Commentary: Racism and Bias in Health Professions Education: How Educators, Faculty Developers, and Researchers Can Make a Difference

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Abstract

The evidence is glaring: Dramatic racial and ethnic health disparities persist in the United States, people of color remain deeply underrepresented in medical school and academic health systems as faculty, learner experiences across the medical education continuum are fraught with bias, and current approaches to teaching perpetuate stereotypes and insufficiently challenge structural inequities. To achieve racial justice in HPE, academic medicine must commit to leveraging positions of influence and contributing from these positions. In this Commentary, the authors consider three roles (educator, faculty developer, and researcher) represented by the community of scholars and pose potential research questions as well as suggestions for advancing educational research relevant to eliminating racism and bias in HPE.

The data on racial and ethnic health care disparities are shocking. People of color in the United States face barriers to health care and suffer health-related outcomes that should shame our resource-rich and privileged nation. Yet despite consistent and clear research documenting persistent gaps in morbidity and mortality between racial and ethnic groups, there has been a reluctance to address the role of racism in driving these gaps. Problematically, the health professions and medical education enterprises have yet to fundamentally change how we care for our patients, how we select future care providers, or how we teach and assess our learners.

Despite the significant body of evidence suggesting that increasing the diversity of the physician workforce positively impacts patient care, people of color remain underrepresented in U.S. medical schools, with the percentage of black and Latino students remaining flat across the country year after year. This lack of representation extends into the health care workforce following postgraduate training where only 7% of full-time faculty at U.S. medical schools identify as black or Latino despite constituting 31% of the U.S. population in 2015. Even more sobering are the critical racial disparities at the professorial, dean, or chair level.

Learning experiences across the medical education continuum are also fraught with bias. There is ample evidence that race is a social construct, yet teaching and assessing race as a biologic category is common in schools across the country. This perpetuates fallacious stereotypes and racial biases among the next generation of physicians. Furthermore, many schools continue to teach the “cultural competency” model where clinical professionals learn approaches to communication, diagnosis, and treatment that reflect culturally specific sources of stigma within the clinical encounter. Unfortunately, this model reinforces reductive understandings of identity markers without consideration of context and does not promote consideration of the impact that bias, stigma, and systems have on illness and health.

At the individual learner level, students who are underrepresented in medicine are at greater risk of poor personal well-being, increased stress, depression, and anxiety and report that their race and/or ethnicity adversely affects their medical school experience. Moreover, learners raise concerns about bias in their assessment and evaluation by faculty who have little formal training in racism and bias. A recent study found that after controlling for numerous demographic and educational covariates, the odds of Alpha Omega Alpha national medical honor society membership for white students was six times greater than those for black students and two times greater than for Asian students.

At the educator level, increasing numbers of faculty are participating in cultural sensitivity and unconscious bias training. Yet, as Acosta and Ackerman-Barger have argued, such trainings are insufficient to prepare faculty to teach or to have dialogues about race and racism either in the classroom or at the bedside.

The challenge and enormity of racism and bias within medical education and the downstream health impacts can,
at times, seem insurmountable given the complexity of the structures and institutions in which they are embedded. In her 2016 Research in Medical Education (RIME) plenary address, Dr. Camara Jones articulated ways we can take action as health professionals by asking, “How is racism operating here?” and then by organizing and strategizing to act. Now in health professions education (HPE) important questions are being raised that seek to address how we, as HPE scholars, need to respond to this deeply concerning state of affairs: To what extent are we responsible and accountable for perpetuating racism and bias in the health professions? As individuals and in teams, what are our most powerful platforms for exposing, documenting, translating, and advocating against bias and racism? At the broadest level, a commitment to addressing race and racism in education scholarship involves going beyond mere documentation of health inequities to include analyses and actions against the power differentials and privileges that create and perpetuate such inequities.16 Building on Dr. Jones’s important call to action, we must commit to applying contemporary theories of race, bias, and racism to the development, implementation, and evaluation of interventions in the areas of curriculum & assessment, faculty development, and medical education research.

As a community of educational scholars, we represent a multitude of overlapping roles and identities. We suggest that these roles and identities offer unique opportunities to engage in scholarship aimed at eliminating racism and bias in HPE. Below, we consider three roles (educator, faculty developer, and researcher), pose potential research questions, and offer examples or suggestions for advancing educational research relevant to these questions.

**Educator**

As educators, many of us are called upon to address race and racism through curriculum development, formal and informal instruction, assessment, and thoughtful changes to our educational environments.20,21 Often we are expected to facilitate discussions that fall outside our zones of expertise or training, model behaviors that no one taught or modeled for us, and listen to and learn from our learners. And as we do this, where and how does scholarship fit into our role and educational practices?

First and foremost, we can be scholarly in our approach as educators. Being scholarly involves inquiring about and reflecting upon educational practices in systematic ways that yield products (e.g., curricular materials, instructor guides, assessment tools, evaluation data) others can use and learn from.21 Guidelines describing components and evidence associated with educational scholarship emphasize clear goals, adequate preparation, appropriate instructional methods and materials (grounded in theory and/or evidence), and evaluation of impact in efforts to guide improvement.23-24 To engage in a scholarly approach to racism and bias, educators can begin by asking the following questions:

**What has my educational program done previously to address racism in the curriculum or in assessment strategies? What have other educational programs done? What is known about the impact of efforts to address race and racism?**

These questions can catalyze thinking and reflection on what currently exists within and beyond our local context. For example, Tsai and colleagues describe a local inquiry process that ultimately informed a longitudinal race-in-medicine curriculum at the Warren Alpert Medical School of Brown University.12 These authors examined how race was presented in basic science lectures occurring in the preclerkship curriculum, noting that most lectures presented race as a biological construct, with little discussion of contextual and cultural dimensions. The discrepancy between recommended pedagogy and actual pedagogy around race in the medical school curriculum documented through this inquiry helped guide change. Further evidence was reported by Clementz and colleagues,25 who described the basis for a novel component of a culture and health curriculum. They identified concerns with multicultural and cultural competence education, which they characterize as categorical approaches to addressing disparities. In an effort to avoid “inadvertent, adverse consequences” of such approaches (e.g., reductionist thinking, reinforcement of stereotypes), the authors developed a program to teach learners how to work with patients from all cultures, regardless of familiarity with the patient’s cultural group.25

**What frameworks or theories can guide my educational approach?**

Educators can draw upon a number of theoretical and conceptual frameworks to guide curriculum, pedagogy, and assessment.26 The literature in K–12 and higher education may be particularly helpful in supplying examples of how to apply critical race theory, antiracist humanism, and social justice perspectives to education.27 Within the health professions, Hansen and Metzl28 recommend structural competency as a theoretical framework to guide educational interventions and pedagogical approaches that teach learners to attend to social and institutional forces affecting patients’ health. Wear and colleagues29 similarly propose a pedagogical orientation, based on antiracist pedagogy and structural competency concepts, that supports development of curricula to prepare physicians to care for patients whose lives and health are impacted by social inequality and injustice. Halman et al30 published a review of critical consciousness as conceptualized and applied in HPE. Their findings and conclusions offer suggestions and examples of how educators might use this theoretical framework to guide pedagogy.

**How do I understand my local context, particularly the goals and needs of my learners, the goals and needs of my institution, my own goals and needs as an educator, and the resources available to support my efforts?**

This question seeks to promote attention to a local needs and resources assessment within the context of racism. Muntinga and colleagues31 published an example of a comprehensive needs assessment used to develop learning objectives and evaluate existing curricula for integration of biomedical and sociocultural elements of diversity. Using an intersectionality approach to diversity, the authors examined key stakeholders’ (teachers’, researchers’, education coordinators’, and educational
policy makers’) views on and suggestions for incorporating diversity into the medical school curriculum. The authors also defined criteria (i.e., learning objectives and outcomes) for a diversity-inclusive curriculum and mapped their existing curriculum to identify how diversity was addressed and where changes might be needed.

What evidence do I need to understand the impact of the educational initiative on learners, on myself as an educator, on my institution, and/or on the health care system and the patients and families participating in that system?

This is a key question for evaluation of any educational initiative; it reminds us of the multiple layers of impact to consider. Leyerzapf and Abma\textsuperscript{32} conducted a qualitative evaluation of cultural minority students’ experiences of intercultural competence activities. The study provided educators with many important insights into minority students’ views of how case materials reinforced negative stereotypes, of the teachers as inadequate role models, and of the learning environment as unsafe and noninclusive largely because of microaggressions.\textsuperscript{33}

Additionally, we must consider opportunities to disseminate our work. Many educators have shared very thoughtful and valuable perspectives, commentaries, and proposals that address or unearth ideas and perspectives of racism in medicine.\textsuperscript{19,29,33} Now we need equally thoughtful evaluations of implemented curricula and learner assessments. What impact have these efforts had? Such analysis is required so that we can learn from one another as a community of practice and collectively work to advance our efforts to eliminate racism in our classrooms, in our clinical learning environments, and in our health care systems. Opportunities for dissemination can take traditional forms including, but not limited to, delivering workshops to help other educators learn the skills necessary to design, implement, and facilitate educational activities targeted at education about racism; submitting abstracts to local, regional, and national conferences; sharing educational materials in peer-reviewed repositories; and submitting manuscripts to journals (innovation reports with an evaluation component, research reports, etc.). Additional forms of dissemination may include accredited online learning modules to reach larger numbers of participants across broader geographies and academic retreats or half-days for housestaff learners. Sharing the products of our efforts to eliminate racism helps our work to have an impact beyond the learners we teach. They can be resources for educators within and beyond our own institutions, which is essential for cultural and systemic change.

Faculty Developer

Faculty developers have the opportunity to systematically change educators’ behaviors, perspectives, assumptions, and unintentional or implicit biases regarding race given their role and influence within their environments. However, most faculty developers teach content in specific areas of comfort and expertise (e.g., small-group teaching, feedback) using “tried and true” approaches and materials that have never been reviewed with an eye toward diversity and inclusion. Unfortunately, this tendency may also mean that faculty development offerings never explicitly address the knowledge, skills, and values that faculty need to engage in meaningful and transformative conversations with learners and colleagues about race and racism.\textsuperscript{19,29}

Acosta and Ackerman-Barger\textsuperscript{19} advocate for new approaches to faculty development that focus on “talking about race and racism.” Additionally, new approaches to faculty development can foster a sense of collective responsibility and for realizing systemic change. This shift in focus presents an opportunity for inquiry and scholarship in faculty development. The framework for faculty development research proposed by O’Sullivan and Irby\textsuperscript{34} suggests a series of prompting questions faculty developers might explore. This framework identifies and helps us understand the processes by which different faculty development interventions may or may not achieve desired outcomes, the needs and perspectives of faculty members (participants in faculty development), and the ways of evaluating the impact of faculty development efforts.

What professional development interventions have been implemented and evaluated outside of medical education to combat racism? What aspects of these interventions could be implemented with faculty in medical education?

Racism is a pervasive problem spanning all levels of education and workforce development. Our efforts in faculty development will be strengthened by attempts to build on what is already known in other fields.\textsuperscript{36,37} We should also work together as a community of scholars to identify promising approaches used in other fields and to translate them into practices we can implement and evaluate in medical education and our institutions.\textsuperscript{36,37} We ought to learn from efforts that have not worked—what challenges arose, what faulty assumptions were made?—so we can avoid wasting time and resources that we cannot afford to spare.\textsuperscript{38}

How do faculty members envision their role and contributions to eliminating racism in the medical education learning environment and institution? What concerns do they have? What support and resources do they need?

Despite growing awareness of the need to address race and racism in education and health care, faculty members vary in the degree to which they feel empowered to and responsible for enacting change.\textsuperscript{19} Many faculty members may not identify themselves as formal educators, yet they play a role in the structure and culture of the institution through formal and informal mentoring and interactions with learners as well as through participation in policy committees, leadership teams, and recruitment and admissions processes. Gaining insight into faculty members’ perspectives, comfort, and ability to discuss topics such as race, identity, culture, and discrimination can inform the design and implementation of faculty development efforts.

Research in these areas is limited, but two RIME papers offer examples of important work this area. Zaidi and colleagues\textsuperscript{40} interviewed faculty about their experiences facilitating discussions around power differentials, racism, and implicit bias. Their work identified strategies experienced facilitators perceived to be effective as well as

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Commentary

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topics they continue to find challenging and desirable for further training. In a 2016 RIME manuscript, Whitgob and colleagues conducted a qualitative study that examined ways in which faculty members would respond to a patient or family member who discriminates against a trainee. Faculty members identified several strategies but also emphasized the need for training and development in this area.

What models of faculty development best support efforts to eradicate racism in medical education?

An elective model of faculty development that relies on formal activities delivered in real time by a limited cadre of voluntary faculty developers may not be able to support the magnitude and pace of change required. Mounting evidence indicates the need to examine ways in which faculty colleagues conducted a qualitative study that examined ways in which faculty and racism can make both the researcher and the community being studied face realities that are at best uncomfortable to recognize, and at worst shameful to acknowledge. So how then to engage in this research? How can we study race and racism in ways that are respectful and productive for everyone involved? In 2007, Milner proposed a framework to help educational researchers incorporate racial and cultural awareness, consciousness, and positionality into their research processes. In building this framework, Milner draws on critical race theory and research on the color and culture line to “elucidate the complex nature of race and culture in the process and outcomes of conducting education research.” This framework offers useful starting points for researchers interested in studying issues of race and racism in HPE:

- What is my racial and cultural heritage? In what ways do my racial and cultural backgrounds influence how I experience the world, what I emphasize in my research, and how I evaluate and interpret others and their experiences? What racialized and cultural experiences have shaped my research decisions, practices, approaches, epistemologies, and agendas?

The first component of Milner’s framework, labeled as researching the self, highlights “the importance of researchers’ engaging in evolving and emergent critical race and culture self-reflection.” This process of racial and cultural introspection requires us, as HPE researchers, to examine our own racial and cultural beliefs and experiences. The questions listed above are prompts that Milner offers to help us engage in researcher reflexivity. These reflections can help to make us aware of known, unknown, and unanticipated issues and perspectives.

In what ways do my research participants’ racial and cultural backgrounds influence how they experience the world? What do my participants believe about race and culture in society and education, and how do they and I attend to the tensions inherent in my and their convictions and beliefs about race and culture in the research process? How do I negotiate and balance my own interests and research agendas with those of my research participants, which may be inconsistent with or diverge from mine?

The next part of the framework, called researching the self in relation to others, has us examine our own beliefs, experiences, perspectives, roles, and practices interact with those of the participants and communities engaged in the research. This framework element asks us to consider what we know about the racial and cultural beliefs and experiences of the people and communities under study. Milner’s reflective prompts (offered above) highlight how the researcher’s and participants’ experiences determine the nature of truth—determinations that are often very different from each other. This part of Milner’s framework asks that “researchers think about themselves in relation to others, work through the commonalities and tensions that emerge from this reflection, and negotiate their ways of knowing with that of the community or people under study.”

How do we (i.e., researchers and research participants) interpret these data? If we work together to create understanding, what do we think these data are telling us about race and culture? What are your interpretations? What are mine? How can we bring them together in a meaningful way?

Engaging in reflection and representation is the third framework element. This element engages researchers and participants in collaborative reflection “to think through what is happening in a particular research community, with race and culture placed at the core.” Working as partners, we (i.e., researchers and research participants) share our perspectives...
on data, offering interpretations and counterinterpretations. In this way, the research reflects multiple interpretations, rather than privileging that of the researcher. This kind of collaborative and participatory research destabilizes the researcher’s position of privilege as the arbiter of knowledge and truth, and instead emphasizes the existence of multiple knowledges and truths. While Milner does not offer prompts for engaging in this third step, we can imagine engaging in regular collaboration meetings and/or focus groups with research participants to interpret data. We offer some prompts for discussion above. It is important to note that these meetings and/or focus group discussions would not be a member checking activity since the researcher would not be looking to have participants confirm her/his interpretations of the data; instead, these meetings would have the participants offer their own uniquely positioned interpretations of the data. The congruities and incongruities between the researchers’ and participants’ interpretations then become a form of data in themselves, creating a multifaceted (and potentially diverging) set of analyses.

What is the contextual nature of race, racism, and culture in this study? What is known socially, institutionally, and historically about the community and people under study? What systemic and organizational barriers and structures shape the community and people’s experiences, locally and more broadly?

Finally, the framework’s fourth element, called shifting from self to system, incorporates historical, political, social, economic, cultural, and racial perspectives into our researcher. Here, we situate our research and findings in the broader contexts that shape race and racism. Milner offers the questions listed above to help us shift from focusing on the self and the individual participants to a broader systems focus.

In this Commentary, we chose to highlight Milner’s framework, one of many available in the literature, since it offers practical steps for both novice and experienced researchers interested in issues of race and racism. We realize, however, that this framework may be difficult for some HPE researchers to embrace. Milner’s framework highlights that there are no color-blind, objective

epistemologies or methodologies to embrace. Instead, this framework embodies a constructionist orientation, emphasizing how “multiple realities exist, realities that are dependent on interactions between the individual and the social world,” all “deeply entangled through dialogue.”

Conclusion

Dismantling racism is something we must all commit to as part of our roles and responsibilities as educators, faculty developers, and scholars in HPE. Leveraging our positions of influence and consistently contributing from these positions will be critical to this journey. Evidence clearly indicates that our current approaches to teaching and learning perpetuate stereotypes, promulgate misinformation, fail to explore the complex predisposing factors that underlie disparities, and insufficiently challenge structural inequities. We must commit to critical inquiry, trying new approaches to achieve racial justice in HPE, and studying the impact of our efforts. We must also join learners and patients in holding leaders of our educational and health care institutions accountable to prioritize inclusivity, social justice, and respect for differences when allocating resources and defining the core values of programs and institutions. Our positions of privilege in medicine demand that we engage fully and completely in this work. We can think of no more compelling a reason to do so than the patients our learners will serve in the future.

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Commentary


