Central Line
Episode Number 18
Episode Title – Diversity in Anesthesia – the LQBTQ experience with Dr. Hernandez-Conte
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(SOUNDBITE OF MUSIC)

VOICEOVER:

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

DR. ADAM STRIKER:

Welcome to another episode of Central Line. I'm your host and editor, Adam Striker. Today, we're going to do the first of what I hope will be a series of episodes on the topic of diversity in anesthesiology aimed at understanding where we're at and how we can improve. My guest today is Dr. Antonio Hernandez Conte. Dr. Hernandez Conte, who currently serves as a partner with Kaiser Permanente Southern California medical group has been a trailblazer on diversity issues and we're happy to have him here with us today to help us start excavating this important topic. Dr. Hernandez Conte, thank you very much for joining us today.

DR. HERNANDEZ CONTE:

Thank you so much, Dr. Striker, it's a pleasure to be here, and I'm happy to be involved in this new endeavor.

DR. STRIKER:

Well, why don't we start off by having you tell us a little bit about yourself and your background?

DR. HERNANDEZ CONTE:

Well, I think as we start to excavate this whole topic of diversity, equity and inclusion it's it's really important to understand that everybody has their own unique set of perspectives and a lot of that really comes into play as we start to learn about people such as myself and others who will be part of these podcasts.

So I am the product of a Mexican American first generation father and a mother who was Ethiopian Italian and born and raised in Ethiopia. So right off the bat, ethnically and racially, I'm quite diverse. Um, when you first meet me you sort of, you're not quite sure, you know, what I am. Some people might think I'm Asian, some people think I'm Latinx, some people think I'm, um, you know, Middle Eastern. Um, so my racial and ethnic background is quite unusual.

My father was in the US military and we traveled all over the world for the majority of my childhood, and ended up in Jacksonville, Florida as I was completing Junior High and then we'll be able to attend and complete high school. So in many ways I sort of look upon Jacksonville, Florida as, as my hometown, but my family has roots in Texas and my father currently resides in San Antonio.

DR. STRIKER:

You've had a multi-ethnic background, and you're openly gay. Has that affected your career in anesthesia?

DR. HERNANDEZ CONTE:

Um, you know, first of all, ironically, um, my being Mexican American or Mexican Ethiopian Italian didn't really seem to come into play for a large portion of my life, I think because of my background of having been a military kid. Most people who are in the US military tend to think of themselves as Americans first, and kind of you know their ethnic origin or race really tends to to play a more secondary kind of role. When you're living overseas, um, people say where are you from and you say I'm from the United States of America. So, for most of my, you know, formative years, you know, I really just considered myself an American but kind of, you know, an unusual ethnic background like many other military families.

Um, it became pretty apparent in my early teens that I was gay, although we never really used that word, in the early 80s when I was in junior high, high school certainly in the most people around me that sort of figure out that there was something a little different about me. And I openly came out when I was in college and I intentionally sought out a college in the Northeast that was extremely liberal where I could openly you know, go through the process of dealing with being a homosexual which at that time was not an easy feat. It's certainly not like today, where there is much, much less stigma, and much fewer barriers. It was very difficult to do, so I intentionally looked for a place such as Brown University where I ended up going to college, um, really outside of my geographic region, outside my circle of friends, and at that point, I really began to sort of go down a path where I intentionally, you know, looked for mentors who were

either under-represented in science and technology, or people who are like myself openly gay.

It really took a while for me to find my place in that paradigm. Luckily at Brown, um, one of the things that really attracted me to Brown was that they had a specific pipeline program that identified people who had an interest in medicine, an interest in science, and they really wanted to improve the representation of Blacks, Latinos, Latinx and Native Americans in the medical structure. So that program was really instrumental to me becoming exposed to sort of the world of medicine, but more importantly it really provided an infrastructure for me to succeed. It identified mentors that I could work with who would sort of endorse me, so to speak, so that I fell into a more protective sphere at Brown.

I think coming from a public high school in the south, I was somewhat naively surprised by exactly how different it would be to be attending an Ivy League institution, where certainly my, my race and my sexual orientation and my background started really becoming quite glaringly obvious to other people, and I had just sort of taken it for granted.

As I proceeded and graduated from Brown, you know I was an openly gay man, living life pretty openly, I arrived at the Boston University School of Medicine and 1987 and all of a sudden the situation was extremely different. And I had to go back into the closet, so to speak. For those of you who may remember 1987 was pretty much the beginning of the peak of the AIDS epidemic, and society at that point really identified, um, gay men with AIDS. So the two were one in the same as far as most people are concerned. So really there was a huge stigma to being openly gay and many people, you know, advised me not to reveal it, not to talk about it, just kind of lay low and, and do your work and get through med school and not worry about it.

I was also dealing with a lot of racial discrimination being in Boston during that same time. Boston with extremely segregated in the 60s, 70s and 80s. There were a lot of obstacles for people of color in my medical school class. They were very few people who are underrepresented minorities in medicine and you know, it was really a difficult experience compared to Brown where I had an infrastructure, I had a support network. Medical school was extremely difficult for me. I think due to the stigma of being gay, and it being associated with HIV and AIDS. You know, I really was dealing with a lot of, I think, negative perception. The issue of race just added another very large overwhelming aspect to this, and it really was a difficult time for me.

There were multiple students in my medical school class who were from underrepresented groups in medicine, and very few of us graduated on time. And I think we all sort of shared the same feelings that we really didn't have an infrastructure. We

didn't have any mentorship. We didn't really have a safe space, to, you know talk about our feelings or to express the difficulties we were encountering and, and some of those were related to being from, um, Latinx or Black or being a woman or being a gay man. It was sort of a combination of all of those things. So despite all that, by the end of residency, I actually did kind of come back out of the closet and declare myself because I just felt it was important for me to be true to myself.

DR. STRIKER:

So where did you go to residency?

DR. HERNANDEZ CONTE:

So when I was transitioning to, um, from medical school to anesthesiology residency, I was really looking for a place that would be a lot more supportive, and very fortunately ended up at Yale for my anesthesiology residency and, um, it was a completely different environment. It was a hundred eighty degree change from being in Boston. I think first of all, the atmosphere within the department at Yale was more like a family. They were extremely open in the way they approached students and residents. They were extremely open about how they asked you about your social life, if you had a significant other. There were a lot of little sort of, very small clues that sort of just alerted me to the fact that it was a great place to sort of start to, you know, train and and begin my life anesthesiology.

I, I've spoken about the concept of having a mentor or not having a mentor and probably one of the most pivotal thing towards my being successful at Yale, during my anesthesiology residency with having two very important mentors. And these are people who I think many people in anesthesiology, um, have gotten to know and they been impacted by the mentorship the first of which is Dr. Paul Barish, who most recently passed away. And the second of which is Dr; Roberta Hines, and they were both Chairs at Yale. What was so special about them, was that they were able to basically create a relationship with their residents and foster their success, foster their development, um, identify what their special talents and skills were, and really lead them, you know, sort of to the next phase of their of their profession. So at the end of the day, you know, a, a large portion of my success in my transition sort of being openly gay and being a Mexican-American, um, really has its roots in these two very, very significant mentors at Yale.

Another common thread that I've really found throughout my career in anesthesiology, is that the majority of my mentors have really been women, for whatever reason. It may be that women are not threatened by gay men, in, in the way that many heterosexual men may feel sort of threatened or uncomfortable, or that they may have also experienced in

a very similar, um aspects of non-inclusion or outright discrimination. But for me, it's always been this recurring theme that women have sort of become my mentors.

DR. STRIKER:

So, where did you go after Yale?

DR. HERNANDEZ CONTE:

When it was time for me to leave Yale, I was really looking for an opportunity where I could develop my, um, sort of, business entrepreneurial spirit and I was looking for opportunity, really in sort of the private practice realm, and I was hoping to either return to Florida or to move to Texas where my family was.

So once again, sort of the ugly head of discrimination started to rear its head as I started to leave this very protected environment at Yale. I interviewed at multiple groups in North Florida and throughout Texas, and just found repetitive environments where they just frankly didn't feel comfortable with having an openly gay man as part of their medical staff. When I confronted many of the Physicians who had interviewed me, they just said well, you know, it's pretty simple, you know gay men aren't doctors. They can be nurses, but they can't be doctors. When I asked women doctors about it in the same environment, they sort of gave me the answer that well, you know, we're trying not to upset the apple cart because we have a job, but you know, it's not that much easier for us either being, you know, the one woman.

So, it was really difficult to sort of try to find the right place where I would thrive and be successful and fortunately I landed at a very unique opportunity in South Florida in Broward County, Fort Lauderdale. This was really a turning point for me because, you know, all of a sudden, one, I was in an environment that didn't seem to discriminate against me based on my, my ethnic or racial origins and certainly my sexual orientation. And more importantly, the hospital in which I was working at was extremely open to having people be a change agent, to having people sort of identify opportunities where the hospital can serve the community a little better.

So that was really a very unique time in my life. I was there for about ten years. We took that group to sort of its completion, ended up selling it to a third party, venture capital entity. And then I moved on to Los Angeles where I worked in another private Community Hospital for 8 years. So now many years, later after having started my journey in anesthesiology, I'm a partner with the Southern California Permanente Medical Group, which is part of Kaiser Permanente, and the Kaiser Permanente Federation.

One of the things that really attracted me to Kaiser Permanente and our medical group was that the group is extremely progressive in the way it looks at practice, the way it looks at physicians leading the organization, in the way that it places an emphasis on culturally competent care that takes care of people in our community. And so I really have sort of been galvanized by the environment in which I work in, and have now been able to sort of rise to becoming the physician champion for LGBTQ care, and I'm the Co-Chair of the LGBTQ Committee. I'm also a physician ambassador for customers and business engagement within the organization and I'm the leader for the Perioperative Translational Research Group. And a lot of that would have never really happened in a in a lot of other environments or in a lot of other practices without this very formal intentional thought out process regarding equity, inclusion and diversity. And so now I find myself talking to you all about how I've landed at this place.

DR. STRIKER:

Well that is an incredibly moving story. The different environments that you have had to navigate are incredibly varied and one question that, that comes to mind is have you become more of a cynic, less of a cynic as you've gone through your journey, um, seeing different cities or locations or practices treat you differently? How has your journey taken you in that regard?

DR. HERNANDEZ CONTE:

Well, I'm happy to say that I've actually be, not really a cynic at all. I'm actually quite hopeful. There's been so much change throughout the United States and I think that's part of why we're having this conversation today, because the Amerian Society of Anesthesiologists are looking towards the future and looking towards how do we, you know, represent our medical community, and and the patients that we serve? So I think there's been a lot of evolution. Unfortunately, we still have a lot of work to do but, um, I think, you know, we are heading in the right direction and there's a lot of hope.

DR. STRIKER:

Well, I'd like to explore your journey just a little bit more. Do you feel, over time, as you've gotten more mature and more experienced, um, in your career, do you feel that your comfort level with being openly gay and um, having to have dealt with diversity issues throughout your career, have you felt that you have grown into being more

comfortable in that regard? Or has society allowed for that? Or is it a combination of things? Or do you feel like nothing really has changed much in either of those factors?

DR. HERNANDEZ CONTE:

I think that's a really interesting question. I think it's it's definitely a combination of, of all of the above. Certainly I have become, you know much more comfortable in my own skin, and I, and I am certainly much more forthright and and not apologetic for who I am or what I am, or where I'm from. And in fact, I'm actually quite proud of of my very diverse background in my upbringing and, um, all of my perspective.

I do think that society has certainly evolved, but it's it's been a little slow. Social change certainly comes about slowly. I think what's actually happened though is that there are more people like me. There more people who are really no longer afraid to step into the spotlight, so to speak, and to speak up and to let their voices be heard. And one thing for certain that sort of I have become is that I am certainly not shy about knocking on doors and looking for opportunities or looking for someone to be an ally or looking for someone to possibly champion an idea or an endeavor with. Whereas in the past, you know, I might stop at the 2nd door that says no, where as now, you know, I might I'm I not stop until it's like the hundredth door that says no and to be frank, I usually find somebody who says yes, you know, usually by the twenties by the 20's, the 15th or 20th door, I found somebody who is actually, oh, the see my perspective and, and they've heard something about it before they, you know, they have some insight about it and they probably agree that something needs to happen. So, you know, I think it's a combination of everything and it does take people to, you know, put themselves out there to, you know, whether you're confident or not your own skin, it always requires someone to make, you know, themselves vulnerable, make themselves vulnerable to rejection, make themselves vulnerable to possibly being ostracized or being marginalized. You know, and that's never really fun.

But I think certainly as, you know, you have more professional credentials and sort of a reputation that precedes you, uh, those things become a little easier because you become more legitimate, you know, when somebody hears you know, something from someone who's been the CEO of a corporation running 200 anesthesiologists, or, you know, somebody who's been authoring chapters in text books and writing, you know, dozens and dozens of manuscript, they certainly realize it's not just some, you know, one-off, kind of hair-brained idea. So, you know, I think it's all of that.

DR. STRIKER:

Based on what you just said, and thinking back to when you were at Brown and you had a very welcoming environment, and you had individuals there who are encouraging of

you going on to medical school, do you think that without that welcoming environment, you would have still pursued that? How much did that help you in your decision to become a physician?

DR. HERNANDEZ CONTE:

For me it was, it was a tremendous, you know, asset. Whether I would have succeeded, you know, in spite of it, or in spite of it, hard to say. But certainly it made me a lot more successful or a lot more competitive in the pool. It certainly, you know, allowed me to go to a, top-tier, or near top-tier medical school. I think one of the things that you really have to call out is that programs like the program that I was part of that Brown called the Health Careers Opportunity Program, those things, they just don't, they're not just things that are done on the fly or there's somebody, you know, sort of second hand thought, they're extremely intentional, they're well-thought-out. They have a vision, they have an operational plan, and they have a strategic directory trajectory. They have, you know metrics with which they're trying to achieve and they really are looking to effectuate change. And so a place such as Brown, it's so forward-thinking and, and, so, you know intertwined with the education of the undergraduate students. I think it's extremely unusual. I don't think that really exists everywhere.

But if we fast forward even to now where we look at organizations, whether they be Fortune 500 organizations or whether they be, you know, organizations in medicine that are successful and that do create trajectories for people to become successful, opportunities and glide paths for people to move into leadership position. It's extremely intentional. It doesn't happen just by chance. It's happening because people who are current leaders have taken the time to investigate a particular deficiency, they've taken a lot of evaluation and examination to try to determine how to change something that is a recurrent problem.

DR. STRIKER:

This is going to be, I think, a common thread throughout this particular series of podcasts, but the idea of perhaps indifference to the problem, versus actively identifying it, and seeking out solutions, do you, do you feel that indifference is a greater problem? Perhaps people not intentionally, you know, looking to keep anyone down, but either turning a blind eye or not caring or not choosing to see it versus someone proactively seeking those individuals that may have unfortunately, feel that they can't achieve what they can because of a personal situation?

DR. HERNANDEZ CONTE:

Well, I think there's a number of factors that come into play. For many people, there simply is, we'll just call it, sort of a blind spot. They may not even, you know, identify or recognize that there is a particular issue at hand, and, for right now, we'll just say, you know, there being X number of women leaders, women in leadership positions or there being X number of underrepresented minorities in the medical community or there being X number of the LGBTQ positions in the medical community. It may not even occupy, sort of a conscious, you know, place in their day-to-day operations.

Now part of what sort of exacerbates that is then, you know the people, or the organization or the infrastructure underneath them, also posseses unconscious biases that just tend to sort of amplify and allow that behavior to persist. Until you really get a, sort of, threshold number of complaints or there's a threshold number of people who are willing to speak up and make that problem known and that that problem or that issue sort of rises above the level of noise and becomes sort of a galvanizing call to action, do things soft of start to become, you know, sort of, realized.

I think, you know, much of why we find ourselves today in in this sort of position is the recent events regarding, you know, the murders of, of multiple Black Americans, and the entire Black Lives Matter movement. We find ourselves today now at a point in society where there, we've risen above, sort of, the noise. We've risen above the fact that the statistics can no longer be buried, we've sort of risen to the point where it's noticeable, and that everyone around us notices these things and whether it's Black Lives Matter, or whether it's sex discrimination with regard to leadership positions, or whether in regards to marginalization of LGTBQ physicians, or persons in the community, all of this stuff has sort of, you know, risen above that threshold and now, you know, it's really taking, you know, a place front and center for many, many organizations, who are, you know, now having to deal with it. And some are dealing with it in a very responsible and intentional way, um, and they have they're developing glidepaths that will accelerate progress in that area. Others are maybe taking a much more, sort of, wait-and-see approach and it may take longer to effectuate change. But I think you know we're at this point now where you know, due to, you know, the internet, Instagram and Twitter and the use of video cams, we're really able to, in a display, you know, very demonstrably, a lot of these types of problems, or societal ills, if you will.

DR. STRIKER:

It's an unfortunate truth that when we talk about diversity of any kind, we have a tendency to expect those who share the minority status under discussion to educate everyone else. Does that feel like a burden at all to you?

DR. HERNANDEZ CONTE:

I, I have never thought of it as a burden. I've always thought of it as basically, um, having the opportunity to tell people a little bit about myself and for them to have a little bit more insight or have them, have them gain little bit more understanding about who I am and where I'm coming from. The reality is, unless you know anybody really speaks up, and sort of speaks their, speaks their experience or, you know, allows their voice to be heard, we really can't expect other people who don't necessarily share the same backgrounds or the same traits, or the same experiences to, you know, explicitly understand that. You know, I think that it's a big leap of faith, for, you know, even the most evolved person with the highest emotional intelligence, that's really a big leap.

When I was at Yale, I came out, I was an openly gay man, and at the time there were no openly gay residents, or no openly gay attendings, there was, nobody really on the professorial staff in the department, and so, you know, people came to me and they asked me a lot of questions and a lot of those questions were really uncomfortable. They were really awkward. Some were kind of silly when you think about it, you almost laugh at how, you know, you know just kind of trivial they were. But I didn't see it as a burden. I saw it as a way, sort of, for me to be open and honest with my colleagues and I took it as you know, I, I looked at it as the fact that these people were interested in hearing about me and they were actually interested in trying to learn about me and trying to figure out you know how to connect the dots. And I think, um, we sort of all have a responsibility to, um, make ourselves known and make ourselves heard.

You know, back in the 1980s when the AIDS epidemic was really at a, sort of a boiling point, there wasn't a lot of governmental action. There weren't many drugs being produced in order to combat AIDS. There were some, sort of, we'll just call them you know progressive radical advocacy groups. And one of their slogans really was quite, quite striking. And I think about that slogan to this day and that slogan, which was by the organization called Act Up, it was entitled Silence Equals Death. And what that really meant is that if you stay silent that at the end of the day your voice won't be heard and it'll probably lead to your own death because, you know, nobody's listening to your needs. And I always think about that, uh, as I kind of meet people or when people sort of don't understand what's going on. If I remain silent and I don't let my voice come through, or I don't, or we don't let the voices of people come true, then inevitably we, sort of, you know, we, we bury them so to speak. They become dead because we don't hear them. We don't see them. We don't acknowledge them. Um, so I, I don't see it as a burden. I actually see it as, um, part of our responsibility to society.

Part of why we've made so many advances and gains is because there have been people before me who have really taken it upon themselves to go out of their way, whether they be, you know, Black Americans who have, you know, sat on the bus and refused to be kicked off, or whether they were women who, you know, just kept at it and didn't allow you know, sex discrimination to, to obstruct their path to leadership

positions, or whether we're LGTBQ people who are marginalized. I think we we all have a responsibility to make our presence known and not be silent.

DR. STRIKER:

I imagine you've been in situations where you're with a group of people and something is said. They perhaps don't realize that you're gay, and perhaps a jarring comment or a joke or something like that that is instantly visceral and, uh, and perhaps offensive. And, in those situations, if you if you've ever encountered them, how do you handle those? Just if you could talk a little bit about that kind of a situation

DR. HERNANDEZ CONTE:

Yes, and for me personally, I've always sort of tried to take the higher ground on things like that. You know I'm not a person who confronts people assertively or aggressively, and I've never really felt that that's the best way to build bridges with people. And I've always sort of looked upon that type of interaction, when a comment is made, or there's a very uncomfortable situation, or you know something that's even said, as you mentioned, that's offensive, I really think about it for a little while. I gather my thoughts and maybe even wait a day, or, you know, at least a few days. And then go and approach that person in private. And I just try to have a very open conversation, just, kind of, letting them know how that felt to me, how that was perceived to me and you know if there was any, you know, malicious intent in in what they said, or if they even realized that what they were saying was offensive to either me or others in the group. I, I don't, I don't ever see, you know, active assaults and confrontations to, you know, be the way out of, or to be the way to solve problems like that. Um certainly, you know, we have situations as anesthesiologists where we work in the operating rooms, and I think, we, we sometimes have to just call it out right then and there and say, you know everybody let's, you know let's lower the temperature of the conversation in the room, because, you know, we're treading on thin ice here. Sometimes you have to kind of call it out, but you do so in a manner that's professional and also respectful.

I, I think one thing to understand is that, you know, we often asked for zero-tolerance, that um, that we're not, you know zero tolerance for racism, or we have zero tolerance for, uh, homophobia. Zero tolerance doesn't mean that you have to completely understand it, or that you have to completely agree with it, or endorse it. It just means that you have to acknowledge that we're coming from a different place and that your behavior, or that your language or your actions, you know, in a particular regard, will no longer be tolerated. It doesn't mean that we're going to completely, you know, change your mind about how you feel about things.

When we sort of start speaking about we're going to have zero tolerance in the operating room, we're going to have zero tolerance in society at large, you know we have to be really, um, we have to really choose our words carefully and we have to understand, what, what we really mean by that.

DR. STRIKER:

When you've handled situations like that, is there a typical response you receive? Is it usually positive? Maybe, uh, certainly in the professional realm, but anywhere?

DR. HERNANDEZ CONTE:

I've found it that it's usually very positive. I've found that usually people are legitimately, um, apologetic that they've said something that they honestly didn't even think that would be offensive. Um, they usually extend an invitation to sort of learn more about either me or the persons involved or the behavior. I've actually always found, um, most people to take the high road really. Maybe that's because you know, I work in a very professional environment or, um, you know, the majority of my, my life, my adult life has been in, you know, large, you know, metropolitan cities, where I think people, um, you know, have been very open to change or you know open to certainly seeing other people's viewpoints, um, from different backgrounds.

But I, I've actually never really had an issue with it. Um, I think it's really important regardless of which side of the, sort of, the table you're sitting on, is to always, you know, understand that you should be respectful. You should be, um, try to be compassionate, you should try to be, um, non-assaultive and non-confrontational, and just try to sort of look at the big picture, and also put yourself in their shoes, um, because I don't necessarily have their perspective and I'd like to learn about you know, someone else's perspective of what may have led to those actions or behaviors or, you know, whatever it was that we are now having a conversation about.

And so, you know part of what, um, I think part of why certain organizations are so successful in, in advancing diversity, equity, inclusion or creating these very progressive sort of work forces or environments, is that they have created safe spaces for conversation. And they've created avenues where people, you know, they're not threatened or they're not intimidated or there's no fear of retaliation for bringing these types of things up. Um, but that, I think is, is not really the norm. I think certainly many people fear, you know, if they speak up there will be retaliation or they they fear that something will happen to them or they'll be passed over for promotions or things like that. So, you know, we still struggle with that.

So I think if we take the, you know, take the high road and always try to be respectful. professional, you know, try to be insightful and to try to see the other side of the coin, I think we can certainly, you know build more bridges than, than trying to blow them up.

DR. STRIKER:

Certainly. Let's steer just a little bit more towards anesthesiology in healthcare. Let's start with anesthesia, your fellow anesthesiologists. Is there anything you'd like them to know? Or, or what, what are things that you wish people knew better in our, in our field?

DR. HERNANDEZ CONTE:

Well, I think anesthesiology is, you know, very unique specialty because, one we have very limited, you know, exposure to the patients before we actually anesthetize them. You know, the majority of us spend 10 to 15 minutes of time with a patient. Um, we sort of we sort of honestly and frankly admit that the patients don't belong to us and that we're not able to, or we think that we are not able to really impact their care, you know, beyond the fear of our immediate operating room environment.

One of the things that I think it's really important for anesthesiologists to, you know, come to terms with, and, and it, they're certainly many leaders in our specialty who have um you know thought about this, you know, how do we, how do we impact care? How do we improve outcomes beyond our immediate area? How do we effectuate change? And the reality is, for us to do that, we have to really step outside of the operating room. We have to be more involved in pre-admission, screening and evaluation. We be more collaborative and work more closely with the primary care providers and the specialists, you know which our patients may belong to, so to speak. Or we may have to work in other environments where we haven't, you know, really had a place.

I think one of the things that has been, you know, so uniting about the COVID pandemic, is that anesthesiologists have really sort of stepped outside of their traditional box and been deployed into other arenas. They've taken, um, you know, they've taken um, the leadership role or they've taken a role in really, you know, stepping to the forefront of managing patients in the Intensive Care Units. Especially for people who don't usually work in those areas, they've, you know, worked creatively with engineering and with operations managers to figure out, you know, how to accommodate these patients. And I think what you've really seen is that anesthesiologists do have the capability and the capacity to effectuate change, as it pertains to a particular patient in the greater construct of medicine. As opposed to just limiting it to, you know, the few hours that we have in the operating room. So, as anesthesiologists, I think, you know, we can continue to sort of extend that thing. You know what? I think we can make our patients lives and their healthcare better if we start to consider, you know, how does

race, you know come in, you know come into the equation? Or how does you know they're being LGBTQ to come into the equation? Or how does, you know, their socioeconomic status come into the equation of, of improving their care? And what can we do?

For me in particular, you know, as a, as a gay man coming of age um, during the AIDS crisis and then sort of seeing the impact of the anti-retroviral therapy in, and HIV positive patients arriving in the cardiac operating rooms, I took it upon myself to become an expert in, you know the management of the HIV patient in the perioperative setting. And it's really become something that I have become extremely passionate about. It's, it's an area that has been not very, has not been well explored by our specialty. Um, we've certainly come to understand it a lot better and made a lot more advances about how to we optimally manage HIV positive patients who are undergoing surgical care. Um, and that's just I think, a small example. I think if every single one of us uses our own particular perspective and background and couples it with something that they're passionate about, we can most definitely effectuate change you know, outside of our immediate sphere in the operating room.

So I think that's really, I think, sort of a call to action for my fellow anesthesiologists, is to you know step back, see what you can do, you know, to improve the health of everyone in our society or everyone in the healthcare system in which you deliver care, um, and try to make it better for everybody because at the end of the day, that's what you know equitable healthcare is all about. It's trying to, you know, eliminate those disparities and trying to make things really, you know, equal for everybody. So everyone has, you know, a good chance of survival, or an excellent chance of survival, or so that you've optimized outcomes for every single type of patient, or patients from every single type of ethnic, um, you know, background or racial, uh, group and things such as that. So I think I think that's, you know, my, my request and my ask of my fellow community.

DR. STRIKER:

I've always felt that we, as a specialty have such a unique opportunity given the short duration we have to spend with our patients typically, not, not in every realm, but usually and how much of an impact that short interval can actually make if we proactively address something in it. Some of the contacts before I've talked about it was been with the opioid epidemic and, um, just asking a couple questions can potentially make a difference in someone's life, or discussing the, uh, treatment in that regard and, and how it can play out postoperatively. But you've certainly touched on a whole litany of other areas as well that you can make a difference in someone's lifestyle and healthcare and, and I, I agree. I think anesthesiologist certainly are well placed to, to make a huge difference in a short amount of time in any patients lives.

DR. HERNANDEZ CONTE:

Absolutely. I definitely agree. I think one of the things that's most wonderful about our specialty is is the fact that you know, we're really, you know, we're really the the the cement or the glue that holds all of the bricks together in the house of medicine, and I mean we are really omni-present in almost every area. Sometimes we're seen and not heard and perhaps it's, it's time for us to be more heard, you know, and for us to step up to the plate and sort of start knocking on doors, whether they be on the primary care doors or the specialty doors or you know, taking taking a leap of faith and start evaluating something that has really not been evaluated at all. You know, I, I think a big example of this is, you know, we know that, that cardiovascular disease is disproportionally, quote, impacts men. Well, we know that because all the research is on men by men.

Um, but we have very few leaders in the world of cardiovascular medicine who are women, and so by default, we don't really know a lot about cardiovascular disease, or we know less about that area because there aren't, you know, women looking at that, um, with regards to women. And so, you know, if you just look at something as basic as that, you know, we have so many opportunities in which we can start evaluating things, you know, in, in partnership with, um, the specialists we work and, and our colleagues who have expertise in it and a wide array of areas. Um, so we need to harness that and use that, and allow their, you know, allow synergy to sort of come in to play. You know, intentional, well-thought-out synergy.

DR. STRIKER:

Let's talk specifically about the LGTBQ community, as long as we are talking about health care disparity. Sometimes simply because of that acronym for for instance, we homogenize the very diverse community that that encompasses. Is that problematic when we discuss the issue of health care disparities?

DR. HERNANDEZ CONTE:

Yes, it's, it's very problematic. I think, you know, it's as problematic, it sort of, you know, whether we make a generalization about, um, you know, women in medicine or whether we make a generalization about quote under-represented minorities in medicine, does being Native American, Latinx or Black, and then those who are LGTBQ, you know. The lesbian, gay, bisexual, transgender and queer community is extremely heterogeneous.

And within every one of those letters in the acronym reside another silo of heterogeneity amongst itself.

Um, part of what sort of happened is that a lot of people sort of you know, have the perception of the LGTBQ community being, you know, a very affluent cisgendered white man, and they think oh, well, you know all gay men, you know, are cisgendered white men, they are affluent, the live a, a nice lifestyle, they have good jobs and everything, and I think part of why that's happened is because that's what the media portrays to us. And that's what's comfortable for us. If we just look at, you know statistics in the LGTBQ community, the vast majority of people who are LGTBQ actually tend to be people of color. They can either be Latinx or Black. They are actually not Caucasian, but yet that's sort of the representation we get from the media or from TV. We also know that the obstacles and barriers that reside within the LGBTQ community with regard to healthcare, are extremely different. The discrimination that an LGB person receives while significant, is certainly nowhere near as bad or as severe as the sort of obstacles and barriers that a person who is transgendered experience.

At Kaiser Permanente, we launched, um, an initiative a number of years ago called the Sexual Orientation and Gender Identity Intake. We refer to it as the SOGI Intake System to attune our physicinas to that very important aspect of a patient's, you know, background. Medical issues, you know, are certainly a consequence of many things and being a lesbian woman and or a gay man, or a bi-sexual person, or a transgender person certainly may place you at risk for a number of, of various, you know, health care issues or complexities and by, um, Kaiser Permanente starting to catalog that and, you know, use that as part of your initial intake, or your ongoing intake, it really has allowed us to improve that that care that we deliver to LGBTQ people as well as to sort of um, you know, diminish the the disparity that exists.

Now Kaiser Permanente it certainly is not an open system, you're not within the system unless you have you know Kaiser Permanente insurance. So we're not able to change, you know, everything within Society at large but we're certainly able to optimize it without our insured population. But has, you know, it really has been noticed and we have been, I think, leading the way. Amongst other things, the COVID-19 pandemic has really, you know, shed light on the disparities that exist amongst LGBTQ people and people who are of lower socioeconomic means and certainly people who are Black and Latinx.

So the state of California has a Senate bill that specifically asks for the intake of sexual orientation and gender identity for any patient who is being treated for COVID We're hoping that will pass into state law and that all healthcare providers and institutions will have to start collecting that data, although it's not that easy to necessarily put in place. It certainly is a manner of trying to better understand the impact of the COVID-19

pandemic on this particular population and it will start leading us in the right direction with regards to that one particular issue.

But we have a lot of work to be done and like many things part of the reason why does disparities exist in the LGBTQ populations is because there aren't as many providers who are comfortable dealing with the population, or are knowledgeable about the specific issues that may affect the various people in that LGBTQ spectrum. And so it it it really is a large obstacle to overcome and certainly even in in 10 or 20 years we've made progress but it hasn't been nearly as as ideal as we would have liked it to be.

Certainly having LGBTQ physicians will help, but it can't be just us. You know we can't improve the health care of marginalized persons all on our own. It has to be an effort made by the entire house of medicine so to speak.

DR. STRIKER:

There's a couple things I want to follow up on with what you just said. Number one: I think it's a point that I think it's probably evident to so many people but probably bears repeating which is the heterogeneity of many people, and the idea often times we're bombarded with the concept of everybody being put into one box, or a group, or an forgetting that the vast majority of us are a makeup of different backgrounds and different experiences and one, or the description of one uniform group probably doesn't tell the whole picture of any given individual or patient. I think that's an important point especially as physicians to remember that it's, the identifiers can be can be misleading and often simplistic when we are trying to get to know a patient.

DR. HERNANDEZ CONTE:

I agree with you completely and I think as anesthesiologist that problem is compounded because we try to condense, you know, as much information as we can about somebody into, you know, a really short concise catch phrase. Or we create these very very sort of snapshot views of people without really recognizing or understanding that there may be really a lot of layers to their background that's impacting the care that we're about to deliver, that you know there really is a very large, you know heterogeneity in what we're doing.

Certainly practicing here in Los Angeles on Sunset Boulevard and I think I treat a facit of the entire world in any one day or any one week. It's just mind numbing. That may not be the case everywhere, but certainly, you know, we try to develop a better perspective or three-dimensionality about how to deliver care, or try to appreciate the nuances of that.

Going back to my research in HIV, I think a lot of people they would just write down HIV-positive or, you know, AIDS, and they wouldn't really think too much about well that person's on 3 to 5 medications, any one of those medications may cause multi organ system, you know, impact or deleterious effects. Those medications have drug drug interactions with some of our anesthetic agents. Most people just write down HIV AIDS and that's about it.

So I think it's just an example of how, you know, as anesthesiologist we get into this code of simplifying in our patients has as much as we can and not really thinking about how really nuanced and three dimensional they are.

So going back to what we were talking about earlier at that as anesthesiologists we have to step back, look at the forest and not the trees. And sort of look at all of this in sort of much broader context. And then how can we become change agents?

DR STRIKER:

Certainly. What can physicians and maybe specific anesthesiologists do to perhaps overcome the healthcare disparity issue than anything the tangible that people listening right now can can do in their practice.

DR. HERNANDEZ CONTE:

Well, I think first of all, so much of the change that’s occurring within our specialty is is really coming via our leadership. It didn't go unnoticed that the ASA really started to take a very, you know, sort of dramatic turn in the way they were, you know, approaching the membership and approaching our presence in the national sort of medical arena up until the time that we started having women presidents, women leading the ASA, you know, recently Dr. Linda Mason from California, currently with Dr. Mary Dale Peterson from Texas, and our president elect Dr. Beverly Philip from Massachusetts. In just three years we’re going to have, you know, basically the entire United States being represented by extremely insightful and visionary women. So right off the bat our specialty in our society is benefiting by a very insightful and intentional leadership structure that is really, I think, becoming aware of the problems that are sort of plaguing us.

I think the very first thing that every anesthesiologist group, or sort of every department, probably need to do is take time to query their members and say listen, let's let's talk about what's bothering you all. Let's talk about, you know, what do you think are the real problems in this group? Or where do you see inequity? Where do you see

discrimination occurring whether that be blatant or unconscious? I think you really have to be honest about creating a safe space for us to have frank conversations and listening to what's happening.

As I mentioned earlier, you know, society is at this point where there's so much, you know, there's so much demand for change and it's sort of risen above the level of noise, But in society in general that's occurred in a country that haa 330 million people but if we bring that down to our own departments and our own hospitals, maybe there's not as much demand for that, or maybe it hasn't risen above the noise level because we're still not really looking, you know, or we're not seeking to listen to our colleagues or we're choosing to, you know, just blatantly ignore them. So I think the first thing I would as is that we be mindful that, just because you don't recognize the problem doesn't mean it, it isn't there. It's just that we need to start being intentionally open to listening to or soliciting it.

Once you sort start that the floodgates start to open and you start to realize that there's a lot of work to be done. And every institution and every place in the country sort of has sort of different issues, they're on different time points of things that need to change or what are particular priorities. And that's well within the purview to establish that

I think we just need to understand that we need to continue to be very mindful that discrimination in the medical workplace and certainly in the anesthesiology workplace continues to occur. We continue to have hostile work environments. There continue to be issues regarding diversity, equity, inclusion and marginalization of people who aren't necessarily that of the majority.

So we have to really continue to address that. And once again the ASA has steps to address that but I think overall medicine is a little bit behind society at large and certainly looking at, you know, Fortune 500 companies who have been extremely successful in many of these regards, we need to look at some of their playbooks and try to adopt some of what's been successfully used and implemented towards their being so equitable and so it sort of state-of-the-art and how they approach their work and start adapting it to us.

DR. STRIKER:

Well you touched on the ASA and some of the evidence of progress somewhat, but they did put out a statement recently on racism in healthcare disparities. And, do you think that was progress? Or do you think it was enough progress? Or was it just a start? I just want to get your opinion on that statement.

DR. HERNANDEZ CONTE:

Yes, actually I think that's part of why I ended up on your podcast. I saw the statement. Dr. Mary Dale Peterson spoke to the California House of delegates at our June meeting. And she spoke a little bit, took a little time to talk about that Twitter message and the background, how it came to be, and you know sort of readily admitted that there was a fraction of the society that didn't think we should say anything, there was a fraction of the society that said we should say something, and there was a fraction of the society that said we should say much more than what was so. So, I think, one, I'm certainly proud that the ASA did say something. Could we have said something more? I think we would probably could have. But given the fact that there were so many statements coming out from so many organizations, you know, I think what we did was actually quite good and I think appropriate for us and our presence.

I think what it did reveal, more importantly, is that there are a portion of people in our in our specialty, in our society, who don't think we should say anything at all. And I think that really points to, you know, an undercurrent to a problem that exists, that there are a percentage of people who don't think that black lives necessarily matter, or that under-represented minorities in medicine don't warrant further evaluation or attention, of that issues pertaining to LGBTQ status and equitable treatment really reside within the purview of the ASA.

And so I think we have to do a little bit more digging because I think what it did is it sort of exposed the tip of the iceberg and us needing to be a little bit more rapid in what we are going to, you know, design and construct to take us to the next level.

DR. STRIKER:

Do you think that people not speaking up is it indicative offeelings that people just don't want to deal with or is it, do you think it's more a result of the environment where people are afraid to say anything because of what might happen if they say anything? In other words, do we, as you just alluded to perhaps, should we be creating that environment to allow people to have an important dialogue?

DR. HERNANDEZ CONTE:

I think it's both. I think, one, I think people haven't really been given an opportunity to speak up and when you don't give them an opportunity or a safe space then they won't.

I think also, a lot of people have seen that when people speak off, you know, they're labeled as you know, a Pollyanna, they're labelled as a complainer, as a troublemaker. And so when you see one of those two things go down and then you're thinking about your, quote, academic career, or your, you know, trying to climb the leadership ladder. You don't necessarily want to jeopardize your own professional trajectory and so people start to, they start to recoil.

I have a feeling that they that they got a lot of responses to that. And I think because it created, it finally created, a little bit of an opportunity for people to speak up a little bit. And as I was alluding to earlier, and will reiterate again now, is that you know, if we don't intentionally create safe spaces for people to speak up without fear of retaliation or without this fear of being ascribed in a negative way then we're never really going to make any progress.

I think once again if there's reinforcing is that much of this change that are specialty society has undergone been under the auspices of our women leadership. And as I alluded to very early in this podcast, my mentors ,as a as a Mexican African gay man, have actually always been women. And so I think women are our allies and I think there are certainly trying to be more insightful and trying to be more deliberate about looking at the entire picture.

DR. STRIKER:

You said this couple times now but important for allies to speak up, correct, staying silent is part of the problem.

DR. HERNANDEZ CONTE:

Yeah. You know, I think, I think you know, it's, it's one thing to allow your voice to be heard. And you know, let's just say we go to the exercise and, and your voice is heard, you allow your there's a there's a space for your story or your journey to be heard, what have you. Nothing really comes of that unless somebody who has a platform the can actually affect change picks up on that and then continues to move with it.

You know, certainly if you're in the rank-and-file, one, you don't have the time to do that. Two, you don't have the resources to really put anything in place and you certainly don't have the authority or the leadership capability to call for it and have it be done. So whether you call them a mentor or whether you call them an ally, or what you call them a leadership executive sponsor, or whether you call to CEO of a company. It really has to come, at some point, it has to come from above, you know, really be endorsed. And then you know when, when sort of that vision is, is embraced then you can operationally start to design it and then and bring it back down and then you have this bidirectional

and multi directional movement in how it gets designed and operationalized and implemented. But you know a single voice on the rank-and-file, that doesn't usually do anything.

And so part of why I'm sitting here before you now chatting with you is I think that, you know, I've been able to effectuate changed in my facility and within the Kaiser Permanente system. I think there's multiple people who've been able effectuate change at their state level, at the national level within, you know, a number of different platforms. So you know we certainly need people whether they be an ally and looks completely different from us or whether they be people like us we certainly have to have enough support and cooperation and legitimization from people who are actually in leadership.

DR. STRIKER:

Let's end this on a hopeful note. What do you think would be your top action items for the ASA and other medical organizations to advance in terms of anti-discrimination actions or policies or or or anything?

DR. HERNANDEZ CONTE:

Sure. Well, first of all, I'm really proud to be a member of the American Society of Anesthesiologists for so many reasons. And I think it's because they have always tried to take the right path and they've always tried to listen to their constituency and take us down the road that makes us better physicians and better able to deal with our community.

So I think the first thing is I think we need to take the recent Supreme Court ruling that affirms that discrimination on the basis of sex or sexual orientation or gender identity is illegal and it will not be tolerated.

There have there been many states, many groups, many organizations that have allowed that discrimination to occur explicitly and implicitly. And our society should definitely take a stance towards ensuring that any person who is a member of the American Society of Anesthesiologists should not be subjected to that. It's taken fifty years almost since the passage of the Civil Rights Act of 1965 for us to actually get to the point where, you know, we have acknowledged that LGBTQ status and sex in and of itself cannot be used to be, as discriminatory measures. So I think the ASA needs to really own that.

I would certainly like to see the ASA assist, you know, many of the groups and many of the … practice environment in and creating resources and tools so that we can better, you know, effectuate change.

As recently as this week ASA Monitor we saw a really nice sort of diagram as to how you begin to create equity, inclusion and diversity within your leadership ranks. And certainly we can, we can take the lead on developing the tools and the resources that our physicians and the groups and, you know, the the multiple organizations that we work with can start to, you know, distal that out. Because it really does sort of come from us. But like I said, we can't do it alone.

So I would really like us to continue to take the lead and, and step up to the plate. And we have a lot of allies. We have a lot of people who are willing to do the work if you just give them the opportunity. So, you know, just send the message out. I think you'll be the ASA will be overwhelmed with the number of people who will want to get involved.

I think lastly is just that we remain intentional in our struggle to continue to speak of this and to not just give it lip service and to say, well we have one woman, you know, out of 80 people who is in a leadership position and the should be enough. Or we have one person who is LGBTQ out of 100 people in a leadership position and that should be enough. I think we have to be extremely, you know, honest and say no, the ASA and you know, the entire sort of hierarchy or in the committee structure or, you know, all of the multiple infrastructural levels of ASA have to more accurately depict, one, the population of physicians at large, and, two, the population of patients that we serve. And there just needs to be a little bit more alignment in that.

And, um, you those sound like three really big asks. But they’re actually, I think, we have the resources and we have the intellect and the capacity to do all of that in a very short period of time.

If anything, the COVID pandemic has really taught us that we are extremely resilient and we are extremely enabling in coming together and developing tools and developing strategies and treatment things that we would never thought of, you know four months ago. And yet here we are in a revolutionizing care in the midst of the pandemic.

DR. STRIKER:

Well, Dr. Hernandez-Conte, I just want to thank you so much for sharing your story, your insights, your perspective and for a joining us today on the podcast.

DR. HERNANDEZ CONTE:

Thank you so much. It's really been my pleasure to chat with you today Dr. Striker and I wish everyone well. Stay safe.

DR. STRIKER:

You as well. Thank you.

DR. HERNANDEZ CONTE:

I started to get a little teary eyed.

(both laugh)

DR. STRIKER:

You were talking though a lot of significant life events and so it's, yeah, that's a lot to go through.

DR. HERNANDEZ CONTE:

Yeah, well, thank you for letting me speak and, um, I'm really excited to hear this entire podcast series. I think our members are really going to enjoy it. I think it's the beginning of a very, very unique, you know, collaboration. You know, I think it's important that all the different voices, or many of the difference voices, get heard. I mean that's really all that people are asking, is just that they get heard a little bit.

DR. STRIKER:

This is Adam Striker, thanking everyone for joining us on another episode of ASA's Central Line and we will see you next time.

(SOUNDBITE OF MUSIC)

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