Rethinking the Use of "Caucasian" in Clinical Language and Curricula: a Trainee's Call to Action

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REFLECTIONS

As a 2nd year medical student with a public-health-oriented undergraduate education, I have been attuned to observing dialogues around race and medicine. As a Black woman at a predominantly white institution, I have had recurring concerns about the way we speak about race in medical curricula. I continue to wrestle with questions such as why do lectures and exams indicate patients' race in clinical vignettes in which race has no bearing? Why do we use race as a proxy for ancestry in cases where genetics *is* relevant? Why do we remain inconsistent in using race terminology, from oversimplifying race by using "African American" and "Black" interchangeably to hierarchizing it by using outdated terms like "Caucasian"?

A recurring lesson I've learned throughout my pre-medical and medical experiences is that words have the power to influence health outcomes. During my gap year, I learned about the nuances of labels like "non-compliant" and the impact they can have on a provider's perception of a patient — or a patient's perception of themselves.[1] During medical school orientation, I learned about the importance of intentionality in word choice: from using phrases such as "person who smokes" instead of "smoker" to avoiding potentially triggering phrases as a way of practicing trauma-informed care. I felt honored to have become part of a field that was conscious about the impact of language on health and was constantly evolving to meet that need. With time, however, I noticed that this same urgency was not applied to language around race and ethnicity. As I attended more lectures, I found myself becoming increasingly distracted by the way race was inappropriately disregarded, unjustifiably overemphasized, and racial bias unknowingly perpetuated.

Of particular concern to me was the persistent and unabashed use of the term "Caucasian", an outdated classification that is often used synonymously with "white." I had learned about the racist roots of this term in college and was shocked to see the frequency at which it was being taught to me in medical school.

I was a college junior sitting in a Racial and Ethnic Health Disparities class when I learned that the term "Caucasian" as a description of white race was intrinsically racist. We had been discussing the systemic oppression of marginalized groups when the professor noted that oppression existed even in language. He told the story of an 18th century anthropologist who encountered a skull from the Caucasus mountains and described it as the "most beautiful" human skull. It had a larger head compared to other "Ethiopian" and "Mongolian" skulls he had studied, which supposedly signified a larger brain and thus a more superior being. Believing that the white race was the most perfect human form, he ascribed the term "Caucasian" to define primarily Europeans with lighter skin.[2]

After learning that a word I had used many times reinforced racism, I froze. I resisted the urge to turn around and scan the classroom for faces as uncomfortably struck as I was. Why hadn't I known about this?

As an immigrant from a predominantly black country, I had had a difficult time adjusting to terms like "white" and "black." In high school, I had heard my white friends describe themselves as "Caucasian" and figured it was a sophisticated way to characterize race while avoiding apparently "abrasive" terms like "white." While I generally avoided using racial descriptors, I adopted the convenient term into my vocabulary. I saw the word in textbooks, applications, and even standardized testing forms, where it was often juxtaposed with "African American/Black."

To my surprise, in the one year that I've been in medical school, I have seen and heard this word used more times than I ever have in my life. The U.S Census Bureau does not use this term; the First Aid medical review book, the mainstay for the USMLE Step 1 preparation, has discontinued its usage; and leaders in the medical field have recently discouraged its use in scientific journals.[3–5] Nevertheless, the term largely persists in medicine. Students and educators should reassess this usage for its harmful racial implications.

A BRIEF HISTORY

The word "Caucasian" as a description of white race is a remnant of 18th century racist thought, invented by

anthropologists who categorized humans into racial groups and created theories about white superiority. In 1785, Christoph Meiners, a German philosopher, divided humans into two groups: the "white-skinned and beautiful" ("Caucasians") and the "dark-skinned and ugly" ("Mongolians"). Meiners *defined* "Caucasian" to mean humans of a "higher tribe," lighter in skin, and thus superior in nature to darker-skinned humans who were less beautiful and "devoid of virtue."[2] Johannes Blumenbach, a more prestigious German anthropologist, adopted "Caucasian" into his own racial schemata, classifying humans into 5 races: Caucasian, Ethiopian, Mongolian ("yellow" race), Malay ("brown" race), and Native American ("red" race).[2] Blumenbach's Caucasian "variety" were white-skinned, rosy-cheeked, narrow-nosed individuals who were "God's original creation"; the other 4 groups were equally human but "degenerate" versions of Caucasians who had departed from the original human form.[2,6]

The idea that white people are "Caucasians" partly stemmed from the widely held but erroneous belief that life originated in the Caucasus mountains, as well as from Blumenbach's encounter with a Georgian woman's skull, which he used as an archetype of "Caucasian" characteristics.[2]

Blumenbach's work was ultimately used as credence to support ideas of an innate hierarchy of human diversity. In an era desperate to create a social order that glorified white skin, "Caucasian" became the word for white people."[6] The idea that "Caucasian" intrinsically defines people of European origin, is a misconception that is out of touch with science, history, and truth.

SOCIAL IMPACT

"Caucasian" as a description of white individuals was an idea borne from racist notions. Continuing to use this pseudoscientific racial classification subtly wields power to racist world views. In 2020, the impact of such views manifested as a slew of racial injustice, including higher COVID-19 death rates among black and hispanic/latinx populations compared to white groups because of systemic issues such as poverty and inadequate access to quality care. Although the pandemic drew attention to these long-existing disparities, it also stimulated a demand for actionable ways to work towards health equity.

The work of building a society that upholds racial equity hinges on our commitment to being anti-racist in every way possible. Systemic racism is everyone's business. Now more than ever, we need to educate ourselves and each other about how to be a part of the solution. This is work we have already started. Beginning in the 1960s, similar terminology such as "mongoloid," "mongolism," and "mongolian idiocy", used to describe what we now call "Trisomy 21," was largely removed from medical language.[7] In 1961, a group of geneticists exposed these terms for their offensive racial connotations and

successfully proposed that they be replaced with terms like "Trisomy 21."[7] "Caucasian" is deserving of similar treatment.

This is especially important considering increasing evidence that language used in clinical dialogue influences physician attitudes towards patients. In a randomized study examining how language affects clinical decision-making, researchers found that stigmatizing language in medical records was associated with more negative attitudes towards patients, and less treatment of patients' pain.[8] It is well known that clinician bias contributes to health disparities.[8] Accordingly, language should be recognized as a key pathway through which we can mitigate bias, and the health disparities that arise from it, thereby advancing health equity.

Furthermore, there is much speculation concerning the usefulness of racial descriptors in clinical cases, as they are not relevant to medical care in a vast majority of presentations: the caveat being that race should certainly be acknowledged when examining the contribution of the social determinants and racism to health inequities. The National Board of Medical Examiners have actually limited the use of race in presentations except in cases where ancestry is relevant, such as in cystic fibrosis, sickle cell, and Tay-Sachs. (*https://www.nbme.org/sites/default/files/2020-11/NBME_Item%20Writing%20Guide_2020.pdf* *retrieved December 2, 2021.*) Nevertheless, even in such cases, race should not be used as a proxy for ancestry/genetics and should instead be replaced with more granular descriptions that specify genetic predisposition, where possible.

CALL TO ACTION

Medical curricula and training directly influence the physician leaders we produce. As a student getting ready to begin clinical rotations, I worry that my peers and I have not been anchored in using conscientious terminology surrounding race and ethnicity. Many recommendations have already been made to adapt the use of race in the medical curriculum, including standardizing language usage in teaching and clinical practice.[9] In our fight to build a world where health outcomes are not dictated by race, the choice to renounce terms that honor racist ideologies is pivotal. As agents of change, students should advocate for educators to remove such terms from their clinical descriptions and promote anti-racist curricula that do not differentiate patients through an arbitrary racial lens.

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