Viewing the Future Through the Lens of the Past: A Personal Reflection on Disparities Education in Medicine and Public Health

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As we move into the second decade of the millennium, we face the continuing challenge of educating medical students and health care providers about health disparities. In my recollection, this journey, which has mostly taken shape over the past 25 years, has faced all the challenges that come with an emerging body of knowledge that must be interpreted, synthesized and translated to effective action. This special supplement to the *Journal of General Internal Medicine* presents promising research and practice to inform how we educate present and future health care providers in this critical field.

As context for this issue, I have found it useful to review my history of knowledge about health disparities over the past 25 years, mining my own experience as a medical student, medical residents, attending physician and public health practitioner over that time. Short of an exhaustive review of the history of health disparities, the goal of this personal reflection is to consider the impact of emerging knowledge about disparities on my experience as a learner and as a teacher.

My first recollection of evidence of racial disparities in health came when I was a medical resident in 1985. Then Health and Human Services Secretary Margaret Heckler released the groundbreaking Report of the Secretary's Task Force on Black and Minority Health.¹ This landmark report documented the significant disparities in the burden of illness and mortality experienced by Blacks and other minority groups in the US population. The report was perhaps the first explicit acknowledgment from a government health agency that such disparities existed. Furthermore, the report led to concrete action, specifically the establishment of the Office of Minority Health in the Department of Health and Human Services. While portions of the report might appear obsolete to us now, the document contains relevant information that is applicable today. The report identified exposure to stressors among minority groups as playing a critical role in health outcomes. Not only did the report identify stress itself, but it identified the availability of "resources available to resolve stressful situations" as playing an important role in health.

The report carried another important but largely unheeded recommendation: Encourage health professions' training insti-

tutions to develop training programs so that health care providers such as physicians, dentists, nurses, social workers, health educators, lay counselors, allied health professionals, and volunteers may gain increased awareness of and sensitivity to the health problems and health attitudes, beliefs, and concerns of minority populations.¹

By the late 1980s, researchers in medicine and public health had turned their attention to documenting disparities in the delivery of health care, particularly diagnostic technology. In 1987, Wenneker and Epstein published a paper that had a notable influence on my education about disparities.² The researchers used Massachusetts' hospital discharge data to show a higher rate of cardiac catheterization among Whites than Blacks. Their approach, and that of other researchers, moved the focus from stereotypical cultural difference to specific diseases and procedures. This step forward left an unclear role for providers—speculating "patient preference, different levels of disease severity and socioeconomic status not adequately accounted for"—but began an era of wide exploration on disparities in various interventions. The impact of this line of research on disparities education moved us to focus more on disparities in **health care** and identified important questions about how patients saw health care, including skepticism of medical procedures, refusal of important care due to financial reasons, and most importantly the role of cultural differences and beliefs.

In my own experience, this next phase of work and disparities focused on the role of culture. In my education, this phase was most embodied in Anne Fadiman's 1998 book, *The Spirit Catches You and Then You Fall Down*.³ This eloquent narrative work, which became standard curriculum in many medical and public health education curricula, highlighted the cultural disconnect between providers and patients. The book detailed the disastrous consequences of provider ignorance of cultural understandings by describing the fragmented delivery of care to a Hmong child with a severe seizure disorder. This book drew my attention and that of many of my colleagues. As junior faculty, we began to incorporate messages about cultural differences into our medical student and resident teaching. At the level of institutions, this cultural message most often activated seminars and forums where specific cultural and ethnic differences among groups were dissected and examined. While enlightening for many, these forums often divorced the cultural from the sociopolitical or environmental circumstances that led to these differences in communication. More problematic was the fact that these cultural differences were presented as exotic or static mental models of diversity.

For me, a critical shift occurred in 2000 when increasingly the health and public health literature began to face the issue

of racism and to more clearly define the roles of discrimination in health. This shift began with an article by Dr. Camara Jones entitled *Levels of Racism: A Theoretical Framework and a Gardener's Tale*.⁴ Dr. Jones's article provided a common teaching language about the complexities of racism. Her delineation of institutional racism, personally mediated racism and internalized racism disrupted the knee-jerk belief that racism was only a problem for white people and expanded the scope of racism to include the entire community.

On the heels of Dr. Jones's paper came the landmark Institute of Medicine *Unequal Treatment* Report.⁵ This compelling study confirmed that disparities were real and damaging to the health of minority communities. For the first time the report placed the responsibility for this not on the patient, but on the providers and the health care systems in which they worked. *Unequal Treatment* identified stereotyping, or so-called cognitive shorthand, as an underlying mechanism by which these disparities happen, but acknowledged the complex interaction of decision making, provider bias and systemic bias. Rather than spawning additional studies to document the presence of disparities, more than any other force, *Unequal Treatment* compelled the health care and teaching communities to struggle to define the problem and find solutions.

In the years that followed and currently, teaching materials have become available to educate medical students and public health students about race and inequity. Powerful documentaries like *Race: the Power of an Illusion*⁶ and *Unnatural Causes: Is Inequality Making Us Sick*⁷ have stimulated a potent classroom conversation in many medical schools in schools of public health. These visual approaches, especially tailored to the needs and demands of today's learners, would not, in my mind, have been possible or useful without the milestones that shaped my learning and teaching of disparities in medicine and public health.

In my medical education, these various phases had an effect on me in two areas. First, these efforts provided permission to talk about racial and ethnic differences, and a shared language for doing so. In my patient care, I was ultimately better able to monitor my own deeply held stereotypes and to seek critical information from patients in their own terms, their own stories. Second, the evolving science of health disparities stimulated a dialogue with colleagues, students and public health advocates that, in my belief, focused attention on the processes of care and how these processes and systems posed their own unique and challenging barriers to effective care.

The research presented in this special supplement to the *Journal of General Internal Medicine* provides an evidence foundation for teaching of residents and medical students. The thoughtful empirical work presented here is highly adaptable for the future and includes model development, cross-cutting issues in diversity, attention to community-based experiential learning, and measurement and evaluation of educational strategies. The research covers a broad spectrum from health care delivery to public health.

The articles presented in this supplement highlight, with good justification, the lack of past critical appraisal of approaches to disparities education. Indeed, rigorous evaluation can be challenging. The complexities of cultural differences and implicit provider biases are intensified by the stresses of the educational and clinical environments. For these reasons, it is essential that we measure and evaluate the impact of disparities education on both the processes and outcomes of education and care. Critical research and evaluation are essential to finding educational strategies that can be disseminated widely across all stages of medical education and practice. Innovations in medicine such as case simulations and electronic medical records provide diverse sources of data for assessing these processes and outcomes of care. While long-term studies to evaluate the effect of disparities education on patient outcomes are essential, we must also assess the effect of disparities education on the processes of care. Promoting dignity and respect in the clinical encounter and fostering effective communication between providers are important ends in themselves.

Taken together, these articles present a robust vision for the future of disparities education where educators provide learners not only with skills but with an approach for future learning and practice. Models of disparities education and community-based education, which are testable and conceptually sound, will build a base of evidence that will impact both institutional and educational policy. As knowledge progresses about the biological effects of stress and the social determinants of health, sound evidence like that presented here can evolve and absorb this new knowledge. Finally, model approaches to disparities education will continue to build and reinforce the critical bridge between medicine and public health.

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