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LETTER TO THE EDITOR

Response to "Barriers to Implementing a Racial Justice Curriculum: CERA Comparison of Family Medicine Program Directors' and Residents' Perspectives"

Julie Ngoc Thai, MD, MPH[a]**; Dylan Hanami, MD**[b]

AUTHOR AFFILIATIONS:

[a] Department of Medicine, Division of Primary Care and Population Health, Stanford University School of Medicine, Palo Alto, CA

[b] Family Medicine Residency Program, AltaMed Health Services, Los Angeles, CA

CORRESPONDING AUTHOR:

Julie Ngoc Thai, Department of Medicine, Division of Primary Care and Population Health, Stanford University School of Medicine, Palo Alto, CA,
thaij@stanford.edu

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TO THE EDITOR:

In their research article, "Barriers to Implementing a Racial Justice Curriculum: CERA Comparison of Family Medicine Program Directors' and Residents' Perspectives," Ho et al explored differences in perceived barriers between family medicine program directors and residents when it came to implementing a racial justice curriculum (RJC).[1] Although both groups cited lack of faculty training, lack of curriculum resources, and lack of time as top barriers, each group prioritized the barriers differently. We commend Ho and colleagues for this important study, especially during a time when national priorities have shifted and requirements specific to diversity, equity, and inclusion have been removed by the Accreditation Council for Graduate Education.[2] We write to offer strategies for addressing the barriers identified in this research.

While faculty wish to teach about racial justice and residents are willing to learn it, both groups are constrained by clinical and curricular pressures of residency.[3,4] This tension raises a critical question: Should racial justice curricula be taught separately from core clinical education in residency? We believe it should not. Incorporating RJC into clinical education can mitigate time constraints while teaching learners to recognize and respond to structural inequities that affect health outcomes. Metzl et al have long argued for a shift from traditional medical education to focusing on structural competency to help clinicians understand how structural determinants (ie, education, socioeconomic status) affect health.[5] This approach moves beyond teaching the morbidity and mortality benefits of SGLT2 inhibitors to examining why racial and ethnic minority groups experience a higher prevalence of diabetes and poorer access to care, thus leading to worse health outcomes.[6] Wang et al's 5 minute moment for racial justice offers a practical five-step framework for discussing race in bedside clinical decision-making.[7] For example, examination of a skin lesion may prompt discussions of how clinical assessments can vary based on skin tone and how racialized practices can contribute to misdiagnosing melanoma in an individual with darker skin. Similarly, in prenatal care, where Black women face markedly higher maternal mortality due to structural racism, Ogunwole and Starks' framework for developing critical racial consciousness can help learners understand historical and structural contributors to health inequities.[8] Racial justice should be taught as part of clinical training, as doing so will directly enhance medical learners' clinical reasoning skills and make them more culturally competent physicians.

Faculty development around teaching racial justice remains essential. Edgoose et al discussed the effectiveness of a curricular toolkit and a day-long faculty development workshop on teaching about racial justice in preparing faculty to integrate equity-focused discussions into clinical teaching.[9] Institutional adoption of similar resources would help faculty leverage their existing expertise to teach about structural determinants of health without treating implementation of RJC as a separate, time-consuming task.

As educators committed to preparing the future family medicine workforce, we believe it is imperative to normalize teaching about structural determinants of health within the clinical curriculum. Integrating RJC into everyday clinical teaching is a feasible and necessary step

toward ensuring that residency education advances health for all—especially those most affected by inequity.

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