VIEWPOINT

PHYSICIAN WORK ENVIRONMENT AND WELL-BEING

Making All Lives Matter in Medicine From the Inside Out

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Invited Commentary

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I was in medical school when I learned that I did not matter in medicine.

One particular day on service started uneventfully. However, after the team's discussion of a patient, all attention turned toward me when a senior physician asked me a question about the rap music that had been playing in the background.

"Help me understand something:" I recall the physician saying. The physician asked about word choice in rap lyrics, and then, pretending to quote a rap song, repeated the word "nigger" several times in rapid-fire succession.

Hearing the n-word sent my pulse racing. Suddenly on defense, I was thrown into the all-too-familiar role of race ambassador: spokesperson for all people and culture considered to be black. I had a repugnant choice: swallow my lump of anger and sadness to preserve group harmony, or risk my grade and reputation by confronting my superior.

My dignity withered during my chosen moment of silence. The subintern of color offered me a weary glance, but my superiors ignored the incident. Like when another physician mocked Jamaican patients a few months earlier, skin color obscured human dignity. I felt 17 again, when a police officer had me at gunpoint—poised to erase decades of my family's struggle in seconds with my body's fate in hand—for walking in my neighborhood. On the street or the hospital ward, I "fit the description." I did not matter.

Minorities of almost all kinds can relate to my experience.[1] I stayed silent because I felt my professionalism demanded my decorum. Anger toward that senior physician might have compromised our team's highest priority: patient care. But my silence violated my personal ethics—namely, to constructively approach harmful ignorance. Engaging the physician after building rapport might have helped us both improve. So why was it so hard for me to do so?

Acts of racial bias in the health care workplace are unlikely to be directly addressed. Workplace racism, like workplace sexism, is taboo and illegal.[2] Nonetheless, features of the medical workplace discourage trainees and students from directly addressing the racial biases that they experience. First, most attending physicians are not racial minorities.[3] As such, they likely endure racial bias less often, and likely feel uncomfortable addressing these incidents—especially when accused of racially biased behavior. Second, students and trainees are serially introduced to new environments and supervisors. Adjusting to a new, fast-paced clinical environment where the focus is appropriately on patients leaves less time for accessing resources to manage experiences of racial bias: only 16% of minority medical students who experienced racial discrimination or prejudice used their Office of Minority Affairs, according to 1 study.[4] Finally, through evaluations critical to career advancement, attending physicians influence the career trajectory of students and trainees, rendering confrontations high-stakes interactions.[5] These factors explain why my team did not defend me: I was a temporary addition to their busy team, they felt uncomfortable, and they had a lot to lose.

Notwithstanding barriers to confronting racial bias, medical students of color experience racism in the health care workplace. Compared with their nonminority peers, medical students who are racial minorities have reported nearly 5-times higher odds of experiencing racial discrimination, prejudice, and feelings of isolation.[4] Moreover, students with these experiences were more likely to screen positive for depression and report lower mental quality of life.[4] Enduring racial bias adds to the stress of medical training, unfairly burdening medical students of color.

Racial bias among attending physicians presents a particularly harmful threat to students and trainees of color. However, according to 1 study[6] in 2017, faculty self-report little to no racial bias. Researchers administered the Black-White Implicit Attitudes Test (IAT) to 140 faculty and medical students from the medical school admissions committee at the Ohio State University. The Black-White IAT detects implicit racial bias. For example, if a study participant associates images of white people with positive words and images of black people with negative words, they are considered to have an implicit white preference. A standard scoring algorithm then grades that preference as slight, moderate, or strong. Although almost all participants reported that they had no racial bias,[6] the IAT results revealed otherwise. Consistent with previous research,[7] faculty had strong implicit white preference, and students had moderate implicit white preference.[6] The relatively small sample size of this study notwithstanding, and contrary to their beliefs and intentions, many physicians hold strong implicit racial biases.

Implicit racial bias not only harms members of the health care team, but also may compromise patient care, as a 2016 study[8] has suggested. Researchers evaluated the individual racial biases of 222 medical students at a large public university and residents at several hospitals in Virginia using the number of false biological differences each believed existed between black people and white people. Each participant then read 2 mock

cases about a white patient and a black patient, rated each patient's pain from 0 to 10, and made treatment recommendations. The more racial bias participants had, the less intense they rated the black patient's pain, and the more incorrect and harmful their treatment recommendations.

Imagining a loved one, colleague, or patient suffering unnecessarily in the hospital owing to their skin color elicits the same indignation I felt that day on service when asked to explain the lyrics of a rap song. How might we identify and address racial prejudice in medical training?

First, assess student evaluations for racial bias. A 2017 study[9] found that after adjustment for US Medical Licensing Examination Step 1 and Step 2 scores and other relevant factors, the odds of Alpha Omega Alpha (AΩA) membership for white students were nearly 6 times greater than for black students, and nearly 2 times greater than for Asian students. Racial disparities in AΩA membership might perpetuate racial disparities in career opportunities. Students who are AΩA members are more likely than those who are not members to match to the residency program that is their first choice and to attain the rank of full professor, dean, or department chair.[9] Since AΩA membership requires favorable evaluation from attending physicians, medical schools should examine AΩA membership and grade distribution across racial groups, and residencies should take into account this racial disparity when considering applicants.

Second, add evidence-based methods of reducing implicit bias to resident and faculty development curricula. For example, a 12-week randomized clinical trial[10] conducted in 2013 split 91 psychology students into intervention and control groups, administering the IAT to both groups 3 times during the trial. Researchers reduced racial bias in the intervention group through methods such as increasing awareness of and exploring the sources of one's racial stereotyping and detailed imagining of racial minorities who challenge racial stereotypes (eg, President Barack Obama). This self-reflection may be challenging, so institutions should provide time and guided instruction to resident physicians and faculty.

Third, financially and administratively support students, residents, and faculty who reveal, study, or otherwise combat racial bias. Anecdotes like mine can galvanize other medical students and residents to organize. Their collective experiences gain salience as action-worthy problems when fully recognized by medical institutions. At the University of California, San Francisco, where I went to medical school, I was a founding co-organizer of the WhiteCoats4BlackLives chapter. The financial and administrative support we received helped catalyze constructive exchanges of ideas among students, residents, and attending physicians. But ideas are not enough. Fully recognizing racial biases as problematic requires operationalizing ideas into interventions.

The November 2016 elections in the United States reinforced the salience of race. Using not only words and protest, but also inquiry and action, medical students and medical schools should fully address racial prejudice and bias. Students, residents, and patients of color should know that their lives matter in medicine, too.

ARTICLE INFORMATION

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