Letters to the Editor

Remove Race as an Initial Identifier From Clinical Presentations

Original Article: Dismantling Anti-Black Racism in Medicine [Editorial]

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To the Editor: I commend the authors of the editorial for seeking to redress long-standing injustices. However, their suggestions in the accompanying table require a considerable commitment of time and effort, not just by individual physicians but also by medical association leaders, medical journal editors, hospital and medical school administrators, and federal and state legislators, to achieve substantive progress. One way to apply the authors' recommendations immediately to family medicine residency programs and medical student clerkships would be to end the practice of presenting patients to the attending physician on rounds and in the clinic by race. There are no Black diseases. For example, concern about the possibility of sickle cell disease or sickle trait can be noted in the patient's family history.[1,2] Similarly, although African Americans have a greater likelihood of lower circulating renin levels than non–African Americans, essential hypertension affects all races.[3] Documentation of race in a patient with hypertension is best confined to the therapeutic plan.

Anderson, et al. addressed the role of race in the clinical presentation more than two decades ago.[4] They reminded us that race is a social construct and, if used at all, should be recorded in the social history, not the opening sentence of the presentation.[5,6] An overemphasis on race can reinforce stereotypes, prejudice, stigmatization, and racialization of social problems.

What to use in place of race in the clinical presentation? I suggest the patient's occupation or other preferred self-identifier (e.g., great-grandmother, fifth grader, Desert Storm veteran, homemaker, retired letter carrier, medical student), which I contend provides more meaningful information about the patient and getting to know the patient than race. I learned this from one of my attending physicians, H. Kenneth Walker, MD, in 1974 when I was a third-year medical student at Emory University, and I have since always presented patients by occupation, not race.

Alan Blum, MD
Tuscaloosa, Ala.
Email: ablum@ua.edu

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In Reply: We are delighted that readers have taken an interest in our editorial and that it generated so many comments. We thank Dr. Blum and other members of the community who have contributed additional suggestions on how to dismantle anti-Black racism in medicine.

In 2001, Anderson, et al. challenged family medicine leaders to examine and eliminate the use of race in the first sentence of patient presentations.[1] However, many clinicians and trainees still do this, and we agree with Dr. Blum that this practice should end. Race should also be removed from the first sentence of every question on standardized exams (e.g., specialty boards, course exams). We caution against using an occupation in that first sentence as a substitute for race because it can feed stereotypes in many of the same ways.[2]

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This series is coordinated by Kenny Lin, MD, MPH, deputy editor.

Recent publications suggest that we should eliminate all stigmatizing language from our notes and verbal communication.[3] Changing how we write, speak, or present about patients will invariably influence how we act around them. As a specialty, family medicine has always led the way in equity, diversity, and inclusion and is the most diverse of all medical specialties.[4] It is time to widen our lead and dismantle anti-Black racism in all forms. Family medicine was born in counterculture, and we can use that revolutionary spirit to accelerate this work.[5] It took time, effort, and resources to introduce anti-Black racism in medicine, and it will take the same to dismantle it. We commend every effort to eliminate anti-Black racism from our medical practices and continue to work with our colleagues to ensure that these efforts lead to dismantling all forms of oppression in our profession.

José E. Rodríguez, MD, FAAFP
Salt Lake City, Utah
Email: jose.rodriguez@hsc.utah.edu

Kendall M. Campbell, MD, FAAFP
Galveston, Tex.

Judy C. Washington, MD, FAAFP
Summit, N.J.

Author disclosure: No relevant financial relationships.

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Correction

Conditions incorrectly listed in table. In the article, "Cervical Ripening and Induction of Labor" (February 2022, p. 177), the second section "Placental or uterine" should not have been included in Table 1, "Indications for Labor Induction" (page 178). Placenta previa; placenta accreta, increta, percreta; and vasa previa all typically require cesarean delivery and, therefore, are not indications for induction of labor. This section has been deleted from the table in the online version of the article. ■