

Racial Justice Beyond the Curriculum: Aligning Systems of Care With Anti-Racist Instruction in Graduate Medical Education

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The process by which idealistic medical students become cynical residents and faculty members reflects a mismatch between what trainees are officially taught and what they learn by example and action.^{1,2} As they adapt to graduate medical education (GME) programs, trainees who received formal anti-racism didactics in medical school find little to no explicit instruction in caring for diverse patients or in racial justice³⁻⁵ and observe stark contrasts in the delivery of medical care based on race and social class. We call for equity-focused, trainee-influenced quality improvement integrated into anti-racist instruction in GME. Without change, the juxtaposition of anti-racist messaging with the daily realities of clinical service is a “hidden curriculum” that threatens to erode idealism in young learners as it perpetuates longstanding health inequities.^{6,7}

Consider the following examples:

A 17-year-old Black male without previous psychiatric history presents to the emergency department (ED) with confusion and agitation. Routine psychiatry screening labs show no drugs or metabolic abnormalities. He is referred to a state mental hospital. A psychiatry resident wonders aloud what makes this patient different from the 17-year-old White female seen with the same presentation and initial tests who was admitted for lumbar puncture, electroencephalogram, and special testing to evaluate for autoimmune encephalitis.

A resident in obstetrics and gynecology quickly observes on her family planning rotation that the majority of patients undergoing surgical sterilization via bilateral tubal ligation are Black and Latinx. When she asks about it, a more senior resident shrugs and says, “It’s the only way they’ll stop having kids.”

A Black male medical resident caring for a 63-year-old Black patient accurately observes that the patient has been unable to access appropriate diabetes care in the years leading up to hospitalization for advanced gangrene. Surgical consultants accuse the patient of poor self-management and schedule a nonurgent bilateral above-the-knee amputation. The surgery is delayed for several days, and the patient and resident experience frustration and anger.

Inequities in the clinical environment are longstanding and well-documented; minoritized populations experience on average lower quality and less accessible health care.^{8,9} The difference between what anti-racism courses teach *should be* and what *is* available for patients places our learners at risk of cognitive dissonance. How will the psychiatry resident incorporate observations about disparate treatment, based on race and social class, within their personal value system, professional development, and future practice? What is the lesson when a Black resident is required to represent the system that has failed to promote the health of his disenfranchised Black patient? How will the resident feel when his scared, angry, and grieving patient challenges him for his complicity in a broken system? Will formal anti-racist training permit and equip learners to effectively advocate for change? A concerning possible answer, grounded in the social psychology of attribution theory and cognitive dissonance,¹⁰ is that learners will instead provide patient care within the constructs of a racist system. In this scenario, they will justify their decisions as if they must be right—even if they believed themselves to be anti-racist prior to clinical training.

At its core, high-quality clinical education relies on the presence of high-quality clinical services, and GME accreditation explicitly seeks to produce a responsive workforce that provides safe, high-quality patient care.¹¹ If we are to also rectify medical

TABLE

Recommended Strategies to Reinforce Anti-Racist Education and Practice in GME

Area of Focus	Strategies for Implementation
Education	- Educate GME trainees in the likely mismatch they will observe between theory and practice, alerting them to the potential for cognitive dissonance - Emphasize nontraditional methods of learning in curricula - Example: Create anti-racist simulation experience
Clinical care	- Embed anti-racist curriculum into clinical rotations - Example: Engage teaching faculty, GME trainees, and medical students in upstander training
Quality improvement	- Develop resident curriculum in QI methodology - Identify equity as a goal in resident QI curricula - Consider equity approach in each QI project - Example: A project for eliminating medication errors on hospital discharge should include stratifying results by patient demographics to identify inequities in medication reconciliation - Involve impacted populations in QI - Example: A project aimed at reducing intake appointments at a specialty clinic for under- or uninsured patients should consider patient experience in designing and implementing solutions
Institution	- Establish faculty champions for resident QI initiative - Support faculty training in QI methodology and anti-racism

Abbreviations: GME, graduate medical education; QI, quality improvement.

injustice in a structurally biased system,^{10,12} we must emphasize intentional GME in structural determinants of health, with straightforward acknowledgment of structural inequities in systems of care¹³ and support trainee-involved advocacy and quality improvement (QI) activities.

To promote anti-racist education and practice, we recommend an intentional, integrated curriculum that involves classroom, clinical, and QI activities throughout the continuum of training and practice to leverage trainees' knowledge and passion (TABLE). Rather than promoting learned helplessness or uncritical assimilation into a flawed system, we could teach important lessons while empowering our learners both emotionally and fiscally, with support from departmental and institutional leaders, to identify and address clinical issues steeped in institutional

bias for their QI projects. Learners would gain valuable lessons on change management, advocacy, and allyship; patients and health care systems would gain valuable improvements in health care quality and equity. Indeed, resident-involved QI has been associated with increased training satisfaction,¹⁴ enhanced systems-based thinking,¹⁵ and improved patient outcomes.^{16,17} An equity agenda in QI would further align with recommendations from major US health care quality institutions, who identify equity as the most urgent concern for health care QI.¹⁸

In one program at our institution, resident-driven QI projects have prompted a variety of improvements—and have helped to identify areas of focus for future study. As one group of residents engaged in a project with an overall aim of decreasing episodes of violence in the psychiatry ED, they collected patient-level data and recognized disparities in triage of patients to the locked area of the ED. With mentorship from the faculty QI champion, the residents succeeded in creating a multidisciplinary project to implement a nurse-driven checklist to more objectively identify patients at risk for agitation. The same data led to resident-driven research investigating systemic racism in behavioral restraint use.¹⁹ The study of 12 977 ED encounters involving psychiatry consultation demonstrated greater risk of physical (adjusted odds ratio [AOR]=1.35, 95% CI 1.07-1.72) and chemical (AOR=1.35, 95% CI 1.15-1.55) restraint for Black patients compared to their White counterparts, even after adjusting for clinical and demographic variables.¹⁹ These results have provided an impetus for discussions with clinical and administrative leadership around processes that might better meet patient care needs. To understand the lived experience of our patients, our multidisciplinary team is actively seeking input through structured interviews of Black individuals treated in our ED in a qualitative study designed to generate patient-centered solutions. Such an approach will help define a growing ethos of advocacy, altruism, and resistance, both personally and institutionally. These efforts mirror resident-led QI projects at other institutions to understand drivers of inequity in clinical care.²⁰

Efforts to implement or expand upon anti-racist didactic curricula are well-intentioned and necessary; however, limiting them to formal didactics risks harm to trainees as well as patients. A scoping review of cultural competency curricula in US GME suggests that retention from lectures was low over time and that nontraditional methods of instruction may serve to better engage residents and fellows.³ Many clinical learners seek institutions with robust anti-racist curricula, and it is critically important to teach our

residents about “food deserts” and “hot zones,” pseudoscientific notions of race-based care, and ways in which criminalization of substance abuse and mental illness disproportionately harms minoritized communities.

It is also important to explicitly address the potential for cognitive dissonance through intentional instruction on the many ways that clinician bias, social injustice, and institutional history adversely affect health. We need to advocate conscientiously and proactively for more equitable clinical services, champion equity-focused QI, and eradicate the vestiges of separate and inequitable care. Leaders of academic hospitals should recognize that, while not all discoveries will be positive, data demonstrating areas in need of improvement will not only help programs meet accreditation requirements but also will have potential to improve care and align resident ideals with their practice.

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