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Creating Action to Eliminate Racism in Medical Education

Medical Education Senior Leaders' Rapid Action Team to Combat Racism in Medical Education

Medical Education Senior Leaders (MESL)

Association of
American Medical Colleges

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This document was created by Medical Education Senior Leaders (MESL) and is intended for the Medical Education Community. All content reflects the views of MESL and does not reflect the official position or policy of the AAMC unless clearly specified.

The AAMC (Association of American Medical Colleges) is a not-for-profit association dedicated to transforming health through medical education, health care, medical research, and community collaborations. Its members are all 155 accredited U.S. and 17 accredited Canadian medical schools; more than 400 teaching hospitals and health systems, including Department of Veterans Affairs medical centers; and more than 70 academic societies. Through these institutions and organizations, the AAMC leads and serves America's medical schools and teaching hospitals and their more than 179,000 full-time faculty members, 92,000 medical students, 140,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences. Additional information about the AAMC is available at aamc.org

Outline:

Executive Summary

The purpose of this document is to provide medical schools' educational leaders and their institutions with guidelines and action steps to dismantle racism in medical education. It is also intended to provide the AAMC Medical Education Senior Leaders (MESL) community with action steps forward to eliminate racism across the continuum of medical education.

Throughout medical training, race is used as a biological risk factor despite the growing recognition that race is a socially derived concept. This misuse creates an improper connection for learners and perpetuates the theory of biologically derived racial differences (Tsai et al., 2016). Medical education senior leaders must immediately embark on educating themselves and assessing their institutions' educational curricula and policies to end racism in medical education that persists and results in health inequities for patients and career inequities for physicians who are Black, Indigenous, and people of color.

The recommendations in this document are divided into immediate actions, short-term goals, and long-term goals. There is an urgency to begin work now, and **immediate actions** for institutions should begin today with acknowledging that racism in medicine is a long-standing and unacceptable problem. Medical school senior leaders must analyze the current state of their educational programs with regard to addressing racism and begin a conversation on how to move forward. Institutional leads for antiracist efforts in medical education should be designated, and resources should be allocated to support the work of these individuals.

Short-term goals should focus on creating structural changes in medical schools and national organizations. We must analyze policies and procedures through an antiracism lens, identifying and removing those that result in systemic racism. Institutions should conduct a structured institutional self-study using a mixed-methods analysis to determine the state of racism in medical education. Finally, faculty development within institutions is essential. Faculty must be equipped with the language and understanding to dismantle racism within education. Transdisciplinary scholars who are able to teach about racism in medicine in medical schools and academic medical centers (AMCs) should be developed.

Medical education senior leaders at medical schools must focus their **long-term goals** on engaging in ongoing evaluation of their changes to address racism and ensuring they continue to move forward towards creating an antiracist culture. Antiracist action items should be added to medical education continuous quality improvement, and all medical education policies should be reviewed regularly to determine if they support antiracist efforts. Antiracism faculty and trainee development should be required and offered at least annually. Institutions should develop coordinated efforts with all affiliated hospitals and associated AMCs to support an antiracist clinical learning environment for all learners.

Finally, as an AAMC convened forum, **MESL** must drive changes to create an antiracist learning environment and ensure this remains a priority in medical education. We must partner with groups within AAMC, national organizations critical to medical education, and students and residents to create structural changes in medical education that persist. Through a national collaborative, tools and metrics need to be created that help medical schools with the process of becoming antiracist learning environments and guide them in understanding the areas that have been impacted by long-standing bias and privilege.

Purpose

As members of the AAMC MESL, we condemn the structures of racism that have allowed inequities in medicine and medical education to persist and are committed to combating racism in medical education by creating policies and changes that will support an antiracist learning environment and culture.

This document is intended to guide medical education senior leaders at medical schools and their administration, faculty, and staff with the process of eliminating racism in medical education at their institutions. It is also intended to guide MESL, the collective group of medical education senior leaders within the AAMC, with action steps to take as a collaborative forum of educational leaders. The goal of this document is to describe immediate, short-term, and long-term actions that can be implemented to support a sustainable antiracist culture.

We are committed to working with our educational partners across the continuum of education and with other organizations to support antiracist efforts to improve the learning environment for all learners.

Background

Racism in medicine has existed for centuries and continues to be present at all levels within our educational and health care infrastructure. Racism is an important factor in racial and ethnic health inequities but has not been explicitly and adequately addressed by medical educators. For example, in many curricula and clinical environments, race continues to be used as a biological risk factor despite the growing recognition that race is a socially derived concept. This misuse creates an improper connection for learners between race, genetics, and sociological racial disparities that perpetuates the theory of biologically derived racial differences (Tsai, 2016). When structural barriers to health care are not examined, blame is often placed on individuals from marginalized racial groups for their health outcomes, and further research and action to remove structural barriers stagnate (Villarosa, 2019).

As stated by the AAMC, "the academic medical community must not be bystanders and must speak out when faced with views that perpetuate racist beliefs and stand in the way of progress" (Skorton and Acosta, 2020). A commitment to addressing race and racism in education goes beyond describing social determinants of health, health disparities, and implicit bias and must also include an acknowledgment of the power and privilege that have perpetuated institutional racism and have reinforced negative stereotypes and false beliefs about racialized groups. In order to change how learners understand and address race-based disparities, medical education leaders must analyze and take action against the power differentials and privilege that create and perpetuate such inequities.

As Dr. Ibram X. Kendi (2019) states, "Like fighting an addiction, being an antiracist requires persistent self-awareness, constant self-criticism, and regular self-examination." As medical educators, we must explicitly address the history of racism in medicine, assess our curricula and training, and develop antiracist policies that will support sustainable change across our institutional structures from admissions to CME. This process requires cultivating a race consciousness in ourselves and our institutions. Ultimately, we need to accept the challenge of implementing antiracist policies and practices within our medical schools, clinical learning environments, national organizations, and governing bodies.

Recommendations for Medical Schools

Immediate Actions

Background

In order to cultivate race consciousness, MESL must embark on a collective education with the following objectives: (i) promote shared definitions of race, ethnicity, ancestry, bias, racism, oppression, privilege, antiracism, diversity, equity, social justice, and dominant culture; (ii) recognize sentinel events in American history and medicine leading to present-day race dynamics; (iii) describe the key manifestations of racism in present-day medical education; and (iv) discuss how these issues are manifested in our communities and institutions locally.

Immediate Actions for Medical Education Senior Leaders

Each medical education senior leader should proceed locally to accomplish the following:

1. Acknowledge with your learners and faculty that racism exists in medicine and medical education and describe its history.

2. With regard to addressing racism, begin a conversation with other senior leaders at your institution about the current state of your educational programs (admissions, curricula, student support programs, assessment systems, Alpha Omega Alpha [AOA], awards and other honors programs, residency selection and education, and CME).
3. Designate institutional leads for the antiracist effort in medical education at your own institution. These may be the education senior leaders themselves, other institutional leaders, or their designees. In designating others to lead this effort, medical education leaders must recognize that this effort cannot be carried out alone by individuals who self-identify as underrepresented in medicine.
    a. Allocate resources for these individuals and their efforts.
    b. Identify problems and create an expectation of defining specific actions and how those will be monitored.
    c. Emphasize changing reactive, immediate responses into long-term, proactive actions.
4. Assess institutional readiness to take part in a national consortium of institutions that wish to participate in antiracist action (according to the steps specified below).
5. Ensure that there is visual representation of diversity at your institution, including on websites and in physical spaces.

Immediate Actions for MESL

1. Convene a special session for interested MESL members at the next AAMC annual meeting to identify and prioritize key antiracist initiatives for medical education within the domains of admissions, curriculum (UME, GME, and CME), assessment, student support, residency selection, faculty recruitment and retention, and faculty development.
2. For member institutions, compile a glossary of terms and a resource list that include key definitions, the history of racism in medicine, and evidence-based articles that can be used for teaching and faculty development.
3. Develop an antiracism self-assessment tool to be used for institutional self-study and delineate institutional and national surveys that can be utilized for self-assessment (including specific items in the AAMC Year Two Questionnaire and Graduation Questionnaire [GQ]).
4. Include antiracism as a standing item on the MESL meeting agenda at least quarterly for updates and progress on action items.
5. Collaborate and communicate with other AAMC groups also engaging in antiracist efforts.

6. Maintain a standing task force to address antiracism in medical education for at least one year as part of MESL.
7. Support the development of a national collaborative focused on antiracism in medical education.

Short-Term Goals

Background

In order to encourage short-term actions and create structural changes, leaders, institutions, and national organizations must commit to ensuring that curricular content, teaching methods, high-stakes exam strategies, and education policies support antiracism throughout the continuum of learner education from premedical pathway programs to independent practice. The short-term goals described here are goals that should be completed after the immediate actions have been taken. They are intended to be addressed within the next 6-12 months with defined action steps.

Short-Term Goals for Medical Education Senior Leaders

1. Educate yourself as you develop programs for your students, residents, and faculty.
    a. Develop a personal development plan for yourself as a leader to better understand the impact of racism on medical education, health, and society.
2. Reflect on and analyze your leadership style and beliefs related to antiracism.

Short-Term Institutional Goals

1. Conduct an internal review of your institutional educational offices and programs.
    a. *Policies:* Investigate policies and procedures through an antiracism lens, identifying and removing or adapting those that result in an unjust system. Specific areas for investigation may include:
        i. Admissions policies and priorities;
        ii. Financial aid;
        iii. Curriculum components, including lectures, cases, rubrics, and assessments that may hold inherently biased or racist content;
        iv. Assessment systems (multiple-choice question exams and clinical assessments);
        v. AOA and Gold Humanism selection;

vi. Residency/fellow selection;
vii. Staff and faculty hiring practices, including diversity of educational leadership (i.e., program directors, clerkship directors, and deans);
viii. Promotion criteria;
ix. Salary equity and incentive programs for faculty and staff;
x. Clinical learning environment, including clinical programs; and
xi. Research practices, particularly those involving communities of color.

b. *Institutional Self-Study:* Conduct a structured institutional self-study using a mixed-methods analysis to determine the state of racism in medical education at your institution.
c. *Faculty Development:* Advocate for faculty development within your institution to equip faculty with the language and understanding to dismantle racism within education. Develop transdisciplinary scholars who are able to teach about racism in medicine in medical schools and AMCs.

Short-Term Goals for MESL

1. Develop tools to conduct self-studies focused on antiracism that can be customized to individual institutions.
2. Develop sample antiracist medical education policies that can be used by institutions (similar to sample affiliate agreements).
3. Work with AAMC, its member groups, and educational partners to identify system challenges that perpetuate racism in medical education.
    a. This may include working with LCME, NBME, USMLE, MCAT Validity study group, and AAMC Diversity Policy and Programs to address topics such as premed and pipeline program investments, medical school rankings, accreditation standards, assessment methods, data gaps in national and graduate surveys, practices in allocation of financial aid, etc.
4. Work with national minority physician organizations, including but not limited to the AMWA, NCAPIP, NMA, AAIP, and NHMA.

Long-Term Goals

Background

Medical education senior leaders must engage in ongoing evaluation of the changes they are making to ensure that they continue to meet the goals set out in this document and that the goals remain current and appropriate. Long-term goals should be developed through an ongoing consortium created by MESL for member institutions. The following items are initial long-term goal recommendations.

Long-Term Institutional Goals

1. Medical Education Program:
    a. All medical education policies should be reviewed to determine if they support antiracist efforts.
    b. Curriculum committees should develop antiracism medical education program objectives.
    c. Antiracist action items should be added to medical education continuous quality improvement efforts.
    d. Antiracism faculty and trainee development should be required and offered at least annually.
    e. Assessment systems such as faculty/resident evaluations of students and student evaluations of faculty/residents should be reviewed for racism and bias.
    f. Institutions should develop coordinated efforts with all affiliated hospitals and associated AMCs to support an antiracist clinical learning environment.
2. Across the Institution:
    a. Embed antiracist language as part of mission statements.
    b. Leaders throughout the administration must demonstrate ongoing commitment to supporting antiracist education for students, faculty, and staff.
    c. Medical education leaders should work with community organizations that promote antiracism and engage with state- and federal-level reform of higher education antiracism policies.
    d. Program evaluation infrastructure should allow for the follow-up of medical school graduates and residents throughout their career to demonstrate whether institutional interventions have impacted health equity and antiracist efforts.

Long-Term Goals for MESL

1. Work with AAMC and its governance (Council of Faculty and Academic Societies, Council of Teaching Hospitals, and Council of Deans) to support MESL recommendations.
2. Develop a program evaluation plan/logic model with metrics for medical schools that will document antiracism initiatives across medical education, including leadership expectations.
    a. Consider development and implementation of a scorecard with metrics similar to the White Coats for Black Lives' Racial Justice Report Card.
3. Collaborate with national organizations to develop metrics that support antiracist and health equity efforts.
    a. NBME, USMLE, ABMS, ACGME:
        i. Examine performance data for racial disparities.
        ii. Examine questions and assessment systems for racism and bias.
    b. Ranking organizations for medical schools:
        i. Include national metrics/rankings for diversity/inclusion efforts and health equity research.
        ii. Reward holistic approaches that are equitable and avoid bias, such as:
            1) Medical school admissions;
            2) AOA, Gold Humanism, and other honor societies;
            3) MSPE rankings; and
            4) Residency/fellowship selection.
4. Review accreditation tools used by LCME and ACGME:
    a. Reexamine the AAMC GQ and ACGME resident surveys and how schools and programs with more racially diverse and equity-focused environments are impacted by national comparative data.
    b. Consider creating normative data based on diversity of schools and clinical environments.
    c. Consider accreditation standards related to antiracism and expanding current standards related to social determinants of health and diversity.

Goals for Upcoming National Collaborative MESL Task Force to Eliminate Racism in Medicine

- Develop antiracism learning objectives across the continuum of medical education.
- Develop recommendations for holistic approaches to admissions, with specific attention to factors and policies resulting from structural racism.
- Develop recommendations for approaches to mitigating structural racism and bias in residency selection, with specific attention to use of USMLE, NBME, and clerkship grading in selection.
- Develop recommendations to mitigate racism and bias in assessment systems across medical education.
- Work with academic honor societies to develop equitable and unbiased nomination and selection processes.
- Develop a research agenda for studying the impacts of racism on medical education and antiracism work on medical education.
- Partner with relevant accreditors (LCME) to map antiracist interventions to the relevant standards and elements.
- Develop tools for UME and GME to evaluate their current state in addressing racism in medicine.

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Note: All references have been used in creating this document, and some have been referenced directly above. References are listed in the order in which they appear in the Statement

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Glossary for the MESL Action to Eliminate Racism: Developing a Shared Language for Understanding Systemic Racism and Antiracism

"But there is no neutrality in the racism struggle. The opposite of 'racist' isn't 'not racist.' It is 'antiracist.' What's the difference? One endorses either the idea of a racial hierarchy as a racist, or racial equality as an antiracist. One either believes problems are rooted in groups of people, as a racist, or locates the roots of problems in power and policies, as an antiracist. One either allows racial inequities to persevere, as a racist, or confronts racial inequities, as an antiracist. There is no in-between safe space of 'not racist.' The claim of 'not racist' neutrality is a mask for racism."
Ibram X. Kendi, *How to Be an Antiracist* (2019)

Ancestry reflects the fact that human variations do have a connection to the geographical origins of our ancestors (Chou, 2017).

Antiracism refers to supporting antiracist policies by one's actions or expressing antiracist ideas (Kendi, 2019, page 22) by consciously deciding to make frequent, consistent, equitable choices daily while incorporating rigorous self-awareness and continual self-reflection.

Bias is a one-sided point of view without objectivity and influences one's decisions and opinions.

Disparity is difference or variation between groups.

Diversity encompasses all dimensions of human differences and is defined in the broadest sense to mean inclusion of all persons regardless of racial and ethnic background, nationality, gender, gender identity, sexual orientation, veteran status, religious beliefs, ability, age, or socioeconomic status. Diversity embodies inclusiveness, mutual respect, and multiple perspectives, and serves as a catalyst for change resulting in health equity (Annie E. Casey Foundation, 2020).

Dominant culture refers to a majority ethnic group in which immigrants and members of other ethnic groups are expected to come to resemble the majority group in terms of norms, values, and behavior. A dominant culture appears in societies where the majority group does not tolerate different ethnic or racial identities (Kendi, 2019, pages 28-31).

Equity is defined as "the state, quality or ideal of being just, impartial and fair" (Annie E. Casey Foundation, 2020) and is achieved by promoting fair treatment and proactively working to remove barriers that have prevented full participation by some populations. Equity is not achieved by treating everyone equally, but rather by treating everyone equitably. Racial equity specifically is defined as "a

state in which outcomes such as health outcomes are no longer predictable by race" (American Public Health Association, 2020).

Ethnicity denotes groups (e.g., Irish, Fijian) that share a common identity-based ancestry, language, or culture and is often based on religion, beliefs, and customs as well as memories of migration or colonization (Cornell and Hartmann, 2007).

Health disparity is a health difference that is closely linked with economic, social, or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater social or economic obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.

Health equity is the idea that everyone should have a fair opportunity to attain their full health potential and that no one should be disadvantaged from achieving this potential. Health equity is the absence of avoidable, unfair, or remediable differences among groups of people, whether those groups are defined socially, economically, demographically or geographically or by other means of stratification.

Implicit bias is the automatically expressed negative associations that people unknowingly hold and that affect their understanding, actions, and decisions; also known as unconscious or hidden bias.

Justice is the systematic and fair treatment of all people that results in equitable opportunities and outcomes for everyone.

- **Racial justice** describes the systematic and fair treatment of all people so that everyone is able to achieve their full potential in life, regardless of race, ethnicity, or the community in which they live.
- **Social justice** constitutes a form of activism based on principles of equity and inclusion that encompasses a vision of society in which the distribution of resources is equitable and all members are physically and psychologically safe and secure. Social justice involves social actors who have a sense of their own agency as well as a sense of social responsibility toward and with others and society as a whole.

Oppression refers to a combination of prejudice and institutional power that creates a system that regularly and severely discriminates against some groups and benefits other groups ("Talking About Race").

Privilege refers to how some people benefit from unearned and largely unacknowledged advantages, even when those advantages are not discriminatory. **White privilege** refers to whites' historical and contemporary advantages in access to quality education, decent jobs and livable wages, homeownership, retirement benefits, and wealth (Kendi, 2019, page 38). The following quotation from a publication by Peggy McIntosh can be helpful in understanding what is meant by white privilege: "As a white person, I realized I had been taught about racism as something that puts others at a disadvantage, but had been taught not to see one of its corollary aspects, white privilege, which puts me at an advantage. . . . I have come to see white privilege as an invisible package of unearned assets that I can count on cashing in every day, but about which I was 'meant' to remain oblivious."

Race a nonbiologically based power construct of collected or merged difference that lives socially (Kendi, 2019, page 35).

Racism refers to a complex system of racial hierarchies and inequities. There are multiple levels of racism, including the micro or individual level of racism, which denotes internalized and interpersonal racism. At the macro level of racism, we look beyond individuals to broader dynamics, including institutional and structural racism (Annie E. Casey Foundation, 2020).

- **Biological racism** refers to the idea that races are meaningfully different in their biology and that these differences create a hierarchy of value.
- **Institutional racism** refers to discriminatory treatments, unfair policies, and biased practices based on race that result in inequitable outcomes for whites over people of color and extend considerably beyond prejudice (Kendi, 2019).
- **Individual racism** refers to the beliefs, attitudes, and actions of individuals that support or perpetuate racism in conscious and unconscious ways (Kendi, 2019).
- **Systemic racism** refers to whites' historical and systematic oppression of non- European groups that manifests in the structure and operations of racist societies like the United States. It is reflected in disparities regarding wealth, income, criminal justice, employment, housing, health care, and education, among other factors (Kendi, 2019).
- **Structural racism** is a system in which public policies, institutional practices, cultural representations, and other norms work in various, often reinforcing ways to perpetuate racial group inequity.

In many ways, *systemic racism* and *structural racism* are synonymous. If there is a difference between the terms, it can be said to exist in the fact that a structural racism analysis pays more attention to the historical, cultural, social, and psychological aspects of our currently racialized society.

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