NEW AND EMERGING AREAS IN MEDICINE SERIES: DIVERSITY, EQUITY, AND INCLUSION COMPETENCIES

Competencies Across the Learning Continuum Series

This document includes the pre-publication version of the new cross-continuum competencies in diversity, equity, and inclusion. Upon publication, they will be freely available in a report that will provide additional information, including: detailed background, sample curricular models for teaching and assessing the competencies, and methodology.

Series Background

The ***AAMC New and Emerging Areas in Medicine Series*** is a guide for everyone who develops curricula within the field of medicine and for people learning to practice or continuing their professional development. Each set of new and emerging competencies is developed by leaders from across the medical education and clinical practice communities, including hundreds of reactors who reviewed iterative drafts over 18+ months. These competencies are intended to add depth to selected emerging areas to help guide curricular and professional development, facilitate critical reflection, formative performance assessment, cross-continuum collaborations, and, ultimately, improvements in health care services and outcomes. Two other sets of competencies are currently available: Quality Improvement and Patient Safety (QIPS) and Telehealth. Diversity, Equity, and inclusion (DEI) represent the third set in this series.

New and Emerging Area Background

Preparing the current and next generations of physicians requires responsiveness to public health and societal needs. In 2020, the U.S. witnessed disparate rates of hospitalizations, deaths, mental health concerns and economic losses due to the COVID-19 pandemic.[1,2] Although these inequities are not new, the pandemic has underscored the need for improved integration of diversity, equity, inclusion, and anti-racism in medical education, especially regarding health care inequities arising from systemic racism and personal bias.

Feedback or Questions: Please direct any questions or comments on this competencies project to AAMC at DEIcompetencies@aamc.org.

Caveats

Here are some caveats to further clarify the design, intent and use of these competencies:

- While building competence in DEI is a journey and not a destination, this work aims to provide a standard set of expectations or outcomes along this developmental continuum. Whether at the beginning or end of their careers, new demands and advances in health care require all health professionals to be learners and acquire new and refresh existing competencies.
- These competencies recognize the important impact that physicians have at the individual patient, health care team, health system and community level. And in all

[1] CDC. Risk for COVID-19 Infection, Hospitalization and Death by Race/Ethnicity. https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html. Accessed on 8/31/21.
[2] The Impact of the COVID-19 Pandemic on LGBT People. https://www.kff.org/coronavirus-covid-19/poll-finding/the-impact-of-the-covid-19-pandemic-on-lgbt-people/. Accessed on 8/31/21.

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cases, the intent is to clarify the role of the physician and what they should know, do, and value in relation to her own practice, their team, and or their system.

- As with all new and emerging areas, this work is dynamic, and these competencies should be considered with this caveat in mind. We plan to review and regularly update the competencies based on feedback from the community as well as new evidence and evolving language in these domains. We welcome your feedback. Please see below for information on where to send your comments.
- Important terms and phrases are defined in the glossary within this document and are from, "*Advancing Health Equity: A Guide to Language, Narrative and Concepts*."[1]
- There are competencies related to systems-level changes, advocacy, policy change, and role modeling that may be aspirational for some depending on their local environment, education, and training. As in other sets of competencies, we strove to strike a balance and reach a consensus between what some may consider below expectation and others as aspirational. We will continue to listen and learn from our diverse communities to inform the next iteration.
- The first set of competencies in this series, Quality Improvement and Patient Safety (QIPS), include a domain titled "health equity in QIPS" and two relevant competencies from that set are included here. We intend to update the full set of QIPS competencies in the near future to better reflect the progress made, not only in health equity, but in the overall domains of quality and safety.
- The competencies are tiered according to level of practice: entry to residency education, entry to independent practice and experienced faculty physician who is responsible for educating students or residents. The third tier is designed for those who teach or supervise student or residents in a clinical learning environment, not all physicians.
- The AAMC has several freely available resources to support teaching and learning the competencies:
    - MedEdPORTAL, the Journal of Teaching and Learning Resources, specifically the Anti-racism in Medicine[3] and the Diversity, Inclusion, and Health Equity[4] Collections
    - The Clinical Teaching and Learning Experiences collection[5]

[3] Anti-racism in Medicine Collection. *MedEdPORTAL.* Accessed November 5, 2021. https://www.mededportal.org/anti-racism
[4] Diversity, Inclusion, and Health Equity Collection. *MedEdPORTAL.* Accessed November 5, 2021. https://www.mededportal.org/diversity-inclusion-and-health-equity
[5] Clinical Teaching and Learning Experiences. Accessed November 5, 2021. https://www.aamc.org/resource-library/clinical-teaching-and-learning-experiences

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Domain I: DIVERSITY

Refers to the identities we carry. There are many kinds of diversity, based on race, gender, sexual orientation, class, age, country of origin, education, religion, geography, physical or cognitive abilities, or other characteristics. Valuing diversity means recognizing differences between people, acknowledging that these differences are a valued asset, and striving for diverse representation as a critical step towards equity.[1]

Medical Student Graduate / Entering Residency **or** **New to DEI Journey**	**Resident Graduate / Entering Practice** **or** **Advancing DEI Journey** ***All prior competencies +***	**Faculty Physician / Teaching and Leading** **or** **Continuing DEI Journey** ***All prior competencies +***
Advancing Diversity and Integration in Practice Knowledge and practices that demonstrate that one values and understands how aspects of an individual's overlapping identities create unique lived experiences that may influence health and health care outcomes		
1a. Demonstrates evidence of self-reflection and how one's personal identities, biases, and lived experiences may influence one's perspectives, clinical decision making, and practice	1b. Mitigates the effects of personal bias in clinical decision making and delivery of patient care	1c. Role models how the practice of self-reflection can help with identifying and mitigating effects of personal biases
2a. Demonstrates the value of diversity by incorporating dimensions of diversity in the patient's health assessment and treatment plan	2b. Gathers and applies patient-identified demographic data to develop a comprehensive patient health assessment and treatment plan	2c. Role models and teaches how to collect and apply self-identified demographic data to develop a comprehensive patient health assessment and treatment plan
3a. Demonstrates knowledge of the intersectionality of a patient's multiple identities and how each identity may present varied and multiple forms of oppression or privilege related to clinical decisions and practice	3b. Applies knowledge of intersectionality to inform clinical decisions and practice	3c. Role models how knowledge of intersectionality informs clinical decision making and practice

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Advocating for Diverse Health Care Team & System Actions that promote social, economic, educational, and policy changes that advocate for achieving optimal learning, health, and well-being within the health care team and the system		
4a. Analyzes policies and practices that promote and ensure diversity of the health care team	4b. Advocates for policies and practices that promote, build, and sustain diversity of the health care team	4c. Role models and teaches how to advocate for policies and practices that promote, build, and sustain diversity of the health care team
5a. Identifies the systems level policies, procedures, and practices that may or may not promote diversity and inclusion in the health care system	5b. Adheres to system level policies, procedures, and practices that promote diversity and inclusion in the health care system	5c. Leads, advocates, and/or participates in the development, implementation, and review of policies, procedures, and practices that promote diversity and inclusion in the health care system

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Domain II: EQUITY

Refers to fairness and justice and is distinguished from equality. While equality means providing the same to all, equity requires recognizing that we do not all start from the same place because power is unevenly distributed. The process is ongoing, requiring us to identify and overcome uneven distribution of power as well as intentional and unintentional barriers arising from bias or structural root causes.[1]

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Mitigating Stigma, Implicit, and Explicit Biases Practices that mitigate implicit and explicit attitudes or stereotypes in favor of or against one person or group compared with another. Biases may influence attitudes and behaviors adversely, leading to discriminatory practices, especially when clinicians and educators are faced with external pressure or limited time.		
1a. Articulates how one's own identities, power, and privileges (e.g., professional hierarchy, culture, class, gender, etc.) influence interactions with patients, families, communities, and members of the health care team	1b. Seeks and acts upon feedback regarding how one's own identities, power, and privileges influence patients, families, communities, and members of the health care team	1c. Role models and teaches how to engage in reflective practices related to individual identities, power, and privileges to improve interactions with patients, families, communities, and members of the health care team
2a. Demonstrates knowledge about the role of explicit and implicit bias in delivery of high-quality care[6]	2b. Identifies and mitigates explicit and implicit biases that occur in clinical decision making[3]	2c. Role models effective strategies to mitigate explicit and implicit biases that may negatively affect clinical decision making[3]

[6] AAMC. Quality Improvement and Patient Safety Competencies Across the Learning Continuum. AAMC New and Emerging Areas in Medicine Series. Washington, DC: AAMC; 2019.

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Eliminating Inequities in Health Care Practices that measurably reduce population-level differences in health outcomes, disease burden, and the distribution or allocation of resources between majority and marginalized groups based on race, ethnicity, sex, sexual orientation, or gender identity, intellectual and developmental ability, socioeconomic, physical (built) environments, psychosocial, behavioral, and health care-related factors.		
3a. Describes the value of working in an interprofessional team, incl patients, to identify and address social risk factors influencing health (e.g., food security, housing, utilities, transportation, etc.)	3b. Works collaboratively with an interprofessional team, including patients, to screen and refer patients for appropriate resources to address social determinants of health	3c. Role models collaborative practices to work with an interprofessional team to address social determinants of health impacting patients and communities
4a. Identifies systems of power, privilege, and oppression and their impacts on health outcomes (e.g., white privilege, racism, sexism, heterosexism, ableism, religious oppression)	4b. Makes collaborative care decisions based upon an understanding about how systems of power, privilege, and oppression influence health care policies and patient health outcomes	4c. Teaches how systems of power, privilege, and oppression inform policies and practices and how to engage with systems to disrupt oppressive practices
5a. Describes how stratification (e.g., by race/ethnicity, primary language, socioeconomic status, LGBTQ identification) of quality measures can allow for the identification of health care disparities[7]	5b. Explores stratified quality-improvement (QI) data for their patient population and uses this data to identify health care disparities[4]	5c. Describes how monitoring stratified QI data can help assess the risk of unintended consequences (e.g., widening the disparity gap). Uses stratified QI data to guide and monitor QI interventions[4]
6a. Explains the role of the health care system in identifying and meeting the local needs of the community (e.g., the role of the Community Health Needs Assessment or Community Health Improvement Plan)	6b. Collaborates with a diverse interprofessional team within one's system and community members to meet identified community health needs	6c. Leads, formulates, or participates in interprofessional partnerships that are designed to improve community health needs

[7] AAMC. Quality Improvement and Patient Safety Competencies Across the Learning Continuum. AAMC New and Emerging Areas in Medicine Series. Washington, DC: AAMC; 2019.

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Practicing Anti-Racism and Critical Consciousness in Health Care Educational and clinical practices that seek to revise and correct local, state, and national policies, institutional practices, and cultural misrepresentations that enable and perpetuate racial bias and race-based health care inequities.		
7a. Describes past and current examples of racism and oppression (internalized, interpersonal, institutional, and structural) and its impact on trust, health, and health care	7b. Engages with the health care team and patients to identify the impacts of racism and oppression and challenges these behaviors and practices in the local setting	7c. Role models anti-racism in medicine and teaching including strategies that are grounded in critical understanding of unjust systems of oppression
8a. Articulates race as a social construct that is a cause of health and health care inequities and not a risk factor for disease	8b. Identifies and corrects misuse of clinical tools and practices that substantiate race-based medicine	8c. Supports and participates in system-level solutions to end racist practices in education and clinical delivery that substantiate race-based medicine
9a. Describes the impact of various systems of oppression on health and health care (e.g., colonization, white supremacy, acculturation, and assimilation)	9b. Collaborates to identify and act upon system level strategies to reduce the effects of various systems of oppression on health and health care	9c. Teaches and examines system level strategies to remedy the impact of systems of oppression on health and health care
Advocating for Equity in Health and Health Care Practices that influence decision-makers and other stakeholders to support or implement system-level policies and practices that contribute to realizing health equity.		
10a. Describes public policy that promotes social justice and addresses social determinants of health	10b. Promotes social justice and engages in efforts to eliminate health care disparities	10c. Leads or participates in organizational and public policy approaches to promote social justice, eliminate health care disparities, and address social determinants of health

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11a. Identifies and, if appropriate, refers patients to relevant community resources that promote health equity and improve the health of local communities and populations	11b. Utilizes resources that support population health improvement strategies (e.g., systems and policy advocacy, program or policy development, or other community-based interventions)	11c. Leads, participates in, or supports interprofessional partnerships with local health departments or community-based organizations to develop culturally responsive interventions

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Domain III: INCLUSION

Refers to how our defining identities are accepted in the circles that we navigate. Belonging evolves from inclusion; it refers to the extent to which individuals feel they can be authentic selves and can fully participate in all aspects of their lives. Inclusion is a state of being valued, respected and supported. At the same time, inclusion is the process of creating a working culture and environment that recognizes, appreciates, and effectively utilizes the talents, skills and perspectives of every employee; uses employee skills to achieve the agency's objectives and mission; connects each employee to the organization; and encourages collaboration, flexibility and fairness. In total, inclusion is a set of behaviors (culture) that encourages employees to feel valued for their unique qualities and experience a sense of belonging.[1]

Medical Student Graduate / Entering Residency **or** **New to DEI journey**	**Resident Graduate / Entering Practice** **or** **Advancing along DEI journey** ***All prior competencies +***	**Faculty Physician / Teaching and Leading** **or** **Continuing DEI journey** ***All prior competencies +***
Fostering Belonginess Practices in the clinical and educational environments that result in individuals feeling valued for their authenticity and intersectionality. These practices create safe spaces to share voices without a fear of retribution, where they can feel validated for multiple identities, and valued for their unique contributions.		
1a. Identifies the practices and values that foster belongingness with a diverse health care team and patient population (e.g., authenticity, respect, and support)	1b. Applies the norms, practices, and values that foster belongingness in partnership with a diverse health care team and patient population	1c. Role models and teaches norms, practices, and values that foster belongingness in partnership with a diverse health care team and patient population
2a. Demonstrates moral courage, self-advocacy and allyship when facing and/or witnessing injustice (e.g., microaggression, discrimination, racism)	2b. Practices moral courage, self-advocacy, allyship, and being an active bystander/ upstander to address injustices	2c. Role models moral courage, self-advocacy, allyship, and being an active bystander/upstander to address and prevent injustices
3a. Seeks mentorship or trusted peers for ongoing consultation and support of professional identity formation, professional development, and well-being	3b. Actively mentors and/or engages with trusted peers for continuous professional development, growth, and well-being	3c. Role models a growth mindset and how to leverage professional networks to enhance professional identity formation, promote an inclusive workplace, and show impact on clinical performance

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Providing Culturally Responsive Patient Care Practices that promote inclusive and collaborative written and spoken communication that helps patients, families, and health care teams understand and actively integrate health care information.		
4a. Describes and demonstrates health literacy universal precautions aimed at supporting all patients' efforts to improve their health[8]	4b. Practices health literacy universal precautions in spoken and written communications with all patients and caregivers[5]	4c. Role models and teaches health literacy universal precautions[5]
5a. Uses language interpretive services to ensure quality and safe patient care	5b. Demonstrates how to work collaboratively with language interpreters to ensure quality and safe patient care	5c. Role models and teaches when and how to integrate interpretive services into practice and teaches alternative strategies to ensure quality and safe patient care
6a. Demonstrates the practice of cultural humility and, when appropriate, provides culturally relevant resources to their patients	6b. Practices cultural humility and, when appropriate, provides culturally relevant resources	6c. Teaches or role models the importance of practicing cultural humility and providing appropriate culturally relevant resources
Advocating for Inclusive Practices and a Healthy and Inclusive Physical (Built) Environment Practices that ensure patients, families, and communities have an equal voice and equal access to services and resources needed for optimal patient care.		
7a. Differentiates between inclusive and exclusive policies and practices within the local health care system to ensure persons from a variety of backgrounds and abilities have equal access to services and resources	7b. Upholds inclusive policies and practices and works to mitigate those that are exclusionary (e.g., reports incidences and suggests improvements) so that persons from a variety of backgrounds and abilities have equal access to services and resources	7c. Actively contributes to creating an environment that ensures persons from a variety of backgrounds and abilities have equal access to services and resources

[8] Brega AG, Barnard J, Mabachi NM, Weiss BD, DeWalt DA, Brach C, Cifuentes M, Albright K, West, DR. AHRQ Health Literacy Universal Precautions Toolkit, Second Edition. (Prepared by Colorado Health Outcomes Program, University of Colorado Anschutz Medical Campus under Contract No. HHSA290200710008, TO#10.) AHRQ Publication No. 15-0023-EF. Rockville, MD. Agency for Healthcare Research and Quality. January 2015.

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8a. Explains how physical aspects of the structural environment can promote or inhibit inclusion	8b. Identifies opportunities to improve the physical/built environment to foster a more inclusive health care environment	8c. Role models how to recognize and implement changes to support a more inclusive physical (built) environment

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Glossary of Select Terms

Many of the terms and definitions used throughout the competencies are listed below. The majority are from, “Advancing Health Equity: A Guide to Language, Narrative and Concepts”. The Guide provides additional background and explanation for the terms below and many others that are not listed.

ableism: “Discrimination of people with disabilities based on the belief that typical abilities are superior. Like racism and sexism, ableism classifies entire groups of people as “less than,” and structures opportunity to advantage some and disadvantage others.”[1]

ally: “Someone who makes the commitment and effort to recognize their privilege (based on gender, class, race, sexual identity, etc.) and work in solidarity with oppressed groups in the struggle for justice. Allies understand that it is in their own interest to end all forms of oppression, even those from which they may benefit in concrete ways.” [1]

anti-racism: “The active process of naming and confronting racism by changing systems, organizational structures, policies and practices and attitudes, so that power is redistributed and shared equitably.” [1]

assimilation (assimilationist): “One who is expressing the racist idea that a racial group is culturally or behaviorally inferior and is supporting cultural or behavioral enrichment programs to develop that racial group with the goal that the group would then be better able to blend within the dominant group.” [1]

class: “Relations of power among networked/ organized social groups that direct society’s major institutions (such as corporations and government authorities), material resources and investments. Classism is the systematic oppression of subordinated class groups, held in place by attitudes that rank people according to economic status, family lineage, job status, level of education and other divisions.” [1]

colonization: “Some form of invasion, dispossession, and subjugation of a people. The invasion need not be military; it can begin—or continue—as geographical intrusion in the form of agricultural, urban, or industrial encroachments. The result of such incursion is the dispossession of vast amounts of lands from the original inhabitants. This is often legalized after the fact. The long-term result of such massive dispossession is institutionalized inequality. The colonizer/colonized relationship is by nature an unequal one that benefits the colonizer at the expense of the colonized.” [4]

culture: “Set of shared attitudes, values, goals and practices that characterize an institution, organization or group. Culture is transmitted and reinforced through tradition, art, language and ritual, among other practices. It has also been defined more broadly as a social system of meaning and custom by a group of people to assure its adaptation and survival.” [1]

disability: “Any condition of the body or mind (impairment) that makes it more difficult for the person with the condition to do certain activities (activity limitation) and interact with the world around them (participation restrictions).” [5]

discrimination: “Treatment of an individual or group based on their actual or perceived membership in a social category, usually used to describe unjust or prejudicial treatment on the

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grounds of race, age, sex, gender, ability, socioeconomic class, immigration status, national origin or religion. Discrimination by default positions some groups to have more advantages, opportunities, resources, protections than others based on a given social characteristic or combination of social characteristics that are differentially valued." [1]

diversity: "Refers to the identities we carry. There are many kinds of diversity, based on race, gender, sexual orientation, class, age, country of origin, education, religion, geography, physical or cognitive abilities, or other characteristics. Valuing diversity means recognizing differences between people, acknowledging that these differences are a valued asset, and striving for diverse representation as a critical step towards equity." [1]

equity: "Refers to fairness and justice and is distinguished from equality. While equality means providing the same to all, equity requires recognizing that we do not all start from the same place because power is unevenly distributed. The process is ongoing, requiring us to identify and overcome uneven distribution of power as well as intentional and unintentional barriers arising from bias or structural root causes." [1]

ethnicity: "Social construct and category based on shared geography, language, ancestry, traditions or history. The boundaries of authenticity (that is, who or what "counts" in recognizing members of an ethnic group) are often changeable and dependent on generational, social, political and historical situations." [1]

experienced faculty physician: A medical doctor who has completed medical school (MD or DO) and residency, has completed at least three years of independent practice, and teaches or supervises learners, either paid or volunteer, full- or part-time.

explicit bias: "The traditional conceptualization of bias. With explicit bias, individuals are aware of their prejudices and attitudes toward certain groups. Positive or negative preferences for a particular group are conscious." [2]

gender: "The social, psychological, and emotional traits, attitudes, norms and behaviors, often influenced by society's expectations, that classify someone as man, woman, both, or neither." [1]

growth mindset: "Individuals who believe their talents can be developed (through hard work, good strategies, and input from others) have a growth mindset. They tend to achieve more than those with a more fixed mindset (those who believe their talents are innate gifts)."[10]

health care inequities: "A measurable, systemic, avoidable and unjust difference in health care access, utilization, quality and outcomes between groups, stemming from differences in levels of social advantage and disadvantage." [1]

health equity: "The absence of avoidable, unfair, or remediable differences among groups of people, whether those groups are defined socially, economically, demographically or geographically or by other means of stratification. 'Health equity' or 'equity in health' implies that ideally everyone should have a fair opportunity to attain their full health potential and that no one should be disadvantaged from achieving this potential." [1]

health literacy universal precautions: "Health literacy universal precautions are the steps that practices take when they assume that all patients may have difficulty comprehending health information and accessing health services."[9]

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health literacy: “Used to describe the ability of individuals to locate, understand, interpret, and apply health information to guide their decisions and behavior” [1]

implicit bias: “Also known as unconscious bias, refers to attitudes or stereotypes that are outside our awareness but nonetheless affect our understanding, our interactions, and our decisions. Researchers have found that we all harbor automatic associations—both positive and negative—about other people based on characteristics such as race, ethnicity, gender, age, social class, and appearance. These unconscious associations may influence our feelings and attitudes and result in involuntary discriminatory practices, especially under demanding circumstances.” [6]

Inclusion: “Refers to how our defining identities are accepted in the circles that we navigate. Belonging evolves from inclusion; it refers to the extent to which individuals feel they can be authentic selves and can fully participate in all aspects of their lives. Inclusion is a state of being valued, respected and supported. At the same time, inclusion is the process of creating a working culture and environment that recognizes, appreciates, and effectively utilizes the talents, skills and perspectives of every employee; uses employee skills to achieve the agency’s objectives and mission; connects each employee to the organization; and encourages collaboration, flexibility and fairness. In total, inclusion is a set of behaviors (culture) that encourages employees to feel valued for their unique qualities and experience a sense of belonging.” [1]

intersectionality: “Leading feminist and social justice theories and practices acknowledge that intersectionality, first coined by Kimberlé Crenshaw, as legal terminology to recognize the unique experiences and legal challenges of Black women, whom as a group experienced both racism and sexism.40 It is the ongoing examination of the overlapping systems of oppression and discrimination that communities face based on race, gender, ethnicity, ability, etc. It is our role to continuously examine the multiple forms and kinds of intersectional exclusions. The call for an anti-racist health care system—one which recognizes and addresses the intersectionality of systems of oppression—amplifies every day.” [1]

LGTBQ: “An acronym for “lesbian, gay, bisexual, transgender and queer.” [7]

marginalized: “Process experienced by those under- or unemployed or in poverty, unable to participate economically or socially in society, including the labor market, who thereby suffer material as well as social deprivation.” [1]

microaggression: “Everyday verbal, nonverbal and environmental slights, snubs or insults, whether intentional or unintentional, which communicate hostile, derogatory or negative messages to persons targeted solely for their membership in historically marginalized groups.” [1]

oppression: “Unjust or cruel exercise of power or authority; the product of injustice. But also, as Iris Marion Young explains, “… the vast and deep injustices some groups suffer as a consequence of often unconscious assumptions and reactions of well-meaning people in ordinary interactions, media, and cultural stereotypes, and structural features of bureaucratic hierarchies and market mechanisms—in short the normal processes of everyday life.” [1]

privilege: “A set of advantages systemically conferred on a particular person or group of people.” [1]

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race: System of categorizing people that arises to differentiate groups of people in hierarchies to advantage some and disadvantage others. Stated another way, race is a social construct or "a symbolic category [actively created and recreated, rather than pre-given], based on phenotype or ancestry and constructed to specific racial and historical contexts, that is misrecognized as a natural category." While often assumed to be a biological classification, based on physical and genetic variation, racial categories do not have a scientific basis." [1]

racism: "Racism is a system of structuring opportunity and assigning value based on phenotype ("race"), that unfairly disadvantages some individuals and communities, unfairly advantages other individuals and communities, and undermines realization of the full potential of the whole society through the waste of human resources" Racism can operate at different levels: structural, institutional, interpersonal and internalized." [1]

- **structural**: "Refers to the totality of ways in which societies foster racial discrimination through mutually reinforcing systems of housing, education, employment, earnings, benefits, credit, media, health care, and criminal justice. These patterns and practices in turn reinforce discriminatory beliefs, values, and distribution of resources" [1]
- **institutional racism:** "Discriminatory treatment, unfair policies and practices, and inequitable opportunities and impacts within organizations and institutions, based on race. Individuals within institutions take on the power of the institution when they act in ways that advantage and disadvantage people, based on race." [1]
- **interpersonal racism**: "The expression of racism between individuals. These are interactions occurring between individuals that often take place in the form of harassing, racial slurs or racial jokes. It may also take more subtle forms of unequal treatment, including micro-aggressions." [1]
- **internalized racism**: "Acceptance by members of stigmatized races of negative messages about their own abilities and intrinsic worth." [1]

role model: "One who serves as an example for others by demonstrating the behavior associated with a particular social position or profession." [4]

sexism: "Discrimination based on sex, typically the belief that cisgender males are inherently superior to all other genders." [1]

sexual orientation: "An inherent or immutable enduring emotional, romantic or sexual attraction to other people. Note: an individual's sexual orientation is independent of their gender identity." [1]

social determinants of health: "Refer to the underlying community-wide social, economic and physical conditions in which people are born, grow, live, work and age. They affect a wide range of health, functioning, and quality-of-life outcomes and risks. These determinants and their unequal distribution according to social position, result in differences in health status between population groups that are avoidable and unfair." [1]

stereotype: "Assignment of assumed characteristics or attributes to the members of a given group (e.g., by ethnicity, nationality, class, or other status/identities). It occurs in a variety of historical representations or expressions that can cause trauma and racial injury by "othering" groups and denying people their individuality, culture and humanity." [1]

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stigma: "Elements of labeling, stereotyping, separating, status loss and discrimination co-occurring in a power situation that allows these processes to unfold." [1]

systems of oppression: "The combination of prejudice and institutional power which creates a system that discriminates against some groups (often called "target groups") and benefits other groups (often called "dominant groups")." [1]

bystander/upstander: "A person who speaks or acts in support of an individual or cause, particularly someone who intervenes on behalf of a person being attacked or bullied." [1]

white supremacy: "Historically based, institutionally perpetuated system of exploitation and oppression of continents, nations, and people of color by white people and nations of European descent for the purpose of maintaining and defending a system of wealth, power and privilege."[1]

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