

A PIECE OF MY MIND

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Eradicating Racial Injustice in Medicine—If Not Now, When?

As a child of the early 1980s, growing up in Baltimore, I would often stare at the speckled ceiling of the room my siblings and I shared and wondered why my family had to deal with basic struggles like obtaining food and keeping the heat on, at times warming the house with the oven. During my teenage years, I often questioned why people who grew up in urban America had similar problems, while these issues seemed nonexistent in more affluent areas. When I became an adult interested in pursuing medicine, I volunteered at several health fairs and realized quickly that many of the patients were from communities similar to mine; not infrequently, people I met had not received medical care in years, sometimes decades. These experiences, and others like them, revealed that the issues I would wonder about while staring at the ceiling were only a small portion of the concerns that communities like mine face daily.

During medical school, I was one of 5 African Americans in a class of 120 students. I listened with great discomfort and despair to countless lectures describing the health conditions that disproportionately harm African Americans. In none of these lectures, however, did any instructor explain or acknowledge what I had observed for many years—that access to care is a primary factor behind these disturbing statistics.

Racism in medicine exists, and bold and decisive actions are needed to solve this problem

One moment continues to resonate: As I sat in my usual seat at the back of the lecture hall, a urologist told the class that African American men are more likely to die from prostate cancer than their White counterparts. Once again, I experienced a sense of despair, and I wanted to crawl into a corner and disappear. When I asked after class about the role of access to care in driving this disparity, the professor's response was clear and emphatic, "No, it's the tumor biology." Sadly, only recently has the notion of "cancer justice" emerged.¹

As a current fellow in urologic oncology, this statement continues to echo in my mind. Innumerable studies have convincingly demonstrated that biology alone does not explain the differences in prevalence and outcomes seen among African Americans—in fact, far from it. More recently, health disparities have been thrust into the national spotlight again, as coronavirus disease 2019 (COVID-19)-related mortalities are unacceptably higher in communities of color.² At the same time, many are now seeing and hopefully gaining broader awareness of the disproportionate impact of police brutality on African Americans. This is yet another form of health disparity. Together, these should serve as

a catalyst to review why these pervasive inequalities exist and how to eliminate them.

How do physicians and the medical community accomplish this goal? An important framework for making substantive change that eradicates disparities in health outcomes for African Americans has been described by psychologist Noel Burch.³ Burch identifies 4 stages of adult learning that allows one to transition from ignorance to mastery. These 4 stages are (1) unconscious incompetence, (2) conscious incompetence, (3) conscious competence, and (4) unconscious competence.

I believe that—like the urology professor in my medical school—before this year many within the medical community remained unaware of the impact both racism and race have on health disparities. In Burch's framework, these individuals were in the first stage of unconscious incompetence.

Given the collective awareness and outrage created by the disproportionate impact of the COVID-19 pandemic and police brutality on the African American community, I am convinced that many in the US are transitioning to the second stage of conscious incompetence, as many recognize the problems. This is evident in the weeks of continuous protesting and dialogues around commitments to change. However, protest alone will not provide solutions to the broader issues facing our nation and profession. At this moment in history, we physicians must purposely lead the transition to becoming consciously competent. Racism in medicine exists, and bold and decisive actions are needed to solve this problem.

Based in part on my personal experiences as a Black man from a disadvantaged background who has become a surgeon and fellow in urologic oncology, I propose the following next steps.

Review and Understand the History of Race and Racism Within This Country

Similar to the practice of medicine, to cure or treat a medical condition, we must first understand the etiology and pathophysiology of the condition. The history of race and racism in this country is no different. We need to review the history of racism and its incorporation in medicine. Although the evidence to support this step must still be established, it is hard to argue that a better and broader understanding among the medical community of the history of race and racism in this country would not have a positive impact on explicitly recognizing and eliminating disparities.

Mandate Antiracism Training

I am a dark-skinned Black man with a bald head and beard. A former football player, I stand approximately 6 feet 1 inch and weigh more than 230 pounds. Based on my physical

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appearance, I realize, to many people, I may look more like a linebacker than a surgeon. However, despite my physical appearance, I am not less intelligent or more likely to commit violent acts. Although it is hoped that implicit bias training allows an individual to recognize they may have such thoughts and possibly modify their initial reaction, I believe that implicit bias is only a small part of the problem. Antiracism training is necessary to broaden the scope of this work by identifying perceptions and recognizing how racism is incorporated into our institutions. This knowledge may lead to systemic changes in medical institutions, to improve not only policies but also the practice of medicine by increasing cultural competence and erasing preconceived notions of racial and ethnic minorities.

The impact antiracism training has on reducing health disparities is unknown. However, data from the Institute of Medicine demonstrate that, after controlling for access to care factors, racial and ethnic minorities receive lower quality of care and experience worse outcomes.⁴ This provides evidence that, in addition to unequal access, the historical perpetuation of racism in medicine further promotes and sustains the existence of health disparities.

Dissect the Incorporation of Race in Medical Practice

All too often, race is identified as a risk factor for health outcomes without a solid biological rationale.⁵ In fact, when I learned how to present a history and physical to an attending physician in medical school, I was taught that my first line should always include the patient's age, sex, and race. But why race? Currently, in medicine, we often accept that a patient's race automatically means they are more likely to have certain health conditions, without any biological basis.

This is evident from widely used clinical algorithms and risk calculators that incorporate race without providing biological evidence and without further identifying and addressing the systemic issues that perpetuate these differences in health outcomes, including, among other factors, differential impacts of food deserts and toxin exposure (eg, Flint water crisis). An example of a successful effort in this area is the nationally publicized initiative to remove race from the vaginal birth after cesarean risk calculator. The impact of this promising work will become more apparent in coming years; however, we can no longer accept the blind incorporation of race into our practice.

Develop Longitudinal Pipelines Nationwide

Many prestigious university hospitals are located in cities, such as my hometown of Baltimore, with the most pronounced health dis-

parities. Not uncommonly, the demographic makeup of the faculty and staff employed by these institutions is starkly different from the demographic composition of the cities where they are located. No longer can we accept our leading medical institutions having limited involvement in the surrounding communities.

It is time for a renewed commitment to diversify the medical field. Despite the efforts of many, and various programs, sadly, the rate of Black men entering medical school has decreased since the 1970s.⁶ Asking hospitals or specific specialties to diversify without increasing the number of Black men and women will not be helpful. Creative and more effective programs must be developed.

Implement Widespread Culturally Aware Mentorship Training

Led by Dr Byars-Winston, the National Research Mentoring Networks⁷ has developed a training initiative. This training starts with both mentors and mentees, reflecting on their identities and then using the thoughts from this reflection to examine their biases toward people from other cultural identities. By discussing these issues among a diverse group of people, it is hoped that individuals are better equipped to handle matters of cultural diversity. Although there is little evidence that programs like this are effective, they are low tech, low cost, and potentially high yield and should be incorporated into institutions of higher learning. Culturally aware mentorship maybe another method to improve diversity in medicine. Increasing the cultural awareness of those in the position to mentor younger physicians, trainees, and students allows mentors to discuss many of the challenges minorities face that discourage many from pursuing certain residency, fellowships, or grant applications.

Although this list is not all-inclusive, it does outline actionable steps to facilitate the necessary advancement of the medical community into conscious competence. Without these steps, I fear that the profession of medicine will continue our current reality of pervasive and inequitable racial disparities in health outcomes. Physicians and thought leaders can no longer tolerate unconscious or even conscious incompetence in health care or society.

Ultimately, the medical community is uniquely positioned to provide leadership during these troubling times, leaving this world in a better place for the next generation. A world that fully embraces the talents of those children currently staring at their ceiling, wondering what the future of this country holds. I ask you if now is not the time to make this transition, then when?

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