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MEDICAL EDUCATION

Exploring Matters of Race through Dialogue in the University of Michigan Medical School's Longitudinal Case Studies Program

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Teaching is the practice of freedom.

-Paulo Freire

In teaching medical students about the social determinants of health, too often do educators omit discussion of how clinicians themselves contribute to health inequity. It is far easier to shine a critical light on disparities that exist in access to care, safety in neighborhoods, and economic opportunity than it is to interrogate individual clinician's biases that inform his or her views about race, gender, sexuality, and economic class. Yet these are the conversations that all medical students should be having because such biases, conscious or not, contribute to patient health, frequently with negative outcomes. The challenge facing medical educators is how to engage medical students in conversations about bias effectively in order to instill a commitment to social justice and promote action toward the eradication of health disparities in the next generation of physicians. The following is an examination of the ways in which clinician bias against black patients affects health outcomes and how, through both student-driven and curriculum-mandated efforts, the University of Michigan Medical School is engaging its students in dialogue about bias and privilege and their impacts on patient care.

Race-Related Bias in Medicine

When considering the social determinants of health, physician bias is rarely cited as a possible contributor to the health disparities that exist between white and black patients. A growing body of literature suggests that physicians do not treat their patients impartially and that black patients, for example, often receive less aggressive medical treatment, are presented with fewer medical treatment options, and spend less time talking with their physicians during the clinical encounter [1-3]. Studies explicitly examining physician racial bias and disparities in decision making suggest that implicit bias can affect treatment decisions, patient satisfaction, referrals for interventional procedures, physician-patient communication, and the amount of information received from a physician during a clinical encounter [4-6]. Of note, Janice Sabin and colleagues found that physicians implicitly associated black patients with noncompliant behavior, despite reporting absence of explicit bias [7]. In a study by John Ayanian, physicians cited patient preference as an important reason why black patients are less likely than white patients to be evaluated for kidney transplantation in the presence of renal failure [6].

These studies do not examine the social and cultural aspects that may inform a clinician's belief that a black patient is more likely to be noncompliant or refuse treatment based on patient preference. In *Black and Blue: The Origins and Consequences of Medical Racism*, John Hoberman suggests that, in the post-civil rights era, physicians' description of African Americans' refusal to consent to certain kinds of treatment as "patient preference" fails to recognize that black patients have legitimate reasons to feel afraid of and disempowered by the medical system [8]. This lack of trust in clinicians and the system as a whole has been shown in qualitative studies documenting the experiences of African Americans with chronic illness [9]. Failure to probe deeper into a patient's refusal of a treatment, merely attributing it to personal preference, may appear innocuous, just as labeling a patient as noncompliant may appear to be a statement of fact instead of a judgment potentially rooted in stereotypes of African Americans as lazy. But it also shows a lack of personal insight into one's own biases; in these ways, health professionals inadvertently contribute to racial health disparities. However, it is here that conversations about bias stand to impact how medical students engage with future patients from all cultural backgrounds.

The conversation about physicians and racial bias demands space and opportunities for critical self-reflection and requires an admission that physician bias may contribute to disparities in levels of care. Instead of these uncomfortable confrontations, health care disparities are often attributed to other social determinants of health, such as the education system, the criminal justice system, and food policy [1]. Despite being another behemoth institution, medicine itself is left unexamined.

Given these circumstances, we assert that medical education has a responsibility to its students and their future patients to design and implement effective curricula for teaching social justice. These curricula should involve giving students space and opportunities to examine personal bias critically in an effort to help close health disparities based on race. Creating medical school curricula that effectively address racial bias is a huge challenge. These types of curricula are often regarded as "nonessential" or "add-ons" in both the minds of medical educators, who typically schedule sporadic islands of time for these discussions rather than aim for their cohesive integration into the curriculum, and medical students, many of whom work under the assumption that "if it's not tested, it's not important." Furthermore, the concept of "cultural competency" itself has been criticized as an overly simplistic, formulaic approach to diversity and culture that ignores issues of bigotry, power, and injustice in health care settings [10, 11]. Implementing an effective curriculum to address issues of racial identity, bias, and its impact on the health of black patients requires a cultural shift in medical education. Fortunately, the environment in medical schools today, largely due to the change in the students who occupy the lecture halls and hospital wards, is ripe for change.

Dialogue as Pedagogy in Medical Education

Medical students today are diverse in both educational background and experience. The past decade has seen a substantial increase in the number of students entering

the University of Michigan Medical School (UMMS) with undergraduate degrees in non-science fields and previous experience in service work benefitting underprivileged communities, such as Teach For America, Americorps, and Peace Corps (R. Ruiz, Office of Admissions, personal communication). These programs provide participants the opportunity to work directly with those whose circumstances differ from their own. More incoming medical students are now equipped with experiences to enrich discussion on race, identity, stereotypes, and bias within the context of medicine. The breadth of student experiences opens doors to a different style of pedagogy.

A potential solution to the naïve simplicity of “cultural competency” is to introduce a new style of teaching and learning in medical education: that of dialogue. Patricia Gurin and colleagues [12] explain that dialogue differs from the teaching in traditional educational settings in that it uses personal sharing and self-reflection in a small group setting with facilitators to guide the participants through thought-provoking and challenging activities. Dialogue is learner-centered rather than teacher-centered. When planned and executed correctly, dialogue-as-pedagogy has the ability to promote “understanding of one’s racial-ethnic, gender and other social identities as well as understanding those of others” [13].

What follows is a discussion of the conceptual underpinnings of this approach to teaching and learning about race, racism, bias, and privilege in medical education, as well as discussion of a specific program, the Longitudinal Case Studies course at the University of Michigan Medical School (UMMS), which implements dialogical principles in the education of future physicians about diversity and social justice. It should be emphasized that the use of race in this discussion is meant to serve as an example of teaching and learning about all kinds of diversity, including gender, ethnicity, sexual orientation, national origin, religion, and socioeconomic class.

The dialogic approach described by Gurin and colleagues has four stages. The first, “forming and building relationships,” encourages active listening and gaining trust within the group. The next stage, “exploring differences and commonalities of experience,” furthers group cohesion, creating comfort to challenge and learn from each other’s experiences. The third stage is “exploring and dialoguing about hot topics.” In medicine, these hot topics may include physician bias and privilege. Ideally, with the development of comfort among the group members during the first two stages, there is space and trust for participants to bring up their biases and privileges, even if it may be difficult to acknowledge. Because clinicians cannot afford to isolate themselves in the sterile world of science but must work in the chaos of everyday life, critical reflection and dialogue on such uncomfortable subjects is mandatory in the education of physicians. In fact, the very idea of discomfort is a major pedagogical tool used in this approach.

The final stage of dialogical learning, “action planning and collaboration,” moves learners beyond understanding to action, which is the ultimate goal of dialogue-as-pedagogy. Application can be as simple, yet as effective, as students having the skills

to reflect on their own emotions, biases, and privileges while interacting with patients to ensure they are providing the best care possible. Gurin and colleagues report that, after the dialogue course, students are more likely to say they would “recogniz[e] and challeng[e] the biases that affect my own thinking,” “avoid using language that reinforces negative stereotypes,” “challenge others on derogatory comments,” and “reinforce others for behaviors that support cultural diversity” [14].

While the dialogues described above were conducted with undergraduate students, the same can be done in medical education. A short dialogue series modeled after these four stages was designed and implemented by one of us (KS) over the course of one month at UMMS. Dialogue among a group of ten, mostly first-year, medical students was facilitated by a medical student (KS) and a class counselor. Overall feedback was positive (unpublished data), and students reported that they appreciated the space for in-depth conversation with their peers about issues of race, gender, socioeconomic status, and sexuality in regards to bias and privilege. Student participants unanimously voiced support for more sessions of the dialogue series and expressed openness to a long-term commitment to such a group.

The larger challenge is incorporating this approach into the formal curriculum. The major principles of dialogical learning have been implemented in a required, small group-based course for first- and second-year medical students at UMMS, the Longitudinal Cases (LCs) course.

The UMMS Longitudinal Cases Course

The best approach to address diversity and social justice in medical education is still contested territory. The notion of cultural competency—“achieved” through the memorization of “cultural characteristics” or learning of “special skills” for dealing with “special people”—has itself been problematized and subjected to critical inquiry [10, 11, 15, 16]. Instead, we assert that by incorporating ideas of critical reflection and understanding of the self, others, and the world into various aspects of the curriculum, a balanced and integrated understanding of bias, privilege, and their impact can be attained and applied to caring for patients.

Although developed separately from Gurin’s ideas, the theoretical framework underlying Gurin’s work finds resonance within the approach of the LCs.

Forming and building relationships. The small LC groups, consisting of 10-12 students and a physician-educator, are formed during the orientation week of medical school and meet on a biweekly basis throughout the first and second years [11]. Four additional meetings are held during the third year to bring clinical experiences into the discussions. Creating ground rules, decided upon collectively by each LC group, and maintaining continuity of contact with the same group of students and clinician educator over several years helps create a safe environment for difficult conversations and dialogues on contentious or sensitive subjects.

Exploring differences and commonalities of experience. The materials and activities used to support small group dialogues include individual narratives—from patients, students, and faculty [11, 17]—and works of fiction and nonfiction. Issues of disparities and injustice are also explored through the creation of artworks, which are used to challenge assumptions and to reflect on experiences of illness [18]. A major requirement in these interactions is to call upon all participants to reveal themselves in these dialogues—their beliefs, feelings, worldviews, values, and lived experiences—for it is only through engagement of the self that transformation of perspective can occur [19, 20].

Exploring and dialoguing about hot topics. In the LC small groups, controversy is not avoided, it is embraced. Medicine itself is a virtual minefield of “hot topics,” such as prejudice and discrimination, abortion, problems with access to care and insurance, immigration, religion and faith, and many others. Confronting unfamiliar experiences, ideas, identities, and perspectives creates a sense of “cognitive disequilibrium,” which fosters critical self-reflection and formation of a worldview that is more discerning, inclusive, and capable of change [11].

Action planning and collaboration. Small group discussions ideally should be designed to culminate in a commitment to address inequities and the fostering of skills to identify and engage institutional, community, and societal resources to implement change. The educational emphasis is not only on development of skilled communication, but also on advocacy; not only on an awareness of the impact of poverty on health, but also on specific steps to be taken with individual patients and with communities to alleviate suffering and optimize health.

Challenges

This approach to education in social justice is more complex than the standard notions of training in “cultural competency” and admittedly comes with many challenges. These challenges include the risk of further marginalizing already marginalized groups (particularly when members of these groups are put in the position of acting as “spokespersons for their people”), the dangers of developing a sense of moral relativism that could leave participants apathetic, instead of outraged, toward inequity, the prevailing view that these subjects are “soft” in contrast to the “hard” biomedical sciences, the lack of curricular time and space for reflection and dialogue, and the difficulties of assessing learning in this area [11].

The design of the LCs as they currently exist at UMMS faces additional challenges, such as variation in the quality of interactions between groups and resistance on the part of some students to considering dialogue and self-reflection necessary to their education. Moreover, the first two stages of dialogue—establishing trust and exploring difference—are not allotted significant curricular time due to pressures to quickly move forward to applying principles to patient care. This results in insufficient time for students to learn and reflect on their own social identities and bias. The lessons learned through these dialogues cannot be fit into a standard one-hour lecture; personal reflection takes more time and a different environment to

develop. It is not a skill or a “competency” that can be mastered, but an organic, ongoing process. Rushing through the foundational stages may diminish the full benefits that dialogue as pedagogy can offer to medical education.

Furthermore, teaching for social justice requires having both students and faculty work towards an understanding of their own social identities. Faculty development is crucial. By teaching faculty and students simultaneously, both ground-up and top-down approaches to social justice education can be implemented. Faculty development for the longitudinal case studies small groups has consisted of emphasis on facilitation skills as well as self-reflection and an approach that involves having faculty model the types of reflective interactions they wish for their students [11].

Conclusion

In the face of evidence that physician bias impacts health care, it is critical to evaluate not only institutional causes, but also those present in individual clinicians. Having the difficult conversations of understanding, accepting, and moving beyond biases can contribute to reducing some disparities in health care.

In the words of Brazilian educator and theorist Paulo Freire, “Human activity consists of action and reflection; it is praxis; it is transformation of the world” [21]. Ultimately, in contrast to the imposition of a fixed set of “cultural competency” standards on passive medical students-as-learners, the dialogical approach above all emphasizes their agency. It is designed to foster reflection, critical awareness, autonomy, and empowerment among all learners (both students and faculty) and instill in them the conviction that to act in a socially responsible manner as a physician is to implement change in the world.

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