The Case for Trainees as Catalysts for Change in Racial Justice

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To the Editor: Health systems have recently begun the overdue work of addressing institutionalized racism and inequity, with examinations of race-based medicine at the forefront. In the early 2000s, human genome sequencing provided confirmatory data that race is a social, rather than a biological or genetic, concept. However, race is still too often taught as a biological risk factor or used as a flawed surrogate for environmental and genetic factors in determining medical risk of a given condition. When we are presented with this incongruity in our training, do we stick with the status quo or work to change it?

Although medical training uses a system of graduated autonomy, racial justice work needs not. This is especially true when institutions are hesitant to prioritize the work of evaluating inequitable practices around the use of race and ethnicity. When trainees take the lead in challenging these long-standing practices and imagine strategies for change outside of existing frameworks, we have the opportunity to work with and advocate for historically marginalized communities, while practicing rigorous, evidence-based medicine. Doing so also provides momentum for others to engage in racial justice work, from fellow students to faculty to senior leadership.

We briefly illustrate the role of trainees as catalysts for change in racial justice work through 3 examples from our own institution: the use of the Pediatric Urinary Tract Infection Calculator (UTICalc), Fracture Risk Assessment Tool (FRAX), and estimated glomerular filtration rate (eGFR). As trainees, we can bring faculty and graduate medical trainees together to discuss equity concerns, as we did for the Pediatric UTICalc, resulting in momentum to revise the current urinary tract infection risk stratification guidelines to no longer decrease their estimation of risk based on African American/Black race. We can also champion departmental education and seminars for widespread reach, a strategy we used to amplify discussion of FRAX’s
underestimation of fracture risk in minorities and challenge the status quo in how we treat fracture risk in minority patients. Additionally, we can leverage community voices and public outcry, as we did through a health system–wide petition asking for transparency around the use and removal of race from eGFR calculations. This led to the formation of a health system working group with trainee representation and the ultimate recommendation of primarily reporting eGFR without the race correction.

As these examples demonstrate, trainees can be catalysts in rectifying inequitable care by initiating discussions, educating other physicians, and organizing communities to remake outdated and racially unjust practices that perpetuate race-based medicine. We train to become physicians and patient advocates; thus, medical trainees hold a unique position in prioritizing racial justice work and bringing the medical field along with us.

Reference