Teaching Undergraduates about Racial & Ethnic Disparities

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I choke up at graduation each spring. It's the time each year when I think that my teaching may not only impact my public administration graduate students, but it may have a broader benefit on the public and nonprofit agencies where the students work after graduation.

Last spring's graduation was unexpectedly emotional. I had taught an undergraduate seminar on racial and ethnic health disparities for the first time. Disparities and inequality in health care are topics that motivate much of my research, and I had wanted to introduce students to articles I had read over the last decade that had touched me personally. It turned out to be far more gratifying than I could have imagined.

The course was structured loosely around the Institute of Medicine's *Unequal Treatment*, which reviews the literature documenting racial and ethnic disparities across different areas of medicine, the factors contributing to disparities, and approaches to address disparities.¹ One of the early class topics was the history of desegregation within medicine. We read an oral history that highlighted precisely how unequal the African American medical facilities were in one small town in Mississippi, both when they were separate from whites and then when they were segregated.² The students were stunned by how recent segregation was and how comprehensive it was ("segregated blood supplies?"). One wrote that while she had studied the civil rights movement, it was the first time she really grasped the extent of separation and inequality that existed in the United States.

We then discussed the remarkable role that the 1966 implementation of Medicare played in integrating hospitals across the country. Because hospitals had to be integrated in order to receive federal Medicare funds, over 1,000 hospitals "quietly integrated" in a period of four months.³ Learning about this slice of history sparked discussions about the profound ways that public policy can impact the social fabric of the nation, when there is sufficient political will and financial incentives. Yet the extent to which some hospitals went—converting shared hospital rooms into singles in order to avoid integrating hospital rooms, underscored to the students the limits of policy in shifting cultural norms, at least in the short term.²

In the middle of the term, I introduced the topic of physician bias and its potential impact on disparities by having students complete two Implicit Association Tests (IATs) and read a related excerpt from Malcolm Gladwell's *Blink*.^{4,5} IATs, which have been widely used in the psychology literature, are tests of unconscious associations.⁶ Gladwell, who is of mixed racial heritage, writes about how disconcerting it was to take the IAT and find it harder to connect positive words with images of African Americans than it was European Americans. His discomfort provided me with a safe way to open up this delicate discussion and the students were willing to share their thoughts. Several said they struggled with learning (from the IAT) that they held unconscious preference for whites over minorities since they truly believed that they were egalitarian and not racist. Others while disappointed, were less surprised to learn of their preference for whites. Some pointed to their lack of exposure to African Americans growing up in small town Oregon while others pointed to the influence of stereotypical media images. After discussing how widely held unconscious biases are, we pivoted the conversation to explore how such biases might influence health care providers. Several students suggested all physicians should take the IAT to become aware of their unconscious biases.

At the close of the term, we focused on cultural competency training. We discussed a study in which medical students who received training on social and cultural issues in medicine were no more aware than those without training that patients' socio-demographic background might influence medical treatment.⁷ One student said she was surprised. She couldn't imagine a training having no impact on students' perceptions, given her gains in awareness from the class.

This was one of those very special moments as a teacher. She had expressed how much the course material had affected her.

A moment later another student suggested that medical providers might benefit from learning about disparities earlier in their training. Early exposure—perhaps in the undergraduate pre-med curriculum, he argued, might prime their receptiveness for when cultural competency skills are taught later on. His argument was that pre-med students are so focused on science courses that many have not thought about the social aspects of practicing medicine.

I was intrigued and wanted to better understand what the students would take away from the class, so on the last day of class I asked them to complete an anonymous feedback form. Of the 11 students who planned on a health-related career, most reported that the class material would directly influence their careers. One decided to continue taking Spanish classes because she saw how much value speaking Spanish would

have as a health care provider. Several mentioned that they had a newfound respect for the non-academic aspects of being a health provider—the importance of communication and building trust with patients. One wanted to seek out opportunities to work with a diverse patient base during training in order to build skills in cultural competence, another wanted to take on a leadership role to address disparities, and yet another said the class “will make me a better physician in the future.”

The 16 students not planning on health-oriented careers also reported that the material had impacted them. Students wrote that the class material challenged their assumptions and raised questions that they had never thought to ask. They overwhelmingly reported increased awareness of how people of color experience life in the United States. “It has opened my eyes to more widespread and implicit discrimination that takes place in all segments of society. The lessons we learned in this class apply to more than just health care,” one wrote.

I choked up so much last graduation because I realized that I may have had a hand in training some future health care providers who will treat patients from minority backgrounds with respect and dignity, with linguistic ability, and with understanding of the challenges they face. And in training those

going into other fields to have greater awareness and sensitivity to inequality in the United States. Teaching about disparities, I realized, could be a way for me as a non-clinician to contribute to narrowing the racial and ethnic disparity gap.

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