Clerkship grades can make or break for medical students’ career aspirations, yet the clinical learning ecosystem isn’t always set up to deliver equity in assessment.

A webinar, “Uprooting Racism Embedded in Medical Education,” produced by the AMA Accelerating Change in Medical Education Consortium, features a presentation on how to measure and eliminate harmful bias in the evaluation of clinical performance.

The presenter, Karen Hauer, MD, PhD, is associate dean for competency assessment and professional standards at University of California, San Francisco (UCSF), School of Medicine, a member school of the consortium.

Why bias matters

Students at UCSF School of Medicine had long questioned the accuracy of clerkship grading, and when Dr. Hauer and her colleagues analyzed the data, they found an interesting pattern. Students from backgrounds that were not underrepresented in medicine scored, on average, a tenth of a point higher on a zero-to-four scale than students from backgrounds underrepresented in medicine. That was true across all eight of the school’s clerkships.

“While we questioned whether that tenth of a point difference could possibly be educationally or clinically meaningful, it translated to those learners who scored a little higher being almost twice as likely to earn clerkship honors and over three times as likely to be selected for the AOA [Alpha Omega Alpha] medical honor society,” Dr. Hauer said. “This important difference leads to differences in selection for residency in specialties of choice and moving on to faculty careers.”
Many students and faculty pointed to those numbers and reasonably concluded some evaluators must be biased, but Dr. Hauer’s team went further and questioned whether the data might also indicate that systemic factors were in play.

They undertook a survey of 666 fourth-year medical students at six medical schools, asking them for their perceptions of accuracy and fairness in clerkship grading. The factors students thought were most important: being liked and who they worked with. The least: knowledge, rapport with patients and improvement.

Moreover, a regression analysis found that one key factor associated with honors earned was vulnerability to stereotype threat, or “the phenomenon in which a member of a stereotyped group fears fulfilling a negative stereotype about their group and as a consequence, performs less well,” Dr. Hauer said.

Shift away from ranking, grading

UCSF School of Medicine has made many changes since that survey was conducted. One change is to give students the opportunity to rate their assessors’ respect for people in the clinical learning environment. Another is to shift its clerkship evaluation to “assessment for learning,” Dr. Hauer said. That means all learners now receive feedback in the course of learning, and their teachers then reobserve them to see if they have made the needed improvements.

With this change, learners are “less focused on keeping ahead of the peer students on either side of them and more focused on their personal learning,” Dr. Hauer said. Now their minds are on: What do I need to learn to get to the next rung on the ladder?

The webinar also features presentations on how educational materials perpetuate structural racism, rebuilding medical curricula to treat race as social construct, and addressing microaggressions head on.

The AMA is challenging medical schools and residency programs to confront the structural racism embedded in their own programming. 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.