Statement on Representative Medical Education

Student National Medical Association
Health Policy and Legislative Affairs Committee
Statement on Representative Medical Education

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INTRODUCTION

Founded in 1964 by medical students from Howard University School of Medicine and Meharry Medical College, the Student National Medical Association (SNMA) is the nation’s oldest and largest, independent, student-governed organization focused on the needs and concerns of medical students of color. SNMA is committed to supporting current and future underrepresented minority medical students, addressing the needs of underserved communities, and increasing the number of clinically excellent, culturally competent and socially conscious physicians. With this mission in mind, we must stress the importance of representing people of color in medical education. The SNMA is dedicated to practices that will provide all medical students with a culturally and socially diverse educational experience to prepare them for future patients from various backgrounds.

Medical education in the United States (US) is based on a two-pillar model of pre-clinical and clinical years, totaling four years. Preclinical years consist of biomedical science courses that are transitioning from lecture format to active learning with small groups, flipped classrooms, and team-based learning sessions.\(^1\) This transition is a response to concerns that medical education delivered in the subject-based and lecture-based format is failing to produce physicians that can handle today’s medical challenges. As this teaching transition occurs, a major feature of medical education must be addressed: the lack of representation of patients of color.

As recently as December of 2019, a study evaluated whether published images related to plastic surgery represented the racial demographics of patients. In their review of six plastic surgery journals from 1992 to 2017, the investigators found the images were not reflective of demographics by region or patient population.\(^2\) Further, Martin et al. reviewed PowerPoint slides from preclinical courses for University of Washington School of Medicine and found unequal representation of women and people of color.\(^3\) Both aforementioned studies discuss the negative impact lack of representation in medical education has on the access to healthcare and health outcomes for people of color. Without adequate racial representation in educational materials, graduating students are falling short of being clinically excellent, culturally competent, and well-equipped to serve the underserved.\(7,10\)

The purpose of this statement is to highlight the lack of representation of patients of color and their clinical presentation in medical education, the history that has perpetuated this issue,
and the detrimental effects this lack of representation has on the health and health outcomes of patients of color.

**BACKGROUND**

Providing the best possible care for patients is a primary responsibility of physicians. Excellent care requires proper education and clinical knowledge regarding the populations, varying from urban to rural, physicians serve. Such knowledge may be enhanced by implementing a more representative curriculum in medical education. By 2050, persons of color will make up more than 50% of the US population. This shift in demographic highlights the urgency of ensuring future physicians are culturally competent and able to properly serve their patients. Individuals with more pigmented skin often suffer missed or delayed diagnoses for common skin conditions, such as psoriasis and acne vulgaris. Further, diseases that occur more commonly in patients of color, such as dermatosis, sarcoidosis, and amyloidosis, are often not even depicted in generalist educational texts. Such conditions and diagnoses must be intentionally represented in general medical education textbooks and resources to help bridge the gap in medical knowledge and allow for better, more comprehensive patient care.

A 2006 study on disparities in educational resources for dermatology evaluated seven major textbooks and found all of them to incorporate pigmented skin in less than 20% of their images. In addition to inadequate representation in textbooks and pamphlets, minority populations have poor representation in clinical trials, which contributes to decreased research and knowledge of the variability in presentation of more common conditions in the Black, Indigenous, & People of Color (BIPOC) community. A portion of this poor representation can be attributed to distrust in clinical trials as a result of historical studies, such as the 1932 Tuskegee Study of Untreated Syphilis in the Negro Male (Tuskegee Syphilis Study), in which Black/African American men were denied standard of care treatment for syphilis as a result of egregious ethical violations. One study found men with knowledge of the Tuskegee Syphilis Study to be 50% less likely to be willing to participate in health-related research studies compared with those who had not heard of the Tuskegee Syphilis Study. As a community of medical professionals, we must make targeted efforts to both include members of the BIPOC
community in our research studies that benefit population health, and to create a safe and inclusive research space that welcomes and gains the trust of BIPOC participants.

**SCOPE OF THE PROBLEM**

Despite race being a social construct, the notion that race creates biologically different bodies has been prevalent both within and outside of the medical community. Biological differences between Black/African American individuals and White individuals have historically been emphasized and used to absolve the maltreatment of Black/African American patients in medical research, as was the case for both the Tuskegee Syphilis Study and the use of Henrietta Lacks’ cervical cancer cells for decades of research without her knowledge or compensation. Some commonly held false beliefs regarding Black/African American bodies are that “Black people’s skin is thicker than White people’s skin,” “black people’s blood coagulates more quickly than White people’s blood”, “black people have thicker skulls and less sensitive nervous systems,” and “the black body is more resistant to pain and injury.” One study found more than half of its sample of White medical students and residents to believe Black/African American bodies to be biologically different and, in fact, stronger than the White bodies. The study further explored how these beliefs influence pain perception of the medical trainees and its impact on the treatment Black/African American patients receive. The trainees who held more of these beliefs rated Black/African American patients feeling less pain than their White counterparts and were less accurate in their treatment recommendation for their Black/African American patients.

Another example of disparities in pain management is a study which showed only 35% of racial minority patients with metastatic or recurrent cancer received adequate pain treatment, compared to 50% nonminority patients. These findings highlight how racial bias in medicine can lead to undertreatment of pain among BIPOC patients and contribute to their negative health outcomes. The institutionalized biases within our healthcare system exist beyond individual beliefs and can only be dismantled with a medical education that is more inclusive and intentional. A representative medical curriculum invites more opportunities to learn, assess, and challenge falsely held beliefs that are harmful to the health of marginalized communities.
Lack of representation in medical education also limits physicians’ knowledge in treating patients of color. Medical textbooks do not reflect the racial demographic of the US and often predominantly include images of White patients. One study revealed 77% of images related to cancer included White patients, while only 22.2% included Black/African American patients and no images for non-Black people of color were included. Further, the study found 93.3% of images depicted light skin tones, 6.7% depicted medium skin tones, and no images depicted dark skin tones. The absence of dark skin tones in medical textbooks impedes medical students’ ability to accurately execute early screening and diagnosis of skin disorders and cancers among BIPOC patients.

A 2004 study in the Journal of the American Academy of Dermatology found Black/African American patients are more likely than White patients to be initially seen with advanced melanoma and have a subsequent worse prognosis (five-year survival rate of 58.8% in Black/African Americans compared with 84.8% in White patients). The authors attribute this disparity to lack of physician training and thus patient education about melanoma on darker skin. Physicians with a lack of adequate training and educational materials to refer to may not recognize various pathologies in different skin tones and may provide inadequate or delayed treatment to the patients who are underrepresented. Dark skin-toned patients are at risk for discrimination, which has been associated with their poorer health outcomes in various illness, such as depression, hypertension, and colon cancer. Further, disorders such as cystic fibrosis have historically been viewed and taught as “White diseases” and therefore often go underdiagnosed in the Black/African American community. The overrepresentation of White patients in the medical curriculum does not reflect the variety of patient encounters that healthcare professionals are more likely to have and does a disservice to the BIPOC patient community. Medical education today, with lack its of representation, marginalizes the BIPOC community and creates inequities in healthcare delivery that must be addressed.

**STATEMENT OF POSITION AND RECOMMENDATIONS**

Representative education holds enormous power on all levels for minority physicians, students, and patients. To combat health inequality resulting from a lack of representative medical education, the SNMA recommends the following institutional advancements:
1. 

*Enhanced medical school curriculum that intentionally incorporates the use of culturally competent tools including educational materials with visuals of Black/African American patients, and standardized patients with diverse skin tones.*

Curriculums should have cultural sensitivity components integrated into every semester during both the pre-clinical and clinical years. Curriculums should also emphasize cases depicting BIPOC patients in each unit, especially dermatology, plastic surgery, psychiatry, primary care, and preventive medicine.

2. 

*Stricter Continuing Medical Education (CME) requirements which incorporate enhanced cultural competency skills.*

Existing trainings should be further developed to incorporate how each training topic relates to racial bias, BIPOC pain management, culturally responsive bedside manner, trauma-informed care, empathetic communication, proper diagnosis, and treatment in BIPOC patients, and other racially conscious topics. We also recommend the addition of new CME trainings focused solely on any combination of the aforementioned topics. To satisfy these requirements, any CME instruction program should be at least six hours in duration and either offered in the classroom, through online workshops, or during group events such as educational conferences.

3. 

*Intentional recruitment and retention of BIPOC physicians for tenured faculty positions.*

Medical schools must have policies that recruit and build the capacity of culturally-sensitive teachers. Faculty must not only have the relevant qualifications and intrinsic inclination to care for diverse communities, but also actively continue to enhance their cultural sensitivity and humility through mandatory training requirements set by strict guidelines. We also suggest an integrated evaluation component at each medical institution, in which medical students have the opportunity to provide honest feedback regarding their faculty that has true impact on faculty’s professional standing.

An increase in BIPOC faculty will not only improve provider diversity and BIPOC patient health outcomes, but also aid in recruitment of BIPOC research study participants in light of trust for principal investigators who look like them.

4. 

*Incorporation of cultural sensitivity screening during the application and interview process for prospective medical students.*

There must be a holistic focus on each applicant with a strong emphasis on social and interpersonal skills, which can be
evaluated through personal statements, letters of recommendation, interviews, and non-academic assessments such as an unbiased version of the Computer-Based Assessment for Sampling Personal Characteristics (CASPer) exam.\textsuperscript{18} We also recommend that medical schools consider implementing an application fee waiver process to increase access for prospective students from underrepresented backgrounds.\textsuperscript{19}

5. \textit{Increased funding for pipeline or pathway programs that support minority students (Pre-Kindergarten to Post-Graduate) who aspire to pursue medicine.} Supporting the next generation of health professionals through funding and mentorship will shape their education on and approach to cultural sensitivity early.

Enhancing representative medicine and cultural sensitivity in our students and providers will aid us in meeting the demands of an ever-diversifying patient pool.\textsuperscript{4} We recommend SNMA and National Medical Association (NMA) members encourage the aforementioned calls to action at their respective places of learning or practice, and to sit on their institution’s advisory and curriculum development boards when possible, while taking special care not to take on undue Minority Tax.\textsuperscript{20}
REFERENCES


