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LETTER TO THE EDITOR

Bridging Intention and Implementation: Reflections on Racial Justice Curriculum in Family Medicine

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TO THE EDITOR:

We read with great interest the recent article by Ho et al., "Barriers to Implementing a Racial Justice Curriculum," which provides timely and valuable insights into the persistent challenges faced by family medicine residency programs in operationalizing equity-oriented educational goals.[1] The authors' use of a quantitative Council of Academic Family Medicine Educational Research Alliance survey, rather than mixed-methods design, strengthens the generalizability of findings across program directors and residents, though interpretation must consider its inherent limitations in capturing nuanced qualitative dimensions of institutional climate. Their comparison highlights not only structural and logistical barriers, but also deeper tensions in educational priorities and institutional readiness.

A striking finding in the study is the discordance between program directors' confidence in implementing racial justice curricula and residents' perceptions of adequacy and impact.[1] This divergence reflects a well-documented gap between leadership perception and learner experience—one that often undermines curricular uptake and trust.[2] Delving deeper, this discordance may reveal underlying communication asymmetries and feedback barriers that hinder curricular cocreation. Addressing this tension requires intentional mechanisms—such as joint director-resident curriculum committees, periodic bidirectional feedback sessions, and participatory evaluation frameworks—to close the loop between intention and lived experience. It signals the importance of feedback loops and participatory curriculum development that genuinely reflect learner needs and lived experiences.

Moreover, Ho *et al.* note that faculty development and protected time are key barriers—echoing findings from prior research emphasizing that curriculum reform, especially around justice and equity, demands more than content insertion; it requires cultural and structural shifts.[3,4] As such, the lack of faculty preparedness should not be viewed solely as a limitation, but as an opportunity to reconceptualize faculty development as an equity competency pathway. Embedding racial justice as a core faculty competency—supported by institutional accountability metrics, mentorship infrastructure, and reflective teaching portfolios—can transform it from an individual responsibility to an organizational standard.

Another area deserving emphasis is the need for longitudinal integration. As noted in literature across medical education, one-off workshops or didactic sessions on racism may have limited lasting impact unless reinforced through experiential learning, reflective practice, and institutional modeling.[5] Examples of such longitudinal integration include embedding antiracism objectives within case-based discussions, incorporating community engagement rotations addressing health inequities, and establishing continuity mentorship models linking residents with diverse faculty advocates. In this regard, curriculum design must align with broader organizational commitments—recruitment, retention, mentorship, and community partnerships—to avoid performative or fragmented efforts. Such alignment operationalizes racial justice not as an isolated teaching module, but as

a crosscutting principle within the hidden and formal curricula.[6]

We also wish to highlight the role of learner-led initiatives. Studies show that residents are often the drivers of social justice innovations in academic medicine, and their inclusion in planning, delivery, and evaluation processes not only strengthens content relevance but also fosters professional identity formation centered on equity. However, genuine resident buy-in requires attention to workload, perceived relevance, and institutional reward structures. Strategies such as coleadership roles, elective time allocation, and recognition through teaching credits can enhance engagement and ownership, particularly in programs where time constraints and peer disinterest are barriers.[7]

Ultimately, as family physicians and educators committed to equity, we must move beyond intentionality and toward implementation frameworks that are resourced, sustained, and measurable. Drawing from both the study's insights and existing curricular theory, a cohesive approach may integrate three reinforcing pillars: (1) faculty development as competency building, (2) longitudinal curricular embedding, and (3) learner cocreation. These strategies, collectively resourced and institutionally endorsed, can bridge the gap between curricular intention and lived implementation. The findings by Ho *et al.* are not just descriptive—they are a call to action. We commend the authors for their scholarship and urge institutions to treat racial justice not as an elective, but as a core function of clinical training and organizational ethics. Making racial justice education foundational in clinical training is not merely aspirational; it is essential for cultivating a generation of physicians who are equipped to advance equity in every encounter.

AUTHOR CONTRIBUTIONS

*All authors contributed to the conception and drafting of this letter.

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