Advocating for Greater Exposure to Domestic Health Disparities in Medical Education

Tehreem Rehman, BA*; Robert Rock, BA*
Yale School of Medicine, New Haven, CT

*Co-first authors

The United States is a world leader in producing innovation in the medical sciences. However, as we spend a considerable amount of our gross domestic product in a race to the cutting edge of medical innovation, we have left behind a large portion of our population in the process. The fault in this paradoxical approach becomes apparent when our country’s health system is compared to those of other developed nations and ranks last despite our scientific innovations. In a country where top ranking institutions treat the most complex diseases, swaths of our population are crippled by or die from preventable illnesses.

The World Health Organization’s Commission on Social Determinants of Health does not embellish when it declares, “Social injustice is killing people on a grand scale.” One manifestation of this injustice is through the adverse impact that one’s socioeconomic status has on one’s health. A recent 2013 Centers for Disease Control and Prevention report reveals higher rates for preventable hospitalizations among residents living in lower income neighborhoods compared with those living in higher income neighborhoods, as well as higher rates for non-Hispanic black and Hispanic residents compared with non-Hispanic white residents. The reality of factors like class and race/ethnicity detrimentally affecting one’s well-being is a gross injustice that threatens to undermine the economic vitality of our entire nation. For instance, according to recent research conducted by the Joint Center for Political and Economic Studies, “eliminating health disparities for minorities would have reduced medical care expenditures by $229.4 billion for the years 2003-2006.” Addressing health inequity through the lens of social justice appears as the most viable remaining means to prevent our country from heading down a highly unfavorable trajectory.

As current medical students invested in health justice, we sought to create greater opportunities for fellow health professional students at our institution to receive education on health disparities. We are, after all, the next generation of providers; hence, it is crucial that we are trained to address shortcomings in our nation’s current approach to health. Our course seeks to initiate such training through instruction on topics related to socioeconomic determinants of health. It also includes training in advocacy, through writing and medical-legal partnerships, to empower future health care professionals to work with local communities in health activism. We hope that our course will be part of a larger movement at Yale and other institutions to reaffirm the notion of social responsibility as an inherent part of the medical profession.
Effectively addressing health inequity will undoubtedly require interdisciplinary partnerships, but health providers occupy a niche that allows them to exert significant influence. As a profession charged with the immediate care of the ill, we have the unique opportunity and privilege to advocate for vulnerable populations when we recognize the social factors affecting their health outcomes. In fact, whether through community-based outreach, education, political activism, or research, medical professionals have the ability to address the various factors that determine health in a manner not confined to the clinical setting. With this in mind, it is crucial that current and future health professionals are equipped with the skills to work toward solutions with these communities.

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Many medical schools across the nation have recognized the imperative to teach students about social medicine and health disparities. Some schools, such as the University of Michigan Medical School and the University of Chicago Pritzker School of Medicine, require all of their medical students to go through intensive training on health care disparities. Others, such as University of California San Francisco, have a specialized track that focuses on urban underserved populations.

Here at Yale School of Medicine, we are in a very exciting time of curriculum enhancement in response to student needs. The entire medical community has come together to critically assess the curriculum with the unified goal of reinventing the educational experience to better suit the needs of future health providers. Ongoing dialogue between students and faculty on medical education reform has fostered an energizing atmosphere at the medical school. Witnessing the faculty’s receptiveness to student voices encouraged us to become proactive in advocating for more instruction on domestic health disparities. The administration’s enthusiasm, a shared passion for the topic, and the freedom afforded by the Yale system motivated us to go beyond simply requesting improvement. Rather, we were able to directly create the change we wished to see at the medical school by creating a new class ourselves.

Both of us had already been developing our passion for social justice and health equity for several years prior to becoming student leaders of the new US Health Justice elective course (Table 1). Upon arriving to Yale School of Medicine, we both strived to find ways to continue pursuing our interests in domestic health inequity. Our experiences early on at Yale enabled us to recognize that while health inequity topics are taught here, students may not intuitively make the connection between the global health topics that are taught very well here and the health inequity that exists domestically.

Through our work organizing events with community leaders, we learned about the rich history of New Haven as well as the social determinants informing the health disparities experienced by its historically marginalized populations. We began to appreciate the general health goals of the city as well as the challenges that stood in the way. As students who would join the effort in caring for this population during our clinical years of training, we saw this information as invaluable, but were frustrated
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<tr>
<th>Session</th>
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<th>Objective</th>
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<tr>
<td>1</td>
<td>Implicit Bias</td>
<td>Identify bias and stereotypes and explore how bias emerges in patient/provider interactions</td>
<td>Discussion on recognizing the assumptions that everyone carries</td>
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<td>2</td>
<td>Socioeconomic Determinants of Health/Medical Legal Partnerships</td>
<td>Recognize how social determinants of health cause health inequity and ways providers can address them in the clinical setting</td>
<td>Workshop led by chief medical officer of a FQHC and child advocacy attorney on identifying local and national trends in health disparities and engaging in medical-legal partnerships to alleviate them</td>
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<td>3</td>
<td>Community Tour</td>
<td>Explore social determinants of health and community initiatives to address them</td>
<td>Tour of local community highlighting history, culture, and local efforts for improvement</td>
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<td>4</td>
<td>Homelessness</td>
<td>Learn about the obstacles in caring for homeless populations and how to connect them to helpful resources</td>
<td>Discussion with homeless outreach nurse, psychiatrist, and interview with domestic violence survivor who lived in a homeless shelter</td>
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<td>5</td>
<td>Food Insecurity Tour</td>
<td>Learn about obstacles to proper nutrition and how communities are mobilizing to address them</td>
<td>Tour of local food desert, interview with food assistance recipient/food advocate, and reflection session on national trends</td>
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<td>6/8</td>
<td>Writing as Advocacy</td>
<td>Explore how to advocate for patients outside of the clinical setting</td>
<td>Workshop led by two physicians on how to write op-eds as a means of health advocacy</td>
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<td>7</td>
<td>Microaggressions</td>
<td>Investigate the impact of microaggressions on mistrust and power dynamics in patient/provider interactions</td>
<td>Art tour and reflection session exploring intersectionality, oppression, and privilege</td>
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<td>9</td>
<td>Patient Skills</td>
<td>Understand how to properly take thorough social histories of patients to adequately address psychosocial factors of health.</td>
<td>Workshop with standardized patients on cases of sexual identity, language barriers, and domestic violence</td>
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<td>10</td>
<td>Community Based Participatory Research (CBPR)</td>
<td>Apply CBPR as a means for academics to collaborate with communities in the effort to sustainably address the social determinants of health.</td>
<td>Seminar on the principles of CBPR, activity highlighting the application of CBPR to specific community issues, and lecture on existing local</td>
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Table 1. Session Objectives and Capacities
by its absence in the curriculum for pre-clinical medical students. The current model does attempt to address these issues; from the first day of medical school, students have the opportunity to explore the biopsychosocial aspect of health care through courses on Medical Ethics and Epidemiology. However, there is a dearth of instruction on the impact of societal factors on the delivery of health care and health outcomes.

We, along with our fellow classmates, will soon be released onto the floors of the hospital. Students will be expected to take part in caring for the sick of New Haven and the areas around it, but will have minimal awareness of the socioeconomic dynamics of the city or how they directly influence the efficacy of the care we plan to give. This reality filled us with a sense of urgency that manifested into the US Health Justice elective, a course dedicated to critically examining the socioeconomic context health care is delivered in as well as arming students with skills to operate effectively as future health care professionals.

Our course aims to teach health professional students about the health inequities plaguing our country. In order to effectively understand the complex subject of health inequity and begin coming up with solutions, we needed a multifaceted approach. Consequently, we had to deconstruct the traditional methodology of medical education and move towards a more multidisciplinary pedagogy where researchers, physicians, administrators, and community leaders had equal influence on this unique learning environment. It was also imperative for this course to be a safe space and dynamic learning experience in which students’ perspectives and insight would be valued equally to those of the invited session speakers. We wanted to do away with the hierarchical understanding of knowledge distribution and create a level playing field that would facilitate collaborative knowledge creation.

With such high aspirations for our ideal learning environment, we had to find and galvanize an inter-professional community of instructors. This was necessary before we could begin delineating the objectives, activities, and assignments for each session. We spent months meeting with faculty. One contact led to another and before long, we had tapped into an amazing community of faculty and hospital administrators invested in health justice. Through this community, we were introduced to New Haven natives and community leaders dedicating their lives to positively changing the conditions of their neighborhoods. With each meeting, we learned about the topics we intended to teach through the eyes of those on the ground living them and combatting them every day. These discussions, combined with a review of what already exists in undergraduate medical education, shaped our planning for each session.

At the start of our second year, we launched a pilot of a formal course open to all Yale health professional students in order to obtain an initial evaluation of the impact it has on students’ understanding of health inequity in the United States, and to explore potential areas of improvement for a comprehensive course. The primary objective of the course is to expose Yale health professional students to social medicine and health inequities that many are not aware exist in their own nation. Research indicates that the attitudes or actions of individual health care providers can contribute to the existence of
health disparities in this country.\textsuperscript{8,9} Hence, providers need to develop a deeper understanding of the history of the relationship between various populations and the medical establishment, as well as the significant impact that race, class, and other marginalized identities have on the lives of patients.

Reception of the class has exceeded our expectations. We have received financial support from multiple offices at the medical school and most importantly have received more than thirty applications for the elective from the three Yale health professional schools. In capturing the attention of faculty, students, and community members, we have created an incredible momentum. Aside from launching the course, we are working to further capitalize on this unique opportunity by forming a student club, the US Health Justice Collaborative, which will serve as a platform to discuss issues of health justice, and serve to advertise and support related initiatives at the university. By bringing people who are passionate about these issues together, we hope to ultimately change the culture at the institution regarding the value placed on and attention given to domestic health equity.

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REFERENCES


