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### MEDICAL EDUCATION: PEER-REVIEWED ARTICLE

#### Training to Build Antiracist, Equitable Health Care Systems

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##### Abstract

All clinicians should provide high-quality, safe, and equitable care to every patient and community. Yet, in practice, health care delivery systems are designed and organized to exacerbate inequity in access and outcomes, and clinicians are incentivized to deliver unequal and inequitable care in deeply segregated academic health centers that are structured to reify white supremacy. This article investigates the nature and scope of health professions educators' obligations to acknowledge harms of segregation in health care as widespread, unjust, iatrogenic, and preventable.

##### Causes of Segregated Care

Physicians and, indeed, all health professionals should provide high-quality, safe, and equitable care to every single patient and community. Health care systems should commit to **antiracist practices and processes** to ensure that physicians and other health care professionals are in fact able to provide equitable care.<sup>1</sup> In practice, however, medicine and health care have been designed, organized, and incentivized to deliver highly unequal and inequitable care, which has contributed to widespread, unjust, and preventable harm to and outcomes for individuals and communities that have been historically marginalized.<sup>2</sup> These far-reaching and persistent manifestations of white supremacy—the false hierarchy of human value based on the color of one's skin—inspired one graduating class at the University of Pittsburgh School of Medicine to create a modern-day Hippocratic Oath. Their oath acknowledges the “fundamental failings of our health care and political systems” in caring for historically marginalized communities and communities excluded from Western health systems and calls for an “enduring commitment to repairing the injustices against those historically ignored and abused in medicine: Black patients, Indigenous patients, Patients of Color and all marginalized populations who have received substandard care as a result of their identity and limited resources.”<sup>3</sup>

Data indicate that the US health care system is highly segregated and inequitable.<sup>4,5,6</sup> The root causes of these health inequities include, but are not limited to, a pervasive culture of white supremacy in academic health care and research,<sup>7,8</sup> clinicians' and

employers' implicit biases,<sup>9,10,11</sup> structural and color-blind racism in health care policies and practices,<sup>12,13</sup> and a **2-tiered payment system** that paradoxically reimburses the least for the patients with the most socially complex needs and structural vulnerabilities.<sup>14</sup> The result is that patients who have been historically marginalized and excluded from health care (eg, white patients with low incomes and Black, Indigenous, and Latinx patients) are offered a constricted set of choices, as affluent "elite" health centers effectively close the doors to them through conscious contracting decisions and capital investments.<sup>15,16,17</sup> The overall effect is a tale of 2 unequal societies across the United States, both within our cities and between urban and rural areas, whereby richer and poorer hospitals serve richer and poorer populations, respectively, with (unsurprisingly) very different results.<sup>5</sup> This article discusses the ways in which institutions that support health professions education have perpetuated and supported inequitable health care and identifies opportunities for educators to address health inequities through their work with students, trainees, and health system leadership.

### **Failures to Address Inequity**

Medical education has historically leaned into and harmfully normalized racial and socioeconomic inequity. Although hospitals no longer explicitly admit patients to different hospital towers or wards based solely on the color of their skin,<sup>18</sup> Black, Latinx, and Indigenous patients, as well as white patients with low incomes, continue to be **differentially funneled** to under-resourced and underinvested safety-net centers and resident clinics, where trainees are encouraged to gain experience working with these "complex" patients.<sup>19,20,21</sup> These clinics—and the health care teams that staff them—differ from private practices and faculty-only clinics within the same academic health centers both in appearance and in the resources available to support patient care within their walls.

The contemporary reality of inequitable health care is exacerbated and perpetuated by a lack of standardized medical education on the historical and present-day root causes of segregation in health care and the structural causes of health inequities. From its earliest days, this nation has been segregated based on false notions of racial hierarchy.<sup>20</sup> Beginning with colonist settler theft of Indigenous lands, government-sponsored genocide, and removal and segregation of Indigenous peoples into circumscribed territories<sup>22</sup>—and continuing through the 20th century government-sanctioned racial segregation of neighborhoods, known as redlining<sup>23</sup>—US cities and states have been designed to separate white communities from people of color. These racist policies were created and are maintained by local and federal government agencies, banks, and other entities through exclusionary zoning, public housing policy, discriminatory practices in homeowner loans and banking, gentrification, and displacement.<sup>23</sup> This geographic segregation continues to reinforce between-hospital racial segregation and inequitable health outcomes today.<sup>5,6,24,25,26,27,28,29</sup> Neighborhood segregation, however, fails to explain the more insidious ways in which segregation persists *within* hospitals. Through insurance status and other facets of institutional racism—as well as health care professionals' biases, behaviors, and, in some cases, racist ideas<sup>30</sup>—racial inequities in access to care, treatment, and outcomes remain the status quo in hospitals in the United States today.<sup>20</sup> These unjust differences in care are exacerbated and reinforced by the ongoing segregation of the health care workforce.<sup>19,31</sup>

Yet, for far too long, little of this de facto segregation has been discussed or taught in mainstream medical education, in part because of the systematic exclusion of people of color, particularly Black and Indigenous physicians, from leadership roles in medical

education and health care organizations. Despite evidence that greater segregation of care teams is associated with higher mortality rates for Black patients<sup>31</sup> and that diverse care teams lead to better health outcomes and organizational performance,<sup>32</sup> white privilege and the erosion of even modest diversity gains through affirmative programs<sup>33,34,35</sup> have kept higher education institutions, and thus physician groups, disproportionately white. The consequence is that many physicians and medical educators remain woefully ignorant of racial injustice and inequities in health care. As such, they frequently lack the knowledge, skills, lived experiences, and expertise to teach medical students how to effectively identify, challenge, dismantle, and redesign the systems and structures of power and oppression that adversely affect their patients and their patients' communities.

In the face of these challenges, medical students and other trainees have started to effectively organize and mobilize to demand more of their educators and institutions. Some key examples of this mobilization include the White Coats For Black Lives movement<sup>36</sup>; the recent passing of antiracist resolutions in the American Medical Association's House of Delegates,<sup>37</sup> many of which were originally submitted for consideration by members of the medical student section; student advocacy supporting the elimination of racist medical algorithms<sup>38</sup>; reimagining of medical school curricula, beginning from an antiracist and abolitionist perspective<sup>39</sup>; and student leadership identifying and seeking to redress harms arising from unequal access to services.<sup>12</sup> Focused attention on these issues has led to structural and policy changes that have advanced equity and antiracism in broad areas of patient care,<sup>8,40</sup> although not without resistance.<sup>41,42</sup>

### **Educators' Roles**

Because the challenges of segregation in health care and the deficits in medical training are complex and multifactorial, solving them will require sustained, cross-sector, collective action. Health professions educators can do their part by working together and committing to educate themselves about strategies to eliminate structural drivers of health inequities; resources have emerged in recent years to do so.<sup>43,44,45</sup> They must then **elevate these issues** and ask students to consider the ethical and fiduciary obligations of health professionals and systems to historically marginalized and oppressed patients and communities.

To begin, faculty must learn to identify and acknowledge when segregated care occurs. Recognizing segregated care will require listening to and learning from patients, students, trainees, and clinicians who identify the ways in which segregation manifests. When structural inequities go unacknowledged, students and trainees implicitly learn that separate and unequal care is justified and even acceptable, both between and within facilities. To ensure that students and residents avoid internalizing harmful messages about the relative worth of different patient populations, faculty must explicitly address the ways in which care systems segregate patients. They must point out the inconsistencies between performative statements of antiracism and organizational behaviors that maintain racist and inequitable care within and beyond the hospital walls. Furthermore, faculty must take seriously concerns raised by residents and students about inequities and racist practices, policies, and systems, and they must support students and trainees in identifying ways to redress these concerns.<sup>8</sup> When the most junior members of the profession see with fresh eyes the injustices to which others have become accustomed, faculty must challenge their own apathy and resist resignation to the status quo. Some institutions have begun to address inequities

identified by students and trainees using restorative justice approaches to addressing past harms. One such actionable framework designed for health system responses to structural inequities and segregated care is the Healing ARC (acknowledgment, redress, and closure).<sup>8</sup>

Health professions education and training must likewise equip tomorrow's health care leaders with the skills to identify and eliminate inequities and to remake health systems. It must foster longer-term transformational thinking rooted in social change and antiracist practice, as well as a sustainable and thriving, diverse workforce.<sup>46,47</sup> Addressing segregated care depends on building individual and team capacities, deepening knowledge, implementing new approaches and methods of practice and evaluation, and building an institutional culture rooted in equity and antiracism. Change must happen at all levels of medical education and requires faculty equipped to lead this work. Educators must emphasize the role that all faculty—not just those who primarily focus on equity, diversity, and inclusion efforts and actions—play in addressing injustice in health care. Mandatory faculty development and education to develop shared understanding of structural racism and other systems of power and oppression, along with guidance and mentoring of faculty who are newer to these concepts, can create shared frameworks and methodologies for creating educational content and presenting it to trainees.<sup>48,49</sup>

In approaching these topics, medical school faculty must also avoid tasking Black, Latinx, and other physicians of color, who bear the burden of the minority tax,<sup>50,51</sup> with this work. Curricula must incorporate longitudinal education and mentorship to address the structural drivers of health—explicitly naming racism and other systems of power and oppression—as part of preparing the next generation of clinicians to both identify and dismantle systemic inequities and to create equitable systems. Structural competency curricula have been developed and are available for use by any institution<sup>52</sup>; some schools have begun to incorporate strategies to teach structural competency not only in the classroom but also by bringing students out of the proverbial ivory tower.<sup>53</sup> Many residency programs have also begun incorporating antiracism and structural competency education into their core curricula.<sup>52</sup> Increased awareness of conscious and unconscious biases and structural drivers of health can increase the likelihood of upstander interventions, including interrupting microaggressions as well as recognizing and addressing racist policies and practices.<sup>54</sup> We anticipate that as antiracism efforts in medical education continue to develop, further evidence of their benefits and of effective strategies for advancing equity in these spaces will emerge. For example, several residency programs have modified recruitment strategies with the explicit aim of their residency classes mirroring the diversity of their patient populations.<sup>55,56,57,58</sup> Some have found success through providing training for selection committee members in structural drivers of educational achievement and holistic review techniques,<sup>55,59</sup> which is confirmed by the first author's personal experience. Faculty education and structural changes to recruitment processes could similarly be focused on addressing other areas of inequity that lead to segregated care and segregated care teams. While a few dedicated fellowship training programs exist to support future leaders in health care equity,<sup>45,60,61,62</sup> antiracist and social justice education must be embedded in every level of the medical education system.<sup>39</sup> The recently published diversity, equity, and inclusion competencies developed by the Association of American Medical Colleges<sup>63</sup> are a foundational component of this effort and must be rapidly integrated into medical schools and training institutions; validated means of measuring these competencies must be developed and deployed.

### **Engaging Health System Leadership**

Faculty must also challenge hospital and university leadership to initiate transformative change that moves beyond the performative antiracist statements that leadership has issued in recent years.<sup>46,64</sup> Ensuring accountability through structured evaluation of programs meant to address segregated care and other manifestations of racism is equally crucial; several new frameworks exist and are now being used by institutions leading work to advance equity within their walls.<sup>8,65</sup>

Health care institutions can and must address segregation not only of patient care, but also of hospital staff. Guidelines for antiracist actions that executives should undertake to address these structural inequities have been developed and are available to guide health system leaders.<sup>65,66,67</sup> As a first step, leaders must correct gross disparities in employee compensation, commit to paying a living wage for all employees and contractors, and provide a comprehensive benefits package that includes health insurance coverage for all health system employees. To do so, they can and should examine employee compensation, advancement, and retention data stratified by race and other key social identities to identify priority areas for policy change that would support equity within faculty and other employee groups. Hiring, promotion, and retention of diverse faculty is critical to ensuring that both learners and patients benefit from the expertise, knowledge, and lived experience of a diverse physician workforce. Equally important for health system leadership to address are the racial inequities in the non-faculty staff. Higher-paid positions—including administrators, physicians, nurses, and other professionals—are disproportionately filled by white professionals, while people of color are overrepresented in lower-paid roles, such as security guards and food services.<sup>68</sup> Creating pathways for economic advancement, career development, and promotion within and across health systems—particularly for the lowest-wage workers who are disproportionately people of color—are additional strategies for fostering diverse health care teams.

Simultaneously, today's leaders must address structural factors that perpetuate segregation to enable the delivery of equitable care both within and between institutions. To fail in this regard ensures both ongoing harms to individuals who have been marginalized (in the form of avoidable deaths and delays in diagnosis and treatment) and devastating moral injury for clinicians who bear witness to these harms while being forced to remain complicit in systems that perpetuate them. For example, medical educators and health system leaders must support health care finance reform that incentivizes equitable care and eliminates the structural incentives that lead to segregated clinics, wards, care teams, and health systems. It is critical to note that the involvement of trainees and students in the evaluation and treatment of some patients (and not others) within training institutions is not the root cause but rather a symptom and consequence of segregated, inequitable care within health systems. If differential clinician and organizational compensation based on insurance were eliminated, such that insurance status no longer functioned as a gatekeeper to certain clinicians and health care services, other structural disincentives to equity could be substantially mitigated. Equal compensation for care—for example, through a single payer system—could allow nonclinical resources, including administrative support, physical space, and ancillary services that address adverse social drivers of health, to be equitably distributed to patients regardless of whether a faculty or resident physician provides clinical care.

If health professionals value the life of all patients equally, they must relentlessly pursue reform and seamless integration of payment systems, clinical structures, health care teams, and clinical education. Although achieving health equity will require broad and deep change in nearly every facet of the health care system, practical first steps can be taken at the institutional level, and large-scale change can be catalyzed by clinicians demanding that health care be equitable.

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