Training Medical Students to Recognize and Address Health Disparities

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As the U.S. population grows more diverse, it is becoming more and more important for medical schools to address health disparities, underserved populations and cultural competency. The growing population places increasing demands on our health care system and requires our medical schools to produce more culturally competent, health-disparity-minded physicians. The 16th Report of the Council on Graduate Medical Education suggests that the demand for physicians after 2015 will be greater than the supply. The persons most impacted will be those who are underserved.

There is no standard vehicle through which to teach cultural competence and health disparities. Many schools have developed curricula that have been woven into various aspects of the educational mission, some with outcomes showing an improvement in awareness of these issues. Increasing awareness certainly is a start, but eliminating health disparities requires a multi-pronged, multi-professional approach that will involve ongoing and evolving implementation and evaluation. Medical students are the pluripotent stem-cell recipients in this implementation, and it is our responsibility to help them develop and differentiate into physicians who appreciate and recognize health disparities. Addressing health disparities in medical education starts much earlier than medical school, involves buy-in and accountability from senior health care officers and offers a unique stage for attention in family medicine.

Training students to recognize and address health disparities begins when young and brilliant minds are not yet swayed by attitudes of society, which often minimize or place little emphasis on the need for addressing health disparities. Grade-school and undergraduate programs have immense potential in teaching the importance of addressing health disparities, and we as family physicians have to reach far beyond our private practices and academic centers to the communities where these young people live to stir their desire. Platforms that lend themselves to such schooling include summer enrichment and community outreach programs aimed at exposing these youth to strategies that address health disparities and to programs that build test-taking and critical-thinking skills. Databases should be created, and these students should be tracked and supported from middle and high school right up through undergraduate training and medical school. What populations should be targeted? It has been well demonstrated that underrepresented groups in medicine (URMs) tend to serve underrepresented populations and those who may be uninsured or underinsured. This emphasizes the need for us to support historically black colleges and universities, which tend to have higher minority enrollment, and consider these institutions as feeders for our medical schools and residency programs.

Simply stated, where there are limited numbers of URMs in medical education, an appreciation and strategy to address health disparities is not as likely to exist, whether intentional or not. Underrepresentation of URMs in our medical programs will adversely affect health disparities and boldly underscores the need for us to ensure cultural competence is taught to all enrollees, whether majority or minority. Enrichment programs work to create a number of applicants for admissions committees to consider — students who not only have the academic ability to be successful but, more importantly, many who have the personality traits and character to become caring and compassionate physicians.

The multi-pronged approach to eliminating health disparities is founded in accountability. The Liaison Committee on Medical Education (LCME) now requires that medi-
Health Disparities

cal schools develop programs to expand diversity in medical schools. Where there is no accountability, there is no change. Even as accountability exists from the LCME and is directly tied to accreditation, there must be buy-in for the need for this initiative from senior hospital and medical school administrators. Support from senior administrators guarantees the life of a program and makes goal achievement possible. With support comes money and additional resources to make the job happen.

We as family physicians are on the front lines of health disparities and owe it to our profession and to our students to ensure that senior administrators appreciate efforts to address health disparities. In stressing the importance of addressing health disparities, it is not unreasonable to link performance to annual evaluations or performance scoring. This concept is far from the thinking in our traditional academic medical centers, which carefully evaluate and score research, medical education and clinical care. The realization that health disparities cut across all missions and have lasting impacts on patient care, medical education and research emphasizes this need for accountability.

What is the responsibility of the family physician in this interplay of professionals poised to meet this challenge? We, as family docs, have the ability to drive change in this area, as there is good evidence to show that primary care providers have a greater desire to serve the underserved. Change begins with perceptions, and those perceptions can’t wait to be shaped in the medical-school classroom, on the wards or during internship. There is a belief that with student progression through medical training, acculturation occurs, and what may have been perceived as a problem upon initially entering medical school takes on less significance as time passes. This certainly may be the case in recognition of health disparities, the need for cultural competency and mistreatment of URMs. Interestingly enough, these perceptions were dependent on the perceiver and varied by race, as URMs were more likely to perceive unfair treatment. Due to under-representation of certain groups in medical schools, at both student and faculty levels, it is plausible that disparities in health could be considered a non-issue. Our position has to be a proactive one in which we aggressively teach and display the character and presence of family medicine and ways in which our profession impacts health disparities.

Family physicians who serve underserved patient populations and teach medical students have the ability to stimulate the biggest interest in fighting disparities. The uniqueness and rewards of caring for this group need to be realized by these trainees and the benefits and challenges to care fully appreciated. Academic centers must value and reward primary care physicians who provide such a crucial and oftentimes self-sacrificing service in both caring for underserved patients and teaching medical students the importance of addressing health disparities.

In conclusion, we have discussed only three of several areas that need addressing to eliminate health disparities. Dialogue is a needed start to meeting the problem, but community outreach, accountability and taking advantage of our unique position as family physicians carry much more weight than talk alone. Let us all remember that disparities exist in health care and make it a priority to see these issues addressed in medical education.

References
2. Liaison Committee on Medical Education LCME Accreditation Standards 2008 update on position on health disparities.