Commentary

A Case for Centering Health Equity as a Research Priority in Majority White Academic Medical Centers

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Setting: In this commentary, 5 women of color who are engaged in different aspects of the research mission at the University of Vermont weigh in on the historical importance, current rationale, and persisting barriers to impactful health equity research. Objective: Based on existing information, we delineate recommendations to grow capacity in this and similar majority White academic medical centers. Conclusion: Our assertion is that an evolving, robust, and engaged infrastructure to support this research will benefit patients, faculty, and systems by providing evidence-based and culturally competent solutions that center and enhance the overall health of marginalized populations. *Ethn Dis.* 2025;35(2):49–52; doi:10.18865/EthnDis-2024-14

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Why Health Equity Research?

Solving the complexities of marginalized group health requires approaches beyond superficially recognizing differences in disease outcomes. Scholars must use a holistic lens to shift from a focus on health disparity toward a focus on health equity.[1] This requires contextualization beyond access to care[2,3] and demands broad examination of health system–related factors, including the diversity of the health care workforce and disease de-stigmatization.[4]

The health care system has played a vital role in slavery,[5] forced sterilization,[6] providing the intellectual basis for discrimination, inappropriate clinical trials,[7] unethical medical experimentation, and lack of intervention against group-targeted societal violence.[8] This history has eroded trust between health care providers, marginalized patients, and their communities. For example, Black and Hispanic patients are more likely to report distrust in their health care providers than their White peers,[9] which might contribute to poor health and mental health care outcomes in these patients and communities. Moreover, research suggests that this history informs the existing complex interaction between different variables, including socioeconomic factors, geography, race, and ethnicity,[10] which governs the basis of the societal issues affecting our current health care system. This history thus contributes to the disparate health experienced by marginalized groups.

Provider groups differ in their belief that health disparities exist and how variables like income, English literacy, education, race, and ethnicity[11] might feed these disparities. White and Asian physicians are less likely to acknowledge health care disparities than physicians of other groups: most believe that health insurance status is the principal driver of health care disparities.[11] This suggests that while they understand potential gaps in health care access, they have yet to connect this to systemic causes. Thus, the largest share of medical providers either misunderstand or willingly choose to ignore the systemic impact of health inequity. The solution(s) to address this mindset are complex. Evidence suggests that gains in bias awareness are often not sustained,[12] and that even while health care providers are educated on bias and its role in perpetuating health disparities, individual providers can retain prejudices that negatively impact marginalized communities' care. Moreover, when this waning awareness occurs concurrently with inertia in structural and systemic forces it serves to maintain health inequities.[12]

One way to combat physician ignorance of health disparities is to consider the very nature of academia, and by extension, academic medicine: who gets to participate, who is supported and meaningfully heard, whose trauma is adequately addressed, who does work that is valued,[13] and who gets to lead.[14] Black women across the academy have (in)formally asked these questions.[15] There is a growing body of literature on

the so-called minority tax in academia and academic medicine, and as Black and Brown female–identified persons at various levels and facets of academia, the authors have relevant and unique perspectives on this issue. In this commentary, we amplify that message and assert that the onus of asking and answering questions relevant to health equity cannot rest squarely on those marginalized in the medical profession.

Accordingly, critical research is vital to advancing health equity. Health disparities research is how qualifying and quantifiable information about the social contexts, mechanisms, and extent of health inequities is gained. However, clinical research needs to extend beyond documentation of health disparities.[1] Health equity research is the critical route by which we derive, test, and assess evidence-based interventions to alleviate health inequities and uplift and center marginalized communities.[16] It encompasses all critical methods and approaches to intentional and rigorous scientific inquiry that could be harnessed in achieving true health equity. Such research must also substantively involve health care consumers and communities—making no conclusions without consulting their members. If done appropriately, such work is a mechanism to acknowledge and interrogate historical wrongs and heal relationships with the health care system.[17,18] It must ensure community access to information, opportunities for project oversight, authorship and training, and pathways to incorporate change.[19]

Opportunities and Barriers in a Predominantly White Environment

Despite the existence of organizationally diverse groups that are actively engaged in health equity research, many academic environments persist in a state of relative underdevelopment in this area.[20] We believe Vermont is representative of those environments. Here, historically unserved and underserved communities, including former refugee, immigrant, Aboriginal, migrant farm-working, and Hispanic/Latinx communities have experienced negative interactions with health care centers, providers, and researchers.[9,10] Similar to other environments, this discord has a historical context. For example, Vermont supported forced sterilization of Indigenous peoples[21] and lagged in its formal recognition of members of this group. Thus, from a moral, ethical, and reconciliatory standpoint, Vermont is ripe for further investment in mentorship, collaboration, and innovation in health equity scholarship.

There are practical reasons to invest in this scholarship as well. Vermont's overwhelmingly White-identified population has seen steady gains in racial and other elements of diversity. In highly populated areas, such as Chittenden county, there has been an increase, in numbers and proportions, of Hispanic, Black/African, Aboriginal, Native Hawaiian/Islander, and multiracial peoples (https://datausa.io/profile/geo/chittenden-county-vt#demographics). For the Vermont health care system to adequately navigate this changing demographic, it needs to understand the mechanisms that drive such elements as systemic racism and its impact on health equity in marginalized groups in the state.

As a result of our web-based comparison of local academic institutions with similar National Institutes of Health funding, we suggest that Vermont's academic medical center has relatively limited infrastructure for health equity research.[22] Moreover, the cumulative proportion of the total health-equity relevant articles published in the English language literature written by investigators affiliated with Vermont institutions has remained relatively constant (eg, 0.3% in 2000 and 0.4% in 2021).[22] However, we assert that since the absolute numbers are significantly increasing (especially after 2012),[22] there is a high potential for increased work in this area.

Much existing research in institutions such as those found in Vermont focuses on health disparities driven by rurality[23] and reduced access to care, patient behavior, or race as denoting genetic predisposition, with limited assessment of social determinants and societal mechanisms of marginalization. Few Vermont investigators focus on the intricate role potentially played by systemic factors in health inequity. However, Vermont's academic medical center is affiliated with a larger academic community with researchers focused on issues such as environmental and criminal justice and food systems, which may be incorporated into the examination of health equity.

Herein we focus specifically on the Vermont context. However, the power and possibilities emerging from our data and through its only academic medical center (and affiliated health institutions) can inform how similarly situated institutions negotiate health equity. In a landscape analysis conducted at our institution, we held focus group–based discussions[22] with physician faculty who were departmental "Diversity Champions" or otherwise self-designated as interested in this research. Overall, the participants expressed interest and commitment to this area of research and desire for further engagement and support. During the discussion, we identified barriers and opportunities to grow research in this area, which we feel are generalizable to institutions outside of Vermont.

A major theme that arose is related to individual faculty capacity building. Many participants were uneasy about the definitions of health disparity and health equity relevant to research. For example, some participants were more willing to attribute lack of health care access to rurality and age rather than categorize systemic barriers as mechanisms of discrimination against racially

marginalized groups. The idea that health equity research is a mechanism to develop and implement interventions to attain health equity generated strong feelings of inadequacy. Some were uncomfortable with the idea of measuring racism and discrimination but were more comfortable with the quantitative notion of measuring representation. However, they acknowledged that lack of representation may be driven by racism and discrimination.

Participants also discussed the overall burden for faculty members from marginalized groups, including undue expectations to also support institutional diversity, equity, and inclusion efforts, which takes time and other resources away from needed focus on research in this difficult area. In addition, some participants faced major barriers and noted specific and critical needs and lack of support for individual investigators in this area, ranging from ideation to funding, through project completion and publication. This strongly pointed to the need for mentoring.

Another major theme was the role of the institutional environment. Participants voiced the need for a strong community of investigators who are committed to this topic, who will incorporate health equity into their current research program, and who will collaborate with, mentor, and support those who are seeking to pursue this work. Participants further identified the need for ongoing institutional support for intentional and positive engagement with marginalized communities and community partners.

An additional concern included the structural biases that decrease the perceived value of this work, the inherent career costs relative to other pathways in academic medicine, the important but underrecognized value of advocacy in general, and advocacy's lack of a place in standard notions of scholarship, career advancement, and promotion. This notion is supported by the remarkably lower success rate of federal funding for investigators from marginalized groups than those from White-identified groups.[24] While this may be attributable to structural racism in academic medicine, one clearly defined factor is that a significant proportion of faculty of color from diverse fields seek to do research in areas relevant to health equity and care of marginalized populations. This area of research is less well funded than other areas[24] and may contribute to the overall lower rates of success,[25] the implications of which expand well beyond Vermont. Despite the stated barriers, all participants felt that this area needs to be addressed and that doing so would benefit patients and the institutions that serve them.

Solutions and Pathways Forward

Because of the persistence of health inequity, we hypothesize that the existing academic and nonprofit medical infrastructure in Vermont may be representative of other majority White institutional frameworks in the need to refocus (eg, enhanced support of investigation into the effect of racism), redefine (eg, include intersectionality), and revitalize the area of health equity research. From our examination of the landscape at our institution, including analysis of data derived from targeted focus groups, we present the following broad recommendations to similarly situated academic institutions and their affiliates:

1) Identify and implement appropriate guidelines, "roadmaps," and strategies to improve health equity research (eg, institutional review board, consultation with community leaders, project review by field experts).
2) Reshape existing infrastructure (eg, faculty development programs, workshops, visiting scholar activities) to build robust, integrated capacity in health equity research.
3) Create additional mechanisms to connect the health equity research community, including information clearinghouses, websites, and round table discussions, and mechanisms to match individual investigators.
4) Increase direct support for health equity researchers through internal funding, assignment of administrative (eg, pre-award and post-award) resources, and revision of metrics for reappointment, promotion, and tenure.
5) Broadly align institutional funding and financial priorities with health equity (eg, strategically prioritize identified areas and fund efforts to address them).

A move toward enhancing health equity research would enable health educators and providers of White-majority institutions like those in Vermont to facilitate conditions wherein equity permeates every process and workflow, including biomedical research. While there are no simple one-size-fits-all solutions, there are specific and measurable goals that scholars, educators, and practitioners can take to move toward generating the evidence-based changes, which in turn would drive health equity. Considering these issues for the good of all has never been more critical.

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Conflict of Interest

No conflict of interest reported by authors.

Author Contributions

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