

The Conscripted Curriculum and the Reproduction of Racial Inequalities in Contemporary U.S. Medical Education

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Abstract

In their attempt to address racial disparities in the provision of health care, the U.S. medical profession has reproduced racial inequalities of their own. In this article, I draw upon interview data with medical educators and students to detail how medical educators routinely offload the instruction on the social underpinnings and consequences of race onto students, particularly students of color. I develop the concept of the *conscripted curriculum* to capture how students' social identities are utilized by educators in the professionalization process. While there are exceptions in curricular approaches, most educators create the conscripted curriculum by eliciting students to share their social experiences with race in the small group setting while only providing students with didactic material on biological understandings of race. As a result, students of color report experiencing more emotionally exhausting and unrewarded labor than their white peers, and educators further devalue the social implications of race for health care.

Keywords

curriculum, medical education, racial inequalities, socialization

Whether one considers the provision of health care (Greil et al. 2011; Stepanikova 2010; van Ryn and Fu 2003), practices of clinical research (Epstein 2007; Gamble 1997), or the composition of the profession itself (Feagin and Bennefield 2014), the medical profession has historically disregarded or perpetuated racial inequalities in the United States.¹ In response, medical educators are required to teach medical students to identify, understand, and address social inequalities to help reduce the role that clinicians play in the production of health care disparities, particularly along racial lines (Liaison Committee on Medical Education [LCME] 2018). The standards governing the first four years of medical school articulated by the LCME require medical educators to instruct students on social inequalities or run the risk of compromising their accreditation status. Yet as sociologists have documented (Kellogg 2011; Timmermans and Berg 2003), the relationship between a standard's

existence and its implementation is an empirical question. After interviewing 60 medical educators and 30 medical students from a sample of top-ranked and middle-ranked U.S. medical schools about the instruction on race and racism, I found that the majority of medical educators implement LCME Standards by conscripting students—especially students of color—into teaching race to their fellow students by asking students to share their lived experiences as members of particular racial groups. I conceptualize this method of instruction as the *conscripted curriculum*.

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I contribute to medical sociology both empirically and theoretically. Empirically, the conscripted curriculum accounts for a key way in which race is taught in contemporary U.S. medical schools. I also draw attention to an understudied component of medical education, which is the experiences of medical students of color. On a more theoretical level, the concept of the conscripted curriculum contributes to medical sociologists' general understanding of medical socialization and how medical educators use the social identities of their students in the professionalization process. Moreover, I argue that when educators use the conscripted curriculum, they establish an inherently heterogeneous professionalization process because they are relying on students to share their personal experiences, and these experiences will necessarily vary from student to student, small group to small group, and year to year. This curricular approach thus produces uneven socialization and represents social understandings of race as inessential for clinicians; otherwise every medical student would be receiving the same, standardized instruction.

My findings involve two sections: the creation of the conscripted curriculum and its consequences. I first show how educators create the conscripted curriculum in their undergraduate medical education (UME) by, one, designating the small group as the central setting for the delivery of content on race and racism and, two, relying on students to share their personal experiences as the main source of content about the social understandings of race. Then, I show how educators' use of the conscripted curriculum has consequences for perpetuating racism by two different methods: first, by disproportionately burdening students of color and increasing their experiences of emotional exhaustion and isolation and, second, by further marginalizing the importance of social understandings of race for clinical practice. By detailing the creation and consequences of the conscripted curriculum, I advance sociological understandings of medical professionalization, the instruction of race in medical schools, and the experiences of medical students of color.

BACKGROUND

Professionalization in Medical Schools

Following the foundational studies of Merton, Reader, and Kendall (1957) and Becker et al. (1961), medical sociologists have focused primarily on the socialization processes that reflect and shape the emotional, moral, and technical lives of the medical

profession's initiates (Bosk 1979; Hafferty 1998; Murphy 2016). These studies tend to depict medical socialization and professionalization processes as homogenous for every medical student. We can explain this assumed homogeneity along theoretical, methodological, and historical lines. First, the promise of homogeneity is part and parcel to medicine's status as a profession. Whether through the standardization of the educational requirements and credentialing (Starr 1982) or acquisition of technical autonomy and expert knowledge around a specific set of tasks and problems (Abbott 1988; Freidson 1970), the educational process is pivotal to both the construction and understanding of the medical profession's claim to legitimacy. Second, as Jenkins (2018) has noted, accounts of the medical profession have depicted a homogenous socialization process because of the centrality of ethnographic methods in the studies of medical education. Many of the foundational studies within the sociology of medical education abstract from a single school.

Third, scholars have assumed that *professional* identity is more salient than *social* identity in the training of medical students. At the time that Merton, Reader, and Kendall (1957) and Becker et al. (1961) were publishing their data, the medical profession was overwhelmingly white (97 percent) and male (91 percent), perhaps leading the scholars to perceive social identities as irrelevant. In challenging this assumed homogeneity, recent scholarship on the medical profession has begun to consider variation in professionalization according to social status or identity (Underman and Hirshfield 2016), prestige of institution (Jenkins 2018; Menchik 2017), or gender (Kellogg 2011; Underman 2015). I join these scholars who analyze heterogeneity in medical professionalization, but in addition to analyzing how social identity matters for the way students are treated, I examine how educators use social identities in the construction of the professionalization process itself. By introducing the concept of the *conscripted curriculum*, I illuminate a central method by which educators press students to participate in the professionalization process of their peers by asking students to share their personal experiences as members of a particular social group.

Instruction of Race in Medical Schools

Despite the arsenal of scholarship detailing how racial classification operates in biomedical research settings (Duster 2005), there is very little sociological

work on the instruction of race in medical education. That which has been published often focuses on one specific medical school (e.g., Anderson 2008). Outside of sociology, medical educators and students have critiqued the current state of how medical schools approach the instruction of race (Saunders and Braun 2017; Sharma and Kuper 2017; Tsai et al. 2016).² Specifically, these authors critique how medical schools tend to reify biological understandings of race and neglect social understandings of race, pointing out that these curricular decisions could have serious ramifications for patients of color down the line.³

In this body of work, medical educators and students describe a formal curriculum where race is depicted as a biological risk factor or as genetic associations between a racial minority group and a particular disease, and a null curriculum of social understandings of race and discussions of racism (Ripp and Braun 2017).⁴ Moreover, other medical educator and student editorials depict medical education as an institution that reinforces biological understandings of race and does little to combat racial injustices in health and health care resulting from the social underpinnings and manifestations of race in the United States (Tsai et al. 2016; White Coats 4 Black Lives [WC4BL] 2018). Further opinion pieces about the silence of educators around race as a topic (Sharma and Kuper 2017:762) and the lack of qualified faculty members to teach about the social determinants of health (Saunders and Braun 2017:51) point to medical educators as untrained and uncertain about how to teach race. While important, these studies focus on the formal components of medical education (e.g., the didactic materials and the faculty members who teach students). They do not capture a key element of race instruction in contemporary U.S. medical schools: the students themselves.

Medical Students of Color

While medical school faculty of color have written autobiographically about their experiences (Cyrus 2017; Tweedy 2015), medical sociology as a sub-field has very little empirical data on how racial minorities may be disproportionately impacted in the course of their professional training. In one of the only studies of race and medical students, a prospective observational study of 3,547 students from a random stratified sample of 49 U.S. medical schools about their implicit racial biases, van Ryn et al. (2015:1754) conclude that instructors often do not exhibit “sufficient depth of knowledge” when teaching the didactic material on race and that

interracial contact impacts students’ implicit racial attitudes. This latter finding about interracial contact posits that white students who reported “favorable” contact with students and faculty of color were more likely to have fewer implicit racial biases toward people of color. While van Ryn et al.’s (2015) study is important for considering racial bias in medical training, the scholars do not explore the interactions that constitute “favorable contact” to identify the process by which these biases may be lessened. Nor do the scholars consider the experiences of students of color.

That said, sociological research on underrepresented minority students in other white-dominated institutions of education have shown that “numerical rarity by race significantly increases ‘token stress’” (Jackson, Thoits, and Taylor 1995:543). Studies of graduate students of color in STEM fields indicate that underrepresented students experience greater isolation, discrimination, microaggressions, mental health issues, and mentoring gaps (Ong et al. 2011). Scholars have also shown that graduate students of color pursuing academic careers face assumptions about their criminality, intellectual worth, and belonging (Brunsma, Embrick, and Shin 2017). These insights may not be generalizable to medical students of color due to the fact that U.S. medical schools enroll a greater percentage of students of color than other professional schools. Therefore, it is possible that with greater representation, medical students of color experience less *token* stress than students of color in other institutional settings.⁵ This ambiguity warrants a study that accounts for the experiences of medical students of color. As I will show, the increase in numbers of medical students of color, combined with their continued underrepresentation, may have created the ideal conditions for the creation of an additional form of “token stress”: the conscripted curriculum.

DATA AND METHOD

To study how race is taught in U.S. medical schools, I start with national-level standards structuring medical education (LCME), which prescribe the formal curricular requirements that undergraduate medical educators must meet to be an accredited institution. I draw upon in-depth interviews with medical educators and students to understand more closely what these curricular standards mean in practice. The central data featured in this analysis are my interviews with medical educators and students about instruction on race and racism; I report

on the dominant instruction patterns that the majority of educators and students recounted.

Sampling and Recruitment

I approached recruiting medical educators and students by creating a list of top-ranked schools and lower-ranked schools, based upon the *U.S. News & Reports* ranking system (Bastedo and Bowman 2010); I oversampled (70 percent) on top-ranked schools, operating under the assumption that educators at lower-ranked schools seek to emulate those at the top (DiMaggio and Powell 1983). My sample of medical educators contained faculty in senior leadership positions, program directors of UME, and teaching faculty that had direct control or responsibility for curricula in the first four years of medical school. Of the 60 educators interviewed for this project, 34 held at least an MD degree (9 held an MD-PhD, with a PhD in a humanities or social science discipline); 11 held a PhD in a humanities discipline; 10 held a PhD in a social science; 3 held a PhD in a biomedical discipline; and 2 held an EdD degree.

Student recruitment followed educator recruitment, as I scheduled interviews with students from the same school as the educators in the sample. While I spoke to a student and an educator at the same medical school for 80 percent of my sample, there were some schools in which I did not speak with a student or educator to yield a match. In total, I interviewed students and educators from 37 schools. Because students' emails or names are not publicly available, I relied on snowball sampling with medical students. At least half of my student participants referred me to other students for recruitment, and as a result I created many small recruitment chains.

The gender identity of participants in the sample of medical educators and students was relatively even: 16 male students, 14 female students, 32 male educators, and 28 female educators. The educator ratio mirrors broader trends in medical school faculties, where women are underrepresented; however, my sample might overstate the degree to which female faculty hold positions of leadership in medical schools (Williams, Pecenco, and Blair-Loy 2013). Regarding racial composition, the educators were largely white, which also mirrors broader trends in medical school and academic faculties (Association of American Medical Colleges [AAMC] 2016); of the 60 educators, only 8 identified as persons of color. The medical students in my study exhibited more racial diversity, with 15 identifying as white and 15 identifying as students of

color—as black or Latinx. By virtue of my snowball sampling strategy, my sample overstates the representation of students of color. In compliance with human research protection protocol, I have kept the identifying information about participants and their affiliated institutions confidential and present data using pseudonyms and generalized language to discuss the respondents and their schools.

Interview and Coding Strategy

The interviews I conducted with participants were semistructured and lasted between 26 and 72 minutes, with an average length of 51 minutes. All of the interviews were transcribed from audio to text, with the exception of five interviews because the participants declined to be recorded. I utilized the same interview guide with each medical student and an expanded version of that guide with educators. Many of the questions were about the objectives of medical education, experiences with course material and program requirements, and general impressions of the medical field.

In this analysis, I draw upon what medical educators and students described during our interviews by comparing their stated intentions and experiences with their didactic material (e.g., syllabi, assignments, PowerPoint slides, lecture notes). My positionality as a white cisgender female was important for the context of the in-person interview with both participants of color and white participants. I believe that my questions about the curriculum (e.g., how race was taught, whether race as a social construct was taught, and whether racism was taught) signaled my concern about how race holds powerful social meanings in U.S. society (Omi and Winant 1994). With white students and educators, I had to ask many iterations of the question about how matters of race were taught in their medical school; with faculty and students of color, I did not need to repeatedly reformulate this type of question. This data collection experience inspired this analysis, as the initial research questions of the project were not set up to evaluate how medical schools perpetuate racial inequality. Moreover, the findings about the emotional and material toll of the instruction of race on students of color emerged inductively, as I was initially coding the interview data (Charmaz 2006). Proceeding iteratively, the experiences of students motivated me to reconstruct the curricular structure of each of the schools, identifying when and how the instruction about race and racism occurred.

It is important to note that there were a few outliers in my data. In other words, educators and students at 3 of the 37 medical schools reported an entirely different approach to teaching race and racism. In these instances, the conscripted curriculum was not created because educators deliberately integrated social understandings of race into lectures and did not solicit students to do the bulk of instruction based on their personal experiences. Students at these schools identified the importance of understanding the social implications of race and racism as inseparable from their future work as physicians. These curricular structures and student experiences were so exceptional that they rendered the more dominant mode of instruction about race in U.S. medical schools much more conspicuous.

RESULTS

The *conscripted curriculum* is a concept that captures when medical educators place students in positions of instruction by asking them to share their lived experiences as members of particular social groups. To elucidate this concept, the findings section is divided into two parts: the creation of the conscripted curriculum and its consequences. Below, I first explain how educators create the conscripted curriculum by, one, choosing the small group as the central setting for the delivery of content on race and racism and, two, providing no didactic material on the social nature of race for students to discuss in the small group and instead relying on students to share their personal experiences. Then I describe the conscripted curriculum's consequences, whereby, one, because students of color are more likely to be conscripted to share their experiences as persons of color they are subject to more emotionally taxing and unrewarded labor than their white peers and, two, social understandings of race become further devalued because they are seen as the personal narratives of students rather than the academic knowledge required to be an effective clinician.

Creating the Conscripted Curriculum

The LCME Standards mandate that medical educators teach students about the manifestations and underpinnings of social inequalities in the first four years of medical school (UME); otherwise, the medical school risks losing their accreditation. The following two standards encapsulate the explicit requirements that medical educators must follow:

7.5: The faculty of a medical school ensure that the medical curriculum includes instruction in the diagnosis, prevention, appropriate reporting, and treatment of the medical consequences of common societal problems.

7.6: The faculty of a medical school ensure that the medical curriculum provides opportunities for medical students to learn to recognize and appropriately address gender and cultural biases in themselves, in others, and in the health care delivery process. The medical curriculum includes instruction regarding:

- The manner in which people of diverse cultures and belief systems perceive health and illness and respond to various symptoms, diseases, and treatments.
- The basic principles of culturally competent health care.
- The recognition and development of solutions for health care disparities.
- The importance of meeting the health care needs of medically underserved populations.
- The development of core professional attributes (e.g., altruism, accountability) needed to provide effective care in a multi-dimensionally diverse society. (LCME 2018:10)

Even though instruction about social inequalities is required, the implementation of these general requirements is open to interpretation by medical educators. For example, there is no further elaboration about what are “common societal problems” or what kinds of “health care disparities” are recognized. Additionally, though race and racism are not explicitly mentioned in these standards, the medical educators in my sample all interpreted these standards as requiring them to address those topics.

In practice, according to most medical educators and students in my sample, the curricular location where these requirements are fulfilled is a course on the Practice of Medicine (POM), a course that might have a different name depending on the school, but, as Dr. Mintz, a dean of medical education at a highly ranked medical school, explains,

Every school has got its own catchy name for what I think is a reasonably similar course. It spans the whole first two years of medical school; it's a half day to a full day a week, every week throughout the first two years. And it's

where the students learn the “how to be a doctor” part of medicine. It’s not where they learn the science; it’s not where they learn the physiology, the structure of the human body. It’s where they learn who patients are, what they are, how to communicate, how to do a physical exam, the bioethics, the public policy, the culture, racism, palliative care, domestic violence. They’re all these topics that are woven into the course.

As Dr. Mintz articulates and the following subsections will show, there are two central components of educators’ decision making that impact this instruction: the setting of instruction and the sharing of experiences.

The setting of instruction: the small group. Educators prefer to use the small group setting instead of the lecture setting as the common format for instruction on social inequalities; the small group setting enables the conscripted curriculum because the small group is predicated on student participation. Either the curriculum committee, dean of medical education, or course directors deliberately plan on having students share their experiences in a small group as the central mode of delivery of the curricular content on social understandings of race.

The idea that “the small group” is an important, state-of-the-art site for pedagogical practice can be seen in a statement from Dr. Krebs, a course director of the POM sequence at a top medical school, who thought that her school was “behind the curve in terms of medical education and having an active engaged small group curriculum.” The notion that the small group was the more effective learning modality and “a lot better than a lecture” was echoed by other medical educators who strived to have more instruction time in a small group setting rather than in a lecture setting for the POM course. Dr. Tortora, another course director of POM at a midranked medical school, proudly stated their ratio of time as “some lecture, but that’s probably less than 20 percent, easily, of our course. The vast majority of it is small group based.” While the time dedicated to lecture and small group varies by school, medical educators overwhelmingly pointed to the small group as the desired environment for the instruction on social inequalities like race.

In general, the small group is a part of the formal curricular structure, reflecting a set of deliberate choices made by educators to teach social inequalities in this forum. These choices are undergirded by the belief that students learn from one

another, as a team. Dr. Callaghan, a curriculum developer and course director at a top-ranked medical school, explained that “the students themselves really learn from each other. That’s one of the things we try to emphasize in the small groups is that we’re in it together as a team, learning.” According to the medical educators, this intimate, team-like structure of the small group is what makes it so beneficial for student learning. With frequent and consistent meetings of the same 8 to 12 students and 1 to 2 faculty facilitators per group over the course of UME, medical educators expressed their impression that the small group provides a place for students to talk about possibly divisive or sensitive topics in a supportive environment. When I asked my interviewees when, in the course of their training, students learned about LCME Standards 7.5 or 7.6, Dr. Stephens responded that students learn

more in small groups. There are some lectures but by design we try to put topics that require honest discussion and that are potentially problematic in our Practice of Medicine groups where there’s continuity in the group for two years and continuity in the preceptor. And the idea being that in these groups they get to know each other, they’re very tight, and people will be less afraid to take controversial positions where they know these are their friends and they’re going to like them anyway. We feel it’s a more honest and more supportive environment.

Therefore, medical educators choose to teach topics on social inequality, like race, within the small group, with the justification being that the small group provides a learning environment that students perceive to be less judgmental and more supportive.

In contrast to the lecture setting, as Dr. Kerns put it, small groups “are about as safe a space as you can get.” With the decision to teach social topics in the small group over lecture, educators explicitly elect to involve their students in teaching each other, a hallmark feature of the conscripted curriculum. A practical limitation of the conscripted curriculum is that if this is the central modality for learning about social inequalities, then small groups will vary according to the individuals that compose each small group; there is no systematic approach. According to Kenneth, a white medical student in his second year, the conscripted curriculum strategy makes the instruction like the “Wild West,” where

“the onus is incredibly put on the person—like on the individual as opposed to the system pushing that forward.”

The content of instruction: relying on student experience. Because the standards do not specify how to teach social inequalities, the medical educators also have to decide what about these topics they will cover and what educational materials they will provide for students. The second way in which educators create the conscripted curriculum is by relegating social understandings of race into the conscripted curriculum, establishing a contrast between biological “facts” from didactic—and tested upon—material and social “experience” from the lives of students.

While didactic material on race may occur in the lecture setting (Tsai et al. 2016), medical educators more frequently include information about the salience of race in hypothetical cases that students solve and discuss in the small group setting. With mock cases, students practice how they would apply the knowledge they have learned in clinically relevant ways. Jeff, a white student in his fourth year of medical school, described a common scenario that medical students are taught in these cases, whereby a biological understanding of race is given:

Like for example sarcoidosis. If you ever go to anyone who has gone through med school and you say “30-year old black woman with a cough.” Step One will teach you that that is sarcoidosis. Like that is the answer before you even hear anything. But if you said 30-year old white woman with a cough then they’d be like I have no idea; it could be anything.

Jeff’s invocation of “Step One” indicates that the USMLE, or United States Medical Licensing Exam, will expect a future physician to associate the racial group-symptom pairing of “black woman with a cough” with the disease state of “sarcoidosis,” a finding consistent with Ripp and Braun’s (2017) examination of the USMLE test-question bank. Similarly, Jan, a student of color in their fourth year, said that they “weren’t really taught about actual racism but about... you know... a lot of the diseases that are preindicative of race,” articulating this biological classification of race as if it were another set of facts he had to memorize.

In contrast to educators providing students with biological framings of race’s salience, educators do

not regularly include lecture- or case-based didactic material where race is defined as social. James, a white student in his third year of medical school, felt like his school and profession were “not particularly interested” in discussions of race beyond biological “facts,” and that the social understanding of race could be considered the null curriculum:

We’re defining disparities by race so we have to talk about what race is. The idea of defining race as like “a system of oppression based on perceived differences” is not defined. I think medicine is not particularly interested in that... they’ll throw out “black people have this, or Hispanic people have this”... essences of race are sort of lumped together and then there’s not really a conversation about “well, are these real, scientific distinctions that we’re drawing between populations?”

Both Jan and James contrasted the formal didactic material with the nonexistent material, perceptions shared by other medical students who noted that they were often presented content on race as biological, but not presented with content on racism or how race is socially constructed and operative. Students reported being given no social science data, such as data on how racism gets inscribed on the body or the lived experience of race (Brown 2000; Shim 2014; Williams 2012).

For the most part, the content on the social nature of race comes from students sharing their experiences in the small group. As Robby, a white student, explains about his school, “The school doesn’t always do a great job of saying this is really important... I think the thing that pushes students to think about it more is other students. And I don’t think it necessarily should be the responsibility of the rest of the class to educate their classmates, but I think that’s what happens because of class structure.” Riva, a third-year white student, describes further,

We have the POM; that was our doctoring course. So this conversation comes up a lot where students are asked to share about their own culture or racial background and then sort of discuss how that influences their work or how that would inform their work. It’s run by physicians and it’s not usually always people who have any particular training in, like diversity training or anything like that. So I think sometimes the conversation sort of glides on the experience of the students.

Many educators described the pedagogical function of sharing personal experiences for learning about social topics. In the course of Dr. Mintz's description of the purpose of their POM course, she explained how drawing upon personal experience was a pivotal dimension to the learning process "because what we're trying to do is help the students understand these people who will become their patients... in small group we spend a lot of time exploring in depth what they've experienced themselves personally." The conscripted curriculum in this case is thus predicated on educators' expectation that students will share their personal experiences with race, and that in sharing these experiences, other students will learn about the social nature of race. Educators, therefore, use students' social identities in this aspect of medical professionalization.

Consequences of the Conscripted Curriculum

By creating the conscripted curriculum, educators aim to incorporate social understandings of race into UME and thus address educational requirements that were established in an attempt to make health care more equitable. However, in practice, the creation of the conscripted curriculum perpetuates racial inequalities by placing an additional burden on students of color and further marginalizing social understandings of race. These consequences are, in fact, linked. The offloading of instruction onto students of color, combined with the numerical rarity of these students and lack of instruction when these students are not present, further devalues lessons about social understandings of race. I address each consequence in turn.

Personal consequences: burdening students of color. At the outset, this reliance on student participation to discuss social inequalities does not—in and of itself—have to reproduce inequalities. However, often within the same explanation of the benefits that the small group bestowed upon students regarding the instruction of race, medical educators pointed to the demographic composition of their student body within these small groups. Therefore, in effect, I found that educators were more likely to conscript students of color in the instruction of race, and that these students of color felt unfairly burdened by this work.

For example, when I asked Dr. Kerns whether they taught race to their students, he replied that

they taught race in the small group, and that they were "a pretty diverse student body so it's not like there wouldn't be a wealth of experience in the room." Or, take Dr. Stephens, who, after describing why the small group was beneficial as a space to learn about social inequalities because it was a supportive environment, went on to say that "something that's very helpful to us in this is that our student body is actually quite diverse." A director of the POM course at a top-ranked medical school, Dr. Glynn, elaborated further upon the notion that diversity—and the student-led sharing of diverse experiences—was a way for students to learn about this difficult course content:

So, it's a really hard thing to teach but we have a very diverse group of students in the class from a lot of backgrounds. Purposely. There are men, women purposely drawn from all different racial, ethnic, and religious backgrounds, transgender, even people from Iraq that are princes, just a lot of people. They're coming from very different backgrounds.

Educators view the increased enrollment of students of color as a boon for their classrooms. When talking to educators and students alike, it became clear how students of color were understood as the workhorses in these small group spaces. These students are often directly prompted to participate or felt compelled to participate because the faculty do not provide didactic material nor push the conversation. Mark, a fourth-year white student at a mid-ranked institution, articulated,

I've been lucky to be around people who have taught me about it... I think race comes up a lot more when people of color are in those small groups and then bring up the fact that this has been my experience, da-da-da. So they basically have to be the catalyst for it to even be on the table.

As another example of how students of color are more likely to be conscripted into sharing their experiences around race, take Dr. Giannattasio, a medical educator who answered my question about whether students were instructed on race by explaining, "Sure. I mean we did one of these exercises where you like all stand up, and then you sit down after the certain qualifiers and you see who's left standing." This exercise, she went on to explain, is a small group activity that prompts students to

publicly identify with particular social backgrounds (e.g., sit down if you have never experienced racial discrimination) and then uses this exercise as a springboard for particular discussions around race. In this type of session, students with visible social identities, like race, are conscripted into participating, solely due to their membership in that particular social group.

In other cases, medical educators described how they relied on what students from nondominant backgrounds brought to the group. In response to my question about when students learn about race, Dr. Lombard pointed out that “some students, they’re not native English speakers or from America, so they have their own cultural concepts that they bring to the patient and the case, so I think that’s where students get the content.” Many of the white students and educators uncritically extolled the benefits of the “diversity” of the small group, along the lines of what Christine, a white student, reported: “Small group sessions have really been important because our class is really diverse and I really like that we have really good conversation about everyone else’s experience going through this process.”

As a result of having to be the conscripted curriculum at a greater frequency, students of color experienced symptoms of emotional burnout, like disillusionment, frustration, and exhaustion. Marian, a student of color in her third year, described the experience of discussing race in the small group setting as having “been a lot”:

I spent a lot of time in my first year trying to educate people, students and faculty alike, and it’s so exhausting to have to do that. I’m constantly the only black person in this small group because there are five of us in the whole school. It’s so exhausting I feel like, it’s not my role to educate you—you can use Google.

As Marian’s account suggests, the numerical rarity of students of color in medical school leads to the fact that students of color are often the only student of their underrepresented background to share their experiences. This can be isolating, as Mark also pointed out how his friends of color were upset that they had to carry this burden, noting that his “school is not like—well med school in general is very homogenous—there is not a lot of diversity.” The conscripted curriculum also made Marian experience exhaustion—a common experience among many of the students of color I interviewed. Her

invocation that students and faculty could “use Google” points to her frustration in having to bear the instructor’s burden in her small group.

Educational consequences: marginalizing social understandings of race. The educators’ use of the conscripted curriculum has implications beyond the students it directly disadvantages because the use of the conscripted curriculum devalues the lessons about the social underpinnings of race. The conscripted curriculum is premised on the presence of people whose social identities confer a particular form of experientially based expertise. This is in contrast to the presentation of factual knowledge, which is uniformly provided by faculty. With faculty-presented information, educators and students alike noted that the scripted, didactic materials reflected what medical students really needed to know. But with the small group discussions about the social nature of race, Chris, a white student in his third year at a top medical school, told me,

It’s just not what we are there for... we spend two years learning basic science and when you spend most of your day learning about pharmacology and pathology and physiology that all of a sudden the social seems less relevant... It’s not on the test that’s coming up. It’s a life skill but it’s not a medical school skill, one you have to learn to get an A on the test.

Similarly, when I asked a dean of medical education at another top-ranked institution, Dr. Capraro, what they taught on race or racism, he explained that they did “not have so much on racism” because as educators their “focus in [their] curriculum tends to be on identifying those things that every medical student should know... there are elements that could probably make them a better physician, but, they aren’t essential for every physician.”

The fact that students are largely the teachers in the conscripted curriculum signals the relative unimportance of social understandings of race in the context of a medical school where students learn to prioritize material on the exam. As Anna, a second-year white student, indicates, “It’s hard because your time is limited, because at the end of the day it doesn’t matter if you understand how race is important for medicine or if you were involved with the urban underserved... you still have to get good grades, you have all these tests you have to do well on.”

Even students who wanted to learn about the social underpinnings and consequences of race in health dismissed the small group sessions—and what students shared—as content that they actually learn. In some instances, students recounted a lack of curriculum altogether. For example, Scott, a student of color at a top-ranked school, who responded to my question about the instruction of social understandings of race by explaining to me that “if you ask the question was [race] taught in any way that was even mildly effective, the answer is a resounding ‘No.’ The fact is that it really didn’t exist.” While Scott described the absence of any instruction in the small group, another student of color, Sam, conveyed his “frustration” for not having “clear instruction” on the social understanding of race. Similarly, Lindsay, a third-year medical student of color, pointed to the broader significance of why student-led sessions are perceived as less important, because the medical school “would never ask students to teach anatomy even if there was a change that needed to be made. Even if they were really great students, they would hire somebody whose job it is to examine and teach that.”

After students share their experiences or opinions, these experiences or opinions may be devalued in contrast to the didactic material of the clinically relevant, biological facts, creating the conditions under which social understandings of race are identified as “activism.” As Lisa, a fourth-year medical student of color, recounted,

I’ve never seen a case about “this 20-year-old white person.” It’s just assumed that white is the norm and any time I ever said something people are just like “oh you’re tripping.” I remember I said it once because I was like real mad. I was like, “Clearly this patient is white because if they weren’t white, it would have said something.” Then I got some shit from one of my facilitators . . . they’re like “Oh, well, your activism is getting in the way of your studies.” Well maybe you mother fuckers should like do something about what I’m saying then I wouldn’t have to do anything I could just pay attention.

Lisa’s frustration and disillusionment are palpable, and she pointed to how the faculty did not address her concerns about the didactic material. The central reason why this example is important is that it shows how the didactic material on biological understandings of race and the small group discussions on the social understandings of race come

head to head. Educators clearly signaled to Lisa that the former was fundamental to her education while the latter was an extraneous distraction. In sum, the educators’ decision to offload the instruction of the social understandings of race onto students while testing students on the biological understandings of race creates the conditions under which social understandings of race are viewed as unimportant by many students.

DISCUSSION

In this article, I have shown how medical educators devolve the instruction on social understandings of race onto students and how these decisions have consequences for students of color and the valuation of social understandings of race. Educators engage in this devolution of responsibility by prioritizing the small group as the main curricular space devoted to the instruction of race and relying on students to share their personal experiences with race. These educators’ decisions create what I call the *conscripted curriculum*, when students are placed into positions of instruction by virtue of their lived experiences as members of particular social groups.

On a theoretical level, I add to recent work by sociologists of medical education analyzing the degree to which U.S. medical schools produce heterogeneous and unequal learning environments (Jenkins 2018; Kellogg 2011; Underman and Hirshfield 2016). In line with this work, I show how the racial background of students may indeed structure their socialization experience. Pushing the topic further, I develop the concept of the *conscripted curriculum* to show how medical educators use students’ social identities in the construction of the professionalization process itself. When educators use the *conscripted curriculum* they establish an inherently heterogeneous professionalization process. In relying on students to share their personal experiences, these experiences by definition will be unique and will vary from student to student, small group to small group, and year to year. While the concept of the *conscripted curriculum* has been developed based on my analysis of the instruction of race and racism, I do not believe that educators’ use of the *conscripted curriculum* is limited to exploiting students of color. The *conscripted curriculum*, as a concept, can capture the experience of any student who is tasked with educating their peers about an aspect of their social identity.

Empirically, I show a key way in which medical educators “teach” students about race: by using students. Previous work on the instruction of race in

medical schools has focused on the didactic materials and the faculty attitudes toward the topic. While the importance of the didactic materials and faculty cannot be overstated—the marginalization of student experience at the elevation of faculty presentation of didactic facts is one of the main consequences of educators’ use of the conscripted curriculum, after all—the literature on medical socialization and the instruction of race has overlooked how students are utilized in the professionalization process. Moreover, this study draws attention to the way in which many educators’ implementation of a curricular mandate to teach about social inequalities may give way to social inequalities of their own.

Despite the fact that medical schools have improved the representation among historically underrepresented racial groups since the 1970s (AAMC 2016), this representation comes at a cost. The increased numbers of students of color in medical school may have helped the circumstances in which the conscripted curriculum can exist. There are enough students of color that a small group is likely to have at least one, but not enough students of color to allow them to escape the isolation or additional burden of the instructional work. Similar to the “burden of expectation” placed upon students from underrepresented minority (URM) backgrounds to pursue primary care practice with underserved populations (Michalec et al. 2017), I find that with the instruction of race in U.S. medical schools, the conscripted curriculum is another burden placed on students of color. What is more, the educators’ use of students of color as the conscripted curriculum is connected to more “identity taxation” down the career pipeline, where faculty members of color are pressed into both departmental and institutional service activities related to diversity and equity (Cyrus 2017; Joseph and Hirshfield 2011; Padilla 1994).

These burdens of expectation and identity taxation—that students of color can draw upon their lived experience as persons of color to teach their peers about race—stem from similar understandings the medical profession holds about why underrepresentation is a problem in the first place. Justifications for increased enrollment of URM students into medical school are often built on the dual pillars of the benefits of diversity for education and patient care, rather than equity-based rationales. For example, medical educators argue that the increased representation of racial minorities will increase educational experiences for all (e.g., majority white) medical students (Morrison and

Grbic 2015). However, as a close examination of van Ryn et al.’s (2015) study revealed, we need to do more research to specify which interracial contacts result in lessened bias and how that occurs. Otherwise, educators may continue to put stock in *any* form of interracial contact—forms like the conscripted curriculum, which actually reify racial inequalities in medical education. The conscripted curriculum is one instance of interracial contact that may *not* be beneficial for white students nor students of color, as it fails to convince white students of the importance of social understandings of race—and thus is not likely to challenge their implicit racial biases—and it places additional burdens on students of color.

Importantly, these experiences are avoidable. Educators who deliberately enact antiracist curricula weave discussions of social understandings of race and racism into their didactic sessions on particular organ systems. As opposed to the majority of student respondents in my sample, when I spoke to students at the few schools where social understandings of race were included in the didactic material, they reported sentiments similar to Flannery, a white second-year medical student, who explained, “We were told multiple times that there isn’t really a biological basis to race, so I believe it’s true. I think it is true that race is something that we construct onto people even though there are no necessarily genetic differences. So that’s been a big topic and an important topic because it affects patient care even though there is no biological reason for it to be relevant.” By taking responsibility for the instruction on the social understandings of race, the educators at Flannery’s institution do not make some students engage in extra labor and convey the importance of why physicians should care about race.

This analysis is limited in a couple of ways. First, the sample of educators and students was constrained by my choices as a researcher as well as the willingness of potential respondents to participate. Second, my small sample of students limits the degree to which my findings represent experiences of students at other medical schools; however, work by the national student group White Coats 4 Black Lives corroborates the claims made here. That said, while the curricular emphasis of my research is well suited to allow me to argue that medical educators could *potentially* create a disproportionately harmful environment for medical students of color, I do not claim that these types of consequences for students are occurring at every medical school.

And, third, my data focus on what students learn, not how they practice. The UME is just one phase in a long series of educational experiences that physicians will undergo. The decision to not instruct students about the social construction of race in a didactic setting could set the stage for students, who may not know any better, to view the accounts of students of color as individual anecdotes rather than systematically collected facts about the historical and contemporary effects of race and racism. Future work could investigate how the training on race shapes doctoring—for both students of color and white students. In this vein, another future direction of research could examine whether antiracist curricular experiences encourage white students to approach colleagues, allied health care professionals, and patients of color in more equitable ways.

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NOTES

1. Research from the past few decades suggests that racism undergirds a large amount of racial inequities in health outcomes, whether racism manifests at the systemic level, patterning how socioeconomic status is correlated with race (Feagin and Bennefield 2014); at the institutional level, patterning exposure to environmental toxins (Brown et al. 2003) and experiences of police brutality (Benjamin 2016); or at the interpersonal level, patterning the likelihood of facing discrimination (Brown 2000; Williams 2012). Moreover, sociologists have pointed to unequal treatment by health care providers as another source of these inequities, regardless

of whether providers themselves are conscious of their racial biases (Greil et al. 2011; Stepanikova 2010; van Ryn and Fu 2003). In addition to the work on disparities, social scientists' work on the deception, mistreatment, and abuse of patients of color demonstrates how the research findings and technological developments of the U.S. medical profession were achieved at the literal expense of people of color (Byrd and Clayton 2001).

2. The White Coats for Black Lives (WC4BL) group, led by medical students, released a report, titled "Racial Justice Report Card," that rated ten medical schools on their antiracism curricula, student support, and faculty development, among other metrics. In their evaluations of the ten medical schools' curricula, they found that the medical schools "did not uniformly provide instruction on the sociopolitical (non-biological) nature of race" (WC4BL 2018:27).
3. For example, Cunningham et al. (2014) show how clinicians' uncertainty around the meaning and application of race in clinical encounters may lead to errors in medical decision making, and van Ryn et al. (2011) detail how implicit bias influences clinical decision making to the detriment of racial minorities.
4. In general, the requirements that medical students must meet to receive their medical degree are contained in the *formal curriculum*, or the explicitly stated and designed materials and courses. Equally as deliberate as what is included in the formal curriculum is what is not, what Flinders, Noddings, and Thornton (1986) have described as the *null curriculum*. Additionally, the *informal curriculum* captures the indirect instruction that is modeled or facilitated by mentors and colleagues. The *hidden curriculum*, although it has been used as an analytical tool with differing definitions (Hafferty and O'Donnell 2015:10), is a concept illustrating the disconnect between what students are taught and what students learn. The hidden curriculum inheres in the medical school's spatial and technological infrastructure, distribution of power, policies, evaluative standards, allocated resources, and institutional slang (Hafferty 2000).
5. At the start of the 2017–2018 academic year, of the 89,904 students enrolled in U.S. medical schools, 6.8 percent identified as black or African American, 6.4 percent as Latino, 21.3 percent as Asian, and 52.0 percent as white; while students of color are still underrepresented, the medical profession enrolls more students of color than other professional schools (AAMC 2018).

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