Addressing Harmful Bias and Eliminating Discrimination in Health Professions Learning Environments: An Urgent Challenge

Eliminating health care disparities and advancing health equity are necessary steps to achieving a high-quality health care system. One approach to advancing not only equity but also diversity in the health care workforce is to mitigate harmful bias and eliminate discrimination in our health professions learning environments and clinical care sites. The 27 papers in this special supplement are intended to inform such efforts within and across the health professions. They grew out of a conference, held in February 2020 and organized by the Josiah Macy Jr. Foundation, whose invited participants—health professions leaders, educators, and learners—developed actionable recommendations to mitigate harmful bias and discrimination in health professions learning environments (available at www.macyfoundation.org).

Bias and discrimination—manifestations of racism and other forms of oppression—are embedded so deeply in American society that they prevent us from achieving the democratic ideals of equality and justice for all upon which our nation was founded. The same can be said for health care. As microcosms of our larger society, our intertwined systems of patient care and health professions education also suffer from these pernicious maladies, which carry serious, potentially deadly, consequences for patients. Harmful biases and racial and other forms of discrimination on the part of health care professionals contribute to disparities in health care access, treatment, and outcomes as well as to the higher rates of chronic illness and disease that plague historically marginalized and excluded populations.

Patients from historically marginalized and excluded populations are known to fare better when interacting with health care providers from similar backgrounds. Regrettably, in most health professions, there is underrepresentation of students, faculty, clinicians, and executive leaders from historically marginalized and excluded populations. Individuals from racial and ethnic minority groups working in the health professions also experience harmful bias and discrimination from colleagues, peers, and patients—and the negative impacts on them include dissatisfaction, burnout, turnover, and attrition.

Amplifying the need for a health system that is both representative of and well prepared to meet the needs of all of its patients is the fact that the population in the United States is growing older, chronically sicker, and ever more demographically and socially diverse. For all of these reasons, it is imperative that today’s health professions educators and learners increase their knowledge about the devastating effects of bias and discrimination on the provision of care and patient outcomes.

In preparation for the February conference on mitigating bias and discrimination in health professions learning environments, the Macy Foundation commissioned and distributed 7 peer-reviewed papers and case studies, which, along with selected articles from the published literature, established a baseline of information for the conferees’ discussions. Those commissioned papers and case studies, combined with others submitted and peer reviewed in response to the foundation’s call for papers, comprise this supplement.

During the conference planning phase, there was a timeliness to the topic, a recognition that harmful bias and discrimination are among several important issues confronting the health professions. Since February 2020, however, the global COVID-19 pandemic and protests against systemic racism, spurred by the killings of George Floyd, Breonna Taylor, Ahmaud Arbery, and others, have accelerated the need to address these issues. Timeliness has become urgency. A June editorial in The Lancet calls racism “a public health emergency of global concern” and the “root cause of continued disparities in death and disease between Black and [W]hite people in the USA.” And a New England Journal of Medicine (NEJM) editorial published the same month refers to slavery’s “legacy of racism, injustice, and brutality” and states that this “legacy infects medicine as it does all social institutions.”

Our world changed in the spring of 2020. Those of us working and learning in the health professions are being called to immediately confront racism and all forms of systemic oppression infecting health care. It is a call that we believe makes the papers in this special supplement a valuable set of resources for our health professions learning environments. In this Foreword, we provide a brief overview of bias and discrimination in health care learning environments and introduce you to several themes from the papers, many of which share practical information regarding ways to mitigate harmful bias and eradicate discrimination in health professions learning environments. We also address the supplement’s limitations in exploring its subject matter.

Bias and Discrimination in Health Care

Harmful bias can be either conscious or unconscious. Unconscious, also known as implicit bias, involves associations outside conscious awareness that lead to a negative evaluation of a person on the basis of characteristics such as race, gender, sexual orientation, or physical ability. Discrimination is behavior; discriminatory actions perpetrated by individuals or institutions refer to inequitable treatment of members of certain social groups that results in social advantages or disadvantages.

Effective interventions to mitigate harmful bias and discrimination in...
health care must continue to be identified and implemented. More research in actual care settings and a rigor in methods employed to test [harmful] biases in health care is needed.1 The NEJM editorial referenced earlier calls on physicians to “recognize the harm inflicted by discrimination and racism and consider this environmental agent of disease as a vital sign” that communicates crucial information about a patient’s condition.13 These and other actions, intended to better understand and address bias and discrimination in health care, would help move health care settings, including health professions learning environments, toward greater diversity, equity, and inclusion.

Efforts to advance equity and inclusion in health care evolved from and expand on the decades-old commitment of increasing numbers of health professionals and health professions learners from historically marginalized and excluded population groups. Despite progress toward the goal of increased numbers, as demonstrated by women matriculants in 2017 outnumbering men for the first time in U.S. medical schools,15 racial diversity has not been achieved among health professions learners, faculty, clinicians, or leadership. One particularly disturbing reality: while the data show slight upward movement in 2019,16 the number of Black men in medical schools has been essentially stagnant for decades.17 According to Laurencin and Murray, this situation “is an American crisis because the declining diversity of doctors reduces the quality of health care in the U.S. as a whole—for all patient populations.”13 This is only one data point illustrating the status of Black men in medicine; there are many more population groups that are underrepresented in medicine and in the other health professions.18 Researchers suggest that a lack of diversity in health care continues to exacerbate health disparities,17 the continued persistence of which has been demonstrated most recently and very publicly by the disproportionately negative impact of the COVID-19 pandemic on minority populations in the United States.2,19

A paradigm shift is needed, one focused on moving health care toward equity and inclusion as a means to increase diversity of the health care workforce and achieve excellence in patient care. Diversity, equity, inclusion, and social justice have been embraced as goals for the field, as demonstrated in the 2002 Physician Charter on Medical Professionalism and the more recent Charter on Professionalism for Health Care Organizations as well as by the American Association of Colleges of Nursing and the Association of American Medical Colleges (AAMC).20–23 As Nivet stated in his Diversity 3.0 Framework for Medical Education: “For the true benefits of diversity efforts to be realized, academic medicine [and we contend all health professions education programs] must move their efforts from the margins to the mainstream.”14 According to this framework, “inclusion must be integrated into the core workings of the institution and framed as integral to achieving excellence.” Further, it defines diversity as embodying “inclusiveness, mutual respect, and multiple perspectives and [serving] as a catalyst for change resulting in health equity.”

Sharing Approaches to Moving the Needle

To effectively move the needle on diversity, equity, and inclusion in health care, many in the field are exploring ways to mitigate harmful bias and eliminate discrimination in health professions learning environments—as described in the papers that follow. Some themes that run through the papers are highlighted below.

Culture change

Many of the papers reinforce the need for people at every level of health care to embrace comprehensive culture change around diversity, equity, and inclusion. They suggest antibias and antidiscrimination trainings for everyone who influences how health professions learning environments function, from governing board members, executive managers, and administrators to clinicians, faculty, students, and staff. This includes antiracism training, bystander/upstander trainings, and trainings in responding to microaggressions. One paper describes how to remove “blame and shame” from difficult conversations about harmful bias and discrimination (Davis, O’Brien), while another discusses how to “act wisely” and reduce the impact of harmful bias (Plew-Ogan et al.). Connected to this is the need, mentioned or discussed in many of the papers, for effective institutional policies and practices regarding how individuals can and should respond to discriminatory behaviors in health professions learning environments.

Listen to learners

Students can and should make valuable contributions toward the development and implementation of antibias and antidiscrimination curricula. Health professions learners bring different perspectives and experiences to their institutions, and their voices must be listened to; this is particularly true for the voices of students who are underrepresented in the health professions. At many health professions schools, learners are calling for curricula that help prepare them to care for patients and work in teams with colleagues who are different from them. One paper in this supplement, by Benoit et al., describes a student-led initiative to identify and address implicit bias in a medical school curriculum. Students also are calling for training for faculty members, who must themselves learn how to teach and mentor learners to work effectively in diverse, equitable, and inclusive learning environments. Another paper, by Lupton and O’Sullivan, describes a faculty development workshop designed to foster equity and inclusion in teaching.

Bias-free assessment and evaluation

Harmful bias is often institutionalized through our systems of reward, promotion, and assessment in health professions education. From the admissions process through clinical training programs, harmful and historical bias is often a factor in determining who is successful. Addressing these structural weaknesses in our system is the focus of several papers in this issue. Lucey et al., for example, conducted a literature review that substantiates concerns about equity in medical education assessments and refers to such inequities as a “wicked” problem, meaning complex and resistant to solutions. The authors suggest a 5-point framework for achieving equity in assessment.

Outlining the Supplement’s Limitations

A critical topic not addressed in the papers is intersectionality, a scholarly
concept recognizing people who identify with more than one marginalized community (e.g., Latina women, transgender Black men) and experience cumulative effects of multiple types of discrimination as a result. The papers in this supplement describe harmful bias and discrimination as they affect people who experience racism and those who experience heterosexism, homophobia, and/or transphobia—though not those who experience both racism and heterosexism, homophobia, and/or transphobia.

Also missing or very limited in number are papers that examine the discriminatory experiences encountered by members of other underrepresented population groups, including: women (sexism and misogyny), people living with physical disabilities (ableism), people from non-Christian religious traditions (anti-Semitism, Islamophobia), people from low-income backgrounds (classism), graduates of international medical schools who are training in the United States (xenophobia), etc. Some of the papers do talk about bias and discrimination affecting all members of all underrepresented population groups and social identities. These describe antibias and antidiscrimination efforts that primarily seek to build health professions learning environments that are equitable for everyone, regardless of identity. Efforts to advance diversity and inclusion for all require understanding both the specific needs of population groups and the needs of unique individuals.

The papers in this supplement also are focused primarily on medical education. This was not intentional and reflects the papers submitted. Several papers do focus on nursing education, and some mention the fact that interprofessional education necessitates learning how to work with colleagues who bring different perspectives, skills, experiences, and backgrounds into the health professions learning environment. We want to be very clear, however, that mitigating bias and reducing discrimination in the health professions is work that must happen in all health professions schools and education programs, including in dentistry, social work, public health, allied health worker, and other programs.

Another topic that requires more exploration: the pressing need for effective institutional policies and procedures that support health care learners and practitioners when they are targeted by patients’ discriminatory behaviors. While significant attention is paid to the ways that practitioners’ biased attitudes and discriminatory behaviors negatively impact patients, health care providers and learners are also harmed when they are discriminated against by patients, which can then also negatively impact patient care. This topic is explored in depth in this issue by Chandrashekar and Jain, who call it a “less-studied and particularly complex topic.” But it is a topic of great concern in the health professions, having recently been discussed in a variety of publications, and it deserves continued exploration. Chandrashekar and Jain provide frameworks for individual clinicians to use when faced with discriminatory patients and describe what is needed at the institutional level.

Conclusion

The presence of harmful bias and discrimination in our health professions workplaces and learning environments diminish all of us—patients, staff, learners, clinicians, faculty, and administrators alike. We are all being called on to dismantle structural racism and legalized oppression in our health system. Mitigating harmful bias and eradicating discrimination in health professions learning environments are necessary to achieving diversity, equity, and inclusion in health and health care. The papers that follow provide insights and lessons from efforts to build learning environments in medicine and nursing education from which others can benefit and learn—including those in other health professions. As some of the papers have suggested, it is the professional responsibility of those of us in the health professions to advance diversity, equity, and inclusion as a means to fulfilling our social contract to improve health and health care for all.

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References


