An Inter–professional Antiracist Curriculum Is Paramount to Addressing Racial Health Inequities

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Abstract: Legal, medical, and public health professionals have been complicit in creating and maintaining systems that drive health inequities. To ameliorate this, current and future leaders in law, medicine, and public health must learn about racism and its impact along the life course trajectory and how to engage in antiracist practice and health equity work.

To fight racism and its inextricable link to health, health care professionals must recognize, name, understand, and talk about racism competently.[1]

Racial disparities in health date beyond our country's founding.[2] Black people fare worse than white people across a range of health outcomes, including birth outcomes, chronic conditions, and mortality.[3] In 2019, Black Americans were expected to live an average of 4.1 years fewer than their white counterparts.[4] Preliminary data show that the COVID-19 pandemic may have widened the disparity to an astonishing 6 years.[5] COVID-19's disparate impact and recent social unrest following police killings of Black people had fueled growing demands for curricula in law, medicine, and public health to critically examine health inequities and teach antiracism.[6]

As law, medical, and public health schools across the country endeavor to create more opportunities to educate about racism and its impacts on health inequities, we share some examples of how Loyola University Chicago students and faculty are utilizing interprofessional and experiential curricular and volunteer opportunities to educate students on the health implications of racism and develop skills to create and sustain antiracist practices.[7] While we acknowledge that racism and discrimination have impacted the health of many racial and ethnic groups demanding attention

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in our curricula,[8] this article intentionally focuses on racism and its effect on the health of Black people.

In this article, we: (1) acknowledge the complicity of our disciplines in contributing to structural racism and health inequities; (2) outline calls for incorporating antiracist education and interprofessional training into our curricula; (3) share examples from our institution of interprofessional didactic, experiential, and volunteer opportunities in antiracism and health equity; and (4) discuss challenges and opportunities in integrating antiracist and interprofessional training into our curriculum.

Section I: Law, Medicine and Public Health Are Complicit in perpetuating Racism & Health Disparities

> *Still, the inescapable reality is that law and medicine have been symbiotic actors in creating health disparities since America began, and they remain inextricably linked to any meaningful solution to health inequality.*[9]

Our legal, medical, and public health systems have contributed to health disparities by creating and sustaining structural racism. For future professionals to dismantle structural racism and advance health equity, they must know the often-untold racist histories of their professions.

The U.S. legal system has fomented and bolstered systemic racial health inequities since its inception. Its laws enabled "genocide, enslavement, oppression, and 'redlining'… which remain forceful predictors of health and well-being."[10] During the gruesomely inhumane period of enslavement, the law required only the most minimal provision of "food, shelter, and medical care" to enslaved Africans to the extent "necessary to protect [enslavers'] financial investment" in slave labor."[11] The law also permitted the bodies of enslaved people to be exploited and dehumanized in the name of medicine.

In the 1857 *Dred Scott* case, the U.S. Supreme Court infamously ruled that Black people were unworthy of citizenship[12] and that Black people were "so far inferior, that they had no rights which the white man was bound to respect."[13] The first printed copy of *Dred Scott* included an appendix by Dr. Samuel A. Cartwright,[14] wherein he offered medical opinions that Black people were anatomically, culturally and religiously destined to be inferior.[15] This linked the Supreme Court's ruling to the racist medically adopted principles of the time. Four decades later, the Supreme Court decided *Plessy v. Ferguson*, holding that separate-but-equal policies were constitutionally valid exercises of state police powers.[16] *Plessy*'s validation of "separate-but-equal" laws paved the way for segregated hospital systems, de jure or de facto.[17] These segregated hospital systems were far from equal and resulted in under-resourced hospitals and inferior care for patients served at hospitals designated for Black people.[18] This problem persists. As of June 2021, higher COVID-19 mortality in Black communities was traced to modern-day segregated hospitals.[19]

Laws serve as a determinant of health. Ideally, laws set forth policies that "enable everyone to lead safe, healthy lives."[20] The practice of law shaped the most celebrated 20th century public health achievements in the U.S., such as the control of infectious diseases.[21] Laws pertaining to Medicaid, Medicare and nutrition assistance programs are premised on supporting the health of vulnerable populations.[22] Yet, racially biased laws, policies and practices, in areas, such as housing, employment, and criminality, have underpinned a system of continuous racial health disparities.[23] Moreover, anti-discrimination laws, like Title VI of the Civil Rights Act, provide insufficient ammunition to combat health inequities resulting from biased laws and policies.[24]· Title VI prohibits racial discrimination by institutions that receive "federal financial assistance," like hospitals. Title VI, however, has limited applicability, namely because: (i) it cannot be enforced to address discriminatory practices of individual physicians; (ii) it does not address disparities in the quality of care received in hospitals serving majority Black communities and those that predominantly serve white patients; and (iii) a 2001 U.S. Supreme Court ruling barred private Title VI lawsuits challenging practices having only disparate impact."[25]

The field of medicine similarly contributed to health inequities. Physicians actively supported the

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slave trade by opining on the health and strength of enslaved Africans at auctions and by enabling medical neglect, mistreatment, and torture by withholding treatment and failing to meet the basic human needs of enslaved people.[26]

Physicians also tortured and experimented on Black people, without consent, to develop new medical procedures. Notably, J. Marion Sims, hailed as "the father of obstetrics and gynecology," practiced gynecological surgical procedures on enslaved Black women without anesthetics and forced them to hold each other down for repeated experimentation.[27]

There are many other examples of medical abuse of Black people and their bodies without informed consent. In her book "Medical Apartheid," Harriet A. Washington detailed the 1961 account of a surgeon performing an unconsented hysterectomy on civil rights trailblazer Fannie Lou Hamer, after she went to the hospital to have only a (likely benign) fibroid tumor removed.[28] This occurred a mere sixty years ago. At the time, the instances of Black women being forcibly sterilized "to reduce the Black population, was so widespread it was dubbed a 'Mississippi appendectomy.'"[29]

From the early development of medical science through the 20th century, physicians promoted notions of biological inferiority and 'physical peculiarities' of Black people.[30] Such 'peculiarities' included thicker skulls, less sensitive nervous systems, and diseases inherent in dark skin."[31] In 2016, a study reported that 50% of medical students and residents surveyed held false beliefs about biological differences in how Black and white people experience pain.[32] The authors reflected, "[i]t demonstrates that beliefs about biological differences between blacks and whites — beliefs dating back to slavery — are associated with the perception that black people feel less pain than do white people and with inadequate treatment recommendations for black patients' pain."[33] These misperceptions and biases negatively impact equitable access to medical care and health outcomes today.

Public health has a relatively recent history of examining the deleterious effects of social determinants and racism on health, advocating for elimination of racial disparities in health, and working toward health equity. However, it, too, is implicated in racist actions resulting in long-term negative consequences. Perhaps most notably was the Tuskegee experiment developed by the U.S. Public Health Service (USPHS) in 1932 in Macon County, Alabama.[34] The study was designed to record the natural history of syphilis in Black men, but participants were told that they would be treated for "bad blood." A total of 600 Black men (399 with syphilis) were lured with the promise of free medical and survivor's insurance. Although penicillin became the standard treatment for syphilis and widely available in the 1950s, the medicine was withheld from the men without their knowledge or consent. The study continued until 1972 when the national press revealed its existence to the general public. By then, 128 participants had died of syphilis or from related complications, 40 spouses were diagnosed with syphilis, and 19 children were infected at birth.[35] In 1997, President Clinton finally issued a formal apology to the survivors and descendants of the Tuskegee experiment.[36]

The lingering harms of the Tuskegee experiment, coupled with medical racism and social mistreatment of Black people, has facilitated racial inequities in health[37] and a deep mistrust of public health officials, doctors, and vaccines including vaccines for COVID-19.[38]

Ideally, laws set forth policies that "enable everyone to lead safe, healthy lives." The practice of law shaped the most celebrated 20th century public health achievements in the U.S., such as the control of infectious diseases. Laws pertaining to Medicaid, Medicare and nutrition assistance programs are premised on supporting the health of vulnerable populations. Yet, racially biased laws, policies and practices, in areas, such as housing, employment, and criminality, have underpinned a system of continuous racial health disparities. Moreover, anti-discrimination laws, like Title VI of the Civil Rights Act, provide insufficient ammunition to combat health inequities resulting from biased laws and policies.

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Section 2: Curriculum Gaps and Calls for Action

There is a growing call for antiracist curriculum requirements in law, medical, and public health schools. As a result, schools have been more intentional in developing antiracist curricula.

Many law schools are working to incorporate antiracist teachings and critical race theory into their curriculum.[39] Currently, antiracist curriculum is not required by the law school accrediting body, the American Bar Association (ABA), however, there are growing demands to rectify this. In July 2020, 150 law school deans asked the ABA to "require, or at least consider requiring, that every law school provide training and education around bias, cultural competence, and antiracism."[40] Additionally, the Society for American Law Teachers[41] and the Clinical Legal Education Association have also requested changes to the curriculum.[42] In August 2021, the ABA's Standards Committee approved recommendations to change law school accreditation standards to require antiracism and bias training.[43]

Similarly, students, scholars, and medical school faculty and staff are asking to include antiracist and health equity curriculum in medical education. In early 2021, the Association of American Medical Colleges called on medical schools to immediately embark on addressing their institutions' educational curricula and policies to end racism in medical education.[44] There have also been demands for the inclusion of antiracist training in medical schools from students, scholars, and medical school faculty and staff.[45] Some schools have already initiated the process, including the four Massachusetts medical schools: Tufts, Harvard, Boston University, and the University of Massachusetts, in partnership with the state Medical Society and Department of Public Health.[46]

In public health, the accrediting body of public health schools and programs requires foundational knowledge and competencies related to understanding the role of racism in creating and perpetuating health inequities, as well as challenging students to advocate for policies and programs that improve the health of diverse populations.[47] However, schools of public health are working to further incorporate antiracist teaching and competencies related specifically to antiracism.[48] For instance, University of Michigan faculty are developing an online course titled "Health Equity via Antiracist Teaching" to help instructors learn how to implement antiracist principles and practices into their courses.[49] Also, faculty at the University of Washington have developed and implemented their own school-wide competency.[50] These are all promising initiatives and are a step toward our programs and schools becoming antiracist institutions.

Section 3: Opportunities to Educate Students on Antiracism and Engage in Health Equity Work

It is critical that educational institutions provide opportunities for law, medicine, and public health students to learn interprofessionally how to collaborate to address racist harms and change future practices through health equity work. Interprofessional collaboration is critical to improving health outcomes and addressing structural racism.[51] In this section, we share examples from Loyola University Chicago faculty and student efforts to engage in antiracist learning and practice.

A. Health Justice Lab: Race and Health Equity Course

In Spring 2021, Loyola faculty introduced a new course called Health Justice Lab: Race and Health Equity. This interprofessional three-credit course grappled with the relationship between racism, law, medicine, and public health. Students studied how structural racism manifests itself in the practices of medicine and public health, all with the imprimatur of the legal system — perpetuating centuries of health inequities for Black populations.

Ten JD students and ten MD/MPH and MPH students enrolled in the class taught by faculty of law and public health and an interprofessional and diverse panel of guest speakers and community partners. Students were led through discussions, case studies, community outreach, and advocacy work to understand the impact of racism on health and to address health inequities. Topics included medical experimentation on Black people, environmental justice, maternal mortality disparities, epigenetics, and the health impacts of inequities in policing and education. Other course materials included a mix of readings, podcasts, films, TED Talks, webinars, and articles from local and national sources with an intentional focus on Black authors and scholars.

One component of the course was a community-focused health equity advocacy project. Students were divided into interprofessional teams and partnered with a community leader to address issues impacting the community such as water affordability, youth suicide, COVID-19 vaccine access, and contaminated soil concerns. These projects allowed students to hone their advocacy skills, practice community-based work, and address health equity issues identified by community partners.

One student who reflected on the course said, "This has been the first class I have ever taken where we

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actually learned about the intricacies of health and racism which [go] deeper than many people may initially think." Another remarked, "This course has shown how systemic racism in our healthcare system harms at every level ... I gained a deeper understanding of how the U.S. healthcare system was not built with every person in mind, rather it was built on a foundation of racism and meant to continue to perpetuate inequalities." Yet another said, "I studied history in college, but still I didn't know 1/50 of what I learned in this course."

B. Engaging Students in Health Equity and Antiracism Work

While a dedicated interprofessional course focused on antiracism and health equity is a critically important tool for educating future health practitioners, there are other methods of engaging students in healthy equity work through volunteer, student-led advocacy, and clinical experiences. Here are some examples of such opportunities offered at our institution.

I. CERCL

The COVID Equity Response Collaborative Loyola (CERCL) is a team of public health, medicine, nursing, law, and social work students and professionals working in partnership with community leaders and public health officials to minimize the negative impact from COVID-19 in Black and Latinx communities in Chicago's near western suburbs. CERCL, founded in April 2020, works to increase testing and vaccine access, support contact tracing efforts, provide social and legal support, and offer opportunities to engage in research.[52]

This interprofessional collaborative has been driven by the ~100 students who have volunteered or interned with CERCL. As of late summer 2021, the collaborative has provided free COVID-19 testing to more than 1,200 residents, trained more than 65 individuals on contact tracing, screened ~800 residents on their social and legal needs, and facilitated vaccination for more than 200 residents.

II. HEALTH JUSTICE PROJECT CLINIC

Medical legal partnership (MLP) clinics like Loyola's Chicago's Health Justice Project (HJP) offer opportunities for direct advocacy to address racism as a social determinant of health. As articulated by MLP scholar Medha Makhlouf, MLPs can address racism by educating health care providers and students on inequitable power formations, providing opportunities to evaluate patient/client experiences through a lens of understanding how race, racism, and systems of oppression have impacted the client, fostering the identification of oppressive policies and practices, and providing opportunities for multidisciplinary approaches to understanding health disparities.[53]

The HJP offers law, medical, public health, and social work students an opportunity to serve vulnerable, predominantly Black and Latinx, patients in collaboration with health providers by addressing health harming legal needs and engaging in upstream policy advocacy. The HJP's corresponding seminar courses and provider trainings address racism and health equity, cultural sensitivity, trauma-informed practice, and upstream practice, all with intentional content related to racism as a structural and social determinant of health. Acknowledgement of the impact of race and racism is built into analysis of individual client cases and advocacy at the systemic level, offering students an opportunity to put their knowledge into practice.

III. WHITE COATS FOR BLACK LIVES

Students at Loyola Chicago's Stritch School of Medicine (SSOM) founded a White Coats for Black Lives (WC4BL) chapter of the national WC4BL student-led organization, following the national outcry for justice following the murder of George Floyd in Minneapolis, MN, on May 25, 2020.[54] The WC4BL Chapter at Loyola aims to eliminate racism in the practice of medicine, foster crucial conversations aimed at recognizing that racism is a public health crisis, and prepare future physicians to treat all patients with equal dignity and respect.[55] Since its founding, WC4BL SSOM has engaged in student and university education and critical advocacy work.

In July 2020, Mercy Hospital and Medical Center located in Chicago's Southside, was on the verge of becoming yet another closed safety net hospital thereby causing detrimental access effects on marginalized populations.[56] WC4BL joined with Chicago Health Equity Coalition and the Kenwood Oakland Community Organization to protest the closure, joining other Chicago area physicians, advocates, residents and medical students by attending rallies, press conferences, calling the Governor and Mayor and testifying at The Illinois Health Facilities and Services Review Board hearings. In March 2021, the Illinois HFSRB approved the sale of Mercy Hospital for $1 to Insight Chicago, an Illinois not-for-profit.[57]

Section 4: Challenges and Opportunities

The momentum around calls to incorporate antiracist, anti-bias, and health equity curricula into medical, law, and public health programs has created opportu-

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nities for programs to include competencies, learning objectives, course offerings, and experiential opportunities for students. Given the historical complicity of the law, medicine, and public health in creating health inequities, these programs have a unique opportunity to work collaboratively to develop these curricular offerings. Creation of these programs and offerings present opportunities and challenges.

The COVID-19 pandemic and shift to online learning for graduate students allows broader opportunities to develop interprofessional curricular offerings online, which can bridge geographic and programmatic barriers. For example, Loyola Chicago's health sciences campus is located 45 minutes from its law school. Further, mainstreaming online learning platforms facilitated the creation of the Health Justice Lab course, allowing online public health and MD/MPH students to participate with law students who would otherwise have been attending in person courses miles away.

There are, however, challenges to creating interprofessional course offerings, including the need to navigate variations in curricular offerings (i.e., medical and public health curricula must include interprofessional offerings while law schools have no such mandate), varying space for elective course offerings for students, different academic calendars, resource issues related to assigning faculty across multiple programs. The key to overcoming these logistical challenges was flexibility. For the Health Justice Lab course, we worked around conflicting semester start and end dates and divergent spring breaks. Use of asynchronous activities allowed us to accommodate conflicting schedules and delivering the course in the evenings allowed public health students, many of whom work full time, to enroll. Listing two separate courses in the law school and the school of public health also assisted with administrative challenges, including faculty courseload assignments and variable tuition costs.

There are also challenges in developing course offerings and materials on antiracism and health equity. Some faculty may feel ill equipped, as integrating it requires buy-in, time (to develop material, learn and engage communities), and commitment at all levels. Loyola University Chicago has offered training to assist faculty in developing these skills and has created faculty positions to assist in developing antiracism and critical race theory curriculum. Other associations, such as the Society of American Law Teachers and the American Association of Law Schools, have also offered training and support to faculty seeking to transform their teaching. This institutional and association aide is critical to supporting faculty in integrating antiracism content throughout the curriculum.

There also may be backlash against faculty and courses that cover racism, bias, and antiracism. For instance, courses that address privilege and racism, generally, are rated more negatively by students.[58] There has also been significant backlash against efforts to incorporate critical race theory ("CRT") into curricula. Since 2020, lawmakers in several states have prepared bills targeting CRT and seeking to ban any teaching that connects the U.S. to its racist past.[59] Those against CRT "have begun using it as a catch-all term to refer to… teaching about racism or LGBTQ-inclusive policies."[60] As of June 2021, dozens of federal and state bills have been proposed to ban teaching on racism and inequity.[61] Though discouraging, these efforts may provide opportunities for solidarity and advocacy among faculty and students.

Conclusion

Our professions are compelled to teach about the intersection of racism and health and to provide antiracist and health equity advocacy tools to our students. These professions have perpetuated structural racism and continue to be complicit in creating and maintaining systems and structures that result in extreme health inequities. Lawyers engaged in health law practice, physicians, and public health professionals should therefore work to combat racism by employing antiracism tools in their professions to transform systems and reduce health disparities. We should provide tools to our students to understand clients, patients, and communities in the context of racism. There are a number of models of courses and activities, clinical, experiential and student volunteer and organizational activities that can further these goals. Our communities, our students, our patients, our clients, and our colleagues are rightfully demanding this. It is long overdue.

Note

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