AMA Journal of Ethics®
January 2024, Volume 26, Number 1: E36-47

MEDICAL EDUCATION: PEER-REVIEWED ARTICLE

Using Critical Pedagogy to Advance Antiracism in Health Professions Education

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Abstract

This article draws on Paulo Freire's *Pedagogy of the Oppressed* to model how health professions education can advance health equity. It first introduces 3 well-known frameworks that can be meaningfully applied as critical pedagogy: structural competency, critical race theory, and participatory action research. It then highlights applications of these frameworks that can prepare trainees for reflection and action that motivate health equity.

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Status Quo in Health Equity Education

Comprehensive health equity and antiracism teaching are neither commonplace nor standardized within health professions education.[1,2,3,4] Curricula purportedly focused on health disparities and social determinants of health often conceptualize social and structural adversity as individual risk factors without considering politico-economic contexts,[5] prioritize reductionist biomedical frameworks over theories grounded in lived expertise,[6] perpetuate problematic narratives about race and class,[7] and feign neutral objectivity in the face of explicit and engineered oppression.[8] When presented, equity-related content and institutional policies are often limited to describing the outcomes of structural oppression without encouraging action or seeking to develop skills to intervene.[6,9,10,11] Ivory tower curricula on health inequities and social determinants are commonly devised *for* students and *for* communities rather than *with* students and *alongside* communities.[12,13,14,15] These practices reinforce a status quo in health professions education that ignores hyperlocal contexts and results in poor learner engagement, adverse learning environments, impaired academic performance for minoritized trainees,[16] and tensions between academic medical centers and the communities they serve.[17]

In research and education, structural racism often remains unnamed as a key driver of health inequity; race is also frequently essentialized as a biological rather than a sociopolitical risk factor.[6,10,18,19,20] Health professions training programs and institutions are racialized organizations, yet they regularly do not explicitly name structural racism or

intervene on its effects on recruitment, retention, evaluation, or segregation within the learning environments.[11,21,22,23,24,25,26,27]

Actions-Oriented Teaching and Learning

To advance antiracist health professions education and teach health professionals to intervene on inequities, a paradigm shift is needed. Paulo Freire's *Pedagogy of the Oppressed* guides us toward this end. Freire defines the ideal outcome of education as praxis—"reflection and action upon the world in order to transform it"[28]—by recontextualizing Aristotle's original definition of *praxis* as the "theory-informed best action in a given situation."[29] In contrast to the traditionally passive, unidirectional pedagogy through which the educator shares "facts" that students must absorb, Freire advocates for a problem-proving approach wherein both educators and students recontextualize their thoughts together.[28] This approach to learning is analogous to the team-based, nonhierarchical decision-making process that should be ubiquitous in interprofessional clinical team work.[30,31] The endpoint of Freirean philosophy is tangible: "discovery cannot be purely intellectual but must involve action; nor can it be limited to mere activism, but must include serious reflection: only then will it be a praxis."[28] In sum, Freire defines fundamental objectives in motivating learners to (1) examine structural underpinnings of inequity, (2) understand how their roles intersect with them, and (3) feel emboldened to work against oppression as critical pedagogy.[28,32] A reorientation toward antiracist action is an ideal solution for medical education's approach to health inequity that has focused much on description but little on skills required to act.[33]

Educating for Action

To advance health justice, educational content discussing health inequities must be contextualized within frameworks that promote critical analysis of existing systems and motivate redress. Structural competency, critical race theory (CRT), and participatory action research (PAR) are 3 existing content frameworks that can be used to implement critical pedagogy.

Structural competency: attending to upstream political determinants. Structural competency emphasizes recognizing the structural and systemic forces that affect a patient's health.[34] In contrast to cultural competency, which emphasizes mitigating the interpersonal stigma and biases that clinicians might bring to patient encounters,[35,36] structural competency underscores how upstream policies and infrastructure—such as food security, zoning laws, and transportation access—contribute to downstream inequities.[37] Five core competencies have been proposed by Metzl and Hansen: "1) recognizing the structures that shape clinical interactions; 2) developing an extra-clinical language of structure; 3) rearticulating 'cultural' formulations in structural terms; 4) observing and imagining structural interventions; and 5) developing structural humility."[34] A praxis-driven approach to structural competency requires exposure to methods, perspectives, and case studies that address health injustice at a structural level.[38,39] With this in mind, resources such as the *New England Journal of Medicine* series, "Case Studies in Social Medicine," can be used to ground structural analyses in clinical circumstances that health professions trainees are likely to encounter.[38] Structural competency curricula need not be separate from regular biomedical curricula; rather, they should be used in tandem. For example, social medicine cases on occupational hazards and migrant worker health[40] can be integrated into musculoskeletal curricula, segregation and exposure-related asthma inequities[41] into

respiratory curricula, intersecting syndemics of incarceration and homelessness[42,43] into infectious diseases curricula, and so forth.

CRT: naming racism and racialization. Biomedical frameworks often employ a "race-neutral" lens purportedly informed by empiricism and objectivity and thereby resistant to human influences like bias and racism. This assertion of neutrality is misguided and empirically false. Medical institutions—and the knowledge, paradigms, and processes that guide them—exist within historical and current contexts that are enveloped in racial dynamics.[21] CRT was founded by legal theorists to guide our understanding of how racism is embedded in the structures of American society.[44,45] A foundational tenet of CRT is *racialization*—how socially constructed racial groupings are used to assign value and hierarchy placement.[45] Examples of racialization in health professions training include widespread uses of "objective" criteria, with strong associations between race or class and Medical College Admission Test® and United States Medical Licensing Examination® scores, quantity of research publications, Alpha Omega Alpha induction,[46,47,48,49,50,51] and even "subjective" clinical evaluations that create space for preceptor biases.[21,52] By offering interdisciplinary perspectives on race, naming power structures, and acknowledging how historical policies and practices contribute to present-day inequality, CRT provides an antiracist lens by means of which learners can take action against health inequality.

PAR: centering voices from the margins. In PAR and community-based participatory research (CBPR), marginalized communities are considered equal partners throughout research formulation, development, implementation, data collection, and evaluation.[53] PAR originated as a "margins-to-center" approach to advance sociopolitical movements for land reform and anticolonialism in the 20th century.[54,55] In their modern applications, PAR and CBPR equitably value the contributions of academic and community experts, reflected both in their financial compensation and in the process of knowledge production itself.[56]

Historical legacies of research exploitation and academic elitism have reinforced marginalized communities' medical mistrust and undermine the potential for ethically partnered research.[57,58] The superimposition of structural racism further exacerbates the downstream harms of these legacies on community engagement and health outcomes alike.[58] PAR requires humility from academic partners and significant buy-in from community partners—a recipe made feasible through sustained relationships built on mutual trust. Even for learners with dominant identities, explicit and personally meaningful exposure to diverse perspectives remains among the very few interventions with demonstrable evidence of implicit bias mitigation.[59] Engaging marginalized communities in research, learner education, clinical redesign, and health systems reform, in tandem with diversifying the health workforce itself, can aid in this process.

Applying Critical Pedagogy

Applying the above frameworks in health professions education will require a shift in educational methods and in the culture of health professions knowledge sharing more broadly. We propose 3 primary means of attaining these goals: redefining who is considered a teacher, implementing novel educational tools, and institutionally embedding and incentivizing antiracism.

Redefining the teacher. All of the frameworks we described, as well as Freire's *Pedagogy of the Oppressed*, emphasize the inherent value of lived expertise. With this in mind, the

University of Nebraska Medical Center (UNMC) created a community-engaged structural competency curriculum that engaged community stakeholders—ranging from small business owners to faith leaders to public agency stakeholders—as partners throughout the development, implementation, and evaluation of the curriculum and as facilitators of small-group discussions.[60] Recent iterations have expanded the curriculum to include financial compensation for partners and engagement across multiple community sites and neighborhoods, with the explicit purpose of establishing and sustaining longitudinal partnerships.[61] Direct involvement of community members as teachers must be systemically embedded to sustain continued community and academic buy-in alike; at UNMC, conversations are underway to create an Academy of Community Teachers to achieve this goal.

Similarly, at Morehouse School of Medicine, students participate in a yearlong community health course wherein they identify health needs via community interviews, focus groups, and surveys; present their results and recommendations to community stakeholders, classmates, and faculty members; and implement and evaluate their intervention.[62] This curriculum encourages students to approach community needs with the same rigor needed to investigate a patient presentation.

Moreover, learners themselves can and should be involved in curriculum development.[63,64] For example, a team of structural competency educators developed an open-access online sexual and reproductive health curriculum in partnership with community scholars, reproductive justice advocates, and medical and nurse-midwifery trainees.[65] Together, these stakeholders worked on problem identification, goal setting, implementation, and evaluation.[65] This curriculum and other interventions highlight the necessity of integrating multidisciplinary perspectives across the social sciences, law, humanities, and other nonclinical fields in the comprehensive delivery of critical pedagogy.[33,39,66]

Finally, recentering health equity expertise in communities can promote a shift in the ideal endpoints of health professions education. The UNMC curriculum was able to achieve its implicitly intended impact—establishment of new relationships between learners and their community—during the COVID-19 pandemic when students' learning translated swiftly into actions: students reconnected with curriculum partners to disseminate masks, multi-language public health information, personal hygiene products, and basic food supplies to marginalized communities and personal protective equipment to under-resourced hospitals and clinics.[67,68,69] We argue that this newfound learning objective—autonomous, self-directed learner-community *action*s to address pressing needs—should be broadly considered as an ideal endpoint of reciprocal community-partnered education.

Implementing novel educational tools. Shifting toward action-based education and career development planning will require deviation from status quo teaching modalities. Neighborhood walking tours and street art tours for resident physicians that were developed and facilitated by community leaders have been shown to improve resident physicians' understanding of neighborhood-level social and structural determinants of health.[70] Another community co-designed experiential learning initiative for emergency medicine residents led to long-term improvements in their self-reported ability to apply trauma-informed de-escalation approaches to agitated patients.[71] Finally, a collection of educational experiences based on Augusto Boal's *Theatre of the Oppressed*,[72] Freire's critical pedagogy, and sensible cognition—the notion that one's understanding of the

world is based in one's senses and influenced by one's emotions—aimed to improve trainees' personal and professional development, understanding of medical training's hidden curriculum, and emotional processing and reconciliation of challenging clinical situations.[66] Extra-clinical experiences like these can ensure that health professions trainees build critical consciousness of and structural empathy for the hyperlocal contexts and lived experiences of their patients and colleagues,[33,35] although evaluation of the efficacy of these novel curricular interventions has often been limited to learner self-reported data.[70,71]

Podcasts can also motivate antiracist action.[73,74,75,76,77] The Clinical Problem Solvers' *Antiracism in Medicine Series* was created by a multidisciplinary, trainee-predominant team at the start of the COVID-19 pandemic and in the aftermath of George Floyd's murder to redress a lack of action-oriented antiracism education in medical training.[78] It should be noted that the series' creation and iterative development itself reflect antiracist action. Moreover, the democratized accessibility of the tool has allowed for its widespread use across undergraduate, health professions, and graduate medical education settings.[79,80]

Embedding and incentivizing antiracism. Structural shifts within health professions education, academic medical centers, and health policy are long overdue. First, praxis-based work should be incentivized rather than discouraged or obfuscated. Recent analyses have highlighted the striking dearth of empirical research published on racism, white supremacy, and health in leading clinical and public health journals that play fundamental roles in reshaping the knowledge and priorities of the health workforce,[81,82] despite an expansive and ever-growing body of research on these fundamental causes of health inequality.[83,84] Second, metrics for admission to health professions training programs, faculty promotion, and program prestige alike often fail to appropriately recognize and protect health equity work.[85,86,87] Reforming admissions criteria and professional advancement incentives can alleviate the minority tax, mitigate compensation inequities, and redress leaks at every stage of the career pipeline.[21,88,89,90,91,92,93] Third, efforts to change institutional culture must be pragmatic and grounded in critical theories. The Icahn School of Medicine at Mount Sinai's Racism and Bias Initiative offers one such transformational change framework, beginning with a margins-to-center problem-proving approach and transitioning through phases of cultural climate evaluation, tangible actions with measurable outcomes, and iterative cycling to ensure that reforms are achieving their stated goals and can be sustained long-term.[94] Lastly, because segregated care within academic health centers and pervasive price discrimination between hospitals divert resources away from marginalized communities,[95,96,97,98,99,100] fundamental payment reform remains necessary to ensure that academic health centers can equitably fulfill a quadripartite mission of education, research, clinical care, and community engagement.[101,102]

Conclusion

Current approaches to health equity education frequently fall short, and, as a result, minoritized learners, marginalized communities, and their relationships to academic medical institutions suffer. Structural competency, CRT, and PAR can guide the implementation of critical pedagogy by striving to foster antiracist praxis: theory-driven actions to redress systemic oppression.[103] By engaging our communities as teachers with valued expertise, expanding the use of creative educational tools, and structurally embedding and incentivizing antiracism, clinicians can be better equipped to mitigate health injustice.

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Citation
AMA J Ethics. 2024;26(1):E36-47.

DOI
10.1001/amajethics.2024.36.

Conflict of Interest Disclosure
Dr Khazanchi served as a health equity consultant to the New York City Department of Hygiene and Mental Health's Coalition for Ending Racism in Clinical Algorithms and to the Office of the Chief Medical Officer, advises the Rise to Health Coalition, and serves on *The Lancet* Commission on Antiracism and Solidarity. The other authors disclosed no conflicts of interest.

The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.

ISSN 2376-6980