HHS Public Access

Author manuscript

JAMA. Author manuscript; available in PMC 2020 December 10.

Published in final edited form as:

JAMA. 2019 December 10; 322(22): 2173–2174. doi:10.1001/jama.2019.19326.

Hiding in Plain Sight

Oluwadamilola “Lola” M. Fayanju, MD, MA, MPHS

Duke University, Durham, North Carolina;

Department of Surgery, Durham VA Medical Center, Durham, North Carolina.

I have a superpower. I can become invisible. But I can’t usually control when and where I do.

Sometimes it’s on a plane, when the flight attendant fails to offer me a snack or a beverage even though my tray is down, and my eyes are seeking hers.

Sometimes it’s in a meeting, when my hand is over-looked while others are called upon to speak, my arm lingering and eventually dropping, having wilted from neglect.

Sometimes it’s on a bus or a train, as I’m squeezed from both sides by legs and elbows that transgress the boundaries of my seat.

But there is one place where I can and do wield my invisibility, using it as both a cloak and a lens: in the hall-ways of the hospital where I work.

I am a relatively petite and youthful appearing, black woman surgeon. New patients are regularly surprised when I introduce myself to them as their surgical oncologist. I would like to think that the counseling and information I provide during these initial consultations–in addition to my long white coat, my name badge, my educational pedigree, and my Press Gainey reviews–go a long way toward assuaging any initial concerns. And indeed, most of my new-patient consults end with a hug, a rare moment of patient-clinician connection in an increasingly bureaucratic system. Nevertheless, I have still had the experience of walking up to one of my patients–status postclinic visit, status posthug–on the day of surgery in my scrubs and operating room hat and having her ask me if I am there to wheel her to surgery and when I think her surgeon might arrive. In those moments, I’m not entirely invisible, but I’m certainly not the surgeon she expects to see.

But in the halls of my hospital, on the dedicated research days when I dare to wear jeans, boots, and a fleece, when I can masquerade as anything but a doctor as I make my way to my office for a day of writing, I can truly hide in plain sight.

Corresponding Author: Oluwadamilola “Lola” Fayanju, MD, MA, MPHS, Department of Surgery, Duke University School of Medicine, DUMC 3513, Durham, NC 27710 (lola.fayanju@duke.edu).

Section Editor: Preeti Malani, MD, MSJ, Associate Editor.

Conflict of Interest Disclosures: Dr Fayanju is supported by grant 1K08CA241390 from the National Institutes of Health (NIH) (principal investigator, Fayanju) and by grant P30CA014236 from the NIH to the Duke Cancer Institute (principal investigator, Kastan).

Author Manuscript

Author Manuscript

Author Manuscript

Author Manuscript

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

So I do. And I watch.

I watch the way no one makes space for me in the hall and contrast it with the small but impregnable berth my white coat typically provides. I watch the way that students and residents continue their beelines in my direction, assuming I will be the one who swerves when the time comes. I watch the way security guards try to hustle me along if they perceive me to be in the way of a patient they are escorting. I watch the custodian continue to mop as I walk by, even as he stopped mopping for the young male surgical resident who had just walked in front of me.

But the people I watch most closely when I'm invisible are the other black women in the hall.

I watch them cede right of way to those walking toward them. I watch them make change in the gift shop in order to have the exact bus fare for their long, winding, multistop rides home. I watch them corral small children through maze-like, light-filled halls lined with floor-to-ceiling windows and expensive art-work, keeping them in line, fearful that others will interpret their rambunctiousness as a sign of a dangerous nature or substandard upbringing. I observe that they do with their children what I do with mine: view them through the eyes of people who might judge their brown bodies and pray that the children give onlookers no reason to judge.

One can learn a lot by watching. As a breast surgeon and researcher who studies health care disparities, I work to identify the risk factors, fixed and modifiable, that contribute to the potentially avoidable health inequities still observed in the women I watch.

Breast cancer is the most common malignancy in women in the United States, with approximately 270 000 cases of invasive disease and an additional 60 000 cases of non-invasive disease diagnosed every year.[1] One in 8 US women will be diagnosed with the disease in her lifetime, and every year, more than 40 000 US women will die. Although rates of breast cancer–related death have declined in the United States over the past 30 years, substantial disparities in breast cancer treatment and outcomes persist across multiple demographic dimensions.[2] For example, although white women are more likely to be diagnosed with breast cancer, black women are 20% to 30% more likely to die of their disease,[3] and a 2016 report revealed that this racial gap in survival is widening.[4]

Health disparities are broadly defined as observed intergroup differences in health outcome that are rooted in inequity and are, at some level, avoidable.[5] In breast cancer research, studies have mainly focused on identifying disparities among groups largely defined by static characteristics such as race/ethnicity, socioeconomic status, or geographic location.

But there is increasing evidence that observed disparities in breast cancer treatment and outcomes are not fully explained by immutable biological or sociodemographic factors.[6] Although the aggressive triple-negative variant of breast cancer is more common in black women, current racial disparities in breast cancer mortality are largely driven by survival differences among women with the less aggressive, hormone receptor–positive tumors commonly seen in women of all races.[3] Biology alone does not explain why black women

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

disproportionately die of breast cancer. Indeed, the focus of my work is identifying the modifiable characteristics, not only of patients (eg, lacking a primary care physician) but also of systems (eg, states that opted out of Medicaid expansion) and clinicians (eg, implicit bias in shared decision-making), that also drive outcomes and for which interventions can potentially be developed.

The forces that shape the lives of the women I watch–the women I closely resemble when I remove my white coat–will also shape their health and can drive the disparate outcomes they experience compared with their white counterparts.

When I'm invisible at work, I can observe patients within a health care setting but outside the role I typically play in clinical contexts. I can see how they are buffeted and battered in small but cumulative ways throughout the day and, indeed, throughout their lives.

My episodes of invisibility inform the work I do as a researcher and the care I provide as a surgeon. These episodes force me to see the world from the perspective of those who often feel invisible. And they remind me that for every patient I meet, I must learn about the person she was before she came into my office and find out about the life she will return to when she leaves.

I am grateful for these opportunities to hide in plain sight. They keep my eyes open to the challenges in health care that many people face every day and that, on reflection, seem obvious. How do you make it to an 8 AM clinic appointment when you have to take a 1-hour bus ride across town with 3 young kids in tow? What choice are you left with if your bus home leaves once an hour and you haven't yet seen the oncologist, but you need to get back in time to meet your children when they get off the school bus? How can you afford a $75 co-pay when even finding bus fare can be a challenge?

All too often, our patients, their challenges, and the ways we could support them are also hiding in plain sight.

References

1. Siegel RL, Miller KD, Jemal A. Cancer statistics, 2019. CA Cancer J Clin. 2019;69(1):7–34. doi:10.3322/caac.21551 [PubMed: 30620402]
2. DeSantis CE, Ma J, Goding Sauer A, Newman LA, Jemal A. Breast cancer statistics, 2017, racial disparity in mortality by state. CA Cancer J Clin. 2017;67(6):439–448. doi:10.3322/caac.21412 [PubMed: 28972651]
3. Warner ET, Tamimi RM, Hughes ME, et al. Racial and ethnic differences in breast cancer survival: mediating effect of tumor characteristics and sociodemographic and treatment factors. J Clin Oncol. 2015;33(20):2254–2261. doi:10.1200/JCO.2014.57.1349 [PubMed: 25964252]
4. DeSantis CE, Siegel RL, Sauer AG, et al. Cancer statistics for African Americans, 2016: progress and opportunities in reducing racial disparities. CA Cancer J Clin. 2016;66(4):290–308. doi:10.3322/caac.21340 [PubMed: 26910411]
5. Hebert PL, Sisk JE, Howell EA. When does a difference become a disparity? conceptualizing racial and ethnic disparities in health. Health Aff (Millwood). 2008;27(2):374–382. doi:10.1377/hlthaff.27.2.374 [PubMed: 18332492]
6. Tamimi RM, Spiegelman D, Smith-Warner SA, et al. Population attributable risk of modifiable and nonmodifiable breast cancer risk factors in postmenopausal breast cancer. Am J Epidemiol. 2016;184(12):884–893. doi:10.1093/aje/kww145 [PubMed: 27923781]