Using Art Observation In Museum Education To Broach Topics Of Bias And Power Among Health Professional Trainees

Robert Michel Rock

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Using Art Observation in Museum Education to Broach Topics of Bias and Power Among Health Professional Trainees.

A Thesis Submitted to the

Yale University School of Medicine

In Partial Fulfillment of the Requirements for the

Degree of Doctor of Medicine

by

Robert M. Rock

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Abstract:

The Liaison Committee on Medical Education has identified training on cross cultural interaction and bias as high-priority topics. There has been little published on the use of fine art, specifically painting or sculpture, as a means of entry into discussion on issues of bias in medicine relating to race, gender, and other identities. Making the Invisible Visible (MIV) is a 3-hour, guided museum tour that uses art observation to facilitate dialogue about biases embedded in Western culture as well as their influence on personal and professional interaction. The tour uses intersectionality and critical pedagogy as theoretical frameworks to approach multiple dimensions of identity and oppression simultaneously. We hypothesized that MIV will promote the cognitive dissonance needed to develop critical consciousness as it relates to historical origins of bias in medicine.

MIV has been incorporated into the Yale School of Medicine’s first year curriculum since fall 2015. Data was gathered immediately after each MIV session for student groups within the first-year class. Data was collected using evaluation surveys from the entire class as well as three volunteer focus group interviews. The focus groups were analyzed by a two-person research team. Of the 74 surveys collected (71% response rate), 78% considered MIV above average (38%) or excellent (40%). Focus groups revealed appreciation for the topic and the use of art. Students acknowledged their own biases and reported a deeper understanding of how biases inform systemic oppression. Although some students admitted to self-censorship, all greatly appreciated peer perspectives that were offered. All participants recognized the need to continue the dialogue throughout medical training. While demonstrating art observation as a viable tool for discussing bias in healthcare, MIV has highlighted a desire for more curricular content on the subject and offered a potential framework for future discussions.
Acknowledgements:

A community of incredible women have been pivotal to the creation and evaluation of this project. I would first like to thank my classmate and comrade in creating the Yale School of Medicine US Health Justice course, Tehreem Rehman, for recognizing the value in the idea and for pushing me to include an art tour in our US Health Justice Course pilot. I owe an incredible debt of gratitude to Cindy Crusto, PhD and Cyra Levenson, EdM for their invaluable intellectual contributions and endless support. They showed faith in me before there was any sign that this would succeed, selflessly investing resources, ideas, and time in helping to shape Making the Invisible Visible and welcoming me into their lives in the process.

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Introduction:

“The paradox of education is precisely this - that as one begins to become conscious one begins to examine the society in which he is being educated. The purpose of education, finally, is to create in a person the ability to look at the world for himself, to make his own decisions, to say to himself this is black or this is white, to decide for himself whether there is a God in heaven or not. To ask questions of the universe, and then learn to live with those questions, is the way he achieves his own identity. But no society is really anxious to have that kind of person around. What societies really, ideally, want is a citizenry which will simply obey the rules of society. If a society succeeds in this, that society is about to perish. The obligation of anyone who thinks of himself as responsible is to examine society and try to change it and to fight it – at no matter what risk. This is the only hope society has. This is the only way societies change.”

“A Talk to Teachers” 1963 – James Baldwin

Health disparities between Black Americans and the White American population are well documented across various health outcomes. When controlled for socioeconomic status and access, many of these disparities persist, which highlights the role of clinician-level decision making in domestic health inequities. Dual process theory is a framework that provides insight on how preconceived notions and flawed beliefs can influence decision making in high pressure situations, particularly when the answer to a clinical question is ambiguous. Although blatant discrimination is not openly supported to the degree it once was, the beliefs of inherent differences in behavior and genetic makeup that served as the justification for the overt racism of the past still exist in our society today as unconscious biases. Research has shown that the prevalence of such biases among health care providers are equivalent to that of the lay public. For this reason, the American Psychological Association states that “awareness of oneself as a
racial/cultural being and of the biases, stereotypes, and assumption that influence world views” is crucially important in allowing therapists and other health providers to deliver care effectively across racial/cultural lines.\(^8\)

The impact of such biases on healthcare disparities informs accreditation standard 7.6 of the Liaison Committee on Medical Education that requires “the faculty of a medical school ensure that the medical curriculum provides opportunities for medical students to learn to recognize and appropriately address gender and cultural biases in themselves, in others, and in the health care delivery process”\(^9\). The standard lacks specific guidelines on executing such educational interventions. However, applicable frameworks, primarily critical pedagogy, exist outside the field of medicine and have been applied to health professional training by contemporary educators in an attempt to facilitate critical introspection\(^10,11\). Arno Kumagai, MD uses critical pedagogy in medical education to promote critical consciousness among trainees. He defines critical consciousness as the placement of medicine in a “social, cultural, and historical context” combined with an “active recognition of societal problems and search for appropriate solutions”\(^10\). Kumagai takes time to distinguish critical consciousness and contemporary medical competencies by explaining:

“From a pedagogic perspective, development of true fluency (and not just “competence”) in these areas requires critical self-reflection and discourse and anchors a reflective self with others in social and societal interactions. By “critical self-reflection,” we do not mean a singular focus on the self, but a stepping back to understand one’s own assumptions, biases, and values, and a shifting of one’s gaze from self to others and conditions of injustice in the world. This process,
coupled with resultant action, is at the core of the idea of critical consciousness.”

The action-oriented social, cultural, and historical contextualization of medicine is vital because it emphasizes the necessity of an exploration into how racial bias is reinforced in medical education, the need for reform, and the institutional conditions that serve as obstacles to doing so. The long history of institutional racial bias in medicine and failed attempts at reform are chronicled in texts such as *Black & Blue: The Origins & Consequences of Medical Racism* by John Hoberman. Such critical historical perspectives provide a necessary framework for contemporary efforts in raising awareness about the perpetuation of racial bias in modern medical education. They also serve to provide a sense of urgency to the growing demand among medical students and leaders in medical education for a restructuring of institutional resources to educate trainees on these topics.

Medical educational interventions aimed at combatting bias among health care trainees have been designed using the Implicit Association Test (IAT) as a tool in raising awareness, but reviews have suggested that focusing solely on the IAT is ineffective. One study using a combination of the IAT, pre-readings, and small group reflection showed that those who deny carrying bias are more likely to show bias on the IAT and more likely to deny the validity of the IAT. Recommendations suggest that to encourage openness and receptiveness to such information, educators should aim to emphasize the shared responsibility of health providers to address the presence of bias and affirm egalitarian goals to providing equal care. These findings highlight the need for innovative educational interventions that go beyond sensitizing participants about their own biases.
Although not explicitly focused on implicit bias, the field of diversity training has faced similar problems in affecting change among participants. Although no single best technique has been identified, literature from within the field of organizational psychology has offered best practices when designing such interventions\(^{18}\). Reviews of multiple interventions have suggested that, “diversity training that provides greater opportunity for social interaction will have stronger beneficial effects on affective-based outcomes, relative to training providing less opportunity for social interaction” and that “diversity training will have stronger beneficial effects on affective-based outcomes, when trainee motivation is high than when it is low” \(^{18}\).

Critical pedagogy’s approach to promoting critical consciousness among its students aligns well with the best practices put forth by both organizational psychologists and medical educators. Paulo Freire highlights the importance of social interaction when he asserts that dialogue in an environment that diminishes hierarchy between teacher and student is a crucial component to promoting critical consciousness\(^{10}\). He goes further to refute the lecture based format of education, referred to as ‘the banker’s model’, which considers students as empty vessels whose only role is to receive knowledge imparted by their teachers\(^{10}\). Instead, Freire posits that the power dynamic must be flattened in a way that recognizes the value of the experiences, beliefs, and identities each student brings to the learning environment so that teachers recognize themselves as learners in a mutual exchange\(^{10}\). Within these small group learning environments, intimate discussion on socially charged topics are meant to provoke ‘cognitive disequilibrium’\(^{11}\). In his paper, Kumagai explains the importance of this goal, saying:

“Evidence from developmental psychology suggests that significant learning and personal growth may occur when one encounters an experience, idea, perspective, or identity with which one is unfamiliar— when one goes through what Piaget
refers to as “cognitive disequilibrium” in moving from one developmental stage to another, more advanced level. Such an encounter with the unfamiliar and the disequilibrium that may ensue stimulate what Habermas terms a “hypothetical attitude”: a perspective which involves turning a critical gaze on one’s own values, assumptions, experiences, and opinions and questioning the moral validity of the state of affairs in the world.”  

Recognizing the identities, values, and past experiences of participants while framing these discussions as necessary in achieving medicine’s egalitarian goals would likely provide the strong motivation the organizational psychology literature considers a prerequisite to attempting to influence affect.

To provoke the cognitive disequilibrium required to promote critical consciousness, an educational intervention must honor all identities and experiences students bring to the discussion. Such an approach requires the purposeful employment of another educational theory, intersectionality, which Collins & Bilge define as:

“a way of understanding and analyzing the complexity in the world, in people, and in human experiences. The events and conditions of social and political life and the self can seldom be understood as shaped by one factor. They are generally shaped by many factors in diverse and mutually influencing ways… When it comes to social inequality, people’s lives and the organization of power in a given society are better understood as being shaped not by a single axis of social division, be it race or gender or class, but by many axes that work together and influence each other…Intersectionality as an analytic tool gives people better access to the complexity of the world and of themselves”.


Critical pedagogy and intersectionality are both used to explore issues of social inequality and the organization of power that informs inequity. In this context, both theories emphasize the importance of “navigating differences [as] an important part of developing a critical consciousness for both individuals and for forms of knowledge” 19. Both theories emphasize the importance of education while criticizing the potentially homogenizing effect contemporary educational practices have on marginalized learners. Both intersectionality and critical pedagogy refute educational systems that coerce students by “assimilating them into dominant Anglo-Saxon Protestant middle-class norms of values” that conscript them into “upholding racism, sexism, and xenophobia by learning how to practice the discriminations that they engendered” 19. With this in mind, the value of applying intersectionality and critical pedagogy to medical training becomes apparent when discussing the lived experiences of students, trainees, and faculty within a medical society that is biased to hold a white, male, heteronormative, cis-gendered world view supreme 20-22. Kumagai stresses how important recognizing such difficult experiences and varying perspectives are to the formation of professional identity and the development of just patterns of practice 23. He also emphasizes the importance of creating the space to do so in medical education curricula 24.

The visual arts have increasingly been used to create such spaces for reflection on a broad array of topics within the area of medical ethics and professionalism. Medical educators employ art because of its ability to relay complex ideas in emotionally captivating ways that effectively facilitate introspection and critical thinking. In his review of the use of the arts in medical training, Haidet identifies a key aspect of the arts that allows for their broad application when she says, “The subjectivity of the arts helped teachers to challenge concrete or literal thinking, and also served to legitimize learners’ personal experiences and emotions in dealing with a variety of
topics”  25. The medical education literature contains multiple reports showing how art can be used to create a safe space for reflection that helps students express themselves in deeply personal ways  25. Gaufberg creates this space by employing the arts as a “third thing” “that provides learners with a safe and effective avenue to approach issues of meaning, explore sensitive or “taboo” topics, or discuss complex emotional responses”  26. In her educational intervention Gaufberg provides prompts that guide students to reflect on personal experiences and asks them to find a work of art that resonates with the specific prompt  26. The arts have also been used as a tool in teaching medical ethics and professionalism, specifically as a means to ease the process of reflection on emotionally charged subjects  27. In both of these interventions, students are not expected to provide an art historical background of the work, but to reflect on their own interpretation of the work’s meaning relative to their prompt.

This focus on the individual’s interpretation of art has been well established in medical education. Art viewing has been incorporated into medical curricula at institutions across the country as a means to teaching better observational skills to medical students and residents  28,29. The goal of these observational skills courses is to prompt trainees to provide more detailed description before forming interpretations and coming to premature conclusions, which is believed to relate to better diagnostic skills in clinical practice  29. Dolev posits that “the use of representational paintings capitalizes on students’ lack of familiarity with the artworks” and that trainees provide more detailed descriptions “because they do not have a bias as to which visual attribute is more important than another”  28. However, a growing body of literature goes against the notion of using representational art to diminish bias and instead actively attempts to explore it. Recent interventions have used photography, artistic narrative, and interactive discussions with artists to expose medical students to these ideas  30,31.
Making the Invisible Visible: Art, Identities, and Hierarchies of Power (MIV) is an educational intervention that builds on current art education practices by combining art viewing and art historical analysis as a means to explore the social, cultural, and historical origins of biased beliefs. In practice, MIV is a three-hour long, guided art tour for medical students that studies the expression of bias in western culture through the stories told in its art. The tour uses art as a “third thing” to ease entry into discussion, but uses an art historical framework to explore the social, cultural, and historical background of the works as a means to facilitating difficult conversation. Based on prior medical education curricula that use art viewing to improve observational skills, the developers of MIV repurposed the technique by using the theories of critical pedagogy and intersectionality to facilitate discussions about the biases inherent to western society, medicine, and the role of future providers in perpetuating them. MIV emphasizes the power dynamics at play in the perpetuation of biases, who they serve, who they stand to hurt. This conversation is inherently difficult because it uses participant interpretations to challenge problematic beliefs along the lines of race, gender, class, national origin and many other identities participants bring to the discussion.

Designed by Robert Rock, Cyra Levenson, EdM, and Cindy Crusto, PhD, MIV was originally intended to as a session within the United States Health Justice (USHJ) course at Yale University School of Medicine started in the fall of 2014. USHJ is a semester-long, interprofessional elective course for students in the medical, nursing, and physician associate programs which focuses on domestic health inequality, social medicine, and advocacy on the part of health providers both clinically and extra-clinically. Since its development within the USHJ course, MIV has been conducted for students, residents, and faculty locally at Yale University and at national conferences.
The tour has been incorporated into the mandatory curriculum at the school of medicine since the fall of 2015. Facilitated by medical students, Robert Rock and Nientara Anderson, through collaboration with faculty from Yale University, the Yale School of Medicine, the Yale Center for British Art, and the Yale University Art Gallery, all first-year medical students participate. MIV is executed for a maximum group of 26 students and is run four times within the Introduction to the Profession (iPro) master course to accommodate the entire first year class of medical students. MIV’s addition to the mandatory curriculum presents an opportunity to explore how such an intervention will be received by a non-self-selected group of students, whether cognitive disequilibrium is achieved, and what ideas such conversations provoke among participants.

**Statement of Purpose (Hypothesis)**

Medical education interventions directed toward exploring and mitigating unconscious racial bias in trainees have become increasingly prevalent despite mixed results. Art educational interventions, effective at prompting discussion and promoting reflection, have been developed to discuss issues of bias in contemporary medicine. However, current examples of arts interventions have not used a historical framework. The study design to be outlined is an attempt to use critical pedagogy and intersectionality as theoretical frameworks in exploring the effect of art education on promoting the cognitive dissonance needed to promote critical consciousness as it relates to historical origins of bias in medicine. This thesis will serve as an instructional guide for executing the tour. It also contains the theoretical framework that can be used when incorporating new works of art into the tour, which would hopefully incorporate identities not emphasized in the original tour.

**Methods**
Study Participants

The entire Yale School of Medicine class of 2021 participated in the MIV tour and reflection session as part of the first master course of the curriculum. The first-year class at the Yale School of Medicine consists of 104 students whose average age is 23.6 and ranges from 21 to 31 years of age. Of those students, 47% are female and 23% are from backgrounds traditionally underrepresented in medicine. There were eight students who identified as Black, 16 who identified as Hispanic/Latino, and two that identified as Native American or Native Hawaiian. The largest racial group represented in the class is Asian/Asian-American/Pacific Islander, which represents 40% of the group. This is followed by White/Caucasian at 37%. One third of the students were born outside of the United States. Within the class, 14% had advanced degrees (Masters or Doctoral) and 41% had enrolled in medical school at least two years after completing their undergraduate studies.

This study was granted institutional exemption from the Yale University Institutional Review Board under federal regulation 45 CFR 46.101(b)(1) which covers “research conducted in established or commonly accepted educational setting, involving normal educational practices.”

MIV Description

*MIV* is a three-hour long, guided art tour and reflection session for medical students that studies the expression of bias in western culture through the stories told in its art. Designed by Robert Rock, Cyra Levenson, EdM, and Cindy Crusto, PhD, MIV was originally intended to be a session within the inter-professional USHJ course started in the fall of 2014. The tour has been incorporated into the mandatory curriculum at the school of medicine since the fall of 2015. Facilitated by medical students, Robert Rock and Nientara Anderson, the session uses the collections of the Yale Center for British Art as well as the Yale University Art Gallery. To
preserve the group dynamics and participation of the USHJ elective for the entire medical student class, MIV is executed for a maximum group of 26 students and is run four times within the Introduction to the Profession (iPro) master course to accommodate the entire first year class of 104 medical students. The data analyzed for this thesis was collected in the Fall of 2017, during the iPro master course. Although participation in the focus groups was voluntary, attendance in the tour and reflection session was a mandatory part of the curriculum.

Before participation in the MIV session, students are assigned a set of pre-assignments meant to provide background knowledge on issues of bias and power in western society (Appendix 4). Although two of the assignments provide a social science framework, a majority of the pre-assignments are based in the humanities in an effort to provide a more personal and nuanced understanding of the issues at hand. The first 90 minutes of MIV occur in the art galleries, where structured art observation is used as an approach to recognizing the inherent assumptions and biases imbedded in western culture. This recognition is meant to spark discussions that inform participant understanding of the problematic interactions (i.e. microaggressions) that often manifest in personal and professional interactions as a result of these imbedded beliefs.

At the start of the session, facilitators introduce themselves and welcome students to the museum. They then explain the reason for leaving the medical campus and the importance of the topic at hand. Referring to the social science pre-reading, facilitators assert the following:

“In the realm of medicine, various groups stress two things that are crucial in allowing health providers to deliver care effectively across lines of identity.

1. **Awareness of one’s self as a racialized/gendered/cultured individual (and all other possible identities)**

2. **Awareness of the biases, stereotypes, and assumptions that influence how we**
see the world, what we expect from it, and how we interact with it.”

Facilitators then establish the connection between bias in general society and its manifest in medicine, by saying:

“I’m sure I wouldn’t be the only one to argue that this is important in everyday interactions too, but it’s extra important for people like you, because the power dynamic between patient and provider, researcher and subject, policy maker and population, will be skewed heavily in your favor. And in such high stakes interactions, the presence and unconscious expression of such biases can undermine relationships before you realize it, dramatically influencing the delivery of health care and the possibility of living a healthy life.”

After conveying the gravity of the discussion, ground rules for the session are established. In an attempt to create a safe space, but critical space sensitive to the lack of experience many participants will have when discussing these issues in academic settings, facilitators announce the three principle ground rules at the start of each session. The first rule focuses on maintaining confidentiality about the specific stories that participants offer to the group discussion. The second rule recognizes that the topics discussed are often not a part of the mandatory general curriculum or pre-med curriculum in American undergraduate universities and that many participants will not have as well formed a vocabulary on the issues as others. Because of this, students are asked to “trust the good intentions of the person next to you and not get caught up in the specific words they use to convey those intentions.” The final rule challenges students to use “I” statements when expressing opinions, beliefs, or experiences in order to take ownership of what they are sharing with the group.

After establishing the ground rules, facilitators explain the steps of the structured observation
exercise that will be used for each work of art. Groups of 13 students and one facilitator will spend 20 minutes at each painting going through the following steps.

1. **Detailed observation of things physically represented in the work** (i.e. Describe the painting as if you’re looking through a window and explaining what you see to someone who cannot.)

2. **Interpretation of scene based on the evidence collected in step 1.**

3. **Exploration of the meaning of the painting based on interpretation**

4. **Exploration of meaning of the painting with context provided by art guides**

5. **Interpretation of message through a modern lens, including its implications in medicine and society.**

As the steps are followed, the facilitator asks general questions, provides some background knowledge, and asks art work specific questions to encourage discussion and challenge assumptions. A detailed description of the time allotment and the prompts for each work of art can be found in Appendix 5.

Each art work used in MIV is specifically chosen by the session designers according to how the aesthetics and thematic content will capture participant attention and spark critical dialogue. Although not explicitly emphasized on the tour, the authors used the *Categories of Microaggression* described by Sue et al to explore how each works thematic content may encourage dialogue. The three paintings used for the fall 2017 MIV session were *Parau Parau (Whispered Words)* by Paul Gauguin ([Figure 1](#)), *Inside Outside* by George Grosz ([Figure 2](#)), and *Elihu Yale; William Cavendish, the second Duke of Devonshire; Lord James Cavendish; Mr. Tunstal; and an Enslaved Servant* by Unknown Artist ([Figure 3](#)).
Figure 1: Paul Gauguin, Parau Parau (Whispered Words) 1892

*Parau Parau* depicts a subdued scene in which a group of brown-skinned figures gather in a clearing within a tropical forest. The scene is painted by Paul Gauguin, a French artist who visited Tahiti, a French colony at the time, in an attempt to escape the industrial revolution and return to nature. The painting and other works by Gauguin depict a land untouched by the French inhabited by a docile people. This is the version of events that has been taken up by western
society, but in academic circles this story is complicated by facts that refute Gauguin’s accounts of what Tahiti and its inhabitants looked like as well as what he actually did when there. Books such as *Going Native: Paul Gauguin and the Invention of Primitivist Modernism* by Abigail Solomon-Godeau as well as *Avant-Garde Gambits (1888-1893): Gender and the Colour of Art History* explore how conflicts between Gauguin’s version of events and first-hand accounts of life in Tahiti at the time speak to the power Gauguin and artists like him had in fabricating unidimensional stories of non-western peoples. In MIV, the racial, cultural, and gender hierarchies that inform this conflict are connected to the power dynamics present in medicine. Specific comparisons are made between the ease with which the artist’s record of events is perpetuated and the perpetuation of the healthcare provider’s version of events in the electronic medical record as opposed to a patient’s version of the story. More details can be found in Appendix 5.

*Figure 2:* George Grosz, *Drinnen und Draussen (Inside, Outside)* 1926
Inside Outside depicts two scenes juxtaposed in a single frame. In the outdoor scene to the left, a gaunt, one legged figure leans against a wall as pedestrians walk by. The indoor scene depicts a party where men and women sit around a table drinking and smoking, seemingly unaware of what is happening in the left side of the painting. Grosz renders the male figures in the painting as highly stylized caricatures, either ruddy faced and swollen or ashen and gaunt. The stark differences in their clothing and dress also emphasize the polarities within the painting. The aesthetic exaggerations Grosz incorporates into the painting intensify the sense of social commentary being made. The visual cues make it easy to recognize the explicit class distinctions and implied value placements often associated with them. When combined with the fact that Inside Outside was social critique created in Germany during the contentious Weimar Republic, the exaggeration of the characters speaks to the social divisions, scapegoating, and stereotyping that was rampant at the time. Although harsh, the visual stereotypes used to portray class, culture, gender, and physical ability are readily understood in the present day. Exploring the ease with which viewers understand the visual stereotypes used almost a century ago speaks to how deeply they are engrained in social consciousness and force participants to question how strongly
these preconceptions may influence how they interact with groups they are not familiar with.

More details can be found in Appendix 5.

![Figure 3: Unknown Artist, “Elihu Yale; William Cavendish, the second Duke of Devonshire; Lord James Cavendish; Mr. Tunstal; and an Enslaved Servant” circa 1708](image)

Elihu Yale; William Cavendish, the second Duke of Devonshire; Lord James Cavendish; Mr. Tunstal; and an Enslaved Servant (Figure 3) is a painting of the five figures gathered around a table on a patio overlooking a large estate where children play in the distance. Yale, the Duke of Devonshire, and Lord Cavendish are seated at the table, while Mr. Tunstal stands to the left of Yale’s chair and the enslaved servant looks on in the far right of the foreground behind the Duke’s seat. Historical record suggests the painting is a depiction of the signing of a marriage contract between Lord Cavendish and Yale’s daughter, who is not depicted in the scene. Such scenes were common at the time as upwardly mobile merchant families married their children into the aristocracy in an attempt to consolidate wealth and power. The specific items included in
the painting, from the luxurious clothing and tobacco to the enslaved servant and sword convey the wealth and power of the men seated at the table.

Patrons commissioned these paintings to influence how society viewed them and to influence how society viewed the world. Yale and others like him spent considerable amounts of their wealth influencing society’s understanding of what power looked like and rearranged various identity hierarchies in the process. In a culture where the standard of comparison is an affluent, heterosexual, white, man, students are challenged to consider how the path to medicine and experience within the medical society may be different for individuals who do not carry those identities. More details can be found in Appendix 5.

After the three art observations, students are taken to the classroom for a reflection session. They are first invited to split into pairs and take five minutes to discuss any past experiences the paintings reminded them of as well as any strong emotional reactions they had during the tour. Students are then brought back together and encouraged to share a summary of their discussion among the group. After sharing, definitions of identity and intersectionality are explained. These definitions lead into the main discussion exploring how these concepts relate to power and structural inequity. The four themes of controlling power, inspired by Feminist theorist Dianee Wolf and presented by Muhammad et al., are used as a framework for a final discussion in an effort to sensitize students to such power dynamics in academic medicine. Using the themes of positionality, the rules of the research process, representation, and the epistemology of power, excerpts from the pre-readings are used to prompt discussion of each theme. Students are then invited to begin to think of ways to dismantle the structures that perpetuate bias before being dismissed. The power point for the reflection session is included in Appendix 6.
Facilitator Training

Working as an MIV facilitator requires a unique set of knowledge, attitudes, and skills. All facilitators to this point have had a robust humanities and/or social science background prior to being recruited to work as facilitators. Upon this foundation, student facilitators are introduced to the tour as participants. Training consists of observation of MIV tours as well as an object file of each work used in the tour. The object files provide art historical analysis and allow the facilitator to understand the likely themes that each object will lead viewers to explore. Facilitators are also given a copy of the written guide of the MIV tour to practice the standard introduction, review the ground rules, and to review facilitation strategies for each painting as well as the reflection session.

Data Collection & Analysis

Attendance within MIV was a mandatory requirement of iPro, the first master course of the medical curriculum. As part of the main curriculum, students were invited to provide feedback through a standard end of session survey. The survey consisted of a single 5-point Likert scale question evaluating the learning experience (poor, below average, average, above average, or excellent) as well as a free response comment section.

Facilitators for both the tour and reflection session were Robert Rock (RR) and Nientara Anderson (NA), fourth and 5th (research year) students at the Yale School of Medicine. Students in the first-year class were informed of and invited to participate in focus groups by the MIV facilitators, RR and NA, immediately following each MIV session. They were notified that the focus group would last one hour, that food will be provided, and that their participation was entirely voluntary. They were also told that it would be conducted by an outside party not affiliated with the medical school and that all discussions held during the time would be recorded.
anonymously. They were then told the time and location to report to the focus group if interested.

Upon arrival at the focus group, interested participants were welcomed by the research assistant, Christina Nelson, and given a copy of the informed consent form to review (Appendix 1). They were notified that the purpose of the focus group was to evaluate participant perceptions of the efficacy and usefulness of the MIV intervention as well as how the tour and reflection session affected their understanding of the themes addressed. Upon agreement to participate, the informed consent was signed and a separate, online demographics form was filled out (Appendix 2). Participants were given a copy of the informed consent form for their records.

Each focus group was audio recorded to insure the accuracy of all information relayed. Recording were transcribed by an unaffiliated service. During the transcription process all names were removed from the transcription to ensure confidentiality of all participants. A thematic analysis of transcripts will be done subsequently.

The transcripts from the three focus groups were analyzed using the methodology specified by Krueger in *Analyzing and Reporting Focus Group Results* 33. Robert Rock (RR) and Christina Nelson (CN), the focus group facilitator, independently read each the first transcript to establish their own codes and then met to discuss their respective findings. Findings were compared to establish a code book, which was used to independently evaluate the subsequent transcripts. Discussion and deliberation were used to resolve disagreements in coding. Major themes from this analysis are presented in the results accompanied by supporting participant quotations.

**Results**

**Demographics and Participants:**

Of the 104 first-year medical students who participated in MIV, 13 (12%) students volunteered to take part in three focus groups immediately after the tours. The gender
distribution was eight males (62%) and five females (38%). The average age of the participants was 24, ranging from 22 to 27 years old. Four participants had a master’s degree prior to starting medical school. In terms of prior exposure to the humanities, eight students majored or minored in the humanities/social sciences as an undergrad, while five majored in the basic sciences exclusively. 11 participants were first-generation Americans whose parents were born outside of the United States. Two participants identified as (non-Hispanic) White, two identified as (non-Hispanic) Black, 2 identified as Hispanic/Latino, six identified as East Asian, and one identified as South Asian.

**Thematic Analysis**

In applying critical pedagogy and intersectionality to art education, we expected the intervention to trigger the cognitive dissonance necessary needed to begin a discussion around the historical origins of bias in medicine. Comments from the focus groups were aggregated and synthesized into major areas that pertained to their experience of the tour, awareness of their own bias, and implications for medical practice. Comments noted by an overall majority of focus group participants or by a consensus of one group of participants are included below. Therefore, everything said during the focus groups has not been included in the following results. Results are presented in six overarching sections: *Appreciation for the Use of Art; Awareness of Bias in Self and Others; Awareness of Societal Bias and Powerful Influencers; Participation Dynamics; Appreciating the Importance of the Topic;* and *Wanting More Discussion (Table 1).* Selected comments from focus group participants are included to provide added context for understanding the results and applying them to future curricular reform.
Appreciation for the Use of Art

- **Appreciation for the Specific Works**: Appreciation for the specific work chosen for the tour and their ability to provoke discussion as compared to less accessible abstract works.
- **Appreciation for the Viewing Technique**: Appreciation for the 5-step technique used in the viewing exercise and how it sensitized students to their own subjectivity even when being "objective".
- **Conversation Starter**: Awareness that this is just the beginning of the discussion as health care trainees
- **Safe Space**: Students reflect on the atmosphere and how it was conducive to flowing discussion.

Awareness of Bias: In Self & Others

- **Self-Bias**: Expressed awareness of personal biases.
- **Class Consciousness**: Sensitization to their own position and/or changing position in the economic hierarchy of society.
- **Dissonance & Impact**: Psychological stress due to contradictory, beliefs, ideas, values.

Awareness of Societal Bias & Powerful Influencers

- **Social Bias**: Awareness of the sociocultural influences on individual bias.
- **Biased Systems**: Awareness of structures of inequity usually taken for granted.
- **Medical Bias**: Made sensitive to or made to think about the existence of bias in medicine.

Participation Dynamics

- **Liberal Class Bias**: Awareness of liberal political leanings of classmates.
- **Cliché**: Students expressing exacerbation toward discussing commonly addressed identities.
- **Self-Censorship**: The fact that these are new students to Yale may inhibit their willingness to voice their opinions for fear of judgement.
- **Allies**: Identification of classmates to possibly form deeper connections with in the future for further discussion.

Recognizing the Importance of the Topic

- **Topic Appreciation**: Appreciation for the time spent discussing topics that often aren't covered.
- **Must be Mandatory**: Appreciation that this activity should be mandatory in order to ensure necessary student participation.

Wanting More

- **More Discussion**: A desire to discuss issues in future conversations.
- **Future Programming**: Expressing intention to find more programming to continue the discussion and learn more.
- **Specific Steps**: Sense of a lack of clarity/closure in terms of instructions on what to do going forward as well as how to organize their thinking about the issue of bias.
- **No Specific Steps**: Rejection of the notion that explicit steps can be given.
- **Applying Technique in The Future**: Expressing intention to applying viewing technique to future decision making.
- **Search for Bias**: Expressing intention to be mindful about the presence of bias in future decisions.

Table 1: Summarized list of themes from Focus Group Sessions

<table>
<thead>
<tr>
<th>Appreciation for the Use of Art</th>
</tr>
</thead>
<tbody>
<tr>
<td>There was a clear message across the groups expressing appreciation for both the viewing technique and the specific works of art chosen for the tour. Participants mentioned that the use of representational, rather than abstract, art allowed for easier accessibility and discussion.</td>
</tr>
</tbody>
</table>
Although the topics the works addressed could be difficult to speak on, the practice of looking at art provided a valued entry point into discussion. Students candidly expressed how easily the conversations flowed when looking at art relative to what might have happened if they were in a room looking at each other. This was often qualified by the fact that students were two weeks into their first year, did not know one another well, and would probably develop greater comfort as discussions continued over their time in medical school.

“I think because it was in a museum for like a piece of art, it gave everybody a kind of a – it gave them a feeling that they could kind of share their opinions about and their thoughts about what these things – what they were seeing and put them out there a lot more easily than if we were just directly having a conversation about racial bias or ethnic bias or any of these topics directly.”

**Awareness of Bias in Self and Others**

Whether through the art tour or the reflection session, multiple participants admitted that MIV sensitized them to new biases or made them increasingly aware of existing biases they had discovered through the IAT. The questions facilitators used during the guided tour exposed contradictory beliefs and provoked cognitive dissonance that allowed students to develop more nuanced understandings of the subject matter and their position in society. Peer comments had a dramatic effect on student experiences and understanding of both themselves and each other. Drawing different meanings from the same work allowed students to expose each other’s blind spots and allowing for a much more intersectional understanding of the topics at hand. Many students commented on an elevated class consciousness sparked by discussion around *Inside, Outside* by George Grosz. Students either spoke to being sensitized to their own position or their changing position in the economic hierarchy upon entering the medical field. The tour triggered a range of emotions including anger, guilt, frustration, and fear in response to these realizations.

“I think I felt maybe not directly during the session but especially in reflecting that maybe overwhelmed by how small and narrow my point of view might be
relative to a lot of the perspectives that I was hearing about... I think that any time I got like mentally a ball rolling about one thing I was thinking about in a certain painting, the next comment might have been something that totally went in another direction or almost like a – it was a totally, totally different perspective from what I was necessarily thinking about at that time. So, for instance, I think in the last painting we did a group, the one with the Elihu Yale, I was more attentive to the sort of – the child that was a slave and there being white men at the table, but I wasn’t – almost not at all, until somebody said it, really thinking about the fact that there were no women around the table. And once we learned that it was a marriage contract signing, I was totally like blown away by that perspective.”

**Awareness of Societal Bias & Powerful Influencers**

The age of the paintings did not escape participants, as many students explicitly discussed how societal assumptions present more than one hundred years ago still inform our daily interactions today despite evidence to the contrary. This was most palpable in discussions around weight bias. Participants also mentioned how the abundance of certain images, as well as the investment powerful sectors of society have made in creating them, have primed them to automatically accept assumptions that they had never consciously considered beforehand. Participants expressed appreciation that MIV explicitly commented on the increased impact certain biases have on marginalized groups when those biases are held by powerful influencers in our society. The was a general consensus around appreciation for the discussion, particularly as it relates to these societal phenomena and the students’ future roles in medicine.

“I did learn that bias plus power equal institutional power that reproduces itself. I wrote that down. But I think that’s a sticking point to thinking about how something on the individual level can become systemic and institutionalized and then reinforce itself and reproduce itself to have harm or disproportionate benefits to certain groups. I think definitely power and bias, that it gets down to even the level how we see the world and how we depict the world. I think it definitely taught me about the relationship between bias and power. I never really thought about that relationship. But I knew like intuitively it might exist, but I never had someone explain it in such an open way.”

“But I think that session really helped put to the forefront that all these medical
things that we do for people are really, really tied to like society and like racism and biases that we all have, and so it kind of like helped put that into the front of my mind. And I think that’s really important to do at the beginning of medical school.”

**Participation Dynamics**

Although general feedback was positive and students greatly appreciated peer input, a number of students identified a trend of liberal political leanings among their classmates. Some identified this as a liberal bias among classmates and expressed the desire to hear opposing perspectives. Some spoke on the desire to balance the critical perspectives with more positive aspects of society in the United States, while others wanted conversation on issues other than race and gender such as gun ownership or the working class. In recognition of the liberal leanings of their classmates, some participants admitted to self-censorship in fear of being judged for less politically correct views so early in their time in medical school. Others appreciated the space to discuss these issues among their peers because it was an opportunity to find classmates to possibly form deeper connections with in the future for further discussion.

“Like I'll just give an example. The only times America or American society were referenced at the whole thing was in a negative light, imperialism, colonialism, racism, slavery. And that’s all true, and it's part of our legacy, and it don’t want to avoid it, but America has greatness to it, and we are a land...But, you know, it's not a coincidence that people from all over the world come here, and we do really value freedom and opportunity, and we do try and get closer to justice for all and living up to our Declaration of Independence and all that and then the values therein. So I think that the world is complex. History is complex. And it's important to acknowledge that complexity even when discussing these issues. So, that would be the only thing that I...Like it would have been nice to hear 1 comment.”

“I think people are surprisingly receptive and not necessarily people who I thought were receptive. It's just like prejudice, right? But it did help me identify like people who would be willing to talk about these in like really deep personal levels. Yeah. So, it helped me identify allies. I don’t know about like the whole class.”
Recognizing the Importance of the Topic

Although the perceived political leanings of the class and general apprehension of possible judgement inhibited some students from fully participating in MIV, all students appreciated the importance of the topic and the time spent discussing it as a class. A number of participants who did not expect to take anything from the session acknowledged its value. Reflecting on their disinterest in MIV when reading the course description, these students acknowledged the need to place such programming in the mandatory curriculum. Such sentiments were echoed by students who had some past knowledge of these topics as well as by students who had no prior exposure to these topics.

“I probably don’t normally have as much appreciation for art as I thought I should. So, when I thought we were going to the art museum, my initial reaction was that this might be cool, but it wasn’t something that I think I would have gone if it had been not mandatory. Now that I've actually gone through it, I'm really happy that I was able to go through it.”

Wanting More

In light of the appreciation for the topic and positive reviews of the session, there was a collective desire for more discussion or an expectation of future programming among focus group participants. Whether through the US Health Justice elective course or various other student groups, a number of students in the focus groups mentioned the desire to actively seek out programming to continue learning about these issues. This desire for more discussion was often came up in association with a disagreement among participants about specific steps to address personally held bias going forward. Some students expressed frustration at the lack of explicit instructions or an algorithm to help organize their thinking and prevent biased thought in clinical decision making. Another group rejected the notion that a pre-defined number of explicit steps could solve the wide array of biases we all hold and the variety of clinical scenarios they
may influence. Although this disagreement was not resolved, a number of participants resolved to apply the spirit of the observation method to future decision making and professional interaction. They expressed the desire to be more mindful about the presence of bias and to openly share their reasoning in hopes that both patients and peers will challenge them when their logic is flawed.

“I hope that it's kind of motivating me to continue to try to have these conversations, these difficult conservations to kind of make that one that doesn’t just like exist within this part of the curriculum, like contained, but it's something that can spread further. So, yeah, I guess I would hope that we could – I could kinda of continue to talk about this and challenge myself to like say things that are difficult to say and risk looking like an idiot.”

“I think this is making me feel a little bit more that it will be important to explain the reason behind like what I'm seeing as being the problems or the health issues that need to be addressed… Like being able to pare down and give information as to why I think that this is the best course of action. And I don’t know – I guess I hadn't really thought of that too much. But being able to share my decisions and my perspectives as a – being more clear about what my information and reasoning is behind what I’m doing and being able to share that with people, especially when I'm suggesting, I'm in a position of like prescribing medication or telling somebody how they should go home and live their life. I think that’s gonna be really helpful in trying to motivate and help people heal.”

**Favorability of Making the Invisible Visible Among the General Student Population**

Out of the 104 students in the first-year class, 74 general course feedback surveys were collected (71% response rate). Survey data reported a 78% of respondents considered MIV above average (38%) or excellent (40%) (Table 2). The free responses from the surveys echoed the themes raised in the focus groups. A number of students with self-disclosed backgrounds in the humanities had strongly positive reviews for the session appreciating both the topic and the use of art to facilitate discussion. However, some of these commenters felt the session was too
superficial and that expert facilitators should have been used to guide students through a more nuanced understanding of issues such as intersectionality.

<table>
<thead>
<tr>
<th>Student Evaluation of Experience During MIV</th>
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<tbody>
<tr>
<td>Excellent…………30 (40%)</td>
</tr>
<tr>
<td>Above Average…..28 (38%)</td>
</tr>
<tr>
<td>Average…………..12 (16%)</td>
</tr>
<tr>
<td>Below Average…..4 (5%)</td>
</tr>
<tr>
<td>Poor………………0 (0%)</td>
</tr>
<tr>
<td>Total 74 responses (71% response rate)</td>
</tr>
</tbody>
</table>

Table 2: Student Ratings of Experience on ‘Making the Invisible Visible: Art, Identities, & Hierarchies of Power’ Museum Tour.

Many respondents reiterated the need for mandatory programming on such issues as well as the self-censorship among classmates who potentially had opposing views. One comment stressed the importance of such content while alluding to private discussions outside of class time.

“Based on private discussions amongst classmates later, it's very clear that experiences like the Art Museum are critical, and that further such experiences are essential. I was disappointed to find that I am very disappointed in many of my classmates.”

The strong similarity in themes between the focus groups and the class-wide free response would suggest saturation was achieved in exploring student experiences during MIV.

Discussion

With 78% of general student respondents considering MIV above average (Table 2) and generally affirmative assessments from focus group participants, positive sentiments toward the session were shared by students whether or not they participated in the focus groups. These reviews emphasized the strengths of this innovative educational intervention as compared to traditional lecture-based teaching formats. These components included the use of structured art observation to broach difficult discussions, the ability of the session to provoke critical
introspection, and session’s emphasis on peer dialogue. These positive sentiments coalesced around a collective desire for more programming or structured discussion in the future.

The ability to coax discussion on difficult subject matter, specifically about racial bias, using art observation builds on existing educational research highlighting the ability of art to act as a third thing. The pre-selected art object, representing complex ideas and questions, create a productive distance between participants and the topic at hand. Through guided observation, MIV facilitators use the object as a medium student can project their ideas and beliefs onto. This lowers the stakes because it is harder to offend an inanimate object than a valued peer, which lessens the burden minority students often face when taking part in such discussions. By simultaneously emphasizing a sense of camaraderie and shared professional responsibility, MIV facilitators use the egalitarian goals of providing equal care to draw students into active participation.

It is specifically the juxtaposition of the egalitarian values held by health professional trainees and the inequitable outcomes produced by the health system that serve as the root cause of the productive discomfort that so many participants felt. By stressing the difference between observation and subjective interpretation as a means to explore the internalized assumptions many fail to recognize they carry, the session implicates students in a way that forces them to recognize themselves as actors in systems the perpetuate structural oppression. Connecting art historical references of cultural norms and practices to contemporary research on healthcare disparities adds a weight to the discussion that sensitizes students to the legacies that they inherit as newly inducted members of the medical fraternity. It challenges students to take a position, highlighting the notion that inaction in the face of structural oppression is tacit approval of its perpetuation.
Although a number of students either noticed censorship or admitted to self-censorship, all appreciated the peer perspectives that were offered through facilitated discussion. This emphasis is reflected in the organizational psychology literature which stresses the importance of social interaction on affective-based outcomes in diversity training\(^{18}\). Critical pedagogy is pivotal to achieving such high student engagement because of the emphasis Freire places on flattening classroom power hierarchies in rejection of the banking model of education\(^{10}\). By recognizing the experiences, beliefs, and identities of all participants, students are ultimately more invested in the dialogue as compared to unidirectional lectures. However, to truly recognize all experiences shared and allow all students to bring their whole selves into the discussion, intersectionality must be a guiding framework. It also allows for more nuanced discussion and learning by allowing students to highlight ideological blind spots that they have never considered. The focus group excerpt where one participant shared how the gender dynamics inherent to the Elihu Yale painting were brought to his attention via the comments made by peers. The ability to discuss multiple dimensions of oppression reduces the need for students with backgrounds traditionally underrepresented in medicine to feel obligated to share or isolated from the larger group.

Despite the weightiness of the subject matter and the inherent discomfort of the discussion, various students recognized the need to continue the dialogue throughout their medical training. How MIV and sessions like it can be incorporated into longitudinal discussions in undergraduate medical education curricula is a topic of ongoing discussion. However, educational theories exist that can place MIV in a larger framework.

**Bias, Power, & Critical Consciousness: A Path to Structural Competency**

MIV relies heavily of critical pedagogy, as originally described by Freire and applied by Kumagai in the realm of health professional education\(^{11}\). The critical consciousness that critical
pedagogy aspires to instill in trainees mandates a reconceptualization of how health is achieved in society and challenges these learners to understand their role in the larger systems of oppression. This action-oriented shift in perspective toward societal systems, as well as the history and cultures that uphold them, is very much in line with the described goal of structural competency. This new theory for medical education, put forward by Jonathan Metzl and Helena Hansen, “seeks to promote skills for recognizing how “culture” and “structure” are mutually co-implicated in producing stigma and inequality” 35. An intervention such as MIV, where discussions about the way biases influence interpersonal interactions and how such biases inform phenomena such as structural racism, directly lead into structural competencies second goal, “developing an extra-clinical language of structure” 35.

Originally housed in the US Health Justice Course, MIV was always imagined as one step, either a conversation starter or a means to continue an existing discussion. Continuing this discussion in the span of an already crowded, four-year undergraduate medical curriculum is a formidable challenge for any administrator. However, there are pre-existing curricular elements that can serve as defined spaces to continue such a conversation. Professional ethics courses and public health modules, required at all medical schools, can speak to and expand upon the themes brought up by MIV. At the Yale School of Medicine specifically, there is already a strong culture of structured reflection in the form of Power Day and reflective writing workshops 36,37. The true challenge for educators is to coordinate curricular components in way that meaningfully builds on the trust students develop with one another and the discussion already had rather than repeat the same content in a stale fashion.

**Questioning the Structure of Academic Medicine**
In the study, multiple focus group participants acknowledged how MIV sensitized them to recognizing medicine as a function of society rather than a purely objective science. If the educational programs can be designed and ultimately integrated into a coordinated, longitudinal curricular component, the question that medical educators must ask is how to deal with the *paradox of education* that James Baldwin highlighted in his *Talk to Teachers* \(^{38}\). How will academic medicine respond when students begin to examine the society in which they are being educated and turn their critical gaze upon the institution itself? Whether disparities in leadership, biased admissions practices, lectures that disseminate flawed understandings of race, biases in mentorship, unequal evaluation practices, or health insurance policies that lead to effective race and class discrimination in hospital admissions, the evidence for how culture and structure produce stigma and inequality in the United States is readily available \(^{13,39-44}\).

Whether through the content discussed or the pedagogy used to teach it, MIV and educational programming like it challenge the hierarchical culture of medicine. Already theorizing the perils of such consciousness among trainees, some medical educators are actively questioning how these students will survive training within a system still dominated by the hidden curriculum and populated by educators never prepared to work with such learners \(^{45}\). For this reason, it is imperative that we consider how such programming can be used in the realm of continuing medical education.

**Limitations**

Although the MIV session was mandatory, student feedback and participation in the focus groups was voluntary. Although unlikely, it is possible that selection bias may have skewed the study’s perception of the collective student experience. The phenomenon of self-censorship among students who may carry strong views to the contrary of the class at large must
also be considered as a limitation. However, the class-wide free response was confidential and allowed for any of these sentiments to be expressed anonymously. Also, the strong correlation between these free response comments and those made in the focus group response suggest that thematic saturation was achieved.

A limitation that most concerns the generalizability of the study is that it is only one year of data at one medical school. Although there is no reason to believe that students at Yale are more well versed in issues of bias than medical students at other institutions, it would be beneficial to evaluate the session over multiple years to see if there is any noticeable change or trend in student perception of MIV and to do it at different schools. Finally, it would also be interesting to evaluate student perceptions at multiple time points after participation.

The next limitation of the study and running MIV as an educational program is reproducibility as it pertains to the skills of the student facilitators. Only individuals with a strong background in art history have been facilitators of the tour. Whether or not the existing facilitator training materials will be enough to create a standardized experience among students is yet to be determined. The need for art historical expertise necessitates the ongoing collaboration between medical educators and museum educators.

The final limitation of the study is that there was no direct, lecture-based delivery of the content of MIV to act as a control to the interactive art tour.

**Future Directions**

In the future, it would be informative to employ a formalized, validated survey tool such as the Contemporary Critical Consciousness Measure (CCM) to evaluate changes in participant attitudes pre- and post-MIV as well as over time in medical school. Although the CCM as formulated does not highlight issues of heterosexism while MIV highlights gender, it would be
worthwhile to incorporate different art works that emphasize these identities. This would further
develop the discussion MIV promotes among students to develop and allow for a more accurate
evaluation of its impact.

Long-term follow up of student participants to assess how the themes of the session
inform their subsequent experience in medical school would be helpful. It would also be
beneficial to recruit health professional student groups at different points of their training (pre-
clinical vs. post clinical) to take part in MIV. Exploring how the exercise facilitates discussions
among students who have more personal experience with bias and power hierarchies as
healthcare trainees would be invaluable.

Conclusions

MIV has demonstrated how structured art observation can be used as a viable tool in
teaching and facilitating discussion on the topic of bias and power in medicine. This is one
possible solution in addressing the growing demand for innovative strategies to engage trainees
in difficult discussions about racial bias in medicine. The experiences of participants highlight
the need to consider and incorporate the expertise of social science frameworks into existing
medical education curricula. There is a strong desire among students to continue these
conversations into the future of their medical training. This study highlights a possible
framework to employ in subsequent programming.

Medical educators are likely as apprehensive as students when it comes to broaching
discussions that directly challenge the egalitarian ideals medicine espouses. However, to say
nothing on the topic of bias during the standard coursework on professionalism and ethical
behavior is setting an example as well. Kumagai et al assert, “We must recognize that choosing
not to discuss issues of injustice and inequity may have its own pernicious effects on social
justice and students’ critical consciousness”\textsuperscript{23}. The ethical pillar of social justice in medicine necessitates social responsibility on the part of practitioners. In revealing medicine as a part of and representation of the greater society, MIV challenges implores trainees to critically examine it and challenge them to act. In the words of James Baldwin, “This is the only hope society has”\textsuperscript{38}. 


9. Functions and structure of a medical school: standards for accreditation of medical education programs leading to the M.D. degree. Liaison Committee on Medical Education;2018.


32. Rehman T, Rock R. Advocating for Greater Exposure to Domestic Health Disparities in Medical Education *American Medical Student Research Journal* 2015;1(2).


Appendix 1: Consent Form

Consent for Participation in a Research Project
Evaluation of the Making the Invisible Visible: Art, Identity, and Hierarchies of Power

Purpose:
You are invited to participate in a research study designed to examine the effectiveness of a unique teaching intervention titled, *Making the Invisible Visible: Art, Identity, and Hierarchies of Power*. A group of stakeholders, including students and faculty, are developing and designing this arts education intervention as a means to educate and promote productive discussion on issues related to implicit bias in patient provider interaction. You have been asked to participate because you have participated in the tour and reflection session.

Procedures:
Focus groups and interviews will be conducted at the Yale School of Medicine and will be facilitated by members of the university-based research team. Focus groups will take about 1 hour and dinner will be provided. Focus groups involve a discussion with approximately 4 to 6 other people where you will be asked about your experiences on the tour how effectively goals were met, the use of art in promoting discussion, and how you understand these themes to inform your future practice.
Before starting the focus group, we will ask you to complete a background and demographic survey so that we know who participated in the focus groups. We will audio record the focus group and take notes so that we have an accurate record of the information shared. We will then transcribe the focus groups and interviews so that we can analyze the data.

Risks and Benefits:
There are no physical risks associated with this study. However, there is a risk of loss of confidentiality. Every effort will be made to keep your information confidential; however, this cannot be guaranteed. Although this study will not benefit you personally, we hope that our results will add to the knowledge about *Making the Invisible Visible* and arts education on topics of implicit bias in general.

Confidentiality:
All of your responses will be confidential. Only the researchers involved in this study and those responsible for research oversight (such as representatives of the Yale University Human Research Protection Program, and the Yale University Human Subjects Committee, offices responsible for fiscal monitoring) will have access to any information that could identify you. Your responses will be numbered and the code linking your number with your name will be stored in a separate locked file cabinet. When we publish any results from this study we will do so in a way that does not identify you unless we get your specific permission to do so. We may also share the data with other researchers so that they can check the accuracy of our conclusions but will only do so if we are confident that your confidentiality is protected.

Voluntary Participation:
Your participation in this study is voluntary. You are free to decline to participate, to end your participation at any time for any reason, or to refuse to answer any individual question. Refusing to participate will involve no penalty or loss of benefits or affect your academic standing within the medical school.

Questions:
If you have any questions about this study, you may contact the investigator, Robert Rock, 646-637-5798, robert.rock@yale.edu.
If you would like to talk with someone other than the researchers to discuss problems or concerns, to discuss situations in the event that a member of the research team is not available, or to discuss your rights as a research participant, you may contact the Yale University Human Subjects Committee, 203-785-4688, human.subjects@yale.edu. Additional information is available at [http://www.yale.edu/hrpp/participants/index.html](http://www.yale.edu/hrpp/participants/index.html).

Agreement to Participate:
I have read the above information, have had the opportunity to have any questions about this study answered and agree to participate in this study.

(printed name) (date)
Appendix 2: Demographics Form Questions

Q1. Gender: _
Q2. Age: _
Q3. In what country were your patents born? (Mother): _
Q4. In what country were your patents born? (Father): _
Q5. Your race (Please Circle Only One): If Multiracial, select ‘other’ and please specify
   - Black/African American
   - American Indian/Alaskan Native
   - Asian
   - Caucasian/White
   - Hawaiian/Other Pacific Islander
   - Other (Please Specify)
Q6. What is your ethnicity?
   - Hispanic/Latino
   - Non-Hispanic/Latino
Q7. What is your highest educational level (Please Circle ONLY ONE)
   - Bachelors Degree (BA/BS)
   - Masters
   - Graduate Student: Specify number of years completed: _
   - PhD/PsyD
   - MD
   - JD
   - Other: Please Specify
Q8. What was your undergraduate major/concentration? _
Q9. If this is not your first career, what career/profession did you have before? _
Appendix 3: Focus Group Script & Questions

Introduction & Overview
Hello. My name is Christina Nelson from The Consultation Center at Yale. First of all, I want to thank you all very much for taking the time to be here today. I’d like each of you to introduce yourself.

Thank you.

I’d like to take a few minutes to review the purpose of this focus group. Our goal is to examine the effectiveness of the teaching intervention you just participated in, *Making the Invisible Visible: Art, Identity, and Hierarchies of Power*. Thus, this research project asks you to talk about your experiences with and perceptions of the teaching intervention.

The focus group will help us develop a clearer plan for continuing to create and improve the exercise. We hope to learn what you think worked about the tour, the topic, what worked, what didn’t work, and how the tour and reflection session could be improved to educate future participants.

We will ask you to first complete a demographic and background information form so that we know who participated in the groups. [Pause 5 minutes]

I want to explain the general nature of focus groups for those among us who have never been a part of one. My role, as the focus group moderator, is to facilitate a discussion between you all, the participants. My job is to make sure that the conversation flows, that everyone has an opportunity to share their thoughts, and to clarify the meaning of the question prompts. There are no right or wrong answers to the questions, and it is okay if there are differing points of view. Please feel free to share your point of view even if it differs from or is very similar to what others have said. Keep in mind that we are interested in all comments and thoughts.

To ensure that we obtain accurate information, we will be audio recording our conversation. During the focus group, we will use code numbers only. We have provided number cards for everyone here that are placed in front of you. We will be using our numbers during the focus group. When we report the results of the group, each person will only be identified by a code number. We do this so to maintain confidentiality.

Does anyone have questions before we start?

**Focus group questions:**
1. What are your impressions of the *Making the Invisible Visible* (MIV) session during iPro?
   a. **Probe:**
      i. *Of the first part of the session where you viewed the objects and followed the four steps of observation? Did any particular work of art resonate with you?*
      ii. *Of the hour or so after viewing the objects where we all come together to talk about our experience and debrief our thoughts, reactions, and feelings about the session?*
      iii. Were any aspects of the first or second part difficult for you?
      iv. Did they bring up any emotions?
2. How did *Making the Invisible Visible* influence your understanding of bias in society?
a. **Probe:**
   i. *Did the session change your understanding of bias in society? If so, in what ways?*
   ii. *Did the session reinforce your existing understanding of bias in society? If so, what was reinforced?*
   iii. Whether bias in general or biases personal to you, has this session affected your comfort with discussing bias among your classmates?
   iv. What about among people with power and authority over you?

3. Bias is a difficult topic to discuss, but social science research says we all have them.
   **What parts of the tour or reflection session were particularly difficult?**
   a. **Probe:**
      i. *What types of biases did the tour make you aware of personally? Race, ethnicity, gender, class, ability, etc.*
      ii. Was there anything about *Making the Invisible Visible* that made it easier to talk about these issues?
      iii. How does the tour relate to your reaction to your implicit bias score? If so, what did you think before participating in *Making the Invisible Visible* and what did you think after?

4. Did any particular experience during the tour or reflection session make you aware of biases you and your classmates bring to their medical education?
   a. **Probe:**
      i. *If so, what types of biases did interactions on the tour make you aware of? (Race, ethnicity, gender, class, ability, or something else) etc.*
      ii. How did these revelations make you reconsider or take note of the different identities you bring to medical school?
      iii. In what way, if any, did the concept of intersectionality inform this understanding?
      iv. Did any identity you carry feel more significant after the tour as compared to before it?

5. **What is your understanding of the relationship between bias and power?**
   a. **Probe:**
      i. *Did *Making the Invisible Visible* change your understanding of the relationship between bias and power? If so, in what ways?*
      ii. *Did the session reinforce your existing understanding of the relationship between bias and power? If so, in what ways?*
      iii. Did the tour make you consider how your own biases might influence your interactions with the people you care for in the future?
      iv. How would those interactions possibly be influenced? How is this impacted by the power differential between clinicians and patients?

6. **How do you think this tour will affect the way you approach your medical education?**
   a. **Probe:**
      i. How do you think it will affect the way you relate to the culture of medicine?
      ii. How do you think it will affect the way you approach your clinical practice?

7. **What is the most important thing you think you took away from the MIV session?**
a. **Probe:**
   i. Professionally?
   ii. Personally?
Appendix 4 – MIV Pre-Reading Assignment Handout

Making the Invisible Visible: Art, Identity, and Hierarchies of Power

Session Facilitator:
Robert Rock, Yale School of Medicine, MS5

Goals:
- To develop comfort in recognizing the inherent assumptions and biases imbedded in culture as well as their influence on personal and professional interaction.
- To recognize the various identity hierarchies that exist in society as they relate to patient provider interaction.
- To develop comfort in describing the inherent assumptions and biases imbedded in western culture as well as their influence on personal and professional interaction
- To create a safe space to discuss the topic of identity and bias as they relate to clinical practice
- To promote critical self reflection and awareness of the identities/beliefs trainees bring to the medical profession
- To explore the potential conflicts these existing identities and beliefs may have with a new identity as a healthcare provider

Outline of Activity:
1. Participants will be taken to the museum and led through a systematic examination of three paintings.
2. The examination will occur in 5 stages:
   i. Detailed observation of things physically represented in the work (i.e. Describe the painting as if you’re looking through a window and explaining what you see to someone who cannot.)
   ii. Interpretation of scene based on the evidence collected in step 1.
   iii. Exploration of the meaning of the painting based on interpretation
   iv. Exploration of meaning of the painting with context provided by art guides
   v. Interpretation of message through a modern lens, including its implications in medicine and society.
3. After examination of the three works, a reflection session will take place where the topics raised by the art are related to contemporary issues in society, science, and medicine.

Pre-Readings
1. Chimamanda Ngozi Adichie – TED – *The danger of a single story*
   a. [https://www.ted.com/talks/chimamanda_adichie_the_danger_of_a_single_story](https://www.ted.com/talks/chimamanda_adichie_the_danger_of_a_single_story)
2. Paul Bloom – TED – *Can prejudice ever be a good thing?*
   a. [https://www.ted.com/talks/paul_bloom_can_prejudice_ever_be_a_good_thing?language=en](https://www.ted.com/talks/paul_bloom_can_prejudice_ever_be_a_good_thing?language=en)
3. Jay Smooth – TEDxHampshireCollege – *How I learned to Stop Worrying and Love Discussing Race* [https://www.youtube.com/watch?v=MbdxeFcQtaU](https://www.youtube.com/watch?v=MbdxeFcQtaU)
Optional Reading


Appendix 5 – MIV Tour Manual

Session Title: Making the Invisible Visible: Art, Identity, and Hierarchies of Power

4. Purpose: Museum Visit & Seminar Reflection Session

5. Objectives:
   a. Skills: Approaches to recognizing the inherent assumptions and biases imbedded in western culture as well as the microaggressions that often manifest in personal and professional interactions as a result.
   b. Knowledge: “Racial microaggressions are brief and commonplace daily verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults toward people of color. Perpetrators of microaggressions are often unaware that they engage in such communications when they interact with racial/ethnic minorities”\(^1\). We will apply this definition to various identity hierarchies as they relate to the patient provider interaction.
   c. Attitudes: Using the art gallery as a safe space and the interpretations of the specified works as a means to broach the difficult topic of bias/discrimination along the lines of race, gender, class, and sexual orientation in the context of our society and its power hierarchies.

6. Activities:
   a. Tour of art gallery where works that highlight themes related to the nine categories of microaggressions as described by Sue, Capodilupo, et al are used as discussion prompts to explore issues of identity, intersectionality, and power.
      i. We have been able to identify nine categories of microaggressions with distinct themes:
         1. Alien in one’s own land
         2. Ascription of intelligence
         3. Color blindness
         4. Criminality/assumption of criminal status
         5. Denial of individual racism
         6. Myth of meritocracy
         7. Pathologizing cultural values/communication styles
         8. Second-class status
         9. Environmental invalidation
      ii. Works to be covered include:
         1. Paul Gauguin, *Parau Parau*, 1892:

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2. George Grosz, *Drinnen und Draussen*, 1926:

3. Unknown Artist, “Elihu Yale; William Cavendish, the second Duke of Devonshire; Lord James Cavendish; Mr. Tunstal; and an Enslaved Servant”
iii. Students will be led through three phases in each painting
   1. Objective observation of things physically represented in the work
   2. Interpretation of scene based on objective evidence
   3. Exploration of subjective meaning of the painting based on interpretation
   4. Exploration of subjective meaning of the painting with context provided by art guides
   5. Interpretation of message through a modern lens and its implications in medicine.

b. Reflection Session where the topics raised by the art are placed in the context of modern day society, medical practice, research, and policy.

7. Facilitators
   a. Robert Rock, MD Candidate, Class of 2018
   b. Nientara Anderson, MD Candidate, Class of 2021

8. Introduction to Participants

   - Greetings everyone, my name is Robert Rock and I am a 5th year student at the Yale School of Medicine. It’s my honor to welcome the clinical scholars to the Yale University Art Gallery, my favorite place on campus, and take you all on a bit of an adventure.
   - If you’ve done the pre-reading, you know we’ve left the medical campus for an important reason, something that has a strong influence on health and health care, but surely did not start there. That reason is bias.
   - In the realm of medicine, various groups stress two things that are crucial in allowing health providers to deliver care effectively across lines of identity.

   1. Awareness of one’s self as a racialized/gendered/cultured individual (and all other possible identities)
2. Awareness of the biases, stereotypes, and assumptions that influence how we see the world, what we expect from it, and how we interact with it.

- I’m sure I wouldn’t be the only one to argue that this is important in everyday interactions too, but it’s extra important for people like you, because the power dynamic between patient and provider, researcher and subject, policy maker and population, will be skewed heavily in YOUR favor. And in such high stakes interactions, the presence and unconscious expression of such biases can undermine relationships, hypotheses, or your understanding of priorities before you realize it, dramatically influencing the delivery of health care and the possibility of living a healthy life.

- This can be some heavy stuff to deal with, so we’re going to use the museum and its art as a safe space to talk about some slippery topics. We’re going to look at the expression of bias in western culture through the stories told in its art, all in an effort to explore the source of all this bias that skews the lenses we perceive the world through. We’re going to look at really old art to see just how long the biases we soak

- I’m sure that you all probably have stories you can think of from your years of training and welcome you to share them on the tour, but I also want you to reflect on other experiences you’ve had too. As people, not just as med students, residents, and attending physicians.

- When I say safe space, I don’t want you to assume that means comfortable. I was us to create the safety to be brave enough to tell our neighbor that they’ve got some racism stuck in their teeth, some homophobia on their breath, a bit of sexism in their beard. That means a few things, for the next two hours:
  1. Although what we learn should be applied in everything we do, the specifics of everything said here stays here
  2. That we trust the good intentions of the person next to you and not get caught up in the specific words they use to convey those intentions.
  3. Anything else you want to add?

- We’re going to spend around 20 minutes with each painting going through a five-phase viewing process.
  1. Objective observation of things physically represented in the work. Describe the painting as if you’re looking through a window and explaining what you see to someone who can’t.
  2. Interpretation of scene based on objective evidence you collect in observation.
  3. Exploration of subjective meaning of the painting based on interpretation
  4. Exploration of subjective meaning of the painting with context provided by art guides
  5. Interpretation of message through a modern lens, including its implications in medicine and society.
9. *Parau Parau (Whispered Words)* by Paul Gauguin

   i. Hierarchies: Culture, Gender
   
   ii. Category of Microaggression:
       1. Pathologizing cultural values/communication styles
       2. Criminality/assumption of criminal status
       3. Second Class Citizen
       4. Ascription of Intelligence

   **Paul Gauguin - Whispered Words**

b. Students will be led through phases in each painting. Script is Below:

   i. **Step 1 (15 seconds):** Give students 15 seconds to silently observe the scene in the painting

   ii. “To start, I will give you 15 seconds to silently observe the painting”

   iii. **Step 2 (3 minutes):** Instruct students to make objective observations of things physically represented in the work. Be sure to echo what each student says and to point to make sure the audience is on the same page.

      1. When students make subjective interpretations, be sure to redirect them by challenging them to provide visual evidence for the interpretation they just made.
      2. “Now we’re going to begin with step one, which is objective observation. I want you to be as objective as possible and begin collecting data by telling the group what you see”

   iv. **Step 3 (2 minutes):** Invite students to begin making interpretations of what is being depicted in the scene according to the visual data/evidence they’ve collected. Interpretation of scene based on objective evidence

      1. “We’re going to begin step 2, which is using the data you collected to back your interpretation of what is going on in the scene”

   v. **Step 4 (1 minute):** Exploration of the meaning of the painting based on interpretation. Let participants know if they’re doing a good job.

      1. “Before I give you some context, tell me what you think the main message the artist was trying to send in this painting”

   vi. **Step 5 (2 minutes):** Exploration of subjective meaning of the painting with context provided by art guides. Give students time to reflect

      1. “You did a great job of examining the paintings and picking up on the visual cues without me having to tell you anything. Here’s a bit of context:

         a. Context: A French painter created this during the tail-end of the French industrial revolution, a time in which factories and trains were revolutionizing the way we lived, worked, and traveled.

         2. “What do you think of your guess at the meaning after learning this? Does your hypothesis change? Do you want to add anything to it?”

         3. Give participants time to respond, then provide more context:

         a. Further Context: In this context, the painting was meant to evoke the theme of a return to nature and simpler times. Gauguin endorsed this with books and articles he wrote about going to Tahiti, becoming one with the natives, and learning to live off of the land.
vii. **Step 6 (4 minutes):** Interpretation of message through a modern lens and its implications in medicine.

1. “*I think you did an amazing job with this work of art thus far. I hope that you feel proud of your ability to collect data and come to the desired conclusion with minimal background information or guidance. However, I also hope you realize how effective visual cues can be at prompting our prior understanding to convey a message.*”

2. “Specific to Gauguin, I want you to know that the message you discovered was what he wanted people to feel and to think when looking at his works”

3. Although Gauguin did go to Tahiti, his version of events is not the whole story.
   a. He left his wife and children in France to go to Tahiti
   b. Tahiti was already a French colony by the time he arrived there
   c. He did not learn to live off of the land; rather he became romantically involved with the 14-year-old daughter of a local leader and used that relationship to live off of the people who lived off of the land.
   d. This scene is not of a specific location or people in Tahiti. It’s actually based off of visual tropes found from other sources.

4. This concept highlights the way we can be primed to interpret reality in ways desirable to one group or individual, but detrimental to another.

5. “I want you to reflect on the way you came to your original conclusion and how new information changed your understanding. Now, I want to hear how you think that applies to medicine, to research, or to policy?”

6. **Give students 3 minutes to think of examples**

7. **Medicine**
   a. The history of a patient’s illness can often be interpreted exclusively from the perspective of health providers. This perspective is passed along through the patient medical record and is often consulted before ever meeting the patient. This can prime providers to see patients in a specific way. The words used to describe a patient in the electronic medical record can have strong connotations, which prime future providers before seeing them.
   b. Can you think of some words that have a strong influence to prime a provider before meeting the patient? (Give 30 seconds)
   c. Words such as:
      i. Frequent Flyer
      ii. Difficult
      iii. Non-adherent
      iv. Drug-Seeking
      v. Poor Historian
   d. For a patient whose history is branded with these terms, providers may enter the interaction primed to interpret all of a patient’s behaviors or reasoning through the lens of the patient deciding not to follow instructions or having ulterior motives.
8. Research
   a. Welfare Queen themed Paper –

9. Policy
   a. Drug Testing Welfare Recipients – we often easily accept the premise because of a prevalent narrative about what poor people are like, but when we look closer, things are different.

10. Reflection Session where the topics raised by the art are placed in the context of modern day society and the patient/provider interaction

11. **Reference Articles:**
   i. Biography and Bibliography:
      http://www.oxfordartonline.com/subscriber/article/benezit/B00071491?q=paul+gauguin&search=quick&pos=1&start=1#firsthit
   ii. Article, “Man Who Makes Human Beings” (JSTOR.com)
      http://www.jstor.org/stable/4385374?Search=yes&resultItemClick=true&searchText=gauguin&searchText=tahiti&searchUri=%2Faction%2FdoBasicSearch%3FQuery%3Dgauguin%2Btahiti%26amp%3Bpro%3Dparau%2Bgauguin%26amp%3Bgroup%3Dnone%26amp%3Bwc%3Don%26amp%3Bso%3Drel%26amp%3Bhp%3D25%26amp%3Bacc%3Don%26amp%3Bfc%3Doff&seq=1#page_scan_tab_contents
   iv. https://www.artsy.net/article/artsy-editorial-art-divided-gauguins-legacy
12. Inside Outside, by George Grosz
   i. Hierarchies: Culture, Class, Gender, Ableism
   ii. Category of Microaggression:
       1. Pathologizing cultural values/ communication styles
       2. Criminality/ assumption of criminal status
       3. Second-class status
   iii. George Grosz – Inside Outside

b. Students will be led through phases in each painting. Script is Below:
   i. **Step 1 (15 seconds):** Give students 15 seconds to silently observe the scene in the painting
      1. “To start, I will give you 15 seconds to silently observe the painting”
   ii. **Step 2 (3 Minutes):** Instruct students to make objective observations of things physically represented in the work. Be sure to echo what each student say and to point to make sure the audience is on the same page.
      1. When students make subjective interpretations, be sure to redirect them by challenging them to provide visual evidence for the interpretation they just made.
      2. “Now we’re going to begin with step one, which is objective observation. I want you to be as objective as possible and begin collecting data by telling the group what you see”
   iii. **Step 3 (2 Minutes):** Invite students to begin making interpretations of what is being depicted in the scene according to the visual data/evidence they’ve collected.
      Interpretation of scene based on objective evidence
      1. “We’re going to begin step 2, which is using the data you collected to back your interpretation of what is going on in the scene”
   iv. **Step 4 (1 minute):**
      1. (60 Seconds) Exploration of the meaning of the painting based on interpretation. Let participants know if they’re doing a good job.
      2. “Before I give you some context, tell me what you think the main message the artist was trying to send in this painting”
   v. **Step 5 (2 minutes):** Exploration of subjective meaning of the painting with context provided by art guides. Give students time to reflect
      1. “You did a great job of examining the paintings and picking up on the visual cues without me having to tell you anything. Here’s a bit of context:
         a. Context: The painting was created in Germany between the World Wars by George Grosz.
      2. “What do you think of your guess at the meaning after learning this? Does your hypothesis change? Do you want to add anything to it?”
   vi. **Step 6 (4 minutes):** Interpretation of message through a modern lens and its implications in medicine.
      1. “I think you did an amazing job with this work of art thus far. I hope that you feel proud of your ability to collect data and come to the desired conclusion with minimal background information or guidance. However, I also hope you realize how effective visual cues can be at prompting our prior understanding to convey a message.”
vii. “Specific to Grosz, I want you to know that the message you discovered was what he wanted people to feel and to think when looking at his works”

1. Since it had to bare the brunt of financing the rebuilding Europe, Germany was financially unstable after WWI. There were large gaps between the poor and the wealthy, unemployment was high, and returning soldiers bore the scars of war both physically and mentally. There was a lot of finger pointing and stereotyping as to the cause of Germany’s plight.

2. The painting creates a strong juxtaposition between two scenes. One of affluence and another of poverty. The artist uses various cues common in visual culture to convey these ideas. Can you name what you saw?

3. **Give students time before providing examples:**
   a. The affluent:
      i. Fat
      ii. Smoke cigars
      iii. Dress nicely
      iv. Wear jewelry
   b. The poor:
      i. Disabled
      ii. Dark
      iii. Dirty
      iv. Beggars

viii. Although the hierarchy between rich and poor would usually lead us to cheer for the underdog, Gross makes it difficult to like either side of the dichotomy. The characters on the outside don’t engage the viewer and on their own don’t attempt to evoke sympathy, as one would expect.

1. **We’re going to take a little detour:** “I want you to put yourself in this painting and decide, if you were sent back in time to Germany, which side of the painting would you be placed on? Which side of the painting would you want to be on?” “Why?”

ix. “I want you to reflect on the way you came to your original conclusion and how new information changed your understanding. Now, I want to hear how you think that applies to the present day?”

1. **Allow students to offer connections first:**
2. You were all very perceptive in picking up visual cues that described the class and possibly the personality of the people in the painting. Is this visual shorthand something we use when interacting with people on a daily basis?
   a. In medicine, is this shorthand useful or harmful when providing care for our patients, particularly when they seem to fit a certain type?
   b. Does someone’s readability in terms of the visual short hand, make you more or less likely to delve deeper into their lives or the history of their illness?
3. When confronted with patients that are difficult to like or easy to dislike, is the role of the physician to pick a side or feel sympathy?
a. This is a question I just want you to reflect on: Is sympathy something providers should have for their patients? Does opening yourself to liking your patients also welcome the possibility to dislike them? What do we do with those emotions?

c. Reflection Session where the topics raised by the art are placed in the context of modern day society and the patient/provider interaction

   i. Reference Articles:

   1. Biography and Bibliography:
      http://www.oxfordartonline.com/subscriber/article/benezit/B00079708?q=george+grosz&search=quick&pos=1&_start=1#firsthit

   2. Article, “George Grosz, The American Scene” (JSTOR.com)
      http://www.jstor.org/stable/40514202?Search=yes&resultItemClick=true&searchText=george&searchText=grosz&searchUri=%2Faction%2FdoBasicSearch%3FQuery%3Dgeorge%2Bgrosz%26amp%3Bprq%3Dgauçuçin%2Btahiti%26amp%3Bgroup%3Dnone%26amp%3Bwc%3Don%26amp%3Bf%3Doff%26amp%3Bso%3Drel%26amp%3Bhp%3D25%26amp%3Bacc%3Don&seq=1#page_scan_tab_contents
Elihu Yale – Unknown Artist

13. Elihu Yale; William Cavendish, the second Duke of Devonshire; Lord James Cavendish; Mr. Tunstal; and an Enslaved Servant by Unknown Artist
   i. Hierarchies: Culture, Class, Gender, Race, etc
   ii. Category of Microaggression:
       1. Myth of meritocracy
       2. Pathologizing cultural values/communication styles
       3. Second-class status
       4. Environmental invalidation
       5. Denial of Individual Racism

14. Students will be led through phases in each painting. Script Below
   a. **Step 1 (15 seconds):** Give students 15 seconds to silently observe the scene in the painting
      i. “To start, I will give you 15 seconds to silently observe the painting”
   b. **Step 2 (3 minutes):** Instruct students to make objective observations of things physically represented in the work. Be sure to echo what each student say and to point to make sure the audience is on the same page.
      i. When students make subjective interpretations, be sure to redirect them by challenging them to provide visual evidence for the interpretation they just made.
      ii. “Now we’re going to begin with step one, which is objective observation. I want you to be as objective as possible and begin collecting data by telling the group what you see”
   c. **Step 3 (2 minutes):** Invite students to begin making interpretations of what is being depicted in the scene according to the visual data/evidence they’ve collected.
      Interpretation of scene based on objective evidence
      i. “We’re going to begin step 2, which is using the data you collected to back your interpretation of what is going on in the scene”
   d. **Step 4 (1 minute):** Exploration of the meaning of the painting based on interpretation. Let participants know if they’re doing a good job.
      i. “Before I give you some context, tell me what you think the main message the artist was trying to send in this painting”
   e. **Step 5 (2 minutes):** Exploration of subjective meaning of the painting with context provided by art guides. Give students time to reflect
      i. “You did a great job of examining the paintings and picking up on the visual cues without me having to tell you anything. Here’s a bit of context:”
         1. Context: This work, painted by an unknown artist around 1708, depicts Elihu Yale (center), William Cavendish, second duke of Devonshire (right), and his younger brother James Cavendish (left). Near them is a man, who is identified on the back of the canvas as a lawyer named Mr. Tunstal. As well as an enslaved servant (Far right). The portrait is believed to commemorate the signing of a marriage contract between Yale’s daughter, Anne, and James Cavendish.
         ii. “What do you think of your guess at the meaning after learning this? Does your hypothesis change? Do you want to add anything to it?”
      iii. Give participants time to respond, then provide more context:
1. Further Context: In this setting, Yale commissioned the painting to be perceived as not only wealthy, but as a powerful man of influence connected to nobility.
   a. What is included in this painting that convey his wealth and power?

   **Give students time to answer**
   i. He sits at the head of the table
   ii. He is the largest figure in the painting
   iii. He and others at the table are dressed lavishly
   iv. The table is filled with items of luxury from around the world
      1. Rum
      2. Silver
      3. Tobacco
   v. He doesn't only own things, he owns people in the form of the slave

f. **Step 6 (4 minutes):** Interpretation of message through a modern lens and its implications in medicine.

   i. “I think you did an amazing job with this work of art thus far. I hope that you feel proud of your ability to collect data and come to the desired conclusion with minimal background information or guidance; it’ll be a crucial skill in your medical career. However, I also hope you realize how effective visual cues can be at prompting our prior understanding to convey a message.”

   ii. “Specific to the painting, I want you to know that the message you discovered was what he wanted people to feel and to think when looking at this work.”

      1. British Portraiture has everything to do with shaping culture and perceptions. Patrons commissioned paintings to influence how society viewed them and to influence how society viewed the world.
      2. Yale and others like him spent considerable amounts of their wealth influencing society’s understanding of what power looked like and rearranged various identity hierarchies in the process. Western society is feeling the effects until this day.

   iii. “I want you to reflect on the way you came to your original conclusion and how new information changed your understanding. Now, I want to hear how you think that applies to medicine?”

   1. **Give students 3 minutes to think of examples**
   2. I could ask you what power looks like and have us reflect on that idea, but instead, I want you all to close your eyes and be honest with yourself in terms of what image comes to your mind when I ask:
      a. What does a doctor look like?
         i. How does this image exist in relation to marginalized identities and communities that don’t traditionally occupy this role?
      b. What does a Yale Medical Student look like?
         i. How does this image exist in relation to marginalized identities and communities that don’t traditionally occupy this role?
3. This concept highlights the way we can be primed to interpret reality in ways desirable to one group or individual, but detrimental to another. It makes navigating through this world easier for some than others because of cultural expectations as to who belongs in what role.
   a. Who will your patients accept as their doctor?
   b. Who will your colleagues accept you as their peer?
   c. Who will faculty chairs consider for tenure?
   d. Who will medical schools consider as a department chairs?
   e. If certain identities are more readily accepted in positions and spaces of power, how does this image exist in relation to marginalized identities and communities that don’t traditionally occupy this role?

4. I didn’t hone in on any particular identity while exploring this work with you, but I’d like to know what identity you think this is about or applies to? Anyone want to offer some suggestions?
   a. It can be and is about any of these identities, because they all exist on hierarchies of power and privilege which benefit some, but are detrimental to others.

5. **Curve Ball (New Identity):** There’s another identity that is very important in this work, one that we all share in this room and one that will significantly influence how you interact with individuals who do not share that identity. **Be sure to give time to allow students to answer the questions themselves.**
   a. Q: Anyone want to offer some ideas on what it is?
      i. A: Yale Medical Student
   b. Q: Why is this an important identity in Academia?
      i. A: Whether deserved or not, your MD degree and the fact that it comes from Yale greases your path to becoming a physician leader. This is because your new identity will influence the both the lay public and other academics to more readily believe what you say, to think of you when a promotion is available, and many other things.
   c. Q: Why is this an important identity in New Haven?
      i. A: Whether it deserves to be applied to you or not, the troubled history of the relationship between Yale and New Haven will influence many of your patients and the communities they come from to see you as a Yale Medical Student. And that is not a good thing. There will be interactions in which you will not be perceived as black, latino, Asian, or any other marginalized race; you will not be male, female, or gender non-conforming; not LGBT; not anything but a living representation of oppression in their lives and the lives of the people they love.
d. Q: For better or for worse, how will you reconcile the identities that you have brought to Yale with the identities Yale will impose upon you? How will you consider your privilege as you begin to write your chapter in the story of Yale and the surrounding community? How will you consider it as you write your story as a future doctor?

15. Reflection Session where the topics raised by the art are placed in the context of modern day society and the patient/provider interaction
Appendix 6 – MIV Post Tour Reflection Discussion PowerPoint & Guide

1. **Slide 0:**
   a. Today focuses on awareness and to a lesser degree knowledge about particular/specific cultural group.
   b. To be most effective in cross-cultural situations, we need to have an understanding of our own culture and the dominant culture: the lens through which we view the world.
   c. The lens through which we see the world shapes our assumptions, stereotypes, biases, prejudices.
   d. If you reviewed some of the suggested videos and readings, we all have prejudices and bias, it’s how our brains quickly process a lot of complex information. It’s what we do about or with them that’s important:

2. **Slide 1:** Explain what the stated objectives of the tour are
   a. Increase your awareness of the multiple lenses through which you operate
   b. Increase your ability to reflect on cultural positions and assumptions and become more aware of others’ positions as means to becoming more effective physicians.
   c. Recognize the inherent assumptions and biases imbedded in western culture as well as the unconscious, unintentional biases that often manifest in personal and professional interactions as a result.

### Learning Objectives

- Increase your awareness of the multiple lenses through which you operate
- Increase your ability to reflect on cultural positions and assumptions and become more aware of others’ positions as means to becoming more effective physicians.
- Recognize the inherent assumptions and biases imbedded in western culture as well as the unconscious, unintentional biases that often manifest in personal and professional interactions as a result.
3. **Slide 2: Pair Up**
   a. I’ll give you 5 minutes to talk with a partner and then we’re going to report back to the group in terms of what we talked about. The question is:
   b. **“Did any part of the tour resonate with you or hit home? Why?”**
      i. Was there any identity that you have or experience that you’ve had that any of the paintings spoke to? If so what and why?
      ii. **Did anyone feel like there were particular identities that were left out or that these themes didn’t apply to?**
   c. **Explore emotions of discussing bias:** Before and during, how did you feel on the art tour?
      i. Were you nervous about offending anyone?
      ii. Were you surprised by anyone else’s interpretations? Did their interpretations help you better understand the art, them, or yourself?
      iii. Were you surprised by your own interpretations or how they changed?

4. **Slide 3: Dimensions of Identity**
   a. **Define Identity:**
      i. **Q:** Anyone want to give an answer or guess
         1. **A:** In lay terms, Identity is how we categorize ourselves and others in relation to us.
            a. **Psychology defines identity as the idiosyncratic things that make a person unique, affecting how one views oneself both as a person and in relation to other people, ideas, and nature**
            b. **Sociology:** the collection of group memberships that define the individual
      ii. **Q:** Name some types of identity categories?
         1. **A:** Show slices of the pie: You hit a lot of the common ones that come to mind nowadays.
         2. **A:** Give second layers of answers: However, there are a lot of different identities

5. **Slide 4: Intersectionality**
a. **Q**: If there are so many potential dimensions of categorization, is it possible for people to just be one thing or nothing?

i. **A**: Nope. We are so many things at one time, simultaneously. This concept is known as intersectionality.

1. A way to understand it is that I’m not more black than second gen Haitian American, or more 2nd gen than black. However, I can feel one identity more than another in a given circumstance.

2. For example, if I’m in a room filled with African American people, my identity as a second-generation Haitian-American may feel more significant.

6. **Slide 5**: Why examine Identity and Bias as they relate to Power?

a. From the tour and the reflection thus far, I hope you’ve taken note of the prevalence of bias all around us. The pockets of prejudice we all accumulate as we make our way through the world are unavoidable.

b. A reason that we are examining identity and bias as they relate to power, is because there are distinct hierarchies within each possible dimension of identity.

i. **Q**: Let’s take the dimension of gender. What is the hierarchy of options within that dimension? Who’s at the top, who’s in the middle, and who’s toward the bottom?

ii. **A**: Men, Women, Transgendered

c. Positionality & Bias

i. Our relationship to this hierarchy or social structure is different according to our position within it.

ii. The further our position is from the top, the more likely we are to pay “attention to the conditions under which such a hierarchy arises, the factors that stabilize that hierarchy, and the particular implications of that position with reference to the forces that maintain it”

d. **Bias + Power = Institutional Inequality that Reproduces Itself**
7. **Slide 6:** Here are some examples of that institutional inequality

   a. **Race:**
      i. In a study of emergency dept triage decisions for chest pain, African American patients, Hispanic patients, those with Medicaid, and the uninsured were less likely to be triaged into the emergent category, to receive basic cardiac diagnostic testing or ordering of cardiac enzymes in the ED.
      
      ii. Racial bias has been identified as a factor in the under-treatment of pain in Black patients

   b. **Weight:**
      i. A patients BMI significantly affected their treatment by physicians. The higher the BMI the less time a physician would plan to spend with them and the more negative their views of the patient would be.

   c. Gender: Add something on gender

   d. These are examples of the product of institutional inequality, but how does the reproduction of institutional inequality happen & work?

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2003: DISPARITIES IN EMERGENCY HEALTH CARE

Racial and Sex Differences in Emergency Department Triage Assessment and Test Ordering for Chest Pain, 1997–2006

Lesly Lopez, MD, MPH, Andrew P. Wiljer, MD, Mavis C. Cervantes, Jonathan R. Betancourt, MD, and Alexander R. Green, MD, MPH

**Abstract:** This study assessed whether sociodemographic difference existed in triage assignment and whether there was an effect on diagnostic testing results in the emergency department (ED) for patients presenting with chest pain.

**Methods:** A nationally representative ED data sample for all adults (18 yr) presenting with chest pain, African Americans (1,120), Whites (1,508), all aged 18–84 yr, was analyzed. The main independent variables were race, sex, patient weight, insurance status, and whether the diagnosis was acute coronary syndrome (ACS).

**Results:** Over 10 years, over 10,000 visits to the ED presented with chest pain. Over-matching with chest pain, African Americans had higher rates of ACS, more black patients used Medicaid, and the uninsured were less likely to have a chest x-ray. Black patients were less likely to have basic cardiac diagnostic testing or ordering of cardiac enzymes in the ED.

**Conclusions:** Persistent racial, sex observed disparities in chest pain treatment: Academic Emergency Medicine

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Weighing the care: Physicians’ reactions to the size of a patient

MB Hebl1,2 and J Xiu2

1University of Houston, Texas, USA; and 2University of Texas, Houston School of Public Health, Houston, Texas, USA

**Objective:** To examine how the weight of a patient affects both the attitudes that physicians hold as well as the treatments they provide.

**Design:** A 2x2x2 randomized design, physicians evaluated a medical chart of a male or female patient, depicted as either average weight, overweight or obese, who presented with a migraine headache.

**Subjects:** A total of 121 physicians affiliated with one of three hospitals located in the Texas Medical Center of Houston.

**Measurements:** Using a standard medical procedure form, physicians indicated how long they would spend with the patient and which of 41 medical tests and procedures they would conduct. They also indicated their initial treatment and behavioral reactions to the patient.

**Results:** The weight of a patient significantly affected how physicians viewed and treated them. Although physicians prescribed more tests for heavier patients, F2, 1,077 = 3.65, P = .05, they simultaneously indicated that they would spend less time with them, F(2, 1077) = .83, P = .46, and viewed them significantly more negatively on 12 of the 15 items.

**Conclusion:** This study reveals that physicians continue to play an influential role in lowering the quality of healthcare that overweight and obese patients receive. As the graph of America continues to increase, continued research and improvements in the quality of such healthcare deserve attention.

**Keywords:** physician attitudes; prejudice; care; stigma

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8. **Slide 7:** Controlling the Common Narrative
a. Quotes from Lorde and Adiche

Controlling the Narrative

“So that is how to create a single story, show a people as one thing, as only one thing, over and over again, and that is what they become” – Chimamanda Adichí

“Mainstream communication does not want women, particularly white women, responding to racism. It wants racism to be accepted as an immutable given in the fabric of your existence, like evening time or the common cold” – Audre Lorde

9. **Slide 8: Controlling the Common Narrative**
   a. Controlling the narrative to reflect their vision of the world
      i. the **representation and writing** of the findings – whose voices are privileged and being heard.
      ii. the **epistemology of power** – how power is exerted in the construction of knowledge
   b. Defining individuals and peoples without their consideration.
      i. Ask for examples from the group:
         1. Can you give examples of how this manifests in your daily life or work?
      ii. Offer two examples of your own:
         1. **Defining welfare recipients as welfare queens and/or drug abusers**
         2. **Defining immigrants as uniformly violent**
10. **Slide 9: Making the Rules**
   a. Ask someone to read: “*What woman here is so enamored of her own oppression that she cannot see her heelprint upon another woman’s face? What woman’s terms of oppression have become precious and necessary to her as a ticket into the fold of the righteous, away from the cold winds of self-scrutiny?*” – Audre Lorde
   b. This isn’t about intending to hurt others out of animosity, it’s about prioritizing yourself and your group to the direct detriment of others.

   **Making the Rules**

   “What woman here is so enamored of her own oppression that she cannot see her heelprint upon another woman’s face? What woman’s terms of oppression have become precious and necessary to her as a ticket into the fold of the righteous, away from the cold winds of self-scrutiny?” – Audre Lorde
11. **Slide 10: Making the Rules**
   a. In research: the **research process** itself – who defines the research **design**, decision making processes, and levels of power sharing
      i. It is easier to get away with making the rules benefit you or your group exclusively if the narrative supports it, if autonomy and personhood have been effectively stripped from others who’d provide a contrary opinion.
   b. Does this resonate with anyone’s personal or professional experiences?
   c. What examples do you see from history from daily life?
   d. In policy and the built environment:
      i. **Research Design**:
         1. How are hypotheses produced?
            a. Is hypothesis formation as rigorous as the scientific method? Is there a scientific method equivalent for asking questions?
         2. What sample is designated as representative of the population:
            a. less women in studies, less minorities, less poor people
      ii. **Decision Making Process**:
         1. Who decides what constitutes research or valuable research?
         2. Who decides what research is worthy of funding?
            a. Funding for biomedical research vs. social determinants research
         3. Who decides whose research is worthy of funding?
            a. Grants awarded to minorities or women
      iii. **Levels of Power Sharing and resource allocation**
         1. Who decides the priority of
         2. Who decides what community should carry the burden
            a. School funding
            b. Waste and Environmental Pollution

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**Making the Rules**

- **The research process itself** – who defines the research design, decision making processes, and levels of power sharing.
- Outside of research, how have you seen **bias + power** in rule making?
  - Research Design
  - Decision Making
  - Levels of Power Sharing
12. **Slide 11: Controlling Access to Power**

   a. **The positionality of the researcher** to the communities being researched and to their academic setting – the extent of privilege of identity (or identities) within societal norms and within the specific community and academic relationship

   i. Who gets to define community in terms of who is in and out?

   1. When people within the Yale bubble say community, what do they really mean? Who’s in the community and who’s not?

      a. Is east rock part of the community?

      b. Is Westville part of the community?

   2. If not, why and what is at stake when we say community instead of “groups of racialized and oppressed peoples”?

   ii. – the extent of privilege of identity (or identities) within societal norms and within the specific community and academic relationship

      1. Are we only looking down the hierarchy? How does this operate within they Yale community in terms of the societal norms and relationships between individuals within the hierarchy?

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**Controlling Access to Power**

- **The positionality of the researcher** – to the communities being researched and to their academic setting

  – Who get’s to define community?

- “the extent of privilege of identity (or identities) within societal norms and within the specific community and academic relationship”

  – Are we only looking down the hierarchy?
13. **Slide 12**: How do we dismantle and/or prevent institutionalized inequality

**How Do We Dismantle/Prevent Institutionalized Inequality**

We know that when it comes to choosing somebody for a job or for an award, we are strongly biased by their race, we are biased by their gender, we are biased by how attractive they are, and sometimes we might say, “Well fine, that’s the way it should be.”

But other times we say, “This is wrong.” And so to combat this, we don’t just try harder, but rather what we do is we set up situations where these other sources of information can’t bias us. – Bloom

14. **Slide 13**: How do we dismantle and/or prevent institutionalized inequality

i. As partners in CBPR

ii. As researchers

iii. As attending physicians

iv. As faculty

v. As influential figures in society

**How Do We Dismantle/Prevent Institutionalized Inequality**

- As students?
- As future physicians?
- As researchers?
- As future faculty?
- As influential figures in society?
15. **Slide 14:** Possibilities for proven intervention
   a. This may seem intimidating, but I want to leave you with hope of studies showing successful methods to combating bias. Although they’re successful, it doesn’t make them easy:
      i. **Stereotype Negation Training** – is more for conscious thought. It’s a process in which you train your mind to undo the habits inherent to negative shortcuts and replace them with more positive ones. (Patricia Devine)
         1. You never forget the stereotypes you have learned, but it stresses separating thoughts from your beliefs.
      ii. **Promoting Counter-Stereotypes** – is more for unconscious thought. The paper to right showed that if you fill your mental library with experiences that go against the stereotype, your biases will diminish. Not forever though; it wears off over time as our memory is filled with things that perpetuate the stereotype.

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### Proven Options for Intervention

- **Stereotype Negation Training**
  - Conscious intervention
- **Promoting Counter-Stereotypes**
  - Unconscious intervention

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**Seeing is believing:** Exposure to counterstereotypic women leaders and its effect on the malleability of automatic gender stereotyping

Nilanjan Dasgupta* and Shashi Agarwal
Department of Psychology, University of Massachusetts, Amherst, MA 01003, USA
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Abstract

Five studies tested the conditions under which social environments can undermine automatic gender stereotypic beliefs expressed by women. Study 1, a laboratory experiment, manipulated exposure to biographical information about famous female leaders. Study 2, a recruiting field study, took advantage of pre-existing differences in the proportion of women accepting leadership positions (e.g., female professor in one university or female teacher in a school). Together, these findings suggest the following: (a) a female leader’s gender stereotype biases when she is seen as an exception to the stereotype, (b) the perception of her might change the stereotype, and (c) the effect is mediated by the frequency with which female leaders are encountered. Results revealed that when women were in social contexts that imposed them to behave as leaders, they were less likely to express automatic stereotypic beliefs about their group (Studies 1 and 2). Second, Study 2 showed the long-term effect of social environments (women’s college vs. mixed college) on automatic gender stereotyping was mediated by the frequency of exposure to female leaders (i.e., female faculty). Third, some academic environments (e.g., science courses with female instructors) produce an increase in automatic stereotypic beliefs among students at the same college but not at the women’s college. Importantly, this effect was mediated by the sex of the course instructors. Together, these findings underscore the power of local environments in shaping women’s stereotypic beliefs about their group.

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16. **Slide Close:**
   a. “We are not good despite our imperfections. It is the connection we maintain with our imperfection that allows us to be good. Our connection with our personal and
common imperfections are what allow us to be good to each other and to be good to ourselves”. – Jay Smooth
b. “That when we reject the single story, when we realize that there is never a single story about any place, we regain a kind of paradise” – Achibe

How Do We Dismantle/Prevent Institutionalized Inequality

“We are not good despite our imperfections. It is the connection we maintain with our imperfection that allows us to be good. Our connection with our personal and common imperfections are what allow us to be good to each other and to be good to ourselves” – Jay Smooth

”When we reject the single story, when we realize that there is never a single story about any place, we regain a kind of paradise” – Achibe
Appendix 7 – Selected Excerpts from Focus Groups

Appreciation for the Use of Art

 Appreciation for the Viewing Technique:
“I thought it was kind of brilliant to actually tie it with art specifically because especially for most people when you come to think about medicine, you think about it in a science, like the objective and everything. And I thought it was really cool to really like tie in the culture, the history through art to something that normally people would not relate at all to like medicine or science and whatnot.”

Safe Space:
“We were looking at paintings. We're all looking at a painting as opposed to sort of like sitting in this big circle observing each other and very conscious of the other’s gaze whenever – whoever’s speaking is up…”

Awareness of Bias: In Self & Others
Self-Bias
“So that means – I mean for me that will be as much as I'm trying to navigate life as someone who’s experiencing bias, I should also be mindful as a – I mean also be aware of my privileges and I should be aware of how my privileges puts – accords to me power and how that could be used in suppression on another person based on my privileges. So that's – So it was humbling to just acknowledging that. Yeah, it was just like a guide moving forward.”

Class Consciousness:
“I think I was a little more aware of maybe some really deeply engrained, I'm not entirely sure what, but some biases in terms of race. Also, it kind of opened my eyes to the fact that with that inside-outside picture, I did ignore like – You know, you walk along the streets, and I don’t even look at the people begging out there.”

Dissonance & Impact:
“It hit upon a lot of issues that were – that go deep into a lot of problems which society had – has and how they're all implicated in it, and I think it was so nuanced that you can't help but to see yourself as like the oppressed also the oppressor in a lot of cases, and I think they did a good job of facilitating that. With that also comes emotional weight and heaviness I think.”

Awareness of Societal Bias & Powerful Influencers
Social Bias
“I think it was really good for like reminding us of our biases. For example, there's the German picture [Inside, Outside] where you have these fat men and [tsk] the fact like you immed- Like you pointed out oh, immediately we tell these fat men are very wealthy but it also like overindulgent, and it's all these negative stereotypes with it. And that just reminds us that oh, a lot of us do carry negative
stereotypes of like fat people and – or obese people.”

“I guess it made me realize how engrained certain things are in me. Like when we were talking about well why do we think that those men in the paintings were wealthy and we all knew they were wealthy. And it's just we've seen multiple paintings of wealthy men with the wigs and the clothing, and it was just like I never doubted those were wealthy people. So it's just like how ingrained I think certain concepts are in us.”

**Participation Dynamics**

*Lib Class Bias:*

“I mean if anything, the bias, quote-unquote, would be the one towards like the politically liberal kind of social justice focused way of viewing the world, which isn't a negative thing, and if you're going into medicine, hopefully you believe in some level of social justice. But there was not anyone there that I had a doubt based on who spoke, that let's say the voted for Hillary Clinton [chuckle] and but though that's – It's important to be around people who you disagree with. And as we saw with the election and what's going on. Everyone lives in bubbles, and that creates all types of problems. I don’t know how you – how you fix – address that problem, but that’s the only bias I saw, was the fact that people tend to agree on matters of politics, and most people spoke very similarly on matters of race and gender. It's good that everyone wants to be inclusive in those ways. So that’s bias but not in the negative connotation.”

*Cliché:*

“I know I am like politically more liberal, so and I feel like a lot of these topics were like the usual. They all like to talk about, like race, gender, all these kinds of things, intersectionality, but I feel like stuff that often needs to be brought into discussion was briefly shown on the slide. It's like political ideology, religion. I mean in America stuff like gun rights issues or like – or even career. Right. Like blue-collar workers, that’s a huge identity for many people, but these are – These are issues of identity I guess I kind of wish maybe that could be brought in, especially then that’s because I guess as somebody who is more politically liberal, I'd like to see a kind of different point of view per se.”

*Self-Censorship:*

“I just feel like, especially because sometimes I'm not the most politically correct person, I really gotta watch what I say ‘cause – I wish I could actually say what I have to say and if it – people think it's wrong, I could have like a calm discussion with them, but that’s generally not what happens. And so even in this experience where we were told you can what you want, there wasn’t anything that I really wanted to say that I couldn’t, but I just had to kind of hold myself back and restrain myself a little, and that was very difficult.”

**Recognizing the Importance of the Topic**

*Topic Appreciation:*
“I'll kinda continue to think about this the rest of the day and like the next few
days, but I don’t – There's nothing that jumped out to me as like oh, this is like
something new that really leaps out to me from having this conversation, like
most of these things that I had kind of already assumed about myself, about like
having biases and whatnot. But I do think it was a really productive conversation
to have and very cool that we did that.”

**Wanting More**

**More Discussion:**

“I think it's educational in the sense that I need to have these conversations a little
bit more with other people, and I think that I can learn a lot of other things, too,
from views. I think I like the pushback, but I do think that if people had a deeper
contextualization in what we were leaning, they would understand why people are
having these liberal slants or… they're jumping to conclusions and assign
negative values to the person who did the colonialist painting. And so I think it's
good that we're learning or we are all starting from. And so even if I knew that
stuff, I need to – it's good that now I know that – now I know where my
classmates are, and also I know where I am.”

**Future Programming:**

“So I do think it's really important to have had this first session, to be aware of my
biases and then hopefully there's some program or something – I know there's a
health justice elective that we could take – something to keep my mind on this
topic and remind myself of what motivated me to want to keep using what I
learned here in the first place.”

**Specific Steps:**

But I think maybe if perhaps the reflection had like – session had like – Maybe if
you have some like concrete action steps to like be aware of like to do at the ends
for everyone, maybe that would be more helpful. Because I feel like what ended
up happening is that like everybody comes up with a bunch of opinions and you
just walk away with the opinion that you came up with versus going like oh,
maybe these are best practices or you should do this.

**No Specific Steps:**

“This is more to initiate the conversation. Like as you were saying. This is just
get people to think about these things and you start discussing it amongst the class
and everything. And, again, because we all just at the beginning of our medical
journey, we have plenty of time to really try to work together. So to me, I didn’t
feel like and I wouldn't even know what you would define as best practices, like
that is going to vary from people – from person to person. Some people are
gonna argue like that’s not the right practice to do.”