A race-conscious approach to CBL cases

Race and ethnicity are social constructs. The genome of people around the world differs by less than 0.1% and there is no single gene that can be attributed to race and ethnicity. When we assign individuals to racial groups, we are imposing assumptions that do not represent biological characteristics (Vyas 2020; Cerdeña 2020). In line with a global movement to de-racialize and de-colonize medicine, our case diversification process is taking a "race-conscious" approach to the presentation of patient identities.

Critical review of current "race-based" medicine—the use of patient's racial identities as a clue to diagnosis or as a guide to treatment—has found that the evidence base for race-based risk factors is inadequate (e.g. risk calculators in cardiology and cardiac surgery, eGFR in nephrology, VBAC risk calculator in obstetrics, the STONE score in urology, various risk calculators in oncology, osteoporosis and fracture risk assessment tools in endocrinology, and pulmonary function tests; see Vyas 2020). The intersectionality of race and the social determinants of health is deeply woven due to prejudicial and racist practices over more than 300 years. In much of the medical literature using race as a biological variable, researchers failed to account for the social determinants of health.

Continuing to use race-based medicine perpetuates inequities in health outcomes between populations. Mentioning patients' race only when it is considered a clue to diagnosis creates biases in clinical reasoning and fails to reflect the reality that (for example) Black patients are Black whether this assists in accurate diagnosis or is potentially misleading.

Although medicine is moving away from race-based practices, in race-conscious medicine, we continue to name social identities, collect racial and ethnic data, and research how they are related to the social determinants of health. How people are perceived in racial or ethnic terms and so treated in society and by healthcare professionals influences their health status. The racial and ethnic communities that people belong to and identify with experience structurally different opportunities for health and wellbeing, with profound effects (Cendeña 2020). In the case diversification process, we also want to disrupt the assumption that when race isn't mentioned, people are white. Therefore, we provide racial self-identification for all patients in the cases.

Some advocate a third approach, "race-blind" medicine, where race is not stated. We can all aspire to a world where racism will no longer be a social determinant of health--but that is not the world we live in. It will take generations of change to achieve such a world, if we ever do.

Students and tutors will continue to see older race-based medicine in textbooks, in clinical practice, and in cases, lectures, and exams while medical practice is rapidly changing. The program welcomes feedback and questions about the treatment of race via the "Language and Imagery" form on One45 (an initiative of the student-led Student Diversity and Inclusion Committee), so that we can continue the conversation and continue to learn.

Our approach in CBL cases does not dictate how race should be handled in every clinical setting (e.g. chart notes, verbal presentations of patients during rounds) or educational setting (e.g. simulation, assessment) (Healy et al. 2022). In some situations, it may be important to omit racial or ethnic information in order to protect patients from bias and stereotyping.

The Black community in the Atlantic provinces illustrates some important lessons about racialized identities and intersectionality. There is a long-standing African Canadian community that has been present in Atlantic Canada for over 400 years. Many Black people in the region immigrated more recently from other parts of Canada, the Caribbean, or Africa (or elsewhere). With different exposures to the social determinants of health, we cannot easily infer from US racial and ethnic data to Atlantic Canadian experiences; we have to consider newcomer health patterns. We have to gather our own data, and Canadian provinces are beginning to do so. In addition, it cannot even be assumed that the sickle cell gene is highly prevalent in local Black communities, because of the specific geographic origin of the indigenous African Canadian community in the Atlantic provinces. Skin colour is a poor indicator of geographic origin at the relevant level of detail. The genes for skin colour are a minute part of the genome and have little relationship to anything of concern for medicine—apart from the fact that physicians need to learn to recognize clinical signs in different skin colours and the fact that how people are treated on the basis of their skin colour profoundly affects their health.

Because race has no underlying biological reality, and because people's ancestral origins and the communities they identify with cannot be inferred from visual impression of skin colour, people should always be invited to self-identify. Race is experienced and named differently by different people. Our diversified CBL cases reflect different ways that people understand themselves in racial and ethnic terms. Self-identified race must be respected and incorporated into medical practice, but not used in to reinforce the historical notion that race is a biological trait.

In the global context, and particularly in North America, it is becoming more difficult to attribute a single race to an individual. A growing proportion of the population will self-identify with two or more groups. This further complicates and highlights the critical limitations of using race-based medicine.

In our approach to race in the CBL cases, some people in the cases are described by very broad racial categories roughly tied to geographical origin, specifically using the broadest categories recommended by the Canadian Institute for Health Information (CIHI): white, Black; of Asian, South Asian, Southeast Asian, Middle Eastern, or Latin American origin; Indigenous (see specific guidance); or mixtures of these given by the patient's family narrative. We acknowledge that the CIHI categories were created for purposes of data collection for various purposes in health care; using them does not imply that continental geographical origin is a scientific basis for race.

Some patients in the cases identify themselves more specifically, by family background and immigration history, for example as Indo-Canadians or as 2nd-generation immigrants from the Philippines. Note that many countries around the world are multicultural, just as Canada is: for example, a Black person may immigrate to Canada from Europe or China or Latin America. Note that not everyone derives the same sense of identity from family history. People are sometimes estranged from their parents or grandparents, or they might have reason to mistrust family histories.

"Ethnicity" is sometimes used in a way closely related to race. It can be used to acknowledge the shared culture of a community that is self-defined in racial terms. (See guidance on ***Ethnicity, culture, and religion in CBL*** *(forthcoming)*.) It can be useful to ask patients more specifically about their family's geographic background to elicit more specific origins, if this is clinically or genetically relevant, or their cultural identification, if this is socially relevant to their experience of health and healthcare. But don't assume that people racialized in the same way (as white, as Black, as East Asian, for example) share the same ethnicity in the sense of language, culture, and religion.

Notes:

- "Caucasian" is not a polite form of saying "white." It is a term with a racist history (Shamambo and Henry 2022; Rambachan 2018) and should not be used.
- In general (but not universally) it is preferred to capitalize "Black" as a marker of self-identification with the Black community, and not capitalize "white." Indigenous is capitalized.
- Canadians of African descent should not be called "African-Americans" (may be obvious, but sometimes overlooked due to the influence of American media in Canada).
- Some people of Asian, Middle Eastern, or Latin American heritage use "brown." This is a personal choice of an individual and it should not be assumed that someone accepts that descriptor, particularly in professional contexts.
- Some forms of racism are closely tied to religious stereotypes and intolerance. See discussion of Islamophobia in the guidance on ***Ethnicity, culture and religion in CBL*** *(forthcoming)*.
- Avoid mixing up origin and citizenship—see guidance on ***Newcomers in CBL*** *(forthcoming)*.
- Reflect on the phrase "racial minorities." Globally, white people are in a minority. Men are a minority (just barely) and white men a minority, but are never labelled that way. Why might that be? What effects might it have to label groups as "minorities"? What does it feel like to be labelled as a "minority" person yourself? Other options include "racialized groups" or "minoritized groups" or "systematically oppressed and excluded persons".
- Avoid assuming that "white" is the default identity of long-term residents of Canada. People of many racial identities have been in Canada for generations, and Indigenous persons resided on this land long before Europeans colonized it.

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