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Unmasking Structural Racism in U.S. Medical Education: Advancing Equity for Underrepresented Medical Students

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Abstract

The COVID pandemic cast a harsh light on the structural and systemic health inequalities that exist in American society and in U.S. medical education. Black and Brown communities were disproportionately affected, and the pandemic highlighted the need for a diverse physician and healthcare workforce. Both the lack of equitable, high-quality healthcare in underrepresented communities and the obstacles that students who are underrepresented in medicine (URiM) experience in medical school are direct consequences of the structural racism that flourishes in U.S. medical schools and healthcare institutions. In this article, we explain structural racism and how it has manifested itself in medical education, including the lack of diversity among faculty and leadership, implicit biases and stereotypes about people of color, and discriminatory language used in evaluations of URiM students. We conclude with potential solutions for addressing structural racism in medical education. These include increasing diversity among faculty and leadership, implementing

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antiracist curricula, and providing mentorship and support for URiM students. Ultimately, we aim to promote discussion and action to eliminate structural racism in medical education in America.

Keywords: *Structural racism, medical education, implicit bias, underrepresented in medicine, equity, health disparities*
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Introduction

Since the outset of the COVID pandemic in America, communities of color have been disproportionately impacted by the virus. Mortality rates among people of color (POC) have been double that of White Americans (Millett et al., 2020; Thompson-Robinson et al., 2021). Underrepresented in medicine (URiM) students have been forced to develop additional coping strategies as they witnessed the societal upheavals that came from the COVID pandemic and the murders of Ahmaud Arbery, Breonna Taylor, and George Floyd (Kwaning, 2020). These events only contributed to the isolation that many URiM students feel while pursuing medical training. Unfortunately, many of the historic challenges that these students face in medical education, which relate to structural racism, were exacerbated during the pandemic. However, now that racism has been declared a national public health issue, the time has come to address structural racism in medical education and to work toward solutions (Thompson-Robinson et al., 2021).

Structural racism is a complex and multifaceted issue that has deep roots in American history. It encompasses a range of societal and institutional factors that have contributed to the perpetuation of racial and ethnic inequality. These factors include historical policies, such as redlining and segregation, which have led to disparities in access to housing, education, and employment opportunities (Thompson-Robinson et al., 2021).

The Flexner Report, published in 1910, was a seminal document in the history of American medical education; it recommended sweeping reforms to medical education (Shim, 2020). While the Flexner Report had some positive effects, such as standardizing medical education and promoting scientific rigor, it also had significant negative effects that contributed to structural racism in medicine (Churchwell et al., 2020).

One of the key negative effects of the Flexner Report was the way it perpetuated structural racism and discrimination against non-White, nonmale physicians. The report recommended that medical schools be held to high standards of academic rigor and scientific inquiry, which had the effect of promoting the dominant, Eurocentric perspective on medicine and dismissing other forms of healing and healthcare practices (Stahnisch & Verhoef, 2012). Medical schools that were focused on non-White, nonmale populations were largely ignored or excluded from the report's recommendations, and many of these schools were forced to close as a result (Laws, 2021).

The report also reinforced structural racism in medical education by promoting the idea that only certain types of individuals were suitable for medical training, such as White men from affluent families (Laws, 2021; Steinecke & Terrell, 2010). This exclusionary approach to medical education had the effect of limiting access to healthcare for marginalized communities, particularly Black Americans and other POC. The resulting lack of diversity in the medical profession has contributed to ongoing health disparities and inequalities that persist to this day (Wright-Mendoza, 2019).

In addition to historical policies, contemporary institutional practices and cultural norms also play a significant role in perpetuating structural racism. For example, discriminatory hiring practices, unequal pay, and limited opportunities for career advancement continue to affect communities of color in the workplace (Fekedulegn et al., 2019; McCluney et al., 2018). Similarly, implicit biases and stereotypes about POC can lead to unfair treatment in the criminal justice system, resulting in higher rates of incarceration and harsher sentencing for communities of color (Saunders & Midgette, 2023).

The impact of structural racism is particularly evident in health outcomes. POC experience higher rates of chronic diseases, such as diabetes, hypertension, and heart disease, as well as higher rates of infant mortality and maternal mortality (Johnson-Agbakwu et al., 2020; Quiñones et al., 2019). These health disparities are not simply the result of individual behavior or genetics, but rather are the product of a complex interplay of social, economic, and environmental factors. For example, POC are more likely to live in neighborhoods with poor air quality and limited access to healthy food options, which can contribute to the development of chronic diseases (Thompson-Robinson et al., 2021).

In medical education, structural racism has manifested itself in some of the beliefs that some medical students hold regarding pain tolerance in Black people. A 2016 study demonstrated that many White medical students believe that Black people have a higher pain tolerance because Black skin is thicker and has fewer nerve endings (Akinlade, 2020). Other ways that structural racism has manifested itself in medical education include the dearth of POC among the faculty in U.S. medical schools, an overemphasis on honors attainment on clinical rotations, which has been shown to negatively impact URiM students' ability to craft competitive residency applications, and discriminatory language used to describe the clinical performance of URiM students in Medical Student Performance Evaluations (Ufomata et al., 2021).

It is crucial to acknowledge and address these issues in medical education to ensure that all students, regardless of their race or ethnicity, receive equitable and high-quality training. Our purpose in this article is to provide a foundation for the discussion of structural racism in medical education. We will define structural racism and provide examples of how structural racism is manifested in medical education. We will end with potential solutions that can be implemented across the medical education spectrum. Our hope is that discussions will be triggered by this article and that they will lead to continued, focused efforts to eliminate structural racism in medical education in America.

Definition of Structural Racism

It is difficult to define the term structural racism, and, historically, it has been used interchangeably with the terms "institutional racism" and "systemic racism" (Dean & Thorpe, 2022). Gee and Ford define structural racism as "the macrolevel systems, social forces, institutions, ideologies, and processes that interact with one another to generate and reinforce inequities among racial and ethnic groups" (Gee & Ford, 2011, p. 117). Gee and Ford emphasized the need to understand the intersections of structural racism, individual racism, interpersonal racism, and institutional racism to be able to understand and, ultimately, dismantle systems of oppression.

Structural racism in the context of medical education refers to the ways in which racial inequality is embedded in the institutions, policies, and practices of medical education (Amutah et al., 2021). This includes systemic barriers and biases that prevent POC from entering and succeeding in medical education and the healthcare profession, as well as disparities in the quality of education and training that are provided to students from different racial and ethnic backgrounds.

Addressing structural racism in medical education requires a comprehensive approach that includes changes to policies, curricula, and institutional culture. This may involve increasing diversity among students, faculty,

and leadership, incorporating antiracist and culturally responsive teaching into curricula, and implementing programs and policies that support the success of URiM students.

Manifestations of Structural Racism in U.S. Medical Education

The U.S. medical education system's embedded structural racism harms URiM students, patients, and healthcare delivery. Structural racism extends beyond the lack of diversity in U.S. medical education and in the healthcare system. It includes bias in medical research and the use of medical devices like the pulse oximeter that perpetuate health disparities. This causes delayed access to treatment options, inappropriate patient care decisions, and delayed healthcare. Black and Latinx patients suffer from historical ignorance of their pain and discrimination in pain assessment and treatment. Structural racism also occurs in medical school admissions, residency selection, and the presence of financial barriers that disproportionately affect URiM students. Additionally, racial trauma, defined as the psychological, emotional, and physical distress experienced by individuals or communities as a result of racism, discrimination, and systemic oppression based on race or ethnicity (Hidalgo & McElroy, 2021; Saleem et al., 2020), experienced by URiM medical students and residents underscores the urgent need to address health outcome disparities for marginalized patients.

Lack of Diversity

One manifestation of structural racism in undergraduate medical education is the lack of diversity in medical school faculty, staff, and leadership (Daher et al., 2021; Guevara et al., 2021). Medical schools in the U.S. are predominantly led by White individuals, with POC significantly underrepresented in leadership positions (Beeler et al., 2019). This lack of representation can perpetuate stereotypes and biases and make it difficult for students of color to see themselves as future leaders in the field. Additionally, a lack of diversity among faculty members means that students may not receive the guidance and mentorship they need to succeed in the profession.

Medical Research and Medical Services

Medical education is richly laced with the historic scientific discoveries that have created the gold standards of medical practice today. Unfortunately, the process of medical research has been heavily influenced by the racist roots of our society, yielding extremely dangerous results. For example, the estimated Glomerular Function Rate (eGFR) contained a multiplier used if the patient was considered "African American" (Inserro, 2020). This multiplier assumed that these patients exhibited, on average, higher muscle mass than that of other races/ethnicities as was demonstrated in three small studies performed between the 1970s and 1990s. The new eGFR for African American patients was elevated because of the multiplier and falsely overestimated their kidney function, leading to delayed access to treatment options like transplants. In 2009, a new eGFR calculation that excludes race was developed and, later, a task force was created in 2021 consisting of the American Society of Nephrology and the National Kidney Foundation to reevaluate the use of race in calculating the eGFR. The task force recommended that race not be included in the calculation of eGFR, but as of this date, many reference labs continue to use the old eGFR calculation (Delgado et al., 2021; Levey et al., 2009; Trang, 2022).

Another example of racialized medical practices is the use of the pulse oximeter, a tool that noninvasively measures blood oxygen saturation levels using the relative absorbance of two wavelengths of light and pulsatile flow in the patient's artery (Jubran, 2015). It is most often used to triage patients in an acute setting, determining who in the patient queue will obtain access to healthcare first. Studies have shown evidence that pulse oximeters are inherently biased, absorbing higher amounts of light in those with darker skin (Jubran, 2015; Sudat et al., 2023; Wong et al., 2021). The tool reports a falsely elevated blood oxygen saturation level, suggesting that patients who may need urgent attention from physicians will have delayed access (Fawzy et al., 2022; Wong et al., 2021).

Medical School Curricula

The pain of Black patients has also been historically ignored. A growing number of studies suggest that racial bias leads to discrimination in pain assessment, based in historic belief that the skin of Black patients is "thicker" than that of other races and that Black and LatinX individuals feel less severe amounts of pain than their White counterparts (Hoffman et al., 2016; Meints et al., 2019; Mende-Siedlecki et al., 2019; Todd et al., 1993). As a result of this indoctrination, it was found that these led to less appropriate treatment decisions for Black patients (Bailey et al., 2021). The eGFR, pulse oximeter, and pain assessment are only three examples of many tools that are built into the modern medical curriculum—a curriculum that fails to teach students and trainees to question the efficacy and equity of such tools.

Indeed, while URiM medical students and residents complete demanding programs with the same requirements as their peers, they are learning in environments where they endure and bear witness to harm to marginalized patients and communities by a healthcare and medical education system that continues to use biased practices. For instance, Black women die of childbirth at disproportionately higher rates, Black patients are 30% more likely to die from heart disease than non-Hispanic White patients, and Black children experience elevated rates of obesity (Hoyert, 2020; Millett et al., 2020; Todd et al., 1993; U.S. Department of Health and Human Services, 2019).

Moreover, consider the impact of the COVID-19 pandemic; in the U.S., almost 20% disproportionately Black counties accounted for 52% of COVID-19 diagnoses and 58% of COVID-19 deaths nationally (Millett et al., 2020). Emerging infectious diseases may continue to have a compounding impact for Black medical students and residents as members of vulnerable communities. Witnessing and experiencing these disparities as patients and providers creates racial trauma, which only adds to the burden that medical students and residents have had to face.

Unfortunately, these disparities are not ameliorated by increases in income, educational attainment, or location of residence, as race and ethnicity themselves continue to be significant predictors of the quality of care and outcomes of care even when differences in factors such as access to care, insurance status, and socioeconomic status are controlled (Smedley et al., 2003; Zimmermann & Anderson, 2019). As a result, diversifying medical education as an approach to rectifying disparities in health outcomes for Black patient populations is not an adequate approach in and of itself.

Bias in Medical School Admissions, Residency Attainment, and Financial Barriers

Implicit bias in admissions is another manifestation of structural racism in undergraduate medical education (Ko et al., 2023). Despite efforts to increase diversity in medical school admissions, studies have shown that implicit bias still plays a role in the process. For example, studies have found that Black applicants are less likely to receive interviews or acceptances to medical school than similarly qualified White applicants (Ko et al., 2023). This bias in admissions perpetuates racial disparities in the medical profession, as POC are underrepresented among physicians.

Matriculating into medical school is not an easy endeavor for URiM students; premedical students often battle against negative stereotyping by teachers and advisors, surmount large financial barriers, and endlessly search for supportive professionals to become their advisors, among many other obstacles (Whaley, 2021; Zhang, 2021). Once in medical school, the struggle continues with similar hurdles that have been linked to the academic achievement gap that exists between Black and White students (Jones et al., 2020; Merolla & Jackson, 2019). Medical students take hours-long exams that were not created with an approach of equity, they work long shifts at the hospital to be evaluated by biased attending physicians, and they spend years crafting an application for discriminatory residency programs to accept or reject. Students and faculty alike have urged their institutions to create a more antiracist environment, but only time will tell if there is any commitment to this endeavor (Alonge, 2020; Merolla & Jackson, 2019).

Finally, financial barriers to medical education contribute to structural racism in medical education. The cost of medical education can be a significant barrier for URiM students, who are more likely to come from lower-income backgrounds (Dyer, 2018). This can limit their access to the medical profession and perpetuate racial disparities in healthcare. Additionally, student debt can be a significant burden for physicians, which can limit their ability to provide care to underserved communities.

Possible Solutions

The pandemic and the racial justice movement of 2020, combined with existing structural racism in medical education, have taken an immense toll on URiM medical students. One positive outcome, however, is that many U.S. medical and healthcare institutions have recognized persistent racism as a public health threat and have vowed to take action to eliminate structural racism (California Health Care Foundation, 2023; Ducharme, 2022). The time for discussing and studying structural racism is past. It is time to act.

Hiring Diverse Faculty, Staff, and Administrators

To bring about an end to structural racism as well as promote health equity, institutions should strive to hire and promote POC to their faculty, administration, and staff. This can be done through targeted recruitment efforts, mentorship and sponsorship programs, and diversity training for search committees. By increasing diversity in leadership positions, medical schools can create a more inclusive environment for students of color and provide them with role models who have overcome similar barriers. The lack of diversity in faculty and leadership positions is palpable and has led to the lack of diverse pedagogy, research, and administrative ideas in the nation's medical schools and healthcare institutions (Griffin, 2019; Guevara et al., 2021; Hostetter & Klein, 2021).

Removing Bias From Medical School Admissions

Another solution is to address implicit bias in admissions. Medical schools should implement training programs to reduce implicit bias in the admissions process. Some studies have shown that implicit bias in health professions admissions makes it difficult to recruit and retain healthcare professionals from marginalized groups as well as hampering diversification efforts (Joseph et al., 2021). Admissions processes should include anonymous application review, implicit bias training for admissions personnel, and a commitment to use holistic review processes to consider applicants' backgrounds and experiences. By addressing implicit bias in admissions, medical schools can create a more diverse and inclusive student body, which can help to address racial disparities in healthcare (Ko et al., 2023).

Reframing Medical School Curricula

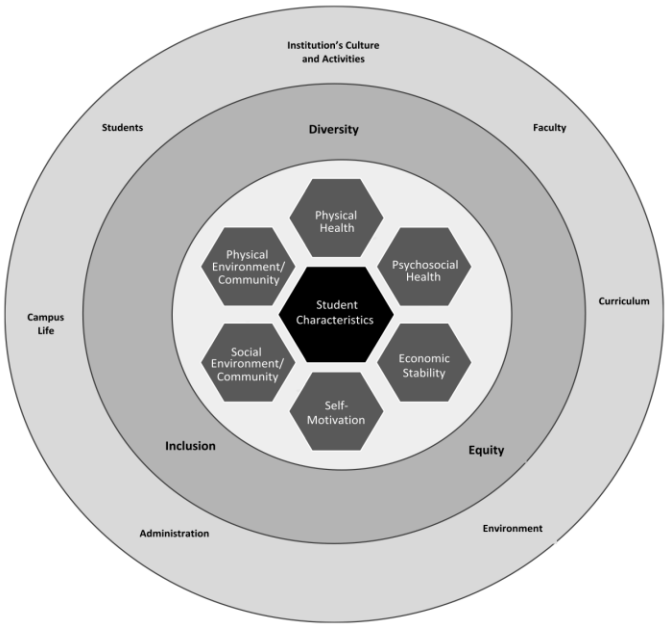
Next, antiracism concepts must be intentionally built into medical school training curricula. Critical race theory has been applied as a lens to examine structural racism in U.S. medical education. Specifically, critical race theory has been used as a framework in the development of antiracism curricula (Tsai et al., 2021). These curricula aim to address the ways in which race and racism impact health, and to equip medical students with the knowledge and skills necessary to provide culturally competent care. This can involve examining the social determinants of health, such as housing and education, and their impact on health disparities, as well as exploring the historical roots of racism in healthcare and medicine. Each of these -isms is related to the diverse ways that the social determinants of health and structural racism influence the health of communities of color and URiM students (Tsai et al., 2021). Medical students, particularly those who will work in marginalized communities, should have a thorough understanding of historical, structurally racist policies (e.g., "redlining" and stop-and-frisk), as well as the social determinants of health that influence the health of communities and individuals (Marmot et al., 2008; Thompson-Robinson et al., 2021; Williams & Rucker, 2020).

To reframe medical school curricula and intentionally introduce diversity, equity, and inclusion concepts into future curricula, it is necessary to adopt new theoretical frameworks. One such framework, the Social Determinants of Learning™ (SDL), was designed with educational justice and health equity in mind (Sanderson et al., 2021a). Developed by Hollinger-Smith et al. to reframe the nursing curriculum at Chamberlain University School of Nursing, the SDL model is a framework that highlights the nonacademic factors that influence a learner's ability to succeed in educational settings (Adtalem Global Education, 2022; Sanderson et al., 2021a). The model recognizes that learning is a complex process that is influenced not only by cognitive abilities and academic skills but also by social, cultural, economic, and environmental factors.

The SDL model includes five domains that affect the learning process (Figure 1):

1. Personal factors: This domain includes the learner's cognitive abilities, prior knowledge and experiences, motivation, and health status.
2. Social factors: This domain includes the learner's family and community support, cultural background, and social networks.
3. Environmental factors: This domain includes the physical environment of the educational setting, including resources and infrastructure, as well as the broader social, economic, and political contexts.
4. Pedagogical factors: This domain includes the teaching methods and approaches used by educators, as well as the curriculum and assessment practices.
5. Institutional factors: This domain includes the policies, structures, and resources of the educational institution, including leadership, governance, and funding (Adtalem Global Education, 2022; Sanderson et al., 2021b).

Figure 1. *Social Determinants of Learning™ Framework*



Note. The Social Determinants of Learning is a trademarked framework developed by Chamberlain University School of Nursing. From "Developing a Social Determinants of Learning™ Framework," by C. D. Sanderson, L. M. Hollinger-Smith, and K. Cox, *Nursing Education Perspectives*, *42*(4), 205–211. https://doi.org/10.1097/01.nep.0000000000000810 Trademark 2021 by Chamberlain University.

The utility of the SDL model in reframing U.S. medical education lies in the model's ability to recognize that a learner's ability to succeed in medical school is influenced by factors beyond their academic abilities. By focusing on the SDL, medical schools can create more equitable and inclusive learning environments that support the success of all learners. For example, medical schools can use the SDL model to identify and address the social determinants of learning that may be barriers to success for learners from disadvantaged backgrounds. This may involve providing additional support and resources to learners who may face financial or cultural barriers to success, such as mentorship programs, financial assistance, or cultural competency training for faculty and staff. Overall, the SDL model may provide a useful framework for understanding the complex and multidimensional nature of the learning process and can help medical schools create more equitable and inclusive learning environments that support the success of all learners.

The SDL model has the potential to reframe medical education by shifting the focus from individual factors to broader social and environmental factors that affect learning outcomes. With this approach, we recognize that factors such as income, education, and social support can significantly impact a student's ability to learn and succeed in medical education. By incorporating this model, medical educators can better address the underlying social and environmental factors that affect student learning and provide targeted support to help students overcome barriers to success. However, there needs to be more investigations and evaluations to determine if this model is viable in practice and can lead to improved learning outcomes for medical students.

Cultural Humility Training

Providing cultural humility training is another potentially important solution for addressing structural racism in undergraduate medical education. Medical schools should require students to complete cultural humility training that emphasizes understanding the impact of structural racism on health outcomes and the importance of providing culturally responsive care (Betancourt & Cervantes, 2009; Solchanyk et al., 2021). This training should be ongoing and integrated throughout the medical curriculum. By providing students with the tools and knowledge to provide culturally responsive care, medical schools may help reduce racial disparities in healthcare (Solchanyk et al., 2021).

A 2012 study conducted in Canada found that videos about the culturally competent care of Chinese patients were successful in improving the cultural competency of medical students. The study revealed that 67.3% of students had acquired valuable skills and knowledge from the videos, enabling them to deliver better healthcare services to immigrant patients. Furthermore, 79.6% of respondents in the study acknowledged that online videos may be an effective method for enhancing cultural competency training (Zhang et al., 2012). Another 2016 randomized control trial that was published by Kron et al. in 2017 compared two distinct types of online cultural humility interventions, which included a module on interprofessional communication and a patient encounter between a student and a Salvadoran family. Students in the study were evaluated via a standardized patient profile; those students who were exposed to the virtual patient module outperformed those who were not exposed to the module.

Providing cultural humility training in medical school may be challenging due to several factors (Solchanyk et al., 2021). First, medical schools have a limited curriculum that must cover a vast amount of information. As a result, there may be limited time available to dedicate to cultural humility training (Buja, 2019). Second, cultural humility training requires a significant amount of self-reflection and critical self-awareness, which can be uncomfortable for some individuals. Medical students and faculty may not be receptive to this type of training, or they may feel that it is not relevant to their future practice (Blue Bird Jernigan, 2016). Additionally, defining and measuring cultural humility has proven to be difficult as differing definitions of cultural competence exist (Goyal et al., 2020). Despite these challenges, it is crucial for medical schools to prioritize cultural humility training to ensure that future healthcare providers are equipped with the knowledge and skills to provide culturally responsive care to diverse patient populations.

Providing Opportunities for Medical Students to Work With Diverse Communities

Increasing exposure to diverse patient populations is also an important solution for addressing structural racism in undergraduate medical education. Medical schools should provide opportunities for students to work with diverse patient populations through community-based programs, international electives, and partnerships with clinics and hospitals that serve marginalized communities. Medical schools should also prioritize placing students in underserved communities for clinical rotations. By providing students with exposure to diverse patient populations, medical schools can help to reduce stereotypes and biases and provide students with the knowledge and experience they need to provide culturally responsive care.

Reducing Financial Barriers

Additionally, reducing financial barriers to applying to medical school as well as obtaining medical education is an important solution for addressing structural racism in undergraduate medical education. Medical schools and policymakers should work to reduce the financial burden of medical education, which disproportionately affects students from marginalized communities (McMichael et al., 2022). This can include increased financial aid, loan forgiveness programs, and policies that incentivize physicians to work in underserved communities. By reducing financial barriers, medical schools can ensure that all students have equal access to the medical profession and are not limited by their financial situation.

Establish Effective Pipeline Programs

Finally, U.S. medical education has a leaky pipeline problem. More attention needs to be given to increasing the numbers of URiM students who wish to pursue medicine, healthcare, and research careers. These efforts, however, should start as early as kindergarten and proceed through university studies and into advanced training programs. As previously mentioned, starting with the premedical years, and proceeding through medical school and residency, URiM students face a multitude of challenges ranging from gaining admissions to medical school to successfully completing their medical training. Pipeline programs should not only focus on recruiting URiM students, but they should also work to ensure retention of these individuals through their medical training, including the completion of residency training (Clayborne et al., 2021).

Discussion

Structural racism is a pervasive issue in the United States and has an impact on various aspects of society, including healthcare. The significance of addressing structural racism in medical education cannot be overstated, as addressing it will play a crucial role in creating a just and equitable healthcare system. Medical education is the foundation upon which physician practice is built, and any structural inequities present in the education of physicians will inevitably lead to inequities in healthcare provision.

Structural racism is the societal system that produces and perpetuates racial inequalities through policies, practices, and norms. The impact of structural racism is apparent in many aspects of society, and the healthcare system is no exception. Despite progress in reducing some forms of racism, structural racism remains a pervasive issue in the United States. Its impact is felt in the form of health disparities, unequal access to healthcare, and discrimination in medical treatment.

Medical schools have a responsibility to equip their students with the necessary knowledge and skills to recognize and combat racism in all its forms. Addressing structural racism in medical education is a critical step in dismantling structural racism in healthcare. This includes a comprehensive education on the history of racism in healthcare, the ways that racism impacts healthcare outcomes, and how medical students and physicians can work to eliminate racism in healthcare. By addressing structural racism in medical education,

medical schools can play a critical role in dismantling structural racism in healthcare and creating a more inclusive and diverse medical workforce that can meet the needs of all patients.

The failure to address structural racism in medical education has implications not only for patient care but also for the medical profession. POC already face significant barriers to accessing quality healthcare, and the perpetuation of structural racism in medical education will only serve to exacerbate these inequalities. Without proper training and education, physicians may continue to perpetuate systemic racism in healthcare, leading to poorer health outcomes for marginalized communities.

In addition to the impact on patient care, the failure to address structural racism in medical education also has implications for the medical profession. The lack of diversity in the physician workforce perpetuates the perception that medicine is a field for only a privileged few, which limits the talent pool and undermines the field's ability to innovate and improve. By addressing structural racism in medical education, a more inclusive and diverse medical workforce can be created that is better equipped to meet the needs of all patients.

Addressing structural racism in medical education is critical for creating a healthcare system that is equitable and just for all. The historical and ongoing harms caused by structural racism must be addressed, and medical educators, physicians, and medical students must work to create a medical education system that promotes antiracism and diversity. Failure to do so will only perpetuate the systemic inequities present in the U.S. healthcare system and lead to poorer health outcomes for marginalized communities. It is time for the medical profession to take a stand against structural racism and commit to creating a more equitable and just healthcare system.

Conclusion

Dismantling hundreds of years of structural racist policies, attitudes, and behaviors will not happen quickly. The solutions offered here are not an all-inclusive list, but they do represent a modest, attainable start that most medical schools and healthcare institutions can implement to work at dismantling the intractable problem of structural racism in medical education. There will need to be a concerted effort to end the policies and systems of oppression on the part of those who have created them. There is also a need to work together with URiM students and faculty to enact meaningful change. It is essential that we move from the realm of discussing and researching structural racism to acting. Campus thought leaders, leaders inside and outside of academia, and other allies must work individually and collaboratively to address structural racism in medical education.

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