Ah, You're A Doctor?

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The year is 1982. I'm a second year medical student, one of three Black medical students in my class and ten in the medical school student body of about 400.

" 215 needs these labs drawn. I'll leave the chart here." I am vaguely aware of a resident physician talking as I root through my patient's chart trying to get a handle on his history and chief complaint. "Did you hear me? I need you to order these labs." Somewhat dazed, I look up quizzically. "Excuse me," I say, genuinely confused. "Are you talking to me? "Oh... Oh," I say with my voice rising. "I don't work here. I'm a medical student. You need to find the ward clerk". I mean, I'm dressed in the coded uniform of a Vanderbilt medical student; short white coat, pockets brimming with cards, handbooks, tourniquets, stethoscope, reflex hammer. My pockets are so full that they often got hooked on chairs or the stuff fell out when I sat down. Surely, all this stuff should indicate that I'm somewhere on the medical professional spectrum.

Maybe he didn't see them, you're thinking. Well, he'd been standing over me for several minutes. Maybe he was distracted? No. He saw my brown skin and just assumed.

This was not the first time that the Vanderbilt medical community seemed incredulous about my presence nor was it the last time. This incident was only the first of hundreds, maybe thousands of times during my 40 year career that I was mistaken for a clerk. For those unfamiliar with the job, the ward clerk was the person who transcribed doctor's orders for medications and labs onto paper forms and scheduled diagnostic tests. In those days, the position required only a high school diploma. Residents, other students, faculty and colleagues continued to misidentify me as a clerk until they were eliminated by computerized medical systems sometime in the late 90s. By then, I was attending faculty at Emory University and later, the Ob/Gyn Department Residency Program Director. Whether I was in Philadelphia or Florida, New Jersey or Nashville or Atlanta, the mistake reoccurred. Even now in my retirement, very little has changed.

These incidents are examples of what are now known as microaggressions, the newest term applied to interpersonal interactions involving misconceptions based on racial stereotypes. Unfortunately, most Caucausians have been slow to acknowledge microaggressions. When I mentioned this incident to two former women residents, they quickly responded that it happens to them. They're still being confused for nurses well into their medical careers.

My predicament is something different. Mis-identification of the two women at least assumed that they're medical professionals; a ward clerk was just the hired help, meant in the demeaning way that they were regarded, one step above janitor.

The assumption that I am hired help is embedded in the stereotypical myth of low Black intellectual capacity. Too harsh you say. Black people will immediately concur; when you live in brown skin, you battle stereotypical assumptions of inferiority daily. In the white, oh-you-must-be-a-nurse scenario, it's not an assumption about intellectual capacity but a tacit recognition of the lack of opportunity for women to become physicians. The rationale for that misconception was based historically in the myth of female frailty. Women were considered incapable of withstanding the rigors of medical training. And there was (and is) the more fantastically conceived aspects of female emotionality (in the early days called hysteria) and their uncontrollable menstrual variation in mood.

One of the two former residents is Asian, but the same assumptions about African American don't hold for her. Current stereotypes of Asians identify them as super intelligent. At the same time, Asians are just as likely to harbor stereotypes about African Americans. After all, if they grew up in this country, they've been bombarded with the same racial stereotypes as everyone else. If they grew up abroad, American values have been exported through current events, US troops, literature and the arts. Historically, the world has understood the circumstances of African Americans; the Nazis and North Vietnamese used it as propaganda among Black GIs.

My experience is not unique nor sadly, a thing of the past. Other stories from the last 5 years include a Black male resident who was repeatedly mistaken for an orderly throughout his training. Another resident recounts that some white patients complained to her team that they never saw a doctor after she had rounded on them earlier, sometimes for several days. Each time she introduced herself as a team physician. Her words, dress and demeanor were futile against the patient's natural prejudices. It just didn't compute.

She also tells a story about updating a patient's family during a surgery. After some complications develop, she is asked to drop out of the surgery and go talk with the family a couple of times. Dressed in her scrubs, white coat, surgical hat and shoe covers, she introduces herself as a physician on the surgical team each time as she visits the family in the patient's room. She sacrificed her surgical experience to comfort the family. With the surgery complete, an irate family confronts them, miffed that no one has bothered to talk with them. "You all just kept sending the housekeeper." In 2006, it was unfathomable for this family to conceive that a Black woman, dressed like all the other physicians, could be one of them.(1)

How is that possible, you ask? I don't doubt that this family doesn't think of itself as racist nor did they mean any harm. But their intention has nothing to do with their actions. The family completely ignored all the normal cues that indicate physician, not once but several times. Why would a housekeeper be dressed like the other surgeons? They ignored not just her clothing but her words. She said she was a surgeon. How would a housekeeper know anything about surgical complications? It's completely illogical. Under any other circumstance, all of those cues would signify that they were speaking to a doctor. How did this go so wrong?

One other thing, she didn't say if any of her team spoke up about it. Her silence suggests that they didn't and she was left to swallow the insult quietly on her own. Discussions about race are extraordinarily difficult but not to acknowledge the racial dimensions at the core of many situations simply reinforces and condones racial stereotyping for all participants and observers. And it leaves the Black physician dangling from a limb.

One more story that relays the collusion of white colleagues and the isolation of minority medical professionals. A medical student of Ghanaian descent is rotating through an outpatient clinic when his preceptor asks the white patient if he objects to having a medical student participate. He shockingly responds, “As long as he doesn’t shoot me!” Pause for a moment to take that in. With the student dressed in his white coat, dress shirt, tie and cardigan, the patient felt comfortable enough to joke about Black thuggery with a perceived ally, the white preceptor. In return, the preceptor joined in laughing in a moment of white male bonding. Stunned, the student took a deep breath or two and proceeded to conduct a professional interview and exam. The incident brings Step’n Fetchit to mind. He gaily swallowed every racist insult with a smile, warming the hearts of white audiences everywhere. Black audiences laughed too, but they saw in him the passive resistance they employed daily because Step’n Fetchit was always successful at a classic racist trope, avoiding work at all costs.

Here too, the Black medical student was betrayed with no place to turn. His preceptor was out of the question, his laughter said it all. This is the very definition of a hostile workplace. The student reflected on his reaction this way:

> “I was primarily angry. I was angry that, despite my best efforts to look the part of a medical professional, this patient could not see beyond the color of my skin to stereotype me as a thug. I was angry that my preceptor did nothing to stand up for me. I was angry that I did not know what to say in order to stick up for myself. I was angry that I had allowed someone else’s prejudice to cause me to doubt whether I belonged in the space that I had worked so hard to enter.”(1)

This mix of emotions, humiliation, the puncturing of his self esteem, his doubt about his accomplishments, the betrayal by his preceptor and importantly, a sense of powerlessness to

control his personal image in the world. Emotionally, these interactions take a heavy toll on minority medical personnel, particularly trainees.

How did I and other African Americans in medicine feel about the racial environment? Importantly, we knew these burdens were ours to bear. At Vanderbilt, there was no one else in the medical center with whom I could share my feelings except the 9 others like me. Tales about my ward clerk job simply joined the repertoire of comedy material shared with them. It was part of our bonding rituals.

My recurring misidentification wasn't a complaint I could take to an all white faculty and advisors then or even late in my career. Even now, as with my former residents, the first reaction is denial; "you're making too much of this" or "they didn't mean anything by it"; as if my emotional pain is less important than a defense of some other white person they don't even know. That denial will soon morph into blaming me for accusing someone of prejudice, tacitly soliciting me to apologize. Trust me, I've been through it over and over again.

The world was different for me than for the current generation. Having attended overwhelmingly white high schools in the 1960s, an Ivy League college and worked in another one, my expectations were low. My family single handedly transformed our neighborhood block in Cincinnati from one Black owned home to a subdivision of black owned homes in a single year. One can't help but revel in that kind of Black Power.

I knew I was battling on the front lines, breaking barriers for generations to follow me. I never expected anyone to stand up for me and I've almost never been disappointed in that. I knew that I had to pick my battles, to defend myself and ultimately others. The rest, I simply had to let slide. That hasn't changed much.

What has changed is a lie that life has become less racist for people of color. This doesn't belittle the accomplishments of those who fought and died to change the law to create opportunity. This generation believed that the world had become safer; that they could be treated as equals. Faces like theirs have multiplied in the medical hierarchy; people who look

like them are routinely seen in advertising, in movies and TV. For God's sake, Barack Obama was elected President of the United States; that must have meant something.

Yes racism became less socially acceptable and the white supremacists went underground. When I arrived in Nashville in 1980 to start medical school, the fully robed Ku Klux Klan collected donations on Music Row, a frightening prospect for a woman newly moved from Manhattan with two children and a white husband. Thankfully, they were gone the next year as the mayor realized that Nashville could never become a tourist destination with the Klan openly supported in its midst.

But the Klan is only the most extreme expression of racism. A constant stream of racial stereotypes pervade the culture, from Aunt Jemima on syrup bottles and Uncle Ben on his box of rice to mug shots on the news. Black youth with hoodies and pants below their butts are characterized as thugs and criminally inclined while similarly clad white youth are merely fashionable. Drug use, particularly marijuana, was considered a Black problem even as it's far more prevalent among white youth and adults. Police racial profiling has resulted in Africans Americans being jailed for drug violations at high rates because the police target Black neighborhoods. How many drug raids occur on college campuses or in white suburbs? From the beginning, the American melting pot was spiced with racial stereotypes and we've all had a heaping helping, including African Americans.

Those images coalesce in the implicit racial biases minority physicians experience in medicine. All Black people look alike has become a common joke and yet, it rings true for many of us whether tall or short, mahogany or beige skinned, long haired or short, curly haired or straight, pencil thin or full bodied. As an Emory faculty member, my department chair once introduced me to an audience by the name of a Black colleague, although we resembled each other not at all. Another time, he acknowledged my question using someone else's name. Both times, I did correct him; it was mostly pride, but I wanted to embarrass him. The audience dismissed it as a slip of the tongue, except for people of color who smiled in instant recognition.

It’s a common problem for them; not infrequently white staff and faculty have confused them too(2).

Although we spent more time in the hospital with each other than with our family and friends during training, the time many whites spent with us didn’t confer the kind of parallel familiarity that they find with each other. Studies from the justice system confirm that Caucasians make poorer eye witnesses than African Americans because they have difficulty distinguishing features in African Americans who, in contrast, are acutely tuned to skin tones, facial features, physical build and clothing.

Whites also have a tendency to see Black males as older, taller and larger than they actually are. Given that 85% of teachers in K-12 schools are white, these assessments play an important role in racial disparities in school disciplinary actions, suspensions and special education enrollment. They are also important in police brutality and shootings, jury trials, racial disparities in the number of Black juveniles tried as adults and death penalties. Critically, it underpins the lack of empathy among the general public for Black victims of police brutality and shootings. This distortion in size, weight and age sparks much of the white anxiety that conceives of all Black men as threatening.

For our part, African Americans adjust to majority white environments by adopting the white-friendly version of ourselves known as code switching. In medicine, it’s a necessary contrivance to succeed. We adjust our appearance and behavior to become acceptable to those who hold our careers in their hands. When one is on the bottom of a hierarchical career path which depends on the evaluations of those more senior, one simply puts their head down, works harder than their white colleagues and crafts a path toward promotion.

The newer generation of medical trainees seems less willing to conform to older restrictions on dress and behavior. The LGBTQ community led the way in nonconventional dress and hairstyles. African Americans now wear the full range of natural hairstyles. They are more likely to be boisterous with friends and to show anger, actions that were discouraged in my

career to counter the stereotypes of the “angry Black woman or man” and “loud, free wheeling Blacks.” This coincides with increasing numbers of African American medical students, 13% in 2018 and medical school faculty, although that number is only 3%. That figure includes the three HBCU schools which have majority Black faculty.

Because medical training remains essentially an apprenticeship, the vast majority of evaluations are subjective. In Ob/Gyn, there are no required written exams that determine resident promotion. Advancement from student to resident to fellowship or private practice depends on a network of relationships among faculty, private adjuncts, former trainees and former trainers, a fairly small circle. Most people know someone who’s trained with someone they know or in another program. Residents join the practices of their clinical instructors; former residents in practice call their programs to recruit new partners. Recommendations are often made over the phone.

In this environment, to be marked as a trainee with a chip on their shoulder or as a troublemaker who is Black is to risk poor evaluations and lukewarm recommendations. Typically, Ob/gyn recommendations are at worst neutral rather than poor, because every program has a vested interest in having its graduates get the best placements. A good reputation of graduate success helps a program to recruit residents in a very competitive match process. But a resident who isn’t favored may find themselves outside the conversation and dependent on commercial recruiters to find a job, typically outside the city in which they train.

A successful strategy for a minority in an environment of innuendo recommendations is to accept multiple affronts and brush them off. To do otherwise is to expend a lot of emotional capital needed to direct your energy toward maximizing your educational experience and learning. For African Americans, each day is a *Groundhog Day* movie: a new day with new people which strangely replays the same incidents, only with different faces.

Traversing a minefield of racialized behavior takes its toll on trainees of color. Data shows that African American medical students have substantially lower graduation rates than

their white counterparts. Unfortunately, data on racial groups available from Association of American Medical Colleges in recent years is sparse as the organization has shifted to gendered statistics. But, between 1987-1995, an average of 7% of Black students left medical school for academic reasons, compared with <1% of white students. During the same period, about 60% of Black students graduated in 4 years, with 85% finishing by year 7. These figures compare with 85% and 90% respectively for white students. However, some later figures are even more ominous. By the class of 2003, only 1120 of the 5166 enrolled first year Black students graduated in 4 years, a dismal 21%.

Subjective evaluations during clinical rotations combined with the bias inherent in a close knit group of evaluators and evaluees may contribute to lower minority medical school graduation rates. A number of elements may apply. Stereotype threat syndrome in education describes anxiety triggered when a student feels their performance must undo racial stereotypes. Oral presentations and group questioning are staples of medical education. The inability to provide a correct answer becomes a source of public embarrassment. As medical education progresses from the classroom to clinical settings, evaluations shift to faculty, which are influenced more by stereotyping and implicit biases, similar to the K-12 school system. For the student, anxiety can trigger stammering or brain freeze where they can't remember an answer or become unable to complete a presentation.

There is a generational component to stereotype threat. I was brought up with the idea of "representin" which meant my every accomplishment represented what the Negro race could do. I had to be among the most intelligent, the most articulate and good at everything I did, a heavy burden which challenged me to excel. I accepted my job was to demonstrate that we're just as good as whites, worthy of full citizenship and equal opportunity. While fashionable at the time, it has proven erroneous. No matter how capable we are, we're incapable of shaking loose deep seated stereotypes dreamed up by powerful white men who have used them relentlessly to maintain their hegemony.

In contrast, younger Black generations thought we had won the argument, not understanding that it's not a true argument when the powerful make the rules. Not inculcated for the battle for equal footing, they haven't been armed with the confidence that they will excel and have faltered under the pressure. Unlike my parents, achievers through education despite segregation who believed that education would pave the way, theirs failed to prepare them.

The new generation of students who grew up with helicopter parenting seem to require frequent doses of reaffirmation; they crave praise and rewards. These things are antithetical to my training, a draconian setting that would make Dickens proud, designed to demean us into learning (it worked). Students today, who appear less self-confident, seem less able to cope with failure and more anxious about success. African Americans seem more vulnerable; one graduate told me bluntly that my generation expected the discrimination but her generation was surprised that so much remained unchanged. She wasn't prepared for the obstacles, not the obvious or the subtle ones.

Another factor in different experiences for trainees of color is the halo effect, where first impressions influence all subsequent observations. In resident education, faculty and resident observations form the sum total of performance evaluation. Criteria in Ob/Gyn focus on surgical performance, diagnostic accuracy and treatment of complications. Faculty are seldom present for history taking and physical exams. In gynecology, the focus is strictly on surgical procedures, with little observation of bedside patient interactions. While the criteria were expanded in 2003, the main faculty focus remained on procedures with the rest considered fluff.

Bad memories dominate recall more than good ones, so failures prove more difficult to overcome in later rotations. Evaluations were frequently done at the end of a 4-6 week rotation using an instinctive gestalt making them more susceptible to halo effect. Preconceptions develop relatively quickly as "reputation", good or bad, precede each rotation. This process frequently discounted individual strengths in other areas and overlooked an unsatisfactory performance in residents reputed to be excellent.

The disparity in resident evaluations between minority and white residents is highlighted in a study where an administrative chief resident noticed a pattern of complaints from nursing staff and faculty about behavior and clinical judgement in minority residents that were not being made against white residents displaying the same behaviors. Their analysis of resident evaluations showed that minority residents received lower objective evaluation scores and that nearly half of them received performance evaluations that were considered “concerning” as compared with 10% of non-minority residents. When presented with these results, the faculty was stunned, testimony to the invisible hand of implicit bias. This phenomenon reflects prejudice that perceives the behavior of Black residents as outside the norm even when it mirrors the behavior of white residents, much like in the K-12 school system.(1).

When African Americans report instances of racial prejudice or lack of an institutional response, they are often tasked with constructing a remedy. This mirrors the historic hoisting of responsibility for fighting racism onto its victims. Unfortunately, departments indicate their low priority when they refuse to allocate dedicated work time or resources to the junior faculty or residents tackling the problem. Inevitably, it can harm the junior faculty’s career, diverting them from building their CV for promotion. Even more senior faculty often don’t receive needed resources. When residents get the assignment, they have even less dedicated time and their remedies tend to disappear when they graduate.

More work without compensation for already overworked faculty is yet another reason why racial bias goes unaddressed. When individuals understand that highlighting a transgression to unsympathetic administrators leads to additional responsibilities that rightly belong in the hands of the white administrators who are not only the purveyors of the racial bias but also have the wherewithal to address it, silence seems like a better choice.

African American faculty are often burdened with additional responsibilities for minorities trainees as well. They are frequently the one person who can provide comfort for residents and colleagues coping with daily microaggressions. They may be the only potential mentor for

minorities as well. They regularly are called upon to create social shelter for residents and their families outside departmental formal gatherings, a place to let one’s hair down. All this in addition to very busy clinical responsibilities that at least in Ob/Gyn require frequent 30-36 hour shifts in addition to teaching assignments.

But mentoring activities may impede their academic promotions as well as reinforce the inhospitable environment in which they work. Given the pay is far less than private practice, minority faculty often drop out before they can become tenured faculty. The process folds back on itself; fewer senior faculty to provide less mentoring to junior faculty who provide less mentoring to trainees. African Americans comprise only 1.6% of full professors compared with 27.5% of all white faculty and 2.1% of all associate professors. These figures must be seen in the context of the three of 143 medical schools that have majority Black student bodies and faculties, accounting for a significant share of these numbers.

Few white Americans would readily admit to believing in the inherent intellectual inferiority of African Americans. And yet, this stereotype echoes in claims by my residents that our patients were poor medical historians and couldn’t provide an accurate history of present illness. Our department began using a computerized prenatal record system called Theresa in the 1980s and residents were required to use Theresa in perinatal encounters, almost on pain of execution. On an often fast paced L&D, that led to a shortcut: ask the patient about her HPI, do the exam and finish the H&P from the computer. It left no room for a patient to correct an erroneous entry in the record.

An objective evaluation of the process betrays that it demeans women and takes away their agency. The circumstances that made that attitude possible were the fact that 90% of the patients were poor African Americans. This is a common complaint from Black women about the healthcare system; medical providers don't hear them. Their complaints go ignored to the detriment of their healthcare outcomes. If respiratory symptoms of millionaire tennis star Serena Williams, despite her history of pulmonary emboli, could be ignored postpartum, then what

chance does a mother on Medicaid have? Black mothers are literally dying because they are not being heard, accounting for their 3-5X higher maternal mortality rate than white mothers. There is a considerable body of evidence that supports this. These are the threads of implicit racial biases.

Medical providers generally want the best for their patients. Few medical providers consider themselves racists; that charge is one of their greatest fears. George Bush 43 has said that the most hurtful incident in his presidency occurred during the response to Hurricane Katrina when Kanye said that Bush hated Black people. That moment still haunts him today.

The majority of whites tend to define racism by its extremes. But assigning the concept of racism to the extremes of racial epithets and white supremacy ignores both the more subtle systemic influence of racial stereotypes and the systematic network of federal and state policies that continue to reinforce discrimination against people of color. In other words, the society is saturated with racism because the government supports it and people carry it around in their minds.

Even those who have emigrated here from other countries are infected with attitudes about racial groups inherited from European empires or the US. For example, India had its own caste system before the arrival of the British; individuals with dark skin were categorized as an “untouchable”, allowed only to perform the dirtiest jobs in society. While the caste system was outlawed in the 1950s, the stigma of the untouchable remains, being played out in class relationships within the country. Indian immigrants, a prominent minority in the healthcare system, tend to live in close knit communities with close ties with their homeland, often continuing to have arranged marriages with women living in India.

What role does implicit bias play in the interaction between races? Our brains employ automatic shortcuts that allow us to continuously assess our environment and respond. These integrated neuronal pathways are retained from hunter-gatherer days, meant to hone our response to danger or identify safe situations. Known as implicit biases and heuristics, a simple

process to find answers to difficult questions, they provide quick responses that may have suited prehistoric man but can lead astray those living in today's complicated environment. Their most important characteristic is that they are completely automatic and unconscious and therefore, almost unstoppable, but not quite.

Some examples of implicit biases include a superiority bias where we all believe we're above average. This is obviously impossible by normal distribution curves; there would be no average if everyone is above it. Others include confirmation bias, where we favor our own opinions and gravitate to those who confirm them and perseverance bias, the tendency to stick with an opinion once it's been made, even in the face of contradictory evidence. The overconfidence bias makes us overconfident in our abilities.

Daniel Kahneman (3) describes two organized systems of thought, System 1 (fast thinking) and System 2 (slow thinking) which is sometimes activated when there are apparent contradictions or gray areas. System 1 is automatic and unconscious while System 2, a more reasoned approach, acts as a guardian but can also sign off on fast thoughts, wrong or right. Fear, fatigue, anxiety and time pressure gravitate against System 2 intervention.

Both systems use an associative network of accessible memories, impressions, experiences and learning to dictate a response, commonly useful but not always appropriate. Through these processes, racial myths are integrated with personal experience.

A process known as priming can often steer implicit biases in one direction through word placement, specific phrases and even color. It turns out our brains are lazy and will substitute an easily answered question for a more difficult one. The advertising industry has mastered the manipulative potential of our automatic mental responses, as have politicians.

One example shows how priming can influence test performance. If students are told before a standardardized test that the tests are culturally biased against racial minorities, those students will get lower scores. Similarly, placing a checkbox for gender at the beginning of a

math test causes girls to underperform. In contrast, when proctor says that girls do well on this test, they perform above expectation.

Implicit biases permeate the medical encounter from before the patient enters a room through her follow-up. Implicit biases are operative in both the provider and patient. Patients who feel discrimination from their provider are less likely to follow medical advice or return for follow-up. There is ample evidence that African Americans experience worse healthcare outcomes across all socioeconomic statuses unlike their white counterparts.

The essence of the problem lies in an approach to a group rather than an individual. Whites see others like them as individuals *first* who are given an opportunity to reveal themselves over time. In contrast, nonwhite individuals automatically are part of a *group* first, filtered through implicit racial bias which instantaneously draws from recollected experiences, feelings, and stereotypes in less than a blink of an eye. Noone wants to believe that's true of themselves, but our brains work the way they work.

For instance, when I meet with people I've only spoken to on the phone, they are often surprised by my color because I don't sound like what's perceived as typically Black. Just recently, a home physical therapist told me bluntly that she was surprised I was Black, especially after first meeting my biracial daughter who looks white. None of it's intentional, it's just happened too many times to ignore. This is the magic of implicit bias.

The medical community has been slow to awaken to the negative impact of racial biases on healthcare outcomes of minorities, despite the 2003 IOM Report, *Separate but Equal* and even slower to act. Given the nature of a healthcare system composed of millions of independent entities with no enforcement levers, change happens slowly, primarily dependent on goodwill. When the choice is between goodwill and profit, there is only the latter; in fact, that's the principle of all business in a capitalist economy. In other words, there's no significant medical will within or outside the system to address implicit racial bias.

Of late, the presence of racial biases in medicine is receiving more attention. The fact that physicians believe that Black patients have higher pain thresholds and are more susceptible to addiction than whites has spared us from the opioid epidemic. Narcotics are often withheld or insufficiently dosed in Black patients from the ER to L&D. So too has been new attention to the complaint from Black women that providers don't listen to or ignore their complaints. Both stories have broken through to mainstream media coverage.

At the same time, some physicians have their own personal medical stereotypes. For instance, one surgeon taught his residents that Black skin is scientifically proven to be thicker than white. Is this 19th century pseudoscience or hypothesis driven scientific evidence? It was just something he'd heard as a resident from an attending which he happily passed onto generations of surgical residents who will pass it on to others.

One of my colleagues continued to resist the standardization of suture orders for cesareans designed to cut hospital costs. She insisted that undyed suture must be used to close tissue below the skin in white patients because otherwise, the suture would show through, while dyed suture was adequate for brown skinned patients. She boasted that she'd learned this years ago as a resident. However, the suture is often placed under as much as 6 inches of subcutaneous fat and even if it were millimeters below the surface, skin is not translucent and can't reveal the color of the dissolving suture below. From the perspective of implicit bias, an associative network of this physician's experiences allowed this mythology to defy her everyday observations since her residency.

Looking back on the Vanderbilt wards, the physician who wanted to give me that chart assumed the interaction had no racial dimension. In his mind, it just reflected the reality of the situation in which he worked. Notwithstanding few Black medical students and residents, I was more likely a clerk or housekeeper. Using his accumulated experience and situational assessment, I was an oddity that his System 1 answered with "clerk". However, if I had been white, despite the large number of white clerks, he would have followed the medical apparel

clues to identify me as a medical professional. In fact, there is a helpful litmus test to determine whether actions have a racial dimension; just ask "would I/they have done the same thing if the other person were white".

The case of the female surgeon illustrates how System 1 dominates System 2 when there is anxiety, unfamiliar surroundings and people. This family with stored associative racial stereotypes for both whites and Blacks expressed a completely irrational, deep seated racial blindness to the possibility that African Americans could be surgeons there.

It is no coincidence that the Black experience in medicine reflects our larger experience in society as a whole. How could it be otherwise? As a society, we have not yet acknowledged that racial stereotypes are the creation of the imagination of the country's foremost white thinkers throughout our history. Quite simply, white people made it all up. And then African Americans were tasked to disprove the fiction to white satisfaction, an unsolvable conundrum when whatever we say or do can be discounted because we've said it. Alexis Toqueville captures the dilemma succinctly in *Democracy in America* (1835)

> "[In] order to induce whites to abandon [their opinions of Black inferiority], the negro must change...But as long as this opinion exists, to change is impossible"

At the same time, when we become accomplished, we're seen as exceptions to the rule that can't be applied generally to African Americans. But when we steal, exactly as many white thieves do, every Black person is painted with a brush of criminality. When various African American spokespersons took up the burden of disproof, they got tangled up in acceptance of racist ideas, particularly in differentiating "low class Blacks" from achievers.

All of these instances of racial stereotyping illustrate one way in which medical education continues to support implicit racial bias within its ranks. Ignoring racism in day to day activities is the first pillar. This blindness confers a sense of normalcy and acceptance. So, the preceptor

who laughed at a racialized joke could continue to degrade his Black medical students. With no one to call him on it, why would he change?

Secondly, most physicians are unprepared to confront their own complicated feelings about race, let alone talk to others about them. They shy away from topics that are purely "non-medical." Their job is to heal the sick, not the society. When I began my training in the 80s, medical schools were actively recruiting minority students side by side with the accepting of overt racism. Consider the photos of blackface partygoers scattered across medical school yearbooks, Vanderbilt, Emory and Virginia governor Northam's Eastern Virginia.

Almost none of this information has penetrated the world of general obstetrics practice away from academic centers. Practicing Ob/Gyns tend to skip medical education that doesn't apply directly to clinical practice. In any case, many Ob/Gyns are loath to change their practice. Studies show that the majority of private practitioners still practice the medicine they learned during residency for 10 years after they finish. For many, it's much longer; the average length of clinical practice is four decades. This remains a huge obstacle to change.

Private practitioners make up a significant part of the clinical faculty who train medical residents. More residents train in community hospitals with private practitioners than train in academic centers. They also serve as adjunct faculty in academic centers. Consequently, with practitioners training newer trainees, information filters slowly into the educational space. Adjunct faculty often become counterweights to the more advanced concepts being taught. These private practitioners recruit new partners for their practices and those residents will inevitably adopt the practices of the senior partners. Implicit racial bias will continue to replicate and resonate for decades without intensive intervention.

Very few people in the system have any training in racial bias, not the faculty and not the students. Confronting racial bias also requires a significant amount of self-reflection, another skill that is underdeveloped in the medical community. To engage in that self-reflection means a difficult personal journey that must inevitably spill over into their lives outside the hospital.

Thirdly, minority students continue to remain stranded in hostile work environments created by not only superiors and colleagues, but also the patients. Failure to acknowledge means failure to confront. This simply reflects the problem in the culture as a whole. The idea that you're not racist because you don't support the KKK ignores the cultural saturation of racial stereotypes that reinforce white superiority and ignores the role of implicit bias. It's as automatic as breathing.

Because medicine is first and foremost a business, every practice, every hospital is scrambling to maintain every customer. No hospital wants to lose business by challenging the racial prejudices of patients and their families. But what happens on any individual team is managed by the physicians. Each carries their own bag of racial stereotypes, that they perhaps don't apply to their Black colleagues whom they consider "exceptional Negroes", but pop up with their Black patients who don't conform to their "white" standards, whether those patients are middle class with insurance or poor.

When we consider that resident at Vanderbilt, if he were playing the odds for my title at the time, the least likely thing I could have been was a medical student. In 1980, African Americans were 2.5% of Vanderbilt medical students and nationally, 5.6%. By the late '90s, Black enrollment was closer to 5 than to 10%. In 2016, enrollment was 7.7%. In 2018 the percentage increased over 1.5 times to reach 13%, equivalent to African Americans in the general population. In comparison, between 1980 and 2016, Asian student enrollment increased 5 fold, jumping from 4% to 21%.

Stereotype threat, subjective evaluations, the halo effect and priming may contribute to lower graduation rates for minority medical students. Data show that African American students have substantially lower graduation rates than their white counterparts. Between 1987-1995, an average of 7% of Black students left medical school for academic reasons, compared with <1% of whites. During the same period, about 60% of Black medical students graduated in 4 years, 85% finishing by year. Comparable figures are 85% and 90% respectively for white students.

However, more alarming figures come from the class of 2003, only 1120 of 5166 enrolled first year Black students graduated in 4 years (2007), a dismal 21%. AAMC appears reluctant to reveal racial statistics having shifted to more data analysis by gender rather than race.

Implicit bias in evaluations may impact minority job placement. Black residents receive fewer job offers from more lucrative practices in part because of the racial bias inherent in the demographics of their patients, but evaluations may also play a role. Minorities may be left out of those favored by program directors who make recommendations to former trainees looking for new partners. Those less favored may have to resort to physician recruiting agencies.

Medical education has begun to pay more attention to issues of race outside of the perennial problem of recruiting minority students and faculty but it’s structured to maintain the status quo. A few institutions have begun their own initiatives. But the organizations that dictate standards, the AAMC and the Accreditation Council for Graduate Medical Education which dictates graduate medical education have virtually ignored implicit racial bias. In the latest ACGME revamping of resident education begun in 2012, there is no mention of implicit racial bias or racial disparities in any of their evaluation templates nor is any attention being paid to research in these areas. See no evil, hear no evil.

Some professional subspecialty organizations have at least called attention to racial disparities in healthcare outcomes if not the role of implicit racial bias. The American Congress of Obstetricians and Gynecologists has paid lip-service to addressing racial disparities. They’ve produced documents with politically correct but empty words, powerless to change an ugly truth.

To become a physician, African Americans must traverse a gauntlet of hostile forces, dodging showers of peebles, basketball sized rocks and good sized boulders. Black trainees must expend a considerable amount of emotional and physical energy to maintain a professional demeanor while finding a way not to succumb to the message “you don’t belong”. They must remain vigilant against random microaggressions from superiors, colleagues, staff

and patients. For each encounter, they must calculate how to react, to report or not and to whom.

They face different standards for academic performance, appearance and behavior. These standards enforce societal norms that denigrate behaviors that are deemed “abnormal”. These standards are reinforced by a rigid medical hierarchy that attempts to chisel Black physicians into dark skinned versions of themselves, using poor evaluations and absence of promotion to exact compliance.

These trainees are high achievers, part of a select group of the academically excellent who have worked hard for the opportunity to take care of the sick. And yet, they face frequent indignities of being identified as lower level ancillary personnel, no matter how long they work or their medical competence. They’re often confused with other Black colleagues, no matter how different their physical appearance. If it’s not their superiors or colleagues, it’s the patients. For most of them, their colleagues are a source of the problem, not support.

The medical establishment has reacted to these revelations like a bear sleepily opening its eyes after hibernation. Instead of leaving the den in search of food it rolled over and decided it's too soon to wake. There has been nominal lip service to disseminating the message throughout the system and high minded statements, what one expects from the white men who control medicine.

There are many who are happy to pass the buck of racial equity to the next generation, believing that it will be bleached away as darker skins are lightened through the reproduction of increasing numbers of interracial couples. Wishful and lazy; tonal variation in skin color will always exist. Racism and implicit racial bias will not disappear until white people get angry enough to destroy it. It is up to those who created it to tear it down. They must find the solutions to reverse implicit racial bias which means that they must invest in the research to create them.

Still, there is room for individual institutional baby steps toward improvement that will enhance the lives of minority trainees, faculty, clinicians, staff and their patients. Change will improve the lives of everyone at those institutions.

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(1) "Bias in Obstetrician-Gynecologists' Workplaces" , a clinical commentary piece in Obstetrics & Gynecology, 2019 which details resident stories.

(2) Similar incidents were reported in Minority Resident Physicians' Views on the Role of Race/Ethnicity in Their Training Experiences in the Workplace. *JAMA Network Open.* 2018;1(5):e182723. doi:10.1001/jamanetworkopen.2018.2723 which confirm widespread misidentification for nonmedical staff by colleagues, families, patients and staff as well as describe being treated as "exotic", from hair texture to questions about "true" ethnic origin.

(3) Thinking, Fast and Slow by Daniel Kahneman. Farrar, Straus and Giroux, 2011