Rebuilding medical curricula to treat race as social construct

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Until just a few years ago, medical education had changed little for more than a hundred years. Vestiges of this outdated model of instruction persist to this day in its language and its clinical tools, often with educators not even realizing it.

A webinar, “Uprooting Racism Embedded in Medical Education,” produced by the AMA Accelerating Change in Medical Education Consortium, features a presentation on how one medical school took a cue from its medical students and undertook a wide-ranging reevaluation of its teaching methods and curriculum to ensure race was viewed appropriately—as a social construct, not a biologic one.

Started with students

The presenter, Paul George, MD, MHBE, is associate director of medical student education at Warren Alpert Medical School of Brown University, a member school of the AMA Accelerating Change in Medical Education Consortium. He noted that it was students who first spotted the problem, six years ago.

“A number of students who were taking a class on social medicine noted that we were using race inappropriately,” he said. “Many of our lecturers were using race to depict a biologic construct rather than a social construct.”

The students wrote a letter to the medical education faculty and asked them to reexamine how it was being used in the curriculum.

“Since then, it’s really been an iterative process to educate our lecturers, our faculty,” Dr. George said.

Learn more with the AMA about why racism is a public health threat.
Practical first steps

The students, along with Dr. George and his colleagues, undertook a number of changes to the medical school’s curriculum. The first was maybe the most obvious.

They teamed up to “examine every slide that was in our pre-clerkship curriculum where race was listed,” Dr. George said. “We then, as a group, came together to decide whether race was being used appropriately or inappropriately. If it was deemed to be used appropriately—i.e. used as a social construct—then we allowed that slide to continue on and within the curriculum. If we thought that race was being portrayed as a biologic construct, we then further categorized it as whether it was being explicitly taught as a biologic construct or implicitly taught.”

The same was done for lectures.

“When the lecturer used race as a biological construct, we did one of two things,” he said. “We asked the lecturer to provide more context—so we asked them to think about race as a risk factor in terms of structural racism and how inequities in health care … and housing … and food … contributed to disease processes. Or if they could not do that, we requested that lecturers remove the slide entirely.”

Dr. George also talked about how his medical school incorporated racial justice longitudinally. In addition, the webinar includes presentations on bias in assessment and how educational materials perpetuate structural racism.

The AMA is challenging medical schools and residency programs to confront the structural racism embedded in their own programming. Medical education must be responsible for its own educational inequities, as seen in distributions of honors grades and awards, differences in language of clinical evaluations and letters of recommendation, microaggressions in the clinical workplace and classroom, and more.

The AMA has shared a process of institutional diversity and inclusion self-study and issued a statement to protect diverse learners during educational disruptions related to COVID-19.

Launched last year, the AMA Center for Health Equity has a mandate to embed health equity across the organization so that health equity becomes part of the practice, process, action, innovation and organizational performance and outcomes.


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