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Editorial

Guest Editorial: Race and the medical school curriculum

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Olamide Dada is the founder of Melanin Medics, a charity that promotes diversity in Medicine.

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The Black Lives Matter movement has taken the world by storm. This movement has been reignited after the death of George Floyd in the US and quickly led to a global uproar. Despite social distancing rules still in place, across the world, people took to the streets in their thousands to protest against anti-Black racism and police brutality. But this is not the only battle the Black community are fighting. It has come to light that those from the BAME community are disproportionately affected by COVID-19 with Black males and females four times more likely to die with COVID-19 than White ethnicity males and females. (1) This has emphasised the existence of institutional racism, racial inequality in medicine and its negative effects on health. It is clear that this lockdown period has forced the world to take notice of the injustices faced by the Black and minority ethnic (BAME) community, and the many ways that they are being failed by the systems that are meant to protect them.

In 2001, BAME groups made up 5.1% of the UK population, which rose to 14% in 2011. (2) It is clear that the UK is diversifying at an exponential rate, but medical culture is yet to catch up with this increase in diversity. (3) Doctors have a duty to deliver optimum care to all patients; but the current medical school curriculum does not adequately prepare medical students to do so effectively.

Race is a critical component of our patients' social identity. (4) When you meet someone, their race is often the first thing you notice. Differences in race represent differences in culture, experiences and ethnic backgrounds which result in differences in health needs. There has been a global outcry within medicine to diversify the medical school curriculum. Students need to be exposed to more diverse patient groups during their training and gain a greater understanding of health inequalities and how racism contributes to health outcomes.

Currently, the majority of teaching resources and clinical images being used only represent white patients. Even though students may be exposed to patients from diverse backgrounds whilst on clinical placements, it is not a guarantee that students will see specific clinical signs on these patients. (5) Additionally, the absence of appropriate terminology makes it difficult to identify and describe certain clinical signs in patients from BAME backgrounds. One example of this being erythema, meaning redness of skin or mucous membranes. This ineptitude can lead to delayed diagnoses and sub-optimum delivery of care to all patients. (6)

As future doctors, cultural competence is crucial. This can be defined as the process of understanding, communicating with and effectively interacting with people from different cultures. (7) Cultural norms influence patient health-related behaviours, by understanding this it heightens the ability to deliver patient-centred care. (8) This area is currently neglected within medical education and is demonstrated by the lack of patients from different ethnic backgrounds within medical examinations, communication skills training and exam questions that perpetuate stereotypes of ethnic minority groups. (9-11) Cultural competence must be a continuous and career-long process focused on understanding the patient as an individual and how their culture influences their decisions. (12)

Furthermore, the specific needs of BAME patients have been marginalised. Health inequalities are caused by a combination of many factors. Although the direction of cause and effect are yet to be determined, health inequalities are further exacerbated by the inaction of institutions to tackle these specific issues. (13) BAME patients have poorer mental health outcomes. (14) Black women are five times more likely to die during childbirth. (15) In a study conducted in America, Black patients were 50% less

likely to be prescribed pain medication. (16) Medical students perceived that Black patients felt less pain. (17) These erroneous ideas are detrimental to patient care and demonstrate how individual racial bias may contribute to differential patient care.

It is important to make clear that something can be done about this. It starts by thoroughly examining the origins of certain decisions and challenging the status quo. Changes to the current medical school curriculum are key to unlocking a future in which racism is not tolerated or perpetuated through systems and the actions of individuals. Medical schools are a training ground for the next generation of doctors; a place to identify, unlearn and challenge maladaptive behaviours and learn new behaviours in a safe environment. Patient-centred care means that diversity must be incorporated within the medical curriculum and medical education in order to better serve patients.

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