EXPLORING EQUITY IN MEDICAL CURRICULUM

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ABSTRACT

The following report aims to understand how inconsistencies in medical curriculum have led to the marginalization of underserved populations. By recognizing the suggestive inconsistencies, the paper will identify how public policy could effectively aid this issue by producing a solution that addresses the report's three main considerations; quality, representation and access.

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PROBLEM DEFINITION

Several studies have shown that social factors such as racial bias, access to care and housing, and food insecurity can significantly impact people's health.[1] These social factors are known as the social determinants of health; economic stability, education quality and access, neighborhood and built environment, education access and quality, social and community context, and health care access and quality (Figure 1) While all separate conditions are interlinked, they have major effects on a community's overall health. For example, people who don't have access to grocery stores due to their built environment are less likely to consume healthy food, therefore leading to higher risk of cardiovascular issues.

This condition has been amplified with the introduction of the COVID-19 pandemic and growing social unrest present within the U.S.[1] Individuals within the health industry cannot deny the links between social/economic factors and increased morbidity and premature mortality.[2] However, the question of requiring SDH screening within practice is a different story. Even though several health organizations, such as the National Academy of Medicine, the American College of Physicians, and the American Academy of Pediatrics, currently recommend that SDH be included in clinical care, medical education has been hesitant to incorporate health equity training into their curriculum.[1] This hesitancy stems from a place of uncertainty; what role do health officials play in mitigating social and economic factors and how do they address them within the medical field? [2]

The answers to these questions can be found through the introduction of the health equity curriculum, but many medical schools are reluctant to adopt it. Looking further at the existing programs causes further concerns to be raised. In 2018-2019, 83 medical schools in the U.S. reported SDH in their academic level one curriculum, but this number dropped by 40 for level two.[3] So, some medical schools in the U.S. do report SHD in their basic curriculum, but this type of material begins to rapidly decline as the academic level increases. Nancy Denizard-Thompson (MD) and other scholars have additionally commented on the poor quality of the existing health equity curriculum. It has been noted that most programs restrict students to small classroom-based experiences rather than community involvement. Further, many schools that have such programs are offered as electives rather than included in the core, required curriculum. [4]

From this, it can be understood that medical schools that do offer some sort of health equity curriculum are often not of high quality and are not required for all students to participate in. Currently, there are no existing federal policies circulating on this issue. Schools may suggest that students take these programs, but no state enforces them. While it is a prevalent discussion amongst policymakers, enacting legislation has been difficult due to the extensiveness of the issue.[5]

GOVERNMENT RATIONALE

A lack of access to quality, health equity programs within medical schools raises several concerns, several of which could effectively be addressed through government intervention. Resolving the suggestive issue through policy would maximize social welfare by promoting high-quality education across all programs. Due to medical schools' variations in implementing such programs, practicing health officials in practice respectively vary in their ability to work with underserved populations.[6] Federalizing health equity curricula with medical school programs could mitigate this concern and increase the likelihood that a practice implements SDH screenings into their examinations.

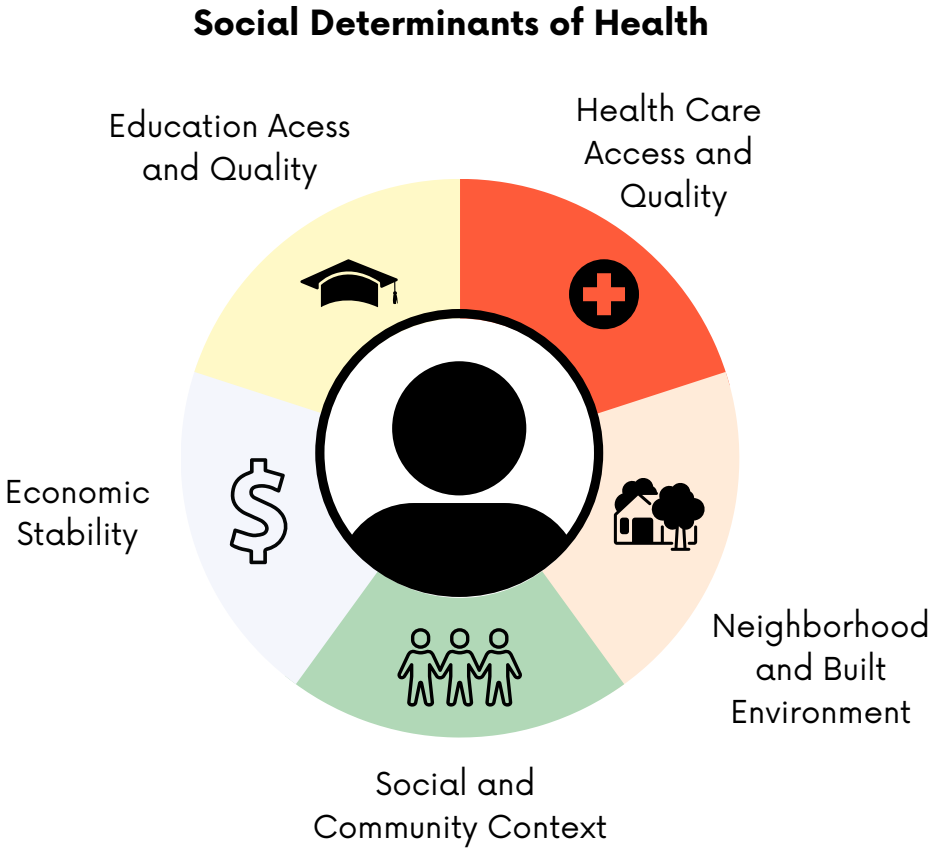
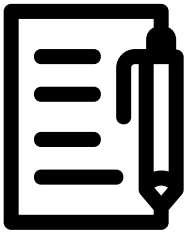


Figure 1: Social Determinants of Health

POLICY ALTERNATIVES

As the social determinants of health suggest, health equity is a major problem in the United States that affects almost everyone. It is important that it is being addressed in the coming years to prevent the issue from developing further.



EQUITY EXAM WITH BOARD CERTIFICATION

The first suggestion would be developing an equity exam that would be included in board certifications. This exam would test students' knowledge on the social determinants of health, current health policy context and ability to implement real world skills. The downfall to this alternative is that taking a paper exam doesn't measure real world skills and the ability to think on your feet. Similar to how students are required to pass their board exam in order to practice medicine they would need to pass this exam to work hands-on with patients.

REQUIRE MEDICAL STUDENTS PRO BONO HOURS

Any strong education requires real world exposure to what you are learning about in the classroom. By enforcing community hours or pro-bono work during the medical school years, students will have a better understanding of what they are learning. These hours should be spread over the 4 years of schooling and should have students in various departments.

FEDERALIZE EQUITY CURRICULUM

In 2019, Wake Forest Medical School developed a curriculum that aims to address health equity during student's third year of study. The program implements various techniques such as in person learning, hands on activities, online modules and presentations to facilitate a better understanding of struggles that their patients face. At the conclusion of the pilot study students self reported knowledge of the social determinants and confidence working with underserved populations showed significant improvement compared to those who did not receive the curriculum.[4]
Federalizing this curriculum would require that all medical schools teach an adaptation of these lessons.

POLICY SOLUTION

After extensive research and analysis, the proposed policy solution would be to federalize a health equity curriculum for all medical schools. The program would be modeled after Wake Forest Medical School's curriculum implemented in 2019.[1] This curriculum is administered during the third year of study and starts with a two day simulation followed by nine online modules that explore the various social determinants through community work. The benefit of completing it during the third year of study is this is the first year that medical students will be working in the field with patients. It was designed to improve medical student's understanding of community, education and organization as outlined by the National Academies of Science, Engineering, and Medicine Framework.

[4] During the orientation week of the third year of study, students participated in a 2 day simulation that allowed students to put themselves in the shoes of the patients. For example, one student would pretend to be a patient who is having trouble getting transportation to and from his doctors appointments each week.[4] After each exercise students come together to discuss what they learned as well as brainstorm ways to help their patients. After the conclusion of their orientation week they transition into online modules that are administered at various times throughout the year.

The modules are broken down into 9 different sessions. Each module has an online or in person lecture, an experiential activity and an evaluation of the work (paper, speech, presentation).

The experiential activities partner with community organizations to help get the students on the front lines. Some examples of activities include delivering meals to low income families and volunteering in clinics. The modules are centered around various social determinants of health and the factors that influence them.

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