Introduction to case diversification for students and tutors

The revised cases

In 2022-3, Med 1 CBL tutorial cases (ProComp and the block units) have a whole new cast of patients. As part of the Faculty of Medicine's commitment to EDIA (equity, diversity, inclusion, and accessibility) and anti-oppression, UGME has established a committee and engaged an EDIA Curriculum Reviewer to incorporate multiple dimensions of diversity in tutorial cases.

What do the revised cases look like?

All cases now include brief, up-front patient-centered descriptions of the dimensions of diversity that intersect in the patients' lives. In most cases, learning objectives will remain the same.

For every patient, we specify pronouns, racialized identity, age, gender identity and sexual orientation, dis/ability, markers of socioeconomic status (such as employment, insurance, housing and food insecurity, literacy) and cultural and religious affiliations; as appropriate, we describe recent immigration experience, language, substance use and body composition, and experiences of incarceration, while combatting stigma.

Every case has a discussion question for reflecting on patient identity. For example, looking back at the identity of the patient, which factors might influence their experience of health care? What structural determinants of health might influence this patient's health status and outcomes? What are examples of community resources that could support this patient? What assumptions might health care providers make about this patient and/or their care? How might that limit or negatively affect patient care? Tutor notes will be provided. These discussions can be open-ended and guided by the contributions and learning needs of the group; there are not specific exam questions that map to these discussions, but the discussions will support learners in developing skills to work with diverse patients in OSCE and clinical settings

Students will have the opportunity to learn elsewhere in the curriculum whether, when, and how to invite patients to share these aspects of their identity in clinical practice. Patients have concerns about their own safety from bias, stereotypes, and stigmatization, and so it would be inappropriate to expect them to share this information up front, and it would be inappropriate to share their information without permission.

Why are we doing this?

Our goal in adding this information to cases is to take something away: to take away the assumption that the "normal" patient is the 70kg white male—who is also heterosexual, cisgender, and of medium to high education and socioeconomic status.

Currently our cases do not address the actual diversity of our patients. Traditionally, medical educators have presented social information, e.g. race, sexual orientation, or disability, only when it is considered a risk factor for disease or when care of a specific population is the explicit learning objective of the case. This "medicalizes" patient identities and creates biases in clinical reasoning.

In the revised cases, every patient is described in the dimensions named above, often "intersectionally" (with more than one dimension of diversity, which interact with each other; as described by Black

feminist legal scholar Kimberly Crenshaw in 1989). Across 200 cases, we seek to meet community health needs while working against biases and stereotypes, by portraying both the health effects of the social (structural) determinants of health for individuals and communities and the fact that at the level of individual clinical reasoning and patient experience, not everyone experiences health effects according to these patterns. We also work against stereotypes by showing different experiences of patient identity. We portray different ways people understand and talk about themselves, instead of just ascribing standardized labels to them.

A good learning environment

The identities in the cases (and their intersectionality) are also present in the tutorial group. We are not talking about "other" people. We are talking about ourselves.

We will all experience case diversification differently due to our own experiences, backgrounds, and beliefs. Some of us will see ourselves represented in cases explicitly for the first time (e.g. Indigenous, newcomer, queer, non-binary, Black, South Asian, etc.). Some of us will be seeing parts of our own identity named instead of being assumed (e.g. white, heterosexual, cisgender). Some will see parts of our identity represented and others left out. There are commonalities and differences for everyone in their experiences of identity. The depiction of one experience of race or sexual orientation in a case does not imply all people experience their identities in the same way.

When your tutorial group discusses group norms, you can begin to discuss how the group can work to ensure everyone feels safe, respected, and engaged in the learning process.

Do not put people on the spot to share aspects of their identity or to address their identity for the group. If you are fortunate that people feel safe to share their experiences, listen and learn.

Consider questions such as the following:

- How do we move forward knowing dimensions of diversity in the cases are present in the tutorial room? Discuss the general idea without putting people on the spot, and what it means for how the group proceeds.
    - For example, avoid speaking about "we" (privileged people) helping "them" ("underprivileged" or "vulnerable") people.
- What should we do when people appeal to stereotypes or use stigmatizing language?
    - For example, we should expect group members to raise questions when this happens and expect the group to take a moment to step back and reflect. Discuss the **possible** interpretations of words and their **impact** on people, without assuming that anyone is being told they are a bad person or have bad intentions. Thank people for raising questions and sharing their perspectives on the impact of how we speak.
- What would contribute to an environment where everyone can make mistakes and learn?
    - For example, asking for reflection on where our language comes from and what it means to different people, instead of ascribing motives.
- Do we need processes to help us remember to use pronouns appropriately and pronounce names correctly?
    - In real life you would ask the patient. Consider asking one person every week to look up and share simplified phonetics for patient and provider names in the cases:

https://mynameis.raceequalitymatters.com/asset/NameShouts%20Phonetic%20Spelling%20Guide.pdf
    - Sometimes a simple correction, thank you, and moving on is the best approach.
    - See the resource on **Names**.
- How do we understand "person-first language"? What are some examples of getting it right and getting it wrong? See Healy et al. 2022 https://link-springer-com.ezproxy.library.dal.ca/article/10.1007/s11606-022-07609-y
- Groups often rely on people with lived experience of these identities to raise questions and teach the rest of the group. How can group members share the work of learning and of raising questions?
    - Examples: The group can "do its homework" and find the educational resources communities have already created.

Working with the cases

When discussing the questions, some participants in the group will have prior course work or professional or personal experience to contribute. As the two years progress, learners will gradually have more and more exposure in the medical school curriculum, in clinical rotations, in their RIM projects, and in Service Learning, to different communities and relevant resources. Early on, you may be raising more questions than you can answer. Think of each discussion as a self-assessment of what you collectively know as a group and an opportunity to learn more.

As you discuss, be aware that every consideration about how the patient might experience their identity is an assumption. Informed assumptions are better than uninformed assumptions, and this involves learning what the history and structural patterns are that affect communities, from communities and from research. Ultimately, only the patient themselves will know how they experience their identity.

The discussion questions sometimes ask about local resources. This is a prompt to start on a life-long learning process of being aware of the kinds of resources available in the health system and in communities. In some ProComp cases, the Service Learning Program has added this information in #RealLifeProComp. You don't need to know everything, but learn a little each time questions are raised. It can be useful to talk about one example, without worrying about knowing how it is done everywhere.

Do you have more questions? Consult the FAQ.

To access support and give feedback:

- Fill out the "Language and Imagery Form" on One45 to give immediate feedback to the Case Diversification Advisory Committee and to raise inconsistencies in the rest of the curriculum.
- The comments you submit in case and unit evaluation will be shared with the Committee.
- Discuss with the student-led Student Diversity and Inclusion Committee (SDIC@dal.ca), who can bring issues to the Case Diversification Advisory Committee.
- Contact your supports through PLANS (plans@dal.ca) and Dr. OmiSoore Dryden, the JR Johnston Chair in Black Canadian Studies (via jrj-chair-admin@dal.ca), the Indigenous Health Academic Lead Dr. Brent Young and Keknu'tmasiek Welo'ltimk (via IHIM@dal.ca), and the Associate Dean for Service and Engaging Society, Dr. Gaynor Watson-Creed (via nobonita.chakraborty@dal.ca) and as discussed in O-Week.

Case Diversification Committee

Keith Brunt (Pharmacology, DMNB), Abdullah Chanzu (Class of 2025; SDIC), OmiSoore Dryden (James R. Johnston Chair in Black Canadian Studies; Community Health & Epidemiology), Jordin Fletcher (Class of 2025), Sarah Gander (Pediatrics DMNB), Leah Jones (Family Medicine; Black Health Academic Lead), Neha Khanna (Class of 2025; DMSS VP EDI), Darrell Kyte (Program Evaluation), Osama Loubani (Assistant Dean Pre-Clerkship), Susan Love (CPDME), Natalie Lutwick (Student Assessment), Anna MacLeod (Director of Education Research; RIM), Eli Manning (Visiting Scholar in Anti-oppressive Practice; School of Social Work), Anu Mishra (Ophthalmology; Skilled Clinician Unit Head), Anne O'Brien (administrative support), Tiffany O'Donnell (Family Medicine, Med 1 ProComp Unit Head), Christopher O'Grady (Class of 2023), Oluwasayo Olatunde (Family Medicine, NB), Sarah Peddle (Community Partnerships and Engagement), Leanne Picketts (EDIA Curriculum Reviewer), Lynette Reid (Bioethics; chair), Jim Rice (Curriculum Refresh liaison), Sanja Stanojevic (Community Health and Epidemiology), Wendy Stewart (Assistant Dean Pre-Clerkship), Gaynor Watson-Creed (Associate Dean for Serving and Engaging Society), Brent Young (Family Medicine; Indigenous Health Academic Lead).