-hurting-minorities-today/>

- Jakubowski, L. (2001). Teaching Uncomfortable Topics: An Action-Oriented Strategy for Addressing Racism and Related Forms of Difference. *Teaching Sociology*, 29(1), 62-79. Retrieved August 17, 2020, from www.jstor.org/stable/1318783
- Koste, J.L. (2012). *Artifacts and Commingled Skeletal Remains from a Well on the Medical College of Virginia Campus: Anatomical and Surgical Training in Nineteenth Century Richmond*. Retrieved on August 23, 2020 from: <https://scholarscompass.vcu.edu/arch001/2/>
- Kumagai, A. K., & Lypson, M. L. (2009). Beyond cultural competence: critical consciousness, social justice, and multicultural education. *Academic medicine*, 84(6), 782-787.
- Mehra, R., Keene, D. E., Kershaw, T. S., Ickovics, J. R., & Warren, J. L. (2019). Racial and ethnic disparities in adverse birth outcomes: Differences by racial residential segregation. *SSM - Population health*, 8, 100417. <https://doi.org/10.1016/j.ssmph.2019.100417>
- Metzl, J.M., Petty, J., & Olowojoba, O.V. (2018). Using a structural competency framework to teach structural racism in pre-health education. *Social Science & Medicine*, 199, 189-201.
- Valderama-Wallace, C.P., & Apeso-Varano, E. C. (2020). 'The Problem of the Color Line': Faculty approaches to teaching Social Justice in Baccalaureate Nursing Programs. *Nursing Inquiry*, (27): e12349. <https://doi.org/10.1111/nin.12349>
- Washington, H.A. (2020, April 18). When a black man's heart was transplanted without consent. *The New York Times*. Retrieved on August 23, 2020 from: <https://www.nytimes.com/2020/08/18/books/review/the-organ-thieves-chip-jones.html>
- Wolf, S., Chapman, D., Hill, L. & Snellings, L. (2017). *Getting ahead: The uneven opportunity landscape in northern virginia*. Retrieved from Virginia Commonwealth University, Center on Society and Health. <https://novahealthfdn.org/wp-content/uploads/NVHF-Issue-Brief-FINAL.pdf>

APPENDIX I

RECENT EFFORTS TO ADDRESS RACIAL DISCRIMINATION, STRUCTURAL RACISM AND HEALTH DISPARITIES AT VCU.

Beginning in June of 2020, health sciences students initiated a call for change, communicating with the VCU health sciences school deans to demand curriculum change in light of the social justice issues across the country.

[Anti-Racist Curriculum Changes](#) letter
[School of Nursing](#) letter
[School of Dentistry](#) action items
[Overview of School of Medicine](#) curriculum

Evidence of the impact of those calls are reflected in the number of firsts in the VCU diversity space:

- VCU Health System initiates search for the inaugural Director of Diversity (Spring 2020)
- VCU School of Medicine appoints an inaugural interim Senior Associate Dean for Diversity, Equity, and Inclusion (CDO) and has approved the search process for a permanent CDO (Summer 2020)
- Office of the Senior Vice President for Health Sciences implements a campus-wide Action Framework to advance diversity, equity, and inclusion climate, infrastructure, and inclusive programming (DEI Action Framework) (Summer 2020)
- Increased integration of VCU Health System and VCU Health Sciences schools relative to advancing diversity, equity, and inclusion (Summer 2020)
- Campus-wide town halls are hosted by the VCU Health System and VCU School of Medicine focused on advancing diversity, equity, and inclusion (Spring 2020)
- VCU School of Medicine incorporates a Crucial Conversations Panel and Break-out Discussions (Fall 2020)
- VCU School of Dentistry hosts its first Diversity Speakers Series (Fall 2020)

Student development opportunities were developed and identified as well, including:

- The [Virginia AHEC Scholars Program](#) recruits, trains, and supports a diverse group of students from across the state, creating a multidisciplinary team of health professionals committed to both community service and the transformation of health care in Virginia. Curricular components of the Scholars Program may include interprofessional education, behavioral health integration, social determinants of health, cultural competency, practice

transformation, current and emerging issues including substance use disorders, and regional topics.

- [Excel](#) provides non-credit “Pop-up” courses to students on diversity and inclusion, including issues specific to health equity and healthcare professionals.
- The Office of Student Experience offers a co-curricular [Unlocking Health Equity](#) series that approaches topics utilizing health related social issues and health inequities relevant to those found in the Greater Richmond population.

APPENDIX 2

FACULTY LEARNING COMMUNITIES: SYSTEMIC RACISM AND IMPLICIT BIAS

Description: Health sciences faculty participated in a six-week program that met weekly for two hours in the fall of 2020. A second cohort will begin in January 2021. Participants engaged in a range of activities in order to develop effective pedagogies for addressing systemic racism and implicit bias in health sciences education. The overarching aim of these sessions was to move towards inclusive teaching that ensures access to educational opportunities and enhances student involvement in academic work. Meetings were conducted via Zoom. In the spring, each cohort will continue to meet monthly in facilitated sessions designed to reflect on the changes implemented in their course and provide feedback and peer support to one another.

Facilitators: [Dr. Faedah Totah](#) from the VCU School of World Studies and [Dr. Theresa Ronquillo](#) from the organization Embody Change will be the lead facilitators for this program. The program curriculum was developed by Dr. Totah, who has extensive experience in designing and implementing inclusive teaching professional development programs for faculty. Prior to the creation of Embody Change, Dr. Ronquillo worked at VCU as an instructional design consultant. Her work is “rooted at the intersection of arts, anti-oppression, and multi-level change.” We are excited to work with both of these experienced educators, as together we re-imagine health sciences education. In October, Dr. Ronquillo worked with the Office of Student Experience to hold a workshop for health sciences students with the purpose of curating their stories of racism in the curriculum, the classroom, and the clinical environment. These narratives guided our work together, as we center the voices of marginalized students. Guest presenters from the [East Marshall Street Well Project](#) joined us for the first session, as we contextualized the need for these important changes.

Background: The events following the murder of George Floyd have precipitated social and political reckoning on the issue of racial inequality in our communities. At the forefront of these protests are young people, many of them students, demanding that systemic racism be uprooted at all levels. In order to uphold VCU’s mission and remain true to its values, it is important not only to listen to students but to make the needed changes to the curricula and programs to meet the new social reality and to make sure that our students are prepared to address social challenges creatively and effectively in their chosen professions. It is also important to recognize how health education and the delivery of health care contributes to racial health disparity.

Objective: The aim of the sessions is to equip faculty in the health professions with the tools, foundations, and fundamentals of pedagogical approaches for designing inclusive courses and assignments and eventually curricula that address the needs of students to have programs that recognize and deal with the role of racism in certain pedagogical practices. The move to inclusive

teaching will also contribute to the personal and professional growth of students, their retention and future success. Participants will also recognize the health inequalities that exist in Richmond due to systemic racism. This is the first step towards a more inclusive curricula, necessary for improving both the classroom environment and institutional climate.

Learning outcomes: Participants will:

1. Be introduced to racial discrimination in Richmond in general, and in the health professions in particular.
2. Recognize and mitigate implicit bias in the classroom
3. Learn about pedagogical practices to decolonize the syllabus
4. Design inclusive courses and assignments
5. Develop skills to be effective leaders for curricular changes in their own units

Short readings area assigned for each session and participants are encouraged to bring questions they have or ideas they want to discuss from these readings.

Part of the program is to rework or redesign a course syllabus and/or an assignment. Before the start of the program, each participant will choose an artifact they would like to work on.

For the artifact chosen they will provide the following information:

1. Briefly describe the course/assignment.
2. What has been your experience with this course/assignment?
3. Questions you have about the course/assignment?
4. How do you anticipate the changes benefit you as an educator? Your students?

Capacity: We will have capacity for two cohorts each semester, with a maximum of 10 faculty participants per cohort. We will schedule specific dates based on the availability of participating faculty and our facilitators.