Youthful optimism. I am disillusioned by the culture of medicine.

I recognize that by entering medicine, I now represent a system that is implicitly inequitable: a white, cissexist, heterosexist colonialist patriarchy dependent on power dynamics to perpetuate matrices of oppression. I have been indoctrinated into a school of thought that uses racialization to assemble differential diagnoses while conveniently ignoring the black and nonblack bodies of color who were exploited and victimized in the name of advancing medicine. The children of these bodies continue to bear the weight of generational trauma. The race-based theory of medicine is an illogical shortcut that serves to support the hierarchy of oppression.

There’s a certain danger in accepting whiteness as a norm. The disproportionate effects of police brutality, environmental injustice, and mass incarceration on people who look like me weighs heavy. Every incident of extrajudicial execution by police makes me feel like a part of me has died. But I am forced to leave my reality at the hospital entrance.

My internal monologue, on repeat, states, “I am thriving in an environment that I was never meant to occupy,” as I navigate classrooms, clinics, and wards in this visibly queer, black, cisgender female body of mine. This mantra is my solution to my own stereotype threat. I am just trying to survive.

The dearth of role models with similar experiences is frustrating, but it is more terrifying to realize that my peers are being indoctrinated into this same school of thought. If we deem the current culture of medicine acceptable, we will forever be victims of inertia. Our silence is violence. The structure of medicine we represent creates and perpetuates health inequities. If we are going to talk about race, we must also talk about racism, oppression, and intersectionality—in classrooms, in clinics, and on the wards. We must hold ourselves and the systems we represent accountable in order to promote health equity and intersectional justice for all.

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**The Barriers to Medical School for DACA Students Continue**

**To the Editor:** As a previously undocumented student with aspirations of entering medical school, I personally understand the barriers that are present for “Dreamers.” Throughout my undergraduate education, I worked hard, hoping that if I became a permanent resident, I would be able to pursue my dreams and apply to medical school. As a junior at the New Jersey Institute of Technology, I finally approached my prehealth advisor because my family was very close to receiving our permanent residency. I also had been covered legally under Deferred Action for Childhood Arrivals (DACA) for about two years at this point. My advisor asked why it took me so long to speak with him about medical school, and when I responded that I was not able to apply because of my legal status, he nodded his head in agreement.

I was so close to giving up on my dreams because I had no idea that even with DACA there was an opportunity for me to apply to medical school. I was lucky that I became a permanent resident before graduating, so I was able to apply the traditional way, but there are still many DACA students who do not know that they too have a path to medical school. I believe both undergraduate institutions and medical schools across the country must not only begin accepting DACA students but also advertising that even DACA students have an opportunity to apply and enter medical school.

Dr. Balderas-Medina Anaya and coauthors’ suggest that medical schools should determine whether they will accept DACA student applications and then should make it well known to the medical school admissions staff. They also recommend the creation of a list of U.S. schools that accept DACA students. Currently, a search for “deferred action” on the American Medical College Application Service Web site provides a link for a current list of medical schools accepting DACA students, but many of these schools have yet to provide that information on their own Web sites. This includes my current institution, Rutgers Robert Wood Johnson Medical School. How do we resolve this? I believe more light needs to be shed on this issue, and that admissions committee members must take an active role in providing this information to all staff members involved in the recruitment and admissions process.

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**Reference**


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**A Call for Critical Race Theory in Medical Education**

**To the Editor:** Amidst national conversations and tensions about race, there is growing recognition that physicians have a responsibility to understand structural racism, its historical roots, and its implications for health disparities. Despite increasing efforts, the existing methods employed to discuss racial inequality in physician training—health disparities, cultural competency, and implicit bias—are often incomplete or problematic. Contemporary medical education finds itself under-equipped to address structural racism in medicine.

Though health disparities curricula have been amplified, these courses often provide only content on the existence of health inequities rather than teaching critical perspectives that illuminate the social, historic, and economic legacies that fundamentally generate health disparities and marginalize people of color. Well-intentioned cultural competency curricula, favored in the past, often mobilize stereotypes of people of color in efforts to cite behavioral choices as likely causes of health disparities. This pathologizes patient populations and omits instruction on systemic forces that create the environments within which people exert autonomy. While implicit bias curricula encourage increased recognition of personal prejudices, their pedagogical approaches fail to consider structural inequities that generate pervasive bias. Absent broader context, implicit bias training can normalize bias and neglect examination of differences in power that enable individuals and institutions to systematically enact prejudice. Lastly, despite research demonstrating that false
belief in innate racial biologic difference increases measures of physician prejudice, race continues to be portrayed as a biologic variable in medical education. A significant number of medical students continue to understand race as an innate characteristic.

Critical race theory (CRT), born in legal studies and further developed in education scholarship, is a framework that centers experiential knowledge, challenges dominant ideology, and mobilizes interdisciplinary and intersectional methodology in order to examine inequality. Ultimately, it “seeks to identify, analyze, and transform those structural and cultural aspects of society that maintain the subordination and marginalization of People of Color.” Teaching CRT offers a process for physicians-in-training to meaningfully understand the causes and consequences of race and racism, namely by locating inequity and interrogating power structures. It equips learners with the faculty to recognize and articulate unjust practices against people of color, in society and in medicine itself, and therefore represents an important strategy for addressing gaps in critical content and perspective in medical education. In light of persistent racial inequality, medical education should teach CRT so that future doctors are more prepared to discuss and treat racial inequities, in and out of the clinic.

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References


The Need for Anti-Racism Training in Medical School Curricula

To the Editor: We began medical school in Baltimore months after the death of Freddie Gray, in a grieving city whose confrontation with the violence of racism had sparked protest and conversation across the country. We hoped the same would be true within medicine, and that part of our professional development would include building the capacity to combat the racial injustice that so frequently undermines health.

In the last two years we have learned about health professional implicit bias, cultural competency, and health disparities through our preclinical curriculum. But as others have powerfully documented, mere exposure to these lessons is insufficient to create a cohort of medical professionals who can transform understanding into action.

We need to expand our lessons beyond awareness of health inequity: Medical schools must develop, longitudinally reinforce, and evaluate skills that will equip their graduates to combat racism and structural oppression. Furthermore, competency in these areas should be enforced as thoughtfully and rigorously as our traditional clinical training is. Standardization and consistent evaluation of these structural and anti-racist competencies would serve not only to bolster skills and determine the effectiveness of the curriculum but would also signal that such teaching is fundamental, not supplementary, to our role as physicians.

We recognize we are not proposing an easy task, and we appreciate the commitment that our institution and others around the country have made toward incorporating discussion of social injustice and inequity within their curricula. However, if we do not fully integrate this skill set into the training we provide and ensure our graduates’ competence in this area, we will fail to produce physicians who can truly make a difference in the communities in which they practice.

Physicians have a role in combating racism because it is implicated in the production of illness. There are few other health challenges more important for us to address, and it is well past time to do so.

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An Argument for Flexible Specialty Board Exam Dates: Reducing Gender Disparity and Improving Learner Wellness

To the Editor: Bates and colleagues1 recently wrote a thoughtful Commentary about barriers women face in academic medicine. The authors outlined a call for change to address salary parity, increase availability of mentorship and sponsorship, remove disparity in research funding, and create career flexibility to improve recruitment and retention. This piece prompted me to reflect on tangible structural barriers in medicine facing families, particularly our profession’s flexibility around maternity and personal leave. These barriers mirror themes surrounding broader efforts to support resident wellness and resiliency.

A recent experience brought one specific barrier to my attention. At a graduate medical education committee meeting, of which I am a resident representative, our program directors were discussing a new policy allowing 12 weeks of maternity leave for military service members. Admittedly, the 12 weeks I would receive as an active duty army resident are a luxury compared with what most civilian programs offer. There is increasing support for the soldier—mom; however, medicine lags behind in supporting the healer—mom. One administrator stated, “Well, tell your residents it is possible, but taking 12 weeks has major consequences.” The primary consequence was the residents’