White Coats for Black Lives

Racial Justice Report Card 2020

WRITTEN BY:

Students of the UC Davis Chapter of White Coats for Black Lives

UC DAVIS HEALTH | SCHOOL OF MEDICINE

WHITE COATS 4 BLACK LIVES

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Introduction

The Racial Justice Report Card (RJRC) is a tool developed by the national **White Coats for Black Lives (WC4BL)** working group to allow medical schools to evaluate their school and larger institution on metrics of racial justice and equity. These metrics vary from aspects of school climate, to equity in curriculum and grading, to equity in healthcare access and quality, and even to research policy. The original report set forth by the national chapter in 2018 recruited 10 top tier institutions across the U.S. and published student-gathered data, "grades," and discussion, and was subsequently made public for replication at additional institutions. Based on input from participating institutions, the metrics were adjusted and revised, and a second report was published in 2019.

> *WC4BL* is a student-led abolitionist, anti-capitalist, anti-imperialist organization whose mission is to dismantle racism in medicine and promote the health, well-being, and self-determination of people of color.

Over the past year, the UC Davis Chapter of White Coats for Black Lives has worked to gather data and produce a 2020 report. The intent of this report is to more specifically delineate which areas of racial justice are doing well and which provide opportunity for focused improvement. Thus, though the baseline assessment is important, the larger spirit of the report is to generate tailored recommendations to improve the overall climate of the school and health system for students, faculty, staff, and patients of color— which ultimately will improve the climate for all members of the health system community.

The following stated goals are taken directly from the 2019 national report:

> "White Coats for Black Lives (WC4BL) believes that in addition to promoting diversity and inclusion, academic medical centers must also commit to policies and practices that intentionally promote racial justice. The Racial Justice Report Card is a WC4BL initiative with three principal goals:
>
> 1. Articulate specific ways in which academic medical centers can promote racial justice.

2. Allow medical students to express their views on the policies and practices of their institutions and facilitate students' efforts to advocate for change.
3. Ensure public accountability for academic medical centers to promote racial justice.

Metrics

For each metric, the UC Davis Chapter of WC4BL reviewed relevant data and assigned a letter grade of A, B, or C, depending on adherence to the national standards. These metrics are listed below, with the final letter grade highlighted for each metric.

1. Underrepresented in Medicine (URM) Student Representation

Medical school students are at least 13% Black, 1% Native American, and 17% Latinx (corresponding to the share of these groups in the U.S. population).

A. All of the above groups are proportionately represented among students.

B. Some of the above groups are proportionately represented among faculty and/or students.

C. None of the above groups are proportionately represented among students, or this information is not publicly available.

In the most recent matriculating (2019) class, 19% of students identify as Black/AA, 2% identify as AI/AN, and 27% identify as Latinx.

2. URM Faculty Representation

Medical school faculty are at least 13% Black, 1% Native American, and 17% Latinx (corresponding to the share of these groups in the U.S. population).

A. All of the above groups are proportionately represented among faculty.

B. Some of the above groups are proportionately represented among faculty.

C. None of the above groups are proportionately represented among faculty, or this information is not publicly available.

While URM representation among students has shown significant improvement from prior years, URM faculty representation (as of July 2019) continues to lag behind with only 1.9% identifying as Black/AA, 0.1% as Native American, and 2.4% as Latinx.

3. URM Recognition

The physical space of the medical school acknowledges the contributions of alumni and other physicians of color (through plaques, statues, portraits, and building names) and does not celebrate racist or white supremacist individuals.

A. The above metric is fully met.

B. There are no items celebrating racist/white supremacist individuals, and also none celebrating people of color.

C. The physical space explicitly celebrates racist/white supremacist individuals.

The physical space of the medical school includes some acknowledgement of alumni, current students, and other physicians of color, primarily through multiple digital screens in the main lobby of the Education Building which include an Alumni Wall of Honor and notable news and announcements celebrating accomplishments within the School of Medicine and health system. The Alumni Wall of Honor currently features Dr. Nadine Burke Harris (current California Surgeon General), while the other screens display students (including URM) that have received scholarships or other recognitions. There are no items celebrating racist/white supremacist individuals.

4. URM Recruitment

The medical school's recruitment policies promote racial justice. The school application does not inquire about the applicant's criminal history. The medical school recruits and admits undocumented students and students of color who attend public high schools in the county or state where the medical school is located. Students of color who participate in recruitment are compensated for their time.

A. The above metric is fully met.

B. Some elements of the metric are met.

C. No elements of the metric are met.

In 2016, UC Davis faculty published a paper titled "Reducing Medical School Admissions Disparities in an Era of Legal Restrictions: Adjusting for Applicant Socioeconomic Disadvantage," which describes a unique tool developed by the faculty to adjust for socioeconomic disadvantage and intentionally place value on diverse life experiences. This score, a figurative measurement of "distance traveled"

on the journey to get to medical school—specifically as they may impact more traditional metrics of a student's application—plays an important role in UC Davis admissions holistic review and correlate with increased URM student representation. For example, of the 7,161 applications UC Davis School of Medicine received for the 2019 class, 2,006 (28%) were identified as disadvantaged via this metric. 1,106 of these 2,006 students (55%) were offered a secondary, and 35% of the 1,006 who completed the secondary were invited to interview. 88% completed the interview (315 of 357 invited) and 148 (47%) were offered acceptance, of which 81 (55%) accepted. Therefore, though only 28% of the original applicant pool was identified as having disadvantaged status, 65% of the matriculants (81 of 125) are disadvantaged students.

The UC Davis School of Medicine secondary application does not inquire about criminal history.

Direct recruitment efforts include outreach through regional and national conferences of the Student National Medical Association (SNMA), Latinx Medical Student Association (LMSA), and the Asian Pacific American Medical Student Association (APAMSA). Students are compensated for travel and lodging to national and regional conferences. For local recruitment tours and information panels (e.g. high schools, community colleges), students receive gift cards.

Though undocumented students can apply to the School of Medicine per administration and public statement, this reassurance is not included on the UC Davis School of Medicine admissions page nor are there specific initiatives to recruit these students.

Additional information can be found at the following links:

- Reducing Medical School Admissions Disparities in an Era of Legal Restrictions: Adjusting for Applicant Socioeconomic Disadvantage
- UC Davis Health Response to DACA Decision
- UC Davis School of Medicine Admissions

5. Anti-Racism Training & Curriculum

The curriculum incorporates information about the history of racism in medicine, intersectional oppression, and racial justice strategies, and explicitly addresses the fact that race is a sociopolitical construct, not a biological one. Lecturers avoid describing race per se (rather than racism) as a risk factor for disease, cause of health disparities, or basis for diagnostic reasoning. Community advocates and students who are underrepresented in medicine are incorporated in the planning and leadership of the pre-clinical curriculum.

A. The above metric is fully met.
B. Some elements of the metric are met.
C. The curriculum fails to adequately address racism in medicine. Race is stated or implied to be biological. Community advocates and URM students do not participate in planning or are not compensated for their time.

All students are required to participate in five 3-hour Health Equity course in the first year of medical school. In previous years, these trainings primarily addressed general concepts of diversity and inclusion, health disparities, and implicit bias, but did not explicitly include anti-racism objectives and discussions. In contrast, the upcoming 2020 Health Equity course aims to discuss the difference between describing race as a genetic risk factor for disease versus disease as a biological manifestation of oppressive systems. However, it still does not critically engage with the violent history of racism in medicine and how the medical system continues to create and perpetuate inequities in healthcare access and delivery.

The only explicitly anti-racist curriculum that meets the above metric in full are in the form of elective courses limited to a small number of students. The first is “The Summer Institute on Race and Health,” a 4-week intensive course available to approximately 10-12 students between the first and second pre-clinical years. This course includes lecture, critical discussion, and fieldwork throughout communities in California to understand the history of racism in medicine and policy that have allowed for the perpetuation of racial health inequities. Fieldwork heavily incorporates the perspectives of community members who are compensated for their time. The other opportunities to participate in anti-racist curriculum are in the form of two elective 4-week Special Study Modules (SSMs) offered to fourth year students: “Race and Health in the United States” and “Culture, Society, and Medicine.” Course attendance for

“Race and Health in the United States” is interdisciplinary with the nursing school, usually with 2-4 medical students per year, and “Culture, Society, and Medicine” is capped at 8 medical students per year.

It is also important to note that although the Health Equity course and additional elective courses are beginning to challenge how race is described in the context of disease, the broader curriculum consistently uses race as an intrinsic, genetic risk factor and basis for diagnostic reasoning.

Students often work with community groups and members to fill gaps in the curriculum surrounding community health/health disparities through guest speaker panels, documentary screenings, and other informational events. However, events that are led by students lack funding to compensate community members for their time and rely heavily on the efforts of URM students who do not receive protected time or compensation.

Finally, in regard to faculty training, all course directors are required to participate in a 6-hour multi-workshop curriculum called “Supporting Educational Excellence in Diversity (SEED).” Learning objectives center on recognizing privilege, intersectionality, and recognizing and addressing bias in the learning and clinical environment. However, these trainings do not include specific anti-racism objectives and discussions and remain optional for SOM faculty that are not course directors.

Additional information can be found at the following link:

- Summer Institute on Race and Health
- Year 4 Curriculum Outline

6. Discrimination Reporting

The medical school has a system for collecting student and faculty reports of racism and other forms of oppression, and a clear plan for follow-up when problems are reported.

A. The above metric is fully met.

B. There is some system for collecting reports, but there is no clear follow-up after reports are made.

C. There is no system for collecting reports.

Regarding student mistreatment, UC Davis School of Medicine has a Learning Climate Committee (LCC) that oversees efforts to reduce student mistreatment and improve the learning climate. This committee is chaired by the Vice Dean for Students and its membership include diversity and inclusion leadership and students. For pre-clinical years, an online mistreatment form is available to students through their learning portal which allows for anonymous submission if desired. Submission of the form elicits a response from the Dean of Students within 72 hours, which includes the option for the student to meet with Dean to provide additional information. However, if the report is submitted anonymously, there is unlikely to be remediation for the reported faculty member due to lack of information/corroboration of the incident by the student. In clinical years, the committee regularly conducts surveys for mistreatment, racism, and learning climate issues. Though these surveys are done regularly, in most cases remediation is left up to the department and is not standardized. Additionally, UC Davis has limited power of affecting remediation for non-UC Davis clinical sites.

Similarly, for faculty/employee mistreatment, the UC Davis Office of Compliance provides an online form to report hate, bias, discrimination, sexual harassment, bullying and mistreatment. Submission of the form elicits a response from the Office of Compliance within 48 hours, and again remediation is left up to the department and not standardized.

Additional information can be found at the following links:

- Mistreatment Incident Report Form
- LCC Members
- Hate and Bias Reporting
- Academic and Staff Assistance Program (ASAP)
- Center for Advocacy, Resources and Education (CARE)

7. URM Grade Disparity

There are no racial disparities in medical students' grades or honors, including AOA election.

A. The above metric is fully met.
B. The school regularly evaluates whether there are racial disparities and has developed plans to address them.

C. There are significant racial disparities in grades and/or honors or this information is not publicly available.

The school does not regularly evaluate the potential for racial disparities in pre-clinical (pass/fail) nor clerkship (pass/fail/honors) grading. An evaluation was completed by students 10 years ago that showed potential bias in clerkship grading, leading to changes in clerkship leadership and a review of grading criteria. However, there has not been a review for racial disparities in grading since this student evaluation.

The school recently examined AOA election disparities and instituted a more equitable process. This has resulted in improvements in AOA diverse representation (9% Black/African American in AOA vs. 9% in the class, 23% Latinx in AOA vs. 25% in class, 32% API in AOA vs. 30% in the class).

8. URM Support/Resources

Black, Native American, and Latinx students have access to designated physical spaces, as well as support staff, including administrators, physician mentors, mental health providers, and peer counselors.

A. The above metric is fully met.

B. There are some resources specifically designated to support students of color.

C. There are no designated resources for students of color.

The Office of Student and Resident Diversity (OSRD) has a lounge area within the Education Building intended to be a safe space for all URM students within the UC Davis School of Medicine and is available for student drop-in Monday through Friday from 9:00 AM to 5:00 PM. OSRD support staff offices are also located within this space and help connect students to resources, sponsor student events and scholarly travel awards related to diversity and inclusion initiatives, and support the wellness of URM students individually and in groups (e.g. Racial Healing and Restorative Justice Circles).

Additionally, OSRD supports the Medical Student Diversity Advisory Council (DAC), made up of officers from each of the student interest groups (SIGs) representing URM students. These SIGs, such as the Student National Medical Association (SNMA) and

Latinx Medical Student Association (LMSA), also have their own faculty-mentor identification processes.

Though UC Davis School of Medicine does support their URM students in many ways, it lacks mental health providers and peer counselors directed to the specific needs of URM students. Psychiatric services are only offered to students that have insurance through the UC Davis School of Medicine (cost-prohibitive to many), and currently the psychiatrist position at the medical campus is unfilled. Counseling services are offered to medical students free of cost, however there are only two available psychologists (one half time) to serve the needs of the entire SOM and SON body. While both have experience working with URM students, there is not capacity to match all URM students with a URM faculty counselor. Additionally, while there is community and peer support within the SIGs, there are no designated peer counselors through the school that are compensated for their time.

Additional information can be found at the following link:

- Office of Student and Resident Diversity (OSRD) Website

9. Campus Policing

There is no hospital/campus police force, or police are used as a last resort after the failure of alternative safety structures such as peer walking escorts, restorative justice councils, and mediation. If police or security officers exist, publicly available data should demonstrate that they have not disproportionately stopped, arrested, or otherwise interacted with people of color.

A. The above metric is fully met.
B. There are some programs designed to reduce reliance on police.
C. There is a campus police force, and no evidence that they have sought to address racism in policing, or this information is not publicly available.

UC Davis has its own hospital/medical campus police force for emergency and non-emergency situations, which does not currently include peer walking escorts. UCDPD “Aggie Host Security Officers” are UC Davis students employed through the UCDPD that provide safe ride services to students, staff, and faculty upon request. While these were previously only available on the main Davis undergraduate campus, effective

February 2020 Aggie Hosts were added to the Sacramento campus with specific focus on the Schools of Medicine and Nursing. Aggie Hosts wear student officer uniforms, all requests for escort services are made through the UCDPD Dispatch line, and when the Aggie Hosts are not available, police officers provide escort services.

In 2014, a UC Davis Police Accountability Board (PAB) composed of students, staff and faculty was established “to develop and promote accountability, trust, and communication between the campus community and the UC Davis Police Department.” This board makes recommended findings to the Chief of Police based on investigations into complaints of misconduct filed against UC Davis police officers. Quarterly closed public meetings are held with meeting minutes posted online and an annual report is published on investigations from the prior fiscal year. However, while the PAB attempts to work towards restorative justice and mediation, it is critical to note that this process relies entirely on the victim of police misconduct to report the incident and proceed with investigation. Additionally, the PAB has no power to provide specific recommendations on disciplinary actions and any disciplinary action taken is not put on public record.

While implicit bias and trauma-informed training are included in police training, there is no explicit anti-racist training.

Finally, in compliance with Racial and Identity Profiling Act (RIPA), the UCDPD began collecting stop data on January 1, 2020; however, they are still discussing how to make this data publicly available on the UCDPD website.

Additional information can be found at the following links:

- Police Accountability Board (PAB) Website
- PAB FY 18-19 Annual Report
- UC Davis Campus Police Training Outline
- UC Davis Campus Police "Safe Rides"

10. Marginalized Patient Population

Expectations for students' level of independence and supervision are clearly documented and are consistent across training sites (for example, students are not disproportionately given the opportunity to "practice" while rotating in VA or public hospitals or while volunteering in free clinics).

A. The above metric is fully met.
B. Policies exist to ensure that all patients receive equally well-supervised student care but are inconsistently enforced.
C. Students are routinely given more independence when caring for marginalized patients.

In terms of clerkship rotations, clinical sites provide policies and practices that ensure a baseline level of supervision and independence for patient safety and learning. Evaluations of clerkship rotations show that the overall adequacy of feedback and direct supervision was rated between high 5 or low 6 out of 7, however there is no site-specific feedback collection that confirms quality is still consistent at sites serving marginalized populations.

UC Davis School of Medicine also has 11 student-run clinics, which most students volunteer with during their pre-clinical years. Each clinic has its own nonprofit status, UC Davis faculty medical director, and governance system for supervising students. Preceptors at the clinics are UC Davis volunteer faculty, residents supervised by UC Davis faculty, or community physicians that have gone through an extended review process. However, the review process for preceptors in the student-run clinics is less intensive than that of faculty working at clerkship sites and there is no overarching policy across clinics for student level of independence and supervision.

11. Equal Access for All Patients

At the primary teaching hospital, patients of color are represented in all services (including specialist services) and practices at their rate in the local population. Patients of color are not segregated in resident or student clinics.

A. The above metric is fully met.
B. There are some efforts to ensure that all patients have equal access to care (e.g. Medicaid patients are seen in faculty clinics).
C. Patient care is highly segregated, or this information is not publicly available.

Basic demographic data is collected by the health system in the following general categories: “Academic,” “Cancer Care,” “Home Health and Hospice,” “Hospital/Emergency Department,” and “Network.” However, this health system data is not publicly available and does not drill down further than these larger categories. Additionally, data is not collected systematically for the student-run clinics. In looking at the example of “Network,” which would incorporate primary care services, representation is as follows (based on “primary race” indicated): 5.3% “African American or Black,” 2.5% “Hispanic,” and no available data for Native American patients. Demographics for Sacramento, CA (where UC Davis Medical Center is located) are as follows as of November 6, 2019: 13.43% “Black or African American,” 27.4% “Hispanic,” and 0.75% “Native American.”

It is crucial to note that in recent years UC Davis significantly reduced the number of Medi-Cal (California Medicaid program) patients it accepts for primary care. Number of Medi-Cal beneficiaries able to receive primary care services is currently capped at 5,000 patients relative to the 424,238 Medi-Cal enrollees in Sacramento County as of December 2019. Additionally, 50% of 13.2 million Medi-Cal enrollees (as of May 2018) identify as Latino, suggesting that there is an especially large discrepancy in primary care services for this population.

- Sacramento Population Demographics
- Sacramento Population Demographics (Ethnicity Included)
- Medi-Cal Managed Care Enrollment Report
- Medi-Cal Facts & Figures Almanac 2019

12. Immigrant Patient Protection

The primary teaching hospital has demonstrated a commitment to immigrant patients including multilingual public signs stating that patients are welcome regardless of immigration status, and a policy of referring immigration authorities to hospital attorneys prior to any cooperation by hospital staff.

A. The above metric is fully met.
B. The hospital has some symbolic commitment to immigrant patients (e.g. signs), but no policies explicitly protecting undocumented patients.
C. The hospital has no public or policy commitment to immigrant patients.

In addition to public statements from UC Davis leadership, the UC system has developed a statewide policy to demonstrate continued support of immigrant patients, specifically how to respond to immigration enforcement issues involving patients in UC health facilities. This policy applies to health facilities as defined in California Health and Safety Code section 1250, clinics as defined in California Health and Safety Code sections 1200 and 1200.1, and substance abuse treatment facilities operated by the associated university. Immigration enforcement-related guidance and model policies for health facilities is entitled “Promoting Safe and Secure Healthcare Access for All: Guidance and Model Policies to Assist California’s Healthcare Facilities in Responding to Immigration Issues.” The model policies address information sharing, responding to immigration enforcement presence at health facilities, providing information on patient rights (including immigrant patient rights) and remedies, monitoring and receiving visitors, and notifying minor patients’ parents of immigration law enforcement actions. UC Davis is also in the process of contributing to an additional UC-wide policy surrounding immigration enforcement and patient protection from immigration authorities, however this policy has not yet been implemented and drafts of the policy are not publicly available.

Crucially, no public signage exists in the hospital currently and thus far implementation of multilingual signage has not been included in the draft policy described above.

Additional information may be found at the following links:

- Promoting Safe and Secure Healthcare Access for All: Guidance and Model Policies to Assist California's Healthcare Facilities in Responding to Immigration Issues
- California Legal Code for Cooperation with Immigration Authorities
- Frequently Asked Questions for University Employees About Possible Federal Immigration Enforcement Actions on University Property
- University of California Statement of Principles in Support of Undocumented Members of the UC Community

13. Staff Compensation & Insurance

All medical school staff and staff at the primary teaching hospital are paid a living wage as defined by local advocacy organizations. All full-time staff have comprehensive health insurance that is accepted at the health system where they work.

A. The above metric is fully met.

B. N/A

C. Some staff earn less than a living wage and/or do not have access to comprehensive health insurance, or this information is not publicly available.

UC Davis implemented the UC Fair Wage/Fair Work Plan program in 2015 which guarantees UC employees working at least 20 hours per week be paid $15 per hour. The plan also requires that contractors doing business with UC guarantee a minimum $15 minimum hourly wage. These salary ranges are designed to meet the California minimum wage and local living wage standards (City of Sacramento's 2019 Living Wage Rates are $13.72 with benefits). Additionally, all employees are eligible for health, vision and dental benefits, which includes access to UC Davis physicians.

Additional information may be found at the following link:

- UC Fair Wage/Fair Work Plan

14. Anti-Racist IRB Policies

IRB approval process requires researchers involved in any research that uses race to include precise definitions of race and how it is being used in the research project.

People of color are clearly identified as being a "vulnerable population for research purposes, and IRB policies outline strategies to protect people of color from abusive practices.

A. The above metric is fully met.
B. IRB process requires researchers to explain their use of race.
C. IRB process has no requirements regarding the treatment of race, or this information is not publicly available.

UC Davis IRB policies include special scrutiny of research involving subjects from a "vulnerable population" (e.g. children, pregnant women/fetuses, prisoners, cognitively impaired adults) but does not include people of color in this definition. There are no specific guidelines around treatment of race in research, and there is no specific review process that addresses responsible treatment of race by a qualified faculty member.

Additional information may be found at the following link:

- UC Davis IRB Investigator Manual
- UC Davis IRB Definition of Vulnerable Populations

Recommendations

Areas of Strength

- Metric 1: URM Student Representation
    - No specific recommendations.
- Metric 3: URM Recognition
    - More explicit and constant, permanent, established celebration of diverse URM/PoC individuals in medicine to culture a community of inclusion and support.
- Metric 13: Staff Compensation & Insurance
    - No specific recommendations.

Specific Reform Efforts

- Metric 4: URM Recruitment
    - Clear support for undocumented student applications on medical student applicant websites, including specific application information and resources.
    - Continued investment in designated financial support for students from disadvantaged backgrounds.
    - ***SNMA comments and recommendations:***

        "We must create strong pipeline programs and continue to diversify the medical field. The class of 2023 is the most diverse class UC Davis School of Medicine has seen. It must not stop there. Black men comprise one of the smallest percentages of practicing physicians in the nation, and the applicants of Black men to medical school have been trending downward. We need to increase the presence of black men on this campus and in the field. Doing so would require understanding the roadblocks of Black male success in early education and creating robust interventions to overcome them."

- Metric 6: Discrimination Reporting
    - Publicize the discrimination reporting process and have a designated reporting mechanism for racial microaggressions within the curriculum.
    - Ensure that student feedback regarding microaggressions leads to tangible change in the curriculum.
- Metric 7: URM Grade Disparity
    - Collect data on grade disparities for faculty review annually; all disparities should be discussed and addressed.
- Metric 12: Immigrant Patient Protection
    - Implement institution-wide, public, multilingual signage demonstrating a commitment to and protection of all patients regardless of immigration status.
    - Create, implement, and publicly disseminate a UC Davis Health System policy for referral of immigration authorities to hospital attorneys prior to any cooperation by hospital staff.
- Metric 14: Anti-Racist IRB Policies
    - Include people of color among their listed “vulnerable populations,” thereby requiring additional scrutiny of research that specifically recruits PoC.
    - Require that all research submissions in which the project involves race have a written definition of race and a description of how race will be used in the research study.
    - Reject any proposed study that will explicitly or tacitly reinforce biological definitions of race.

Areas for Ongoing Improvement

- Metric 2: URM Faculty Representation

    - Collect un-collapsed demographic data for URM faculty.
    - Continue and increase external recruitment and retention of faculty of color, as well internal evaluation of bias against promotion and compensation of faculty of color.
    - Recognize the additional labor provided by faculty of color and provide compensation for efforts towards anti-racism education, mentorship, and clinical training.
    - ***SNMA comments and recommendations:***

        > "Black preclinical IORs are necessary. We are well aware of the profound impact physicians of color have on the patients that look like them. This ideology must be adopted in our educational system as well. Moreover, this is a necessity for the students of color who want to become faculty and medical education leaders in the future. We know too well the difficulty of trying to be what you cannot see."

- Metric 5: Anti-Racism Training & Curriculum

    - Include sessions during orientation week that describes how UC Davis will commit to anti-racism principles and practices, specifically in regards to daily student life (e.g. how race should be discussed in the context of disease and health, support/resources for URM students, mechanisms for curriculum inclusivity and mistreatment incident reporting, etc.).
    - Following the example of University of Washington (UW) School of Medicine, implement an anti-racist summer reading program prior to matriculation.

        Source:
        https://docs.google.com/document/d/1c_2rUYXqSIsPffy8sylRET3AZHus9dkEWaSXNU8d7o8/edit

    - Create a continuity "thread" of anti-racism throughout the curriculum for all 4 years.
    - Implement mandatory anti-racist training for all faculty that interface with students, including guest lecturers, active learning session facilitators, etc.

- Create a standard metric to make sure that every lecture, clinical skills session, and group learning session is in line with anti-racism goals and require IORs to uphold these standards.
- Require IORs to review lecture slides of all course lecturers to ensure compliance with anti-racism curriculum standards, e.g. race is not described as a biological risk factor for disease.
- Streamline the process for students to report racism and microaggressions in lectures through the Learning Climate Committee (LCC) and have a clear system to ensure that perpetrators of racial microaggressions are required to complete corrective action.
- Formally integrate community member voices in planning and deliverance of curriculum regarding racial health inequities and compensate them for their time.
- ***SNMA comments and recommendations:***
    - "Revise and reform the curriculum. Racism is a public health issue, and as physicians-in-training, our curriculum should effectively prepare all medical students to address it. Our curriculum should have the aim to understand the systemic racism that produces health disparities. We request that our new curriculum fully integrate antiracism discourse. We ask to adopt the framework including – but not limited to – the UC Davis Race and Health Summer Institute, led by Dr. Jann Murray-García, and discourse recommendations from the SNMA. We also ask that our educators increase the representation of Black people and people of color in clinical cases and standardized patients to supplement this new curriculum."
    - "Training in diversity and inclusion should be expanded and longitudinal. We recognize the efforts of implemented training through the Supporting Educational Excellence in Diversity (SEED) module. Let us remember the need for inclusion as well. This learning opportunity should be extended to all staff in roles that intersect with student education, including auxiliary staff. Furthermore, uprooting the stems of racism, including bias and microaggressions in education, is an ongoing pursuit. We request that training be thorough and implemented within each block (i.e., biannually) to reach the depths of this issue. Moreover, the UC Davis Health should

institute annual antiracism training for all employees. Similar to requirements such as Health Insurance Portability and Accountability Act (HIPAA), Safety and Security, and Sexual Harassment that focus on prevention, this should be a priority as well."

- Metric 8: URM Support/Resources
    - ***SNMA comments and recommendations:***
        - "We need long-term investments in wellness interventions. Our mental health has a direct impact on our ability to thrive as medical students. An understanding of historical racial traumas and how they affect our academic performance and community engagement is imperative. Now is the time to rely on the expertise of Black therapists equipped to help black students process traumatic experiences and heal from them. We request this individual as a permanent addition to our wellness team."
        - "The hiring of the Dean of the Office of Student and Resident Diversity (OSRD) is long overdue. Black students need a designated person to turn to when injustices take place within the classroom and beyond. We look forward to the OSRD dean not only listening to our grievances, but also amplifying them and implementing policies that will provide continued support to aid in our success. At a time when police are unjustly weaponized against Black medical students on campus and the larger issues of systemic racism inciting uprisings around the country, now is a critical time for the Dean of OSRD position to be filled. Additionally, within medical education leadership, there is not one single Black or African American Faculty member. Representation is an important part of change. We truly need an advocate who has a voice, positionality, authority, and a shared identity to speak for us."

- Metric 9: Campus Policing
    - Publish data on stops and arrests for patients, community members, and students and address any findings of disproportionately higher police contact among PoC.
    - Restructure police trainings to include explicit anti-racism practices with strict focus on de-escalation tactics.
    - Publicly denounce using race as an identifier and descriptor for reports.
- Metric 10: Marginalized Patient Population
    - Require feedback and data collection from third year students to investigate site-specific discrepancies in student supervision and patient care standards.
    - Ensure that site-specific differences in supervision are not correlated with patient demographics or insurance type.
    - Fully fund and support Student-Run Clinics.
- Metric 11: Equal Access for All Patients
    - Have U.C. Davis hospital system accept all Medi-Cal patients for primary care.

Appendix: Statements from WC4BL National

Medical Schools

Policing is incompatible with education. This means that medical schools must:

- End their relationships with local law enforcement.
- Publicly commit not to collaborate with ICE enforcement actions.
- Publicly release data on the race of students, faculty/staff, and community members involved in interactions with campus police officers and develop a clear action plan to address racist inequities in campus police interactions.
- Eliminate the budget for campus policing, and reallocate those
- funds to programs supporting BIPOC (Black, indigenous, and people of color) students and staff and individuals in crisis.

Black people make up 13% of the U.S. population, but only 5% of physicians. To create a representative physician workforce, medical schools would need to admit classes made up only of Black, Latinx, and Native American students for the next 10 years. Medical schools must therefore commit to admitting incoming classes in 2021 with over-representation of Black, Latinx, and Native American students (at least 26% Black, 34% Latinx, and 2% Native American). This means that medical schools must:

- Publicly release a detailed plan about how they plan to create a first-year class in 2021 with **overrepresentation** of Black, Latinx, and Native American students.

Medical schools must fully support their BIPOC students. This means that they must:

- Publicly release data on the preclinical/clinical grades and rates of AOA election for students of different races and develop a plan to immediately address any inequities. This plan would likely include the abolition of AOA.
- Increase by at least 50% the funding dedicated specifically to supporting BIPOC students, including mentorship, scholarships, and dedicated support staff.
- As part of a broader project of reckoning with medicine's troubling history of racism, undertake research into the ideologies and activities of individuals featured on their campuses, and remove the names and images of those found to have supported eugenics or other white supremacist causes. This research must extend not only to historical figures, but also to contemporary donors who

have engaged in practices such as weapons manufacturing, exploitation of low-wage workers, funding of racist political causes, and employment discrimination.

Hospitals

Policing is incompatible with health. This means that hospitals must:

- End their relationships with local law enforcement.
- Publicly commit not to collaborate with ICE enforcement actions.
- Publicly release data on the race of staff, patients, and family members involved in interactions with hospital security officers and develop a clear action plan to address racist inequities in security interactions.
- Eliminate the budget for hospital security, and reallocate those funds to programs supporting BIPOC (Black, indigenous, and people of color) patients and staff, and to alternative strategies for supporting people in crisis (e.g. social work and mental health services).

Although racial segregation of medical care is illegal, most health systems effectively segregate patient care through triage decision-making, discrimination based on insurance status, and use of trainees to care for marginalized patients. This means hospitals must:

- Publicly release data on the racial demographics, primary language, and insurance status of patients seen in each hospital practice and hospital within a health system.
- Publicly release data on the demographics of patients seen by providers of different training levels within the health system (residents, NPs, PAs, fellows, attendings).
- Develop a clear action plan to address inequities in access to comprehensive care by fully trained providers.

Over 1 million healthcare workers and their children live in poverty, and these workers are disproportionately Black women. This means that hospitals must:

- Publicly release data on the minimum wages paid to hospital and subcontracted staff.
- Develop a plan to immediately increase the minimum wage for all hospital and subcontracted staff to the local living wage.