Prioritizing Health Disparities in Medical Education to Improve Care

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Health and health care disparities exist for specific populations worldwide. These populations—defined by race/ethnicity, socioeconomic status, gender identity, and sexual orientation, among other attributes—are the human capital with whom institutions must partner to achieve educational, clinical, and research excellence in health disparities. Partnerships that foster shared leadership will enable academic health centers (AHCs) to be at the vanguard of providing quality, population-based health care and in addressing disparities. We propose the development of heightened partnerships between underserved communities, institutions of higher learning, AHCs, and federal agencies to tackle health disparities through institutional and community commitment and accountability, new governmental incentives and regulation, and an enhanced physician workforce.

First, to change, AHCs must commit to and be held accountable for understanding and eliminating the health disparities in their communities. This may include incorporating health improvement of neighboring populations into institutional mission statements and core values, offering scholarly concentrations in patient advocacy and community health for medical students, providing financial or in-kind support to community health groups and organizations, and reporting outcomes for all institutional efforts to the affected communities. Fulfillment of these commitments requires recruiting and retaining faculty and students who are empathetic to the community’s needs. Valuable strategies for institutions to support and develop such individuals include creating a multidisciplinary center with research support staff, recognizing health disparities research as scholarship worthy of promotion consideration, and implementing novel methods to identify medical school applicants best suited to address disparities. Similarly, strong community organizations willing to commit to and be held accountable for addressing their respective community disparities are needed to partner with AHCs to ensure equally shared leadership in efforts to improve population health.

Second, changes in incentives and regulations on a national level may effectively address disparities. Healthy People 2020 has explicitly made research and policy-making priority areas for specific disparities. Additional grant funding from governmental and nongovernmental groups are needed to support students, faculty, staff, and resources for community-level educational programs and participatory research. Excellence in addressing health disparities is challenging and should be financially incentivized. Institutions should be held accountable for their impact on the health of neighboring populations, and an institution’s proven performance and commitment to reducing disparities could determine assistance from governmental programs and serve as criteria in competitive grant applications, especially those specifically addressing health disparities. Such incentives and accountability may help to prioritize health disparities at all AHCs.

Finally, an impassioned and skilled workforce, with a comprehensive appreciation of a people’s history, culture, vernacular, and notable interactions with the health care community, is needed. The acquisition of knowledge, attitudes, and skills coupled with experiential learning in the community creates providers who administer culturally competent care. Unfortunately, limited expert faculty, limited curricula time, insufficient financial resources, and difficulty identifying interested medical school applicants have impeded institutional efforts in building a competent workforce to address health disparities.

Early engagement and mentorship are critical for workforce development. Course work in public health and community-based research methods should be available and encouraged among students interested in health-related careers. The Stanford University School of Medicine Patient Advocacy Program, for example, places undergraduate students in community-based clinics to design and implement a clinic-based project that meets a specific health need. A community-based participatory research component allows students to assess the effectiveness of their projects. These students with in-the-field community-based experiences and policy-making skills may have a greater appreciation of health care disparities and may serve as valuable resources for institutions. In medical school, these students may become acculturated into the medical community, but they can provide additional perspective on a community’s needs while contributing to a diverse, competent physician workforce. As they advance toward faculty positions, these leaders will represent diversity at all professoriate and administrative levels.

Health disparities exist everywhere. Reducing disparities will require broadening medical education to include partnerships and coordinated efforts by multiple committed entities, including students, faculty members, community members, and institutions. A daunting task as a whole, implementing the elements proposed here may prove to be a manageable and efficacious beginning to improving the health of our communities.

References