PHYSICIAN LEADERSHIP: RACIAL DISPARITIES AND RACISM. WHERE DO WE GO FROM HERE?
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(COMMENTARY; AUGUST 2020)

Political diatribe paints a huge swath

I read the above referenced article with equal measure of angst and offense, amazement and incredulity, irritation and, some would say, typical white male denial. The authors have succumbed to the zeitgeist currently enveloping our country and painted us all with one huge swath of the same proverbial brush—inappropriately.

No doubt certain reforms are needed in our society and perhaps within areas of medicine. I am for anything that improves all peoples' lives and health. The country is rightfully clamoring for equality. That means equality for all, however. But by way of one small example of systemic overreaction, many articles now are replete with comments about "Black people and Brown people and white people." Adjectives have been turned into proper nouns, but applied only to some groups, not all. That foments continued inequity, not equality.

The authors implore us to strive for "engaged, passionate, and innovative leadership deliberately aimed toward antiracism and equity." In my view, the best way I can do that is not by words but actions, and that is to do what I am trained to do, which is take care of patients the best I can regardless of their color or creed. I have always done that, and everyone I work with does as well. For the authors to imply I (we) don't is at a minimum offensive and pejorative, and flat wrong.

I agree to a certain extent that our health care contributes to poor, or at least less desirable, outcomes. But so do the actions or inactions of our patients. I do not agree that it is a racial issue. It affects all people. I see it every day. I am probably in the minority of physicians who think we should go to a single-payor system (note I did not say free). But to state that the system creates poor outcomes only for "Blacks, Indigenous, and Latinx," I disagree. Tennessee has TennCare (Medicaid) and almost anyone can get it, and if they are pregnant they certainly can. Access is not an issue. All people have to do is avail themselves of it. It does not matter the race!

The authors call for the implementation "of system-wide intersectional and antiracist practices" to address "racism, sexism, gender discrimination, economic and social injustice." They are preaching to the wrong crowd. If I (we) pursued all these lofty goals, I (we) would not have time to care for the very patients they are now lamenting don't have enough care or proper care.

I facilitate conversations on a regular basis with my black patients as well as my white patients. I recently asked a patient if she distrusted me because I am a white male. It is enlightening to hear patient comments, which are mostly along the lines of "the world has gone crazy." That is a polite interpretation of their comments. Maybe they say what they think I want to hear, but I don't think so.

"Repair what we have broken…" by "uplifting their voices and redistributing our power to them." I don't see how I (we) have broken anything. If taking care of all comers as best as one can has broken something, then I am guilty. Regarding that I need to examine how "we have eroded the trust of the very communities we care for" and that we are guilty of "medical experimentation on and exploitation of Black and Brown bodies," what are we to examine? How have I (we) eroded the trust? Present-day physicians had nothing to do with things like the Tuskegee Institute experiment, and I hardly see how blaming us today for that abominable episode in our HISTORY is a valid point. Implying that we add to that distrust by not giving the same pain relief to certain people because of race is just preposterous. Further, asking to let others lead, for example, on the medical executive committee or in positions such as chief of service or chief of staff usually are not something one "gets" to be, but something one usually is "talked into." There is not a racial barrier to those roles, at least at my institution, and once

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again the brush has inappropriately painted us all.

I understand the general gestalt of this article and agree with its basic premises. But while well meaning, this political diatribe belongs in the halls of Congress, not in the halls of our hospitals or the pages of a medical journal. I am tired of being told, directly or indirectly, that I am a racist by TV news, newspapers, social media, professional sports teams, and now by my medical journals. I would ask the authors to be careful who they throw under the bus.

Scott Peters, MD
Oak Ridge, Tennessee

Drs. Mengesha, Arora, and Levy respond

We appreciate the opportunity to respond to Dr. Peters. Our article brings long overdue awareness to systemic and structural problems that result in disproportionately inequitable outcomes for people of color. We are not debating the morality of individuals or talking about racism as an inherently "bad" trait that some people have, but rather recognizing the impact of social structures on health and well-being in which we all—Black, Brown, and White—live. We all have inherent biases, recognized or unrecognized, that impact our actions, decisions, and behaviors. We are humans with upbringing, backgrounds, and learned frameworks influenced by our sociocultural context that conditions our responses to a given situation. This is also woven into our hospitals, exam rooms, and even our medical journals. It constantly influences the health, well-being, and livelihood of patients—nothing that we do in medicine is in isolation of this greater context. Our health care system is steeped in this sociocultural context and impacts all patients in intersecting ways, whether that be by race, class, gender, or other social identities. And while we did not create the system in which we operate, we now have abundant evidence that shows it continually delivers inequitable outcomes particularly for people of color.

We are very clear that physicians and health care professionals strive to provide the very best care for each and every patient. We do not discount the hard work and good intentions of our colleagues. And while some individual patient behaviors may somewhat modify outcomes, we also strongly disagree with the premise that patients are to blame for poor or less desirable outcomes they face. Instead, our position is focused on the impact that the systems we work in are creating barriers to equitable care at levels of influence above a single individual, and that it is our collective professional responsibility to acknowledge and take action to lessen those barriers.

System-wide changes would not be at the expense of patient care, and physicians cannot and in fact should not shoulder these changes alone. Our current paradigm of training does not give us the capacity to do so, and a single individual cannot make such a large system change alone. The change we are advocating for requires collaboration within multidisciplinary and interprofessional teams, long-term planning, and incremental but intentional change. This is not dissimilar to the recognition over 20 years ago by the Institute of Medicine (now the National Academy of Medicine) that "to err is human." Our eyes were opened to the structural issues resulting in medical errors, and very slowly our profession has acknowledged the necessity to recognize, report, and analyze the root causes of those errors. We do so because it is critically important to ensure that the same error never happens again. It is part of the commitment to honor our oath to "do no harm." Similarly, racial inequities in health outcomes should also be "never events" as there is no biological basis or individual blame for these inequities, but rather systemic and structural processes (which is de facto racism) that contribute to disproportionately worse outcomes.

Disparities in COVID-19 vaccination rates for people of color is a current example that illustrates the deep distrust in our health care system that historical events, like Tuskegee, have created. In Tennessee, for example, 7% of COVID-19 vaccines have been administered to Black people despite the fact that they make up 15% of cases, 18% of deaths, and 16% of the total population.[1] *There are other ongoing systemic issues, including inequities in distribution, prioritization, and access, that are contributing to the lower vaccination rates among people of color; however, as physicians and advocates for our patients, it is crucial for us to acknowledge the fear of, and resistance to, government-sponsored health programs which has resulted from events like Tuskegee.*

We are advocating for building our systems to help support all of the social and societal determinants of health our patients are faced with, including racism, while they are receiving care from us. Patients are faced with undue morbidity and mortality because of our health care system's ineffectiveness in incorporating this as a part of systemic care delivery to all. We must work together alongside other health care professionals, public health and policy agencies, and community advocates to stop this deadly cycle. There will be no improvement and no end in sight unless we work together toward this common goal.

Reference

1. Ndugga N, Pham O, Hill L, et al. Latest data on COVID-19 vaccinations: race/ethnicity. Kaiser Family Foundation website. February 1, 2021. https://www.kff.org/coronavirus-covid-19/issue-brief/latest-data-covid-19-vaccinations-cases-deaths-race-ethnicity/. Accessed February 11, 2021.