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Perspective

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First Impressions — Should We Include Race or Ethnicity at the Beginning of Clinical Case Presentations?

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A long-standing tradition in American medicine is to mention a patient's race or ethnicity at the beginning of oral case presentations or written chart notes, particularly those by medical students or trainees. For example, an oral presentation might begin, "A 50-year-old Black man presents with intermittent chest pain" or "This 70-year-old White woman presents with increasing dyspnea." Given persistent racism in medicine and the growing recognition that racial and ethnic categories are socially constructed and not biologically coherent, the practice of mentioning race or ethnicity immediately in case presentations — alongside age and sex — is worth revisiting.

According to a survey that one of us conducted more than a decade ago, medical schools varied considerably in their perspectives on mentioning race or ethnicity at the beginning of case presentations.[1] Overall, 11% of schools taught students to mention race routinely, 63% taught them to include it selectively, 9% discouraged the practice, and 18% simply did not address the issue. Most schools (62%), however, acknowledged that residents at their institutions frequently mentioned race in the first sentence of case presentations, regardless of the school's stated position. Whether the prevalence of this practice has changed substantially is unclear; recent discussions with medical educators lead us to believe that it has decreased somewhat, but that the practice remains common at some institutions.

What are the fundamental objectives of oral presentations and written notes? Oral case presentations are tools for communication with other clinicians who are or will be involved in the patient's care; their content generally unfolds in a standardized sequence that is anticipated by listeners and intended to facilitate accurate understanding of the case. Particularly when patients have new clinical problems, the initial portion of the presentation triggers the process of diagnostic clinical reasoning: almost instantly, listening clinicians begin to formulate diagnostic hypotheses, some of which are perceived as more likely than others. Written chart notes serve a similar purpose and also provide a historical record, so that clinical teams need not rely on memory. For students and residents, there is an additional educational objective: oral and written case presentations are evaluated by supervising clinician-educators to assess skills in information gathering, clinical reasoning, and communication.

The question at hand is whether mentioning race or ethnicity at the beginning of an oral presentation or chart note enhances or undermines these objectives. Some proponents may argue that this information suggests initial biologic probabilities that are immediately relevant for hypothesis generation, diagnosis, and treatment. For example, proponents may cite genetic examples such as sickle cell disease (far more prevalent among Black Americans than in other U.S. racial or ethnic groups) and hemochromatosis (far more prevalent among White populations than in other racial or ethnic groups). Other proponents may argue that race or ethnicity should be acknowledged immediately even if it has little diagnostic or therapeutic relevance for most patients — that there is a benefit to processing an individual patient's history and physical findings through the lens of race or ethnicity, given the impact of racism on health.

We believe these arguments are problematic, for reasons that fall into two main categories. First, routine inclusion of race or ethnicity at the beginning of a case presentation reinforces the still-prevalent but mistaken belief that race or ethnicity is a robust surrogate for genetic or innate biologic predisposition to disease.[2,3] Racial and ethnic groups are not static, uncontroversial categories; because they are socially constructed, they are fluid and evolve over time. Moreover, commonly used racial and ethnic categories are often confusing mixtures of skin color, geographic location, ancestry, culture, and religion. Although there may be a strong statistical correlation between patient-identified race or ethnicity and a particular clinical diagnosis in a specific geographic area at a given point in time, these rare exceptions — which are often mediated by ancestry[4] — should not drive the standard template for case presentations. Moreover, immediately mentioning race or ethnicity may predispose clinicians to premature diagnostic closure, a cognitive error in clinical reasoning. The subliminal effect of classifying a patient by race or ethnicity before hearing or reading about the patient's illness history and physical findings may result in incorrect inclusion or exclusion of diagnostic hypotheses.

Second, immediately mentioning race or ethnicity may result in conscious or unconscious demographic or cultural stereotyping. Differences in demographic features such as socioeconomic status often reflect systemic racism, but they are statistical constructs that do not necessarily apply to an individual patient. Similarly, immediately mentioning race or ethnicity may trigger implicit and potentially inaccurate inferences about a patient's beliefs or values, based on stereotypical assumptions about the patient's cultural background. Even if certain beliefs are prevalent in certain groups at a given point in time, they are not necessarily held by all members of a given group.

In our view, the arguments against inclusion of race or ethnicity at the beginning of case presentations are more persuasive than arguments for including it. Avoiding the routine use of race or ethnicity as an immediate cognitive framing device increases the probability that the listener or reader — and perhaps even the person presenting the case — will initiate clinical reasoning and clinical decision making in an unbiased fashion. Later in the case presentation, clinicians can review strong associations between suspected diagnoses and ancestral groups and can propose appropriate testing for genetic or biologic markers — on the basis of all clinically relevant information and not simply race or ethnicity. Some clinicians may nevertheless choose to include racial, ethnic, or ancestral categories at the beginning of case presentations in carefully selected clinical scenarios, usually when the category is thought to suggest a specific diagnosis with near certainty. These exceptions, however, do not undermine the fundamental point that in general, diagnostic probabilities associated with race, ethnicity, or even ancestry are not decisive and that these labels are often entangled with biases and stereotypes.[2]

We are not advocating a "color blind" approach to clinical decision making and health care, which would most likely reinforce existing biases and health inequities.[2] To omit racial and ethnic labels early in the case narrative is not to ignore the growing recognition that racism can affect health through biologic mechanisms or to downplay the influence of systemic racism on the provision of medical care. Accordingly, clinically relevant and patient-specific socioeconomic considerations, cultural beliefs, and race-related barriers to high-quality health care should be acknowledged and addressed later in the case presentation.

In a recent article, a multidisciplinary group of authors enumerated the ways in which preclinical curricula in medical schools misrepresent race and propagate physician bias.[3] Their examples included inaccurate conflation of race and ancestry, pathologizing race and present-

ing race-based differences in disease rates without providing proper context, and teaching race-based clinical guidelines without acknowledging their controversial elements. Mentioning race or ethnicity at the beginning of case presentations represents a similar problem in the clinical years of medical training: it reinforces the misrepresentations of race or ethnicity to which students are exposed in the preclinical years.

In his thought-provoking book *Black Man in a White Coat*, physician Damon Tweedy describes his reaction when, during his residency, a colleague began an oral case presentation with, "Mr. Gary Warren is a fifty-five-year-old African American male." Tweedy writes, "This three-pronged age-race-gender description was the traditional way to present a case. Once again the only black person in the room, I wondered if anyone else there had ever given thought to this method and shared any of my concerns. . . . [W]hy did it matter so much whether the patient was white, black, or something else? Did this way of presenting cases assume that race should automatically color the way a doctor approached a patient's chest pain or achy stomach?"[5]

Tweedy appears troubled by the inclusion of race at the beginning of case presentations; we share his concern. We believe that in medical schools and residency programs where this practice remains prevalent, clinician-educators should acknowledge its potentially problematic impact on clinical reasoning and use it as a springboard for discussions of stereotyping and racism in medical practice.

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1. Nawaz H, Brett AS. Mentioning race at the beginning of clinical case presentations: a survey of US medical schools. Med Educ 2009;43:146-54.
2. Roberts D. Fatal invention: how science, politics, and big business re-create race in the twenty-first century. New York: The New Press, 2011.
3. Amutah C, Greenidge K, Mante A, et al. Misrepresenting race — the role of medical schools in propagating physician bias. N Engl J Med 2021;384:872-8.
4. Borrell LN, Elhawary JR, Fuentes-Afflick E, et al. Race and genetic ancestry in medicine — a time for reckoning with racism. N Engl J Med 2021;384:474-80.
5. Tweedy D. Black man in a white coat: a doctor's reflections on race and medicine. New York: Picador, 2015:135.

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Calling Out Aversive Racism in Academic Medicine

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Structural racism is a form of racism that is embedded in the laws, policies, institutions, and practices that provide advantages to certain racial groups while disadvantaging others.[1] Although structural racism is well documented as an important contributor to health care inequities, its effects on medical students, trainees, and faculty have received less attention. We believe aversive racism is a critical and overlooked contributor to structural racism in academic medicine.

"We want diversity, but we also want qualified people."

Aversive racism, an established construct in social psychology, is defined as exhibiting racist tendencies while denying that one's thoughts, behaviors, or motives are racist.[2] According to John Dovidio and Samuel Gaertner, who defined the concept in the 1990s, aversive racism occurs when people endorse egalitarian values in principle, but when faced with ambiguous situations or unclear guidelines, discriminate against people from historically marginalized groups while rationalizing or justifying their actions on the basis of factors other than race.[2] Aversive racism is pervasive in both academic medicine and society at large. In areas ranging from medical school admissions decisions to executive leadership appointments, aversive racism in academic medicine impedes diversity, equity, and inclusion efforts. Understanding this construct and developing strategies for combating aversive racism will help diversify academic medicine and reduce health disparities.

"If he just kept his head down and stayed under the radar, he would be a lot more successful."

Aversive racism undermines the substantial investments in antiracism initiatives that many institutions have made to combat structural racism. One manifestation of aversive racism in academic medicine is ongoing inequalities in the promotion of faculty from historically marginalized groups.[3] Although Asian students and students from groups that are underrepresented in med-