

## Research Is (Not) a Bad Word

Angela Renee Rodgers, MD<sup>a,b</sup>

### AUTHOR AFFILIATIONS:

<sup>a</sup> Contra Costa Family Medicine Residency Program, Department of Emergency Medicine, Contra Costa Health Services, Martinez, CA

<sup>b</sup> Department of Family and Community Medicine, University of California, San Francisco, CA

### CORRESPONDING AUTHOR:

Angela Renee Rodgers, Contra Costa Family Medicine Residency Program, Department of Emergency Medicine, Contra Costa Health Services, Martinez, CA, [angela.rodgers21@gmail.com](mailto:angela.rodgers21@gmail.com)

**HOW TO CITE:** Rodgers AR. Research Is (Not) a Bad Word. *Fam Med*.

2025;57(8):1-2.

doi: [10.22454/FamMed.2025.774718](https://doi.org/10.22454/FamMed.2025.774718)

**PUBLISHED:** 30 June 2025

© Society of Teachers of Family Medicine

The withholding of treatment in the Tuskegee Syphilis Study.<sup>1</sup> The misappropriation of human cells from Henrietta Lacks.<sup>2,3</sup> Sterilization without consent of the Indigenous and those of Latin American descent.<sup>4,5</sup> Growing up, I was taught that research was a means of harm for people with my skin color. I learned how the government tricked my ancestors, how researchers stole their bodies, and how the health care system lied to communities of color. Research was a bad word, and I wanted nothing to do with it. My goal was to serve by improving the health of historically marginalized communities like my own. I wanted to be a face that could be trusted. Research was not for people who looked like me.

However, research was highly favored in medical school applications. Therefore, like my classmates, I worked as a research intern. I traveled into Black and Brown communities and administered surveys. I felt terrible. I didn't understand the research aims and felt like I was interrogating vulnerable individuals. I felt like a spy and thief, taking precious information from people who looked like me and giving it to entities for unknown purposes. Neither I nor the community was informed how this study would benefit them (or even if it would benefit them), and that bothered me. I was now part of the system taking from my own people. I stayed for the duration of the study because I thought that was what I had to do to become a physician. But the shame I harbored for participating in research remained. I wanted to be a doctor, but not like this.

After residency, I was introduced to family physicians who identified as Black, Indigenous, and/or People of Color (BIPOC) who led global health projects to support communities in starting family medicine residencies. They shared stories of building trust, fostering relationships, and lifting up communities to improve health care outcomes. They shared how research made them happy and, when done right, was a means to serve the underserved. Around the same time, I started the Society of Teachers of Family Medicine Leadership Through Scholarship Fellowship, which teaches family physicians underrepresented in medicine how to produce written scholarship. That was the first time I participated in an academic program led by physician leaders of color with all participants identifying as BIPOC faculty. Under a protective umbrella of psychological safety, the fellowship leadership interwove personal tales of challenge and triumph within seasoned didactics and dedicated group writing sessions. I came to understand the articles published by fellowship leadership about inequity of diverse learners and physicians directly related to patient care and outcomes of historically marginalized communities. During the fellowship, I met a colleague whose passion for equity in preventative health led to an impactful podcast, article, and programming that has educated and inspired clinicians to provide vital care to the most vulnerable communities. I treated individual patients from vulnerable communities, but I was challenged by my new cohort to do this on a broader scale. This fellowship offered an invitation. An invitation to be what—up to that point—I had not seen. I was introduced to how a person of color could not only be the physician caring for those with illness, but also the educator, researcher, and advocate preventing the illness. I realized that I was doing only part of the job of a physician. I began to look around myself to consider how I could promote scholarship in family medicine.

My first idea was case reports. As a family physician working in a county emergency department, I see lack of access, miscommunication, and discrimination lead to delays in diagnoses. I remember one case well. A respected elder of his family with dark skin framed by short curly salt-and-pepper hair came to us worried about his prolonged fever. Seen by multiple providers in clinic and urgent care, he now sat in a blue gown in bed in

our emergency department sharing his story with me. His gentle nod of gratitude after being given a diagnosis imprinted in my mind. I asked whether he would consent to his case being used to educate providers on how not to miss diseases in patients who look like us. He was overwhelmingly thankful: “Of course! Thank you so much doctor.” My second idea was inviting residents to lead scholarly projects. As a student, I learned about research being harmful for communities of color, and talking with learners who identified as BIPOC made apparent that stories of these same historical atrocities had caused them to be uncomfortable participating in research too. A colleague and I created an introduction to scholarship lecture and shared our stories of how we use scholarship to lift up marginalized communities. We were dedicated to role modeling how research can strengthen one’s passion for serving the underserved. My third idea was narrative writing. In addition to encouraging residents to use journaling to reflect upon their professional identities and clinical experiences, I use narrative writing to process experiences in medicine that others may be able to relate to. Sharing stories of my experiences has been a validating journey in an effort to educate and foster community.

I am at the beginning of my career, but I am humbled by the encouragement I have received in viewing research differently. Research and health systems have harmed communities of color in the past, but that doesn’t need to continue. Research is for everyone in health care. We need everyone to harvest the true power of research. The responsibility is on all of us. My perspective has been transformed. I still can focus on improving the health of historically marginalized communities like my own. I still can be a face that can be trusted. My goal of service remains the same. But I now realize that research can be for physicians who look like me. Research is *not* a bad word.

## REFERENCES

1. Public Health Service Untreated Syphilis Study at Tuskegee. About the untreated syphilis study at Tuskegee. *Centers for Disease Control and Prevention*. 2024. <https://www.cdc.gov/tuskegee/about/index.html>.
2. Wolinetz CD, Collins FS. Recognition of research participants’ need for autonomy: remembering the legacy of Henrietta Lacks. *JAMA*. 2020;324(11):28.
3. Washington HA. *Medical Apartheid: The Dark History of Medical Experimentation on Black Americans From Colonial Times to the Present*. Doubleday; 2007.
4. Lawrence J. The Indian Health Service and the sterilization of Native American women. *Am Indian Q*. 2000;24(3):400–419.
5. Novak NL, Lira N, Connor O, et al. Disproportionate sterilization of Latinos under California’s eugenic sterilization program, 1920–1945. *Am J Public Health*. 2018;108(5):611–613.