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SHORT TAKES: INNOVATIONS IN HEALTH HUMANITIES

Novel Integration of a Health Equity Immersion Curriculum in Medical Training

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Abstract
Health disparities education is an integral and required part of medical professional training, and yet existing curricula often fail to effectively denaturalize injustice or empower learners to advocate for change. We discuss a novel collaborative intervention that weds the health humanities to the field of health equity. We draw from the health humanities an intentional focus retraining provider imaginations by centering patient narratives; from the field of health equity, we draw the linkage between stigmatized social identities and health disparities. We describe a longitudinal health equity curriculum for the Hospice and Palliative Medicine fellowship in Memphis, Tennessee, to give trainees exposure to the concept of structural violence and how it affects clinical care. The curriculum was developed in partnership with humanities and social sciences faculty who staff a Health Equity academic program at a small liberal arts college in Memphis. This curriculum has been implemented for the past four years in support of 22 hospice and palliative medicine fellows. Group debriefs and a mixed methods survey have revealed widespread and lasting impact towards understanding health equity concepts, enhanced communication and treatment of patients, and empowerment to address the broader needs and policies affecting patients and the communities in which they live. Ultimately, we model an educational initiative that integrates equity across the full scope of healthcare practice and equips learners with skills for sustaining compassionate practices, focusing on equity-oriented, person-centered care across the full scope of healthcare practice.

Keywords Health equity · Disparity research · Humanities · Medical education

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Introduction

The Accreditation Council for Graduate Medical Education (ACGME) recently issued a mandate for residency and fellowship programs to incorporate health disparities education into their training. In response, multiple task forces and academic groups created curricula and disseminated resources specific to health equity (Maldonado et al. 2014). Often, these curricula simply name the existence of health differences and pair them with lists of social determinants of health. Without relating health disparities to the root causes and power structures that marginalize populations, these curricula may have the effect of naturalizing injustices (Tsai, Lindo, and Bridges 2021; Vela et al. 2022). Further, the traditional focus on the biological mechanisms of pathology fails to empower learners to combat injustice (Tsai, Lindo, and Bridges 2021). What is needed is a shift in imagination that allows healthcare providers to link individual patient narratives to structural forces, thereby denaturalizing injustice and producing moral motivation to advocate for change.

Here, we discuss a novel collaborative intervention that shifts the focus of health equity education to the social production of health and disease, applying an equity lens that clarifies the relationship between social inequalities, stigmatized identities, and health disparities. In order for healthcare providers to meaningfully engage with diverse populations, they must have (1) the capacity to recognize biomedicine as a culture, (2) the ability to examine one's own social location and understand how it both opens and limits one's perspective, and (3) the creativity to enter imaginatively into the lived experience of health seekers (patients/clients) from backgrounds far different from one's own, all of which are derived from health humanities approaches. Our approach is deeply influenced by the humanistic study of health, particularly as it has been developed by historians (Cooper Owens 2017; Washington 2008), womanist theologians (Townes 2006), disabilities scholars (Schalk 2022), and narrative theorists (Frank 2022). But learners also need (4) a framework to think structurally about the conditions that produce health and disease and (5) the wisdom based upon best practices to advocate effectively for equity, and these we derive from the field of health equity (Marmot 2016). Our approach effectively links the health humanities to the field of health equity in a place-based curricular path for medical fellows and residents. Ultimately, the aim of this intervention is to equip trainees to serve as effective advocates for equity-informed change within their healthcare systems, medical disciplines, and the communities where they practice.

Distinctive Features of Our Approach

Amid widespread health equity educational interventions nationwide, our course models a unique space for this immersion with five key characteristics. *(1) Health humanities framework.* The course centers on a humanistic approach to healthcare and partnerships that provide a deeply contextual approach to thinking about patient populations. The lectures focus on structural injustices and historical contexts, and they teach participants how to gather information about the intersection between neighborhood dynamics, health outcomes, and health-seeker narratives. *(2) Formational exchange.* Traditional approaches have focused on the acquisition of knowledge as opposed to aiming for an extensive formational exchange. We focus on character formation as much as the transfer of information. *(3) Training to enact change.* Through skills-based training, we place an emphasis

on teaching trainees how to enact change in clinical practice as well as equip them for advocacy. Learning *about* inequities is insufficient; we must also *do something about* them (Sharma, Pinto, and Kumagai 2018). *(4) Experiential learning.* While other models have demonstrated value from experiential learning, our careful scaffolding with local experts uniquely situates participants to better denaturalize injustice. *(5) Intentional timing and intensity.* The immersion is part of a one-month primer at the beginning of the fellowship year. As a result, it serves as a foundation or frame of reference for the year. It creates a shared vocabulary for trainees and builds a learning community that continues throughout the year. It creates rapport amongst trainees and faculty where it is not only safe but also an expectation to continue these conversations.

History of Our Program

A longitudinal health equity curriculum was designed for the Hospice and Palliative Medicine (HPM) fellowship in Memphis, Tennessee, to give trainees exposure to the concept of structural violence and how it affects clinical care. HPM is a specialty that focuses on whole-person care—physical, psychological, spiritual, and social. Given this, HPM specialists are well-positioned to appreciate a humanistic approach to health and to understand that social and systemic factors have profound impacts on human health.

The curriculum was developed in partnership with faculty in the Health Equity Program at Rhodes College, a small liberal arts college in Memphis. The curriculum is tailored for different contexts; in the HPM immersion, it consists of 13 sessions occurring in the first month of a one-year fellowship and one follow-up reflective session during the second half of the year. The pedagogical methods include a flipped classroom approach, experiential learning using neighborhood exploration, peer-teaching, and writing an op-ed piece at the end of the first 12 sessions. The sessions include (1) Understanding the Social Production of Health, (2) Agency Bias, (3) Intercultural Communication, (4) Cultural Intelligence, (5) State Violence and Racism, (6) Environmental Racism, (7) Global Health, (8) Transportation, (9) Housing, (10) Healthcare Access and Policy, (11) Food Apartheid, (12) LGBTQIA+ Health, (13) Fellow-led teaching and sharing of op-ed pieces, and (14) a reflective session.

The first month of this HPM fellowship consists of learning basic palliative medicine concepts, home hospice visits, wellness sessions, social/relational activities, and the health equity curriculum. This combination of learning and growing together at the beginning of the fellowship is formative and affects the trainees' approach to patient care and their relationships with each other for the subsequent 11 months. Each session is a full day and requires pre-reading and watching a pre-recorded lecture on the theme for the day. These materials inform the morning discussion led by a content expert from Rhodes College. After the discussion, the faculty member delivers an interactive lecture deepening the understanding of the topic being discussed. The second half of the day is experiential. In collaboration with the Rhodes faculty, fellows choose a historically redlined neighborhood to explore and are given a brief history of that area. In each neighborhood, they eat lunch together at a local restaurant, explore the neighborhood (preferably on foot or bike), interact with people as appropriate, and make observations. Subsequently, they debrief their exploration time and discuss observations in the context of their lectures. Two additional afternoons are devoted to (1) riding public transportation from one of the specified

neighborhoods to the hospital and (2) attending a free clinic that addresses people's social, physical, financial, and psychological well-being.

Because uncritically engaging with patients and families who are struggling economically, are members of racialized groups, or are otherwise stigmatized can reinforce stereotypes, the experiential components of the curriculum are carefully planned and executed. To accomplish this, we provide a structure that helps learners situate their individual clinical encounters with health seekers within a broader set of political, economic, and cultural systems that create unique healthcare assets and challenges. Broadly, our curriculum integrates a theoretical framework for understanding the relationship between social forces and health status with experiential opportunities, followed by reflective practices to denaturalize injustice, contextualize patient experiences, and make hidden curricula visible.

The curriculum has been completed for the past four years, with 22 HPM fellows finishing the training. In addition, 8 Internal Medicine and Internal Medicine-Pediatrics global health track residents have participated in a modified version of this curriculum, and 18 Family Medicine residents per year have completed a parallel and more immersive longitudinal curriculum in Memphis for the past four years.

Immersion Assessment

The course is designed to provide a conceptual map that enables trainees to situate their individual clinical encounters within a broader set of political, economic, and cultural systems. Trainees are encouraged to develop "structural imagination," which helps to reframe clinical encounters in ways that avoid judgment and blame. The course introduces structural violence on a broad scale and creates a framework to understand the disproportionate distribution of disease. It empowers participants to contextualize patients' experiences both within the hospital system as well as during home hospice visits through deeper knowledge of the city. Trainees report that it enhanced cultural humility and fostered character formation through the cultivation of curiosity and humility. It enabled participants to practice advocacy for structural change through writing and teaching. Fellows report feeling a sense of mutual support and learning that endured throughout the year as they were able to mutually reinforce the equity framework for one another.

At the culmination of the year, trainees reengaged with Rhodes faculty to reflect on the immersion and their experiences throughout the year. One participant reflected, "I started questioning 'common knowledge,' specifically about what areas of town are considered unsafe and why that perception exists." One participant questioned, "How often do we say 'unsafe' when we mean 'uncomfortable?' " They further reflected on the question of whether clinical spaces are considered safe and welcoming for others and how they might shift these perceptions. The group shared a sense of connecting "differently" with patients than previous experiences, building rapport more easily and noting that patients were sometimes surprised when fellows were familiar with the cultural and social paradigms of Memphis. The cohort noticed when other colleagues lacked empathy or made unfounded assumptions.

A mixed methods survey was shared with all HPM fellows who completed the health equity immersion course. Of the 22 eligible participants, there were 19 responses (86%); of note, one participant intentionally did not respond to the survey, given they are a co-author of this manuscript, to minimize the potential for bias in response. Fifteen respondents identified as women (79%), and participant ages were mostly between 29–37 at the time of

fellowship completion, with one individual completing the fellowship at 53 years of age. Responses were evenly distributed across the four cohorts and represented 10 adult and 9 pediatric program fellows. All respondents felt that they understood health equity concepts somewhat well or extremely well after course completion. They also all agreed or strongly agreed that understanding social determinants of health has helped them understand, communicate with, and treat their patients; further, all respondents believed that the course has helped them work better within their practice, hospital/health system, and professional organizations in addressing the broader needs and policies affecting their patients and the communities in which they live. Specifically, 17 respondents (89%) felt that the exploration of Memphis neighborhoods helped to advance their understanding of social determinants of health. One respondent shared, "I feel more prepared to recognize and communicate about inequities impacting my patients. I also feel aware of how limitations in my practice, such as business hours, cause inequity for some families."

Eighteen respondents (95%) felt that their perception of health equity concepts have changed over time, citing continued experiences that have broadened their perspectives about inequity in healthcare. One respondent commented, "After participating in the health equity education, I saw systematic and structural racism more clearly in medicine and in each city that I have practiced since then." Participants indicated that the most important takeaways from the course were (1) learning about how policies, frameworks, and structures affect daily lives and the systems we live and work within, (2) exploring Memphis history (e.g. redlining) and how it has contributed to structural racism, disparities in healthcare, and differences in life expectancy, (3) discussions of faith in the community, (4) the role of transportation in shaping inequities and accessibility, linking this to visiting neighborhoods and taking public transportation, and (5) bonding opportunities with colleagues, sharing insights and experiences. One respondent reflected on personal goals to "remove ALL personal bias and judgment and being deliberately mindful of how social determinants of health can impact health care and its execution at the provider and patient level."

The skills that persisted with fellows also included the following: (1) how to conduct a root cause analysis using "the five whys" technique, (2) replacing accusations disguised as questions ("why don't they just?") with curiosity based ones ("I wonder why"), (3) using data and site visits to learn the structural story and "know your place," (4) avoiding stereotyped descriptors like "nice," "pleasant," or "lovely" family, (5) and how to give an "elevator speech," a brief intervention with a colleague that reframes reflections with an equity orientation. For this purpose, trainees were encouraged to have a few "hip pocket" facts ready, with concepts and data they feel comfortable exploring with colleagues in short-form interventions to reframe conventional wisdom with a health equity perspective. When reflecting on how they have striven to enact change, fellows developed skills and confidence to maintain relationships while also intervening when hearing racist or classist assumptions; these are often expressed in the form of assuming that patients are financially able to adhere to a care plan, can afford medications, have reliable transportation, live near safe recreational spaces where they can exercise outdoors, and have access to and can afford nutritious foods. Fellows reflected on their levers of power and advocacy as physicians, as exemplified through writing an op-ed, using the power of their social location as physicians to amplify other voices, identifying places in healthcare systems to advocate (connecting proposed equity projects to hospital system community benefit initiatives, system policies, etc.), and learning to tell a story and connect it with institutional logic to create culture and system change.

Identified opportunities for improvement in future iterations of the course include increasing opportunities to engage in active change-making in the community, inviting

more physicians to participate to more clearly ground concepts in clinical practice, adding more longitudinal touch points throughout the fellowship, and adding the development of a "change-making proposal" to course requirements. This assignment is designed to advance an equity goal by linking it to system logistics. Ideally, the proposal will be presented to a senior decision-maker who can offer advice and critique about the feasibility of each proposal. Some respondents identified discomfort in independently exploring neighborhoods and shared that more structure to these visits could enhance meaning.

Call to Action

With an ongoing health equity crisis and ACGME requirements for integration of healthy equity curricula into training programs, we must stretch ourselves beyond the narrow scope of the health care system and simplistic transfer of knowledge approach to instead design formative contextual courses to empower future generations of physicians to create change. Developing a culture of equity requires cultivating skilled and compassionate providers who operate out of an equity orientation that shapes everything from how they interact one-on-one with underserved patients to how they evaluate patient safety concerns, as well as from how they frame questions about healthcare system policies to how they approach ethically challenging situations. As such, healthcare disparities education must integrate equity across the entirety of healthcare practice and equip learners with skills for sustaining compassionate practices in challenging circumstances. Only through this reflective approach can we provide equity-oriented, person-centered care across the full scope of healthcare practice.

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Declarations

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