Tutor and student FAQ

WHAT AND WHY questions

1. ***Why are we diversifying the cases?***

   Medical research and medical education have traditionally studied and taught students to provide care to the 70 kg male (who is assumed to be white, cis-gender, heterosexual, without a disability or a mental health condition, and of medium-high education and income).

   An audit of our case-based learning (CBL) cases shows that they do not accurately represent our patient populations, locally or nationally, or serve learners' educational needs in relation to priority communities.

2. ***We've been conditioned to think that race and sexual orientation (for example) should only be mentioned when it is "clinically relevant". Why are these characteristics being mentioned in all the cases?***

   This is what medicine has done in the past — saying that patients are, for example, Black or disabled or gay only when it is a clue to diagnosis. This "medicalization" of identities creates stereotypes that harm patients.

   Physicians have been conditioned to think (for example by common clinical tools like UpToDate (Cerdeña 2022)) that race is clinically relevant, but race is not a proxy that survives scientific scrutiny. For genetics, ancestral origin (family history) is relevant, not skin pigmentation. In much of the medical literature that recommends the use of race as a biological variable, researchers failed to account for the social determinants of health.

   With the diversified cases, students and tutors will learn with a variety of *different* Black, Indigenous, gay, trans, disabled, immigrant, neurodiverse, etc. patients with a variety of medical concerns, counteracting bias and normative assumptions. And we will pay attention to avoiding stigmatizing language and attitudes.

3. ***Shouldn't we treat everyone the same regardless of their identity?***

   This is a widely shared ideal. We may someday achieve a world where people's differences don't lead to health and social inequities. We may someday be able to avoid having assumptions that lead us to treat someone else as being the same as us when they are different from us.

   Meanwhile, the diversified CBL cases interrupt the assumption that everyone is the same and normalize getting to know people for who they are.

4. ***Some of the work I've read around changing approaches to race and ethnicity in medicine tells me that if race doesn't affect illness/treatment/outcomes, we shouldn't include it in a patient's chart notes. Doesn't including race up front introduce bias?***

Medical educators are trying both approaches now—removing race and ethnicity everywhere (a race-blind approach) and adding race everywhere (a race-conscious approach). After discussion with stakeholders and review of the literature, we're taking a race-conscious approach. See our more detailed document on Taking a Race-Conscious Approach to CBL cases. It admits that even if the goal is a world where we treat everyone as individuals without labels, that is not the reality we live in. Removing race, ethnicity, and sexual orientation (for example) from CBL cases leaves in place the assumption that patients are white and heterosexual, and existing biases will be left unchallenged. By diversifying the health experiences of people who are of different races, gender identities, sexual orientations, abilities, and socioeconomic status in the CBL cases, we will raise and discuss biases and assumptions before learners enter the clinical setting (recognizing though that many learners have prior experience in the health professions). There will be enough diversity in the cases to stimulate curiosity about (for example) racism as a social and structural determinant of health without enforcing the assumption that all persons of a given racialized identity experience the same social determinants of health.

The entire medical education community will be learning over the next few years the strengths and weaknesses of each approach.

5. ***This seems unnatural!***

Let's think about why it seems unnatural.

One way privilege works is that some people have to say who they are (that they are different) and other people can take for granted that the world [correctly] assumes they are who they are. We're not used to seeing people labelled as white, cis-gender, heterosexual, and able-bodied. Now, all the CBL patients "say who they are".

Some people protect their privacy and shield themselves from potential stigma and discrimination by not revealing their identity. This should be respected in individual cases. To address stigma and discrimination, and to correct assumptions, we reveal these hidden dimensions in our CBL cases.

There are other important concerns about why it seems unnatural — for example that labelling people is wrong — and these concerns need longer answers. See 6 and 7 below.

6. ***Why are the patients' descriptions given up front? Don't physicians learn about patients through clinical interactions?***

This question is very important. The Case Diversification Committee considered various aspects of this concern and different dimensions of identity (visible and invisible) and concluded that we should start with putting almost all dimensions of diversity up front, from the patient's perspective. As this project evolves, identities may be woven into cases in different ("more clinically realistic") ways without losing the patient's perspective.

In the medical interview, this information is not gathered up front. There are different approaches to gathering different aspects of patient identity and context, and to forming trustworthy relationships, and learners will practice these approaches in other contexts (Skilled Clinician, Professional Competencies, Electives, Service Learning, and Clerkship).

In some cases we may specifically include information up front that the patient would not reveal to the physician during their encounter, and that the patient may actually feel is irrelevant or private.

The dimensions of diversity described up front in the CBL cases are the patient's identity—this is NOT a clinical checklist for students to apply to patients. Students will learn appropriate approaches to patient diversity in the Skilled Clinician Unit and elsewhere.

7. Are we imposing labels on patients?

Discussing how it feels to be labeled and the ways that people experience labels that do or don't fit them is very relevant and appropriate. We should always ask people how they understand themselves and what language they like to use.

These descriptions of patients are different from the descriptions most people would give of themselves in daily life. Various things are important to people (music, movies, games, dress, religion, etc.). When you introduce yourself to someone, you choose what to reveal based on the context you are in.

The description is how the patient would describe themselves if asked in the healthcare context about these dimensions of their identity.

We don't use "in-group" language that (for example) lesbian, gay, and bisexual people might use among themselves; we use the language that is commonly used to present ourselves to people who are different from us.

Sometimes we use language people wouldn't use, to highlight what is considered "normal" (or "normative"). Those who are of normative identities (e.g. cisgender) consider it *unnecessary* to describe themselves to others.

We do show that patients describe themselves in different ways. For example, some people might use the Canadian Institute for Health Information's (CIHI) very broad terms for people whose ancestry lies in the Indian subcontinent (South Asian); other patients might say that they are Indo-Canadians (or Pakistani-Canadians), or that they their grandparents immigrated to Canada from India (or Pakistan).

Learners meet many volunteer and simulated patients in the MD program and patients in clinical electives and placements who do not come with labels attached.

Working through written cases in which the diversity of patients is made explicit contributes to developing comfort in asking, instead of assuming, who patients are and how the structural determinants of health affect them. Learners learn when and how to do this in other Units.

8. How authentic are these cases?

The advisory group includes people of diverse identities, and in addition, we have worked with clinicians who work with communities and with the Office of Community Partnerships and Global Health to engage community agencies and people with lived experience in reviewing and brainstorming patient identities. We recognize that people within communities are very

different from one another and have diverse experiences, so not every person's experience of their identity will be represented in the cases. We welcome feedback via ugmeaa@dal.ca.

9. But don't I need to know (what I have been conditioned to think is) the patient's "real" sex?

The cases have patients of diverse gender identities. Sometimes patients are not cisgender, and in such a case, the physician needs to ask the patient for anything medically necessary about their sexual characteristics within a respectful clinical relationship—e.g. what sex they were assigned at birth; what variations in sexual development they have been diagnosed with; what surgical or hormonal procedures they have had that could be relevant to your clinical reasoning, given that anatomy, chromosomes, or hormones may be relevant to diagnosis and treatment.

In clinical reasoning, we often rely on studies that exclude women, and researchers have not often clearly differentiated sex (biological) and gender (social) (see Mauvais et al. 2020). In addition, some gender-diverse people are nonbinary ***in their biological sex*** (persons with intersex conditions, or persons with gender affirming surgery or hormone treatment). They are also excluded or not considered separately in clinical trials. There is an evidence gap on diagnosis and treatment with people of non-binary sex identities. Also, as with the research base for race and health, we have uncertainty about the real causal factors (biological and/or the social determinants of health) in men's and women's health. Now that patients present with affirming surgery, hormone treatment, or being raised as intersex without having had coerced surgical gender assignment, this gap in the evidence base becomes more clinically important.

Because science educators are also considering how to teach biological sex with greater appreciation for the fact that sex is not a simple binary, cases will sometimes reflect their recommendations that we give clear factual descriptions of genital (anatomic), hormonal, and chromosomal features, removing often redundant tagging of these as "male" or "female" (Long et al. 2021) Obstetrics and Gynecology is exploring approaches to these questions in reproductive context (Moseson et al. 2020).

Medicine will continue to debate the right language and explore gaps in the evidence for some years.

HOW questions

10. How can we include meaningful discussion of these dimensions of patient identity?

Learner feedback tells us it is important to discuss identity in the tutorial and/or show its relevance as the case unfolds. This is important for making the diversification of patient identities meaningful and not an empty exercise. In consultation with the Unit and Component leadership, case authors, experts in EDI (equity, diversity, inclusion), and communities themselves, we have also added details to the unfolding of the case narrative. For most cases, there is an added discussion question with tutor notes.

11. Are the cases going to become too complex or too long for tutorials?

The cases are going to become more realistic both to patient diversity and to clinical practice. This addresses the hidden curriculum that results from presenting students with homogenous patients in cases. It does not necessarily make the case any longer.

In a few cases where medical science is critically rethinking old race-based or sex/gender-based clinical reasoning, objectives and content may have been adjusted in consultation with the Unit leadership, scientific experts, and case authors.

Sometimes tutorial groups might have to think about relevant differences in pharmacology or test interpretation for different age groups, body composition, concurrent conditions, or substance use, for example.

Tutorial groups will have the opportunity to explore the relevance of the patient's identity to the clinical context, the social and structural determinants of health, and their experience of health and healthcare through specific discussion questions.

Because this diversification is happening to all the CBL cases, there is no pressure to have an extensive discussion of patient identity in every case. Tutors should ensure that over time, the discussion questions are covered to the degree that supports student learning and group function, and the goal of better clinical care for a diverse population.

As always, tutors and students have the opportunity in case evaluation to give feedback on the length of cases and adequacy of discussion.

12. ***How do we make the tutorial a safe space for students and tutors who share these dimensions of diversity? For all students to learn?***

When you establish group norms and boundaries at the beginning of your tutorial group experience, include this in the discussion. Consult the Introduction document for some ideas.

Two key things to think about:

a) **Learners and tutors who share these identities are in your group whether you know it or not**. Do not talk about "us" and "them," without thinking about your own assumptions. Do not expect students or tutors to teach the group about their communities. Some students or tutors may choose to share their personal experience. This is a gift. Recognize that there is diversity within an "identity" and make space for this diversity.

b) The language used during tutorial will impact people regardless of intention. Opening space to reflect on and change language can be helpful. People who raise questions about the impact of language should be thanked: the group should step back and discuss, listening to different perspectives without judgment, while also appreciating the real impact language has on people.

13. ***What feedback can students give, and what support is there for students in this process?***

Learners can give feedback about the diversified cases via case evaluation if it is comfortable to do it in the group. Feedback can be provided individually via the Best Practices in Language and Imagery form on One45, by email via ugmeaa@dal.ca, or via the student-led Student Diversity and Inclusion Committee via sdic@dal.ca. Feedback left in the End of Unit Evaluation forms will also reach the Case Diversification Committee.

14. How should I handle pronouns in tutorial discussion?

The cases include the patient's pronouns. This is an opportunity to practice in a safe environment using people's pronouns and describing sex and gender in contemporary ways, so that we are prepared to do the same with simulated and real patients in practice.

Pay more attention to practicing what is less familiar to you (e.g. using "they" when talking with and about nonbinary patients and gaining comfort in not knowing their assigned sex at birth, and figuring out when and why you need to know the sex assigned at birth for clinical care, whether it will be helpful, and the possibility that it won't be binary either).

15. How should I handle scientific uncertainty around old race-based and sex-based clinical reasoning?

The scientific reality is that many traditional practices around race-based risk factors are being re-evaluated. Sometimes race is a social reality, and racism a social determinant of health. Sometimes "race" is an old-fashioned and very imprecise proxy for genetics, which is more accurately a matter of ancestral origin and the environmental exposures in very specific environments. Family history may contain more useful and accurate information that ascriptions of race or ethnicity. Even when there are genetic risk factors tied to ancestral origin, it is difficult to apply this in a diverse, immigrant society like Canada. (For example, MS and CF are underdiagnosed in Indigenous persons due to the common medical belief that they are white, European diseases.) Sometimes the traditional studies medicine has relied on were the direct result of the researcher's own racial prejudice. The current approach is to move away from race-based medicine and towards race-conscious medicine.

Similarly, there are many specific discussions in clinical areas about what belongs to biology and to social structures in sex/gender differences and inequities, and how to speak and act in ways that are more inclusive of a range of gender identities and to diversity in biological sex (including biological variation related to intersex and medical transitioning).

16. How do I pronounce this name?

We ask you to model a kind and patient-centred approach to people's names. In real life, asking the person how to pronounce their name is of course important. For CBL cases, google "how do I pronounce" and the patient's name. Several websites are available to help. Practice using the name *as a matter of course* in case discussion—without making a deal out of how difficult or easy it is, while supporting everyone as they practice doing a better job of respecting people's names. See our more detailed help document on Names in Cases and Tutorial Groups.

Some people adopt anglicized names to avoid having their names chronically mispronounced or highlighted as "difficult" by others. This process will be reflected in some cases.

17. How can I be aware of language that might be considered old-fashioned or offensive?

Check out the guide provided by the Student Diversity and Inclusion Committee Language Matters and the sources listed in that guide. A recent review by Healy et al. listed below is helpful. There are also selected language notes in the documentation for each community.

18. What support is there for tutors? Where can I raise concerns or get help?

A general introduction to the diversified cases with suggestions for the tutorial process is posted in Bright Space and on the CPDME website. Specific resources on specific topics will be released throughout the year.

A number of webinars and white fragility clinics are offered, with sign-up information listed here: https://medicine.dal.ca/departments/core-units/cpd/faculty-development/important-update-for-med-i-tutors-regarding-changes-to-cases-beg.html

You are welcome to contact the Case Diversification Committee via email (ugmeaa@dal.ca).

19. What's the science behind this approach?

A selection of resources the Committee has consulted:

Canadian Pediatric Society. Gender identity. 2021. https://caringforkids.cps.ca/handouts/behavior-and-development/gender-identity

Cerdeña JP, Plaisime MV, Tsai J. From race-based to race-conscious medicine: How anti-racist uprisings call us to act. The Lancet 2020;396:1125–1128. https://doi.org/10.1016/S0140-6736(20)32076-6

Cerdeña JP, Emmanuella NA, Marie VP, Hardeman RR. Race-based medicine in the point-of-care clinical resource UpToDate: A systematic content analysis. The Lancet EClinicalMedicine 2022;52:101581. https://doi.org/10.1016/j.eclinm.2022.101581

Goodman, CW, Brett AS. Race and Pharmacogenomics-Personalized Medicine or Misguided Practice. JAMA 2021;325:625-626. https://doi.org/10.1001/jama.2020.25473

Gruner D, Feinberg Y, Venables MJ et al. An undergraduate medical education framework for refugee and migrant health: Curriculum development and conceptual approaches. BMC Medical Education 2022;22. https://doi.org/10.1186/s12909-022-03413-8

Healy M, Richard A, Kidia K. How to Reduce Stigma and Bias in Clinical Communication: A Narrative Review. J Gen Intern Med 2022;37:2533-2540. https://doi.org/10.1007/s11606-022-07609-y

Karkazis K. The misuses of "biological sex". The Lancet 2017;394:1898–9. https://doi.org/10.1016/S0140-6736(19)32764-3

Long S, Steller L, Suh R. Gender-inclusive biology: A framework in action. The Science Teacher 2021;89:27–33. https://www.nsta.org/science-teacher/science-teacher-septemberoctober-2021/gender-inclusive-biology-framework-action

Mauvais-Jarvis F, Merz NB, Barnes PJ et al. Sex and gender: modifiers of health, disease, and medicine. The Lancet 2020;396:565-582. https://doi.org/10.1016/S0140-6736(20)31561-0

Rubino F, Puhl RM, Cummings DE, et al. Joint international consensus statement for ending stigma of obesity. Nature medicine 2020;26(4):485-497. https://doi.org/10.1038/s41591-020-0803-x

Moseson H, Zazanis N, Goldberg E, Fix L, et al. The imperative for transgender and gender nonbinary inclusion: Beyond women's health. Obstet Gynecol 2020;135:1059–68. https://doi.org/10.1097/AOG.0000000000003816

Vyas DA, Eisenstein LG, Jones DS. Hidden in plain sight - reconsidering the use of race correction in clinical algorithms. N Engl J Med 2020;383:874–82. https://doi.org/10.1056/NEJMms2004740

Topic specific resources from the Committee are posted here:
https://medicine.dal.ca/departments/core-units/cpd/faculty-development/important-update-for-med-i-tutors-regarding-changes-to-cases-beg.html

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