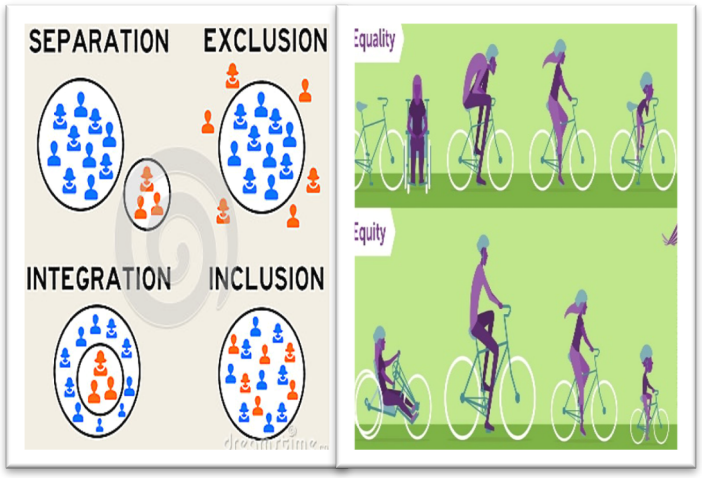
How to Meaningfully Incorporate a New *IDEA*: Inclusion, Diversity, Equity and Antiracism

While we recognize the scope of each talk may not relate directly to race or disparities in care, it remains relevant since not providing insight into where differences may exist only serves to propagate them. Please use this guide as a way to pay attention to what disparities may exist and, in doing so, teach others the importance of maintaining equitable and unbiased care. Use the below mnemonic as a suggestion or guide to generate your own thoughts on how you can meaningfully identify how inclusion, diversity, equity and/or antiracism are relevant to your topic. By incorporating a slide(s) on this topic, you can promote awareness, challenge practice patterns, encourage important conversations and ensure rounded, essential education. Thank you.



Epidemiology
- What is the incidence across various populations?
- Are there differences?

Question
- If disparities exist, why might that be?
  - Genetic* (*please see reference in Resources section*)? Harmful stereotypes? Access to care? Socioeconomic status?
- What are some hypotheses or reasons underlying this inequity?

Unfair
- What individual biases might exist?
- What institutional or systemic biases might exist?

Action/Advocacy
- What actions to address this disparity and promote inclusion/equity?
- What opportunities for advocacy exist?

Lead
- How can the medical community take steps to offer more equitable care?
- What can we do?

Consider doing a literature search combining "your topic" with different keywords or medical subject headings (MeSH). Here are three related MeSH search terms in the MEDLINE subset of PubMed:

+ *"Health status disparities"[mesh]* – studies on the difference in the health status of populations
+ *"Healthcare disparities"[mesh]* – studies addressing difference in delivery of health care, including social, economic and/or environmental disadvantage
+ *"Health equity"[mesh]* – studies on the right to health, including policies, laws and infrastructure

To find a paper where one of these concepts is the main topic of a paper, try adding [majr] to search. This search will often yield more sensitive articles, non-MEDLINE records and often newer material.

+ *"Healthcare Disparities"[majr] AND breast cancer*, for example

Other keywords to consider including in combination with your topic:

+ *Social segregation, population groups, vulnerable populations, continental population groups, ethnic groups, minority group*, race, racial, racism, ethnic, ethnicit*, nonwhite, ageism, age discrimination, social discrimination, prejudice, sexual and gender minorities, transgender*, homosexual*, bisexual*, transsexual*, lgbt, gay, lesbian, bisexual*, gender minorit*, sexual minorit**

Resources and Examples

[The problem with race-based medicine | Dorothy Roberts – YouTube]

*Important talk identifying race as a social construct that can mislead physicians into conflating race with genetics. Racism, which CDC defines as the structures, policies, practices, and norms that assign value and opportunities based on the way people look or the color of their skin, results in conditions that unfairly advantage some and disadvantage others, placing people of color at greater risk for poor health outcomes.[1]

	How race is used	Rationale for race-based management	Potential harm	Race-conscious approach
eGFR[6]	eGFR for Black patients is multiplied by 1·16–1·21 the eGFR for White patients, depending on the equation used	Black patients are presumed to have higher muscle mass and creatinine generation rate than patients of other races	Black patients might experience delayed dialysis and transplant referral[8,9]	Use eGFR equations that do not adjust for race (eg, CKD-EPI Cystatin C)[10]
BMI risk for diabetes[7]	Asian patients considered at risk for diabetes at BMI ≥23 *vs* 25 for patients of other races	Asian patients are presumed to develop more visceral than peripheral adiposity than patients of other races at similar BMI levels, increasing risk for insulin resistance[7]	Asian patients screened for diabetes despite absence of other risk factors might experience increased stigma and distrust of medical providers[11]	Screen patients with lower BMIs on the basis of indications of increased body fat (eg, body roundness,[12] body fat percentage), not based on race
FRAX[13]	Probability of fracture is adjusted according to geography or minority status, or both	Different geographical and ethnic minority populations are presumed to have varied relative risks for fracture on the basis of epidemiological data	Some populations, including Black women, might be less likely to be screened for osteoporosis than other populations[14]	Screen patients for osteoporosis on the basis of clinical risk criteria, rather than race; counteract existing biases that place Black patients at risk because of racial essentialist beliefs about variation in bone density[15]
PFT[16]	Reference values for pulmonary function are adjusted for race and ethnicity	Racial and ethnic minority groups are presumed to have varied lung function on the basis of epidemiological data	Black patients might experience increased difficulty obtaining disability support for pulmonary disease[17]	Use unadjusted measures of lung function for all patients; counteract existing biases that harm Black patients because of racial essentialist beliefs about variation in lung capacity[18]
JNC 8 Hypertension Guidelines[19]	Treatment algorithm provides alternate pathways for Black and non-Black patients	ACE-inhibitor use associated with higher risk of stroke and poorer control of blood pressure in Black patients than in patients of other races	Black patients might be less likely to achieve hypertension control and require multiple antihypertensive agents[20]	Consider all antihypertensive options for blood pressure control in Black patients; adjust as needed to achieve goals and manage adverse effects
Paediatric UTI diagnosis[21]	White race in girls and non-Black race in boys are considered independent risk factors for UTI	Study of febrile children in the emergency department found highest prevalence of UTI among White girls and non-Black boys[22]	Experimental data suggests that these guidelines could affect management of UTI by race[23]	Treat UTI in children on the basis of clinical presentation, regardless of race
ASCVD risk estimation	Race-specific equations included to estimate ASCVD risk	ASCVD events higher for Black patients than patients of other races with otherwise equivalent risk burden[24]	Black patients might experience more adverse effects from recommended statin therapy, including persistent muscle damage[25]	Recommend preventive therapy on the basis of clinical metrics and comorbidities; consider pathways by which structural racism might increase cardiovascular risk among Black patients and promote resources to reduce racial stress and trauma[26]
Eltrombopag dosing	East Asian patients receive half the starting dose compared with non-east Asian patients	Limited pharmacokinetic studies suggest reduced metabolism of eltrombopag in patients of East Asian descent[27]	Some East Asian patients might receive inappropriate dosing[28]	Initiate same starting dose for all patients, regardless of race, and adjust as needed on the basis of platelet response

Examples of race-based medicine were chosen to represent multiple racial groups (eg, White, Black, Asian) and domains in which race is essentialised as biological (eg, pharmacokinetics, bone density, lung capacity). ACE=angiotensin-converting enzyme. ASCVD=atherosclerotic cardiovascular disease. BMI=body-mass index. CKD-EPI=Chronic Kidney Disease Epidemiologic Collaboration equation. eGFR=estimated glomerular filtration rate. FRAX=fracture risk assessment score. JNC 8=Eighth Joint National Committee. PFT=pulmonary function test. UTI=urinary tract infection.

Table: **Examples of race-based medicine, the potential harm to patients, and race-conscious alternatives**

[1] Cerdeña JP, Plaisime MV, Tsai J. From race-based to race-conscious medicine: how anti-racist uprisings call us to act. Lancet. 2020 Oct 10;396(10257):1125-1128. doi: 10.1016/S0140-6736(20)32076-6. PMID: 33038972; PMCID: PMC7544456.