Diversity Is Not Enough: Advancing a Framework for Antiracism in Medical Education
Sonja R. Solomon, MD, Alev J. Atalay MD, and Nora Y. Osman, MD

Abstract
Medical students, residents, and faculty have begun to examine and grapple with the legacy and persistence of structural racism in academic medicine in the United States. Until recently, the discourse and solutions have largely focused on augmenting diversity across the medical education continuum through increased numbers of learners from groups underrepresented in medicine (UIM). Despite deliberate measures implemented by medical schools, residency programs, academic institutions, and national organizations, meaningful growth in diversity has not been attained. To the contrary, the UIM representation among medical trainees has declined or remained below the representation in the general population. Inequities continue to be observed in multiple domains of medical education, including grading, admission to honor societies, and extracurricular obligations. These inequities, alongside learners’ experiences and calls for action, led the authors to conclude that augmenting diversity is necessary but insufficient to achieve equity in the learning environment.

In this article, the authors advance a 4-step framework, built on established principles and practices of antiracism, to dismantle structural racism in medical education. They ground each step of the framework in the concepts and skills familiar to medical educators. By drawing parallels with clinical reasoning, medical error, continuous quality improvement, the growth mindset, and adaptive expertise, the authors show how learners, faculty, and academic leaders can implement the framework’s 4 steps—see, name, understand, and act—to shift the paradigm from a goal of diversity to a stance of antiracism in medical education.

As medical educators, we strive to nurture an educational alliance with our trainees. This alliance, built on shared goals and trust, mirrors the therapeutic alliance that is core to our professional identities and mission.1 When our patients aches, we listen. Likewise, when our learners aches, we must lean in and hear their cries. The national reckoning with structural racism has amplified medical students’ and residents’ calls for changes in the structure and stance of health care and medical education in the United States. Our trainees are calling upon us to acknowledge and speak about topics that are often left out of standard academic medical discourse2,3 and to address parallels between the injustices outside the walls of academic medicine and those within. Honest conversations about race and racism require shared language and definitions. By understanding race as a social construct and racism as the hierarchical system that advantages certain racial groups and disadvantages others,4–6 we can come together to describe and grapple with the presence and persistence of racism in medical education and advance a framework for change.

Racism is deeply entrenched in American health care.7 Its history includes forced sterilization,8,9 surgical and medical experimentation without consent,10 and the deliberate withholding of medical therapy.11,12 Today, in 2021, we witness racial disparities across the spectrum of health outcomes, including life expectancy, infant and maternal mortality, and surgical outcomes.13 However, we have been slow to attribute these inequities to the effects and consequences of structural racism.

American medical education too is plagued by a legacy of racism. Early anatomy instruction involved the illegal seizure of Black bodies.7 Black students were denied admission to U.S. medical schools until the middle of the 19th century.14 Abraham Flexner’s 1910 blueprint for medical education reform15 led to the closure of all but 2 of the historically Black medical colleges founded in the late 19th century. Flexner’s recommendations shifted not only how we train physicians but also whom we train, stripping opportunity from Black students and depriving generations of patients of access to racially and culturally concordant care.16 Today, many medical schools continue to teach race as biologically, rather than socially, determined.17,18 Stereotyped representations of race and culture remain pervasive within curricular materials and resources designed to prepare students for standardized examinations.19,20

Until recently, efforts to redress historical and present harms have largely focused on increasing diversity in medicine.21 Diversity has been shown to be important for patients22–24 and academic leaders can implement the framework’s 4 steps—see, name, understand, and act—to shift the paradigm from a goal of diversity to a stance of antiracism in medical education.

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

Correspondence should be addressed to Nora Y. Osman, Department of Medicine, Brigham and Women’s Hospital, 75 Francis St., Boston, MA 02115; telephone: (617) 732-5500; email: nosman@bwh.harvard.edu.

First published online July 20, 2021
doi: 10.1097/ACM.0000000000004251
Copyright © 2021 by the Association of American Medical Colleges

Academic Medicine, Vol. 96, No. 11 / November 2021

Copyright © by the Association of American Medical Colleges. Unauthorized reproduction of this article is prohibited.
Research shows that the existing learning environment perpetuates educational inequity. UIM learners experience social isolation, heightened visibility, othering, and stereotype threat.\textsuperscript{35–39} In the absence of formal curricula about race and racism in medical school, UIM learners are frequently conscripted to teach peers and supervisors about race through the lens of personal experience.\textsuperscript{40} UIM learners and faculty are tapped to lead efforts to improve diversity and equity, often without dedicated time or resources.\textsuperscript{35,41}

There are racial disparities in grading\textsuperscript{42} and in admission to honor societies,\textsuperscript{43,44} which persist after adjusting for exam scores, clinical grades, and research productivity. Even slight differences in the assessment of clinical performance between UIM and non-UIM learners can translate to significant disparities in grades and admission to honor societies.\textsuperscript{45} This “amplification cascade”\textsuperscript{45} perpetuates inequity in access to future opportunities.

As these observations make clear, augmenting diversity is necessary but insufficient to achieve equity in the learning environment. Indeed, some steps taken to advance the goal of diversity may reinforce systems and structures that perpetuate inequity, including tokenism and the minority tax.\textsuperscript{41} We therefore suggest realigning our focus from the goal of diversity toward a stance of antiracism in medical education. This paradigm shift places antiracism as the foundation upon which we build an equitable learning environment. To paraphrase experts in the field, problems rooted in racism demand solutions grounded in antiracism.\textsuperscript{4,46}

**Advancing a Framework for Antiracism in Medical Education:**

**See, Name, Understand, and Act**

The medical education literature presents many instructive examples of antiracist innovations in pedagogy and educational structures. However, the steps required to implement these innovations are not always made explicit. We propose that the principles and practice of antiracism in medical education can be organized into a 4-step framework that builds on the framework proposed by Dr. Camara P. Jones\textsuperscript{4} and the work of others\textsuperscript{47–49}. See, name, understand, and act. Each step of this framework parallels skills and concepts that are familiar to us as medical educators—teaching clinical reasoning, confronting and learning from medical error, engaging in continuous quality improvement, and cultivating a growth mindset and adaptive expertise. These parallels allow us to harness familiar processes for the challenging, unfamiliar work of dismantling structural racism in medical education. We expand on each of the steps, below.

**See**

We cannot change what we do not see. Some manifestations of racism are overt, whereas many are subtle and not universally recognized. The extent to which we see racism as operating within our learning environment depends greatly on our personal experiences and the complex, multifaceted context of our socialization.\textsuperscript{51} The work of antiracism begins with training ourselves as individuals and as a community to become aware of the legacy of power and advantage inherent in the norms we take for granted. This story of power and advantage is repeated in the makeup of medical school faculty,\textsuperscript{52,53} in how we recognize and memorialize success and contributions,\textsuperscript{44} in how we care for our patients,\textsuperscript{59} and in how we learn about illness and health.\textsuperscript{60} Learning to see means becoming aware of both the dominant narrative and counternarratives. It means recognizing that the power structures and norms to which we are acculturated are not the only ones possible.

Even when we are strongly motivated to confront our blind spots,\textsuperscript{56} the practice may be daunting. Yet, we can approach this work by incorporating the processes of clinical reasoning. We teach our learners to observe, to think aloud, and to describe patterns in the form of illness scripts. We encourage them to draw on their experience and prior knowledge to understand a new situation.\textsuperscript{57} We caution them to avoid the error of premature closure by attending to information that challenges their first hypothesis. We can apply these habits when we train ourselves to notice, attend to, and describe both overt and insidious patterns of racism.

We can formalize the work of seeing at both the individual and institutional levels. As individuals, we can engage in training that fosters mindfulness and self-awareness.\textsuperscript{58} Institutions can offer formal implicit bias training for faculty, staff, and trainees, coupled with facilitated discussion of racial disparities within the learning environment. This training should be conducted by faculty who have specific expertise in creating spaces that are psychologically safe\textsuperscript{59} and do not unintentionally perpetuate harm.\textsuperscript{50} Institutions can organize morbidity and mortality or quality and safety rounds during which the effects of racism are explicitly brought into the discussion of medical cases.\textsuperscript{59,60} Institutions can leverage both narrative\textsuperscript{46} and data\textsuperscript{55} to deepen collective knowledge and understanding of racism.

**Name**

Once we see racism, we must name it.\textsuperscript{4} We have been socialized against naming racism by conceptualizing it as solely the intentional and malicious beliefs or actions of individuals, rather than as ubiquitous structures of power and advantage.\textsuperscript{4,46} Some among us may also be constrained by feelings of shame or avoidance or by inexperience and insecurity in speaking about race and racism. Some may mistakenly believe that we can attain educational equity without being explicit about the legacy and persistence of racism within our learning environments. However, naming confers specificity, clarity, and importance. The language we use empowers us to understand, rectify, and move forward.\textsuperscript{41}

We can teach ourselves and our learners to name racism by drawing parallels with our approach to confronting and learning from medical error. We teach learners that both individuals and systems are vulnerable to medical error and that every clinician has a role in responding to it.\textsuperscript{52,63} We build multilayered structures to prevent safety lapses, and we champion the creation of a just culture that shifts the focus from blame to understanding and growth.\textsuperscript{64} Knowing that error is inevitable, we strive to acknowledge, disclose, apologize, and learn. We can create and nurture a culture that recognizes that we are all vulnerable to perpetuating racism and responsible for rectifying it. Naming racism requires moral courage, but of a sort that should not be alien to us.

Institutions can formalize and standardize the process of naming racism. They can create reporting systems for racial bias or mistreatment that uphold principles of confidentiality, trust,\textsuperscript{65} and
Faculty and institutional leaders can disclose and discuss observed racial disparities in key medical education metrics, including those pertaining to medical school admissions and matriculation, grading and awards, residency and fellowship placement, and academic promotion. By naming what we see, we explicitly make a commitment to doing better. Structures and policies that promote transparency and honesty reflect curiosity, courage, and openness to change.

Understand

The many manifestations of racism in medical education are complex, and the solutions require robust characterization of the problems. When we see and name racism, we must explore its underpinnings and consequences with the same methodological rigor that we would apply to any area of scientific inquiry or process improvement. Without critical examination of the problems we observe, we risk hasty, unilateral, and incomplete solutions. Possible barriers to achieving a nuanced understanding of racism within the learning environment include the inability or reluctance to see or name racism or, conversely, the desire to act quickly and decisively. However, some of the most complex and intractable disparities in medical education—such as racial disparities in assessment, the impact of structural inequity on standardized test performance, and the academic attrition of UIM faculty—cannot be solved simply. Local drivers of disparities can be as important as larger structural factors. Therefore, the work of understanding must encompass data collection and analysis at the level of individual medical schools, academic medical centers, clinical departments, and affiliated hospitals.

Institutions can support the step of understanding by partnering with learner groups, patient and community groups, and faculty and administrative leaders to gather both quantitative and qualitative data. They can designate resources to enable thorough and nuanced examinations of observed problems. Adopting a culture of quality improvement by shifting focus from individuals to systems is an integral step.

Institutions at the forefront of antiracism innovation have conducted comprehensive and multilateral needs assessments through surveys and exploratory sessions with stakeholders. Some have taken this work further by bringing outside advisors and assessors in to help them see what they may not be able or willing to see.

Act

Once we see, name, and understand racism within our learning environment, we must act. Enacting antiracist changes in pedagogy, policy, and culture requires personal and institutional commitments. Despite best intentions, antiracist interventions may be hindered by institutional inertia, comfort with the status quo (particularly among those who benefit from it), and the caution and risk aversion that we may adopt in our professional training.

We can support one another in the work of antiracism by embracing the concepts of the organizational growth mindset and adaptive expertise. When individuals and institutions hold a growth mindset, they engage with what is uncomfortable, seek out what is challenging, learn from and feel emboldened by failure, and embrace a sensibility of continuous striving.

Adaptive experts use problem solving to apply new knowledge in flexible, creative, and innovative ways, pushing the limits of their knowledge and tolerating the associated risk. Embracing these concepts will steer us toward action that is iterative, sustained, and collaborative.

Institutions can be accountable by investing robust resources in the development and implementation of sustainable change. We must identify measurable goals and metrics and be transparent about processes and progress. Leaders and learners can collaborate across institutions to exchange ideas and best practices. National organizations can establish priorities, share knowledge, and reinforce accountability. New approaches grounded in equity must be implemented and evaluated within every domain of medical education, including admissions, curricula, assessment strategies, the learning environment, and institutional culture. Although some of these changes will be visible and publicly celebrated, small innovations are just as important. The interventions within our walls must also be accompanied by transformative change in the relationships between academic medical centers, the people that they employ, and the communities they serve.

Conclusion

Medical educators bear intersecting responsibilities to our learners, patients, and communities. Our professional obligations demand that we see, name, understand, and act to dismantle the destructive effects of racism within the learning environment and the inequitable structures that undergird our institutions. To do so requires that individuals and institutions realign our efforts from a goal of diversity toward a deliberate stance of antiracism in medical education. This paradigm shift can only take place in a just culture that empowers us to unlearn entrenched assumptions and habits, to acknowledge and grow from our inevitable errors, to tolerate risk, and to cultivate shared purpose and inclusivity.

In conceptualizing antiracism as a stance, we understand it not as a task, an event, or an outcome but as a shared, lifelong practice. This transformative work will be challenging, but we must embrace these challenges undaunted. It is our professional and moral duty to do so.

Acknowledgments: The authors would like to thank David A. Hirsh, MD, and the Harvard Medical School Academy, Barbara Gottlieb, MD, MPH, Beverly Woo, MD, Edward Krupat, PhD, and the Brigham and Women’s Hospital Department of Medicine.

Funding/Support: None reported.

Other disclosures: None reported.

Ethical approval: Reported as not applicable.

S.R. Solomon is instructor of medicine, Department of Medicine, Brigham and Women’s Hospital, Boston, Massachusetts.

A.J. Atalay is instructor of medicine, Department of Medicine, Brigham and Women’s Hospital, Boston, Massachusetts.

N.Y. Osman is assistant professor of medicine, Department of Medicine, Brigham and Women’s Hospital, Boston, Massachusetts.