

Prioritizing Equity video series: The Myth of Meritocracy

This March 14, 2022, edition of the Prioritizing Equity series explores the myth of meritocracy, its presence in health care and how physicians can push past it to advance health equity.

Panel

- **Daniel Markovits, JD**—Guido Calabresi Professor of Law and Founding Director, Center for the Study of Private Law, Yale Law School
- **Melody S. Goodman, PhD**—Associate Dean for Research/Associate Professor of Biostatistics, New York University School of Global Public Health
- **Tomás Díaz, MD**—Assistant Professor of Emergency Medicine and Medical Educator at Columbia University Medical Center

Moderator

- **Fernando De Maio, PhD**—Director, Health Equity Research and Data Use, Center for Health Equity, American Medical Association

Transcript

De Maio: Welcome to Prioritizing Equity. I'm Fernando De Maio, director of health equity research and data use at the American Medical Association and a professor of sociology at DePaul University, where I teach social epidemiology and data analysis in our Master of Public Health program. I'm grateful to the AMA for hosting today's conversation and to our amazing set of panelists for joining us. I want to begin today's show by acknowledging the passing of Dr. Paul Farmer. Dr. Farmer was a noted leader in health equity, in global health, an inspiration to many of us, an inspiration to countless

people around the world. He was an infectious disease specialist and medical anthropologist and co-founder of Partners in Health. He died earlier this week.

And as I think about the topic at hand for today, the myth of meritocracy, I can't help but also think of the lessons that Dr. Farmer gave us. You can't read any of his books, "Infections and Inequalities," "Pathologies of Power," and so many others, without grappling with the notion of structural violence and the real constraints that people face in their day-to-day lives. Throughout his books, Dr. Farmer showed us in devastating detail the harm caused by simplistic narratives of individual merit, through the lives of his patients around the world.

In today's discussion, we're going to dive deeper into this myth of meritocracy, its longstanding and damaging presence in U.S. society, and how countering this myth is critical to the advancement of health equity. The myth of meritocracy attributes success or failure to individual abilities or merits, praising people for pulling themselves up by their bootstraps. This narrative, as we'll see, is pervasive throughout the United States, tied with historical notions of American exceptionalism and individuality. It fails to address the centuries of unequal treatment that have intentionally robbed whole communities of the vital resources they need to thrive.

Inequitably distributed social, structural and political resources make meritocracy a flawed concept in U.S. society. However, medical education and hiring are still largely based on these ideals. Biases held by physicians with regard to the myth of meritocracy have a profound effect on health care, and today's guests will help us to examine this myth of meritocracy and the importance of changing and challenging dominant narratives within health care itself.

To help us take a deeper dive into this conversation, I'm pleased to welcome some amazing leaders and dynamic voices in this work today. Mr. Daniel Markovits, Guido Calabrese Professor of Law and founding director of the Center for the Study of Private Law at Yale Law School.

Markovits: Hi, pleasure to be here. Thanks for having me.

De Maio: Dr. Melody Goodman, associate dean for research and associate professor of biostatistics, New York University School of Global Public Health.

Dr. Goodman: Hi, thanks for having me.

De Maio: And Dr. Tomás Díaz, assistant professor of emergency medicine and medical educator at Columbia University Medical Center.

Dr. Díaz: Hello, happy to be here.

De Maio: I'm excited to be here with you all today. To begin, please let us know where you are physically and how you're doing today. Mr. Markovits, can we start with you?

Markovits: I am in my office in New Haven and delighted to feel like others are increasingly in offices too. And so I'm well, thank you.

De Maio: Fantastic. Dr. Goodman.

Goodman: I am in New York City, what I think is the best place on earth.

De Maio: Very good, very good. And Dr. Díaz.

Dr. Díaz: I also am in New York City, the greatest place in the world, and admittedly am feeling a little bit disinhibited. I worked a shift last night, and I have not slept.

De Maio: Well, we are particularly grateful that you're here with us, and we hope you can get some rest right after this call. All right, so I'll begin my first question for Dr. Díaz. We know that the civil rights activist and the first woman of color appointed to a tenured professorship at Harvard Law School, the late Lani Guinier, often critiqued our society's definition of merit. She argued that a reliance on standardized test scores serves the elite and is actually a more reliable assessment of wealth rather than future success. So, I wanted to ask you, how does merit currently function within medical education, and what are some of its broader implications in your perspective?

Dr. Díaz: Absolutely. I think it's important to think about the history of merit in medical education, and we can't talk about merit and medical education, really education more broadly, without talking about racial segregation. Our current medical education model is born out of segregation and exclusion of individuals from racially marginalized groups. And specifically with the legacy of the Flexner Report of 1910, which, for anyone who may be unfamiliar, was an educational survey of U.S. medical schools performed by a single man, Abraham Flexner, who was a former school teacher.

His report ultimately, in part, concluded that Black doctors and patients should be kept separate from white doctors and patients so as not to spread germs from the Black community to the white community. This report really idealized the German model of medical education and had the additional impact of splitting the field of public health from medicine and deprioritizing the healing and service roles of physicians, and sort of standardized a very narrow definition of excellence that informs how we construct merit within medical education today.

To borrow from another education scholar at Emory, Vanessa Siddle Walker, there wasn't true integration of Black and white ways of knowing and practicing medicine, but rather those who were from marginalized identities experienced a second class integration and were retrofit into white spaces, white priorities, white ways of knowing. So in terms of the way we currently construct merit in

medical education, it's all informed by that.

And I think that currently, frankly, merit serves a little bit as a tool of exclusion. Inequities in representation and power in medical education are normalized as merit. We point to these high stakes tests or whatever the case may be to say that this is justified or this is appropriate. But as I mentioned, it's important to acknowledge that we're using a very narrow definition of excellence when we do that, and we are deciding or prioritizing certain definitions of excellence over others.

De Maio: Great. Thank you. Do you have a sense of what changes might be useful or needed in shifting how we define meritocracy in the health care ecosystem?

Dr. Díaz: That's where it gets really hard. I think that question is not so easily answered. But I think, initially at least, this is a little bit of a vague answer, but I think we need to embrace flexible definitions of merit which better align with institutional missions, which after 2020 have oftentimes incorporated equity and justice into those missions. And we need to think about relevant societal outcomes. That's a big Pandora's box—what are relevant societal outcomes—and defining them will certainly be difficult. That doesn't mean that we shouldn't do it.

I think it requires thought and input from all stakeholders, community members, scholars alike, and may vary, actually, depending on the needs of a specific location or practice context. And I think that's okay. So when I think more specifically, in terms of the merits, that might include facility with advocacy or service or collaboration, critical inquiry, emotional literacy, things like that. But ultimately this is going to be a very challenging task, and an inclusive meritocracy is going to require collective commitment and collaboration and a lot of hard work.

De Maio: Thank you. Those are important observations. And it really gets to the heart of the issue, that this is such an embedded concept throughout all our society and in health care in particular as well. Mr. Markovits, turning to you. In your book, “The Meritocracy Trap,” you discuss how inequities caused by meritocracy is not simply a flaw, a mistake, but rather the result of how the system is supposed to work. Can you talk a little bit around that and your critique overall of American meritocracy?

Markovits: Of course, and thanks again for having me on. It's a pleasure be on with all of you. I think I want to make two points. The first follows directly from what was just said, which is that meritocracy, which allows people to advance based on their accomplishments, is not the same thing as fairness or equality of opportunity. There are at least two ways in which it's not the same. The first is what counts as an accomplishment or what counts as an excellence can itself be biased, and it can be biased in ways that are aligned with existing types of subordination, racial subordination, gender subordination, class subordination.

And then the second is that even if what counts as accomplishment isn't biased, in order to accomplish something, you need not just talent and effort, you also need training and investment in you. And in a world in which certain people, rich people, male people, white people, get a lot more invested in them from birth onwards, if you then measure their accomplishments or their excellences, it's going to mean that even if excellence isn't biased, people who don't get things invested in them won't have as much accomplishment.

That's why you can get to a world in which, if you look at, say, the Ivy League, it tries relatively hard now, I think sincerely, to admit a wide range and diverse set of people. But it overwhelmingly admits rich kids, because to get in you have to have an A average, you have to have high SAT scores, and it's very hard to get those things if you didn't have a lot invested in your education as a child, so that meritocracy is an obstacle to equality of opportunity. That's the first point I want to make.

The second point, which is really important and I think is less appreciated, is that what counts as an excellence is itself a function of the system. Let me give a concrete example. We can transplant a human heart. We can give someone an artificial heart. Here's something we don't know the answer to. Is it better for my heart health to exercise intensively once a week, moderately three times a week, or just to walk to work every day and always take the stairs? We don't know the answer to that question because we have not invested enough in assessing the health effects of lifestyle, nutrition, figuring out how to help people get healthier, fitness trainers, various forms of counseling. We don't invest enough in that. We don't have enough knowledge in that.

What we have is we've invested disproportionately in a narrow class of super specialist, super meritorious doctors, the people who do the transplants or who invent the transplant technology, at the cost of investing in nurse practitioners, public health officials, nutritionists, exercise therapists. And if we invested more in those other things, we would actually have better health outcomes as a population. It's not coincidence that the U.S., which is so disproportionately, so to speak, meritocratic in its health care system, also spends more money to produce worse outcomes and more unequal outcomes than other countries. So our health system would be better.

And then the last thing to say is, all those jobs I described, the nutritionist job, the nurse practitioner job, those are good middle class jobs that it would make the health care system not just good for patients, but better for workers who work in those jobs, and better for our broader labor market and society to be much more egalitarian in those ways also.

De Maio: You raise great points. And again, you get me thinking of Dr. Paul Farmer and the importance of community health workers, the importance of protecting the social fabric of communities as a fundamental source of well-being and health in society.

Markovits: Exactly.

De Maio: One follow-up question. Despite the immense evidence that we've seen that exposes the illusion of naive versions of meritocracy, much of our society still buys into this myth. It's pervasive. It's deeply ingrained. Why do you think that's the case, and what are possibly some ways of engaging in a conversation and perhaps even countering that narrative?

Markovits: I think there are three reasons why. The first is, it benefits the elite, because it makes the elite believe that it deserves its position, and so that creates an enormous amount of ideological pressure. A second reason why is, in the previous exchange, when you asked, well, what should we do about this, the answer is, well, that's a hard question. When people think about getting rid of meritocracy, what they think about is, well, do we want to go back to aristocracy? Do we want to go back to race- or caste-based systems of priority? No, of course not. And so, figuring out how to explain a livable alternative is hard.

And then the third reason is, meritocracy has also had triumphs. Yale Law School's student body is now half women and over half people of color, and the reason for that is meritocracy, because no gender or race dominates ambition. When you get rid of categorical exclusions based on racism or other axes of bigotry, you create an elite that is more diverse, more inclusive, and that's a genuine moral achievement. At the same time, meritocracy also excludes lots and lots of people, so it's a complicated thing. It has some real accomplishments and some real forms of subordination, and the accomplishments are charismatic and powerful. That's one of the reasons why it's hard for people to shake.

De Maio: I appreciate you bringing out the nuance and the complexities of the argument. Dr. Goodman, turning to you. Your work focuses on developing solutions to improve the health of historically marginalized communities. Can you talk a little bit about how the myth of meritocracy serves to deter us from taking a deeper look at the root systems, the systems of power and oppression, that create and perpetuate health inequities?

Dr. Goodman: I think both of our panelists have touched on this, but the roots of meritocracy make it feel like health is an individualistic thing, that you in yourself can control your health. And while we know there are things that individuals can do that can impact their health, your health also has a lot to do with where you live. We know place really impacts health. We know systems and structures impacts health, particularly racism and other systematic structures. And so, where meritocracy comes in is that people feel like when there are differences between groups of a certain condition, then one group should just fix themselves or do better or be better or behave better, and that will make the health outcome different.

But take, for example, diabetes. If someone has diabetes, let's say the doctor says, "Well, you should be more physically active and you should eat healthier." Well, can this person afford to go to the gym? Maybe, maybe not. Do they have a park in their community? Maybe, maybe not. If they have a park in their community, is the park a safe place for them to go and work out and be active? Do they have

sidewalks in their community? Maybe, maybe not. So physical activity becomes a maybe, maybe not for some people.

Then you say, eat healthy. Well, do they have access to healthy fruits and vegetables at a reasonable price that they can afford to eat meals? And so you have to think about when you ask someone to do something, are they in an environment where they can actually do those things? And meritocracy sort of takes out the idea of being in an environment where even if I want to do something, I'm not really capable of doing those things.

De Maio: Right. You've got me thinking of the sociologist C. Wright Mills, who advanced a very simple model of personal troubles and public issues. Personal troubles are the elements of our biographies, and public issues transcend our individual lives. They're acts of history, of politics, of economics. Meritocracy is very much a personal troubles kind of story. It's within our control, presumably within our control, if only we work hard enough. But it neglects the constraints of structure, of the public issues in which our lives play out.

I want to open up the floor to any of you now, on a closing thought, and it's this. How do you see the conversation around the myth of meritocracy advancing in U.S. society? In this moment of intense political polarization, where many conversations are breaking down, do you see any hope, any potential that this concept and this debate around it might be a step forward and might engage people who otherwise might not be in conversation with one another? Any closing thoughts around that?

Goodman: I hope people think about what they mean when they say meritocracy. Who gets to set the standards, and are the standards attainable for everyone? And then I hope people think about what they can do in their own spaces to do that. As someone who works in education, we think about the idea of many health professions have a service requirement. If you're going to be a great student, in addition to having great grades, you should also do service. Well, only certain social economic status populations really have time to do service, in addition to being great students. Some of us have to earn money to help support our family. And so just thinking about some of the requirements we put in place, is service a necessary requirement to be a great nurse or whatever we're talking about? Is that really what is needed? And so I hope people really start to think about what is needed and what we can do.

I also think in education, there's this idea of schools competing for the best students. Well, who are the best students and why aren't education institutions ... If I'm a really good teacher, then what would make me a really good teacher is if I could take someone you don't think has the best potential for outcome and get them to a place where they're going to have a great potential. So we should be competing to turn the students that, I don't want to say they're the worst students, because I don't think they are, but take poor performing students or students that we've classified as poor performing and make them better through education, because that is what education is supposed to do, instead of competing for students who we think, we already know are going to do well when they come here.

That doesn't make me a great instructor if I can teach someone I know is going to do well when they come here. What makes me a great instructor is, can I help someone get this information who would not otherwise have access to it?

De Maio: Great point. Thank you. Dr. Díaz, any closing thoughts from you?

Dr. Díaz: I completely agree. And I think that what might offer me a little bit of hope is, as I alluded to, I think that many institutions in the wake of 2020 put pen to paper, or at least advertised certain priorities and certain values that offer us as advocates an opportunity to hold their feet to the fire a little bit. And in today's day and age, I guess, there are lots of people who are thinking about this in lots of cool ways, interesting ways. I think where I still worry and struggle is, how do we amplify those people who are really doing creative work or thinking in creative ways and try to prevent them from being lost in the noise? As we've all alluded to, it's something that's really challenging, and it's going to require a collective push in order to really advance this cause.

De Maio: Agreed, agreed. And Mr. Markovits, any closing thoughts from you?

Markovits: You know, I think one thing that's come through in this conversation is that it's really hard to see through the ideology that makes something that's constructed as a form of inequality or hierarchy or subordination seem natural, deserved, inevitable. And one thing that gives me hope is that over the past five or six years, we as a society have gotten a lot better at seeing through those ideologies and understanding that what seems like, or seemed like, it just was rational and necessary is the construction of power and hierarchy. Young people in particular are really getting better and better and better at that. That's not a sufficient condition for broad-based reform, but I think it is a necessary condition, and it wasn't in place a half generation ago, and it is in place now. And so that's a good place to begin. And I think we are at the beginning, not in the middle and certainly not at the end, of this set of reforms.

De Maio: Indeed, indeed. There's also a growing scholarship and growing community, a growing conversation around the myth of meritocracy and all kinds of taken-for-granted assumptions that we carry around with us in education and health care and all fields. To viewers, I thank you very much for tuning in today. To our panelists, I thank you so much for your time and energy and wisdom, for the conversation, which I greatly enjoyed and benefited from.

To close, I'll remind viewers of our Advancing Health Equity Guide to Language, Narrative and Concepts, which the AMA recently published, together with the AAMC Center for Health Justice. It contains a section on the myth of meritocracy and additional discussion on individualism, on the social construction of race, and many other deep dominant narratives in U.S. society. We encourage you to check that out.



We also hope you'll visit the AMA website and in particular, the AMA Ed Hub, where there is a growing collection of materials and content curated by the Center for Health Equity, with CME bearing credit. On the AMA website, you can also find our Health Equity Resource Center for COVID-19 and a growing set of materials. And visit the Center for Health Equity page to learn more about our strategic plan to advance racial justice and embed health equity in medicine. Thank you all so much for your time today.

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