UNC School of Medicine

Task Force to Integrate Social Justice into the Curriculum

Final Report

Julia Draper, MPH; Alexa Mieses Malchuk, MD, MPH; Emily B. Vander Schaaf, MD, MPH; Stephanie H. Brown, PhD, MA; Georgette Dent, MD; Neva Howard, MD, MS; Beat Steiner, MD, MPH; and E. Nathan Thomas III, PhD

October 2020

UNC
SCHOOL OF MEDICINE

TABLE OF CONTENTS

1. Initial Charge and Report Structure……………………………………………...…3

2. Task Force Members……………………………………………………………....…..4

3. Glossary and Important Terms……………………………………………...……...6

4. Executive Summary and Recommendations……………………………………...…..9

5. The Relationship between Diversity, Equity, and Inclusion and Social Justice……….15

6. Justification for Integrating Social Justice into the Curriculum with Anti-racist Components………………………………………………………………………….17

7. The process to integrate Social Justice into the Curriculum with Anti-racist Components………………………………………………………………………….20
    - Learning Environment…………………………………………………………20
    - Curriculum Innovation………………………………………………………….24
    - Faculty Development…………………………………………………………...31

8. Charge 4 and Next steps: Integrating Social Justice into Graduate Medical Education, Allied Health Curricula, and Biomedical and Biological Science Graduate Programs..36

9. Summary…………………………………………………………………………….37

10. References…………………………………………………………………………...38

11. APPENDIX A - Task Force Recommendations Organized by Suggested Responsible Party…………………………………………………………………………………42

Initial Charge

At UNC SOM we recognize the importance of integrating social justice into the curriculum to prepare our students and trainees to improve health equity and reduce health disparities. In addition, a just learning environment where faculty are well prepared to support a diverse learner group is essential for our success.

These have been priorities of our institution for the long term, and we are proud of our diverse student body and alumni cohorts, our innovative curriculum in social and health systems science, and many markers that demonstrate our commitment to the reduction of health disparities. Nonetheless, there is still much more to do.

To that end Dr. Julie Byerley, Vice Dean for Academic Affairs, convened the Task Force for Integrating Social Justice into the Curriculum on July 28, 2020 and gave it four charges:

1. Report recommendations on the learning environment, faculty development, and curricular innovation regarding social justice topics to the Education Leadership Committee by **October 5, 2020**;
2. Establish clear goals, strategies, action steps, metrics, and outcomes for enhancement of integration of social justice into the medical school curriculum and create recommendations to submit to the Education Committee for consideration by **October 5, 2020**;
3. Specify the anti-racism components to the curricular pieces proposed
4. Identify other key partners within UNC SOM, expand the task force, and work collaboratively with those partners to make recommendations on best approaches to integrating social justice into the curricula for graduate medical education, allied health, and biological and biomedical graduate programs by **November 2, 2020**.

Report Structure

This report is divided into four sections: 1) A glossary of important terms to inform the reader, 2) An executive summary that includes a list of the task force's recommendations, 3) Foundational information to define and justify the importance of integrating social justice into the medical curriculum, and 4) Under the constructs of the learning environment, curriculum innovation, and faculty development: a detailed synopsis of the gaps, goals, objectives, metrics, outcomes, and recommendations to integrate Social Justice into the curriculum. The information and recommendations presented in this report will help the School of Medicine implement specific strategies related to the learning environment, curriculum, and faculty development. To that end, integrating social justice principles with anti-racist components into the curriculum will involve the collaboration and coordination of multiple facets of the School of Medicine.

Task Force Members

Leadership team: Provided direction for the task force

Chair: E. Nathan Thomas III, PhD, Vice Dean for Diversity, Equity, and Inclusion
Social Justice Strategist: Stephanie Brown, PhD, MA, Strategic Manager for the Office of Inclusive Excellence
Lead experts:
- Co-chair for Medical Curriculum: Alexa Mieses Malchuk, MD, MPH, Assistant Professor, Co-director of Curricular Innovation for Health Equity
- Co-chair for Medical Curriculum: Emily Vander Schaaf, MD, MPH, Assistant Professor, Co-director of Curricular Innovation for Health Equity

Sub leads (small groups):
- Learning Environment Lead: Georgette Dent, MD, Associate Professor, Associate Dean for Student Affairs
- Curricular Innovation Lead: Neva Howard, MD, MS, Assistant Professor, Director of Learning Innovations
- Faculty Development Lead: Beat Steiner, MD, MPH, Professor, Senior Associate Dean for Medical Student Education

Large group: Task Force

Faculty Development-Beat Steiner
- Giselle Corbie-Smith, MD, MSc, Kenan Distinguished Professor of Social Medicine Director, Center for Health Equity Research Professor, Internal Medicine
- Brenda Mitchell, PhD Associate, Professor, Associate Chair of Department of Allied Health Sciences Office of Student Services and AHEC Operations
- Raj Telhan, MD, MFA, Clinical Assistant Professor
- Rasheeda Monroe, MD, Wake Med Physician Practices
- Julia Draper, MPH, Medical Student

Learning Environment-Georgette Dent
- Claudis Polk, MA, Director, Office of Scholastic Enrichment and Equity
- Dorian Burton, EdLD, Philanthropy Executive at Kenan Family Foundation
- O'Rese Knight, MD, Assistant Professor
- Alexis Flen, Medical Student, Paul Godley Scholar
- Casey Olm Shipman, MD, MS, Assistant Professor

Curriculum Innovation-Neva Howard
- Johanna Foster, MPA Senior Director of Academic Affairs
- Gary Beck Dallaghan, PhD, Director of Educational Scholarship
- Raul Necochea, PhD, Associate Professor
- Quinta Fernandes, Medical Student, Paul Godley Scholar

Collaborative Partners

Allied Health Sciences: Steven Hooper, PhD, Associate Dean for Allied Health Sciences
Biological & Biomedical Science Program: Jean Cook, PhD, Associate Dean for Graduate Education
Graduate Medical Education: Clark Denniston, MD, Designated Institutional Official

Email Addresses:

Nate Thomas, PhD nate_thomas@med.unc.edu

Alexa Mieses Malchuk, MD alexa_mieses@med.unc.edu

Emily Vander Schaaf, MD emily_vanderschaaf@med.unc.edu

Stephanie Brown, PhD stephanie_brown@med.unc.edu

Georgette Dent, MD georgette_dent@med.unc.edu

Neva Howard, MD howardn@email.unc.edu

Beat Steiner, MD beat_steiner@med.unc.edu

Giselle Corbie-Smith, MD gcorbie@med.unc.edu

Brenda Mitchell, PhD brenda_mitchell@med.unc.edu

Raj Telhan, MD raj_telhan@med.unc.edu

Rasheeda Monroe, MD ramonroe@email.unc.edu

Julia Draper, MD Candidate julia_draper@med.unc.edu

Claudis Polk, MA claudis_polk@med.unc.edu

Dorian Burton, EdLD dburton@kenancharitabletrust.org

O'Rese Knight, MD orese_knight@med.unc.edu

Alexis Flen, MD Candidate alexis_flen@med.unc.edu

Casey Olm Shipman, MD caseyo@neurology.unc.edu

Johanna Foster, MPA johanna_foster@med.unc.edu

Gary Beck Dallaghan, PhD gary_beck_dallaghan@med.unc.edu

Raul Necochea, PhD raul_necochea@med.unc.edu

Quinta Fernandes, MD Candidate elizabeth_fernandes@med.unc.edu

Steven Hooper, PhD stephen_hooper@med.unc.edu

Jean Cook, PhD jean_cook@med.unc.edu

Clark Denniston, MD clark_denniston@med.unc.edu

Glossary of Important Terms

Anti-racism: the practice of opposing individual and systemic racism in society. Anti-racist practice requires deliberate actions to combat racial prejudice and discrimination and provide equitable opportunities for all people regardless of the racial group with which they identify.

Curriculum: the totality of learning activities that are designed to achieve specific educational outcomes through a coherent structure and processes that link theory and practice in the professional education of a professional.

Health disparity: a particular type of health difference that is closely linked with economic, social, or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater social or economic obstacles to health based on their racial or ethnic group, religion, socioeconomic status, gender, age, or mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion. Health disparities are primarily determined by structural factors, rather than by biological ones or by individual behaviors.

Health equity:

1. the elimination of health disparities, conceptualized as two separate parts: 1) the principle as a vision to aspire towards and 2) the practice as the action needed for current structural change to occur.
2. providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.
3. the principle underlying a commitment to reduce—and, ultimately, eliminate—disparities in health and in its determinants, including social determinants.
4. social justice in health (i.e., no one is denied the possibility to be healthy for belonging to a group that has historically been economically/socially disadvantaged).

Hidden curriculum: the unwritten, unofficial, and often unintended lessons, values, and perspectives that students learn in school. While the "formal" curriculum consists of the courses, lessons, and learning activities students participate in, as well as the knowledge and skills educators intentionally teach to students, the hidden curriculum consists of the unspoken or implicit academic, social, and cultural messages that are communicated to students while they are in school.

Implicit Bias: the attitudes or stereotypes that affect our understanding, actions, and decisions in an unconscious manner. These biases, which encompass both favorable and unfavorable assessments, are activated involuntarily and without an individual's awareness or intentional control. Residing deep in the subconscious, these biases are different from known biases that individuals may choose to conceal for the purposes of social and/or political correctness. Rather, implicit biases are not accessible through introspection.

Intersectionality: the complex, cumulative way in which the intersection of different identities overlap and interact with systems in which they operate.

Marginalize: to relegate to an unimportant or powerless position within a society or group.

Microaggressions: brief, subtle, and commonplace actions, snubs, slights and insults directed at historically stigmatized or marginalized groups that implicitly communicate inferiority and/or hostility that are often unintentional and based on unconscious bias.

Professional Development: the process of maintaining or expanding knowledge, skills, values and behavior for a specific career trajectory.

Race: The designation of human "races" is a social construct, strongly tied to the process of European state-formation and, later, imperial expansion and colonialism. Racial distinctions from the 17th century onwards, moreover, implied the establishment of racial hierarchies that justified military/political control and the assertion of the intellectual, physical, and moral inferiority of colonized and/or enslaved peoples. Medical and scientific claims of "racial differences" beginning in the 18th century, such as those made in comparative anatomical, clinical, or behavioral studies, emerged in this context and have contributed to the equivocal notion of "biological race." In practice, the critical insistence on a purported "biological basis of race" simply perpetuates racist views and practices that have existed for centuries.

Relationship-based pedagogy: Relational pedagogy emphasizes the social, dynamic, and interconnected nature of human development, promoting belonging and trust. This challenges educators to think deeply about their role and their commitment to personal and professional growth. It examines what it actually means to have strong, authentic, intentional, and responsive relationships with students, and how this is critically connected to student well-being and success.[1]

Social accountability in medical schools: the obligation of medical schools to direct education, research, and service activities towards addressing the priority health concerns of the community, region, or nation that they are mandated to serve. The priority health concerns are to be identified jointly by governments, health care organizations, health professionals, and the public.

Social Determinants of Health: conditions in the environment in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks, such as availability of resources to meet daily needs; access to educational, economic, and job opportunities; and access to health care services.

Social justice: the view that everyone deserves equal rights and opportunities —this includes the right to good health.

Social justice curriculum (SJC): a course of study that prioritizes health equity as it teaches students to recognize social and structural determinants of health and prepares them to address the consequent health disparities.

Social responsibility: state of awareness of duties to respond to society's needs.

Social responsiveness: course of actions addressing society's needs.

Structural Determinants of health: upstream policies, systems, and practices that influence social determinants and health outcomes, including: Racism & white supremacy; Sexism and patriarchy; Classism and capitalism; Heterosexism, homophobia, and transphobia; Ableism; Xenophobia; and Imperialism

UNC School of Medicine Diversity Definition and Policy: the School of Medicine strives to create a culture of belonging where its students, faculty, and staff can thrive regardless of their race, ethnicity, creed, gender identity, gender expression, sex, sexual orientation, religion, physical ability, culture, socio-economic status, age, political ideology, national origin, or veteran status. The School of Medicine also endeavors to increase the presence of those who are committed to serving under-resourced and rural populations. While working to create an inclusive welcoming environment for all, the School of Medicine is committed to ongoing systematic recruitment and retention activities to achieve its mission appropriate diversity outcomes. (https://unc.policystat.com/policy/8063477/latest/)

Underrepresented (UR): the concept of underrepresentation refers to population groups whose numbers (in certain geographic areas or within a defined category or discipline) are disproportionally less than the general population (i.e., gender, race/ethnicity, sexual orientation, first generation, low income, veteran status, disabilities, people who identify with more than one race/ethnicity, and depending on context this can also include other identity groups).

Underrepresented Minority (URM): traditionally this terminology is used at the university or organizational level and includes race/ethnic groups – American Indian/Native American, Asian/Asian American, Black/African American, Hispanic/Latino/Latinx, and Native Hawaiian or Pacific Islander who have been historically disadvantaged, in part, because of historical oppression.

Underrepresented in Medicine (URM/URiM/UIM): those racial and ethnic populations that are underrepresented in the medical profession relative to their numbers in the general population, as defined by the Association of American Medical Colleges. This includes American Indian/Native American, African American/Black, Hispanic/Latinx, and Native Hawaiian or Pacific Islander. For the purposes of Asian Underrepresented, this terminology is defined by some medical schools as those who do NOT identify as Chinese, Japanese, Filipino, Korean, Asian Indian, or Thai. *Please note, it is important to clarify the difference between Underrepresented Minority and Underrepresented in Medicine when reporting on diversity and diversity statistics.*

Underrepresented in Research (https://diversity.nih.gov/about-us/population-underrepresented)**:** Blacks/African Americans, Hispanics/Latinos, American Indians or Alaska Natives, Native Hawaiians, and other Pacific Islanders, individuals with disabilities that substantially limit one or more major life activities, and certain individuals from disadvantaged backgrounds. Women are underrepresented in senior faculty and leadership positions. (See NIH definitions for more details.)

Executive Summary

Introduction

The UNC School of Medicine has long valued social justice as critical to its mission of providing care to underserved populations and reducing health disparities in North Carolina and beyond. Yet, upon review of the medical curriculum at UNC, it was found that social justice was often de-emphasized or ignored outside of the formal Social Health Systems courses. Additionally, the review found that instructors were often not prepared to discuss the intersection of health, disease, and their social determinants, often resorting to outdated and inaccurate explanations for the prevalence of medical conditions within certain groups. Finally, a growing number of medical students reported that the hidden curriculum (i.e. the unwritten, unofficial, and often unintended lessons, values, and perspectives that students learn in school) left them feeling mistreated, discriminated against, and undervalued based on various aspects of their identities. In order to address these findings, the School of Medicine convened the Task Force to Integrate Social Justice into the Curriculum.

Methods

The Task Force used a multifaceted approach to achieve its goal and recruited a diverse group of individuals for the sake of equity and inclusion. By recruiting a diverse group and using a concentric ring structure of leadership, we aimed to distribute power to all participants and allow thoughts to flow in all directions among members. The first ring of participants was a core team made up of four individuals who were well connected to theory and practice of their respective areas, and who understood the administrative processes necessary to integrate social justice into the curriculum. The second ring was the leadership team, which included content-experts in the areas of the learning environment, curriculum, and faculty development. The third ring included the entire task force, which was composed of administrators, faculty, staff, and students who were involved in this work and could move it forward within the school. The last ring was the School of Medicine student community, in which task force members hosted town halls to keep individuals apprised of what we were doing and to receive their feedback.

The leadership team identified three key areas that would require systemic change in order to effectively integrate social justice into the medical curriculum: the learning environment, curricular innovation, and faculty development. The task force was divided into three workgroups, each of which focused on developing recommendations in one of these three areas. The entire task force met monthly for three-hour workshops. During these workshops, the group convened as a large group for 30 minutes, then met among the three sub-committees for 120 minutes, and concluded with a 30 min report out and discussion.

Task Force Recommendations

Recommendations were formed through the information gathered by the task force. The recommendations address key gaps, goals, objectives, metrics, and outcomes to integrate social justice into the curriculum. The rationale for the recommendations are discussed in greater detail under the section: The Process to Integrate Social Justice into the Curriculum with Anti-

Racist Components (Page 20). Furthermore, Appendix A outlines suggested individuals and departments who might implement the recommendations (e.g., Education Committee, Office of Faculty Affairs and Leadership Development, etc.). To advance this work we suggest the establishment of a collaborative committee to manage the process, work with individuals, and bring departments together to implement agreed upon recommendations. Below is an abridged version of the recommendations, which are organized around the learning environment, curriculum innovation, and faculty development.

Learning Environment

Recommendation 1.1: Perform a qualitative/quantitative analysis of the personal and professional needs of students to get a better idea of the resources it will take to promote their success.

Recommendation 1.2: Perform a qualitative/quantitative analysis of the UNC SOM hidden curriculum and its impact on the learning environment.

Recommendation 1.3: Hire an embedded SOM counselor with expertise and interests in diversity and inclusion.

Recommendation 1.4: Perform a qualitative/quantitative analysis of the causes of the opportunity gap in UNC SOM students so that programs to reduce the opportunity gap can be implemented.

Recommendation 1.5: Review the composition, training, and processes associated with the Student Progress Committee, Admissions Committee, Student Support Committee, and other committees that impact student success.

Recommendation 1.6: Create systems that ensure that faculty responsible for career advising are effective and accountable including providing them with salary support and protected time.

Recommendation 1.7: Improve accountability measures for students, faculty, staff, and residents who either fail to promote a positive learning environment, contribute to a hidden curriculum that does not support SOM values, or are involved in the mistreatment of medical students.

Recommendation 1.8: Recruit working group/task force of content experts from SOM and other UNC Schools, including resident, fellow, and medical student representatives, to develop core competencies, content, and case studies for an online curriculum as it pertains to social justice, DEI, and healthcare disparities. From November to end of January, establish core competencies, outline content, and identify case studies that can be used to teach key concepts.

Recommendation 1.9: Secure formal sponsorship from the SOM and UNC Hospital GME and designate executive leads. They will be responsible for reviewing and advising upon deliverables, supporting alignment of initiatives and goals between UME and GME as they pertain to this initiative, and help facilitate progress and remove barriers.

Recommendation 1.10: Analyze outcomes of UNC SOM matriculants including academic and professionalism performance, transition to GME, and retention to the North Carolina physician workforce, to instruct a modification of the admissions committee processes by April 2021.

Recommendation 1.11: Modify existing screening processes to identify applicants with an increased likelihood of success at the UNC School of Medicine and service to the North Carolina community more effectively for implementation by the 2021-2022 Admissions Cycle. Periodically review matriculant outcomes to continue to fine tune recruitment and selection algorithms.

Recommendation 1.12: Develop specific initiatives to recruit applicants from UNC System institutions (both majority and minority) inclusive of potentially developing new/supporting existing healthcare sciences pipeline programs at each institution.

Recommendation 1.13: Require that all members of the admissions committee complete trainings related to the principles of holistic review, selection bias, and patient care, research, and education goals of the UNC School of Medicine for implementation by the 2021-2022 Admissions Cycle.

Recommendation 1.14: Modify the applicant selection algorithm to prioritize applicant factors consistent with success with the UNC School of Medicine curriculum and retention to the North Carolina physician workforce.

Recommendation 1.15: Examine barriers to recruiting and maintaining an admissions committee that mirrors North Carolina's demographics by 2021. Develop a plan to sustainably minimize those barriers by 2022.

<u>Curriculum Innovation</u>

Recommendation 2.1: Provide/develop workshops by content experts for phase leadership and departments on how to incorporate outlined core concepts of anti-racism, with a plan for ongoing use.

Recommendation 2.2: Directors of all phases will begin to examine and change content as needed to include anti-racist concepts as defined in the objectives.

Recommendation 2.3: School of Medicine and directors of all phases will examine and develop assessment procedures (including post-foundation, post-application, and finish-line questionnaires, AMA grading tool, and focus groups) that are ongoing to measure student and faculty impressions.

Recommendation 2.4: OIE will secure formal relationships with REI, UNC LGBTQ+ Center, and other leading expert organizations or individuals for use in the curriculum as needed.

Recommendation 2.5: Phase leaders will ensure that instructors in all phases coordinate to make explicit connections between the topics/concepts addressed in the curriculum.

Recommendation 2.6: Continue TEC Leadership work group to develop case bank for Foundation Phase.

Recommendation 2.7: Develop and start relationship-based training for faculty and students on team-work, conflict resolution, and inclusivity including evidence-based concepts of the relationship between belonging, trust, wellness, and anti-racist curricula.

Recommendation 2.8: Appoint inclusive work-group for long-term transformation of curriculum.

Recommendation 2.9: Full implementation of new curriculum 2023-2024.

Recommendation 2.10: Form a work-group to:
- Determine the breakdown of assessments in all phases by 2021.
- Identify best practices for use of a wide variety of assessments for a student portfolio by 2022 with phased implementation.
- Identify the necessary resources required for portfolios and determine if institutionally feasible (software, coaches, admin support).

Recommendation 2.11: Appoint group (including colleagues from the Gilling's School of Public Health) to:
- Revise advocacy competencies for medical students.
- Develop group project assignment, assessment method(s), and implementation plan. Should include longitudinal, robust community partnership projects, that involve needs assessments, evidence-based interventions, assessment, and sustainability plans made effective by Individualization phase at the latest (Refer to work done by Dr. Pedro Greer at Florida International University SOM).
- Determine best placement in curriculum for this project.

Recommendation 2.12: OIE to Secure relationships with NCMS (North Carolina Medical Society), NC School of Public Health, and NC Law School for partnerships available for student projects/collaboration.

Recommendation 2.13: Appoint a diverse advisory group to develop expectations/milestones and review course directors and curriculum leads every three years with a decision for renewal or not. Portfolio for review will include:
- DEI Certificate
- Demonstration of growth mindset with application of learning theory to program/teaching
- Student and peer evaluations (including anonymous evaluations)

Recommendation 2.14: Course directors who already have a documented history of discrimination (two or more actions) will be excused from leading teaching responsibilities.

Faculty Development

Recommendation 3.1: Develop curriculum for core education training sessions which includes but is not limited to training on implicit bias, the history of discrimination and racism in the US and their relationship to health and health care, and skills to effectively incorporate issues of discrimination based on race/ethnicity, gender, sex, sexuality, nationality, religion, veteran status, socioeconomic status, body size, and other factors into teaching.

Recommendation 3.2: Allocate the resources and support needed to develop the capacity to train all UNC SOM faculty.

Recommendation 3.3: Develop a system to help faculty develop and use Individualized Education Plans.

Recommendation 3.4: Develop a communication strategy system where reflection prompts are widely disseminated to SOM and UNC Health Employees and where high-quality reflections are shared and celebrated.

Recommendation 3.5: Develop uniform policies and procedures on how social justice contribution is integrated into the annual reviews and tied to incentives.

Recommendation 3.6: Revise Promotion and Tenure Guidelines to include a social justice domain required for promotion.

Recommendation 3.7: Develop mechanisms for rewarding faculty members who demonstrate excellence in their teaching in the domain of social justice above and beyond the typical incentive plans (e.g. rotating endowed chairs).

Recommendation 3.8: Ensure that the selection process for leaders at the UNC SOM includes assessing an applicant's growth mindset as it relates to social justice.

Recommendation 3.9: Increase financial investment to recruit, support, mentor, and retain URM faculty.

Recommendation 3.10: More visibly display our commitment to social justice and the concrete action steps we're taking to move toward that goal to learners, faculty, staff, and the wider community. Examples might include but are not limited to multimedia public relations campaigns, inclusive signage, and architectural and design changes in the physical space.

Recommendation 3.11: Develop more rigorous pathways and outreach programs to recruit, mentor, support, and retain URM faculty, trainees, and students.

Recommendation 3.12: Develop an active URM faculty network that can raise awareness about open positions and encourage applications.

Recommendation 3.13: Increase the diversity of educational leaders and faculty serving on key committees to reflect the diversity of the communities of North Carolina.

The Relationship between Diversity, Equity, and Inclusion (DEI) and Social Justice

While there are more extensive definitions around DEI in higher education, at its core Diversity is about difference related to race, gender, sexual orientation, age, religion, veteran status, first generation status, and/or other group identities; Equity is about making sure people have what they need to be successful, which is fundamentally different from the concept of equality, which advocates that everyone should be treated the same; and Inclusion is about making sure individuals from diverse backgrounds feel valued and a sense of belonging. In order for DEI to work within different spaces of an educational environment, the tenets of social justice must exist to ensure individuals understand issues related to access to opportunity, human rights, respect, recognition of the voices of marginalized and oppressed groups, equity, and an understanding of the effects of discrimination.

To further illustrate the connection between DEI and social justice, Dr. Damon A. Williams's book, *Strategic Diversity Leadership*,[2] summarizes the evolution of diversity efforts within higher education through three primary models that are tied to social justice (Figure 1): 1) The Affirmative Action Equity Model, 2) The Multicultural and Inclusion Diversity Model, and 3) The Learning, Diversity, and Research Model. The Affirmative Action Equity model started in the 1950s - 1970s and focused on compositional diversity with the goal of ending discriminatory practices that impacted faculty, staff, and students. The Multicultural and Inclusion model originated in the 1960s and 1970s and focused on cultural understanding of diverse groups (historically underrepresented racial and ethnic groups, women, the LGBTQI+ community, and other minority groups). The Learning, Diversity, and Research model originated in the 1990s to present and focuses on the integration of diversity into the curriculum and research.

To meet the expectations of justice for all and the needs of a growing diverse society, the evolution of these three diversity models in higher education harnesses the synergy of social justice, the educational value, and the business case to improve learning and working environments, organizational outcomes, and social change (the interactions and relationships between humans that transform culture, behavior, institutions, and social structures). As a result, in June of 2020, the University of North Carolina School of Medicine implemented a DEI Framework grounded in social justice (Figure 2) based on five dimensions: 1) Infrastructure, 2) Access and Success, 3) Curriculum and Scholarship, 4) Community Engagement, and 5) Climate. To meet the needs of a growing diverse state, a curriculum embedded in social justice and anti-racist components is essential to patient care, health equity, reduction of health disparities, and most importantly, social change.

Figure 1: Three Primary Models of Diversity in Higher Education

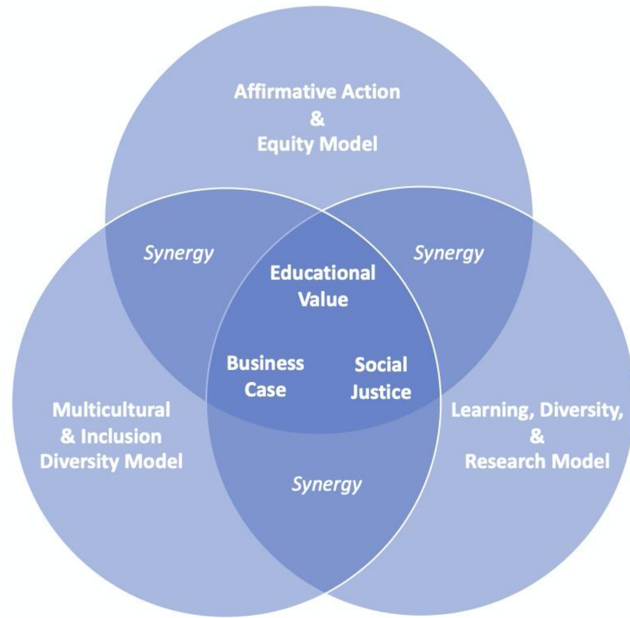


Figure 2: UNC School of Medicine DEI Framework

Justification for Integrating Social Justice into the Curriculum with Anti-racist Components

A wealth of literature has demonstrated disparities in health care access, quality, and outcomes. We now know these disparities are apparent both across our healthcare system and within most individual providers' patient panels.[3,4] Despite advances in medical technology, many health disparities persist and have even worsened over time.[3–6] One of the contributors to the enduring nature of health disparities is the education of health care professionals. Throughout their four years in undergraduate medical education (UME), medical students who enter the field eager to serve are known to lose empathy, become less keen to care for the underserved, and fortify biases against minorities as they become acculturated into medicine.[7–14] These implicit biases, or the stereotypes and attitudes that affect our perceptions and actions in an unconscious manner, are unwittingly reinforced in medical curricula as inaccurate Civil War-era (and even earlier) assumptions about race-based biology and genetics that are still used in everyday diagnosis and treatment algorithms and are passed on to the next generation of physicians.[15–20] These less-examined aspects of medical education directly feed into ineffective communication, lower quality care, poorer outcomes, and eventually population-level disparities for marginalized populations.[10,21–25] Fortunately, medical schools can decrease these biases and seek to reduce health disparities if we intervene early, make the priority of health equity clear, and use a varied and iterative approach to teaching students about how social and structural determinants of health (SDH), such as racism, classism, sexism, and heteronormativity, contribute to health disparities.[14]

Encouraging learners to understand and address social inequities has become a benchmark for medical institutions; schools are ranked by their social mission score and the Global Consensus on Social Accountability of Medical Schools guides institutions in answering the escalating calls for medical schools to respond to the needs of society's most vulnerable.[26–29] The Liaison Committee on Medical Education (LCME) considers teaching about societal problems, cultural competence, and health care disparities to be standard curricular content.[30] The Association of American Medical Colleges (AAMC) has also created the Tool for Assessing Cultural Competence Training (TACCT) which provides a list of 42 learning objectives in the area of health disparities, community strategies, bias/stereotyping, cross-cultural communication, use of interpreters, and self-reflection/culture of medicine that it expects medical students to review by graduation.[31,32] Additionally, countless medical associations and educators are calling for medical schools to clearly acknowledge racism as a public health emergency by incorporating more education about systemic racism and how to practice anti-racism into training.[33–36] In October 2020, the AAMC released its own *Framework for Addressing and Eliminating Racism at the AAMC, in Academic Medicine, and Beyond*, acknowledging the role that racism plays in academic medicine.[37] Not only are accreditation bodies and educators calling for this curricular content, but medical students are interested in it. The AAMC's annual Medical School Graduation Questionnaire shows medical students increasingly value diversity of student backgrounds and the enhanced learning that comes with embracing that diversity.[38] This questionnaire revealed a 28% increase in students reporting they plan to care primarily for underserved populations from 2015 to 2019.[38]

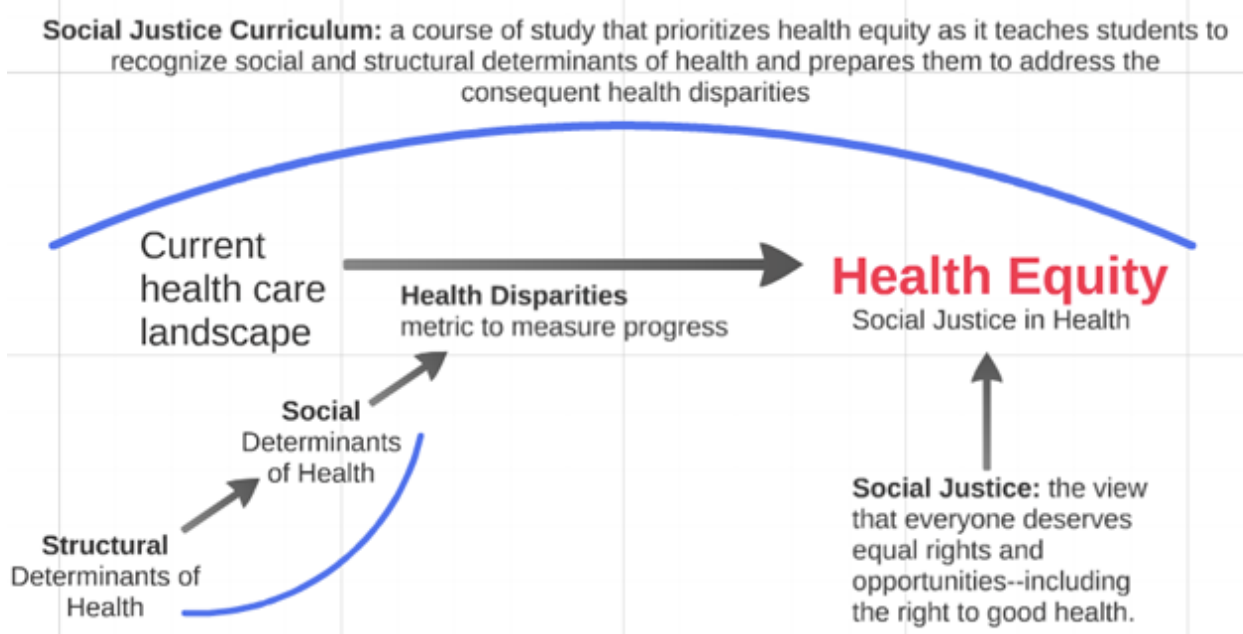
Despite the expectation that institutions provide this content, there is substantial uncertainty regarding standardization, integration, and best practices in teaching these concepts. The AAMC's 2018-2019 Curriculum Inventory demonstrates SDH education, if provided at all, is infrequently provided after the first year and often is still optional.[39] A 2019 scoping review of 89 articles on educational strategies to aid students in understanding and decreasing health disparities discovered schools are implementing a variety of methods to teach this content, though many are still only using short individual trainings and less than half of interventions are reporting favorable outcomes.[40] Another 2020 scoping review examining 154 articles on cultural competency teaching in medical schools observed fewer than half of trainings on this topic are mandatory for all students, a majority are lecture-based, and only 29% are longitudinally integrated.[41] These and numerous other reviews and society guidelines have concluded that education about health disparities, SDH, and cultural competency should be taught through a variety of techniques and integrated longitudinally into the core medical curriculum.[40–43]

Introducing Terminology

One of the challenges in meeting the aforementioned expectations is the variation in educational content and terminology. To teach about SDH, health disparities, and anti-racism, educators must have clear definitions of these terms as well as a concept of the end goal: health equity. Braverman defines health equity as "social justice in health," describing this as a state in which "no one is denied the possibility to be healthy for belonging to a group that has historically been economically/socially disadvantaged."[44] In this schema, as outlined in Figure 3, health disparities are the metric by which we measure progress, or lack thereof, toward achieving health equity and the social and structural determinants of health (SDH) are the upstream conditions that affect a wide range of health and quality-of-life outcomes.[45,46] Though the acronym "SDH" is commonly used to refer solely to the social determinants of health, it is used here to refer both to the social and structural determinants of health that together shape an estimated 80% of our health outcomes before we ever arrive in clinical care.[47] See the Glossary above for detailed definitions of these and related terms.

The World Health Organization (WHO) has embraced addressing health disparities through the lens of social justice for several decades.[48] The American Public Health Association defines social justice as the "view that everyone deserves equal rights and opportunities—this includes the right to good health."[49] The American Board of Internal Medicine's (ABIM) Charter on Medical Professionalism lists social justice as one of the three fundamental principles of medical professionalism.[50] To ensure medical graduates enter the workforce ready to embody this professional ethic, educators must utilize a framework to guide curricular integration.

Figure 3: Social Justice Curriculum Schema



The Process to Integrate Social Justice into the Curriculum with Anti-Racist Components

The Learning Environment, Curriculum Innovation, and Faculty Development: Understanding gaps and developing goals, objectives, metrics, outcomes, and recommendations to integrate social justice into the curriculum with anti-racist components

LEARNING ENVIRONMENT

I. Gaps - The task force sub-committee on the learning environment identified the following areas where change is needed in order to create an environment that would be supportive for all medical students.
   A. Opportunity gaps exist for students matriculated within the School of Medicine. The roots and relevant influence of those gaps are not fully understood (e.g. life and social factors, wealth disparities, internalized oppression, hidden curriculum).
   B. The demographics of students, staff, faculty, and leadership does not reflect that of the state, due in part to recruitment, admission/hiring, mentoring, and retention. This leads in some cases to a “black/brown tax” on many members of the School of Medicine community that others may not be aware of.
   C. Students, staff, and faculty belonging to underrepresented groups are subject to implicit and explicit biases within the learning and clinical environments that directly affect the mental and physical health, as well as the ability to succeed academically and in their careers.

II. Goals, Objectives, Metrics, Outcomes, and Recommendations
   A. **Goal 1: To provide an environment where diverse groups of students can succeed and thrive.**
      1. **Objectives**
         a) To provide a more holistic approach to student support that considers students’ financial, medical, psycho/social, and academic needs.
         b) To develop programs that mitigate the opportunity gap.
         c) To provide career development to medical students that better integrates Dean’s Office staff with faculty representatives from the different SOM departments.
         d) To create a diverse environment in order to facilitate recruitment and retention of a diverse group of students.
         e) To recognize and reward students who exemplify the SOM professionalism competencies related to social justice.
         f) To develop policies that promote greater transparency related to students who do not comply with the SOM professionalism competencies related to social justice.
         g) To promote a hidden curriculum that provides an environment where diverse students can thrive and supports UNC SOM values

of providing care to underserved populations and reducing health care disparities across North Carolina and beyond.

2. **Metrics**
    a) 50% reduction in the number of URM students who withdraw or are dismissed is achieved by 2024.
    b) A reduction of the opportunity gap such that the performance of URM students is more evenly distributed and no longer concentrated in the bottom quartile by 2024.
    c) 50% improvement in student satisfaction in all student support areas including financial aid, academic assistance, career advising, psycho/social support, and health care needs as assessed by student surveys by 2022.
    d) 50% increase in satisfaction with the learning environment as assessed by student surveys by 2022.
3. **Outcome**
    a) Students from diverse backgrounds will thrive and demonstrate levels of achievement on par with their classmates from dominant backgrounds.

RECOMMENDATIONS

Recommendation 1.1: Perform a qualitative/quantitative analysis of the personal and professional needs of students to get a better idea of the resources it will take to promote their success.

Recommendation 1.2: Perform a qualitative/quantitative analysis of the UNC SOM hidden curriculum and its impact on the learning environment.

Recommendation 1.3: Hire an embedded SOM counselor with expertise and interests in diversity and inclusion.

Recommendation 1.4: Perform a qualitative/quantitative analysis of the causes of the opportunity gap in UNC SOM students so that programs to reduce the opportunity gap can be implemented.

Recommendation 1.5: Review the composition, training, and processes associated with the Student Progress Committee, Admissions Committee, Student Support Committee, and other committees that impact student success.

Recommendation 1.6: Create systems that ensure that faculty responsible for career advising are effective and accountable including providing them with salary support and protected time.

Recommendation 1.7: Improve accountability measures for students, faculty, staff, and residents who either fail to promote a positive learning environment, contribute to a hidden curriculum that does not support SOM values, or are involved in the mistreatment of medical students.

B. **Goal 2: UNC residents and fellows will receive formal education and training in areas of social justice; diversity, equity, and inclusion; social determinants of health; and healthcare disparities. This training will emphasize knowledge and skills for enhancing patient care delivery as well as interprofessional teamsmanship, including support and integration of medical students in the clinical learning environment by resident/fellows.**

1. **Objectives:**
    a) Develop Health Systems Science interactive online curriculum designed for UNC residents and fellows statewide as part of AMA Reimagining Residency initiative, with a pilot focus on the FIRST residency programs (Family Medicine, Internal Medicine, Pediatrics, Psychiatry, Ob-Gyn, Surgery), to include a specific focus on core competencies related to social justice; diversity, equity, and inclusion in healthcare; and healthcare disparities. This will be developed with an aim of creating synergy and harmonization between the core competencies valued by both GME and UME.
    b) To ensure accessibility of the curriculum to all trainees and feasibility of delivery, the platform for delivery must be adaptable for independent learning (i.e., similar to an EdX course).
    c) Ideally, it will also be designed to facilitate a "flipped classroom" model, whereby a faculty leader will utilize modules as case studies for group discussions tailored to specific patient populations, embedding these within resident didactics and other existent case conferences within each Department/Residency Program.
2. **Metrics:**
    a) An online social justice curriculum will be available for all residents by 2022.
    b) 75% of residency and fellowship programs will engage with the curriculum by 2023.
    c) 50% of residents and fellows will complete the curriculum by 2024.
3. **Outcomes:**
    a) Survey of residents pre/post regarding knowledge base surrounding social justice, DEI, social determinants of health, and health care disparities.
    b) Medical student evaluations of residents/fellows/faculty to include metrics pertaining to social justice, DEI, social determinants of health, and health care disparities.
    c) The trend of internal and external assessments of the learning environment should show improvement in measures related to the learning environment. Examples of external measures include the

AAMC Y2Q and GQ. Examples of internal assessments include the midline and finish line surveys.

RECOMMENDATIONS

Recommendation 1.8: Recruit working group/task force of content experts from SOM and other UNC Schools, including resident, fellow, and medical student representatives, to develop core competencies, content, and case studies for an online curriculum as it pertains to social justice, DEI, and healthcare disparities. From November to end of January, establish core competencies, outline content, and identify case studies that can be used to teach key concepts.

Recommendation 1.9: Secure formal sponsorship from the SOM and UNC Hospital GME and designate executive leads. They will be responsible for reviewing and advising upon deliverables, supporting alignment of initiatives and goals between UME and GME as they pertain to this initiative, and help facilitate progress and remove barriers.

C. **Goal 3: The work of the admissions committee should be guided by the UNC School of Medicine's education and patient care missions to recruit students from highly diverse backgrounds to create a socially responsible, highly skilled workforce that reaches underserved populations and reduces health disparities across North Carolina and beyond.**

1. **Objectives**
    a) To admit a class of medical students that shares the UNC SOM's values of service, social justice, equity, and inclusion.
    b) To admit a class of students that promotes a welcoming learning environment for students from demographically diverse groups.
    c) To build an admissions committee whose composition reflects the demographic and talent diversity of the student body it is charged with recruiting and matriculating.
    d) To develop an ongoing social justice curriculum for medical school admissions committee training that reinforces the principles of holistic review, selection bias, and the patient care and education goals of the UNC School of Medicine for implementation by the 2021-2022 Admissions Cycle.
    e) To develop a scope of work for faculty members of the admissions committee that can be clearly communicated to department chairs for the purposes of granting sufficient release time and consideration in promotion and tenure decisions.
    f) The application screening, interview, and selection processes of the admissions committee should be equitable for all applicants across the socioeconomic spectrum and aligned with the UNC SOM patient care and education mission.
2. **Metrics**
    a) UNC SOM's student body will have demographics that more closely mirror the demographic makeup and projected growth of the state of North Carolina (which, as of 2018, was 63% white,

21% African American, 10% Latinx, 3% Asian or Pacific Islander, 2% multiracial, and 1% American Indian or Alaskan Native) by 2024.

b) 100% of members of the Admissions Committee will complete continuing social justice training by 2021.

3. **Outcome**

a) UNC SOM's student body will be supportive, inclusive, and with a growth mindset, eager and able to provide unbiased and excellent patient care to residents of North Carolina.

RECOMMENDATIONS

Recommendation 1.10: Analyze outcomes of UNC SOM matriculants including academic and professionalism performance, transition to GME, and retention to the North Carolina physician workforce to instruct a modification of the admissions committee processes by April 2021.

Recommendation 1.11: Modify existing screening processes to identify applicants with an increased likelihood of success at the UNC School of Medicine and service to the North Carolina community more effectively for implementation by the 2021-2022 Admissions Cycle. Periodically review matriculant outcomes to continue to fine tune recruitment and selection algorithms.

Recommendation 1.12: Develop specific initiatives to recruit applicants from UNC System institutions (both majority and minority) inclusive of potentially developing new/supporting existing healthcare sciences pipeline programs at each institution.

Recommendation 1.13: Require that all members of the admissions committee complete regular trainings related to the principles of holistic review, selection bias, and patient care, research, and education goals of the UNC School of Medicine for implementation by the 2021-2022 Admissions Cycle.

Recommendation 1.14: Modify the applicant selection algorithm to prioritize applicant factors consistent with success with the UNC School of Medicine curriculum and retention to the North Carolina physician workforce.

Recommendation 1.15: Examine barriers to recruiting and maintaining an admissions committee that mirrors North Carolina's demographics by 2021. Develop a plan to sustainably minimize those barriers by 2022.

CURRICULUM INNOVATION

I. Gaps: The task force sub-committee on curriculum innovation identified the following areas where transformation is needed to curricular content that supports diversity, equity, and inclusion.

A. Students report continued use of discriminatory language and/or images in portions of the curriculum.
B. Pedagogical structure and delivery that privileges the large lecture format is unengaging and systematically shortchanges URM students.
C. Assessment methods based primarily on multiple-choice testing do not fully measure nor promote professional skill-acquisition, and fail to promote social justice principles.
D. Accountability to social justice and evidence-based teaching is lacking.
E. Effective advocacy on behalf of patients beyond the clinical setting is underdeveloped among graduating medical students.

II. Goals, Objectives, Metrics, Outcomes, and Recommendations

A. **Goal 1: Eliminate from the curriculum racist content/terminology and implicit bias and create content that uses inclusive concepts, imagery, and terminology regarding race/ethnicity, gender and sex, sexuality, nationality, religion, socioeconomic status, and similar factors.**

1. **Objectives**
   a) All block directors and course directors will have changed their curricula by the fall of 2021 to adhere to the following core concepts:
      (1) all lectures addressing known health disparities will attend to those disparities and WHY they exist
      (2) each lecture should have a "structural context" section, in addition to basic science and clinical material
      (3) when presenting clinical images, present multiple skin tones
      (4) when discussing race, emphasize that race is not a set biological category
      (5) explain the difference between sex and gender and how specific organs and cells do not belong to specific genders
      (6) mindfully assess question stems/cases to avoid stereotypes
      (7) explicitly include anti-racism content during lectures and small group discussions
      (8) use inclusive LGBTQI+ language
      (9) ensure that standardized patients are representative of the public
   b) All course directors will have implemented a continuous method of identifying curricular inclusivity deficits by the fall of 2021.
2. **Metrics**
   a) 75% of medical students and 50% of teaching faculty will be aware of the SOM curricular reporting system that is designed to allow students to anonymously report issues with the curriculum by 2022.
   b) 50% of incidents reported by 2021 will not be repeated in 2022, 75% will not be reported by 2023.
   c) Rash photos will be shown on multiple skin tones 100% of the time by 2022.

d) 50% of relevant topics will give health disparities involved in disease processes, and the reasons for those disparities, by 2022.
e) Surveys administered to students after each phase will show an ongoing increase in satisfaction on inclusivity of curricular content.
f) 50% of targeted areas will have anti-racist content by 2022, 90% of targeted areas by 2023.

3. **Outcome**
   a) Faculty will consistently and proactively use appropriate language, concepts, and imagery regarding race/ethnicity, gender and sex, sexuality, nationality, religion, and socioeconomic status, leading to: less biased students, more timely diagnoses, and greater student engagement by traditionally marginalized students.

RECOMMENDATIONS

Recommendation 2.1: Provide/develop workshops by content experts for phase leadership and departments on how to incorporate outlined core concepts of anti-racism, with a plan for ongoing use.

Recommendation 2.2: Directors of all phases will begin to examine and change content as needed to include anti-racist concepts as defined in the objectives.

Recommendation 2.3: School of Medicine and directors of all phases will examine and develop assessment procedures (including post-foundation, post-application, and finish-line questionnaires, AMA grading tool, and focus groups) that are ongoing to measure student and faculty impressions.

Recommendation 2.4: OIE will secure formal relationships with REI, UNC LGBTQ+ Center, and other leading expert organizations or individuals for use in the curriculum as needed.

Recommendation 2.5: Phase leaders will ensure that instructors in all phases coordinate to make explicit connections between the topics/concepts addressed in the curriculum.

B. **Goal 2: Transform MTEC101, MTEC102, and MTEC103 into a relationship-based curriculum (defined in glossary above) where students are placed in small group learning communities and where cases allow the organic introduction of social determinants of health, stereotype threats, and implicit bias.**

1. **Objectives**
   a) Create or secure a group of cases for small groups that both intentionally advance medical science concepts and social justice concepts concurrently by 2022, in coordination with similar work carried out in PCC and SHS.

b) Hire and train all small group facilitators on team-work, social justice, management of conflict, and pro-active student support by 2022.
c) All students will receive the majority of their foundation phase instruction in small and supportive learning communities by the fall of 2023.

2. **Metrics**
    a) The foundation phase curriculum will be 50% small group by 2023.
    b) 25% decrease of URM remediation for the 2022-2023 academic year, 50% by 2023.
    c) Remediation of URM will be reflective of student-body make-up by 2023.
    d) 25% annual improvement in wellness metrics, including belonging and trust, until that of URM students is at or surpassing that of other students.
3. **Outcome**
    a) Students and faculty will engage in the curriculum as a team to address race/ethnicity, gender and sex, sexuality, nationality, religion, and socioeconomic status, leading to: less biased students and faculty, closing a part of the opportunity gap based on pedagogical structure and delivery, and greater student engagement by traditionally marginalized students.

RECOMMENDATIONS

Recommendation 2.6: Continue TEC Leadership work group to develop case bank for Foundation Phase.

Recommendation 2.7: Develop and start relationship-based training for faculty and students on teamwork, conflict resolution, and inclusivity including evidence-based concepts of the relationship between belonging, trust, wellness, and anti-racist curricula.

Recommendation 2.8: Appoint inclusive work-group for long-term transformation of curriculum.

Recommendation 2.9: Full implementation of new curriculum 2023-2024.

C. **Goal 3: Develop and use assessments (e.g. Student Portfolios and progress testing, correlated with improved performance by URMs[50]) that include measures that align with all of our competencies. This can be achieved by using multi-faceted measures of performance that promote the development of skills for diverse groups. Assessments must be infused with social justice principles and practices for each competency area, identified by demonstrated decreases in bias compared to traditional testing methods.**

1. **Objectives**
    a) Create a balance between formative (progress testing) and summative assessments in grade breakdowns for all courses.
    b) Diversify the types of assessments, de-emphasizing high-stakes (very significant gains or losses), multiple-choice exams.
    c) Explore and implement student portfolios by:
        (1) Determining achievement milestones for enabling competencies that are appropriate for each phase of the curriculum. The milestones must increase intentionally with expected skill development and be as free as possible of potential bias.
        (2) Identifying assessments with decreased levels of bias that measure milestone achievement.
2. **Metrics**
    a) The percentage of high stakes exams should not exceed 50% by 2023.
    b) 50% of exams will be moved to criterion-referenced testing (measure performance against a standard) by 2022, 100% by 2023.
    c) Annual improvement in average course grade of URM students beginning in 2023, until at or exceeding non-URM students.
3. **Outcome**
    a) Students will have opportunities to correct thinking, skills, and behavior through formative assessment prior to summative, high-stakes assessments, making the learning process transparent for students who have not had previous exposure to curricula that teach these metacognitive strategies. Students will have the opportunity to demonstrate their knowledge and skills through a variety of assessments versus a single, traditional method, such as a multiple-choice exam (an extreme source of anxiety for URMs who traditionally do not perform as well on MCQ exams, a narrow representation of learning). Students will have an opportunity to transparently see and address their progress toward well-articulated milestones through the use of portfolios intentionally created to reduce bias.

RECOMMENDATIONS

Recommendation 2.10: Form a work-group to:

- Determine the breakdown of assessments in all phases by 2021.
- Identify best practices for use of a wide variety of assessments for a student portfolio by 2022 with phased implementation.
- Identify the necessary resources required for portfolios and determine if institutionally feasible (software, coaches, admin support).

D. **Goal 4: Students will be able to effectively advocate on behalf of their patients within and beyond the clinical setting, with a robust understanding**

of the structural and social factors that affect health and health disparities and a foundation of medical knowledge that does not contribute to stereotypes or bias related to race, ethnicity, nationality, sex, gender, sexuality, religion, immigration status, or socioeconomic status.

1. **Objectives**
    a) All students will be trained in core advocacy skills by 2023, including the following:
        (1) analyze the history, structure, and influence of institutions that shape health
        (2) explain the cultural norms, laws, and policies that influence health
        (3) explain the laws and policies that regulate advocacy
        (4) build coalitions and relationships to bring about change
    b) All students will be able to deploy advocacy skills in the following health realms by 2023, including:
        (1) care of special patient populations in need of distinct forms of access, treatment, and/or information
        (2) US ratification of the basic human rights treaties and conventions of the international community
        (3) realization in statute of health care as a human right
        (4) restoring US leadership to reverse climate change
        (5) achieving radical reform of the US criminal justice system
        (6) ending policies of exclusion and achieving compassionate immigration reform
        (7) ending hunger and homelessness in the US
        (8) ensuring every single person's vote counts equally
    c) Students will demonstrate the ability to develop longitudinal, robust community partnership projects that involve needs assessments, evidence-based interventions, measurement, and sustainability plans.
    d) Students will demonstrate a robust understanding of the local, state, and national historical and current policies and structures that affect health and health care delivery, to allow them to better serve their patients.
    e) Students will demonstrate effective methods for developing and delivering an advocacy message, including via traditional media, social media, letters, and/or legislative advocacy via a chosen project (new or a continuation of a previous group's project).
2. **Metrics**
    a) Revision of advocacy competency milestones by 2021.
    b) Advocacy implementation, development, and assessment plans by 2022 (Refer to work done by Dr. Pedro Greer at Florida International University SOM).
    c) 100% of students will participate in chosen advocacy group projects by 2023.

d) 50% increase in proportion of students who engage with legislators, local communities, scholarly presentations will increase by 2023.
e) 50% increase in the number of students who present advocacy projects at scholarly meetings will increase by 2023.
f) 25% improvement in student burnout measures by 2024.

3. **Outcome**
   a) Students will actively engage and advocate on behalf of patients in our communities, resulting in greater empathy for their community at large[52] as well as decreased burnout amongst students.[53]

RECOMMENDATIONS

Recommendation 2.11: Appoint group (including colleagues from the Gilling's School of Public Health) to:

- Revise advocacy competencies for medical students to reflect above objectives.
- Develop group project assignment, assessment method(s), and implementation plan. Should include longitudinal, robust community partnership projects, that involve needs assessments, evidence-based interventions, assessment, and sustainability plans made effective by Individualization Phase at the latest (Refer to work done by Dr. Pedro Greer at Florida International University SOM).
- Determine best placement in curriculum for this project.

Recommendation 2.12: OIE to Secure relationships with NCMS (North Carolina Medical Society), NC School of Public Health, and NC Law School for partnerships available for student projects/collaboration.

E. **Goal 5: Create a culture of high functioning teams of teachers in all phases of the curriculum with high expectations and accountability towards social justice task force outcomes and evidence-based teaching practices.**

1. **Objectives**
   a) All teaching assignments at all levels, including course directors, phase directors, Deans, and advisors will be reviewed for whether their teaching is accountable to social equity and evidence-based teaching and learning by 2021. All teachers including leadership will be reviewed every three years thereafter.
   b) All faculty will have engaged in educational theory training with diverse groups and demonstrate application by 2022.
2. **Metrics**
   a) 25% decrease in reports of difficulties with teachers regarding overt and implicit racial discrimination by 2023.
3. **Outcome**
   a) A culture of student-centered teaching in an equitable environment will be created.

RECOMMENDATIONS

Recommendation 2.13: Appoint a diverse advisory group to develop expectations/milestones and review course directors and curriculum leads every three years with a decision for renewal or not. Portfolio for review will include:

- DEI Certificate
- Demonstration of growth mindset with application of learning theory to program/teaching
- Student and peer evaluations (including anonymous evaluations)

Recommendation 2.14: Course directors who already have a documented history of discrimination (two or more actions) will be excused from leading teaching responsibilities.

FACULTY DEVELOPMENT

I. Gaps
    A. Training
        1. Health Equity Training: rigorous assessment, requiring basic fluency
        2. Mandatory at all levels, properly incentivized
        3. Ongoing. Not one and done
        4. Course directors require “maintenance of certification” in social justice; otherwise ineligible to continue
        5. Giving and receiving feedback is vital with emphasis on growth mentality
    B. Incentives
        1. Integrated into departmental incentives
        2. Integrated into promotion and tenure
        3. Leadership accountability
    C. Faculty recruitment, support, mentorship, and retention
        1. Incentives and support to encourage faculty to teach and mentor URM students
        2. Mentorship of underrepresented faculty

II. Goals, Objectives, Metrics, Outcomes, and Recommendations
    A. **Goal 1: All UNC SOM faculty, as part of the core expectations of being a faculty at UNC SOM, will be expected to effectively integrate social justice content into their teaching, be able to teach their content through a social justice lens, and be able to effectively respond to feedback on that teaching.**
        1. **Objectives**
            a) All UNC SOM faculty will complete core educational training on teaching through a social justice lens that includes (but is not limited to) training on implicit bias, the history of discrimination and racism in the US and their relationship to health and health care, and skills to effectively incorporate issues of discrimination based on race/ethnicity, gender, sex, sexuality, nationality, religion, and socioeconomic status into teaching by 2024.

b) All UNC SOM faculty will complete further annual training on issues of social justice based on their individual needs and teaching responsibilities.
c) All UNC SOM faculty will be encouraged to regularly participate in reflections on their contributions to social justice, responding to prompts developed by the Office of Inclusive Excellence and others by 2021.
d) All CPE sessions for UNC SOM faculty will be taught with a social justice lens as evaluated by post conference surveys by 2024.

2. **Metrics**
    a) 50% of UNC SOM faculty will have completed core educational training sessions by 2022.
    b) 90% of UNC SOM faculty will have completed core educational training sessions by 2024.
    c) 90% of UNC SOM medical students will report feeling satisfied or very satisfied with the teaching related to social justice on the Post Foundation Phase, Post Application Phase, and Finish Line surveys administered by the Office of Medical Education by 2024.
    d) Reports of mistreatment by medical students on the Graduation Questionnaire will remain below the national average and will trend down over time.
    e) 80% of UNC CPE sessions will have greater than 80% attendees agree or strongly agree that the session was taught with a social justice lens by 2024.
3. **Outcome**
    a) Faculty will consistently and proactively develop learning materials and assessments that teach their content with a social justice lens, seek to engage students from various backgrounds, and actively resist the disparities that result from unaddressed biases in the learning environment.

RECOMMENDATIONS

Recommendation 3.1: Develop curriculum for core education training sessions which includes but is not limited to training on implicit bias, the history of discrimination and racism in the US and their relationship to health and health care, and skills to effectively incorporate issues of discrimination based on race/ethnicity, gender, sex, sexuality, nationality, religion, veteran status, socioeconomic status, body size, and other factors into teaching.

Recommendation 3.2: Allocate the resources and support needed to develop the capacity to train all UNC SOM faculty.

Recommendation 3.3: Develop a system to help faculty develop and use Individualized Education Plans.

Recommendation 3.4: Develop a communication strategy system where reflection prompts are widely disseminated to SOM and UNC Health Employees and where high-quality reflections are shared and celebrated.

B. **Goal 2: All UNC SOM Faculty will be assessed regarding their contributions in the domain of social justice and incentivized for such contributions.**

1. **Objectives**
    a) All annual faculty reviews will include an assessment of how the faculty member contributed to social justice or DEI in their work and this assessment will be linked to the department's incentive plan and other rewards by 2024.
    b) The UNC SOM Tenure and Promotion Guidelines will have been modified to include an assessment of how the faculty member contributed to social justice or DEI and such a contribution will be required for promotion by 2024.
    c) All chairs will report on their department's contributions to social justice or DEI and such contributions will be linked to the chair's individual incentive plan by 2024.
2. **Metrics**
    a) 50% of departments will have evaluation tools (e.g. 360 evaluations) that assess and incentivize a faculty member's contributions to social justice in their teaching by 2022.
    b) 100% of departments will have evaluation tools that assess and incentivize a faculty member's contributions to social justice in their teaching by 2024.
    c) Promotion and Tenure Guidelines will have social justice or DEI added as a domain required for promotion for all faculty by 2024.
3. **Outcome**
    a) Faculty see work related to social justice or DEI as central to their work as faculty members.

<u>RECOMMENDATIONS</u>

Recommendation 3.5: Develop uniform policies and procedures on how social justice or DEI contribution is integrated into the annual reviews and tied to incentives.

Recommendation 3.6: Revise Promotion and Tenure Guidelines to include a social justice or DEI domain required for promotion.

Recommendation 3.7: Develop mechanisms for rewarding faculty members who demonstrate excellence in their teaching in the domain of social justice above and beyond the typical incentive plans (e.g. rotating endowed chairs).

C. **Goal 3: UNC SOM will improve recruitment and retention of URM faculty to reflect the diversity in our communities.**

1. **Objectives**
    a) UNC SOM will continue to improve the learning and work environment so that all faculty, students, and trainees feel valued, supported, and empowered to thrive.
    b) UNC SOM will strengthen diversity, equity, and inclusion as a core and highly visible part of the culture of the UNC SOM.
    c) UNC SOM will make a significant, visible, and sustained financial investment to recruit, mentor, support, and retain URM faculty.
    d) UNC SOM will strengthen the commitment to a growth mindset in the domain of social justice for all faculty that results in the cultural change necessary for us to recruit and retain diverse faculty.
    e) UNC SOM will strengthen efforts to ensure that its educational leaders (Dean's Office, course, phase, campus, and advisory college leaders) as well as faculty serving on key committees (education, student progress, and admissions) reflect the diversity of our community.
2. **Metrics**
    a) All chairs will be held accountable to increase the diversity of their departments to reflect the demographics of North Carolina related to race/ethnicity and gender by 2024.
    b) All departments will more closely reflect the demographics of North Carolina related to race/ethnicity and gender in 2024 than it does in 2020 and that trend will continue over time.
    c) All faculty in all departments will be evaluated on a growth mindset related to social justice in their annual review process by 2024.
    d) The representation in the Dean's Office; course, phase, campus, and advisory college leaders; and leaders on key committees will more closely reflect the demographics of North Carolina related to race/ethnicity and gender by 2024 than it does in 2020 and that trend will continue over time.
3. **Outcome**
    a) UNC SOM is a place that nurtures and supports all faculty and is a place that faculty from other institutions actively seek out.

RECOMMENDATIONS

Recommendation 3.8: Ensure that the selection process for leaders at the UNC SOM includes assessing an applicant's growth mindset as it relates to social justice.

Recommendation 3.9: Increase financial investment to recruit, support, mentor, and retain URM faculty.

Recommendation 3.10: More visibly display our commitment to social justice and the concrete action steps we're taking to move toward that goal to learners, faculty, staff, and the wider community. Examples might include but are not limited to multimedia public relations campaigns, inclusive signage, and architectural and design changes in the physical space.

Recommendation 3.11: Develop more rigorous pathways and outreach programs to recruit, mentor, support, and retain URM faculty, trainees, and students.

Recommendation 3.12: Develop an active URM faculty network that can raise awareness about open positions and encourage applications.

Recommendation 3.13: Increase the diversity of educational leaders and faculty serving on key committees to reflect the diversity of the communities of North Carolina.

Charge 4 and Next Steps: Integrating Social Justice into Graduate Medical Education, Allied Health Curricula, and Biomedical and Biological Graduate Programs

The fourth charge to the SOM Task Force to Integrate Social Justice into the Curriculum was to identify other key partners within UNC SOM, expand the task force, and work collaboratively with those partners to make recommendations on best approaches to integrating social justice into the curricula for graduate medical education, Allied Health, and biological and biomedical graduate programs. To that end, the task force leadership has expanded to include representatives from each of those three areas. Jean Cook, PhD will lead this initiative for the biological and biomedical graduate programs; Clark Denniston, MD will lead for Graduate Medical Education; and Stephen Hooper, PhD will lead for Allied Health. These leaders will solicit colleagues from their areas to serve on the larger task force in order to ensure that social justice is integrated into all curricula across the School of Medicine.

As the task force membership shifts to meet the needs of the areas beyond medical education, the members of the task force will build on the experiences gained during the initial phase focused on medical education. By employing the same framework used to recommend changes to medical education (i.e. approaching changes by looking at curricular content, the learning environment, and faculty development), the task force will ensure that social justice is being integrated into the curriculum in a way that is holistic and able to affect meaningful changes to the institutional culture of the School of Medicine.

Summary

COVID 19 and the murder of George Floyd (and countless other people of color) has unveiled an ongoing reality that race has been and continues to be an extreme problem in America. To navigate this problem we must continue to address the implications of race in our educational system and history. If we fail to meet this challenge, we will continue to experience and witness the disparities that disproportionately affect people of color. Ultimately these disparities, and the structures that perpetuate their growth, undermine the quality of life for all individuals and the vitality of the state.

To that end, the culmination of our work is bold, yet sensitive to the disruption we need to cause in a medical educational system that does not prioritize the voices of people of color and others belonging to oppressed or marginalized groups. This report highlights the gaps that exist and strategies required to advance the learning environment, curriculum, and faculty development at the UNC School of Medicine. It is our hope that the recommendations shared in this report will transform the work of our students, trainees, and faculty. While social issues will continue to exist, each generation has a chance to create social change and make this world better for marginalized and oppressed groups. Our goal is to one day eliminate the oppression and marginalization of diverse people and groups in our state and society. To do so, would allow everyone to lead a healthy and high-quality life.

References

1. Eckleberry-Hunt, J., Lick, D., & Hunt, R. (2018). Is Medical Education Ready for Generation Z? Journal of Graduate Medical Education, 10(4), 378–381. https://doi.org/10.4300/JGME-D-18-00466.1
2. Williams, DA. Strategic Diversity Leadership. Stylus Publishing; 2013.
3. Smedley B. Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care . Washington, D.C.: National Academies Press; 2003. doi:10.17226/12875
4. Blackman DJ, Masi CM. Racial and ethnic disparities in breast cancer mortality: are we doing enough to address the root causes? J Clin Oncol. 2006; 24(14):2170-2178. doi:10.1200/JCO.2005.05.4734
5. Leading Causes of Death. Centers for Disease Control and Prevention. https://www.cdc.gov/nchs/fastats/leading-causes-of-death.htm. Published March 17, 2017. Accessed June 14, 2020.
6. Thornton RLJ, Glover CM, Cené CW, Glik DC, Henderson JA, Williams DR. Evaluating strategies for reducing health disparities by addressing the social determinants of health. Health Aff (Millwood). 2016; 35(8):1416-1423. doi:10.1377/hlthaff.2015.1357
7. Batt-Rawden SA, Chisolm MS, Anton B, Flickinger TE. Teaching empathy to medical students: an updated, systematic review. Acad Med. 2013;88(8):1171-1177. doi:10.1097/ACM.0b013e318299f3e3
8. Newton BW, Barber L, Clardy J, Cleveland E, O'Sullivan P. Is there hardening of the heart during medical school? Acad Med. 2008;83(3):244-249. doi:10.1097/ACM.0b013e3181637837
9. Hojat M, Vergare MJ, Maxwell K, et al. The devil is in the third year: a longitudinal study of erosion of empathy in medical school. Acad Med. 2009;84(9):1182-1191. doi:10.1097/ACM.0b013e3181b17e55
10. Sabin JA, Rivara FP, Greenwald AG. Physician implicit attitudes and stereotypes about race and quality of medical care. Med Care. 2008;46(7):678-685. doi:10.1097/MLR.0b013e3181653d58
11. Crandall SJ, Volk RJ, Cacy D. A longitudinal investigation of medical student attitudes toward the medically indigent. Teach Learn Med. 1997;9(4):254-260. doi:10.1207/s15328015tlm0904_2
12. Gonzalez CM, Kim MY, Marantz PR. Implicit bias and its relation to health disparities: a teaching program and survey of medical students. Teach Learn Med. 2014;26(1):64-71. doi:10.1080/10401334.2013.857341
13. Teal CR, Gill AC, Green AR, Crandall S. Helping medical learners recognise and manage unconscious bias toward certain patient groups. Med Educ. 2012;46(1):80-88. doi:10.1111/j.1365-2923.2011.04101.x
14. van Ryn M, Hardeman R, Phelan SM, et al. Medical school experiences associated with change in implicit racial bias among 3547 students: A Medical Student CHANGES Study Report. J Gen Intern Med. 2015;30(12):1748-1756. doi:10.1007/s11606-015-3447-7
15. Roberts D. The Problem with Race-Based Medicine. Presented at the: TedMed 2015; 2015.
16. Hogarth RA. Medicalizing Blackness: Making Racial Difference in the Atlantic World, 1780-1840. UNC Press Books; 2017.

17. Inker LA, Shafi T, Okparavero A, et al. Effects of Race and Sex on Measured GFR: The Multi-Ethnic Study of Atherosclerosis. Am J Kidney Dis. 2016;68(5):743-751. doi:10.1053/j.ajkd.2016.06.021
18. Lujan HL, DiCarlo SE. Science reflects history as society influences science: brief history of "race," "race correction," and the spirometer. Adv Physiol Educ. 2018;42(2):163-165. doi:10.1152/advan.00196.2017
19. Braun L. Spirometry, measurement, and race in the nineteenth century. J Hist Med Allied Sci. 2005;60(2):135-169. doi:10.1093/jhmas/jri021
20. Understanding Implicit Bias. The Ohio State University Kirwan Institute for the Study of Race and Ethnicity. http://kirwaninstitute.osu.edu/research/understanding-implicit-bias/. Published 2015. Accessed June 24, 2020.
21. Burgess DJ. Are providers more likely to contribute to healthcare disparities under high levels of cognitive load? How features of the healthcare setting may lead to biases in medical decision making. Med Decis Making. 2010;30(2):246-257. doi:10.1177/0272989X09341751
22. Sabin JA, Greenwald AG. The influence of implicit bias on treatment recommendations for 4 common pediatric conditions: pain, urinary tract infection, attention deficit hyperactivity disorder, and asthma. Am J Public Health. 2012;102(5):988-995. doi:10.2105/AJPH.2011.300621
23. Dovidio JF, Fiske ST. Under the radar: how unexamined biases in decision-making processes in clinical interactions can contribute to health care disparities. Am J Public Health. 2012;102(5):945-952. doi:10.2105/AJPH.2011.300601
24. Cooper LA, Roter DL, Carson KA, et al. The associations of clinicians' implicit attitudes about race with medical visit communication and patient ratings of interpersonal care. Am J Public Health. 2012;102(5):979-987. doi:10.2105/AJPH.2011.300558
25. Green AR, Carney DR, Pallin DJ, et al. Implicit bias among physicians and its prediction of thrombolysis decisions for black and white patients. J Gen Intern Med. 2007;22(9):1231-1238. doi:10.1007/s11606-007-0258-5
26. Mullan F, Chen C, Petterson S, Kolsky G, Spagnola M. The social mission of medical education: ranking the schools. Ann Intern Med. 2010;152(12):804-811. doi:10.7326/0003-4819-152-12-201006150-00009
27. Boelen C. [Global consensus on social accountability of medical schools]. Sante Publique. 2011;23(3):247-250.
28. Ventres W, Boelen C, Haq C. Time for action: key considerations for implementing social accountability in the education of health professionals. Adv Health Sci Educ Theory Pract. 2018;23(4):853-862. doi:10.1007/s10459-017-9792-z
29. Ritz S., Ellaway R., Beatty K. Advancing "social accountability" through critical literacy: How can we promote an understanding of power and privilege in medical learners? Medical Education, Supplement. 2011;45:10.
30. Standards, Publications, & Notification Forms: Functions and Structure of a Medical School. Liaison Committee on Medical Education (LCME). https://lcme.org/publications/. Published March 2020. Accessed April 29, 2020.
31. Lie D, Boker J, Cleveland E. Using the tool for assessing cultural competence training (TACCT) to measure faculty and medical student perceptions of cultural competence

instruction in the first three years of the curriculum. Acad Med. 2006;81(6):557-564. doi:10.1097/01.ACM.0000225219.53325.52
32. Lie DA, Boker J, Crandall S, et al. Revising the Tool for Assessing Cultural Competence Training (TACCT) for curriculum evaluation: Findings derived from seven US schools and expert consensus. Med Educ Online. 2008;13:1-11. doi:10.3885/meo.2008.Res00272
33. Ceasar J, Crittenden F, Okungbowa-Ikponmwosa J. Statement on Racism as a Public Health Issue. 1st ed. (Sajjadi A, Akpovi EE, Wright V, eds.). Student National Medical Association Health Policy and Legislative Affairs Committee; 2019.
34. Declare Racism Public Health Emergency, AAFP Tells White House. American Association of Family Physicians. https://www.aafp.org/news/government-medicine/20200612racismpriority.html?cmpid=em_AP_20200612. Published June 12, 2020. Accessed June 14, 2020.
35. Hardeman RR, Medina EM, Boyd RW. Stolen Breaths. N Engl J Med. June 2020. doi:10.1056/NEJMp2021072
36. Mieses Malchuk A. Doctors Should Learn to Fight Injustice, Not Just Pandemics. Medscape. June 2020.
37. AAMC Releases Framework to Address and Eliminate Racism. Association of American Medical Colleges. https://www.aamc.org/news-insights/aamc-releases-framework-address-and-eliminate-racism. Published October 6, 2020. Accessed November 30, 2020.
38. Medical School Graduation Questionnaire 2019 All Schools Summary Report. Association of American Medical Colleges (AAMC); 2019.
39. Number of U.S. Medical Schools Reporting Social Determinants by Academic Level: AAMC Curriculum Inventory, 2018-2019. Association of American Medical Colleges. https://www.aamc.org/data-reports/curriculum-reports/interactive-data/social-determinants-health-academic-level. Published 2020. Accessed June 14, 2020.
40. Brottman MR, Char DM, Hattori RA, Heeb R, Taff SD. Toward cultural competency in health care: A scoping review of the diversity and inclusion education literature. Acad Med. September 2019. doi:10.1097/ACM.0000000000002995
41. Deliz JR, Fears FF, Jones KE, Tobat J, Char D, Ross WR. Cultural competency interventions during medical school: a scoping review and narrative synthesis. J Gen Intern Med. 2020;35(2):568-577. doi:10.1007/s11606-019-05417-5
42. Dogra N, Bhatti F, Ertubey C, et al. Teaching diversity to medical undergraduates: Curriculum development, delivery and assessment. AMEE GUIDE No. 103. Med Teach. 2016;38(4):323-337. doi:10.3109/0142159X.2015.1105944
43. Doobay-Persaud A, Adler MD, Bartell TR, et al. Teaching the social determinants of health in undergraduate medical education: a scoping review. J Gen Intern Med. 2019;34(5):720-730. doi:10.1007/s11606-019-04876-0
44. Braveman P. What are health disparities and health equity? We need to be clear. Public Health Rep. 2014;129 Suppl 2:5-8. doi:10.1177/00333549141291S203
45. Social Determinants of Health. Healthy People 2020. https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health. Published April 25, 2020. Accessed April 27, 2020.
46. Structures & Self: Advancing Equity and Justice in SRH. Innovating Education in Reproductive Health. https://www.innovating-education.org/course/structures-self-

advancing-equity-and-justice-in-sexual-and-reproductive-healthcare/. Published 2015. Accessed April 27, 2020.

47. HealthPartners Institute, Magnan S. Social determinants of health 101 for health care: five plus five. NAM Perspectives. 2017;7(10). doi:10.31478/201710c
48. Alma-Ata. Primary Health Care: Report of the International Conference on Primary Health. 6th-12th ed. Geneva: World Health Organization (WHO) & the United Nation's Children's Fund; 1978.
49. Social Justice and Health. American Public Health Association. https://apha.org/what-is-public-health/generation-public-health/our-work/social-justice. Published 2020. Accessed April 29, 2020.
50. ABIM Foundation. American Board of Internal Medicine, ACP-ASIM Foundation. American College of Physicians-American Society of Internal Medicine, European Federation of Internal Medicine. Medical professionalism in the new millennium: a physician charter. Ann Intern Med. 2002;136(3):243-246.
51. Eddy, S. L., & Hogan, K. A. (2014). Getting Under the Hood: How and for Whom Does Increasing Course Structure Work? CBE—Life Sciences Education, 13(3), 453–468. https://doi.org/10.1187/cbe.14-03-0050
52. Wear, D., & Kuczewski, M. G. (2008). Perspective: Medical students' perceptions of the poor: What impact can medical education have? Academic Medicine. Lippincott Williams and Wilkins. https://doi.org/10.1097/ACM.0b013e3181782d67
53. Dyrbye, L., Herrin, J., West, C. P., Wittlin, N. M., Dovidio, J. F., Hardeman, R., … Van Ryn, M. (2019). Association of Racial Bias with Burnout among Resident Physicians. JAMA Network Open, 2(7). https://doi.org/10.1001/jamanetworkopen.2019.7457

APPENDIX A

<u>Task Force Recommendations Organized by Suggested Responsible Party</u>

Vice Dean of Academic Affairs

Recommendation 1.7: Improve accountability measures for students, faculty, staff, and residents who either fail to promote a positive learning environment, contribute to a hidden curriculum that does not support SOM values, or are involved in the mistreatment of medical students.
Recommendation 1.9: Secure formal sponsorship from the SOM and UNC Hospital GME and designate executive leads. They will be responsible for reviewing and advising upon deliverables, supporting alignment of initiatives and goals between UME and GME as they pertain to this initiative, and help facilitate progress and remove barriers.
Recommendation 2.14: Course directors who already have a documented history of discrimination (two or more actions) will be excused from leading teaching responsibilities.
Recommendation 3.8: Ensure that the selection process for leaders at the UNC SOM includes assessing an applicant's growth mindset as it relates to social justice.

Education Committee

Recommendation 1.5: Review the composition, training, and processes associated with the Student Progress Committee, Admissions Committee, Student Support Committee, and other committees that impact student success.
Recommendation 1.8: Recruit working group/task force of content experts from SOM and other UNC Schools, including resident, fellow, and medical student representatives, to develop core competencies, content, and case studies for an online curriculum as it pertains to social justice, DEI, and healthcare disparities. From November to end of January, establish core competencies, outline content, and identify case studies that can be used to teach key concepts.
Recommendation 2.1: Provide/develop workshops by content experts for phase leadership and departments on how to incorporate outlined core concepts of anti-racism, with a plan for ongoing use.
Recommendation 2.2: Directors of all phases will begin to examine and change content as needed to include anti-racist concepts as defined in the objectives.
Recommendation 2.3: School of Medicine and directors of all phases will examine and develop assessment procedures (including post-foundation, post-application, and finish-line questionnaires, AMA grading tool, and focus groups) that are ongoing to measure student and faculty impressions.
Recommendation 2.5: Phase leaders will ensure that instructors in all phases coordinate to make explicit connections between the topics/concepts addressed in the curriculum.
Recommendation 2.6: Continue TEC Leadership work group to develop case bank for Foundation Phase.
Recommendation 2.7: Develop and start relationship-based training for faculty and students on team-work, conflict resolution and inclusivity including evidence-based concepts of the relationship between belonging, trust, wellness, and anti-racist curricula.
Recommendation 2.8: Appoint inclusive work-group for long-term transformation of curriculum
Recommendation 2.9: Full implementation of new curriculum 2023-2024.
Recommendation 2.10: Form a work-group to:

- Determine the breakdown of assessments in all phases by 2021.

- Identify best practices for use of a wide variety of assessments for a student portfolio by 2022 with phased implementation.
- Identify the necessary resources required for portfolios and determine if institutionally feasible (software, coaches, admin support).

Recommendation 2.11: Appoint group (including colleagues from the Gilling's School of Public Health) to:

- Revise advocacy competencies for medical students to reflect above objectives.
- Develop group project assignment, assessment method(s), and implementation plan. Should include longitudinal, robust community partnership projects, that involve needs assessments, evidence-based interventions, assessment, and sustainability plans made effective by Individualization phase at the latest (Refer to work done by Dr. Pedro Greer at Florida International University SOM).
- Determine best placement in curriculum for this project.

Recommendation 2.13: Appoint a diverse advisory group to develop expectations/milestones and review course directors and curriculum leads every three years with a decision for renewal or not. Portfolio for review will include:

- DEI Certificate
- Demonstration of growth mindset with application of learning theory to program/teaching
- Student and peer evaluations (including anonymous evaluations)

Associate Dean of Admissions

Recommendation 1.10: Analyze outcomes of UNC SOM matriculants including academic and professionalism performance, transition to GME, and retention to the North Carolina physician workforce, to instruct a modification of the admissions committee processes by April 2021.
Recommendation 1.11: Modify existing screening processes to identify applicants with an increased likelihood of success at the UNC School of Medicine and service to the North Carolina community more effectively for implementation by the 2021-2022 Admissions Cycle. Periodically review matriculant outcomes to continue to fine tune recruitment and selection algorithms.
Recommendation 1.13: Require that all members of the admissions committee complete trainings related to the principles of holistic review, selection bias, and patient care, research, and education goals of the UNC School of Medicine for implementation by the 2021-2022 Admissions Cycle.
Recommendation 1.14: Modify the applicant selection algorithm to prioritize applicant factors consistent with success with the UNC School of Medicine curriculum and retention to the North Carolina physician workforce.
Recommendation 1.15: Examine barriers to recruiting and maintaining an admissions committee that mirrors North Carolina's demographics by 2021. Develop a plan to sustainably minimize those barriers by 2022.

Office of Faculty Affairs and Leadership Development

Recommendation 3.2: Allocate the resources and support needed to develop the capacity to train all UNC SOM faculty.

Recommendation 3.4: Develop a communication strategy system where reflection prompts are widely disseminated to SOM and UNC Health Employees and where high-quality reflections are shared and celebrated.
Recommendation 3.6: Revise Promotion and Tenure Guidelines to include a social justice domain required for promotion.
Recommendation 3.7: Develop mechanisms for rewarding faculty members who demonstrate excellence in their teaching in the domain of social justice above and beyond the typical incentive plans (e.g. rotating endowed chairs).
Recommendation 3.9: Increase financial investment to recruit, support, mentor, and retain URM faculty.
Recommendation 3.11: Develop more rigorous pathways and outreach programs to recruit, mentor, support, and retain URM faculty, trainees, and students.

Office of Inclusive Excellence
Recommendation 1.12: Develop specific initiatives to recruit applicants from UNC System institutions (both majority and minority) inclusive of potentially developing new/supporting existing healthcare sciences pipeline programs at each institution.
Recommendation 2.4: OIE will secure formal relationships with REI, UNC LGBTQ+ Center, and other leading expert organizations or individuals for use in the curriculum as needed.
Recommendation 2.12: OIE to Secure relationships with NCMS (North Carolina Medical Society), NC School of Public Health, and NC Law School for partnerships available for student projects/collaboration.
Recommendation 3.1: Develop curriculum for core education training sessions which includes but is not limited to training on implicit bias, the history of discrimination and racism in the US and their relationship to health and health care, and skills to effectively incorporate issues of discrimination based on race/ethnicity, gender, sex, sexuality, nationality, religion, veteran status, socioeconomic status, body size, and other factors into teaching.
Recommendation 3.10: More visibly display our commitment to social justice and the concrete action steps we're taking to move toward that goal to learners, faculty, staff, and the wider community. Examples might include but are not limited to multimedia public relations campaigns, inclusive signage, and architectural and design changes in the physical space.

Office of Medical Education
Recommendation 1.1: Perform a qualitative/quantitative analysis of the personal and professional needs of students to get a better idea of the resources it will take to promote their success.
Recommendation 1.2: Perform a qualitative/quantitative analysis of the UNC SOM hidden curriculum and its impact on the learning environment.
Recommendation 1.3: Hire an embedded SOM counselor with expertise and interests in diversity and inclusion.
Recommendation 1.4: Perform a qualitative/quantitative analysis of the causes of the opportunity gap in UNC SOM students so that programs to reduce the opportunity gap can be implemented.
Recommendation 3.12: Develop an active URM faculty network that can raise awareness about open positions and encourage applications.

Recommendation 3.13: Increase the diversity of educational leaders and faculty serving on key committees to reflect the diversity of the communities of North Carolina.

Clinical and Basic Science Chairs

Recommendation 1.6: Create systems that ensure that faculty responsible for career advising are effective and accountable including providing them with salary support and protected time.
Recommendation 3.3: Develop a system to help faculty develop and use Individualized Education Plans.
Recommendation 3.5: Develop uniform policies and procedures on how social justice contribution is integrated into the annual reviews and tied to incentives.