Published in final edited form as:

JAMA. 2020 August 04; 324(5): 451–452. doi:10.1001/jama.2020.12432.

Eradicating Racial Injustice in Medicine: If not now, then when?

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Keywords

racism; racial injustice; health disparities; health outcomes; bias

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

In medical school, I was one of five African Americans in a class of 120. I listened with great discomfort and despair to countless lectures describing all of the diseases that disproportionately harm African Americans. In none of these lectures, however, did any instructor explain or acknowledge what I had observed for so many years - that access to care is a primary factor behind these brutal statistics.

One moment continues to resonate: As I sat in my usual seat at the back of the lecture hall, a urologist taught our class that African American men are more likely to die from prostate cancer. 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."

Now as a fellow in Urologic Oncology, this statement continues to echo in my mind. Innumerable studies have now convincingly demonstrated that biology alone does not explain the differences in prevalence and outcomes seen in African Americans—in fact, far from it. More recently, health disparities have been thrust into the national spotlight again, as COVID-19-related mortalities have been unfathomably higher in communities of color. At the same time, we are now seeing broader awareness of the disproportionate impact of police brutality on African Americans. This is yet another form of health disparity. Together, these

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

How do we accomplish this goal? An important framework for how we can work to make real change that eradicates disparities in health outcomes for African Americans has been described by psychologist Noel Burch.[1] Burch identifies four stages of adult learning that allow one to transition from ignorance to mastery. These four stages are as follows:

1. Unconscious incompetence
2. Conscious incompetence
3. Conscious competence
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 pandemic and police brutality on the African-American community, I'm convinced that we are transitioning to the second stage of conscious incompetence, as the majority of Americans 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 us as a nation and profession. Now that we find ourselves at this place in history, we must purposely transition to becoming consciously competent. We know the problem exists, and we must now take action to solve it.

Based on my 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:

1. 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 in medicine and explicitly identify the many causes of both historical and current disparities.

2. Mandate Anti-racism training.

   I am a dark skin Black man with a bald head and beard. As a former football player, I stand approximately six foot one and over two-hundred and thirty pounds. Based on my physical 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 implicit bias training allows an individual to recognize that they may have such thoughts, and possibly modify their initial reaction, I believe that implicit bias is only a small part of the problem. Anti-racism training is necessary to broaden the scope

of this work by identifying our perceptions and recognizing how racism is incorporated into our institutions. This knowledge allows us to make systemic changes in our medical institutions, not only to improve policies, but also our practice of medicine by increasing cultural competence and erasing preconceived notions of racial and ethnic minorities.

3. 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. 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 diseases, 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 (e.g., 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 section (VBAC) risk calculator. We can no longer accept the blind incorporation of race into our practice. Failure to identify these factors will ultimately propagate existing disparities.

4. Develop longitudinal pipelines nationwide.

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

By establishing longitudinal pipelines that start at the elementary school level, the students of the inner cities will receive additional education in the fields of Science, Technology, Engineering, and Math (STEM). Furthermore, this exposure will help increase diversity in STEM-related careers, including medicine. This is an actionable step that many healthcare professionals can take that will have a significant impact on our field's future. Diversifying the medical field is yet another way to address many of the present health disparities. Increased diversity not only provides more physicians comfortable treating various minorities but also increases patient trust and satisfaction.

5. Implement widespread culturally aware mentorship training.

Led by Dr. Byars-Winston, the National Research Mentoring Networks[2] 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 own biases toward people from other cultural

identities. By discussing these issues amongst a diverse group of people, individuals are better equipped to handle matters of cultural diversity. This training initiative or others like it should be incorporated into all of our institutions of higher learning. Culturally aware mentorship is another method to help 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 and/or grants.

While this list is not all-inclusive, it does outline actionable next steps to facilitate the necessary advancement of the field of healthcare into, conscious competence. Without these steps, I fear that we will continue our current reality of pervasive and inequitable racial disparities in health outcomes. We can no longer tolerate unconscious—or even conscious incompetence in health care or society.

Ultimately, we all can agree that we seek to leave 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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