Teaching About Racism in Medical Education:

A Mixed-Method Analysis of a Train-the-Trainer Faculty Development Workshop

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BACKGROUND AND OBJECTIVES: Curriculum addressing racism as a driver of inequities is lacking at most health professional programs. We describe and evaluate a faculty development workshop on teaching about racism to facilitate curriculum development at home institutions.

METHODS: Following development of a curricular toolkit, a train-the-trainer workshop was delivered at the 2017 Society of Teachers of Family Medicine Annual Spring Conference. Preconference evaluation and a needs assessment collected demographic data of participants, their learning communities, and experience in teaching about racism. Post-conference evaluations were completed at 2- and 6-month intervals querying participants' experiences with teaching about racism, including barriers; commitment to change expressed at the workshop; and development of the workshop-delivered curriculum. We analyzed quantitative data using Statistical Package for the Social Sciences (SPSS) software and qualitative data, through open thematic coding and content analysis.

RESULTS: Forty-nine people consented to participate. The needs assessment revealed anxiety but also an interest in obtaining skills to teach about racism. The most reported barriers to developing curriculum were institutional and educator related. The majority of respondents at 2 months (61%, n=14/23) and 6 months (70%, n=14/20) had used the toolkit. Respondents ranked all 10 components as useful. The three highest-ranked components were (1) definitions and developing common language; (2) facilitation training, exploring implicit bias, privilege, intersectionality and microaggressions, and videos/podcasts; and (3) Theater of the Oppressed and articles/books.

CONCLUSIONS: Faculty development training, such as this day-long workshop and accompanying toolkit, can advance skills and increase confidence in teaching about racism.

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"Of all the forms of inequality, injustice in health care is the most shocking and inhumane."
—Dr Martin Luther King, Jr

The United States is riddled with shocking and inhumane racial and ethnic health and health care disparities. Teaching health care professionals to address these inequities has typically focused on disparity statistics, cultural competence, and social determinants of health. This approach has failed to address the more intransigent problems that contribute to health

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disparities in the United States, such as poverty, institutionalized racism and sexism, sociopolitical disenfranchisement, limited educational attainment, residential segregation, and structural vulnerability and violence.[1-3] Further, it contributes to misconceptions of race as a biologic construct, ignores clinician implicit bias, neglects historical and structural context, and exacerbates stereotype threat among learners who are underrepresented in medicine. Despite consistent and extensive evidence about pervasive gaps in morbidity and mortality among racial and ethnic groups,[4] there is often little to no discussion of the role of racism as a contributor to these gaps.

Many well-intentioned educators have invoked cultural competency as a remedy. The Liaison Committee for Medical Education (LCME)[5] and the Accreditation Council on Graduate Medical Education (ACGME)[6] have either focused entirely or placed a strong emphasis on curricular development in "cross-cultural medicine," which may or may not include content on the role of race and/or racism in society. One systematic review of 34 cultural competency training programs for health professionals found only 6% incorporated concepts of racism, bias, or discrimination.[7]

While social determinants of health (SDOH) are increasingly seen as drivers of health outcomes and inequities, many SDOH educational approaches in medicine focus on the lack of resources, rather than on systems and behaviors that perpetuate inequitable resource distribution. This creates a focus upon content, rather than actionable skills.[2] Lessons from other academic disciplines (eg, critical race studies, sociology, economics, anthropology) demonstrate an overdue need to embrace structural competency in medical education,[1] which can lead to meaningful, innovative, and compassionate strategies to combat social inequities. Racism is perhaps the most challenging and poorly addressed SDOH.

Learners now demand curricula on racism.[8] David Acosta, the chief diversity and inclusion officer of the Association of American Medical Colleges, challenges faculty to acquire not only knowledge but also skills in confronting racism as a critical SDOH that affects patients, learners, health care providers, and educators.[9] Practical guidance acquiring such skills is severely lacking. Resources and support are often inadequate to successfully integrate issues of racism and inequities, and to manage the emotional tensions that often arise.[10] Such a curriculum requires not just content knowledge, but also demands introspection on the part of both learner and facilitator.

In order to address complex issues of race, power, privilege, and identity, one must develop skills that facilitate open dialogue, preserve safety, and address conflicts in hope of achieving new perspectives, insights, and understanding. To provide clinical learners with curricula that address structural competencies, faculty development is a necessary but neglected step.[11] To this end, members of the Society of Teachers of Family Medicine (STFM) Group on Minority and Multicultural Health met in 2015 to develop curricula that went beyond teaching about race and health disparities to embrace a more complex discourse on racism and health inequities. The group developed and assembled the *Toolkit for Teaching About Racism in the Context of Persistent Health and Healthcare Disparities*,[12] which included facilitator resources and curricular activities that study team members were piloting at their home institutions. In 2016, the study team piloted a 1.5-hour workshop attended by over 120 participants that sampled an activity in the toolkit. Participants reported statistically significant changes in attitude and knowledge regarding their understanding of issues of racism and in their personal commitment to address them.[13] In response to the request for more training by participants, the study group expanded this work into a daylong interactive faculty development preconference workshop that incorporated guidance for facilitation of complex conversations of identity and oppression and further explored application of the toolkit by demonstrating four toolkit activities. We hypothesized that with expanded training on supportive self-reflection, guidance on skills for complex conversations, live demonstration and skills practice, and a compendium of knowledge resources, participants would be more willing and able to develop curriculum around structural competence, focusing particularly on racism. We created a train-the-trainer workshop to provide participants an approach to teaching about racism in medical education and then followed up with them on their experience of doing so in their home institutions.

Methods

The daylong preconference workshop, "Teaching About Racial Justice: A Train-the-Trainer Faculty Workshop," was held at the 2017 STFM Annual Meeting. Its goals were to promote participants' facilitation of complex conversations around identity and racism; ask participants to reflect on personal bias and privilege through experiential and reflective learning, engage participants to deconstruct and explore racism in their home institutions, and practice skills to counter microaggressions experienced across the health care spectrum by patients, learners, and themselves. STFM workshop participants typically consist of educators from family medicine residencies and departments around the United States. Preconference participants were required to register in advance for a full-day preconference of the STFM Annual Spring Conference, that included an additional registration fee. STFM limited registration to 60 participants. In preparation for the workshop, participants completed two Implicit Association Tests (IATs): the race IAT and one additional IAT of their choosing (https://implicit.harvard.edu/implicit/).

Table 1 outlines a descriptive agenda of the workshop. An initial

Table 1: Workshop Outline

Topic (Time Allowed)	Purpose
Consent for evaluation of the workshop obtained and pretest distributed to study participants (5 min)	To assess preworkshop experience about teaching about racism, barriers and challenges, importance and confidence of teaching about racism, and demographic information
Welcome and needs assessment using Poll Everywhere (10 min)	To establish participants' baseline anxiety and hopes for the workshop
Foundational principles and ground rules (10 min)	To assure a common starting point and a respectful, mutually supportive environment
Keynote address (30 min)	To frame the context and urgency of racism as an issue in health and health care
Small group reflection (40 min)	To discuss experiences: (1) teaching about racism OR (2) responding to microaggressions (witnessed or experienced) as potential teaching moments
Privilege walk (30 min)	To highlight the concept of privilege in each participant's life
Break (10 min)	
Facilitating courageous conversations (70 min)	To share strategies including potential pitfalls and pearls of engaging groups in discourse about racism by an experienced facilitator
Implicit bias (40 min)	To review the topic, including evidence-based interventions to mitigate implicit bias
Break (lunch, 60 min)	
Theater of the Oppressed (120 min)	To provide a model to allow participants to revisit microaggressions (experienced or witnessed) and an opportunity to collectively "act" one's way into an alternative outcome
Break (15 min)	
Toward institutional change (45 min)	To review institutional racism and provide a structured small group activity that allows participants to explore where they place their home institution in a continuum from a monocultural to anti-racist multicultural institution
Stand up and commit (30 min)	To offer a space for participants to articulate their thoughts for bringing change to their home institution
Wrap up (15 min)	To provide a reflective summation of the day by the keynote speaker
Posttest evaluation of consented participants[b] (5 min)	To evaluate immediate knowledge and skills gained, ongoing concerns, commitment to change, and importance and confidence of teaching about racism

[a] Participants were encouraged to take the two Implicit Association Tests (https://implicit.harvard.edu/implicit/; Race and one other of their choosing) prior to attending the workshop.

[b] Subsequent 2-month and 6-month postworkshop surveys were sent to respondents via Qualtrics.

needs assessment using an audience response system called Poll Everywhere assessed baseline hopes, fears, and goals of participants at the start of the workshop and was captured using free text with only one response per question. Description of the specific activities (eg, Privilege Walk, Theater of the Oppressed) completed during the workshop can be found in the *Toolkit for Teaching about Racism in the Context of Persistent Health and Healthcare Disparities.*[12] Facilitators assigned to each table of participants took notes for the activities that involved small group discussions that were then available for qualitative analysis.

The study group reviewed participant responses to Poll Everywhere for major themes, beginning with independent open coding. The group used a constant comparison approach in which members articulated their perceptions of key conceptual themes. They discussed their notes and built consensus on identified themes. The group performed coding using written methods to articulate themes and conceptual relationships and then edited the written document using selective coding to solidify major themes and organize pertinent concepts within thematic groups.

The evaluation of the workshop included written data collected through self-administered surveys (Table 2) during the workshop (pre- and immediate post-), and postworkshop surveys via Qualtrics (Provo, UT) at 2- and 6-months. Each participant provided a unique personal identifier consisting of the last two numbers of their zip code and the last two numbers of their mobile phone number, enabling pairing of pre- and posttest surveys. Pretest surveys collected demographic data of the individual participants, their learning communities, and a description of any activities or resources (if any) that participants used to teach about racism. Both pre- and posttest surveys included questions regarding participants' experiences teaching about racism, including barriers and challenges. The 2- and 6-month posttest surveys also reviewed the application of the toolkit and reflection on participants' commitment to change as expressed at the end of the workshop. Completion of each survey took 5 to 10 minutes. Participants received one reminder email if no response was received within 2 weeks.

The study team summarized participant demographics; analyzed pre- and postsurvey results to assess change in knowledge, attitudes, and behavior and uptake/impact of the toolkit using the same coding approach as above; and conducted content analyses of postworkshop survey comments to identify the most salient barriers and challenges to teaching about racism and to guide the prioritization of the next steps. Content analysis methodology described by Downe-Wamboldt uses a descriptive approach in coding of the data and its interpretation of quantitative counts of the thematic codes.[14,15] We used this method in this study to illuminate themes in the qualitative data and highlight meaningfulness across a broad group. It allowed for identification of themes in the data, rather than using preconceived categories to describe and quantify anticipated barriers and challenges. This is useful because existing theory in teaching about racism in medical education is limited. Two members of the author team independently applied a constant comparison approach to identify, solidify, and organize major concepts into thematic groups. A third member of the author team was available to resolve any discrepancies. We counted the number of times the concept appeared and divided it by the total number of responses in that group to give a quantitative value to the themes. Additionally, pre/postsurveys were analyzed using Statistical Package for the Social Sciences (SPSS). Florida State University granted this study human subjects approval on April 7, 2017—HSC # 2017 20534.

Results

Demographics (Table 3)

Forty-nine people consented to participate in the evaluative survey study. The majority of participants were women (83%, n=38), identified as white (62%, n=29), and between the ages of 30 and 59 years (80%, n=37). Most participants reported that their own race/ethnicity and that of their learners differed from the race/ethnicity of their patients, (85%, n=10; and 78%, n=36, respectively).

Needs Assessment (Table 4)

The Poll Everywhere questions, asked at the outset of the preconference workshop, revealed anxiety, worry, and a strong interest in obtaining skills to employ at their home institutions.

Pre/Postsurveys

All 49 participants completed a pretest survey. Immediately following the workshop, participants who completed any part of the survey were counted in a response rate of 94% (n=46). Postsurvey response rates at 2 months and 6 months following the workshop were 47% (n=23) and 49% (n=24), respectively. Each person did not respond to every question on the pre- and postworkshop surveys. The surveys consisted of close-ended and Likert questions as well as free-text open-ended questions.

Table 5 shows how participants reported their own teaching about racism prior to the workshop and at 2 months and 6 months. Only 96% (n=43) respondents completed this portion of the survey immediately after the workshop, which decreased to 48% (n=22) and 37% (n=17), respectively, for the 2- and 6-month surveys. Due to the limited data, we were unable to compute a correlation or paired *t* test. The association between the 2- and 6-month tests regarding importance and confidence in commitment, however, suggests that use of the toolkit and feelings of importance and confidence were likely to persist over this time period. Furthermore, while variability in respondents at these time points limited longitudinal analysis, no respondent at 6 months had "never taught about racism."

Posttest survey Likert responses revealed a consensus as to the importance of teaching about racism throughout the 6-month study period, with improved confidence in teaching about racism after the workshop (Table 5).

In the free-text comments, participants described that they had engaged in formal discussions with their department faculty on racism and health equity; had joined or created committees on diversity, equity and inclusion; had developed new curricula that included lectures and workshops; and incorporated pieces of the STFM training into their precepting of clinical learners. Participants found responses to their new teaching very positive, although one experienced backlash.

Participants identified that the most rewarding aspects about their increased involvement in teaching about racism included influencing learners' perspectives ("Encouraging students to be more politically engaged"), collaborating with colleagues ("Working with [a] diverse group of faculty in developing a

Table 2: Description of Surveys

	Pretest	Immediate Posttest	2-Month Posttest	6-Month Posttest	Multiple Choice	Open-Ended
Total number of questions per survey	7	6	13	15		
Please describe all of your active teaching about racism (check all that apply).	X				X	
List three activities or resources you use to teach about racism.	X	X	X	X		X
List at least two barriers that prevent you from teaching about racism at your institution?	X		X	X		X
What aspects of teaching about racism do you find most challenging?	X	X	X	X		X
In my continued efforts to improve health care and/or teaching, I rank the importance of teaching about racism as:	X				Likert scale	
I would rate my confidence in teaching about racism as:	X				Likert scale	
Demographics	X				X	
List at least two things that were most helpful about this workshop		X				X
I would like to commit to the following goal to make personal changes to deal with racism in patient care and in educational interactions as I reflect on this workshop. Please take a photograph of your goal for future reference:		X				X
Reflect upon your goal from the preconference (refer to the written goal you photographed on May 5, 2017). What changes have you been able to make regarding teaching about racial justice?			X	X		X
In my continued efforts to improve health care and/or teaching, I rank the importance of this goal as:		X	X	X	Likert scale	
I would rate my confidence in completing this goal as:		X	X	X	Likert scale	
Please describe all of your active teaching about racism (check all that apply).			X	X	X	
Have you used the *Teaching about Racism in the Context of Persistent Health and Healthcare Disparities Toolkit* to support your curricular work?			X	X	X	
If no, why did you choose not to use the *Toolkit*?			X	X		X
If yes, please rank at least three references and/or activities you found useful/helpful (1 being most useful/helpful):			X	X	Ranking	
Was there an aspect of the *Toolkit* that you found not to be useful/helpful (check all that apply)?			X	X	X	
What material from the *Toolkit* elicited a negative reaction when your tried to teach using this?			X	X	X	
What do you think is missing from the *Toolkit*?			X	X		X
Please describe your experience of teaching about racism.				X		X
Rewards of teaching about racism and social justice.				X		X

workshop," "Finding allies to help with this work"), and professional and personal growth ("Becoming a better educator," "In it for the long run," "Being comfortable in my discomfort," "I am a better person").

Toolkit Use and Impact

Of the respondents who provided input about whether or not they had used the toolkit, the majority reported using it at 2 months and 6 months (61%, n=14/23; and 70%, n=14/20, respectively). While formal statistical analysis was limited by the amount of data, the association between the 2- and 6-month tests regarding use of the toolkit suggests that application of the toolkit continued over this time period. Participants found the "definitions/developing common language" portion of the toolkit most helpful at 2 months, and "exploring implicit bias" section most helpful at 6 months with "definitions/developing common language" as the second-most helpful tool at that time. Some commented on challenges related to systemic issues of racism and implicit bias, and discomfort in exploring privilege, intersectionality, and microaggressions. Other challenges included facilitating the Theatre of the Oppressed and the Privilege Walk exercises found in the toolkit with mixed resident and faculty participants.

Challenges to Teaching About Racism

Participants were asked about challenges to teaching about racism in medical education. Their postsurvey comments (n=291) were categorized into the following categories, listed in descending order of frequency: (1) institutional (49%, n=143); (2) educator (21%, n=62); (3) communication (10%, n=30); (4) societal/cultural (10%, n=30); and (5) learner (9%, n=26).

The most common institutional barriers were time constraints on teaching (28.0%, n=40) and issues regarding the curriculum (28.0%, n=40). Time constraints stemmed from the lack of specified time in the

Table 3: Participant Characteristics

Gender	**n (%), Total n=46**			
Male	8 (17.4)			
Female	38 (82.6)			
Age in Years	**n (%), Total n=46**			
<30	2 (4.3)			
30-39	15 (32.6)			
40-49	10 (21.7)			
50-59	12 (26.1)			
60+	7 (15.2)			
Race	**n (%), Total n=47**			
White	29 (61.7)			
Black/African American	12 (25.5)			
Asian	3 (6.4)			
Multiracial*	3 (6.4)			
Ethnicity	**n (%), Total n=47**			
Non-Hispanic	42 (89.4)			
Hispanic	5 (10.6)			
Years Since Training	**n (%), Total n=44**			
0-5	12 (27.3)			
5-10	10 (22.7)			
10-15	5 (11.4)			
More than 15	17 (38.6)			
Professional Setting	**n (%), Total n=43**			
Academic health center	24 (51.8)			
Community health center	22 (51.2)			
Private	10 (23.3)			
Other	7 (16.3)			
Does the racial/ethnic demographics of your faculty reflect the patients they care for?	**n (%), Total n=46**			
Yes	7 (15.2)			
No	39 (84.8)			
Does the racial/ethnic demographics of your learners reflect the patients they care for?	**n (%), Total n=46**			
Yes	10 (21.7)			
No	36 (78.3)			
Racial/Ethnic Demographics of Learners	**Total n=45**			
	Min	**Max**	**Mean**	**SD**
% Learners are White	10	99	68.1	23.1
% Learners are People of Color	1	90	31.8	23.2

*Multiracial: one person reported Asian and White; two people reported Black/African American and White.

Table 4: Responses to Participant Needs Assessment

Theme	Examples	Number of Responses
Question 1: What are you nervous about today?		**Total n=59**
Being racist or committing a microaggression	"I fear hurting someone, unintentionally"	n=10
Experiencing negative emotions	Fearing that the experience will yield "discomfort," "tension," "anger"	n=10
Being judged	"I will be seen as uniformed and dismissed," "perceived privilege," "assumptions about me"	n=8
Experiencing defensiveness, conflict and resistance	"naysayers," "pushback," "backlash," "retaliation"	n=6
Experiencing microaggression	"Whitesplaning," "Being preachy," "racism"	n=5
Being White	"Since I am a White person and need to listen and respect but also join the conversation as a White person," "White fragility"	n=4
Experiencing a lack of engagement	"No one will talk," "turned off by the topic"	n=4
Not knowing next steps	"What to do next?" "Action items," "Questions about how to fix the problem"	n=3
Other: experiencing mistrust, imposter syndrome, fatigue	"What authority do I have?" "Fostering the same old thing"	n=9
Question 2: What are your hopes and goals for today?		**Total n=44**
Obtain tools	"tools to help facilitate the work at my own institution," "tools to discuss racism with my learners and make it a dynamic part of the didactic curriculum," "to learn resources for teaching racism and social determinants of health to residents and medical students"	n=12
Gain skills in teaching	"learn strategies for teaching complex topics," "grounding my knowledge and ability to teach this," "learn strategies to help facilitate discussions and understanding when teaching cultural humility to learners," "have strategies to teach non-people of color about racial justice and implicit bias"	n=11
Gain skills in communication	"learn how to talk to White people about race," "develop clear, helpful language for difficult conversations," "learn to address racism, as I perceive it, with a positive effect"	n=8
Develop increased confidence	"self confidence in teaching about race," "want to know how a White lady can teach about racism in a way that rings true given I have never been in the position of a person of color"	n=5
Self-exploration	"to learn and grow," "find constructive ways to confront my own White privilege…" "understand my own bias better"	n=8

curriculum for inclusion and discussion, lack of flexibility in learners' schedules, lack of time to develop curricula or prepare content, and lack of time to have meaningful in-depth discussions and debriefing sessions. Issues with curricula that created barriers included conflicting priorities in already overcrowded content the lack of a formal curriculum, discontinuity in both the curricular content and the availability of students, and a lack of teaching tools and resources.

The most common educator barriers reported were lack of knowledge, expertise, or experience (29.0%, n=18); lack of partners or collaborators (16.1%, n=10); educator discomfort (11.3%, n=7); and a feeling of lack of credibility to discuss racism because of educators' own race and/or gender (11.3%, n=7; ie, individuals from nonpersecuted categories felt they could not facilitate discussions about oppression).

The most common communication barriers reported focused on a lack of knowledge or skill to present the topic of racism (70%, n=21; eg, not knowing the right language to use or how to communicate with individuals with diverse backgrounds, experiences, and perspectives). Other barriers included lack of safe, supportive environments for dialogue, and the need for more voices and perspectives to be included in the conversation.

A broad range of societal/cultural issues surfaced, with the most reported barriers being the difficulty of

Table 5: Teaching About Racism: Pre/Postsurvey Results, n=Number of Responses (Quantitative Data)

Teaching Experience	Preworkshop (Total Responses, n=43) n (%)		2 Months (Total Responses n=22) n (%)	6 Months (Total Responses n=17) n (%)
Has never taught about racism	7 (16.3)		2 (9.1)	0 (0.0)
Teaches as part of clinical teaching when the opportunity arises	27 (62.8)		15 (68.2)	13 (76.5)
Teaches peripherally in didactic teaching sessions	18 (41.9)		9 (40.9)	9 (52.9)
Teaches one regularly occurring didactic session	15 (34.9)		5 (22.7)	7 (41.2)
Teaches a formal longitudinal curriculum on racism and health equity	10 (23.3)		6 (27.3)	7 (41.2)
Does not teach about racism but teaches about implicit bias	4 (9.3)		4 (18.2)	1 (5.9)
Does not teach about racism but teaches about microaggression	2 (4.7)		1 (4.5)	0 (0.0)
Other	6 (14.0)		10 (45.4)	5 (29.4)
Perception	**Preworkshop (Total Responses n=43)**	**Immediate Postworkshop (Total Responses n=44)**	**2 months (Total Responses n=22)**	**6 months (Total Responses n=17)**
Level of importance of commitment to change goal.[a]	NA	8.5	8.1	8.5
Level of confidence in completing the commitment to change goal.[b]	NA	6.9	7.1	7.2

[a] Likert scale of 1 (not important) to 10 (very important)

[b] Likert scale of 1(not confident) to 10 (very confident)

the topic and strong emotions surrounding the topic of racism (40%, n=12) and ignoring or denial of racism as an issue (26.7%, n=8).

Learner barriers included learner discomfort and sensitivity discussing racism (30.8%, n=8), student disinterest (23.1%, n=6), the diversity of learners (19.2%, n=5), and student pushback and resistance (11.5%, n=3).

Discussion

Future health professionals need highly skilled faculty who can effectively teach about the impact of racism on health and health care. To begin addressing this need, a day-long faculty development workshop was conducted to provide resources, strategies and experiential learning about how to develop and teach antiracism curriculum. Follow-up surveys with the participants identified that the two most significant barriers to teaching about racism in medical education are institutional (lack of time and prioritization) and educator-related (lack of knowledge, skills, and partners). A major theme from the responses was relief at being given structured faculty development that included not only content, but also concrete examples of educational activities and facilitation training in a safe and nurturing environment. Increasing such opportunities is critical to address the issue, as major barriers to implementation are lack of curricula and anxiety around how to manage conflict or uncomfortable conversations about racism.[8] Given the system- wide dearth of underrepresented in medicine faculty, any expectations that these individuals will lead antiracism curriculum development may lead to anxiety, exhaustion, and their decreased promotion and retention. Nurturing allies who are skilled in this work is an important strategy to overcome this challenge.[16]

The *Toolkit for Teaching About Racism in the Context of Persistent Health and Healthcare Disparities* is an important first step toward providing formal curricula. We encourage educational and professional organizations to develop and make available vetted, transportable curricula that may someday help drive development of competencies and metrics related to teaching about racism and systems of inequity.

Participants' experiences in teaching about racism included discussions and dialogue, forming committees and workgroups,

curriculum development, and professional growth and commitment. Educators have found many rewards, including influencing students, collaborating with colleagues, and professional and personal growth. Although this workshop primarily impacted participants individually, at a structural level, participants also identified action-oriented opportunities and activities for institutional change.

Generalizability of these results is limited by a number of factors. Participants self-selected the workshop, but notably, curricular change in home institutions will be aided by faculty who are already motivated to do this teaching. Participant data were all self-reported, and thus only from their perspective on such issues as learner barriers, institutional barriers, and degree to which they actually implemented the toolkit. As there was no control group, we could not assess the specific role that our intervention played in any curricular changes. Generalizability is also limited by variability in participants' settings. Finally, the sample size was small, and not all who participated answered all of the questions in the postworkshop survey, and an even smaller proportion of participants completed the 2-month and 6-month postworskhop surveys. Nonetheless, reports of barriers and toolkit application by those who completed all postworkshop surveys may reflect real issues faced by faculty committed to implementing this work.

Faculty development training such as this daylong workshop and accompanying toolkit as we have described, can promote learning skills and increase confidence in teaching about racism. Although more sustained faculty development is needed, workshops that provide such intensive, concrete training can make an important difference.[16]

Health equity is achievable.[17,18] We will only realize this goal when institutions and faculty are intentional about their teaching. Teachers and learners must value all people, rectify historical injustices, and provide resources according to need.[19]

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