

## Minority Physicians Are Not Protected by Their White Coats

### TO THE EDITOR:

We applaud the authors' work in their brief report "Implicit Bias Training in a Residency Program: Aiming for Enduring Effects," and their work to address bias on a systemic level.<sup>1</sup> A priority of the study was to provide insight into how biases perpetuate institutional inequities, exacerbate structural racism, and the significant damage this causes. We wish to add that minority resident physicians are not protected by their white coats. They are also subjected to bias and discrimination from staff, patients, attendings, and colleagues. This has a direct, negative impact on patient care.

In the article "Minority Resident Physicians' Views on the Role of Race/Ethnicity in Their Training Experiences in the Workplace," the authors capture the experiences of Black, Hispanic and Native-American residents. They describe daily microaggressions, indignities that communicate hostile, derogatory, or prejudicial slights and insults, throughout the entirety of their residency training. Underrepresented minority residents were the target of bias and discrimination not only in interactions with patients, but also from coresidents, attendings, program leadership and other health care team members. Despite clear recognition of discriminatory practices and behaviors toward patients and their own personal workplace experiences, residents expressed reluctance to formally report or even discuss such events due to perceived vulnerability.<sup>2</sup> These unchecked incidents are very much present in health care systems and training programs alike, and are a factor in the perpetuation of health care disparities.

Similar to underrepresented minority faculty, minority residents may be reluctant to discuss these events due to concerns of creating friction amongst their colleagues, social and academic isolation, loss of important opportunities, or even retaliation for speaking up.<sup>4</sup> Recurrent exposure to discrimination contributes to emotional exhaustion, depression, and suicidal ideation, and can lead to total abandonment of one's position and profession.<sup>2-5</sup> As

physicians of color care for 53.5% of minority patients and 70.4% of non-English speaking patients,<sup>6</sup> this affects the diversity and inclusion of the current and future physician workforce and wholly compromises health care outcomes, especially for traditionally disadvantaged groups. Measures and safeguards must be implemented to address the daily micro- and macroaggressions underrepresented minority residents endure within the larger framework of reducing systemic bias to thwart lasting negative effects.

People of color suffer from pervasive discrimination and deeply ingrained systemic issues that result in disparate outcomes. Minority resident physicians are not protected by their white coats, and unchecked biased behaviors toward them directly impacts patient care. Medical professionals of every color, and in every sphere must endeavor to consistently denounce and dismantle everything resembling prejudice for both our patients and our underrepresented minority residents to thrive. doi: 10.22454/FamMed.2020.737963

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## Authors' Reply to "Minority Physicians are Not Protected by Their White Coats"

### TO THE EDITOR:

We thank Drs Amaechi and Rodríguez for their thoughtful comments in response to the implicit bias training program we recently described.<sup>1</sup> We absolutely concur and affirm their message that the white coat does not provide immunity to bias among physicians, including the residents we teach.

As is common with qualitative research, the focus groups we conducted as part of our evaluation expanded into interesting areas beyond our specific training program. Some of our residents spontaneously described incidents of microaggressions they had experienced in the hospital due to the color of their skin. As this was not the central focus of our evaluation, we did not include these reflections in the original manuscript, but they apply directly to Drs Amaechi and Rodríguez's comments. Specifically, two different residents shared the following:

I think a lot of our challenge is bringing up specific times when microaggressions happen or maltreatment of patients happen. A lot of the challenge of that is hierarchy, it's true, but ...there are a lot of times in my life that I've experienced treatment where I was like, "Did they do that because I was a woman? Did they do it because [of my race]? Did they do that because they perceive me as young? Or are they just like that to everybody?" And when you experience a lot of microaggressions, and maybe a higher volume because of how you look, it's exhausting because you ask yourself that question all [the time].

When you're in the hospital and you're a resident...it's the mixture of who do you tell, what do you tell them, and are you sure the thing actually happened.

Thus, we share Drs Amaechi and Rodríguez's concern about the multiple impacts of unchecked discrimination on many levels, especially our patients and residents. As noted in our first quotation above, residents may experience discrimination due to many variables, certainly including the color of their skin but also their gender, age, and resident status. The impacts of these multiple layers of discrimination can accumulate and contribute to many

adverse outcomes, including mental health problems and leaving the profession.

Therefore, as educators we see our mission as three-fold: (1) to advocate and affect systemic change to decrease implicit bias at our institutions, (2) to help our residents debrief individual episodes of either explicit or implicit bias, and (3) to empower residents with tools and support to advocate for themselves and for the communities they serve. As faculty, and as training programs, we must strive to be aware of our own blind spots, advocate for systemic change, and work to create safe work places for our residents and patients where discrimination is never tolerated and all feel safe to share their discomfort and experiences.

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## Screening for Adverse Childhood Experiences

### TO THE EDITOR:

In their recent commentary "Addressing Adverse Childhood Experiences in Family Medicine: A Multigenerational Approach,"<sup>1</sup> Drs McKelvey and Edge recommend several helpful strategies that should precede "the initiation of screening" for adverse childhood experiences (ACEs). However, they do not address the important and vexing issue of whether to screen for ACEs even when a practice is adequately prepared. Many have advocated for routine ACE screening for adults and children, and the State of California is now encouraging ACE screening by reimbursing clinicians for each completed ACE screen.<sup>2</sup> Before implementing widespread screening for ACEs, it should be rigorously reviewed using the accepted standards necessary for screening programs.

The potential benefits of reducing the negative health effects of ACEs are enormous. Unfortunately, no interventions have been demonstrated to improve outcomes in

patients who report a high number of ACEs. While there are effective treatments for many of the sequelae of ACEs such as posttraumatic stress disorder, panic disorder, and depression, they are not effective or appropriate to use with all patients with high ACEs, especially those who do not report any psychological distress. There is no consensus as to what events should be considered an ACE, and there are over a dozen different ACE questionnaires.<sup>3</sup> The original ACE questionnaire was developed as a research tool and was never intended for clinical use. It provides population-based risk data that are not appropriate to apply to individual patients.

There are many potential harms of ACE screening. Patients may be retraumatized by screening. Children and adults with high ACE scores risk being labeled at high risk for psychological and physical health problems, which can result in psychological distress. Parents and teachers of children with high ACEs may look for and even create the predicted behavioral problems, the so-called “expectancy effect.” Most family physicians do not have adequate time to complete evidence-based clinical preventive services,<sup>4</sup> such that few children and adults have received all the recommended services.<sup>5</sup> Implementing an unproven screening program would only worsen this problem.

I agree with Drs McKelvey and Edge that family physicians should strengthen evidence-based screening programs for many of the consequences of ACEs, such as depression, substance abuse, and domestic violence, to assure that all of our patients receive these services. More research is needed on screening instruments, potential interventions, and the potential harms of ACE screening. However, it is premature to implement screening programs for ACEs until the effectiveness of such screening can be demonstrated.

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## Response to “Certified Nurse Midwives as Teachers of Family Medicine Residents”

### TO THE EDITOR:

I read with interest the February 2020 article<sup>1</sup> by Dr Farahi and colleagues on the role of certified nurse midwives (CNMs) in family medicine maternity training. I am a family physician and current fellow in nonsurgical obstetrics at the University of Colorado’s Anschutz Medical Campus. I agree with Dr Farahi that CNMs are well positioned to teach maternity care to family medicine residents. I’d also submit that, for those seeking postgraduate training in maternity care, CNMs are an underutilized resource.

During my third year of residency I searched—unsuccessfully—for a women’s health fellowship that was midwifery-based and included inpatient adult medicine practice. Fortunately, with the support of the University’s midwifery department and our family medicine department, I was able to create my own. A core component of my fellowship is shifts with the midwives where I am involved in obstetric triage, labor management, deliveries, and postpartum care.

I was lucky to train alongside this same midwife team during my residency, developing connections that eased the development of my fellowship. Together, we worked out how I could fill a gap on the labor deck and also learn in an interdisciplinary fashion. Specifically, I perform obstetric triage for OB and midwifery groups and I care for the midwifery group’s labor patients with their support and instruction. I can say without hesitation that my fellowship has significantly improved my skill and confidence in obstetric triage, labor support, and delivery management. I think the midwifery style of obstetric care nicely complements the family medicine model, and our residents seem to agree. When I supervise on the family medicine service, for example, I regularly get feedback from residents that they enjoy learning about nonpharmacologic interventions for pain management, birthing positions that can help with fetal malposition, and ways to integrate patient and family into their

own birth experience—all skills that I learned from the midwives.

As Dr Farahi's article suggests, experience in team-based care is essential and CNMs have a great deal to offer doctors in training. They ought to have a larger role. While some academic centers like Boston Medical use midwives as instructors in their collaborative maternity care models for residents and medical students,<sup>2</sup> I am not aware of any examples in postgraduate training. This is likely a missed opportunity for family medicine residents who graduate with low obstetric volume but would like to include maternity care in their practice. Embracing this approach could also help remedy the decline of family physicians as maternity care providers.<sup>3</sup> I would strongly encourage family medicine residency programs

to find novel ways to draw on the rich experience of our CNM colleagues, both in residency curriculum and postgraduate training.

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