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Teaching the Legacy of Slavery in American Medicine and Psychiatry to Medical Students: Feasibility, Acceptability, Opportunities for Growth

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Abstract

Introduction: Understanding the legacy of slavery in the United States is crucial for engaging in anti-racism that challenges racial health inequities' root causes. However, few medical educational curricula exist to guide this process. We created a workshop illustrating key historical themes pertaining to this legacy and grounded in critical race theory. **Methods:** During a preclinical psychiatry block, a second-year medical school class, divided into three groups of 50-60, attended the workshop, which comprised a 90-minute lecture, 30-minute break, and 60-minute small-group debriefing. Afterwards, participants completed an evaluation assessing self-reported knowledge, attitudes and beliefs, and satisfaction with the workshop. **Results:** One hundred eighty students watched the lecture, 15 attended small-group debriefings, and 132 completed the survey. Seventy-six percent (100) reported receiving no, very little, or some prior exposure to the legacy of slavery in American medicine and psychiatry. Over 80% agreed or strongly agreed that the workshop made them more aware of this legacy and that the artwork, photographs, storytelling, and media (videos) facilitated learning. Qualitative feedback highlighted how the workshop improved students' knowledge about the legacy of slavery's presence in medicine and psychiatry. However, students criticized the lecture's scripted approach and requested more discussion, dialogue, interaction, and connection of this history to anti-racist action they could engage in now. **Discussion:** Though this workshop improved awareness of the legacy of slavery, students criticized its structure and approach. When teaching this legacy, medical schools should consider expanding content, ensuring opportunities for discussion in safe spaces, and connecting it to immediate anti-racist action.

Keywords

Racism, Slavery, White Supremacy, Health Equity, Anti-racism, Diversity, Equity, Inclusion

Educational Objectives

By the end of this activity, learners will be able to:

1. Recall and define four historical arcs characterizing the legacy of slavery in American medicine and psychiatry: an ideology of racial difference (White supremacy and Black inferiority), the human rights abuses of forced scientific experimentation, Black professional exclusion, and organized medicine and psychiatry's silence regarding racism and injustice.
2. Relate and connect at least one racial health inequity (e.g., the relatively higher rates of maternal mortality, the overdiagnosis of schizophrenia among Black people) to slavery's enduring historical arcs of oppression.
3. Recognize and describe at least one example of the history of forced scientific experimentation beyond the Tuskegee Syphilis Study.
4. Advocate for and support at least one reason why historical knowledge of the legacy of slavery provides the necessary foundation for an anti-racist future in American medicine and psychiatry.

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Introduction

Rationale and Background

America and American medicine have deep historical roots in slavery.[1] Understanding this legacy and how it laid the foundation for contemporary racial health inequities is crucial for implementing meaningful anti-racist practices.[2-6] For

example, Black reparations represent a definitive intervention for the structural racism born from slavery and its aftermath, particularly related to residential segregation, and maintaining persistent Black–White health disparities.[7] Medical students are leading a burgeoning national movement to abolish race-based corrections for medical instruments and clinical algorithms. Race-based corrections perpetuate the scientific racism the medical profession initially constructed to justify slavery and has maintained ever since to sustain White supremacy.[8] They uphold race as a biological, rather than a social, construct and deny people of color appropriate care today.[9] A growing number of national medical organizations are apologizing for their centuries of White supremacist policies and practices. These include overpathologizing Black people and barring them from medicine, while revering White cisheterosexual men as fathers of their professions, despite their innovations' dependence upon torturing enslaved people.[10,11]

Many persistent and worsening inequities stem from the ongoing degradation of Black humanity and suffering and the exaltation of White supremacy that American chattel slavery required over 400 years ago.[12] These include Black maternal mortality, the undertreatment of Black pain, the crisis of Black men in medicine, and White men's domination of medical leadership, policies, and clinical and research agendas.[13-16] Policing and mass incarceration, both of which derive from the slave patrol and the chain gang, continue to wreak havoc on Black lives through family separation, trauma, and the school-to-prison pipeline.[17-19] Their carceral logics pervade medicine through the excessive restraining of Black children, drug testing of Black mothers, and reporting of Black families to child welfare.[20-22] Abolition, a term originally applied to the movement to end slavery and more recently to the movement to vanquish the prison industrial complex, represents an emerging movement in medicine. It reimagines the work of medicine as an anti-racist practice by abolishing practices reinforcing biological race, desegregating the medical profession, demanding reparations for communities devastated by forced medical experimentation, and insisting on longitudinal anti-racism training rooted in the history of racism in medicine.[23,24]

Medical school curricula provide an opportune forum for confronting this history of brutality and its contemporary inequities,[25] while priming the next generation of physicians to challenge it.[26] Unfortunately, no established guidelines or competencies exist regarding how to teach this legacy comprehensively, transparently, and in a way that promotes actionable change. This gap becomes more glaring vis-à-vis the broader national context's mounting recognition of this legacy. The Pulitzer Prize–winning *New York Times* 1619 Project, recently integrated into public education curricula nationwide, provides a key example.[27] This gap widens amidst the growing number of curricula addressing racism in medicine yet failing to expose this history. *MedEdPORTAL*'s own Anti-racism Education Collection features 38 resources teaching anti-racist knowledge and clinical skills, the majority published since 2020.[28] Though several reference the history of racism in medicine, none explicitly examine the legacy of slavery.

The Legacy of Slavery in American Medicine and Psychiatry workshop attempts to fill this void among medical students. Its core themes evolved as part of the 2017 Foundations in Racism curriculum created for child psychiatry fellows and using a small-group discussion format of 12 fellows or fewer.[29] Foundations in Racism emphasizes how slavery and the American Indian genocide shaped racism's many forms, drive contemporary (mental) health inequities, and influence the practice of psychiatry. One of the four lectures features a 60-minute talk about the legacy of slavery in American psychiatry, which recognizes slavery as the DNA for every major American institution, including medicine and health care.[1] Here, we describe how this lecture was expanded to meet the educational needs of medical students at an earlier stage of training and adapted for a large-group lecture format.

Past Implementation (2019): Content Development and Pilot

Content development—book chapter and Foundations in Racism lecture: A book chapter inspired the workshop's conceptualization of key historical arcs: a narrative of racial difference (Black inferiority/White supremacy), scientific experimentation and exploitation, denial of treatment and health care as a human right, Black professional exclusion, and silence about oppression and injustice.[30] The workshop retained several core components from the Foundations in Racism curriculum lecture on the legacy of slavery in American psychiatry. For example, the lecturer (Rupinder K. Legha) began by sharing her positionality as a cisheterosexual daughter of Punjabi-Sikh immigrants, who benefited from the legacy of slavery in their ability to secure a mortgage loan, evade the harms of redlining, and finance her medical education. This disclosure modeled the imperative of situating oneself within the legacy of slavery and cultivating self-reflection to engage in meaningful anti-racism that challenges this oppressive history.[3] Slides featured artwork by Kara Walker, images of people impacted by the legacy of slavery (e.g., Dr. Shalon Irving[31]), and recent events like Trayvon Martin's murder. This artwork and media aimed to

connect learners to this history viscerally and to guard against solely intellectualizing it. The workshop extended Foundations in Racism's exploration of slavery's legacy beyond psychiatry to include other subspecialties and medicine more broadly.[29] Finally, the slides featured multiple key references intended to provide evidence for the content's contentions and to legitimize the multidisciplinary scholarship required to understand it. This strategy emerged based on the lecturer's (Rupinder K. Legha) previous experiences teaching at predominantly White medical schools nationwide, encountering significant resistance to confronting this history, and fielding multiple requests for proof of its veracity.

2019 medical school pilot (in person) and needs assessment: We piloted the Legacy of Slavery in American Medicine and Psychiatry lecture with medical students in 2019 during a 90-minute in-person lecture given to an entire second-year class (180 students) as part of their psychiatry preclinical block. Student course evaluations were overwhelmingly positive. Several commented that it was the "best," "most impactful," and "most important" lecture they had ever attended in medical school. We observed that students were emotionally moved, wanted to process the content, and appreciated the lecturer's (Rupinder K. Legha) highly interactive approach. Faculty leading the 60-minute standard small groups of 10-12 students following the lecture did not feel equipped to help students process. Some faculty criticized the pilot, suggesting the lecture harmed students by confronting how their White privilege facilitated their journey to medical school while revealing how centuries of anti-Black racism created inordinate obstacles for their Black classmates. Additional anecdotal feedback from a half dozen racially diverse medical students recommended setting an appropriate tone for engagement, removing graphic images of lynchings and massacres, making this history relevant to contemporary practices, adding a break after the lecture, and organizing skilled facilitation of small-group discussions.

Methods

Content Revision

The 2020 content (Appendix A) retained the major historical arcs of oppression highlighted in the 2019 lecture while incorporating the aforementioned feedback. It established critical race theory as its guiding conceptual framework, highlighting racism and White supremacy's omnipresence and ordinariness in American society, including medicine and psychiatry; emphasizing the importance of race consciousness to acknowledge racism's workings in one's personal life; and underscoring race's social construction fueled by scientific racism.[2] To make the history more relevant to contemporary health care, we incorporated scholarship pertaining to historically informed anti-racist clinical practices.[3,5] We also noted recent events, like nurse Dawn Wooten's whistleblowing of the forced sterilizations taking place at Immigration and Customs Enforcement detention centers in 2020,[32] and expanded the contemporary correlates for each historical arc.

Setting

The 2020 lecture switched from in-person to Zoom format due to the COVID-19 pandemic. To ensure engagement and respect for the content, the lecture opened by asking learners to put phones and other electronics away and to turn on their cameras. Learners were second-year medical students participating in their required psychiatry preclinical block 1 week before the 2020 presidential election. Based on feedback from the 2019 pilot, the workshop team planned to follow the 90-minute lecture with a small break followed by small-group discussions lasting 60-75 minutes. The lecturer (Rupinder K. Legha) anticipated supervising small-group facilitators composed of 12 pairs of residents and faculty well versed in anti-racism. We created a discussion guide (Appendix B) to help these facilitators lead racial affinity groups[33] consisting of 10-15 medical students. In the weeks leading up to the workshop, however, medical school leadership expressed significant concern for students' emotional well-being related to the stress and anxiety of the election and the racism surrounding it.[34] Apprehensive about the risk of traumatization, they canceled the small-group discussions. Instead, they permitted hosting office hours after the lecture at which small groups of students could elect to dialogue with two of the authors (Rupinder K. Legha, Misty Richards) and other faculty. Based on feedback from the previous year, the workshop transpired at the end of the day so that students would not have to transition into other classes or clinical responsibilities afterwards. Rupinder K. Legha and Misty Richards invited faculty leading the standard small groups to watch the lecture, though few expressed interest in receiving formal training to advance their own professional development.

2020 Pedagogy Revision and Implementation

We formally implemented the workshop over the course of 3 days in November 2020. Groups of 50-60 second-year medical students attended a 90-minute slide-based lecture (Appendix A) via Zoom or watched the recording. Due to medical school leadership's concerns regarding the provocative nature of the content and the upcoming election, we made the lecture completely didactic, with no pauses to discuss the content, and offered office hours after the lecture as the sole opportunity

for discussion. Only a small number of students (15 out of 180) attended the three sets of office hours.

Learner, Lecturer, and Small-Group Facilitator Prerequisites

We did not require prerequisite knowledge for students but assumed some basic knowledge about racism and White supremacy's definitions (Appendix A, slide 2). We also encouraged learners to scaffold this content amidst other discourses, like anti-racist clinical care and reparations as a public health intervention (Appendix A, slide 2). The week before the workshop, we sent an informed-consent email explaining the content's provocative nature, offering mental health support as needed, announcing lecture attendance and office hours as optional, recommending two brief prereadings (Appendix C),[35,36] and suggesting two videos as additional resources (Appendix D).[37,38] This informed-consent process developed in direct response to the 2019 implementation, when students reported feeling caught off guard by the lecture's gravitas and emotional impact. The lecturer (Rupinder K. Legha) was a child psychiatrist who had written and spoken extensively about racism, anti-racism, and White supremacy as they pertain to health care and had developed culturally responsive medical education curricula in diverse settings worldwide.

We recommend sending learners the prereadings, suggested videos, and an informed-consent communication (Appendices C and D) the week before the workshop. Prerequisites for teaching the didactic content and supervising the small-group facilitators include content expertise about slavery, racism, anti-racism, and related topics; skills including critical consciousness, positionality, and facilitating meaningful racial dialogue[2,39,40]; and support and allyship to traverse barriers and process challenges (Appendix E). Lecturers should feel comfortable teaching the material in an organic, nonscripted manner. Anticipating frequently asked questions (Appendix E) can facilitate this process. We suggest 90-120 minutes for the lecture to allow for interaction and discussion, followed by a short break lasting 15-30 minutes and small-group discussions led by pairs of facilitators and lasting 60-75 minutes. We advise forming racial affinity groups of 10-15 medical students led by small-group facilitators who have reviewed the guide and fulfilled prerequisites related to exploring positionality, racial identity development, and stage of anti-racism journeys (Appendix B). The lecturer teaching the didactic content should meet with the small-group facilitators one to two times before the workshop to discuss the questions and to practice moderating them. After the workshop, we recommend distributing the slides and small-group facilitator guides to students so they can continue to reflect and explore resources.

Evaluation and Data Analysis

Because students' anecdotal feedback for the 2019 lecture was so impactful, we developed a survey to solicit more formal feedback from the entire medical school class in 2020. This evaluation aimed to assess the workshop's benefits and areas of improvement and to share generalizable results regarding how to optimize teaching this legacy of slavery to medical students nationwide. The postworkshop survey (Appendix F) asked participants to define the extent to which they had studied the legacy of slavery in American medicine and psychiatry prior to attending the workshop (1 = *very little or not all,* 5 = *extensively*). It solicited students' level of agreement with various statements before and after the workshop (1 = *strongly disagree,* 5 = *strongly agree*) and included self-rated competency with workshop objectives (Kirkpatrick level 1: reaction[41]). It assessed key teaching strategies' importance for learning. Finally, through free-text responses, it queried participants' overall impressions and feedback to improve the workshop. The two open-ended questions generated 143 narrative notes that were analyzed using content analysis (64 for question 6, 79 for question 7). Key concepts were coded into discrete categories by theme and subtheme. Two independent coders performed data reconciliation and then discussed and reconciled discrepancies in coding. Analyzing these free-form notes strove to uncover students' feedback about the data in order to improve the workshop and generalize its implementation to other settings. The University of California, Los Angeles, Office of the Human Research Protection Program determined that this project met the criteria for an exemption from IRB review.

Results

One hundred eighty second-year medical students completed the Legacy of Slavery in American Medicine and Psychiatry workshop, of whom 132 (73%) filled out the survey. Of these respondents, 55 (39%) were Asian or Pacific Islander, 17 (12%) were Black or African American, 38 (27%) were White/Caucasian not of Hispanic/Latinx descent, 22 (16%) were Hispanic/Latinx, and four (3%) identified with a racial categorization beyond what was provided. There were no American Indian/Alaska Native, Native Hawaiian, or other Pacific Islander respondents, and five (4%) chose not to disclose their racial/cultural identification.

Seventy-six percent of respondents reported no or some experience of having studied the legacy of slavery in American medicine and psychiatry prior to the workshop (Figure 1). Using the Kruskal-Wallis test, we found a statistically significant increase in participants' self-reported awareness across all domains (Kirkpatrick level 1: reaction; Figure 2). Of the three domains,

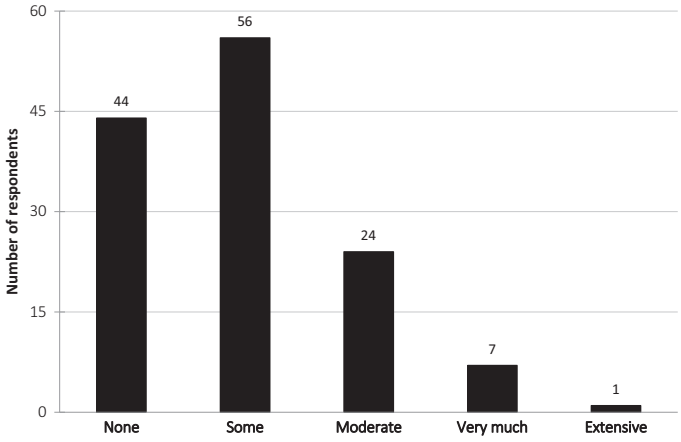

Figure 1. Extent of studying the legacy of slavery in American medicine and psychiatry prior to attending the workshop (survey question 1).

91% of respondents agreed or strongly agreed that art, photo, storytelling, and media were important for content learning (Figure 3A). Ninety-four percent either agreed or strongly agreed that this content was important for medical education and faculty development and that they desired to learn more about this topic (Figure 3B).

Two major themes emerged from the free-form questions (Table). One pertained to the lecture's impact (45% of total responses) in terms of acquiring knowledge, provoking a strong reaction, inspiring duty or action, or confirming what learners already knew. The other highlighted ways to improve it (55% of total responses) in terms of delivery and content.

Improved knowledge, the first impact subtheme (29% of total responses), included increased self-reported awareness of racism's magnitude in medicine (8%), scientific experimentation beyond the Tuskegee Syphilis Study (5%), the long history of racism in medicine resulting in contemporary health disparities (5%), why Black Americans do not trust the health care system (5%), and racism's presence in organized medicine (2%). Within the impact subtheme of provoked a strong reaction (12% of total responses), examples included hope and gratitude for the content (6%), sadness and disappointment regarding racism's magnitude (4%), and criticism and disdain for the workshop (2%). Examples for the third impact subtheme, inspire a sense of duty or action (11% of total responses), highlighted the need for action to challenge (5%) or learn more (5%) about the legacy of slavery. Eight percent of responses indicated that the content, while important, did not change the respondent's knowledge or awareness. Rather, it confirmed what they already knew, which served as the fourth impact subtheme.

For the 55% of total responses focused on how to improve the workshop, delivery (38%) and content (22%) emerged as subthemes. Regarding the delivery subtheme, 13% of total responses criticized the lack of opportunity to engage in (small-group) discussion; 11%, the scripted nature of the talk; and 10%, its didactic/noninteractive approach. Four percent of total responses suggested integrating and expanding this content in the medical school curriculum longitudinally and introducing it earlier. Regarding the content subtheme, 7% of total responses advised including more perspectives of patients and Black people; 7%, more content through additional lectures and videos; and 6%, more examples of anti-racist action they could engage in right away. Several comments offered praise and advised that no changes be made at all, the third improvement subtheme.

Discussion

To our knowledge, this workshop represents the first medical educational effort to teach the legacy of slavery in American medicine and psychiatry to medical students. Organized medicine increasingly recognizes how foundational this legacy is for challenging health inequities,[11] yet few prior examples of integration into medical school curricula exist.[23] The workshop demonstrated that covering this vast history in a 90-minute lecture is feasible, including when using a virtual format, and that this format can heighten students' self-reported knowledge and awareness of slavery's historical arcs of oppression, particularly related to forced scientific experimentation other than the Tuskegee Syphilis Study and how a narrative of racial difference influences diagnosis and treatment. Medical students' limited exposure to this legacy prior to attending this workshop reinforces the urgent need to address this educational gap. Similar to the 2019 pilot, medical students overwhelmingly endorsed its significance for their medical education, emphasized the need for faculty development, and requested learning this content earlier in the training and expanding its presence in their medical education curriculum. Our qualitative findings suggest that understanding the legacy of slavery can facilitate anti-racist action by inspiring learners to challenge it or learn more about it.

Students criticized adjustments medical school leadership made in response to the 2020 presidential election and students' related distress, specifically, eliminating small-group discussions and interaction during the lecture itself. Students from the 2019 pilot emphasized how impactful the material was because of these elements. Collectively, these findings indicate how crucial dialogue, discussion, and reflection are for this material. The survey yielded important data about the workshop's benefits and

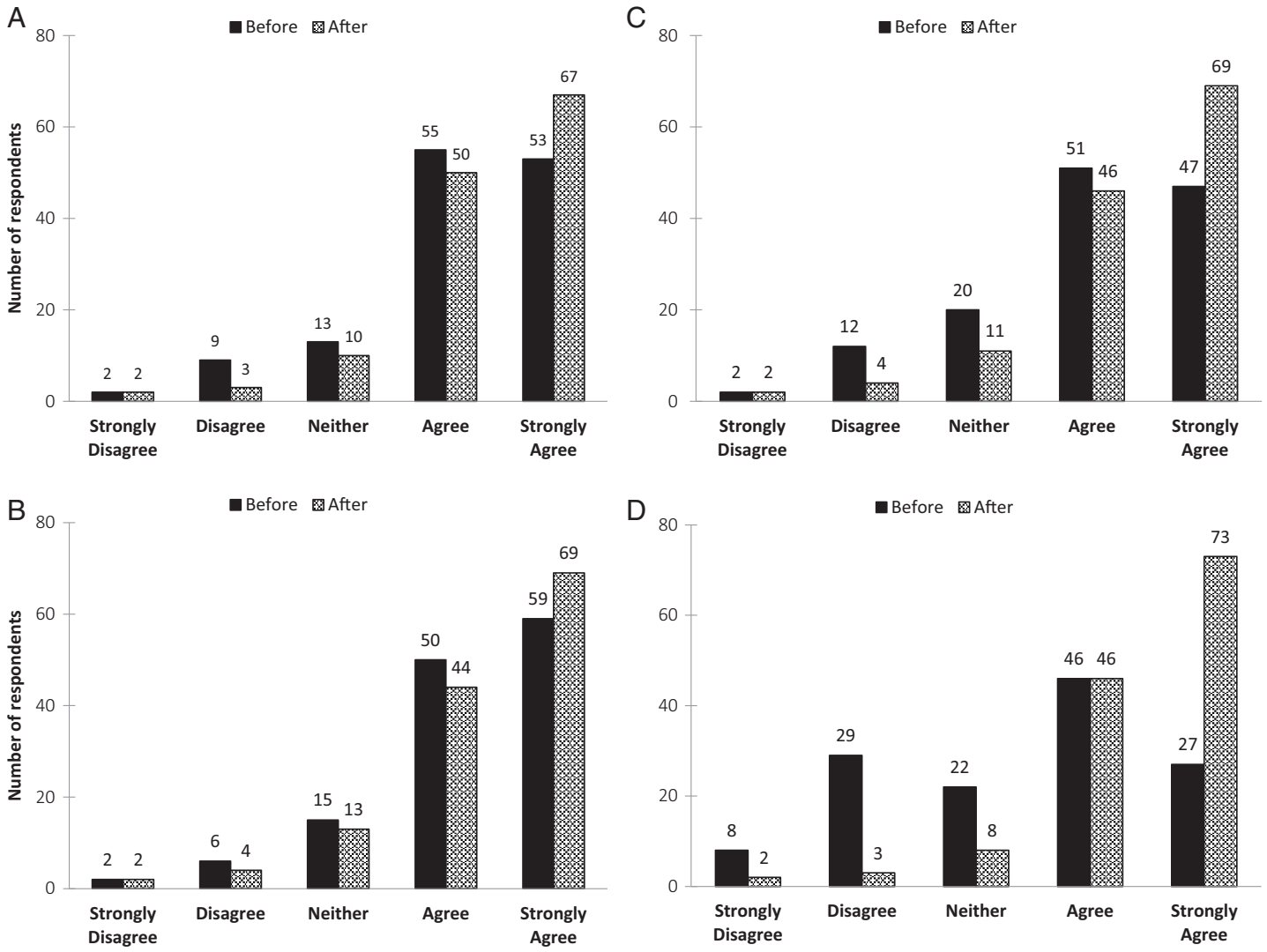

Figure 2. A: Awareness that slavery produced a legacy of racism and brutality that shapes contemporary health inequities and structural racism (survey question 2). B: Awareness that legalized segregation and state-sanctioned violence (e.g., lynching) contribute to structural racism (survey question 3). C: Awareness of how a narrative of racial difference (White supremacy and Black inferiority) influences diagnosis and treatment (survey question 4). D: Awareness of the history of scientific exploitation beyond the Tuskegee Syphilis Study (e.g., J. Marion Sims, forced sterilization campaigns, fenfluramine study; survey question 5).

areas for improvement. However, it did not adequately assess the workshop's primary learning objectives, in part because it gauged students' perceptions of their knowledge and awareness.

Prior sessions related to this workshop revealed how self-disclosure of positionality, expert facilitation of racial dialogue, transparency regarding histories of oppression, and visually engaging media were particularly impactful elements. The 2019 pilot also demonstrated faculty's overall early stage of White racial identity development characterized by obliviousness to racism, refusal to acknowledge injustice, and inability to recognize one's own White racial dominance.[40] As a result, we retained these impactful elements in the workshop and focused on implementing small process groups facilitated by individuals with expertise in anti-racism. Unfortunately, the primarily didactic approach, which stemmed from administrative concerns about risk of traumatization, served as the primary shortcoming, preventing more interaction and small-group discussion. An important lesson learned involves the reservations, discomfort, and resistance medical schools might have in response to this material. For this reason, individuals teaching this content need administrative support, allies, and strategies for traversing barriers as a team so no individual is singled out. Our qualitative findings also demonstrated that students have strong opinions

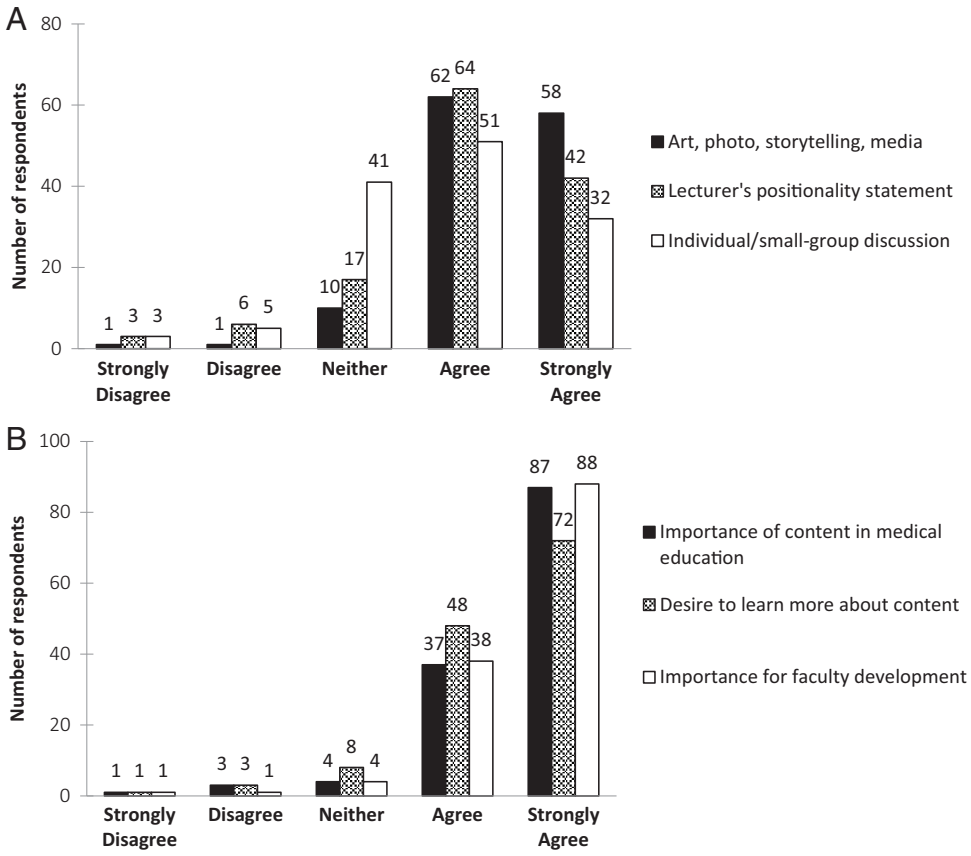

Figure 3. A: Importance of various workshop elements for learning. B: Overall impressions.

about how to teach this content. The facilitator prerequisites we established draw upon these lessons (Appendices B and E).

These limitations, challenges, and key findings offer guidance for medical schools seeking to pilot and disseminate content confronting violent histories of slavery and colonization. Visually engaging media (e.g., artwork, photos, and video clips) enliven this history. Disclosing positionality situates lecturers within the racism, White supremacy, and other matrices of oppression they are teaching and models for learners how to do the same. Teaching examples of forced scientific experimentation beyond the Tuskegee Syphilis Study can leave a particularly strong impression on learners (see Harriet Washington's *Medical Apartheid*[42] and Vanessa Gamble's scholarship[43]). Lecturers focusing less on perfecting their delivery and more on interacting with learners by welcoming questions and feedback in real time may engage learners more. However, chat features, polls, and inviting people to raise their hands to speak provide opportunities for interaction if a virtual platform is used. Regardless of mode of delivery, discussion and processing are crucial, and medical schools should consider racial affinity small groups.

We encountered significant resistance rooted in White supremacy, and it surprised, humbled, and taxed us. We received support and solidarity from allies who prevented this effort from ending before it could begin. We were pleasantly surprised by our findings that medical students wanted a broader range of perspectives. A racially diverse team of educators including clinicians, historians, and community members could supplant a single physician teaching the content. Because medical students are eager to connect this history to clinical and other contemporary practices, a multidisciplinary approach is crucial for making this history salient to contemporary anti-racism efforts. Medical schools need faculty development to support not only expertise in this content, which involves social sciences and biomedicine, but also skills with guiding meaningful racial dialogue.[39] Teaching the legacy of slavery calls for a self-reflective practice that unpacks how this legacy shapes our own lives as much as it shapes inequities. Students ask difficult

Table. Results of Open-Ended Queries About Workshop's Impact and Ways to Improve It, December 2020-January 2021[a]

Theme	Subtheme	Secondary Subtheme	Frequency	%	Example/Key Quote
Impact			64	45	
	Improved knowledge		41	29	
		Racism's magnitude in medicine	12	8	"Before the workshop, I recognized that racism in medicine existed [but] I had no idea how deep or systemic it really was. Thank you for informing me."
		Scientific experimentation beyond Tuskegee	9	5	"I did not know about [J. Marion Sims'] experimentation on females in the Ob/Gyn area. This really struck me and will always stay with me."
		Long history of racism in medicine (resulting in disparities)	8	5	"I was aware that these disparities existed, but it was helpful to have a more specific framework of how they developed."
		Why health care is untrustworthy for Black Americans	7	5	"There were a lot of historical aspects I was unaware of that still currently feeds into the distrust African Americans have of physicians."
		Racism among organized medicine	3	2	"It taught me how medical authority organizations (like the AMA) perpetuated racist beliefs and practices for their own monetary and social benefit."
	Provoked a strong reaction		17	12	
		Hopefulness; gratitude/praise for the workshop	8	6	"It was powerful to learn more about this specific history.""Thank you for putting this workshop together. It is a challenging topic to discuss, and I really appreciate the thought and sensitivity that went into this lecture."
		Sadness/disappointment about racism's magnitude	6	4	"Made me sad that it exists but I realize that continued exposure to this topic will help me challenge my biases."
		Criticism/disdain for the workshop	3	2	"It felt like [the medical school] was merely checking a box to fulfill their anti-racist 'quota.'... It would have been helpful to hear from actual Black patients [about] their experiences or Black experts in the field.... We can do better, please."
	Inspired a sense of duty or action		16	11	
		The need for action to challenge this legacy	9	5	"It highlighted... how it is a duty for all of us in positions of power to do everything we can to rectify this [history].""Helped me see that we have work to do."
		Plan to learn more about the legacy of slavery	7	5	"After this lecture, I started to read *Medical Apartheid* to learn more about racism + slavery in medicine.""Left me wanting more."
	No change/ confirmed what I already knew		11	8	"While this workshop did not change my perception of racism in medicine, I do think it is essential that anyone who enters this field is educated on the topic."
How to improve			79	55	
	Delivery		54	38	
		Need for (small-group) discussion	18	13	"There was no attempt to open the session up to a larger discussion... which I think diluted the impact of the session and was a great disservice to the students.""Small group discussions would be helpful too. I think I learn a lot from talking with my classmates about these topics."
		The lecturer was too scripted	16	11	"I know there is a lot of sensitive material to cover and the lecturer wants to make sure to get everything right. She was very knowledgeable. However, most of the talk seemed like it was directly being read from slides. It would feel more natural, passionate, and personal if some of the talk wasn't communicated verbatim."
		Make the lecture more interactive (e.g., quizzes/polls, discussion during lecture, storytelling, in-person not Zoom format)	15	10	"Should be in person, Zoom does not do it justice.""I think honestly this lecture was very much impacted by the fact that it was held over Zoom.... I think [the lecturer's] passion for the subject didn't really shine through because she was so nervous. I think engaging the audience is one of the quickest ways to make an impact on them, and passion and fire in your tone catches people's attention. Hopefully next year this presentation can be held live."
		Integrate content into the curriculum and introduce it earlier	6	4	"This should be an introductory lecture at the start of medical school [and] should be longitudinal, not a one-off."
	Content		32	22	
		More perspectives (patients, Black people)	10	7	"I think sharing several Black patients' stories from their voices would help students (especially non-Black students) better understand what it feels like to navigate health care as a Black patient."
		More content (multiple lectures, history, videos)	10	7	"I would have also liked to see a talk or afternoon session on the impacts of Latinx, Native American, and Asian/Pacific Islander identity and race on health delivery and outcomes since I know that a lot of cultural biases and racist notions still pervade in these groups as well. I thought it was excellent that this session was part of our mandatory curriculum. I have attended a couple lunch talks on, for example, Latino and Asian experiences with medicine, but since these were smaller talks and not attended by every student in the class, the reach they had was not as great."

(*Table continues*)

Table. (*continued*)

Theme	Subtheme	Secondary Subtheme	Frequency	%	Example/Key Quote
		More examples of immediate anti-racist action	8	6	"I wish there was more content on what I could actually DO (as a white individual) to make things better for my patients and peers of color. I honestly felt a little depressed and hopeless afterwards, but I know I needed to face the true reality of racism in medicine as I had not done that before."
		Less sanitized, more critical	2	1	"This lecture was way too 'sanitized'[.] I understand that the presenter was trying to be sensitive about language and ensure that students of color were not exposed to potentially triggering imaging or statements while also making sure that the facts were presented. However, I think that her deliberateness left little room for exploration of the nuances inherent in the topic at hand. In addition, the format (reading directly from pre-written documents) made the session much more dull than it could have been."
	Praise/no change		8	5	"It was a powerful and wonderfully delivered session!"

[a]Survey respondents provided a total of 143 discrete responses.

and surprising questions and can be critical of teaching efforts, as our qualitative results demonstrate. However, anticipating and engaging these difficult questions (consult Appendix E's Frequently Asked Questions From Learners) can foster collectivity and encourage students to repair this history. Cultivating the faculty expertise necessary for expanding this content through all 4 years of medical school requires extensive workforce development. Faculty of color need protection from their institutions because confronting this history is painful, innovating this content is difficult, and fearing retribution if students have a strong response compounds minority taxation. Our prerequisites for lecturing and facilitating (Appendix E)—knowledge, skill, and support—offer three focal points to facilitate such faculty development and support.

As medical organizations continue to atone for their histories of racism and medical students increasingly demand anti-racism in medical education,[11,44] medical schools must innovate curricula that highlight these histories to prepare the next generation of physicians to challenge them.[45] This project, the first to explore the feasibility and acceptability of teaching medical students about the legacy of slavery in American medicine and psychiatry, offers important lessons regarding necessary elements for disseminating this content. Future studies might explore the impact of small-group discussions, the risk of traumatization—real or imagined—when confronting this history, the competencies and skills medical educators need to teach histories of oppression, and medical schools' resistance to uncovering and repairing their legacies of racist harm.

Appendices

A. Legacy of Slavery Slides.pptx

B. Small-Group Facilitator Guide.docx

C. Prereading and Guide.docx

D. Suggested Readings.docx

E. Facilitator Prerequisites.docx

F. Workshop Survey.docx

All appendices are peer reviewed as integral parts of the Original Publication.

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