

A Piece of My Mind|May 19, 2015

A Silent Curriculum

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During my medical training thus far, Trayvon Martin lost his life, Michael Brown was left to die in the streets of Ferguson, Missouri, and Eric Garner was choked by officers as he repeated 11 times that he could not breathe. But these events were rarely mentioned in the lecture hall, my small-group sessions, or morning rounds. Was I supposed to ignore their implications for the lives of my patients, and for my role as their caregiver?

It wasn't that I didn't receive any education on race. In fact, there have been many well-intentioned curricular attempts to understand the intersections between race and medicine. Since first year, I've been inundated with lecture PowerPoint slides that list diseases with higher rates among minorities. But few of them delved into an explanation as to *why* these disparities exist. Many electives boasted discussions of health inequalities between communities, but rarely did we discuss how skin color played a role. And in doctoring small groups, we avidly discussed the association between poor health outcomes and poverty, but less enthusiastically talked about why standards of care are still not met for black patients with chest pain. As soon as racism was mentioned, conversations fizzled, highlighting the palpable discomfort in the room.

These attempts to address race may be reflective of a community eager to understand these issues. However, they did not adequately predict or acknowledge the conflicting lessons I would learn as my education continued.

In the classroom, I learned that culture may be an explanation for higher rates of sexually transmitted diseases and type 2 diabetes among patients of color. In textbooks, I saw what psoriasis and drug-related rashes look like on white skin, but what syphilis looks like on black skin. While practicing the medical interview, I was told that Latinos may say yes to all review of system complaints and that *cultural competence* meant minimizing some of their concerns. While studying for boards, I learned that the race of the patient was often a hint to his or her disease.

When I arrived in the hospital, I learned to insert my patient's race in the opening of my oral presentations, as though it has as much impact on the medical details to follow as their sex or age. I learned that among two patients in pain waiting in an emergency department examination room, the white one is more likely to get medications, and the black one is more likely to be discharged with a note documenting narcotic-seeking behavior. I watched a young white teenager receive extended opiates for a post-lumbar puncture headache because she *looked like a good kid*, yet witnessed scrub nurses make fun of a Latino gunshot survivor for crying out in pain. On another occasion, an attending explained that *some cultures* have lower thresholds for pain.

I learned to blame miscommunications and poor adherence on the patient, rather than any language barrier. I learned it was acceptable to deliver the diagnosis of terminal cancer in broken Spanish and to use a 13-year-old girl to translate the details of her intubated father's care. I was told that I wouldn't learn anything new by continuing to follow a black woman fighting drug addiction and struggling to adhere to her medications, since I wouldn't change her behavior.

I learned that white women are allowed to refuse my involvement at the birth of their child, while poor immigrants are given less space to turn me down. I learned I am more likely to be asked by a resident or attending to try a new procedure when there is a language barrier or a power dynamic that will prevent a family from understanding, refusing, or complaining.

These lessons came from physicians, nurses, classmates— many of whom I admire and call my mentors. Some

lessons came when I made my own discriminatory statements and no one challenged them. Others came when I allowed myself to participate in the unconsented care of patients and prioritized my learning, evaluations, and reputation over my values.

These lessons have been collected alongside the differential for chest pain, the algorithms for acid-base disorders, and the treatment for pneumonia. They have informed my own clinical decisions and interactions with my superiors. And I grow increasingly concerned that they are more likely to influence my future practice than the work I do to examine my prejudice and understand racialized health disparities.

I entered medicine believing that physicians are in an ideal position to understand the roots of health inequalities. We have access to the intimate details of our patients' lives and struggles. We have unique opportunities to see how deteriorating schools, mass incarceration, and geographic segregation place people in situations that gravely impact their health. But instead I've learned that stereotypes and blame permeate our practice as widely as the news on our televisions, influencing our diagnosis and compromising our care.

I must mention that I am white. I know that my words are less likely to be disregarded and labeled as angry, that I may be more likely to receive praise for my observations than words of doubt. I have watched my peers experience racism as trainees of color and know my privilege is as powerful as my stethoscope.

I doubt that these experiences are unique to the hospitals or the medical school at which I have thus far trained. I expect that they pervade health care systems throughout the country. I give credit to my medical school for teaching me to be critical of the culture of medicine, apply interdisciplinary perspectives to clinical quandaries, and reflect on my experiences. I acknowledge that caregivers work in extreme conditions—with unrelenting obligations and stress—and that decline of empathy may have played a role in many of the stories I have told

But regardless of intent, the message I got was clear. I've learned to minimize the pain, forgo the consent, blame the behaviors, and dismiss the concerns of my patients of color. I've witnessed missed opportunities for healing and the loss of patient trust. And I believe that if we refuse to deeply examine and challenge how racism and implicit bias affect our clinical practice, we will continue to contribute to health inequalities in a way that will remain unaddressed in our curriculum and unchallenged by future generations of physicians.

ARTICLE INFORMATION

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