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Addressing Health Equity Leadership in Action: A Pilot Partnership Experience

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Abstract

Due to systemic injustices, people of color and other underserved groups experience higher rates of illness and death across a multitude of health conditions. This leaves a large group of individuals medically vulnerable, limiting the health of the nation. Achieving health equity requires intentional, mindful, action from leaders, physicians, community partners, business executives, and all those impacted by inequity. As part of a collaboration between the Feagin Leadership Program (FLP) at the Duke University School of Medicine and the Augustus A. White III Institute for Healthcare Equity (AAWI) in Boston, we orchestrated a Health Equity Leadership forum. The resulting discussion brought forth several key actionable solutions to improving health equity, specifically in the field of medical education. It is our hope that by shedding light on this pilot collaborative effort and sharing the actionable outputs from the forum, we can inspire and empower intentional leaders to utilize this model to make changes towards equitable healthcare today.

Keywords: health equity, intentional leadership, health disparities, mental health disparities

1. Introduction

1.1 Problem Introduction & Study Importance

The Association of American Medical Colleges (AAMC) has deemed health equity integral to providing all patients with the accessible care they deserve (Dawes, 2016). Health equity is defined in this context as the ability to have your healthcare needs met regardless of gender, race/ethnicity, sexual orientation, socioeconomic status, or any other social construct. Despite an increased understanding of its importance, challenges of healthcare disparities continue to plague the United States, as well as globally. In the National Institutes of Health (NIH, 2016) report on the state of healthcare disparities in the United States, the NIH describes the impact of the current burden of health disparities on specific population groups' ability to attain full

health potential with regards to such parameters as incidence, prevalence, mortality, disease burden, and other adverse health outcomes. While the specific healthcare topics contained in this report are beyond the scope of this article, we mentioned this here to introduce the necessity of actionable models that efficiently and effectively address healthcare disparities.

The good news is that these issues are now getting more attention from leaders and educators in healthcare. In 2016, the AAMC released a statement on "Why Health Equity Matters," (Dawes, 2016). Following this, educators at multiple undergraduate medical institutions released statements publicly reporting the ways in which bias in medical education contributes to healthcare disparities and took action to institute medical education reform (Li et al., 2022; Mount Sinai Rolls Out Its Anti-Racism Program to Other Medical Schools | Mount Sinai Today, n.d.; Deyrup & Graves, 2022; Vilson et al., 2022). While this addresses one facet of the problem, this change is occurring slowly.

Luckily, there are some solutions that can be seen as 'low-hanging fruit,' that can be immediately implemented in medical training and beyond. We believe achieving health equity requires intentional, mindful, actionable collaboration from leaders, physicians, community partners, business executives, and all those impacted by inequity, namely all of our fellow humans. Prior research in this domain suggests that multidisciplinary collaborative efforts can be utilized for public health benefits (Hahn & Truman, 2015). While the idea that collaboration is integral to health equity is not new (Jackson-Triche et al., 2020; Teitelbaum et al., 2019; Kegler et al., 2019; White-Williams et al., 2022), there are no published studies to our knowledge that highlight inter-professional collaborative modeled efforts to promote solutions related to health equity for leaders. Through the pilot collaboration between the Feagin Leadership Program (FLP) at Duke University School of Medicine and the Augustus A White Institute for Health Equity (AAWI) in Boston, real-time solutions to address health equity within the field of medicine were discussed and generated (Feagin Leadership Program, n.d.; What We Do – Augustus A. White III Institute, n.d.). The results, which are curated and outlined in this paper, serve as a working guide for leaders in healthcare to answer the critical question— "what can I do today to help work towards health equity within my sphere of influence?" Ultimately, we present that an interprofessional, collaborative forum can be an effective model for determining both broadly applicable and community-specific solutions towards health equity.

1.2 The Collaboration

Understanding the two organizations that collaborated for this experience helps elucidate how solutions within health equity were addressed. The mission of the FLP is to provide a transformational learning experience that develops effective ethical leaders who positively influence healthcare. The FLP, established at Duke University School of Medicine in Durham, NC, USA in 2009, honors Dr. John Feagin, Jr. – humanitarian, compassionate physician leader, renowned orthopedic surgeon, and fellow human.

The FLP is a nine-month educational experience that engages the Feagin Scholars (a select group of medical students, residents, and fellows) in leadership development journeys. The program includes didactic sessions, individual executive coaching, team projects/meetings, an

offsite trip, and attendance and presentation at the annual Feagin Leadership Forum (Feagin Leadership Program, n.d.). The Program uses a patient-centered educational framework which focuses on the competencies of Emotional Intelligence, Teamwork, Critical Thinking, Integrity, and Selfless Service (Figure 1).

Figure 1. The Duke Healthcare Leadership Model. This educational framework is used both by the Feagin Leadership Program and the Duke University School of Medicine as a guide to intentional leadership education and development. Note: Printed with permission. ©2017 Dean C. Taylor, MD. All rights reserved (Hargett et al., 2017).

The FLP is focused on healthcare for all - which requires that physicians, nurses, physician assistants, physical therapists, medical assistants - everyone who influences patients and patient populations, treat our fellow humans with dignity and respect – regardless of who they are, what their socio-economic background is, where they come from, or what they believe. This kind of care demands healthcare professionals develop both the cognitive and emotional skills of Emotional Intelligence (Self-Awareness, Self-Management, Social Awareness and Relationship Management) which, for example, can help professionals to both recognize and mitigate implicit bias (White et al., 2022). These are the exact skills the FLP centers its developmental experiences on. The key developmental experiences of the FLP are the team projects, which require Feagin teams (a mix of 6-7 medical students, residents, and fellows) to address a challenge in healthcare. One team focused on a partnership with the AAWI.

The AAWI is an initiative based in Boston, MA, USA that seeks to address the healthcare inequities that many underrepresented minorities (URMs) experience. The AAWI leadership board forms multi-sector collaborations to curate, communicate, and mobilize best practices and resources for individuals most impacted by health inequities. They also strive to provide education to healthcare professionals on these topics (What We Do – Augustus A. White III Institute, n.d.).

2. The Method

This collaborative effort between the FLP team and AAWI resulted in a co-hosted three-hour hybrid panel discussion to address issues of mental healthcare access in URM communities. The pilot topic for the panel was chosen based on extensive background research and literature review regarding the mental health of young adults living in Boston during the COVID-19 pandemic. The panel included a medical student, psychiatrist, orthopedic surgeon, community activist and government figure, and psychologist. These individuals were identified and selected through research into the field of mental health in the Greater Boston area and through connections within the FLP and AAWI. We intentionally selected individuals from a broad range of training levels and professional domains to facilitate a rich, multi-lens discussion of the issue of health equity, with a focus on mental health equity. The in-person event was held at the Beth Israel Deaconess Medical Center, an academic medical center located in Boston, and virtual attendees participated via Zoom. Approximately thirty attendees participated in the robust discussion and were members of both the Boston and Duke health communities. The main target audience for this intervention was medical professionals, trainees, and community leaders in the mental health sphere. The audio from the event was recorded and used in aggregate with speakers de-identified to extrapolate proposed solutions generated at the forum. Results were generated by FLP team members both from notes taken during the live event and after the event using the audio recording. Several key takeaways were identified from this panel and highlight guiding tools in enacting changes toward health equity. They are detailed below.

3. Proposed Solutions

There were many impactful conversations throughout the event; some key actionable takeaways are worth highlighting for a broader audience. The subject matter, remarks, and suggestions from the panelists are presented in aggregate to preserve anonymity. One key theme repeated throughout the panel discussion is best captured by the following quote: “There are practical and daily things that healthcare professionals can do to make health equity a reality.”

The first topic was the importance of representation. Actionable areas discussed are numerous pertaining to this topic and include the following: increased diversity in standardized patients at the medical student level, and diverse mannequins, media, and images at the broader level. For example, defining conditions only by their appearance on less pigmented skin delays prompt and necessary diagnosis for patients with more pigmented skin. Teaching medical professionals how to diagnose and treat using evidence-based medicine and providing diverse skin pigmentation in educational images are actionable ways to create more intelligent and socially aware physicians.

This panel highlighted that another area in need of improvement is medical literature. Socially defined race should not be used in a biological context in medical textbooks. More specifically, it should be clarified, when relevant, that the sequelae of institutional racism, not race, predispose certain populations to worse health outcomes. This work is becoming more prevalent~~,~~; for example, this key study highlights the importance of ensuring evidence-based

medical education (Li et al., 2022). It is imperative to recognize that health inequities exist due to the presence of systemic oppression and before they can be rectified, leaders must acknowledge, apologize, and provide equitable access to necessary resources.

This forum also highlighted the implications of utilizing algorithms and lab values with race criteria, another topic of rich discussion (ex. estimated glomerular filtration rate - eGFR). These practices are counterproductive to the goals of health equity and often yield inequitable access to evaluation and treatment such as kidney transplants (Ku et al., 2021). The implications of eGFR calculations in the field of urology have been summarized well (Vilson et al., 2022).

Lastly, this panel emphasized the importance of administrative buy-in for, and financial backing of, work pertaining to improving health equity. Similar to how institutions value research productivity, we must place value in the form of resources and financial investment in individuals and institutions working towards dismantling inequities in healthcare.

Limitations to this case study include a relatively small sample size of participants and audience members as well as a single event study. This model may be utilized by others to create discussion related to health equity topics, but there may be challenges in replication, which could include uniform methodology in identifying panelists, difficulty with institutional buy-in, etc. Because the pilot topic was specific to the Boston community, it may be difficult to directly apply every proposed solution to a wider audience, however, many of the solutions raised in this forum were broadly applicable. In addition, the model used to create this forum could be applied to other communities of interest and health equity topics outside of mental health could be explored. This hybrid event could be adapted to be a virtual-only event, increasing the accessibility and decreasing potential costs. Future directions for these efforts could include short and long-term assessment of understanding of health equity issues and actionable solutions as well as assessment of perceived individual empowerment to initiate changes towards health equity both before and after panel attendance.

Overall, these suggestions, if acted upon, would change the culture within leaders' sphere of influence, and create a more inclusive environment for patients. Institutional change may take time, but individual action does not. A caution from many of the panelists was the lack of psychological safety when underrepresented in medicine individuals are looked to and expected to "carry the mantel" for actions such as those listed above. Our panelists charged the leaders in attendance to question, challenge, and act to ameliorate the inequities in medical education, which directly translate to inequities in patient care and health outcomes.

4. Conclusions

Oftentimes, improving health equity is viewed as a philosophical concept for institutions to strive towards but few truly know what actionable steps to take to work towards reaching this state. Here, it is highlighted that the ability to recognize inequity is not always the issue at hand, but rather, the action of the individual to work towards correcting inequities that is the challenge. The first AAWI health equity leadership forum cohosted by the FLP unveiled

several actionable solutions in the health education realm to specifically target ways in which the medical educational system leads to health disparities. Disparities in healthcare affect so many people and the workload needed to address this challenge requires efforts from a multidisciplinary team of leaders including healthcare workers, business executives, community partners, and patients themselves. "We" need to do things now. Both the FLP and the AAWI are part of the now. We hope that by providing these potential solutions, it creates a toolbox of sorts for intentional leaders to begin making actionable changes toward equitable healthcare today. Dr. White, in his opening speech at the forum, summed it up well, "it's not rocket science."

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