Morehouse School of Medicine Case Study:
Teacher–Learner Relationships Free of Bias and Discrimination

Martha L. Elks, MD, PhD, Khadeja Johnson, MD, and Ngozi F. Anachebe, MD, PharmD

Abstract
Bias can impact all aspects of human interactions and have major impacts on the education and evaluation of health care professionals. Bias in these settings is a systematic error in judgment by an assessor. In interpersonal interactions, human beings act on the basis of assumptions that are based on prior experiences or instruction. We learn from interpersonal interactions, develop assumptions based on these interactions, and apply them to subsequent interactions. These heuristics facilitate daily functioning, but can lead to unfair presumptions that impair learning and contribute to a toxic learning environment.

While it is true that these biases, which we apply in interactions every day, can be positive or negative, they can cause errors in judgments. We make assumptions, we infer, that, in general, individuals who smile and interact warmly are knowledgeable, caring, and empathetic because that has been the character spectrum we have associated with these observable behaviors. The truth is that we may be dealing with an uncaring but convincing actor or heartless manipulator. Or we may be put off by quirks, attire, or mannerisms and make other assumptions which may or may not be true. These assumptions—positive or negative—can lead to bias in assessment. These biased assessments, in turn, impact the effectiveness of interpersonal interactions in health care settings, can impact not only the quality of care and quality of learning assessments but also fairness of the learning environment.

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Health care and health professions education, being very dependent on interpersonal interactions and learning and on the assessment of interpersonal behaviors and skills, are particularly susceptible to the positive and negative effects of bias. Verbal communication skills are commonly evaluated in a clinical setting. Even trained and experienced evaluators can be affected by biases based on appearance, attractiveness, charm, accent, speech impediment, and other factors that should not play a role in the assessment of a skill. At the Morehouse School of Medicine, elements in the curriculum and the milieu help decrease the burden of bias experienced by learners. In addition, many of the learners develop knowledge, skills, and attitudes that appear to assist them with navigating bias in other learning or practice environments. In this case study, the authors reflect on these elements and how they can be replicated in other settings. According to the authors, modifying the learning environment to enhance and sustain relationships is key in addressing toxic bias.

Please see the end of this article for information about the authors.

Correspondence should be addressed to Martha L. Elks, Morehouse School of Medicine, 720 Westview Dr. SW, Atlanta, GA 30310-1458; telephone: (404) 752-1881; email: melks@msm.edu.

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we can see each other, each learner, and each patient as the unique person that they are?

The Morehouse School of Medicine (MSM) is a historically Black institution with about 70% of the MD program student body being from URiM groups—a 64% Black, 5% Latino, and 1% other URiM. Faculty are about 66% Black and 2% Latino. MSM has a track record of students outperforming their entering credentials on Step 1. Part of this success is due to elements in the curriculum and the milieu that decrease the burden of bias experienced by learners. In addition, many of the learners develop knowledge, skills, and attitudes that appear to assist them with navigating bias in other learning or practice environments. In this case study, we reflect on these elements and how they can be replicated in other settings.

Environment Supports Learning Through Relationships

From the beginning, the tripartite mission of the MSM has been to enhance diversity of the health care workforce, expand the primary care workforce, and address the health care needs of underserved populations. In fulfilling this mission, MSM developed a uniquely nurturing environment with high expectations, sustained support, and strong and lasting faculty–student interactions. Recruiting an academically diverse student body, MSM has achieved key outcomes including being recognized as number one in social mission as defined by percentage of URiM graduates, graduates practicing in underserved areas, and graduates practicing primary care. MSM is also recognized for “shifting the curve” of academic performance, enabling students whose performance on the Medical College Admission Test was a standard deviation below the mean for national matriculants to accredited medical schools to have Step 1 scores at and above the national mean.

MSM has built on the student-centered focus intrinsic to its roots as a historically Black institution to support a family atmosphere and a welcoming environment that is characterized by a high degree of engagement by a core of highly dedicated faculty and staff so that every learner can succeed. MSM has created a way to address bias in the health care environment through a threefold approach:

1. Creating a relationship-centered, welcoming environment that values faculty–student and student–student relationships and diversity in the broadest sense;
2. Fostering a growth mindset, with high standards and high support; and
3. Preparing learners to collaborate in changing the environment and be “agents of positive social change” committed to mission.

This approach is summarized in Table 1 and is described below.

Commitment to relationships in a welcoming environment

MSM, like many historically Black institutions, fosters a family-like environment in which students are known as individuals and faculty bring their whole selves to work. Regardless of background, race, gender, orientation, or other factors, MSM faculty, staff, and students are bound together by a shared commitment to mission and to learning in relationship. To foster the development of strong student–faculty and student–student relationships, our students participate in longitudinal learning communities from day one of year one of the MD program. These communities, named for our core values (including Knowledge, Wisdom, Excellence, Service, Integrity, Innovation, Leadership, and Compassion) include a cross section of the diverse class and are led by 2 or more faculty.

In these learning communities, students discuss and practice teamwork, communication skills, leadership skills, dealing with ethical dilemmas, career awareness, transitions, and other similar skills and tasks. The communities are structured to be relational and to help students form strong connections with each other. They continue in these same learning communities throughout their 4 years. The differences in points of view in these groups help students to develop approaches to dealing with different opinions and to be able to disagree without being disagreeable. This foundation in learning communities helps students to appreciate different perspectives and to practice skills in keeping peers on task.

Supportive relationships between faculty and students are nurtured through a curriculum that assures significant longitudinal faculty–student contact. These core faculty are a cadre of diverse and highly committed teachers who have each provided more than a thousand hours of direct medical student education. In every contact, they demonstrate that they truly care for the students and embody the commitment of the institution to our students and to excellence. Rather than a different faculty member for every session of the curriculum, students have significant contact over months to years with these 20+ core faculty. This relationship-centered learning empowers a sense of belongingness on the part of the students that allows them to excel academically. These interactions foster the trust of faculty and the hard work necessary to succeed. This environment enables the students to develop an empowering self-confidence that counteracts the toxicity of prior experiences with bias and prepares them to navigate future bias.

Core to the mission is a commitment to the community we serve. We are surrounded by an underserved community, and we engage with the community in every way. First of all, we are of this community, with many of our faculty, staff, and students coming from Atlanta and Georgia. Our students are in and with the community from the first year. In small groups, MD students participate in a yearlong service-learning course in community health. The groups (same as for the learning communities, but with different faculty mentors) work with a local community to do a needs assessment and to design and carry out an intervention. Core to this experience is focusing on community self-assessment of health needs rather than abstractly applying what the experts say. This experience supports teamwork as well as truly and respectfully engaging with community members. In this course, as well as in multiple other activities of MSM, we are of the community, in the community, and with the community, as we cocreate a healthier community. This experience helps the learners to confront personal, peer, and other biases and to start to build a repertoire of skills to navigate these many biases.

Faculty role models are an important aspect of this welcoming, connected environment. MSM has Black and
Table 1
Elements at Morehouse School of Medicine That Diminish the Impacts of Bias

<table>
<thead>
<tr>
<th>Domain</th>
<th>Elements</th>
<th>Results</th>
<th>Impact on bias</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learning in relationship</td>
<td>Core cadre of faculty with significant longitudinal student contact</td>
<td>Students and faculty come to know each other as individuals</td>
<td>Relationship diminishes stereotypical biases</td>
</tr>
<tr>
<td></td>
<td>Strong faculty-student and student-student interactions</td>
<td>Trust and belongingness</td>
<td>Trust diminishes negative bias</td>
</tr>
<tr>
<td></td>
<td>Diverse role models</td>
<td>Identification of shared experiences</td>
<td></td>
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<td></td>
<td>Story-telling and sharing</td>
<td>Diminished barriers of differences</td>
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<td></td>
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<tr>
<td>Growth mindset: All belong here and can succeed</td>
<td>High expectations</td>
<td>No “racism of low expectations”</td>
<td>Readiness to confront bias</td>
</tr>
<tr>
<td></td>
<td>High support</td>
<td>Academic success</td>
<td>Skills to overcome bias</td>
</tr>
<tr>
<td></td>
<td>Support for all</td>
<td>Diminished stigma of receiving support</td>
<td>Sense of right to support without bias</td>
</tr>
<tr>
<td></td>
<td>Variety of perspectives for defining success</td>
<td>Broader definition of success</td>
<td>Awareness of narrowness of biased views</td>
</tr>
<tr>
<td>Commitment to mission: “You are agents of positive social change”</td>
<td>Discussion of biases and their impact on health and health care</td>
<td>Awareness of the role of bias</td>
<td>Skills in recognizing bias</td>
</tr>
<tr>
<td></td>
<td>Role models of activism and commitment to service</td>
<td>Insights on navigating bias</td>
<td>Skills in responding to bias</td>
</tr>
<tr>
<td></td>
<td>Focus on social determinants of health</td>
<td>Awareness of the context of bias</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Meaning and purpose of mission</td>
<td>Awareness of the central role of confronting bias</td>
<td>Importance of navigating bias</td>
</tr>
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</table>

African American faculty as well as a broad spectrum of faculty of diverse cultures, races, ethnicities, religions, countries of origin, sexual orientation, disability status, and other characteristics. These faculty demonstrate strong interpersonal skills and commitment to mission. They serve as role models for learning in relationship as well as providing guidance on navigating complex sociocultural experiences. MSM is blessed with large numbers of women in leadership positions, as well as faculty representing the lesbian, gay, bisexual, transgender, queer spectrum who serve as role models for a variety of learners. Through personal stories and reflections on lived experiences, they provide guidance for navigating bias and demonstrate approaches to confronting and ending injustice. Our faculty and our students are diverse in so many ways, with a broad spectrum of races, ethnicities, and cultures of origin. Our students have clinical experiences not only at Grady Memorial Hospital but also in a variety of settings across the state of Georgia. Thus, MSM students work with a broad spectrum of faculty, staff, and patients during their training. This diversity hone’s their skills of adapting to multiple cultures and expectations.

Together, these elements of a connected, welcoming environment create safe opportunities to explore the elements of bias and to develop skills in navigating complex situations of differences. The commitment of leadership to diversity and awareness of bias is also key. Unconscious bias is addressed experientially in class sessions. These are addressed in year one in lecture and discussion on the context of the racism and bias that has been a part of American history since its founding and has impacted national policies on health care throughout history. This discussion is continued in years 2 and 3 both in clinical skills instruction and experience and in small-group discussions.

In these ways, MSM prepares learners for an environment of bias by connection, role modeling, shared stories and experiences, and structured experiences. Students learn from each other and from the diverse family that is MSM. These strong relationships with each other, the faculty, and members of the community provide students a direct experience of the ways true relationships can overcome the biases of superficial contacts. These experiences give learners a richer context in which to view the issues of health care and bias and to develop skills to perceive and navigate the biases intrinsic to health care.

Growth mindset with high expectations and high support

In recruiting and supporting an academically diverse student body, MSM faculty and leadership systematically promote a growth mindset of high expectations in an environment of high support. As outlined by Carol Dweck, a growth mindset focuses the potential for learning and skill-building in everyone.4 Using metrics, analytics, feedback, and support, MSM students academically outperform their entering credentials. The strong student–student and student–faculty relationships support overcoming stereotype threat and the residual toxicities of prior bias. The academic success of students in this nurturing environment helps students to develop the skills, confidence, and tools to navigate bias in the environments that they will experience. Even after leaving MSM for residencies, alumni network with faculty and current learners to help guide their pathways in less supportive environments.

Student academic performance is closely monitored by the team of faculty course leaders. Faculty course leaders review scores as a team, and students with deficits in any area are closely monitored and linked to resources. These resources include free tutoring by paid near-peers (available to all students regardless of academic performance), as well as counseling and academic coaching. Faculty are approachable and often provide one-on-one or small-group sessions as needed to help students master certain key concepts.
Another aspect of support is through the Office of Student Learning and Educational Resources. This office oversees more intensive coaching of students who show a pattern of low exam performance. This effort includes coaching on study skills, time management, use of learning materials, critical thinking skills, and content and concept review. The faculty involved with the students seek to know the students well and provide appropriate guidance based on the student’s individual skills and strengths as identified by the student, by exam performances, and by faculty assessments. Key faculty with extensive content knowledge meet as needed with students and groups to build concept knowledge and critical thinking skills.

Commitment to mission: “You are agents of positive social change”

MSM recruits and admits with specific attention to our mission. We then create learning environments that train for the mission, and we foster our students’ seeking residencies and practice sites that fulfill the mission. MSM faculty, staff, and students share a passion for excellent care for all peoples. For MSM, the mission has been core from the foundation and is present in all aspects of the institution. This commitment to the mission is broadly welcoming. From the first day at MSM, MD students are in an environment where they are regularly coached that they are “agents of positive social change” and the “doctors America needs.” Class sessions engage directly with the limitations of the health care system in addressing the needs of underserved patients, the impacts of social determinants, and the importance of being a part of changing the system for the better. With a school vision of “leading the creation and advancement of health equity,” there is no doubt about the expectation that MSM will catalyze vital changes in health for our nation. This audacious vision turns the personal challenge of bias to a surmountable barrier in the necessary struggle to improve health for all. The global commitment of the institution to this mission creates and sustains a sense of meaning and purpose that energizes students and faculty to exceed expectations.

In these ways, MSM students experience a multifaceted experience to prepare them for the bias that they or their colleagues will face. MSM does not eliminate bias. It does not simply train bias away. Neither of these is possible. Through the shared experiences of our diverse student body, environment, curriculum, support, and a relational culture, MSM prepares our graduates to recognize and navigate bias and to help minimize and detoxify bias in the health care environment. Many of these elements can be replicated in other settings to decrease bias in the learning environment.

**Impacts of Bias in American Culture and Health Care**

The culture and priorities of health care and medical education may exacerbate the development and perpetuation of negative biases or restrictive/biased stereotypes. The cultures of American health care have often been hierarchical and impersonal. While professing commitment to “excellence,” hierarchical structures have overvalued the demands of certain physicians in power and have silenced the needs of trainees and fellow professionals on the health care team. Competitive pyramidal training programs and long training hours have been partially curtailed by current graduate medical education policies. Unfortunately, work-hour restrictions may have further impersonalized the residency training experience as shift work, treating physicians, trainees, and patients as interchangeable parts. The electronic medical record (EMR) and the ubiquitous computer screen have further added to the disconnect between people. With eyes on the i-patient rather than on the patient, the caregiver is deprived of the breadth of deeper human connection. The overemphasis on multiple-choice, single-best answer testing to progress into and through medicine and health care training creates and sustains some biases. We inadvertently encourage all of our health care trainees to favor typical associations and take mental shortcuts that lead to heuristic errors and bias in the management of specific patients from certain backgrounds. Risk associations such as sickle cell in African Americans, cystic fibrosis in Caucasians, or ischemic heart disease in men can result in correct answers on critical exams and blindness to these conditions in those not expected to be at risk.

In addition, the lived experience in many health care settings is that persons of color and women are more likely to be in custodial or support roles rather than leadership roles. Combined with historical hierarchies in medical centers, biases based on gender, race, ethnicity, sexual orientation, disabilities, or other differences enhance the development of dysfunctional biases when learners have clinical experiences. If one’s only experiences with people of a certain race, culture, ethnicity, disability, or other difference is only in the context of serving such populations in a safety-net hospital or free clinic setting, one may incorrectly develop a mental heuristic that “this is the way all people of this background are.” Without intentional action to change or counteract these realities, the milieu of American health care enhances the development of biases that impair the achievement of the vision of a diverse engaged health care workforce.

The antidote to bias is relationship. As President Abraham Lincoln famously stated, “I don’t like that man. I must get to know him better.” Neither faculty nor learners nor patients are interchangeable parts; they do not have all the same talents or the same needs. These differences are best explored in developing strong relationships. Edward T. Hall defined high-context and low-context cultures. In low-context cultures or transactional cultures, a relationship is not necessary for business to take place. This is exemplified in the chains of fast food establishments that line our interstates. One knows exactly what one will get when one orders the hamburger. It is different in the high-context or relational culture of the independent restaurant that one may frequent in the neighborhood. One may know the servers, and they know one’s preferences. In a relational culture, building trust is central and there is connection before content. Marginalized and underserved populations in the United States have often experienced direct bias in health care settings because their lives and realities do not fit the model of “the ideal patient.” They are different, more complex, more time-consuming.

The ideal educational environment involves trust and relationship between teacher and learner. This is a core aspect of success in historically Black colleges and schools. As noted by educator Lisa Delpit (referring to K-12 students), “Our students don’t learn FROM a teacher,
they learn FOR a teacher.” A common theme in stories of success for students who are URiM is the strong relationship with a teacher or teachers who believed in the student and had a long-term trusting relationship with the learner. These environments would be characterized by sociologist Edward T. Hall as high context environments would be characterized by the student and had a long-term trusting relationship with a teacher or teachers who believed in the student and had a long-term trusting relationship with the learner. This can be to the advantage of a charming, extraverted lover who looks and sounds like a doctor and to the disadvantage of anyone without these characteristics. In these transient settings, superficial biases are likely to take predominance over deeper assessments. Combined with the time stress of work-hour restrictions, the time-consuming EMR, and increasingly complex evaluation forms, deep and careful assessments are unlikely. These transactional environments foster the perpetuation of biases that favor the privileged. This perpetuation is antithetical to our goals of an equitable and fair learning environment that supports the training of a diverse workforce to meet the needs of the diverse patients who need care. Time in a relationship is critical. If the clinical supervisor does not have enough time to truly come to know the learner, then the evaluation will perform generic and undetailed.

Bias in the health care learning environment not only adversely impacts underrepresented students, but it can also lead to the perpetuation of bias in fellow trainees that will adversely impact their ability to optimally care for their future diverse patients. The experience of upper-class and upper-middle-class trainees with people from some backgrounds may be entirely limited to those they encounter in safety net settings. If 90% of the African American people with whom one has had interactions in one’s life are those using safety net systems, then one’s mental heuristics inevitably build a construct of African Americans as impoverished, poorly educated, and marginalized. If one does not consciously weave cultural diversity and mutual appreciation into a multicolor tapestry of health education and health care, one may not be able to fully address these challenges of bias. Failure to address this deficit in the educational experience of nondiverse trainees will perpetuate biased health care and derail the creation and advancement of health equity.

Conclusions

For these reasons, addressing bias requires awareness and action on the part of teachers and leaders and also requires skills and awareness on the part of learners. Addressing bias requires educational leadership to set a tone of openness and to model inclusion. It also requires modifications to the learning environments, including elements of setting, timing, recurrence, team structures, learning materials, curricula, and other elements that can impact individual bias, responses to bias, and perpetuation of bias. As noted above, sufficient time and duration of contact can be a critical element to diminish the impact of bias in learner evaluation. Obviously, decreasing bias in the health care environment is also a critical though more challenging goal to completely address. With supportive guidance and trusting relationships with supervisors/teachers, trainees can learn to recognize and navigate bias in the learning environment.

As has been demonstrated at MSM, having diverse faculty, residents, physicians, and high-level administrators is important in helping individuals who are not from underrepresented populations to see underrepresented learners as having capacity to serve in nonmenial and supportive roles. This will help change the script regarding how such individuals may be perceived by individuals who come from majority segments of the population. Medical schools recruiting a diverse class must also recruit and retain a diverse faculty, high-level staff, and administrators to provide role models and mentors for students from underrepresented groups and to help redefine the mindset that such individuals serve only in low-level supporting roles. Seeing health care as a business has invited industrial models that seek to standardize all interactions and codify best practices in guidelines. These can work well for what are truly transactional medical encounters—routinely screening, immunizations, and similar tasks. Chronic diseases and life-threatening conditions are another issue. We all long for that all-knowing physician who will take the time to know us, know our circumstances, and tailor the remedy to our uniqueness. In the shift work of today’s medical center, this is often an unfulfilled wish. What we deeply crave is relational care.

Our students crave relational learning. It is human nature to learn. It is also human nature to learn best from each other. It is human nature to crave direct approval from those who guide us. Medical center faculty, staff, and students are burning out due to a lack of relational experience, which is a human need. Modifying the learning environment to enhance and sustain relationships is key in addressing toxic bias. These are changes that are possible. These are changes that are energizing and vital for us to thrive.

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M.L. Elks is senior associate dean, Educational Affairs, professor of medical education, and professor of medicine, Morehouse School of Medicine, Atlanta, Georgia.

K. Johnson is associate professor of medicine, Morehouse School of Medicine, Atlanta, Georgia.

N.F. Anachebe is associate dean, Admissions and Student Affairs, and associate professor of obstetrics and gynecology, Morehouse School of Medicine, Atlanta, Georgia.

References


