

Race is not a biological category: challenging this misconception will help tackle racism in healthcare

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Rapid Response:

Re: Race is not a biological category: challenging this misconception will help tackle racism in healthcare

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Dear Editor,

I welcome Jasmeen Kanwal's article outlining the importance of rejecting race as a biological category because it leads to patient harm through racism. I wholeheartedly endorse this argument but must challenge the assertion that this is not taught in medical schools or within the canonical medical curriculum.

At Lancaster Medical School (LMS), I teach this topic over the first three years as part of our social sciences theme. Students are introduced to race as a social construct rooted in histories of colonial violence. Students also critically examine the strengths and limits of categories such as 'ethnicity', 'culture' and 'ancestry' in explaining health inequities. The students develop an understanding of how 'race' and 'ethnicity' are 'flawed surrogates for multiple environmental and genetic factors in disease causation, including ancestral geographic origins, socioeconomic status, education and access to health care' (1). We also consider how cultural practices may be misread as racialised or ethnic difference, producing misleading explanations of inequities.

Students are then introduced to 'racialisation' - how race persists despite its scientific debunking and creates racialised health inequities. Teaching covers racism in its multiple forms and how it is different according to who is being subjected to it, highlighting that racism is not singular but pervasive, including within medical knowledge and practice. They also learn about intersectionality, and the specific mechanisms by which racism leads to racially minoritised groups' impoverishment and social disadvantage, including how histories of colonialism and enslavement may impact descendants' health today.

One issue that faces medical education is that it comprises a wide range of different disciplines, and not all of them are valued equally. The social sciences have been part of medical curricula since at least the 1960s, although they have faced widespread resistance, disdain, and limited funding and curricular space (2,3). The General Medical Council's Outcomes for Graduates require application of social science principles, including recognising 'sociological factors that contribute to illness, the course of the

disease and the success of treatment and apply these to the care of patients - including issues relating to the social determinants of health' (4). The BeSST Sociology Core Curriculum likewise includes discrimination and marginalisation, including racism, as core learning outcomes (5). And yet, Kanwal reports they were not taught this during their degree, and they are likely not alone. This suggests an issue not of absence, but of visibility, integration or perceived relevance.

Research and education must also change together. LMS students complete coursework critically examining racism as a social determinant of health, exploring topics such as inequities in maternity outcomes, disparities in pain management, dermatology's preoccupation with lighter skin tones, breast cancer outcomes for black women, and COVID-19 mortality. Some of our students have presented their work at national conferences (6). Students frequently encounter a lack of UK-based research and inconsistent terminology - from 'BAME' to 'ethnic minority' to 'race' - often without consideration of how defining the target population will impact the findings. These inconsistencies limit applicability to the NHS and reflect structural racism in research cultures that hinder both learning and progress.

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