Published in final edited form as:

Lancet. 2021 October 16; 398(10309): 1398–1399. doi:10.1016/S0140-6736(21)02217-0.

Superhuman, but never enough: Black women in medicine

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Historically, Black women have long been disregarded in the USA. The Three-Fifths Compromise of the US Constitution discounted Black women as only “part” of a human being, to be counted for congressional representation and direct taxation but nothing more. Even in prominent social justice movements, Black women have been excluded. Racism and elitism were embedded within the 19th-century and early 20th-century US women’s suffrage movement, which prioritised white women over voting rights for all women. In 1913, the historically Black sorority Delta Sigma Theta marched in the Women’s Suffrage Procession on Pennsylvania Avenue in Washington, DC, but were segregated to the back and denied full participation in the parade. More recently, some feminist initiatives have failed to address racialised sexism against Black women. Black women have long been at the forefront of the struggle for justice and equality, yet their contributions have been largely overlooked in dominant social justice narratives. Similarly, a unique combination of demanding expectations and hyperscrutiny can constrict Black women in medicine. The medical profession does not confer special protections. Black women physicians are simultaneously considered superhuman, but never enough. We suggest this double bind leads to a sense of disquietude as Black women’s identity conflicts with their success.

The problem begins with a medical field that has long been dominated by white men. Black Americans make up about 13% of the US population but comprise only 5·4% of the physician workforce, and of these only 2·8% are Black women. There are even fewer Black women in academic leadership roles: only 0·8% of full professors at US medical schools in 2020 were Black women. In 2021, KMarie King became the first ever Black female Chair of Surgery at an academic medical centre in the USA (Albany Medical Center), and was followed shortly thereafter by Andrea Hayes who became Chair of Surgery at Howard University, one of the USA’s historically Black colleges and universities (HBCUs). Although the history of these moments should be celebrated, such long-overdue appointments are reminders that Black women have too often been seen as less qualified,

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less capable, or less deserving in academic medicine—even within their own spaces of HBCUs.

A paucity of Black women in academic leadership and medicine not only limits the role models students can take inspiration from but may also contribute to inadequate care for Black patients, particularly given the importance of racial and gender concordance in health care. We know some Black patients will go out of their way to see Black physicians; one of us (FCS) has had Black women wait months for a clinical appointment because they know that a Black woman physician will listen, understand, and care.

Yet Black women face many challenges in pursuing a career in medicine. Structural barriers, including segregated housing, economic instability, and underfunded school systems, are products of a violent history against Black communities in the USA. As one of the most disadvantaged racial and ethnic minority groups in the USA, Black women face some of the greatest adversities and fewest opportunities. American medical education itself has been shaped by histories of racism and discrimination. For instance, the American Medical Association sponsored 1910 Flexner Report contributed to the closure of historically Black medical schools and women's medical colleges in an attempt to professionalise medicine. The legacy of such traditions persists today for aspiring Black women physicians through the lack of a comprehensive pipeline to medicine and academic leadership.

As such, Black women who battle through this historically exclusionary medical education system to become physicians might justifiably be portrayed as a certain type of superwomen. Unfortunately, these victories are often accompanied by relentless pressure to succeed—or rather, not to fail. Any failure may be seized upon by critics who see success among people from racially minoritised groups as the exception, not the rule. Indeed, Black women physicians may be regarded by such critics as having been admitted to the profession not on their merits but to fill a certain inclusivity quota, thus being unable to meaningfully contribute to the academic environment.

To combat such racist, misogynistic stereotypes, Black women physicians typically must work twice as hard to get half as far. They are not given the agency to step back because there is no safety net beneath them if they make missteps and fall. Black women's unique position means that they are often asked to do everything from paving the way for others

behind them to serving on diversity committees or the latest health equity initiative. They are expected to care for patients, train students, and do research, all while serving as unofficial spokeswomen for health equity. While Black women physicians are often happy to help combat racial and gender inequities, we encounter issues when the onus to solve structural barriers is unjustly thrust upon individual Black women. Pedestalising Black women physicians as a solution to medical racism deflects from institutional responsibilities and inadvertently exacerbates systemic disparities by overburdening this underrepresented group. Medicine is hard enough. As Black women in medicine, hard can become impossible.

That impossibility comes in many forms, including concurrent obscurity and hyperscrutiny, wherein achievements are undervalued and mistakes spotlighted. FCS is a physician–scientist at Harvard Medical School, yet she has repeatedly had her qualifications questioned and been patronisingly advised to remove her achievements from her curriculum vitae. During residency, a senior colleague expressed concern that she would have a “nervous breakdown” because she was balancing research, two residencies, and organisational responsibilities. When asked whether his apprehension was elicited by any performance faults, he explained that he had simply never seen it done before. Underneath his concern, there was likely confusion rooted in implicit bias. FCS was the only person in her residency cohort instructed to slow down. Hysteria has long been weaponised to delegitimise and deny autonomy to women, particularly women of colour; “nervous breakdown” and other misogynistic rhetoric perpetuate that history.

Black women suffer from a version of the Goldilocks dilemma: they are either insufficient and unsuitable or boastful and overdone—never just right. In fact, if they do speak up about inequities, advocate for reform, or seek to advance institutional diversity, these physicians can be caricatured as just another angry Black woman and dismissed as being unreasonable and melodramatic.

Some recent US cases highlight the potentially endemic nature of these issues. At Tulane University School of Medicine, Princess Dennar was suspended from her position as the Director of the Medicine-Pediatrics residency programme after filing a lawsuit alleging over a decade of sexist and racist behaviour by supervisors. At New York University School of Medicine, Uché Blackstock resigned due to a perceived inhospitable environment for Black trainees seeking professional mentorship and for Black faculty seeking promotion. At Kaiser Permanente Bernard J Tyson School of Medicine, Aysha Khoury was suspended after her facilitation of a classroom anti-racism discussion.

We believe that many Black women in medicine are angry—angry of not being heard, angry of not being valued, angry of being told these experiences are only unfortunate individual anecdotes. But the experiences of Black women in medicine are not anecdotes: they represent the collective struggle for equality. As a cofounder of the Black Lives Matter movement Alicia Garza asserted: “The fight is not just being able to keep breathing. The fight is actually to be able to walk down the street with your head held high—and feel like I belong here, or I deserve to be here, or I just have right to have a level of dignity.”

Long-overdue attention has highlighted the double bind faced by Black women, but awareness without actionable change is not enough. The American Medical Women's Association Give Her a Reason to Stay in Healthcare campaign has inspired thousands to demand pay parity, harassment-free workspaces, and child-care services to support female physicians. Yet we must also take more concrete, enduring action. In instituting diversity, equity, and inclusion (DEI) work as a criterion for faculty promotion, Harvard Medical School provides a template for formalising the often-invisible work Black women physicians embrace under the banner of collective action. Similarly, the National Institute of Health's Faculty Institutional Recruitment for Sustainable Transformation programme is a career-development initiative that fosters cultures of inclusive excellence through the hiring and retention of diverse faculty, integrated systems to address bias, and the development of a Data Coordination and Evaluation Center for the evaluation and measurement of systemic cultural change. Health-care organisations need institutionally driven diversity programmes to improve advancement, retention, professional opportunities, and the campus climate for all community members. Such efforts must be embedded at all levels of academia, from an institution's mission to its innovation and business interests. We must endorse and expand such initiatives that recognise DEI work as a shared responsibility and offer Black women physicians the space to move the needle forward without overburdening them in the process. Institutions must spearhead these efforts to open opportunities and reduce adversity for Black women and to construct inclusive and equitable environments in which all their faculty can thrive. Structural problems require structural solutions.

Acknowledgments

FCS receives funding from the National Institutes of Health and Massachusetts General Hospital Executive Committee on Research, the National Institutes of Health NIDDK P30 DK040561 and L30 DK118710.

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