Central Line
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VOICE OVER:

Welcome to ASA's Central Line, the official podcast series of the American Society of Anesthesiologists, edited by Dr. Adam Striker.

DR. BROOKE TRAINER:

Welcome to Central Line. I'm your guest host for today's episode, Dr. Brooke Trainer, and I'm happy to be joined by Dr. Keya Locke, guest editor of the December ASA Monitor. Dr. Locke and I are going to be talking today about equity and what that really means in terms of DEI. This is certainly an area of passion of mine, and I'm excited to hear what she has to say. So welcome to the show, Dr. Locke.

DR. KEYA LOCKE:

Hi there. Thanks so much for having me.

DR. TRAINER:

Dr. Locke, to get us started, would you please tell us about yourself and why this topic is so important to you?

DR. LOCKE:

Happy to. So I'm Keya Locke. I am a physician anesthesiologist, and so I am a second generation Caribbean American. My mother is from Trinidad. My father is from Barbados. I'm one of eight children, so I come from a really big family. I'm the only physician in my family, and I'm one of the few people in my family to have attended and matriculated from college. Post residency training, I went back and got an MBA because I realized very quickly and very early in my career that sort of the business of medicine was a gap in knowledge, and I wanted to be able to speak eloquently in that space. So outside of that, I didn't actually do like a fellowship or anything. I was more interested in that side than anything.

So I have the experience of being a black American, and so the interest has always been there. But the impetus for me to become vocal about it really started forming once I started getting involved in the ASA on the national level. I went to my first ASA meeting as a third year resident to practice management, now called ADVANCED. And after that meeting, you know when you see all the flyers come out and all the social media posts, I was in probably ten things. My picture was there front and center. And while that was like, wow, my picture is there, I quickly realized that my picture was there because there weren't a lot of other people who looked like me at that meeting. Now, that was a long time ago, and the meeting looks a little bit different now. Um, but when I realized that, I realized that because I was in that space, it felt almost imperative to me that I start to to speak about some of the things that normally we kind of save for the kitchen table and the things that you only talk about with other minority physicians or minority trainees. I felt it was really important to get comfortable with talking about an uncomfortable topic. And so that's kind of how I ended up here.

DR. TRAINER:

And, you know, I think your experience probably resonates with a lot of listeners. And we're going to touch upon some of those things in a little bit more depth as we go through some of these issues. I do want to ask you about your relationship between what you were speaking about in medical education and in your residency, but particularly, you know, we're here to talk today about what equity is. I think, first of all, we might need to remind our listeners about what that actually means. Specifically, there is a big difference between the word equity and equality. And so I want you to elaborate on that. And then I want to ask you about your relationship between equity and medical education and then health care delivery as well.

DR. LOCKE:

Well, thanks so much. I think you bring up a good point when it comes to IDEA or inclusion, diversity, equity and access. I think we've talked about it in so many different venues. And the default option has been to address diversity, right? We default to talking about implicit bias training, diversity and inclusion, and things like that. But a lot hasn't been done to talk about equity. So what do we mean when we say equity? And I like to talk about equity in its relationship to equality. Because equality is implying that we're giving everybody the same thing. So everybody is the same. And we don't recognize any sort of difference. We just everybody gets the same thing. When we talk about equity. Equity is more of an ongoing process that requires us to not only identify, but to overcome intentional and unintentional barriers to those around us. So the example that resonates most with me is that equality is ensuring that everyone has a pair of gloves on a cold winter day, whereas equity is ensuring that everyone has a pair

of gloves that fits their hands. And so I think that distinction of being intentional about understanding that some folks are going to need other things that others are not in order to give us an equal playing field is really important. Um, and, and addressing that has to happen at the very beginning.

I think it's important to start looking at how we are going to address equity from the ground up and the ground being our medical education. I recently saw as of 2022, if you think about our medical training in this country and where black and brown physicians are coming from, I was surprised to learn that over 85% of black physicians in this country have matriculated from an HBCU or a historically black college and university. Which tells me that there's some sort of barrier to them being accepted and matriculating from traditional houses of medicine. And if that's the case, why is that the case in 2023? Um, and so I think addressing sort of where we start is a great place to figure out where we're going to go and how we're going to get there. And so that's my big focus now, is trying to put some real, um, a spotlight onto the education process from from the beginning.

It's important to to think about that, because that's going to play into the type of care that we can deliver, meaning the type of physicians that we're putting into the workforce will directly reflect the type of care that we can deliver. And we know that the medical institution in this country has a long history of either overtly mistreating black and brown Americans or implicitly being biased against that group of patients. Right. And that is historical from, you know, gruesome experiments on enslaved people, forced sterilizations of black women, and the infamous Tuskegee study. And so, since we know that we have this medical mistrust that is rooted in past legacies of mistreatment, we also have to recognize that a lot of that mistrust stems from contemporary experiences of discrimination in the health care system. And in order to right that, I think it's very important for patients to be in front of physicians that look like them whenever possible.

DR. TRAINER:

I just want to expand a little bit upon some of the points you made. You mentioned the percentage of the black physicians matriculating from the HBCUs. I'm curious as to why that that is. For example, is it because they're not getting accepted into these other places, or is it because maybe they preferentially apply because they feel more comfortable, which also is a problem in itself? Like why do they feel more comfortable going or applying to these HBCUs rather than other universities? And so I do think that's a systemic problem that needs more understanding, more research. And and I'm curious to see if we really know the difference.

DR. LOCKE:

Well, I can tell you, because when I learned that, it really spiked my interest, like I said, I was, I was surprised. I didn't go to an HBCU for medical school. Um, but when I talk to folks and I do a lot of interacting with, you know, medical school hopefuls and residents, both things that you mentioned are true. There are structural barriers that, you know, people are applying and they're not getting into a traditional schools. And when I say structural barriers, I mean, like, you know, people do not always have access to interview coaching. And I just speaking from personal experience, when I went through the medical school admissions process, I was granted educational opportunity money to even apply to medical school to be able to afford the applications. I was granted educational opportunity money to be able to afford an MCAT prep course. And so a lot of things that are not available to folks because they require money, um, inhibits their ability to do as well as they would like to do in order to get into some of these colleges.

I've heard that I've also heard that some students are preferentially saying, you know what, I'm a bright student. I've done well, but I have always been at a predominantly white institution. And when it comes time for medical school, I want an opportunity to learn in a space where I am not the only one. And so I think it's a it's a double pronged problem as you stated. And it's going to take a effort, as you also stated, you know. When you talk about equity, achieving equity takes money and it takes effort. And I think that's why more has been done around diversity than has been done around equity.

DR. TRAINER:

Right. And so my next question for you is how do you think our specialty is doing when it comes to equity, but also diversifying our workforce? It does seem like that seems to be the first step in a lot of efforts is diversifying our workforce. So I'll let you speak to that. And then I'm curious how you think we're doing as far as equity as well.

DR. LOCKE:

Um, I think there has been progress. You know, the the millennial spirit in me screams that not enough has been done and when are we going to be there. But I think there has been progress. In 2019, when I was first starting to speak on a national stage, the percentage of black anesthesiologists in the specialty was 3 to 4%. When I went back and looked at more recent AAMC data, it was around 5 to 5.3%. We're still doing poorly when it comes to Latino populations, which was only still around two and a half to 3%, and pretty dismal when you start talking about Native Americans. And so I think there has been improvement, but we still have a lot of work to do.

The story I shared in the beginning about, you know, the ASA meetings both ADVANCE and then the national meeting, the meetings look a lot different. When I go to the medical school tracks of those meetings or the resident tracks of those meetings, they are hugely diverse, and so it's kind of warming to see that while things haven't changed possibly at the speed that I would have liked to see happen, they are slowly changing.

You can think about it in that way, and you can also think about it--and I always try to take everything back to a story of some sort--but, you know, just thinking about the city that I live in, I am the only black female practicing anesthesiologist in this city, you know. So when people say, oh my gosh, like, I think you were my anesthesiologist, it's like I probably was. If you think that it was me, it probably was me. And so I think that I am hopeful. In the time that I have been present and active on a national level, I've noticed that on a national level, anyway, we seem to be doing better than where we were in 2016 when I attended my first meeting.

DR. TRAINER:

I just want to speak a little bit about being like a representative, you know, on the national level and in a leadership position. And it actually reminds me a little bit about a story. I am an editor on our state society newsletter, and we were doing a DEI issue, and I went, of course, to one of the residents and asked her if she wouldn't mind to write an article about it, and her response was, why does every white person ask me, the only black person to write on this? Why don't you write on this? I'm just being very raw here because it was an eye opener for me to say, oh my God, she's right in. Her point was, if more people in leadership positions like myself would start speaking on this, it would help all of us. It can't just be the minorities coming out and speaking and leading in this arena. There has to be an example of all nationalities, ethnicities, sexualities speaking on this. She pushed me to again come out of the comfort zone to speak on this. And so, again, you know, being a leader, being someone who has that opportunity to have a platform and a voice that is you as well, it makes a difference to be that example for all of your uprising residents and, and your patients. So my next question is going to be leadership opportunities. So we did once upon a time have underrepresented minorities join our specialty, like you were saying, and getting, you know, involved. But they didn't have the face to represent them in leadership at that time. Right. We have better representation now, especially, you know, this year. But what do you think we need to do to help advance and support those upcoming leaders who have representation of all these different minority, sexual orientations? How can we encourage them to be a leader, to speak out and to join our specialty and be the face of our specialty?

DR. LOCKE:

Well, that's a great question. And so firstly, I applaud your your young trainee for for pointing that out. So as you probably know, this topic in some sense has been talked about so much in recent years that what I always caution people when they are requesting that you, you know, speak about something or that they want to collect stories about your experience. What I always caution is that you are not asking an already marginalized group of people to bear their scars simply for your education. If you are asking me to bear my scars, then it has to be because you have an action plan to address them. Otherwise, it feels like a cruel joke. Because as much as I want to, to speak and to educate, I know what it means to be marginalized. And if somebody else wants to know what it means to be marginalized, it the onus is on them to educate. The onus is not always, always on the marginalized group. And so I applaud her for bringing that to light.

And so when we talk about leadership positions, I'll start with the AAMC data. And so the 2020 AMC data looking at chairs of departments. So we're talking about chairs of anesthesiology departments across the country. What are the numbers say? Across the country there is one black female. There are three black men. There are zero Hispanics. There are zero Native Americans. And there are 95 white men and 15 white women. And thinking about my own department, I can almost guarantee you that the next four chairs of the department will not be underrepresented minorities. Thinking about my own department because I recently decided to put together sort of, um, a BSU, but for faculty. So a black student union. But we're not students, we're attendings, but still that sort of safe space. Um, that was always so vital for me during my education. And looking at the folks that I pulled together, an overwhelming majority of these physicians were--and I'm in academic medicine--so an overwhelming of majority of these physicians were still assistant professors, regardless of age, regardless of the amount of years they had been at the institution. Some had been here 16, 17, 20 years. Some had gone their entire careers mentoring countless young physicians like myself, and had never even been promoted so much as to be an associate professor. And what I came to understand is that talking with people, you know, and not to be crass, but they had never learned how to play the game. And the path to success had certainly never been laid out for them. And so I feel as though while we have made big strides in diversifying both our training and our our medical education to some extent, once we get folks here, I don't feel as though we've done a great job as a specialty about locking arms around those folks and giving them what they need to succeed. Once we've got them here, it's almost as if we pat ourselves on the back. Great job. Oh my God, there's there's a couple of non-white people in this space. But then how do they do more than just survive? How do they thrive if we haven't put actionable things into place in order to support them?

And I feel like, on the national level we've done a better job. And I can speak from personal experience. Like I said, when I first joined the ASA and got involved in 2016 to now I've had some great mentors and sponsors, kind of lock arms with me and say, you know, keep coming, we need you. I'm going to put your name forward for this or your name forward for that. And some of those, most of those sponsors, believe it or not, have been white men. I mean, I'm talking about people like Dr. Lewis and Dr. Jay Mesrobian and Dr. Jeff Jacobs. There's countless others, but I feel like on the national stage, we've done a better job of supporting our folks than what is happening across the country and people's individual places. That's sort of the the feedback that I've been getting as I continue to engage in these sorts of conversations. And so it's my hope and my current torch to carry. Is to how to help support folks once we do have them and how to ensure. That we are preparing them to be leaders and to move into the next space, right? So to move into the C-suite and forward. Um, and so and that's a big task. It's a big task. But I think it's a certainly a worthy one.

DR. TRAINER:

I want to kind of help make that point a little bit more prominent. One of my personal experiences was as a past president of Association for VA anesthesiologist. We had our annual meeting and we discussed the speakers. And I had done a quick, deep dive into the lineup of speakers over the past, like five, you know, preceding five, six years. And you see those exact statistics that you speak about. You see a lot of white. I listened to an audio digest about American Heart Association past president. He talked about how at the American Heart Association, he made it an effort, his initiative, his number one priority was to diversify the speaking panels so that no panel at this meeting would be comprised of more than 50% of each gender. So it had to be 50% female, 50% male. And I brought that idea as a possible one we could explore to this meeting. And the response I got universally was, but that wouldn't be equal. We'd be, you know, sacrificing a good speaker for maybe a suboptimal one. And my response to that was, there's a lot of folks who sit in the shadows of these prominent air quote speakers, right. That doesn't mean that they're a suboptimal speaker. It's allowing a group who otherwise wouldn't get that opportunity, the opportunity to raise up and become more notable because how do you become more notable? You get the opportunity. And so if we never give that person the opportunity, they never become that leader. We have to spend more time grabbing those speakers and pulling them up with us in order to create equity. That just really struck, you know, as an example of something we can intentionally be doing in our specialty and in our society, even at our meetings to help improve equality, diversity and equity. So anyway, I do want to talk more about how this is impacting quality of care. So just stay with me through a short break and we'll be right back.

DR. ALEX ARRIAGE:

Hi, this is Dr. Alex Arriaga with the patient Safety editorial board. Medication errors are not uncommon in health care systems in the field of anesthesiology. Medications are often prescribed, prepared, administered, and recorded by a single individual, all while working in a complex and dynamic environment. Pediatric anesthesia has additional intricacies surrounding weight based dosing. Physiology and pharmacodynamics. There are several measures to reduce the risk of medication errors in pediatric anesthesiology. Ensure accurate patient weight prior to procedures. Label all syringes and use standardized color coded labels when possible. When administering medications, particularly, very small volumes ensure the IV line is flushed and that the medication does not stay in line. Provide a well-lit workspace, and standardize organization of medication jars by promoting medication safety within individual systems as well as nationally and internationally, providers can work towards providing even safer anesthetic care to the pediatric population.

VOICE OVER:

For more information on patient safety, visit asahq.org/patientsafety22.

DR. TRAINER:

So welcome back. I'm here speaking with Doctor Locke about equity in health care delivery, and I'm interested to talk with her more about how equity and health care delivery intersects with quality of care. So quality has been a priority for some time now, but equity has not been similarly emphasized. And so considering the deficits, I'd like for you to speak a little bit on where those are. And how does a lack of equity equate to lower quality of care? Dr. Locke.

DR. LOCKE:

Thank you so much. And thank you for your your previous comments. The response of making strides to make things equitable and getting feedback that what you're doing is preferential or unfair is a common rhetoric. And putting together one of my talks, something came across my desk that was happening over at Brigham Women and Children's Hospital, where a couple of cardiac physicians there wanted to look into why there was data showing that black and Latino patients with heart failure at their institution ended up getting admitted to general medicine floors, rather than to the cardiology unit, where better outcomes were obvious. And so they found that there were explicit discrepancies and how that was coming about, and they wanted to look into why that was happening. And so when they looked into why that was happening, they looked

at all the other differences in these patients populations, and they accounted for insurance status, established links to care, and all the other medical conditions that the patients had, as well as their socioeconomic status. And they found that a lot of the white patients advocated better for themselves, and therefore they ended up on the cardiology units, like they were better informed, they knew what questions to ask and what to ask for. So they implemented a whole program that would start to specifically address that. And so aiming at equity, they implemented actionable items to specifically try to give their black and Latino patients what they needed in order to get the care that would be best for them. That prompted rallies outside of the hospital. The physicians who were in charge of that research, their pictures printed on flyers that were handed out outside of the hospital saying, you know, we won't stand for anti-white healthcare, and that they felt like the physicians were, you know, being racist in trying to achieve equitable care for these patients. And so that's what we're up against.

I think that it is it already speaks for itself that health care delivery and quality of care intersects very closely with diversity. And so we know that when it comes to delivering care, having already accounted for socioeconomic status and insurance status and all of the other things that we can look at, at the very heart of things, there is something that is going into ensuring that black and brown patients are having poorer outcomes in almost every health care area. And almost every health illness. And so we know that a lot of that is rooted in institutional racism and in implicit biases. So we understand that as physicians, our first instinct is to do the right thing. And a lot of what happens happens on an unconscious level. There's been a lot of research looking into medical students and how medical students felt Black people perceived pain, right. And so understanding that they felt that black people had thicker skin and that a lot of times their pain complaints weren't viewed in the same way. And so we know that this is happening from the very beginning, and this is often influencing our actions on a subconscious level. And so I think there has been a lot of work to show that when you work not only, you know, specifically to diversify your workforce, there are tangible and measurable benefits to doing so.

DR. TRAINER:

Absolutely. And you spoke about the mistrust in the medical system. I've actually had that same situation where, you know, a couple of the residents came to me and says, this patient's refusing to have surgery. It was an emergency surgery. And you go over to realize that the presentation with how they were presented seemed very threatening. The residents needed to be more culturally sensitive and explaining things, and they didn't realize that the way they were coming across was maybe being offensive and and scary to this patient. And so that implicit bias, where you just don't realize what you don't realize and you can't put yourself in their shoes. And if you don't put yourself in

their shoes, you're you're going to mistreat them, even inadvertently, even if it's not your intention. And that is a sad reality.

DR. LOCKE:

I 100% agree. And like I said, a lot of it oftentimes is unconscious. I had a patient similar to that who came down to the operating room for sort of an urgent procedure, and I walked in just to do, you know, my regular thing, get my consent and talk to them. And when he saw me, he said, thank God you're here. These white people are trying to kill me. And I was completely thrown off by that statement. I'm like, whoa, whoa, whoa. I mean, I had to pause mentally, like, okay, what is going on here? And so the crux of it being, you know, he said, I don't know what's wrong with me. They were taking him back for a biopsy, and he's like, I think I'm dying, and no one's telling me. Turns out he had an HIV diagnosis. or they were strongly suspicious of HIV, but they had not told him that. And I think he suspected that. But he felt like someone was hiding something, or someone was trying to do something to him that he didn't need done. Um, and I wasn't in any way a specialist, you know, I'm not a hospitalist or I'm not the person taking care of you normally. But you look at me and immediately felt a sense of trust. And now that's a big burden for me. Number one. And at the same time, it's it's almost you know, I don't know what you want to call it. It is it's it's a burden and a blessing because at the same time, I had the opportunity to advocate for someone who felt like they couldn't advocate for themselves because it was the same type of thing. You know, they didn't really wanted to go to the operating room. And everyone's like, well, you know, maybe we should just cancel. And it's just like, no, he just literally did not trust anyone who was talking to him and felt that we weren't acting in his best interest.

DR. TRAINER:

This story, I'm sure many of us listening probably have similar stories. It's all about being aware of that, right? And like basically having the wherewithal and the the awareness to pause and say, this doesn't seem right. There must be something else here. Right. You know and when we approach it differently and we think about it differently, you know, we're able to get these people better care, get them taken care of in a humane but also compassionate and empathetic way.

We talked a little bit about some of the examples how we in anesthesiology can help, but is there anything else that, as an anesthesiologist, we can be doing when it comes to helping advance health equity, other than what we've talked about? And can you please also speak to why this matters to every anesthesiologist?

DR. LOCKE:

So sure. I feel like, you know, we are positioned to lead on this forefront. I think because we have contact and access, if you will, to patients across specialties, that we have an opportunity to advocate at some of the most critical points in patient care. And so I always tell folks, you know, a lot of people don't really you know, you tell somebody you're a doctor and they just assume, oh, you're a doctor, you know? But I always tell folks that I'm the type of doctor that is there at a crisis moment. And so I think because we are there at such crisis points in time, whether it be in the on the obstetrics side or in the operating room, we do have an opportunity to lead and to advocate at critical at critical junctures. And so in thinking about why everyone in this specialty should care, it always takes me aback, because for me, you know, obviously I have no choice but to care. But in talking with other people, it's important for me to remember that it's often times hard for people to empathize with something that they may not have as part of their reality. And so that's where I've had to pause to say, like, you know, the question of why should everyone care? Try not to be offended by that question, but understand that everyone's reality doesn't put this in their face on a regular basis. However, it does put it in their face on a regular basis because we have to take care of patients. So while you may be able to go home every day and not be confronted with this problem. Every day at work you are confronted with this problem. And so I feel like in order to be both competitive and compassionate in today's world, it's imperative that you have a, um, a global cultural competency. It's very important for delivery of care that this remain at the top of your mind. I mean, because I feel like when you are cognizant of the fact that we talked about, you know, that there may be some mistrust when you walk into certain rooms or you encounter patients for the first time. If you're cognizant of that and you're sensitive to it, there are things that you won't miss. There are stories that you won't miss. There are diagnoses that you won't miss because if you're being sensitive to it, the patients are able to talk with you and open up to you in a way that maybe they wouldn't feel comfortable doing if you weren't sensitive in that space. And so I think that your ability to talk with people and to relate with them in some way directly reflects your ability to give them the best care possible.

DR. TRAINER:

Absolutely. And that's a great, great way of putting it. So I'm curious to hear if you have some tangible examples of how this lack of equity can really impact patients. And maybe you could touch upon how that impacts health care disparities a little bit deeper. Sure.

DR. LOCKE:

Sure. I'm happy to. I saw recently the American Heart Association put out a statement talking about this that really, um, caused me to pause. And they stated that 265 Black people die a day who would not die if there were no racial inequities in health care. And that was after adjusting for all the other outlying things like health insurance status and socioeconomic status, so strictly based off the fact that they were black. And so for me, I felt, how could this be? And you look for other examples. We think about breast cancer, for example. The incidence of breast cancer is higher in white women. However, the incidence of mortality from breast cancer is significantly higher in black women and at a younger age. Why is that? We look at mortality data for children undergoing surgery. And they found that for healthy children, the 30 day mortality for black children was three and a half times greater than for white children.

And so when we look at these statistics, if the only differing factor is race, what does that say about us? Because we are the arbiters of health care. And so I think those examples, in addition to, you know, the well-known examples about morbidity and mortality on the obstetric floor with black women in combination, just says we have a really big problem. Um, and it's, for me, it's important to remember that the reason that we are in this place happened over decades, and it happened in an intentional and a in a well laid out way. Right. You know, the country has a deep, dark history of ensuring that black and brown people were treated as less than. And so we've come a long way from that. But the structural determinants to health inequity are very much alive and well. That's what the data is telling us. And so I think it's important to understand that as we diversify our workforce, we need to include in that diversity effort, efforts to ensure that we are working towards equity and not just diversity.

DR. TRAINER:

Right, right. And can you give us some specific, tangible steps that we leaders, clinicians can take to advance that equity? Like what does that look like. And, you know, how does that keep patients safer?

DR. LOCKE:

It's important to look at what drives health in the first place. And so in order to be healthy, we have to have opportunities to be healthy at home, to be healthy at work, and to be healthy at play. We have to have opportunities to ensure that every person has an early childhood that is not wrought with adversity. There is a strong relationship between education and health. And so I think it's very important that as physicians, we take the time to educate folks. I know personally I've started, you know, when you see patients in the preoperative area or the perioperative area, you know, you see a patient and you can look at them and tell they have sleep apnea and they tell you they're not

using a CPAp. You know, I try to tell folks, hey, once you leave out of here, you might want to have a sleep study. You probably need a CPAp. But you've got to go the extra mile to say that to people. You're under no obligation to. No one's watching. But perhaps if you educated in that space, the next time they come back, they're somewhat healthier.

When we talk about opportunities to be healthy in neighborhoods, we're talking about getting involved in your local governance, where there are efforts to create safe spaces where the ability to make a healthy choice is now the easy choice. We know that there are portions of the country that are what people call food deserts, right? And that they have been built that way in an intentional fashion. Racism has played a vital role in ensuring that that's the case, including the country's history of racial redlining. So I think it's important not only to be involved on a national level, but to be involved on a local level and efforts that seek to address that.

Thirdly, I think it's important for us as physicians to get comfortable with getting uncomfortable when it comes to interacting with patients that you normally would not feel you could relate to. Um, and to understand that what we may often assume to be known may not be known or understood.

And I think lastly, it's important in this space to also support our colleagues who are underrepresented minorities. And I gave a talk at an outside institution about racism and structural racism within the House of medicine, and some of the feedback or sort of pushback I got was that, you know, I need to check my own biases, because how could I assume that every other black anesthesiologist had the shared experience of me? And so at that moment, I think it was important for me to say, you know, yes, I can assume that because we have all had the shared experience of being black in America. And the most striking thing about that particular conversation is that there was one black woman in their institution, and she stood up and said, yes, she can assume that because she's black and so am I. And she told me offline that after that talk, it was as if her colleagues realized for the first time that she was black, that they had never even really acknowledged that. Or when they said that, he said to her offline, I was shocked to hear you say that. And she thought, oh my gosh, we have a lot of work to do. If you were shocked to hear me say that. And so I think supporting our colleagues in situations where they are often the minority, and ensuring that they have a voice because they have an important voice that can only benefit us. But in order to use that voice, they're going to have to feel supported. I think that's also a vital piece to ensuring that we get to an equitable situation when it comes to delivery of care.

DR. TRAINER:

I just want to share one more story with you, because I think it speaks to the unintentional lack of awareness. If you don't pay attention, you miss a lot. So I was speaking with a resident at a meeting who said that they were one of the only minorities in their entire anesthesia residency class of, I think, 20 residents. And they said that that had been historically the case. And I asked, why is that? And they said, well, they could pretty much put a finger on it. When they go to interview at this residency program, first of all, you start with the entire interview panel out of 6 or 7 people like majority were white male. That wasn't as bad as the fact they take the applicants out to dinner at a restaurant that has Confederate flags all over the restaurant. And this was the traditional restaurant that they always took all the applicants to. And I said, oh my God, this sounds horrible. And did you ever say anything? And they said, no, I never said anything. Well, I know some of the folks who work there and asked them. I said, do you realize that you're taking these residents to a like, offensive restaurant with Confederate flags everywhere, and that could be contributing to your lack of diversity in your applicant pool? And this person with wide eyes--and I believe them from the bottom of my heart-- was like, oh my God, I never thought about that. And I never thought about it because no one never mentioned it. It's a popular restaurant. This is where we've always gone. This is something we've always done. I found it a little bit hard to believe they didn't recognize it or pay attention to that, but it definitely made sense from the residents' perspective why they wouldn't choose that program. Right? And that is something just very subliminal, but it is passively offensive. And those are little things that we need to pay attention to.

DR. LOCKE:

I agree. It's just, it's it's not uncommon. And you bring up a great point. You know, it's. It's in the little things that again, it does not affect you therefore it's not on your radar. Right. So I think, you know, for instance, when I moved down here, um, one of my colleagues invited me out to their subdivision. They were having some little party out there. Sure. No problem. The name of the place was called The Plantation. And I thought you live on the plantation. And their face paled like, oh my God, like it's been called that for 50 years. I never really thought about it, you know? And so I understand that. And at that stage in my life, I was in a space past training and I felt comfortable speaking on it. But you bring up another point. You know, when you're at the stage where you just want to make it, the advice that your mom is giving you and your grandparents are giving you and your uncle and your friends are giving you is keep your head down and your nose clean, and don't say anything. You just need to make it. And so kudos to you for asking the question and prompting and providing a safe space for her to express that. Um, but those sorts of instances are happening all the time, and people continue to receive the advice to just keep your head down and your nose clean. Don't don't rock the boat, don't make any noise, don't speak up and just do what you

have to do. And so because I have moved out of the training space now, and I'm now in a space where my livelihood is not quote unquote threatened or I'm not being judged by every little thing I do, it is an obligation upon me to speak. And so that's why I'm speaking today.

DR. TRAINER:

And I think you have to speak out. And we have to be deliberate. We just need more of us speaking out on it. And so I'm just going to ask you one last question before I let you go. I'd like to hear a little bit about your experience as a guest editor for this Monitor issue, and ask if there's anything specific that you hope readers will get out of the issue.

DR. LOCKE:

Um, so I've had a great experience with the Monitor. And this is my first time being a guest editor. And so I felt like it was an honor and a privilege. I am also on the editorial board of the Monitor. So for me, that was, again, an honor and a privilege. And I love to write. And so in another life, I would have just been a writer. But now, you know, I can do this and write. So that's nice. And so I felt like being involved in this, this particular issue and being given the opportunity to have a platform by the monitor's editor in chief was a heartwarming thing. So it was a great experience. I enjoyed both writing the articles and reading the articles. I enjoyed the opportunity to be able to reach out to folks that we may not have heard from in the past to say, hey, here's your opportunity. Would you like to write an article? And so that was also very rewarding for me.

And so what I hope that folks will get out of reading the articles and listening to us today is to have courage. Because the things that we are talking about will require courage. It will require the best of us. I spoke with this topic about a colleague at a meeting and she said, you know, I empathize with you Keya because I am in the LGBT community but when I needed to hide that fact, I could. And so I empathize with you and the fact that you cannot hide your minority status. You cannot hide your skin or who you are when you walk into a room. And she said, while I could hide that fact about my status and I did, it's not something I'm going to do going forward. And so I hope that people gain from this the courage to be the trailblazer, the courage to be the person speaking up.

DR. TRAINER:

Exactly. That's that's so true. And thank you so much for sharing your expertise and your experience. It's been a pleasure having you on the show. And for our listeners interested in learning more about this topic, don't forget to check out the monitor at

asamonitor.org Thanks to our listeners for tuning in to Central Line and join us again next time. Thank you.

(SOUNDBITE OF MUSIC)

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