

Racial Trauma and the Physician Craft: From Understanding to Humility

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It was another busy clinic day as a new doctor in the late 2000s. In family medicine, I enjoyed, and was ever-refining, the art of rapport building in the exam room. I believed I could relate with anyone once I understood their lived experience. This, I thought, was at the heart of the physician's craft—to find a way to walk in another person's shoes—and I thought I was off to a great start.

I, a young White woman, entered the room to meet my patient, a young Black woman. As a late Gen-Xer, I trained in medicine during the time when information technology transformed health care. Going through training as systems evolved from paper charts to full electronic health records, I thought I was computer savvy. I became comfortable with turning my screen around to review labs and studies with patients, discovering over time how integrating the EHR into the visit was helpful. I sensed that patients enjoyed seeing what doctors saw, learning terminology doctors used, and discussing their own chart along with their doctors.

I also developed a habit of using the computer to quell patient anxiety. With young adults, it was common to have deep conversations in the exam room, only to receive messages hours later, asking about their diagnoses. *At least they are comfortable enough to ask me*, I thought, but considered how I could have presented things to cause less concern. So I began a process, after making a diagnosis and treatment plan with a patient, of turning the screen around, opening a web browser and declaring, “If you look up this diagnosis on the internet later, you will probably find a lot of scary things. Why don't we look it up together, right now, so I can answer your questions.”

The patient, whom I had just diagnosed with a dermatologic condition, and with whom I thought I had developed good rapport, looked back at me and said, “How do you know it is molluscum?”

“Well,” I said, “molluscum has a characteristic appearance on the skin, with a little dot in the middle of a raised bump, like you have. Do you want to see pictures of how it looks?”

“Sure!” She said, sounding intrigued and interested, almost forgetting about the unsightly rash she had come in with that day.

I confidently opened a web browser, which was turned toward her, efficiently typed the words into the image section, hit Enter, and up popped dozens of images, all of molluscum contagiosum on white skin.

I froze. I felt my body temperature instantly rise, and my cheeks and neck became flushed with embarrassment. I scrolled down, thinking surely there would be an image or two which I could quickly enlarge to distract from all the photos on the screen, but I scrolled and scrolled, only to see rows and rows of images of molluscum on white skin. I looked from the screen to her face, which had turned into a blank stare.

She asked me again, “How do you know *I* have this problem? How do you know this is what *I* have?”

I felt ashamed to realize, with the computer screen already turned toward her, that none of the images looked like her. My years of training and experience to date had not prepared me for the moment I now confronted.

Despite my earnest intention to heal and empower, I had done harm to this patient. The multiple similar images of molluscum contagiosum on white skin revealed more than just a redundant set of photos. They also represented a painful example of systemic racism, showing up in one of the most sacred places to be occupied in medicine: the exam room.

I stammered, “I’m so sorry, let me see what I can do to find something...”

“Never mind,” she said, “How can I make it go away?” I tried my best to regain some ground of connection, but I felt it slip away, just out of reach, unable to be pulled back into the energy of the conversation. I quickly reviewed her treatment instructions and she went along her way.

This encounter made me realize my incorrect assumption that the computer would generate images inclusive of everyone. It is vital to remain up to date with ever-changing technology and to be creative with how we use it. But we must also practice with humility when we engage with tools of technology, being mindful and pausing before we turn our computer screen to the patient until we view its display and consider its impact. When searching for dermatologic conditions, we should include skin tone as part of the search, to obtain images that are specific to the patient. Medical textbooks should include all skin tones in illustrations, and web browsers should include all skin tones in searches. These changes require shifts at multiple levels of a system of which we are all a part, and until they become fully realized, none of us can be complacent with what shows up on the computer screen. Since the late 2000s, many resources have been developed to close these gaps, but there is still so much work to do to prevent racial trauma in the physician craft.

I wish I had done better for this patient but have since moved on from this practice and community. I cannot find this patient to thank her for grace in a moment she should not have had to endure. I have not shared this story for a long time, too abashed at my own flaws in failing to disrupt racial trauma in my practice. And yet, understanding our inherently flawed system is vital to moving forward. The physician craft must embrace the exam room as sacred space not just for diagnosis, but for discussion of the effects of systemic racism, for both the physician and the patient. These are the intentional steps required to create systems of equity and justice in the spaces where we work and live.

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