

Black Physicians' Experience with Race: Should We Be Surprised?

Surveys done over the past 3 years show that minorities have drastically different perspectives on race and race relations in the United States than their white counterparts (1). For instance, African Americans are more likely than whites to feel personally discriminated against in public life and at their place of employment, less likely to feel that they have equal job opportunities, and less likely to feel that race relations in the United States are “somewhat good” or “very good.” Even as ground is broken in our nation’s capital for the new Martin Luther King Jr. memorial, African Americans are less likely than whites to feel that the United States is making significant progress toward achieving King’s dream of racial equality.

In this issue of *Annals*, Nunez-Smith and colleagues (2) present the findings of a small qualitative study that explored how physicians of African descent experience race in the workplace. In brief, the physicians participating in the study felt that race permeated their experience in the workplace, shaped their interpersonal interactions, and defined their institutional climate; that responses to racism at work ranged from minimization to confrontation; that the health care workplace is often silent on the issue of race; and that these collective experiences can result in “racial fatigue,” with personal and professional consequences. These findings are extremely disappointing and discouraging; however, since they mirror many of the perspectives on race reported by African Americans in society, should we be surprised? We don’t think so.

A recent Institute of Medicine (IOM) report titled “In the Nation’s Compelling Interest: Achieving Diversity in the Health Care Workforce” (3) highlights that, of the 70.5% of U.S. physicians whose race and ethnicity is known, Hispanics account for 3.5%, African Americans 2.6%, and American Indian and Alaska Natives fewer than 0.5%. Furthermore, minorities comprise only 4.2% of medical school faculty nationally—and 20% of the minority faculty are at the 4 historically black medical schools in the United States and the 3 accredited medical schools in Puerto Rico. In addition to detailing the importance of diversity in the health care workforce and providing several recommendations to address this critical issue, the IOM report discusses how lack of diversity can lead minority health care professionals to feel isolated and disempowered within their profession. As a result, the health care workplace itself magnifies these physicians’ “minority” status and its accompanying challenges.

Several studies corroborate the corrosive effect of race in the health care workplace (4, 5). Minority faculty, especially African-American faculty, are much less likely than white faculty to hold senior academic rank, even when the data are controlled for self-reported numbers of publications, research grants, and years of service (6); have lower career satisfaction (4, 5, 7); perceive ethnically and racially

based disparities in recruitment for training and faculty appointments (8); experience subtle manifestations of bias in the promotion process; and face structural barriers to academic success and professional satisfaction (5, 8). Therefore, we should not be surprised that a group that still experiences discrimination in society, is underrepresented and disempowered in medicine, and has negative race-related experiences in the health care workplace would provide the perspectives described by Nunez-Smith and her colleagues. Another influential IOM report, “Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care” (9), found no direct evidence of racial profiling in medicine; however, given the persistent evidence of discrimination in our society, it would be naive to think that physicians were incapable of racial prejudice—or at least racial stereotyping—toward their minority patients and professional peers. Both prejudice (the conscious, knowledgeable prejudgment of individuals) and stereotyping (the subconscious process of applying beliefs and expectations about a group to any individual from that group) may lead to disparate treatment. Negative beliefs and expectations about minorities may be subconsciously “learned” from negative images and portrayals in the media or from the entertainment industry. Although there are probably multiple factors that explain the key findings of this study, we have ample reason for concern that prejudice and stereotyping are playing a role.

The study by Nunez-Smith and colleagues is a significant addition to the literature because it explores the particular circumstances that have led to negative race-related experiences of physicians of African descent in the health care workplace. Its strengths include the use of open-ended questions to encourage dialogue about a complex and potentially sensitive topic and the remarkable congruency in the reports of study participants, despite their different specialties, practice settings, and length of professional experience. The study also has limitations. By design, this research has a small, heterogeneous study population and is not expected to be generalizable. The participants all practice in New England, and their experiences may differ from those who work and live in other regions. Despite these limitations, this study highlights for *Annals* readers the need to be attentive to issues of race in the health care workplace.

Where do we go from here? Unfortunately, some of the themes identified in the Nunez-Smith study reflect a society where race matters; they are not amenable to simple policy or practice changes. Physicians of color will always be “aware” of their race and know that race-related experiences may shape their interpersonal interactions. However, the perception of these physicians and physicians-in-training (10) that race-related experiences *define* their institutional climate—that they feel invisible and isolated,

lack supportive mentors, feel “cast” when asked to perform certain activities, and are held to higher performance standards than their peers (2, 10)—remains troubling. It is also troubling that these physicians view the health care workplace as silent on issues of race; that issues of race are not openly discussed and policies against discrimination are not discussed, monitored, or enforced; and when faced with difficult situations, they must have a “thick skin.” These experiences, which take a personal and professional toll, may be amenable to intervention.

For health care organizations that are truly committed to excellence and equality, several take-home points emerge from this research. First, these organizations should openly acknowledge that race matters as much in the health care workplace as it does in society. Open and honest dialogue, understanding, transparency, and partnership should trump defensiveness and denial when it comes to identifying and addressing the issues raised here. Leaders should create forums and venues for frank, confidential discussions with minority faculty about their experiences in the health care workplace. By unearthing issues that might otherwise fly under the radar, these discussions may serve as a catalyst for change. Second, given the importance of diversity in the health care professions (3), organizations should make concrete efforts—supported by ample resources—to develop, mentor, and monitor the progress of minority physicians. This support can take many forms, including offices and programs dedicated to this mission, such as those in place at Massachusetts General Hospital and Johns Hopkins, among others. Third, all health care professionals should be taught about the impact of stereotyping and prejudice as part of their employee orientation and ongoing in-service training (for example, in grand rounds). Fourth, organizations should develop explicit, enforceable policies that prohibit all forms of racial discrimination. Although some health care institutions have venues for reporting discrimination in the workplace, the evidence shows that these forums are not serving their intended purpose and that physicians may be unwilling to use them to raise issues. Other industries employ an ombudsman (or other officer outside the standard organizational hierarchy) to provide a safe place for disclosure, which is the starting point for corrective action. Fifth, institutional leaders should heed the message of research showing that the development of diverse clinical care teams can promote greater understanding among individuals from various racial backgrounds (11). It has been shown that when organizations task a racially, ethnically, culturally, and socially diverse team (in which each member is given equal power) to achieve a common goal, a sense of camaraderie develops that prevents the future development

of stereotypes based on race and ethnicity, sex, culture, or class. Finally, larger, more generalizable quantitative and qualitative studies are needed to further examine the impact of race on physicians and physicians-in-training.

Nunez-Smith and colleagues' provocative research shows that race matters in the health care workplace, just as it does in all aspects of society. We hope that leaders in the health care workplace are surprised enough by these findings to take tangible steps to ensure that all minority physicians feel respected, valued, and empowered.

Joseph R. Betancourt, MD, MPH

Andrea E. Reid, MD, MPH

Massachusetts General Hospital and Harvard Medical School
Boston, MA 02150

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Requests for Single Reprints: Joseph R. Betancourt, MD, MPH, Institute for Health Policy, Massachusetts General Hospital, 50 Staniford Street, 9th Floor, Suite 901, Boston, MA 02150; e-mail, jbetancourt@partners.org.

Current author addresses are available at www.annals.org.

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Current Author Addresses: Dr. Betancourt: Institute for Health Policy, Massachusetts General Hospital, 50 Staniford Street, 9th Floor, Suite 901, Boston, MA 02150.

Dr. Reid: Massachusetts General Hospital, 55 First Street, Boston, MA 02114.