A PIECE OF MY MIND

Good for Us All

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I began my second year of gastroenterology fellowship after logging hundreds of procedures, scoring high marks in peer and patient reviews, and developing a reputation as a strong endoscopist and clinician. I was proud of my progress but was even more thrilled to no longer carry the department's on-call pager every other night. One day while rounding on the transplant hepatology service, I met a patient who prescribed me an awkward dose of reality.

That day began like any other. The patient's primary physician led the conversation while I listened, took notes, and placed electronic orders. Having gotten good news about a pending liver transplant, the patient was in good spirits and insisted each person introduce themselves by name, title, and role. After every introduction, the patient effusively said, "Nice to meet you Dr X. Thank you for taking care of me."

Eventually the patient and I made eye contact, but before I could state my name and role, the patient asked if I was a student on the team. I responded as others had, "Good morning [patient's name], my name is Dr Issaka and I am a gastroenterology fellow." The patient looked at me curiously, and eventually responded..., "Well, good for you!"

Dismantling structural racism in medicine is a collective responsibility, and everyone has a role.

After what felt like an eternity of awkward silence—I was the only Black person on the team, in my fellowship program, and in the entire division at the time—the attending physician broke the silence by sharing the care plan and morning rounds resumed.

The patient's patronizing verbal pat on the back, "Good for you," was a reminder that despite my accomplishments, there would always be an assumption by some that I didn't "belong." I've replayed that conversation and many similar experiences in my mind, feeling as though I'd failed by not responding more articulately. I've since realized the constant need to justify my presence is instead a failure of the medical profession. Statements like "good for you" are called microaggressions, and the onslaught of small encounters have an outsized negative impact in reinforcing norms of racial inequality.[1] When these norms result in inequitable health outcomes for patients, they are called racial health disparities. Both microaggressions and racial health disparities stem from structural racism.

Structural racism is embedded in medicine's policies, practices, cultural representations, and norms that reinforce inequities.[2] As the United States confronts the disproportionate impact of coronavirus disease 2019 (COVID-19) on Black people, the unjust killings of George Floyd and other Black Americans has ignited the most cohesive civil rights movement since the late 1960s. Despite the focus on law enforcement and criminal justice, medicine's history of exclusion and exploitation also fuels this racial reckoning; thus, medical institutions must play a critical role in forging a different path forward. The medical profession must acknowledge its history of inequality; the persistent impact on Black patients and medical professionals (including trainees, faculty, and staff); and the implications on the missions of patient care, education, and research.

With respect to microaggressions, the Twitter thread #Blackinthelvory recounts stories of structural racism in academia and medicine. Although it may be uncomfortable, everyone in medicine should feel a responsibility to directly respond in these situations and challenge accepted norms as I have learned to do.

When a patient says, "You're not what I expected my doctor to look like!"

I now respond, "Do you mind elaborating? What did you expect your doctor to look like?"

When a colleague says, "Do you work here?"

I now respond, "I thought wearing my badge would make it obvious. Was there anything in particular that made you believe I did not work here?"

When a patient says, "I don't want to see you. Is there another doctor?"

I now respond, "All of our doctors are qualified to provide excellent care regardless of race or nationality, but if you prefer to seek care elsewhere, that is your right."

With respect to racial health disparities, achieving health equity has been elusive across multiple health conditions. Medicine often focuses on changing downstream health outcomes (heart disease, obesity, cancer, etc) without seeking to understand or address the upstream determinants (structural racism in health policy, housing, environmental regulation, etc).[3] Black people who might opt for stool-based colorectal cancer screening for convenience are subject to higher insurance deductibles and co-pays, symptoms of pregnant Black women are frequently dismissed, and Black children experience negative health outcomes based on their zip codes. As a result, Black men are almost 2 times more likely to die from colorectal cancer than White men,[4] Black mothers are 3 times more likely to die from pregnancy-related complications than White women,[5] and Black children have higher rates of disability than White children.[6]

Eliminating structural racism in health care requires a radical reimagination of the medical profession and taking sometimes uncomfortable action to create

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change. This change has to begin with state and federal policy with engagement from medical professionals. A bold declaration of structural racism as a public health crisis would bring financial resources to bear and encourage agencies to work together on novel policy solutions. Policies that address upstream determinants will benefit everyone, not just historically underserved populations.

Medical schools and health care systems must train everyone to identify and respond to structural racism when they see it. Education is critical to provide the language and tools to discuss structural racism and its adverse effects on Black patients and medical professionals. Integrating such education into the curriculum and employee trainings is an initial step toward creating a culture where everyone recognizes their role in addressing structural racism.

Medical institutions must also ensure their entire workforce, including leadership, reflects the diversity of our country in order to improve persistent inequities in health outcomes, cultural competency, and overall patient satisfaction. Black Americans represent 13% of the US population, but only 3.6% of full-time medical school faculty are Black.[7] To overcome this shortfall, medical schools and health care systems should invest in pipeline programs, actively recruit, retain, and promote Black faculty into leadership positions and make sure external advisory boards are racially diverse.

Additionally, medical schools and health systems should rewrite mission and vision statements with a health equity lens. Doing so would tie financial resources and organizational visibility to recent verbal commitments and encourage the use of metrics to track progress. Institutions that yearn to create antiracist environments, and all should, must be ready to listen to and work with Black trainees, faculty, staff, and patients to make it so.

Dismantling structural racism in medicine is a collective responsibility, and everyone has a role. Throughout June 2020, thousands of medical professionals around the country observed 8 minutes and 46 seconds of silence to bring attention to racial injustice in policing. This demonstration, initially conceived by the medical student organization, White Coats For Black Lives, was impactful. Beyond calling out structural racism in other spheres, educators and colleagues of Black medical professionals must also speak up when racial mistreatment or bias occurs within medicine. It would have been a powerful statement if my attending would have said to the patient, "Actually, Dr Issaka's presence on our team is good for all of us."

Colleagues can also help address structural racism in medicine by reporting frequent offenders, mentoring Black trainees, and citing and promoting Black colleagues, whose work is often undervalued. Researchers can ensure proportional representation of Black patients in scientific studies and clinical trials, and clinicians can advocate for more deliberate collection of patient information on race, ethnicity, primary language, and integration of social determinants of health in the electronic medical record. Beyond simple data collection, these facts should fuel local initiatives to connect historically underserved populations with resources to promote their overall health.

Finally, the success of Black trainees and faculty in this era cannot be overstated, which is why trainees and faculty must first prioritize self-care and preservation. Organizations like the Student National Medical Association for trainees and the National Medical Association for faculty, as well as digital communities, provide spaces to recharge and a forum to document and share experiences about structural racism for personal reflection and collective action. Medical institutions can support Black trainees and faculty in these efforts by providing resources (money and physical space) to limit isolation and promote inclusivity.

Years later, my exchange with the patient and my team's silence is still memorable. As medical professionals, it is time to call out structural racism in medicine and work fervently to dismantle it. Doing so will not just be "good for me," Black medical professionals, or patients but will ultimately be "good for us all."

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