

White Privilege in a White Coat: How Racism Shaped my Medical Education

Max J. Romano, MD, MPH

MedStar Franklin Square Medical Center,
Baltimore, Maryland

ABSTRACT

In this essay, I reflect on some of the ways racial privilege influenced my experience as a white physician in training. While white Americans often think of “racism” as a social construct primarily affecting people of color, “racism” is a system of both racial disadvantage as well as reciprocal racial advantage. Medical professionals are increasingly aware of how social determinants of health lead to important health disparities, however white physicians seldom ask how their own racial privilege reinforces a white supremacist culture and what effects this may have on our patients’ health. Drawing attention to the powerful legacy of racial discrimination in medical institutions, I call on other white physicians to name their privilege in order to dismantle the systems that propagate racism in our profession.

Ann Fam Med 2018;16:261-263. <https://doi.org/10.1370/afm.2231>

He was a young man in his late teens or early twenties, African American, and no longer alive. He entered the Baltimore hospital on a stretcher with multiple gunshot wounds piercing his torso and head with paramedics compressing his chest while pushing oxygen into his lungs. Within minutes of arrival, it was clear that further attempts at resuscitation were futile.

In the suddenly quiet moments following the pronouncement of death, the medical staff busied their restless hands cleaning the trauma bay and arranging the body for family members to pay their respects. Hastily torn sterile wrappers were brushed aside, torn and bloody clothing was removed, and a semblance of order was recreated in preparation for a suddenly grieving family.

One hospital staff member removed a cell phone from the patient’s pocket and then removed a second phone from the same pocket. A medical resident, wearing three pagers and two phones as part of his responsibilities on a busy night in the hospital, joked, “Maybe he was on call.”

Another resident corrected him, “No, I’ve seen *The Wire*, I know what this is about,” referencing a fictional television series set in Baltimore about drug-dealers who use multiple cell phones to evade police wire-taps.

In an instant, the room switched from nervous cleaning to nervous laughter. The humor resided in its improbability: a young black man shot in the chest and head was unlikely to be a physician on overnight call, instead he was immediately implicated as a criminal drug dealer based on his age, race, gender, manner of death, and the contents of his pockets, all substantiated by the house staff’s expertise in television crime dramas.

That young man’s death has haunted me for years. I’ve turned it over again and again, troubled by those residents’ jokes and how they reflected the deeply ingrained racism of our medical system. Their mockery reinforced my implicit racist attitudes as an impressionable white medical student standing at the bedside. I failed to speak up and name the racist jokes for what they were, which I now deeply regret.

Conflicts of interest: author reports none.

CORRESPONDING AUTHOR

Max J. Romano, MD, MPH
MedStar Franklin Square Medical Center
Family Medicine Residency
Johns Hopkins Bloomberg School
of Public Health
General Preventive Medicine Residency
615 N. Wolfe St. WB602
Baltimore, MD 21205
Mromano4@jhu.edu

That experience also drove me to question how racism benefits me as a white physician. Racism is a “system of structuring opportunity and assigning value based on appearance that unfairly disadvantages some individuals and unfairly advantages other individuals,” however white people are seldom asked to recognize the ways that our race advantages us.¹ While I also accrue unearned power due to my class, wealth, religion, ethnicity, language, nationality, gender, and sexual orientation, the role of racial privilege in my day-to-day interactions as a family medicine resident in Baltimore is overwhelmingly apparent.

Inspired by the work of Peggy McIntosh, who cataloged the contents of her “invisible knapsack” of unearned white privilege, I set out to catalog some of the ways I accrue unearned privilege in medical training as a consequence of my white skin color²:

- I have been taught since an early age that people of my own race can become doctors.
- Throughout my education, I could succeed academically without people questioning whether my accomplishments were attributable to affirmative action or my own abilities.
- During college and medical school, I never struggled to find professors and academic role models who shared my race.
- When I applied to medical school, I could choose from many elite institutions that were founded to train inexperienced doctors of my race by “practicing” medicine on urban and poor people of color.
- I am reminded daily that my medical knowledge is based on the discoveries made by people who looked like me without being reminded that some of the most painful discoveries were made through inhumane and nonconsensual experimentation on people of color.
- When I walk into an exam room with a person of color, patients invariably assume I am the doctor in charge, even if the person of color is my attending.
- If I respond to a call for medical assistance on an airplane, people will assume I am really a physician because of my race.
- Every American hospital I have ever entered contained portraits of department chairs and hospital presidents who are physicians of my race, reminding me of my race’s importance since the founding of these institutions.
- Even if I forget my identification badge, I can walk into the hospital and know that security guards will probably not stop me because of the color of my skin.
- When I travel to and from the hospital late at night as required by my job, I do not fear that I will be stopped, delayed, unjustly detained, inappropriately touched, injured, or killed by the police because of my race.
- I can attend most professional meetings confident that I will be surrounded by physicians who look like me, and that we will likely have mutual acquaintances who also share our race.
- I can speak my native language in my own dialect in professional settings without being viewed as uneducated or out-of-place.
- I know that I can leave the impoverished area where I work without being accused of abandoning my community.
- I can criticize medical institutions without being cast as a cultural outsider.
- I can name racism in my professional workspace and not be accused of being angry, potentially violent, or excessively emotional.
- When patients tell me they are “glad to have a white doctor,” I am not personally threatened, and I can choose to confront their racism or ignore it.
- I can pretend that health disparities don’t affect me or my family without acknowledging that we accrue benefits from a system that systematically favors our skin color.

In a society that sees casual racism among its most powerful leaders, white people can ignore the power of racism all around, or they can choose to acknowledge and confront it.

Our medical system is structured to individually and systemically favor white physicians and patients in ways that white people are trained to ignore. Most white doctors do not think race affects them or their clinical decisions and are taught to ignore their own racial privilege in favor of a meritocratic social myth. However, multiple studies reinforce the existence of racial bias among physicians and its negative implications for patient care.³ Collective inaction has led to a decline in the absolute number of African-American male matriculates to US medical schools from 1978 to 2014.⁴ Black men make up just 2% of male full-time faculty at MD-granting institutions. Failure to confront racism within the medical profession has implications for the patients we serve: infants of color continue to die at higher rates, children of color get less needed care, and adults of color receive poorer quality care than their white counterparts, and the trends are not improving.⁵⁻⁷

Although systems of racial oppression take generations to dismantle, we must begin with an awareness of the problem. As I reflect on that bullet-riddled body and the callousness with which my colleagues mocked the memory of his life, I think of the important work we have left to do. White physicians have an opportunity to acknowledge the unearned racial privilege that benefited their careers and actively work to dismantle the systems that propagate racism in medicine. I chal-

lunge other white physicians to speak out against the racism we have all benefited from and to work towards racial justice in our medical system for our colleagues and our patients.

To read or post commentaries in response to this article, see it online at <http://www.AnnFamMed.org/content/16/3/261>.

Submitted May 22, 2017; submitted, revised, November 10, 2017; accepted November 30, 2017.

Key words: racism, professionalism, white privilege, European continental ancestry group

Funding support: This paper was developed with the support of the Baltimore Racial Justice Action's Building Racial Justice in Baltimore Fall 2015 Workshop for White People. The author's participation in the workshop was funded by the Pisacano Leadership Foundation.

References

- Jones CP. Confronting institutionalized racism. *Phylon*. 2003;50(1-2):7-22.
- McIntosh P. White privilege: unpacking the invisible knapsack. *Peace and Freedom Magazine*. 1989:10-12.
- Chapman EN, Kaatz A, Carnes M. Physicians and implicit bias: how doctors may unwittingly perpetuate health care disparities. *J Gen Intern Med*. 2013;28(11):1504-1510.
- Association of American Medical Colleges. *Altering the Course: Black Males in Medicine*. <https://members.aamc.org/eweb/upload/Altering%20the%20Course%20-%20Black%20Males%20in%20Medicine%20AAMC.pdf>. 2015. Accessed .
- Rossen LM, Schoendorf KC. Trends in racial and ethnic disparities in infant mortality rates in the United States, 1989-2006. *Am J Public Health*. 2014;104(8):1549-1556.
- Flores G, Lin H. Trends in racial/ethnic disparities in medical and oral health, access to care, and use of services in US children: has anything changed over the years? *Int J Equity Health*. 2013;12(10):10.
- Shavers VL, Fagan P, Jones D, et al. The state of research on racial/ethnic discrimination in the receipt of health care. *Am J Public Health*. 2012;102(5):953-966.

Get the *Annals of Family Medicine* by E-mail

Make sure you see every new issue while it's fresh; have the table of contents sent to you by e-mail for easy access to articles of interest.

Don't miss important research. Request the e-mail table of contents at http://www2.highroadsolution.com/aafp_annals_preference_center/search.aspx

ANNALS OF FAMILY MEDICINE
Indexed in the MEDLINE and MEDLARS databases WWW.ANNFAMMED.ORG JANUARY/FEBRUARY 2018 VOL. 16, NO. 1

Now Available:
The Wonder and the Mystery
Annals anthology of personal reflections and innovative ideas

The full text of the journal is available online at <http://www.annfammed.org> and through various aggregators, including PubMed Central, EBSCO, and MDCConsult. The *Annals* is indexed in the MEDLINE and MEDLARS, Science Citation Index Expanded, Current Contents/Clinical Medicine, PsycINFO, EMBASE, and CINHAL databases.

EDITORIALS

In This Issue: Size Matters
Kurt C. Stange

Achieving PCMH Status May Not Be Meaningful for Small Practices
Kelley K. Glancey; James G. Kennedy

The Paradox of Size: How Small, Independent Practices Can Thrive in Value-Based Care
Farzad Mostashari

ORIGINAL RESEARCH

Solo and Small Practices: A Vital, Diverse Part of Primary Care
Winston R. Liaw; Anuradha Jetty; Stephen Petterson; Lars E. Peterson; Andrew W. Bazemore
Family physicians in solo and small practices outnumber those in larger practices.

Large Independent Primary Care Medical Groups
Lawrence P. Casalino; Melinda A. Chen; C. Todd Staub; Matthew J. Press; Jayme L. Mendelssohn; John T. Lynch; Yesenia Miranda
Large physician-owned groups have the potential to make primary care attractive to physicians and improve patient care.

Primary Care Physician Panel Size and Quality of Care: A Population-Based Study in Ontario, Canada
Simone Dahroug; William Hogg; Jaime Younger; Elizabeth Muggah; Grant Russell; Richard H. Glazier
In Ontario, larger patient panel sizes do not decrease quality of care, but cancer screening rates are slightly lower.

Willingness to Exchange Health Information via Mobile Devices: Findings From a Population-Based Survey
Katrina J. Serrano; Mandi Yu; William T. Riley; Vaishali Patel; Penelope Hughes; Kathryn Marchesini; Audie A. Atienza
Willingness to exchange health information via mobile devices varies with the sensitivity of the