

MEDICAL EDUCATION: PEER-REVIEWED ARTICLE

How Should We Discuss Inequity and Iatrogenic Harm in Academic Health Centers?

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Abstract

Discussing errors and quality improvement is a tradition in academic health centers, particularly in morbidity and mortality conferences embedded in surgical training and during teaching rounds. Little, if any, attention is typically given to iatrogenic harms from structural racism, however. This article canvasses ways in which training programs recognize and address health care-generated harm from inequity and identifies areas for improvement.

Cultural Dexterity

Over the last decade, the #BlackLivesMatter movement has brought wider acknowledgement of both the deleterious effects of racism on the lives of Black Americans and pervasive structural racism in nearly every aspect of American life.¹ In response to this increased impetus for social awareness, many have committed to combating racism, including those in health care. Academic medical centers have made noticeable efforts to mitigate the impact of racism on their patients' clinical outcomes through education. Such efforts have ranged from curricula designed to expose implicit biases to integration of "cultural dexterity skills" into clinical competency tracking.^{2,3} These efforts are in their infancy; although some studies have shown that implicit bias is related to patient outcomes,⁴ support for specific interventions, such as implicit bias training, is scant. While curricula designed to address racism in health care are relatively new, a long-standing "hidden curriculum" that perpetuates inequalities has been described and targeted as an area of improvement.^{5,6} Given these obstacles, it is not surprising that little attention is given to how **academic medical centers** troubleshoot and discuss iatrogenic harm resulting from structural harm, including racism. In this paper, we discuss initiatives and potential areas of improvement for recognizing and addressing health care-generated inequity, particularly in physician training programs.

Health Equity in Academic Health Centers

Bias training. Academic health centers as a whole have inconsistently played a role in health equity initiatives.⁷ However, in recent years, many health care providers have issued statements acknowledging the patient harms that result from health inequity.⁸ As a result, academic centers are experiencing pressure to reckon with how they might cause or exacerbate such inequities. Here, we aim to describe current strategies by

which academic health centers identify and discuss iatrogenic harm and inequity. It is unclear which strategies, if any, are associated with improving patient outcomes.⁴

Morbidity and mortality conferences. Discussion of medical error is a tradition in clinical education.⁷ For both surgical and medical trainees, the Morbidity and Mortality (M&M) conference has been a mainstay of conversations concerning adverse patient outcomes and patient safety and quality improvement initiatives.⁹ Although there are diverse formats, a common strategy is for trainees to present patient complications to an audience that asks questions regarding decision making and management.¹⁰ In the authors' experience in the field of surgery, M&M conferences tend to address a specific clinical detail in a way that is divorced from the patient who is experiencing the injury or illness. Complications are attributed to causes such as the natural history of a disease, technical error, or error in judgment. Far less often do these conversations address how a patient's outcome may be affected by their identity and the system as a whole.

Some have recognized the potential for utilizing the M&M platform for health equity initiatives. Harris et al's Cultural Complications Curriculum was developed in the context of academic surgical training.¹¹ This curriculum discusses cultural complications experienced by patients, or harm engendered by racism, sexism, and homophobia. The curriculum has gained traction within a wide range of academic training programs. Benefits cited in integrating such discussions on inequity into M&M conferences include their structured, **longitudinal format** and the requirement for the entire department to attend, which distributes the onus of pursuing health equity among both faculty and trainees.^{11,12}

Rounds. Another strategy for discussing iatrogenic harm and inequity in health care is Capers et al's "bias and racism rounds," teaching sessions that facilitate documentation and critical review of patient-clinician interactions in a format akin to teaching clinical medicine.¹² This format differs from M&M in its smaller scale and multidisciplinary nature; participants include a team of nurses, social workers, medical trainees, and faculty physicians caring for patients within a clinical unit. Similar to Harris's curriculum, this platform troubleshoots circumstances in which racism adversely affects patient outcomes by facilitating discussion of individual real-life patient cases that are flagged for discussion. An outcome of interest is the "elimination of discretion," a bias mitigation strategy in which limits are placed on the freedom of clinical decision makers. Important decisions for the patient are made by a group of people that "check" one another's clinical judgment. This strategy ensures that multiple team members are asking questions about whether bias was present or caused harm in a given patient scenario. For example, the authors describe the case of an elderly Hispanic patient whose recurrence of chronic myeloid leukemia was assumed to stem from medication nonadherence; as a result, he did not receive appropriate work-up for medical causes of chemotherapy-refractory cancer.¹² In discussion of this case, rotating trainees and professionals exercise bias mitigation strategies in real time by asking themselves and one another how racism or other forms of bias affected the patient's outcome. Advantages of this model include its convenience in providing regular anti-bias training in a clinical curriculum and its improvement of care delivery for patients of clinicians who undergo the training.

Pitfalls in Health Equity Education

Based on examples we identified of existing curricula that discuss iatrogenic harm and health equity, we make the following observations. First, documented interventions with

measured outcomes are few and far between. Among the educational strategies we found, there was minimal solicitation of patient perspectives to troubleshoot inequity and iatrogenic harm. Understanding inequity in clinical encounters is incomplete without this perspective. At the same time, care must be taken to avoid placing the onus of solving inequity on those who are most affected by it. For example, many strategies, such as recruitment and mentorship of trainees, rely heavily on the labor and involvement of physicians of color, particularly Black physicians.¹³ We must also take care to incorporate into our work the experiences of patients in communities most affected by racial inequity—this involvement presents a unique burden that unaffected or lesser affected counterparts do not shoulder. While inclusion is challenging, an ideal strategy would balance the perspectives of clinicians, patients, and communities.

Second, overturning racist practices remains challenging even when they are acknowledged and identified. For example, the use of **race-based calculators** in routine clinical practice and teaching has led to sustained and widespread appeals from students, residents, and faculty at multiple institutions across the country to abandon such tools.^{14,15} The resistance encountered as part of these efforts suggests that there are significant barriers to promoting health equity in medical education. A qualitative study piloting antiracist curricula at one medical school found that students believed bias training to be hypocritical and ineffective in the absence of corresponding faculty and institutional actions, which have more weight in effecting changes in clinical practice.¹⁵ Distributing responsibility for health equity across all levels of the clinical hierarchy remains challenging even in formats such as the Cultural Complications Curriculum, which intentionally engages all members of the academic hierarchy.¹¹ While the curriculum is centered on inequity, the presence of high-ranking faculty may intimidate younger members from participating and subsequently critiquing iatrogenic harm.

Conclusions and Recommendations

Multiple formats exist for troubleshooting iatrogenic harm. In our view, discussing racism and structural harm as a form of medicine-generated inequity is essential for medical education. Achieving justice within the health care system demands a sustained effort that takes into consideration diverse perspectives and requires introspection at all levels. Given academic medicine's newfound interest in incorporating health equity in mainstream programming, new ideas and means of discussing iatrogenic harm will likely continue to emerge in the near future. Structural racism is being challenged in a multitude of settings,¹⁶ and we will continue to monitor academic health centers' various responses to and roles in these movements. An ideal strategy for mitigating iatrogenic harm due to racial bias and structural racism would (1) incorporate perspectives of clinicians and patients, (2) aim for tangible changes in individual and institutional roles in perpetuating inequity, (3) develop evidence-based interventions for monitoring the progress of such changes, and (4) allow for safe and open discussions of iatrogenic harm as a structural entity that changes patient outcomes.

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