

PERSPECTIVE

# THE IMPORTANCE OF BEING OUTRAGED

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The mentoring conversation with a second-year medical student is going well. He is keenly interested in general surgery and we talk about how he came to that decision, what he values about the specialty, and about his options for success and obstacles he will likely have to navigate. He is a proud, accomplished young African-American man attending a highly regarded school of medicine in a city with an ultra-liberal reputation.

We devise a plan. My role is both mentor and professional matchmaker. He will meet with a diverse array of faculty and trainees in general surgery to learn more about what he needs to focus on over the next two years in order to be a competitive applicant and the culture and climate of programs to which he might want to apply. With him, I balance communicating hope with realism.

During our meeting, I think about the afternoon before I met him in the campus library. I stood in a circle with my colleagues at the conclusion of our division of general internal medicine retreat. In the circle I saw people I deeply care for who have offered me honesty, directness, and affiliation leading to relationships of mutual trust. I saw the faces of men and women with whom I've shared thorny clinical problems and seemingly insoluble problems about mentoring trainees. To the people I work with most closely, I could honestly say that I love them. I would do anything I could to help them with personal problems or professional needs.

During our four-hour retreat, race was never mentioned as an issue, never mentioned as a major social determinant of health for our patients, or as a factor that overdetermines and undermines success in medical education. Homelessness, opioid misuse, chronic pain, and other complex psychosocial problems were part of the conversation from the opening of the program. Why is race and health equity absent in the agenda? I am the only African-American physician. I am the only under-represented minority physician in a division with 28 faculty members. *Again.* Still. I am alone, and I am outraged.

I am outraged for our patients who are African-American male veterans who do not have the opportunity

to consult a physician who shares their experiences of both pride and challenge as African-American men in America. When one of the patients I treat declines potentially lifesaving interventions because he has developed an adaptive mistrust for healthcare professionals in response to experiences of bias and discrimination, I wonder how racial equity in our division might improve patient trust. I know that my colleagues desire providing an experience in primary care that is fair and respectful for all, but the glaring absence of physicians that share identity with approximately 12 percent of VA patients nationally (African-American men are intentionally over-represented in my practice) speaks volumes about a system of racial inequities. Patients have said things like "I know she is probably a very fine person, but I don't see how a young white woman can relate to my experiences as an African-American man with prostate cancer." A recent working paper indicates that for African-American male patients, race and gender concordant doctor patient pairs could achieve a 19 percent reduction in the black-white male disparity in cardiovascular mortality.<sup>1</sup> Relationships can be as powerful as our most effective medications but to African-American men we fail to offer the humanistic and equitable intervention that could save lives.

Martin Luther King, Jr., asked, "Where do we go from here?" and that interrogation requires us to look unflinchingly at where we are now. AAMC data indicates that there were fewer African-American male medical students in 2014 than there were in 1976. This is a medical problem, a public health problem, and a moral problem. Our healthcare system reflects an ongoing systematic racism that affects the education that black males receive which directly results in fewer candidates progressing from pre-school to graduate school.

Outrage can motivate action. Because we can't improve what we don't measure, we need to assess the needs of those who are members of marginalized groups by convening focus groups of patients and community partners. I need to listen carefully to conversations about patient satisfaction because my identity as a woman of color in medicine does not mean I always

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understand what's important to minority patients. Let's pay close attention to the number of young African-American and Latin men who attend STEM pipeline programs and how many of them matriculate to medical school and go on to have meaningful careers. Let's set goals to repair our leaky medical school to faculty pipeline by recognizing and dismantling

structural racism and implementing interpersonal remedies for inequities in the physician work force through effective personal and professional mentoring that begins on day one of medical education and continues throughout the career of minority physicians. Dr. King said, "A time comes when silence is betrayal." Time's up. Speak up about inequity in the physician work force!

**References**

1. Alsan M, Garrick O, Graziani GC. Does diversity matter for health? Experimental evidence from Oakland NBER Working Paper No. 24787. <https://www.nber.org/papers/w24787>. JEL No. C93, I12, I14. Published June 2018. Revised September 2018. Accessed March 1, 2019.

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