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The elephant in the room: talking race in medical education

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Abstract The deaths of black men and women while in police custody, rising anti-immigrant sentiment and rhetoric in high-income countries, and the continued health disparities experienced by Indigenous communities globally have brought race and racism to the forefront of public discourse in recent years. In a context where academic health science centres are increasingly called to be "socially accountable," ignoring the larger social context of race and racism is something that medical education institutions can little afford to do. However, many such institutions have largely remained silent on the issue of race and racism, both within and outside of healthcare. Most medical education continues to emphasize a primarily biological understanding of race. We argue that a different approach is needed. Highlighting the social construction of race is an essential starting point for educators and trainees to tackle racialized health disparities in our clinics and to challenge racism in our classrooms, educational and research institutions, and communities.

Keywords Race · Racism · Social responsibility · Social accountability · Medical education

As we write this, it has been two years since the shooting of Michael Brown in Ferguson, Missouri brought the issue of racialized police violence to the fore of American thought. It has been two months since the beating and death of Abdi Abdirahman while in police

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custody in Canada's capital city, sparking national discussion and outrage. It is also a time of unprecedented migration, with 60 million displaced people globally. Indigenous communities worldwide continue to grapple with social inequities and health disparities. It is impossible to discuss these issues, or their health implications, without discussing race. And yet race is a topic on which medical schools and medical educators are largely silent.

When we do use the term race in medical education we use it messily, relying on a 'common-sense' understanding of race as biological truth and valid unit for comparison or analysis. Trainees learn of race as a social determinant of health, as a predictor of healthcare access, quality, and outcomes (WHO 2016), whereas they are rarely taught about patient (and trainee) experiences of racism (Montenegro 2016; Beagan 2003). They are increasingly taught about advances in genomic research, which has led to renewed interest in a genetic basis for racialized health disparities (Frank 2007). This 'common-sense' understanding of race as biological truth, however, is in fact a political and contested understanding that was rejected as early as 1950 by the United Nations Educational Scientific and Cultural Organization (UNESCO 1950). Viewing race as biological truth ignores major scientific limitations to the use of race as a biological and genomic predictor, and positions attendant health risks as inevitable. In so doing, it functionally teaches students that while race-based health disparities exist, there is little to be done about them.

In contrast, understanding *race as a social construction* can fundamentally change how medical educators, trainees, and education researchers conceptualize racialized health disparities. While this notion is widely accepted outside of medicine, uptake within medicine has occurred at a glacial pace. The idea of 'race' has been historically fluid, highly contextual, and contested. Rather than biological truth, race is a social process that ascribes (usually hierarchical) meaning to physical and cultural differences between people (Beagan 2003; Dei 2009). This does not mean that race is not *real* in its consequences for individuals and communities, for there is an incredible "salience and centrality of race" in peoples' lived experience (Dei 2009). The term *racialization* is useful here, allowing an interpretation of race and racism as fractured, multilayered, and actively occurring processes by which socially constructed 'racial' and ethnic categories are ordered. The term *racialization* shifts our gaze away from the racialized subject and towards race as a mutual and dynamic process (Ford and Airhihenbuwa 2010). In other words, it is not that medical educators should avoid discussing race as a social determinant of health, or that researchers should shy away from understanding the deep and undeniable health consequences of racialization and racism. Rather, these endeavours must be undertaken in a way that acknowledges the socially constructed nature of race as a concept and classification. It is not the differences, but the meanings ascribed to them, that matter.

In medical education, this means a potentially painful discarding of claims of cultural and racial neutrality both in clinical practice and in education research. As Beagan (2003, p. 860) notes:

> we tend to deny the relevance of differences, in an effort towards greater equality, proclaiming proudly, 'I'm colour blind. I don't even notice the ''race'' of my students.'… Not to notice a social feature that profoundly affects the life chances and everyday experiences of whole groups of people is an act of privileged ignorance. We need, rather, to learn to acknowledge differences without reinforcing hierarchies of superiority and inferiority.

This can be done in a number of ways. At the admissions level, equity issues must be addressed to improve diversity and representation in our classrooms (Kuper 2016). In our classrooms, we can challenge our assumptions: around 'normal ranges' based on primarily

Caucasian populations, or of "white" being the default race when none is mentioned (Turbes et al. 2002). As educators, this means simultaneously employing and challenging the notion of race as we study and teach about racialized disparities. Central to this process is cultivating a *race consciousness*—the acknowledgement and explicit study of racial dynamics personally and socially (Ford and Airhihenbuwa 2010). Such consciousness entails reflexivity into our own privileges and oppressions, recognizing that all of us—white, black, brown—are part of a process of racialization, and experience this process and its impacts differently. It involves recognizing that medicine and its purveyors *do* have a culture, and it is not enough to become "culturally competent" by versing ourselves in how to "deal with" the cultured or racialized other (Taylor 2003).

Race consciousness also involves paying attention to who is marginalized in our classrooms, clinics, and research communities, and how. Educators are thus called to challenge the *ordinariness* of "everyday racism"—when the Phillipino medical student is mistaken for an orderly, or when the brown-skinned junior resident is asked repeatedly where she is from and where she learned to speak English so well—and to work towards uncovering the colonial and racist foundations of medical knowledge (Beagan 2003; Ford and Airhihenbuwa 2010). Explicit and conscious explorations of the ways in which medicine has participated in colonial and racist practices are critical to unpacking medicine's complicated relationship with the notion of race. When teaching about contemporary race-based disparities, educators must also stop reinforcing discourses of biological difference and foster an intersectional approach to health that considers race, class, gender, culture, and sexuality as part of our individual and collective identities. Here, educators can learn from trainees, who have been active in calling for these perspectives in the midst of the Black Lives Matter movement (Charles et al. 2015).

In research, race consciousness means recognizing ourselves as situated knowers whose racial vantage points influence our ontologies, epistemologies, and methodologies. Knowledge production as a site of racialization—where racialization can shape a project's ontology, epistemological groundings, and methodological choices, or where a project can serve to reinforce prevailing beliefs about racialized groups or phenomena (Ford and Airhihenbuwa 2010). Researchers must be wary of 'epistemological racism,' whereby our current epistemologies, born out of dominant social and historical discourses, reflect and reinforce certain ways of viewing the world (Scheurich and Young 1997). Scheurich and Young (1997) note that

> our current range of research epistemologies—positivism to postmodernisms/post-structuralisms—arise out of the social history and culture of the dominant race, that these epistemologies logically reflect and reinforce that social history and that racial group (while excluding the epistemologies of other races/cultures), and that this has negative results for people of color in general and scholars of color in particular (p. 8).

Even progressive scholarship can "silence race through supposedly acknowledging racism (and not race) as the problem," as is the risk when such scholarship assumes race to be a biological truth rather than a human-made construction (Dei 2009, p. 230). In contrast, scholarship can make conscious efforts to "center in the margins," shifting knowledge production to the issues and concerns of the most marginalized, attempting to privilege the voices of the marginalized, highlighting creativity, resilience, and resistance (Ford and Airhihenbuwa 2010).

A commitment to addressing race and racism in education scholarship involves going beyond the documentation of health inequities (Ford and Airhihenbuwa 2010). We must

certainly name and identify racialized health disparities, but to do so without further analyzing power and privilege can be considered a form of institutional racism and often serves to reinforce prevailing beliefs about racialized groups (Scheurich and Young 1997). Rather, to truly change how race-based disparities are taught about and acted upon, education researchers should analyze and take action against the power differentials and privilege that create and perpetuate such inequities (Ford and Airhihenbuwa 2010).

Challenging a discourse as pervasive as 'race as biological truth' is not easy. However, can we afford not to do so? Conceptualizing race as a social construction could allow us as educators and trainees to tackle racialized health disparities in our clinics and to challenge racism in our classrooms, educational and research institutions, and communities.

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