



American Society of  
**Anesthesiologists™**

Residents In a Room  
Episode Number 15  
Episode Title – The Black Experience in Anesthesiology  
Recorded August 2020

(SOUNDBITE OF MUSIC)

VOICE OVER:

This is Residents in a Room, an official podcast of the American Society of Anesthesiologists, where we go behind the scenes to explore the world from the point of view of anesthesiology residents.

Having each other's backs is a start, having allies is huge.

Just because I wear the weight well, doesn't mean it isn't heavy.

They ask me, can you show us some sort of proof that you're a physician?

DR. DARYL KERR:

Hi everyone, good evening. My name is Daryl Kerr. I am a, uh, fellow at Duke University Medical Center and welcome to Residents in a Room, a podcast for residents by residents. And I'm accompanied here by a couple of my fellow anesthesiologist colleagues.

DR. LYNDSLEY BRADLEY:

Hi everyone. My name is Lyndsey Bradley. I am currently, uh, a first-year fellow in, in chronic pain at UT Southwestern in Dallas, Texas.

DR. ELIZABETH FEENSTRA:

Hi everyone. I'm Elizabeth Feenstra. Um, I am currently a chronic pain fellow, um, and I am at UCLA right now.

DR. JASON CAMPBELL:

Hey guys, uh, Jason Campbell. I am a PGY3 CA2 here at Oregon Health and Science University in Portland, Oregon, uh, and, I, uh, don't have fellow behind my name, so I'm, I'm just glad to be in on the conversation.

DR. KERR:

We're, we're glad to have you, Jason, fellow or not.

DR. CAMPBELL:

I appreciate you.

DR. KERR:

All right, thank you guys for, uh, joining us today. I kind of just want to let us jump right in to the topic here, which is the Black experience in anesthesiology. But also, please share your experiences as a physician. So let's start off by, uh, sharing some of the experiences we've had, um, maybe as a Black medical student or as a resident, you know that some of our, we'll just be plain, white colleagues, might be surprised to hear about. You know, times that we've been singled out. Or um, you've had your expertise questioned and you felt like that was based on, on your race rather than on merit. And sometimes it can be painful and exhausting, which I know, mm, but we're going to talk about our experiences. And, I know that we each have one, two, maybe more experiences so I can start by sharing mine first and then I can let the, let us go around and talk a little bit more about what you guys have experienced.

I recall a time when I was a medical student, you know, just walking into a lecture hall and, you know, unbeknownst to me, there was some projector issue, um, that was going on prior to me arriving. And, um, this particular instance you know, kind of burned itself into my memory because when I walked into the room as a medical student, you know, typically go to lecture you don't have to dress up necessarily kind of wear track pants or wear, or wear like a loose-fitting t-shirt. So I was kind of dressed casually walking into lecture when I was stopped by a professor, who asks, oh, are you here to fix our projector?

DR. BRADLEY:

Wow.

DR. KERR:

And, you know kind of looking around and trying to see okay, you know where is the punch line? Um, but there really wasn't one. Um, so that's something that really, you know, stuck with me and one of the things is that, um, albeit that this experience, you know, wasn't in the US, I know that you guys will for sure have some experiences. Do you want to talk about them?

DR. BRADLEY:

I can, um, go next. I have experienced several different instances over the course of my training where I thought that I was sort of, well, it was clear to me that I was being singled out being, um, an African American female. Um, the first instance that I can recall very clearly is as a third-year medical student on my internal medicine rotation. I have never in my life before been called a racial slur directly to my face and I had a patient that we were seeing on rounds for the first time who had been admitted overnight. So, you know, you're sort of introducing yourself, um, as part of the team that will be taking care of them and, um, a gentleman, uh used a racial slur and said that he did not want me to be a part of his care team, uh, because in his past experience, um, African Americans were thieves. And so that was very sort of shocking and, and I think because I was so much younger, um, it really was traumatizing at that time. I remember I had to take a couple moments and break off from everyone else.

And then, um, more recently in residency, I was about to start a case with an African-American attending and our patient, uh, requested that another team take care of them for their anesthesia. Um, and it was sort of very clearly, um, him wanting providers who were not African-American. So those two big things stand out in my mind, but then there's also the little day-to-day things that I feel like I can encounter sometimes. Like just when I go to introduce myself to a patient in the morning and I'm standing next to, uh, maybe a (sic) who is of a different race, um or is white, and immediately the patient will say oh doctor, referring to them. And never crossed their mind that I am the physician, resident, fellow in that scenario.

DR. KERR:

Wow, sorry to hear that.

DR. FEENSTRA:

Yeah, thank you.

DR. CAMPBELL:

Yeah, I agree.

DR. BRADLEY:

Yeah, definitely. Um yeah I've, I mean I think I've had, you know, some similar experiences with you, Lyndsey, (sic) you're talking about though, with sort of the day to day things that, that sort of wear on you over time. You know, being with, you know

white, um, medical students, and always, you know, you're clearly the one, you know, giving me information about anesthesia, and you know, what, what's going to take place, um, and you can see the patient sometimes just, instinctively, you know, they'll always look towards the, the medical student even though you're the one doing the talking and you're the one who's introduced yourself, you know, as the physician. Um, that's happened to me, probably more times than I can count, unfortunately.

Even, you know, I've had a scenario relatively recently when I was, um, just finishing up my critical care rotation at the end of residency, um, where, I can you know I can think of where that happened, um, where we had a medical student, and um, even though I was the one actively managing this sick patient in the ICU, you know, the surgical teams came up, and instead of directly interfacing and talking with me, they were trying to get information from the medical student, and you know, I was trying to show them, I'm, like, you know, I'm, I'm the resident here and I'm the one who's been, you know, actively managed this patient, so, you know, those are the things that, that I've experienced, you know, um, um in residency.

You know even outside of the hospital, a couple of years ago, I was on a plane and they called for medical assistance. I've had, um, you know, friends who even as early as medical school, when they were on a plane, um, and someone called for medical assistance, you know, they presented themselves and the flight attendants, you know, willingly had them join the team to take care of, of whoever was in need of assistance. But, you know, in this scenario, I was in residency and I, you know, I went to the, the flight attendants and told them, I'm like, I'm a physician, I am happy to help out, I'd love to help out, uh and they, they asked me, they were like well, can you show us some sort of proof that you're a physician? And I, I, well, I don't have my, I don't have my medical, you know, license on me, I'm on vacation right now. So, I ended up, you know, not being involved with helping out. I think, you know, someone else must have presented themselves, or they decided they could deal with it. Um, and so, yeah, you know, I was fully qualified, but, you know I think they looked at me and in, initially didn't think that I looked like who they thought a physician looks like and so asked for credentials, which I couldn't, you know, present at that time, so, so yeah, that was definitely another experience, where, yeah, it really, you know, hits you when you, when you have all these experiences sort of building up over time.

(Agreement)

DR. CAMPBELL:

Absolutely. You know, I don't have, um, an in hospital experience like what you guys have mentioned, and I think that I always try to present that one as a blessing but also, um, as a means to say but still supporting what you guys are saying and maybe people

will recognize that just because it hasn't happened to a Jason Campbell, doesn't mean that it hasn't happened to many of my colleagues, all of my colleagues, some of my colleagues, and anything like that happening to more than one person is an issue.

And so I think that, uh, the one experience that I've written about is when I was um, 2011/2012, um, I was a um, (sic) in AmeriCorps program and driving back from my girlfriends house at the time, kind of just fell asleep at a red light after a long Friday day of working, um, and then woke up and kind of might be pressing the gas pedal and went through, uh, what was then, um, kind of a light going from red to green, but it was definitely a little bit premature and that and that manner. I had remembered that there was a cop near me. And so I said, oh, um if he's still near you, he's probably going to pull you over. I should just pull over, you know, to kind of accelerate this process and hopefully, you know, uh, demonstrate some will, willingness as so far as acknowledgement, and so pulled over. He came to the window. I kind of started off with like, you know, hey, sorry I had a long day and I kind of realized I had, you know, kind of ejected out into the intersection a little bit early. Um, and this is probably 11:30 at night. But at this time, you know, everything's going fine, asking for my license and registration and he's being respectful, um, and he's an Asian American gentleman, and then he says, well, do you have any, any weapons in the car? And I say, no, uh, I don't. It's my mother's Lexus and just, you know headed home from dropping off my girlfriend, um, and he says do you mind if I look? And so in this situation, as I've noted, there's two ways to handle it. One, whether you look at what's right or wrong, legal vs. Illegal, you can play that game, or you can play the how do I want to better, how do I want to get home safely? How do I want the situation to go best for my own good? And so I said sure, no problem. Got out of the car, took a step back, he felt underneath the seat for probably ten seconds, said have a good night and kept it moving.

So of course there are a ton of things that are going through my head, when something that happens, but at the end of the day, it's like, home safely, I can write about this later, talk about this later, help others navigate waters like this if they ever happen. And I just think that, um, these experiences are, are far too common, and, and are too often race related, or race-based.

DR. KERR:

Right, we've highlighted some of the key factors and points that we experience as, uh, Black individuals. You know where our race or color affects us professionally and in the community regardless of what our profession is, but I do want to particularly ask, the, the uh, ladies, do feel that being a Black woman and I stress the woman part because I know that women in medicine, um, particularly have a difficult time with patients as well demonstrating that they are substantially in the (sic) position as a physician, but do you

feel like that also kind of pushes a bit more of that uh, that prejudice towards, you know, being a Black person and a female?

DR. FEENSTRA:

I think, um, I would say yes, I think there's both of those factors are involved when, when we have patients who, you know who, who have difficulty believing that we're physicians, or um, you know tends to um, not think that we're, you know, credible enough to be a physician, um, I think yeah, I think there probably is sort of that double whammy of being both Black and being a female in, in the field of medicine.

DR. CAMPBELL:

In the field of life.

(LAUGHTER)

DR. CAMPBELL:

You know, talk how it is. You know, we're recording this podcast right now and one day, after Joe Biden has selected Kamala Harris to be his, uh, VP running mate, having her as the vice presidential nominee, I mean, these things matter for all of us, right? It's just huge.

DR. BRADLEY:

Yes, um, because we are on the precipice of this very historic moment, um, in which we have the first African-American uh, nominee for, on a presidential ticket and it's been amazing over the past 24 hours seeing all these women come together and say we are so excited to have ourselves represented. It means so much to us to have someone who looks like me on the television in this capacity. Um, and so I think on top of what Elizabeth was saying, it's that double whammy of two different implicit biases. Um, one being you're under-qualifications as a physician because you're a woman and then you're under-qualifications as a physician because you're a woman, and then your under-qualifications because of your race. Um, and so both of those factors do come into play and I think, in part, it's because people are really not used to being us, um, as part of their healthcare teams in positions of organizational power and so it is a very foreign concept and one that sometimes, in their minds, uh, needs to be rejected.

DR. CAMPBELL:

Sure, an African American female who, who looks like you, thinks like you, is ambitious like you, and to finally normalize these concepts and actions and acts for the world to see, and for you to see, I mean, I know that for Daryl and I, I mean in 2008 I was in Atlanta as, you know, President Barack Obama was, you know, won. And, I know for me, (sic) Atlanta, Chicago or, or DC, those were like the three cities to be in for that, and I was just like, you know, I was in one of them, and I was like is incredible, you know as a young Black male then, 10 years, 12 years later now, it was like, you know, this is something that you're never got forget, and hopefully changes the world and all of us individuals for the better.

DR. KERR:

Right, right, and then you know kind of going along, um, you know, changing things for the better, you know, when we talk about these biases that we experience in our day-to-day lives, do you guys, and you guys can speak freely, do you try to correct someone when they are showing an implicit bias? Whether it be your colleague or you know, do you try to correct even a patient? Do you say, like, hey, that's not an appropriate thing to say or that's not an inappropriate thought. Do you try to help steer them and direct them down the correct, you know, path in that sense?

DR. BRADLEY:

I will say that, um, I think that I have different approaches when it comes to direct patient care. If I'm in a situation with a patient and they might say something insensitive or, um, racially charged or make an, an off-color joke. I've had patients do such things in very critical situations. You know, patients who are coming in, uh, with stab wounds being wheeled into the OR and we're trying to get lines started and, and, and drips going, and, and they're saying some sort of, uh, insensitive or crazy things. Um, that is not the time that I usually use to correct patients, and, um, if I think that it's going to, you know, in some way be an obstacle to their care at that moment, I won't necessarily bring it up at that time.

But in other situations, um, especially over the last few years, um, if it's in the workplace, even if it is an attending, um, or someone in a position of power and something like that comes up, I do try, um, and make it known, even if it's in a joking manner, like wow, that was a really stereotypical thing to say, or wow, um, I wonder how so-and-so would feel if they heard you say that? And I think it's just so vital for us to do that because it's in those little moments, and those little comments, and those little micro aggressions that go unchecked largely over and over again, that sort of perpetuate this undercurrent notion that is okay and acceptable and it's 100% not. And I feel like if I'm going to ask, um, my white counterparts or other people in medicine to stand up when they hear these things, um, and I, I ask them to be a good ally, uh, then I

myself must also take that uncomfortable position at times and, um, take the time to educate, correct, inform, stand up.

DR. FEENSTRA:

Yeah, I, I agree with you, um, there Lyndsey. I, I think that, um, you know, it, it does create some uncomfortable moments and uncomfortable conversations, um, and I myself still, you know, especially wrestle with, um, when these moments happen with attendings, just because it's the, you know, hierarchical nature of, of medicine and, um, I think for me it's a lot easier when it's a colleague vs. um, you know a co-resident, co-fellow, then when it's, um, then when it's an attending. But you know, I do agree that, you know we are asking our, our white colleagues, to be, to be allies in this with us. And so, um, you know if we're asking them to, to, to stand up, um, and say something and have the uncomfortable conversations then, you know, we, we should be too. And it's sort of only in these uncomfortable moments that we can sort of create these conversations that are, that are im, important.

DR. KERR:

And I totally, I totally agree with you both, you know. I um, I pride myself on being a funny guy. I know that our, our viewers, and our listeners can't really see me, but you know they used to call me Eddie Murphy when I was a kid, and because we have some similar features, and I can laugh like him and do the whole bit. But you know, with that, while I'm at work, I am quite humorous and will make jokes, plenty of times, um, making my colleagues and my attendings laugh. But whenever I come across an instance of, you know, a micro aggression or, um, I feel like something doesn't sit right with me, with how an attending addresses something, whether it be with myself or a, a patient when it, um, I think that race or ethnicity is kind of involved, my tone completely changes and they understand the gravity of, you know, kind of what they're, what they're saying and how that can come across and what the perception is from both, you know, the receiver and bystanders around who are, you know, listening to what they're saying.

And it's hard to kind of do that in a way when you're dealing with an authority, uh, an authority figure like an attending or, um, you know, a Program Director, a Chair, um, it's hard to kind of do that without having the fear of compromising your professional progression, right? Because at the end of the day, that's, we all kind of want to keep things moving forward, especially for ourselves professionally. But at the same time, we want to have that integrity to stand up for ourselves and say, no, this is not okay.

DR. CAMPBELL:

Yeah, and that's easier to do in some ways, the higher up you get. So, it's one of those things, for me as a resident still, um, and I'm, you know, a relatively outspoken kind of guy, but I still know that there is a fine line that, you know, you have to walk to pay (sic) to what your institution's policies are, both formally and above ground, and informally. Um, and I think that, so it really helps when you have fellows like you guys, when you have attendings like you guys will be soon to really stand up for the, the pre-medical student, the medical student, the resident, uh, and building on that cycle, uh, because there are, regardless, there are not a lot of us out there. And so having each other's backs is a start. Having allies is huge, um, but having allies where we're not supporting each other, that doesn't work either. And if we only support each other, we don't have white, Asian, Latino, Latina allies, then we're not going to get to the same place that we need to get to together.

So there's a lot that goes into it, and, and I guess I ask you guys, kind of, what led you to where you are right now because for me, you know, I'm a DC guy and they say, well, you're in Portland Oregon like, not the most diverse state, so talk to us, what's going on? And I said that's true, but my hospital, like my anesthesia department is diverse. You know, they're arguably one of the most diverse anesthesia residencies in the country, in Portland, Oregon. So you talk about intentionality, and so I went somewhere that I said you're going to support me, they're going to understand me, and there are others that walk in the room in the OR and the pre-op area that look like me. Trust me, things aren't perfect. But you understand that was one thing that led me here. I don't know what along your path have been decisions that you've made to be successful based on color of your skin, based on your gender, and if you want to share any of those.

DR. BRADLEY:

So yes, I can say, um, being someone who's from the South, being born in North Carolina, um, and raised in Texas my entire life before leaving, uh, to go to undergraduate, I made a conscious decision very early on knowing the political climate that I grew up in, the social climate that I grew up in, um, I really wanted to find more diverse faces and spaces in which I would not, um, have any restrictions placed on my education or the care that I was able to give patients, um, based on, uh, certain things that might just be going on politically in a state that I was in. So I sought out very intentionally going, uh, to Vanderbilt for undergraduate which I'm have a very diverse, um, and within that, a large African American community and then deciding to go west, um, out to UCLA and wanting to be part of a very progressive program. Um, I will put an asterisk there, um, and say that for anyone who is listening and thinking, you know that a radical change such as that is what you need to do in order to get a great medical training, um, that is not always the case. Um, you can receive great training anywhere and you can be the change that you want to see, um, wherever you start your medical training. Um, and I will say actually that coming out to Los Angeles where I thought

surely everyone's going to be much more progressive, um, I found that people were only a lot more vocal about their stances than I had experienced in the South. But, uh, the same stereotypes, biases, uh still tended to, uh, hear their ugly had in, you know, Santa Monica California. Um, so definitely not, not immune to uh, those types of things happening anywhere, but I, I do think it's great to try and find a program, um, and community that you know you'll be supported.

DR. KERR:

Yeah, I totally agree with you and I think that what kind of helps your professional development is finding a place where you feel very comfortable in your surroundings, where you don't feel like you have to look over your shoulder for every micro aggression that might occur. Right? Or the prejudice and might be right around the corner and you can kind of really just focus on, you know, your professional development honing your craft and really just focus on the job at hand which is becoming a very good an, anesthesiologist.

I did want to actually just keep going with that thought because in addition to dealing with the biases aimed at us, you know we're often sometimes seeing those same biases within, being directed towards patients, Black patients, Brown patients, um, Asian-Americans Latinos, Latinos. Particularly with the, you know, Black population which is what we're trying to focus on today, um, you know, there is always sort of this undertone of these, these patterns that particularly and sometimes undertones, sometimes overt, practices that disadvantage people of color. Right? So, I know, I know the four of us probably are well aware, um, of this sort of history lesson, but just for, you know, listeners who are not sure or haven't heard about this, um, but you know, Tuskegee. There was a study done that looked at the, it was a study based on the untreated syphilis in the Negro male, right, the Black male. It was a 40-year study started in the thirties and ended in the seventies, for a disease that we learned eventually that could have been treated with Penicillin. Right? So during this 40-year time period, men were offered, you know free medical exams free meals, burial insurance, but the fact that they weren't provided the treatment for something that was already well-known and founded, is where a lot of Black patients kind of have a issue with trusting physicians.

And if we're talking about physicians, you know, historically the image that people have, which is why we have these issues with biases amongst patients, is that they envision a white person as a physician. So that when we come into a place with diversity, right, exactly what we were saying about Kamala Harris, right, we are seeing ourselves, you know, our Black sister as a nominee on a presidential ticket. We see ourselves in, and in the in the Black community and say, oh my God, that's great. I see, I can see myself, there's someone there who looks like me. I feel a type of way that's better.

Patients, when they come into the hospital and they see a, a diverse group of physicians and they see a Black physician here and they see a (sic) physician there, they see, you know, not one, not two Black people as physicians, they too also feel that way. Now have you guys also experienced this at your, at your hospitals, or during your training where Black patients would say, oh my God, I'm so proud of you. Like you're representing us. Please, keep going, please keep doing, keep fighting for us.

DR. CAMPBELL:

Oh, without a doubt

(AGREEMENT)

DR. CAMPBELL:

I mean, serving a patient, serving a Black patient is like what keeps you going on some days, you know, it's just like that, you know, it's great to see you. I know that, I know that what it took you to get here with a lot without even knowing you, um, and so yeah, that that very quick sometimes, but very love filled interaction is, is amazing.

DR. FEENSTRA:

Yeah, no, I 100% agree and, um, I think, um, Black patients when they see you, um, you know, they're hopeful that you maybe understand some of the things that, that other physicians, White physicians, may not understand about, you know, where they're coming from and, you know, why they may have difficulty taking their medications and, um even accessing (sic) in the first place. Um and so yeah, I have many, many instances of, um, Black patients just being very grateful to see, to see uh, a Black physician taking care of them.

DR. KERR:

Right? I wanna pull this in a little bit more because now, especially now dealing with COVID. You know, for years, we've been dealing with conditions that greatly affect, uh, Black people. Right? We've had very well documented, um, higher mortality rates in Black women, um, during pregnancy. And now we're also seeing this higher COVID mortality rates among Black Americans. Do you guys feel that medicine will kind of start to understand what it's like to be a Black person as a patient and having a Black physician and having both of those present and having the, a marriage between those two will be able to help patients? Or do you think the medical community's kind of not ready to do that?

DR. BRADLEY:

I think our patients are yearning for that so strongly that whether the larger medical community is ready or not, um, it has to occur. Things are going in such a way that I feel that that there has to be a shift. Um, for so long, we have had to deal with the ramifications of systemic racism, so these political and social structures that have held minorities back, um, from achieving the same things, um, that maybe, uh, their white counterparts were able to achieve. Um, and so when you have African American patients, when I do, like Elizabeth was alluding to, there's, there's this recognition of a shared experience, a lack of judgment for um, some social circumstances that may arise.

Um, I can't tell you how many times I've been in a situation where a patient was discriminated against based on the fact that they were African American and assumptions were made about their med compliance, why they did not show up for appointments, um, and a whole host of other things without looking at the context of uh, the structures that are in place that have made it difficult for us to have the same outcomes as others, that like you were saying Derrick, have led to us to have these higher morbidity rates with certain diseases and mortality rates overall and that affect um, women, um, giving birth uh, to children and the higher rate of complications that African American women face. and I think it's so important that you brought up Tuskegee because that was only 40 years ago. That is astonishing to me when I think of that. My, my father was born in 1952. That experiment had been going on for 20 years and would go on for another 20 years, and I think it's easy to say, okay, well even so, that would never happen now. But, in many ways there are things that persist, um, that we still unfortunately tolerate as far as different groups of people having access to different things that still persist strongly in our society to this very day.

DR. KERR:

And just to dig into that a little bit more, Lyndsey, Jason, Elizabeth, please feel free to chime in here. People may say that, oh that won't happen now, but what balances and checks have the medical community put in place for those things do not happen now? Right? We're looking for a vaccine right now, hopefully for COVID-19. And what is to stop patients from thinking, oh, in, with Tuskegee, they had a, they had a treatment but they didn't offer to us. How do we know that you guys may have a treatment for COVID-19, but you have us acting as a control group? To put it in a very politically correct way, um, a control group or guinea pigs for COVID-19 that's already adversely affecting our community.

DR. CAMPBELL:

Oh, I just think that, you know, I'm a, I'm a kind of a glass 75% full kind of guy. So, I, I do believe that I don't know what we have implemented yet. But I do know that we have, I believe, enough persons that do look like us in more powerful positions to at least ensure what happened 85, 90, 100 years ago doesn't happen again. At least not to that severity, and hopefully not to that severity, and hopefully not at all.

Um, and now I have to say my grandma is 97 years old, fully coherent, just talked to her two days ago on her birthday. And so she's reliving, she's dealing with stuff that she dealt with as little girl in the 1930's now in 2020. And it just, it, it blows my mind. I can't even comprehend what she looks at on TV and what he thinks about with all of her lived experiences. Proud to say that I still see an optimism, that in her eye, and I hear in her voice, that I try to live out individually and expect. And so we'll see if I could be wrong and, and Daryl, Dr. Kerr, right? But I just hope and expect the fact that, you know, when this vaccine comes out, it'll be given, maybe to healthcare workers first, and that will be the how you know, things are kind of marginalized, but I certainly hope that it won't be a, a racial issue. Could be socioeconomic status? Yes, because we know that socioeconomic status is arguably more determinant of certain things than race, but we don't have enough time for that today, so, I'll let Lyndsey go.

DR. BRADLEY:

Um, I think that African American patients would definitely be well within their rights to have an opinion or a question about what a potential vaccine uh, could mean for them. Uh, again, just looking back at the historical context, um, you know Tuskegee was just one of the many things, um, that unfortunately, um, happened, uh, in our history. Um, Dr. Sims, who is known as the father of modern gynecology, um, and is still uh, touted as such in books to this day, um, who actually, uh, developed the speculum, uh, that we all know, but he did all of his experiments on enslaved African women during the late 1800s. And so we have this history of repeated trauma at the hands of health care systems, government, um Flint with their water contamination. And so I couldn't, I couldn't tell an African American patient that they should not potentially ask additional, additional questions, that their fears were not warranted. Um, and I feel like it's up to us as healthcare providers to help change those perspectives. And I would ask not only that African-American trainees and physicians, but also, um, those from other backgrounds to take the time to actively think and say okay I'm thinking of all of this knowledge that this person might be coming in with, all of this historical trauma that might be consciously or unconsciously on their mind. How can I help reach this person today?

DR. FEENSTRA:

I agree with both of, you know, both of what you've been saying and you know, like talking about this reminds me of my aunt who, um, she's in her upper seventies now and she's someone who consistently throughout her life, um, has had a pretty deep-rooted, um, mistrust of, um, the medical system, you know, because of things like Tuskegee and, you know, more recent things like Flint. I mean, I'm from Michigan my aunt actually lives in New York, so she's not in Michigan but, you know, all of these history sort of repeating itself multiple times, um, I think that there will be, you know, many, many people like her who will be, you know, hesitant and reluctant to, um, get the COVID vaccine um, because, because of what they've seen as history has repeated itself.

So I think, you know, it will, it won't, it won't be easy and how, how do you, you know try to, to talk through this and and sort of, um convince patients that, you know, even though they are reluctant to get the vaccine because of, because of things that have happened in the past, that COVID itself is also a huge, um, healthcare threat to Black and Brown, um, patients. So I think you know, I think that will be difficult. But again, the more, the more, um, Black trainees, physicians, and, and allies that we have as colleagues, I think hopefully we will be able to help with some of these, um, patients who will surely be hesitant to, to get a vaccine.

DR KERR:

And you know I, and I think they were all kind of on the same page here in thinking that our Black community will, you know, look up to other Black physicians to provide guidance on whether they should receive certain treatments or not. Right? Because as our patients, yes, they see us similar to them in the position that we're in, I think they inherently have a little bit more trust in us as Black physicians to say, hey, we're not trying to do you harm here. As a medical community, this particular plan is the best plan for you.

DR. CAMPBELL:

Right.

DR. KERR:

And I think that, um, you know, that onus has fallen on us to do that. So I want to ask you guys, do you feel, do you feel that we should simply take on this onus or do we feel like the other races and ethnicities can and should also try to, you know, tell their patients the appropriate thing and try to develop that trust? And if not refer to us, if they, if you feel comfortable you can talk to someone of the same ethnicity as you.

DR. CAMPBELL:

You know, I just want to repeat what you said that was so eloquent. You said our patients see us as themselves. I mean, man, that's, that's great stuff right there. You know, in short, I'll just say that I think that it's, it's always necessary for physicians to be well read in the literature, to do what's necessary for the patient regardless of their race, or maybe I should say actually specifically, you know, in, in hopes of bridging the gap, bridging the divide. I tell people if you come into the OR, or into the pre-op bay, you know, you're 70, 80 years old, I look at you like you're my own grandmother. And I say, how many of my white colleagues and counterparts think about it that way if it's an African American elderly person. And if we can start having that mindset and we need our allies to, to come on board, you'll see change at the national level, the institutional level, you'll see change in communities, um, and I think that's what we, what we need, and I think that's what's missing.

DR. BRADLEY:

Yeah, um, to go, um, off of what you brought up about moving forward and the responsibility, uh, that is on us as Black healthcare providers, I, I do think in many ways uh, the charge will fall to us on as it has previously. Um, as we all know, um, a justice too long delayed is often denied and, and the progress that we've had, we've had too many instances scraped for tooth and nail, um, and so I think that we will have to be in those positions to educate others, but also our counterparts do also need to help us, um, because we can't, we can't do this alone.

And I always have heard, um, the saying and it just really, really rang true in residency, um, towards the end of my training as we all sort of bore witness to the deaths of Ahmaud Arbery, Breonna Taylor, George Floyd...

DR. CAMPBELL:

George Floyd

DR. BRADLEY:

...yes, and my um, white counterparts would come to me and say, you know, well, you know, what should I be doing and all, all these things and one actually did say to me sometime one time, wow, this must be very hard for you to be the d... the one to, the one who has to disseminate all this information. Um, and I told them that, first off, if there was another way I would be open to it, um, but wanting this change to happen so badly, I'd gladly take up the charge of helping to educate others and encouraging others to speak out against things. But just because I wear the weight well doesn't mean it isn't

heavy. It is an extra task that falls to us. It's an extra emotional undertaking that we take on when we have these conversations and we share our experiences, and I, I just hope that our colleagues will continue to want you educate themselves and come alongside us instead of just sort of being a passive learner and waiting for their African American colleagues to bring information to them.

DR. KERR:

That was very beautifully said, Lyndsey, and I, I 100% agree with all that you said. To bring this back into the world of an anesthesiologist, how do you, you guys, you know maybe have ideas, maybe you don't, how do you guys, you know, see our anesthesiology community kind of um, putting a stamp on, you know, leading with anti-racism policies or, you know, taking action? And, you know, working with other organizations to kind of advance this situation?

It is very difficult, right? In anesthesiology, it's, I think compared to some of the other specialties, it's not supremely diverse, but there is some diversity in anesthesiology. And do we enough people in our backing, and I think we do, to really make an impact on being a Black person in the community and managing Black patients in medicine?

DR. FEENSTRA:

I agree with you uh, Daryl, with what you were saying. You know, I think, you know, in anesthesiology, I think sometimes it's maybe a little bit more difficult to think about ways, um, that our specialty and our community can sort of, um, take a stand, um as opposed to maybe some of our primary care colleagues in pediatrics or family medicine and other, you know, related specialties. And obviously, you know this is relevant, especially to Lyndsey as we, we're training in pain medicine. But, um, you know, I think even the way patient's pain is perceived and treated differs, um, in Black and Brown patients as opposed to white patients. Um, you know both perioperatively as well as, you know, chronic pain in terms of, you know, again the perceptions of pain and patients perceived pain thresholds, and you know, what medications and other treatments are, are prescribed for pain. And so I think, you know, in, in that regard I think, you know, there are a lot of implicit biases in pain, but I think, you know, recognizing that and again having, you know, us, there are a few of us, but um, having, having our allies and, and counterparts, um, who also are aware of these things, um, I think is a good step for changing them and toward, you know, realizing that patients are treated differently, um, unfortunately, um, based on, you know, the color of their skin.

Um, I'm hopeful you know that this period of time has opened up conversations for people and I know it has, um, at least for me personally with, with my, um, colleagues, um, sort of given this opportunity where it's more at the forefront of, of people's minds.

And so, um, I'm hopeful that these discussions and, you know, beginning to sort of put this at the forefront of everyone's mind on more of a daily basis is, you know, a good step in the right direction.

DR. CAMPBELL:

Perfect note to end on.

DR. KERR:

I think so. Well, thank you Elizabeth, Jason and Lyndsey for joining us on today's podcast. You know, we've had a great discussion on, you know, what it's like being a Black male and female physician um, and how, you know, our, the color of our skin affects us in our community, how it affects us professionally, kind of what it means to our patients to be in medicine and kind of what the, the gravity of the weight that we carry. I can't put as eloquently as Lindsay said it, but you know, the, the weight, as she said is, you bear it well, but it doesn't mean that it's very easy to bear that weight. And I think that's true through anesthesiology and likely through other specialties as well. So I think we'd just like to end on a great note that, um, we are hopeful that a discussion like this can be had with, more so with our colleagues, especially in this particular climate, and hopefully making advances and improvements with, between ourselves as physicians and with patients. So thank you for listening. This is Residents in a Room, a podcast for residents by residents.

(MUSIC)

VOICEOVER:

From small practices to the world's best teaching hospitals, ASA members have a wealth of experience. Tap into to this knowledge through the ASA Community your hub for real conversation, meaningful connection and valuable support. Find your voice at [community/asahq.org](https://community.asahq.org).

Join us for Residents in a Room where we'll share timely info, advice and resources designed to help residents succeed in residency and beyond. Find us wherever you get your podcasts or visit [asahq.org/podcasts](https://asahq.org/podcasts) for more.