

Racism, Health Injustice, and Healthcare Workforce Training

A Statement of the of Academic Units for Primary Care Training and Enhancement* (AU-PCTE)

A well-trained, appropriately distributed, adequately resourced, and racially and ethnically diverse interdisciplinary primary care workforce is a powerful tool for promoting wellbeing and improving health in communities. Sadly, the practices, policies and incentives in the current training and healthcare ecosystem embody long-standing racism that exacerbates health inequities. As members of a collaboration of Academic Units for Primary Care Training and Enhancement* (AU-PCTE), we are committed to, and call for immediate collective action to, eliminate racism in all its forms and its effects on healthcare workforce diversity and health.

Summary points:

- A diverse primary care workforce that is trained in social determinants of health, integrated behavioral health, and oral health is vital for addressing the physical, social and mental health needs of marginalized urban and rural populations.
- To realize the ideal of health equity and health justice, it is necessary to confront racism in all its forms. Racism is a key determinant of health inequities and the principal driver of social injustice. It is pervasive and deeply embedded in society and in the practices of institutions that train the healthcare workforce.
- In taking concrete steps to eliminate racism, institutions should draw on the conviction that healthcare workforce diversity and health equity are achievable. Initiatives that meaningfully address racism will benefit everyone, but require dismantling embedded structural racism throughout the pathway from cradle to career.
- Institutions should strategically realign their mission, vision, and values to enable reconciliation on racism, psychological safety for people of color (Blacks, Indigenous, and People of Color); racial diversity; racial inclusivity; and health equity and justice. Transparency and accountability within and across institutions should be fostered with measurable outcomes based on meaningful representation of people of color in institutions, and on the quality and safety of care received by marginalized populations.

Background

Racism is experienced by all people of color (Blacks, Indigenous, and People of Color). With a 400-year history, racism pervades all aspects of the lived experiences of Blacks/African Americans and everyone else in society. Slavery, Jim Crow, under-resourced public schools, and discrimination in education and employment, and other acts of racism are imposed because Blacks are deemed unequal and less deserving of health and economic opportunities. The 'doll test' used in *Brown vs. Board of Education* by [Dr. Kenneth Clark](#) demonstrated in the 1950s that internalization of racism caused Black children to feel inferior in society and in academic environments.

Experiences of systemic racism by trainees, faculty members, and healthcare workers of color impact their training and career advancement opportunities. An Institute of Medicine (IOM, now the National Academy of Sciences, Engineering, and Medicine) report, "[Promoting Health: Intervention Strategies from Social and Behavioral Research](#)," noted how racism "restricts and truncates socioeconomic attainment." Data from the [Association of American Medical Colleges](#) and Accreditation Council for Graduate Medical Education for the 2018-2019 academic year show that Blacks represented 8.3% to 9.0% of medical school applicants, 7.4% of matriculants, 4.4% of residents, and 3.6% of full-time faculty at Academic Medical Centers. In contrast, they comprise about 13% of the US population.

Racism and social injustice are at the pinnacle of social determinants of health, creating and sustaining disparities in access to money, power and resources needed to promote wellbeing and improve health. The landmark IOM report, "[Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care](#)," identified racism or racial discrimination as the single most important factor in [health disparities](#) for people of color, including low-quality care and a high burden of preventable causes of death among Blacks. These inequities are evident in the impact of the COVID-19 pandemic that has [ravaged black communities](#) all across the United States.

Recommendations

In institutions of healthcare professions education, racism is institutionalized and reflected in structural and social biases as well as acts of unconscious bias. We applaud healthcare organizations, training programs, professional societies and associations, and accrediting bodies that have made statements denouncing racism and have taken or are contemplating steps to eliminate racism and address this collective societal injustice.

Principles

Entrenched systems become accepted as ‘business as usual’ and are hard for those living within them to recognize. We therefore provide guiding principles or ideals for transforming statements into action and reality.

1. Healthcare workforce diversity and health equity are not just abstract ideals, they are achievable, but only if set intentionally as the core purpose of education, research, and clinical care.
2. Realizing the ideal of health equity requires dismantling a range of complex policies and incentives that shape current healthcare delivery models.
3. While racism is inherently abhorrent and a uniquely detrimental experience for people of color in the United States, it affects everyone and thus the transformations to eliminate racism should benefit everyone.
4. Educational pathways and role models are critical to workforce diversity. Thus, efforts to eliminate racism should extend and engage all institutions and stakeholders across the entire continuum of education.

Call to Action

With those principles in mind, all healthcare profession schools, residency training programs, and relevant stakeholders should take immediate steps to meet the moment by examining past history, confronting racism, and designing effective ways to achieve healthcare workforce diversity and inclusivity. We call on all stakeholders in the training of primary care health professionals, including academic medical centers and affiliated entities, institutions with graduate medical education programs, professional associations and societies,ⁱ and accreditationⁱⁱ and certification bodiesⁱⁱⁱ to take bold actions to eliminate racism in all of its forms and embrace the transformation needed as an individual and collective value, with the end result in mind: just and fair learning and career environments that are inclusive of people of color and foster community and connectedness, productive risk-taking, and personal and professional growth

We call on all healthcare organizations and health professions schools to examine their current mission, vision, and practices and give equal footing to health equity, integrate it as a core value, and commit to the goals of:

1. **Racism-free environments:** As [Desmond Tutu](#) and others have noted, silence in the face of injustice is injustice itself. Institutions and organizations should create open environments for dialogue and reconciliation, and not complicity, on racism and social injustice. This should be evident in value statements and in policies and actions demonstrating that racism is not tolerated and health equity and justice is the purpose. People of color should flourish at all institutional levels as empowered role models and champions. Climate surveys should be publicly reported by all stakeholders on shared metrics on racism and psychological safety for people of color.
2. **Racial diversity:** Increase diversity in health professions by dismantling the structural impediments along the entire educational continuum from cradle to career. This should be reflected in strong pathways for progressive increases in the percentage of students, trainees, faculty, and clinical and academic leaders of color, both male and female, in Academic Medical Centers to reflect their representation in the general population.
3. **Racial inclusivity:** Create learning environments that, by design, acknowledge the impact of racism, embrace cultural differences of all people as assets, and take intentional steps toward inclusion of people of color at all levels at institutions. To foster transparency, annual surveys by the AAMC, ACGME, LCME, AAP, SGIM, AAFP, ABFM, STFM, CAFM Educational Research Alliance (CERA), ADFM, PAEA,^{iv} and AANC should include and publicly report on experiences of racism.
4. **Health equity:** Design learning environments within and outside institutions that advance health equity by enabling equal access to human, physical, and economic resources and opportunities that promote social, mental, and physical health. All institutions should publish an Annual Health Equity report by race/ethnicity and other social domains for their patients and their contiguous communities. A Racial Equity report should be part of all institutional quality and safety initiatives to enable the highest quality and value of care for people of color.

*About the AU-PCTE Program

The AU-PCTE program works to bolster the primary care workforce to address the needs of vulnerable and rural populations by enhancing workforce diversity and advancing training models on social determinants of health, integrated behavioral health, and oral health.

Academic Units for Primary Care Training and Enhancement

National Center for Integrated Behavioral Health (NCIBH)

Mayo Clinic, Rochester, MN (PI: [Chyke A. Doubeni, MD, MPH](#))

University of Pennsylvania, Philadelphia, PA (Julie A. [Sochalski, RN, PhD, FAAN](#))

The NCIBH promote models of integrated behavioral health using team-based care in primary care training programs and institutions to provide high-quality care for mental health disorders and substance use disorders.

National Collaboration for Education to Address the Social Determinants of Health (NCEAS)

Northwestern University, Chicago, IL (PI: [Stephen D. Persell, MD, MPH](#); [Wivine M. Ngongo, MPH](#))

NCEAS provides and spreads resources for educators, practitioners and communities to understand and address and reverse how social, economic and environmental factors impact health and healthcare.

Center for Integration of Primary Care and Oral Health (CIPCOH)

Harvard School of Dental Medicine, Boston, MA (PI: [Christine Riedy Murphy, PhD, MPH](#))
Harvard Medical School, Boston, MA ([Russell Phillips, MD](#))

University of Massachusetts Medical School, Worcester, MA ([Hugh Silk, MD, MPH](#))

CIPCOH consolidates the evidence base for systems-level oral health integration into primary care training with a vision of integrative training and practice and mobilize stakeholders to integrate oral health into primary care training and delivery.

National Center on Medical Education, Development, and Research (NCMEDR)

Meharry Medical College, Nashville, TN (PI: [Patricia Matthews-Juarez, Ph.D.](#))

NCMEDR focuses on evidence-based interventions for vulnerable populations including the widespread enhancement and development of a diverse primary care workforce that will produce better health outcomes for LGBT, homeless and migrant worker populations.

Center for a Diverse Healthcare Workforce (CDHW)

University of California at Davis, Sacramento, CA (PI: [Tonya Fancher MD MPH](#))

CDHW leads research focused on recruiting, training, and retaining a diverse healthcare workforce to advance health equity. It focuses on healthcare workforce needs unique to underserved communities to enhance the diversity of their healthcare workforce.

The Collaborative for Rural Primary Care Research, Education and Practice (Rural PREP)

University of Washington, Seattle, WA (PI: [Davis G. Patterson, PhD](#))

Rural PREP focuses on improving and sustaining education of primary care health professionals for rural practice by bringing together educators, researchers, and practitioners to share evidence-based practices, generate new ideas for research and evaluate rural primary care training, encourage scholarship, and promote rural practice.

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ⁱ American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), Society of General Internal Medicine (SGIM), Association Department Family Medicine (ADFM), and Society of Teacher Family Medicine (STFM)

ⁱⁱ Liaison Committee on Medical Education (LCME), Accreditation Council for Graduate Medical Education (ACGME), and American Nurses Credentialing Center (ANCC).

ⁱⁱⁱ American Board of Family Medicine (ABFM), American Board of Internal Medicine (ABIM), and American Board of Pediatrics (ABP)

^{iv} ADFM=Association Department Family Medicine; PAEA=The Physician Assistant Education Association