# BREAKING DOWN BARRIERS *for* WOMEN PHYSICIANS OF COLOR

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**Anthony Galace** · Bridges to Health Director **Irene Calimlim** · Bridges to Health Intern

**The Greenlining Institute** and **Artemis Medical Society** · **October 2017**

## About the Greenlining Institute

Founded in 1993, The Greenlining Institute envisions a nation where communities of color thrive and race is never a barrier to economic opportunity. Because people of color will be the majority of our population by 2044, America will prosper only if communities of color prosper. Greenlining advances economic opportunity and empowerment for people of color through advocacy, community and coalition building, research, and leadership development. We work on a variety of major policy issues, from the economy to environmental policy, civic engagement and many others, because economic opportunity doesn't operate in a vacuum. Rather than seeing these issues as being in separate silos, Greenlining views them as interconnected threads in a web of opportunity.

## About Artemis Medical Society

Founded in 2012, Artemis Medical Society helps promote an environment in medicine where women of color from around the world can come together to support and learn from each other across all medical specialties. Since its formation, the organization has worked diligently to create a supportive environment by fostering a strong sense of community among its membership. Artemis Medical Society believes women physicians of color are a vital part of an effective physician workforce that is responsive to and aims to deliver quality health care to increasingly diverse communities. Through mentoring, networking, and advocacy, the organization is providing the foundation necessary to create a diverse physician workforce vital to a rapidly changing society. For more information, visit www.artemismedicalsociety.org.

## The Greenlining Institute Bridges to Health Program

Nothing is more essential than our health. Everybody should have access to good health regardless of race or income. Health care must be responsive to the nation's growing communities of color, but health care is not enough. People also need access to the things that lead to good health such as safe neighborhoods, healthy foods, clean environments and decent jobs. Greenlining brings the voices of communities of color into critical decisions that affect all of our lives and health.

## About the Authors

**Anthony Galace, Bridges to Health Director**

Anthony's passion for advocacy lies at the nexus of public policy, health equity, and racial justice. As the child of Filipino immigrants, his desire to advocate for underserved communities was shaped by his exposure to the struggles his family and other immigrants faced while coming to the United States. His background in health includes direct health care services, health education, and local advocacy. Anthony leads Greenlining's health advocacy efforts to ensure fair and equitable implementation of the Affordable Care Act and access to health care and workforce opportunities for boys and men of color. Additionally, Anthony oversees Greenlining's community benefit advocacy, which focuses on increasing investments towards upstream, preventive health resources to improve community health. Anthony is a native of Chula Vista, California, and a graduate of the University of California Berkeley, with a degree in Integrative Biology.

**Irene Calimlim, Bridges to Health Intern**

Irene's passion is in improving the built environment and social conditions in marginalized, low-income communities of color, particularly through the capacity building and empowerment of local residents. Irene is currently completing a Master's in Public Health and city planning at UC Berkeley. As an intern at Greenlining, she has been investigating community benefit investments of nonprofit hospitals and researching the barriers along the medical career pipeline for women physicians of color. Prior to that, Irene worked in rural India with the Comprehensive Rural Health Project to learn about their model of empowerment and development working with women village health workers and in her hometown of Stockton doing local organizing around health justice issues with Fathers & Families of San Joaquin.

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# EXECUTIVE SUMMARY


- The Greenlining Institute and the Artemis Medical Society interviewed 20 women physicians of color to understand their experiences and the barriers they face during their education/training as well as in their practice as physicians. While the majority were from California, nine came from states in other regions of the country. Women of color are severely underrepresented among physicians; in 2013 they made up only 11.7 percent of active MD physicians in the United States.

- Many described a lack of support from high school and college counselors, college professors and graduate students. Shockingly, 40 percent of interviewees recalled at least one instance when a high school or college counselor attempted to discourage them from pursuing a career in medicine. Over half questioned their prospects of succeeding as a physician because they had never met a physician who shared their racial identity.

- Multiple barriers impeded both the entry of these women into the medical field and their success once they became physicians. These included the expense of the medical school application process, which cost each interviewee several thousand dollars, repeated tokenization (such as being asked to serve on various committees simply to fulfill a diversity quota), and lack of diversity—and sometimes incidents of overt racism—among medical school faculty. Several participants cited specific instances when lecturers casually referenced racist tropes to describe unruly patient interactions. Many interviewees described unequal treatment during medical school and residency, such as instances in which male students were encouraged to voice their opinions while women were more likely to be silenced.

## *Recommendations:*

- Health sector employers must increase their support for health career pipeline and training programs that recruit young people of color, especially young women of color. Community benefit programs required of not-for-profit hospitals can be one avenue for such support. Foundations and universities should increase scholarship opportunities for young people, especially young women of color from disadvantaged backgrounds, and the federal government should increase its support for such programs.

- Medical schools need to act aggressively to increase diversity in both student admissions and faculty. The present severe lack of faculty diversity influences leadership and curriculum decisions at medical schools across the country, in ways that may not be readily apparent to white administrators and faculty. Lack of medical school diversity also perpetuates implicit bias, and inhibits responsiveness to the health needs of diverse populations.

- Universities and hospitals must establish robust mentorship and support networks across the physician pipeline. Every single physician we interviewed noted the importance of strong support networks.

- Medical education and training must adopt higher standards of cultural competence and sensitivity, including specific training covering racism and cultural competence. Medical schools and residency programs must also strengthen anti-discrimination and reporting policies, to assure that those who suffer discrimination will feel safe in reporting it, and that such reporting will actually make a difference.

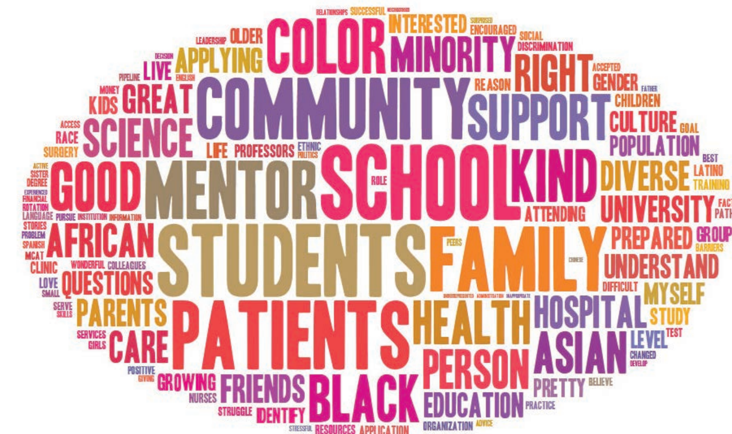
- The entire medical field must address financial and structural barriers that now create obstacles, including gender pay inequity and unfair maternity leave policies.

# INTRODUCTION

The ongoing shift among hospitals, medical schools, and other health institutions to embrace health equity[1] has allowed physicians to focus "upstream"[2] and impact patients' lives more holistically than ever before. Given the numerous inequities that disproportionately impact marginalized communities, especially women and people of color, the health sector must elevate the voices of physicians who represent an intersection of these identities—***women physicians of color.*** Yet, women physicians of color continue to face barriers and challenges that inhibit their ability to be community leaders. To improve the quality of patient care for the most vulnerable and underserved communities, medical schools, hospitals, and all health institutions must empower women of color to achieve their potential as health equity champions within the health care system.

In May 2016, The Greenlining Institute partnered with the Artemis Medical Society (AMS), a national collective of women physicians of color dedicated to nurturing women physicians of color to serve as health care providers, community leaders, and role models thereby increasing physician workforce diversity and diminishing health disparities. Together, Greenlining and AMS sought to shed light on the narratives of women physicians of color in order to understand the barriers that may hold them back and find ways to support and uphold their leadership. By looking at these personal experiences in light of available data, we sought to identify several policy solutions to address challenges that women physicians of color face; these include recommended policies and best practices for medical schools, hospitals, and other health employers.

The women physicians of color interviewed for this report represent diverse communities across the nation, where they mentor many aspiring leaders. We analyzed all 20 interviews and highlighted the most common themes in the following theme cloud[3] which provides a visual representation of the most prevalent words/concepts raised by the participants. The five most frequently mentioned themes provided a roadmap to developing our policy recommendations—**they are: students/schools, patients, family/community, mentor, and support.**



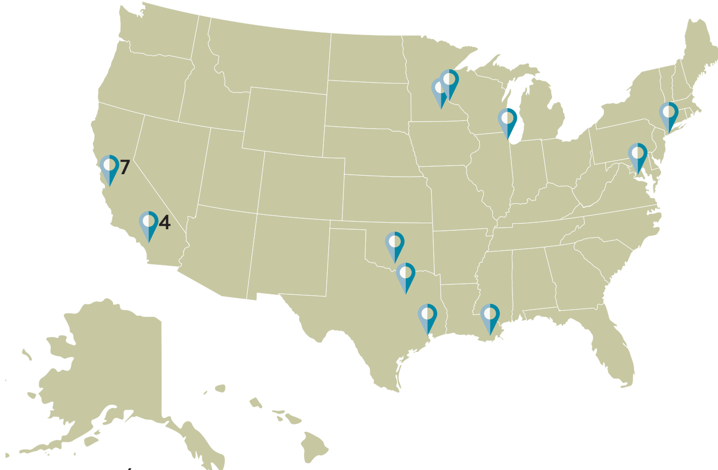

# METHODOLOGY

From June 2016 to May 2017, Greenlining partnered with AMS to conduct and transcribe semi-structured interviews with 20 women physicians of color from across the country. These interviews explored the challenges that interview participants faced along the physician pipeline. The terms "participant" and "interviewee" are used interchangeably throughout this report.

Greenlining connected with interviewees through advocacy partners, personal contacts, and AMS's extensive network of women physicians of color. Greenlining and AMS prioritized outreach to Black/African American, Latina, Native American, Southeast Asian, and Pacific Islander women physicians, who are among the most underrepresented in the physician workforce.

**The 20 interviewees identified as follows:**

- **Race/Ethnicity**




- **State/Region of Practice**

Eleven from California—seven from the Bay Area, and four from southern California

Nine participants came from the following nine cities: New Orleans, Louisiana; Oklahoma City, Oklahoma; Chicago, Illinois; Minneapolis, Minnesota; Saint Paul, Minnesota; Bronx, New York; Baltimore, Maryland; Dallas, Texas; Houston, Texas

Greenlining also conducted a literature review regarding statistics and data about women of color in medicine or along the physician pipeline and used this information to further inform the policy recommendations drawn from the interviews. Unless otherwise noted, the names of participants have been changed to protect their privacy.

## *Limitations*

Only limited background research exists on the experiences and challenges of women physicians of color. Given these data challenges, Greenlining adopted a qualitative, interview-driven approach, which captured the lived experiences of women physicians of color in ways that a quantitative survey cannot. Each interviewee shared deeply personal experiences that highlight the painful impact of discrimination and harassment in medicine.

Our recruitment methods led to gaps in representation among participants. Recruitment and outreach through local networks led to an overrepresentation of women physicians of color who practice in California. As a result, certain barriers more prevalent in other states may not be adequately covered in our interviews. Also, despite several attempts to contact and interview women physicians from underrepresented racial and ethnic backgrounds, we were ultimately unsuccessful in recruiting participants from some groups, including Pacific Islander or Native American women physicians. Furthermore, all participants studied at allopathic medical schools, limiting our network to physicians with a Doctor of Medicine (MD) degree.

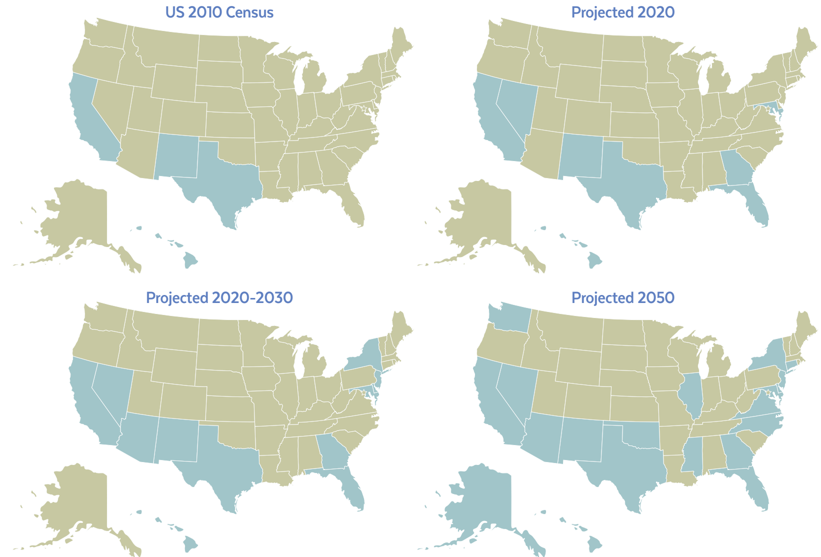
Finally, our findings do not reflect a statistically representative sample of the views of all women physicians of color; rather, this report provides a snapshot of the barriers and narratives that women physicians of color face. As health industry leaders and advocates discuss policies that affect this group, we hope to refocus these debates around the lived experiences of those who will be impacted by these potential reforms. We hope this report sparks interest in further research and advocacy to address the needs of women physicians of color.

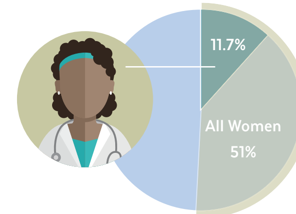
# FINDINGS

Available data show a notable lack of diversity and representation in the physician workforce:

In 2013, women of color made up only 11.7 percent of active MD physicians in the United States.[4] Furthermore, male doctors outnumbered women doctors among Latino, Asian, and American Indian or Alaska Native physicians. Only among the Black/African American physicians did women outnumber men.[5] These statistics contrast starkly with the population of the United States, of which women comprise 51 percent.[6] Per the 2010 census, people of color are already the majority in four states, and by 2050, women of color will be the majority of all women in the United States.[7]

Women physicians of color face challenges that mirror the barriers to health care that impact marginalized populations. For example, underserved groups, such as communities of color and women, are disproportionately more like to receive poorer health care than Whites, a trend that parallels the mistreatment of women physicians of color.[8] The following sections address specific types of challenges that emerged during the interviews.

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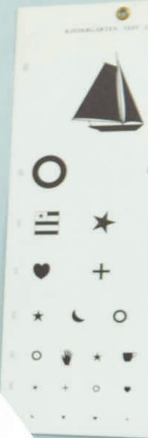
TOLA



# Addressing The Lack Of Support For Women Physicians Of Color

## Modeling Leadership through Advocacy and Mentorship

During college, Dr. Mikaela Norris (as noted above, all names are pseudonyms unless otherwise noted) developed a strong passion for caring for the underserved, and became interested in a wide range of health careers. She developed a close-knit network with other African American students who provided guidance and counsel, and encouraged her to pursue a career in medicine. However, she struggled to find support from faculty members who offered little direction.

When asked about her experiences in finding mentorship and support, Dr. Norris stated:

***I didn't have any support from my professors or graduate students. The mentorship I received came from upper level undergraduate students who offered advice, and sponsored tutoring sessions through the Black Student Health Alliance... Mentorship and safe spaces should be multicultural. As an African American woman, there are issues unique to being African American; however, there are issues that resonate with all women of color. We need to create spaces for students, especially young women, to feel safe and share their experiences. This can hopefully decrease bias and racial profiling, since we're no longer in separate communities.***

In response to this gap in diversity and mentorship, Dr. Norris established a nonprofit organization dedicated to increasing the representation of underrepresented health professionals through mentorship, career exposure, and leadership development. This organization connects students of color with mentors who are practicing health professionals, and facilitates a robust peer mentorship and alumni network. In discussing her motivation, Dr. Norris said:

***As an emergency medicine resident, I noticed that many of the patients in our ER didn't look like the provider that was serving them. There were language barriers, or just relational barriers, that prevented providers from getting a full understanding of the patient's needs. I meet a lot of students who aspire to address this challenge, and that's when professional mentorship comes in. If students are only doing the classes, but not getting the mentorship, there's still a huge barrier, for the student and their patients."***

## *Bridging the Gap in Social Support and Mentorship*

All interviewees emphasized the importance of encouragement and supportive guidance, especially for young people of color. However, 40 percent of interviewees recalled at least one instance when a high school or college counselor attempted to discourage them from pursuing a career in medicine. Participants described these attempts to undermine their goals as being rooted in the counselor's concerns about their suitability for a career in medicine. Some interviewees were told that they lacked the necessary qualifications and that medical school would be too difficult, while others were pressured into starting a family.

Several interviewees connected this discouragement to young women of color's historical lack of exposure in school to science, technology, engineering, and math (STEM) courses, and other precursors to medicine. One participant shared: "I see a lot of discouraged students from elementary throughout high school. We need to do a better job of encouraging children of color as early as elementary school to love math and science."

Forty-five percent of interviewees stated that the lack of STEM education in high school left them at a strong disadvantage once they transitioned to college and enrolled in pre-medicine course-work. The difficulty of excelling in pre-medicine coursework due to lack of STEM preparation challenges many aspiring women physicians of color, and represents one gateway in the physician pipeline where many students fail.[9]

Nearly all interviewees stressed the role that mentorship plays for students as they matriculate through the physician pipeline navigate the varied academic, professional, and extracurricular requirements. This is especially crucial for women of color because, as several of the interviewees shared, they were not informed of nor exposed early on to the physician pipeline. Forty-five percent of participants said they questioned their prospects of succeeding as a physician because they had never met a physician who shared their racial identity. One interviewee explained: "The challenge with being a little brown girl is that when you tell people it's your aspiration to be a doctor, they don't believe you can do it. They try to push you into nursing or something else where they have seen someone like you."

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*"Even if it's for a summer math and science program, children of color are not being encouraged by counselors. Younger students are especially susceptible, and it's really important to involve them in math and science rather than just completely ignoring them and assuming that's not something that they're into."*

Almost all interviewees underscored the value of developing a network of mentors and peers who shared their intersecting racial and gender identities. Especially for students from underrepresented back-grounds, finding a social support network built on shared cultural history and values is crucial to maintaining physical and mental health. Eighty-five percent of participants echoed the experiences outlined in Dr. Norris's narrative—their support system provided encouragement through each stage of the physician pipeline, when more official support channels often failed. Additionally, their social network offered resources for scholarships and application support, as well as a safe space to share their experiences and challenges.

Interviewees clearly felt that health institutions must play a larger role in facilitating mentorship and support for women physicians of color, especially young women of color who aspire to become physicians.

## *Leveling the Playing Field for Women of Color*

The persisting racial and gender wealth gaps continue to be among the greatest barriers for women of color. Sixty percent of participants had to overcome socioeconomic hardships during their adolescence and early adulthood. These barriers manifested during the medical school application process, which cost each interviewee several thousand dollars. These expenses included exam preparation courses, Medical College Admission Test (MCAT) registration, primary and secondary application fees for dozens of schools, and travel to and from multiple interviews. Participants expressed their sadness and frustration in knowing that stellar young women of color—including some of their mentees—had to limit their medical school options because they could not afford the mounting application fees, travel and accommodation costs to attend these interviews.

> *"Particularly for women and people of color, the cost is so expensive. I've had excellent mentees limit the range of schools they applied for because it cost too much. Some of them couldn't afford to fly out to each interview. Even if you have some financial support from mentors, there is still such a large cost in the application process."*

Throughout college and medical school, a few of the interviewees benefited from resources specifically for students from underrepresented backgrounds—two programs mentioned were the Students National Medical Association and the Robert Wood Johnson Foundation Minority Medical Education program. However, half of participants felt that these resources must be extended earlier in the physician pipeline. One stated: "Most students drop off the pipeline or do not even enter the pipeline once they're in high school, so we are missing a whole generation of students. I think we lose half of the students before they even get to college; but when they get to college, we lose the other half because that's when the resources become more limited. Some think they've made it once they're in college, but that's when they need more mentorship, academic counseling, professional development, and internship opportunities, and more."

INSUFFICIENT DATA

# Diversifying Leadership And Representation In Medicine

## Addressing Tokenization by Promoting Equity

Dr. Christina Le lived without health coverage early in life because her family did not qualify for Medicaid and could not afford private insurance. Despite excelling in school, she noticed that others perceived her as “less-than” due to her race and immigrant status.

Driven by these experiences, Dr. Le decided to pursue a career in medicine, and now serves as one of the few women of color faculty members at a top-ranked medical school. However, she constantly feels tokenized because she is frequently asked to only serve on various committees to fulfill a diversity quota. She refers to these commitments as a “minority tax,” because she receives no supplementary compensation for participating, despite the added time commitments and responsibilities. Dr. Le also claimed that her leadership and participation on these committees were not considered in decisions about professorships or tenure, while these responsibilities were considered and looked upon favorably for her male colleagues serving in similar roles. When asked to elaborate on these challenges, Dr. Le said:

***I’m constantly being referred to sit on committee after committee because my presence will ‘check a box.’ And for women of color, this problem is larger—either they tokenize us, or ‘ghettoize’ us by only putting us in charge of diversity offices and initiatives.***

In response to these practices, Dr. Le mentors medical students of color, especially first-generation medical students. She encourages them to share their story, citing her own narrative as a powerful example.

## *Diversifying Medical School Faculty to Promote Cultural Competency*

Efforts to ensure diversity among medical students must go hand in hand with diversifying medical school faculty and administration. Unfortunately, academic medicine suffers from a lack of diversity at least as bad as the overall physician workforce. In 2012, African Americans made up seven percent and Latinas made up nine percent of admitted medical students, despite making up 14 percent and 16 percent of the population, respectively.[10] Forty-five percent of interviewees experienced this disparity during medical school or residency, and some felt isolated and unsupported by their peers in confronting those responsible for racially insensitive or offensive comments, and other forms of institutional racism and sexism.

The lack of diversity among medical students is accompanied by an even greater lack of diversity among medical school faculty; people of color only make up eight percent of all medical faculty positions—up only one percent over the past two decades.[11] One participant stated: "About 30 percent of medical students are from underrepresented backgrounds; but there is a huge drop off in diversity for internship and residency programs… When you examine the faculty, diversity dips even lower—it decreases to about seven percent. We really need to look at why we start with 30 percent students that are underrepresented, but the faculty is only seven percent."

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>
> Without adequate racial, ethnic and gender diversity, medical school curricula and procedures will likely perpetuate racism, sexism, and implicit bias.

Without adequate racial, ethnic and gender diversity, medical school curricula and procedures will likely perpetuate racism, sexism, and implicit bias. Several participants cited specific instances when lecturers casually referenced racist tropes to describe unruly patient interactions. This can make the classroom a very jarring and uncomfortable setting for students of color, given the nature of these discussions. One interviewee recalled an instance when a faculty member outlined an offensive stereotype for the class to respond to: "The lecturer, a psychiatrist, referenced to a patient stereotype—a black male with gold chains, gold teeth, and knee pain—who, she claimed, probably had gonorrhea. She kept sharing these types of blatantly offensive examples, and I noticed that she didn't mention race until she got to the Black male with like HIV or something like that who was a drug abuser"

These examples highlight the need to promote diversity in order to assure cultural competency in medicine.

## *Advancing Health Equity Through Physician Diversity*

Sixty percent of participants said they decided to pursue a career in medicine to serve marginalized and under-resourced communities, similar to areas where they grew up. Studies have shown that physicians of color are far more likely to provide care in communities with large numbers of people of color;[12] moreover, these communities are far more likely to have limited access to quality medical care, due to geographic isolation[13], systemic disinvestment[14], and redlining.[15] Some have also developed a sense of distrust in the medical system due to the troubling history of racism in medical research and health care.[16] Several interviewees cited the need to diversify the physician workforce in order to increase access to culturally competent care, and reduce health disparities that disproportionately impact people of color.[17] One participant stated, "There is still a lot of distrust in minority communities towards health care professionals. That gave me motivation because I saw that my community needed people that looked like them—people that looked like me."

Fifty percent of interviewees also mentioned the importance of speaking the patient's native language as a critical aspect of improving health outcomes, especially for immigrant and non-English speaking patients. Several participants recalled instances in which they connected with a patient because of their shared identity; the sense that they understood the patient's cultural beliefs and practices provided comfort and assurance.

> ***"I remember seeing a patient speaking to the lead staff physician while doing my rounds as a medical student. The staff doctor would be talking to the patient, and then she'd turn to me—mind you, I'm the lowest on the totem pole—and ask 'what do you think I should do?' I believe that, because I looked like her, she thought that I could relate and understand her better."***

# Combatting Racism And Sexism

## Confronting Discrimination and Inequality in the Physician Pipeline

Dr. Maribeth Bernal encountered numerous incidents of discrimination and harassment, particularly during her residency. She recalled one occasion when her male co-residents circulated a vulgar and derogatory video demeaning Latina physicians. She recalled:

***The other residents were laughing as they shared the video with each other even though I was in the program, and even if I was in the room while they watched. Moments like that made me feel like program faculty didn't care about me. Even though I reported these incidents, there were no consequences. It was like they were telling me I was just too sensitive and that I should have handled myself better.***

As she progressed through her residency, her colleagues became more skeptical of her leadership, and frequently questioned her judgement. She felt this was symptomatic of a cultural distrust of women of color leaders in medicine, especially given that her White male counterparts were scrutinized less:

***There were definitely instances when I felt that I was treated differently. I noticed a lot of subtle incidents when certain people interacted with me differently than how they interacted with others. For example, junior residents would question my authority even though they didn't have any particular reason. Was it because I'm a woman or Hispanic? I don't know, but I do know that they never disrespected male or White residents—at least not like they treated me.***

Unfortunately, these incidents are far too common for women physicians of color. Still, these narratives illustrate the courage and strength of women physicians of color who must overcome these attacks on a regular basis.

## *Destigmatizing Pregnancy and Motherhood Among Women Physicians of Color*

Half of the women physicians of color interviewed for this report were discouraged from starting a family after they became physicians, or witnessed a colleague endure criticism for becoming pregnant. Several participants felt that starting a family put them at a disadvantage; one participant recalled being asked during her medical school interview whether she planned to have children—a question that was not directed to male candidates. Moreover, some of the participants' families discouraged them from even applying to medical school because of concerns they would not start a family.

One interviewee recounted several heartbreaking incidents: Dr. Marcella Wyatt was eight weeks pregnant when she suffered a miscarriage as an MD/Ph.D. student. She then had to have surgery to stop hemorrhaging. After this tragic experience, she petitioned for reinstatement in the MD/Ph.D. program; this required that she take a qualifying exam, which she had already passed. When she asked to postpone her exam date due to her medical condition, she was refused and met with disdain: "I went into the office and one person said, 'This is why we don't want students coming in late because they don't finish their thesis on time and then they expect special accommodations.' I had just lost a baby, but they were so insensitive and disrespectful."

Ultimately, Dr. Wyatt was forced to take the exam without an extension, only to find out later that other students were permitted to postpone their test date. She reported the incident to the medical school dean, but no action was taken to rectify the situation.

Tragically, during her surgical residency, Dr. Wyatt had another miscarriage during her second trimester. Yet, despite having suffered through such a traumatic experience, she returned to her residency program to find her co-residents and colleagues maligning her character and integrity. She recalled: "Some of the attending physicians openly said that women in surgery shouldn't have children. They would spread nasty rumors about me, saying I was just lazy and belligerent. It was painful to deal with such condescending, rude, and insensitive people... I don't know how much of it was gender- or race-based, but if I hadn't had baby, a lot of this wouldn't have happened. I also think if I'd been a White woman or a White man going through the same experience, they would've treated me differently... These things are really familiar to people of color."

Again, this incident is not uncommon—four other interviewees experienced or witnessed some form of discrimination associated with starting a family. These incidents highlight the stigma surrounding motherhood among women physicians. It is invasive and insensitive to demand that women physicians abandon their desire to start a family since the physician pipeline can extend into the early- to mid-thirties, approaching the end of their childbearing age.

### *Breaking Through the "Old Boys Network" in Medicine*

Every participant noted that the physician workforce is still largely White and male, as is the dominant portrayal of physicians in the media. Sixty percent noted instances of patient bias that favored White male physicians, deferring to them more often, whereas women physicians of color were sometimes mistaken for nurses, administrative and support staff, or students. Thirty-five percent of interviewees recalled instances of an apparent double standard during medical school and residency, situations in which male students were encouraged to voice their opinions while women were more likely to be silenced. Some interviewees also noted how junior residents, and even some nursing staff, were more likely to question the authority and decisions of higher ranking women physicians of color. One participant recalled: "The male students were almost always allowed to ask questions or even object to the attending physician's decision. But for some of my classmates who were women, many just became silent because they were tired of being shut down and silenced, so they chose not to deal with it. That's a sad thing but that's definitely a reality in medicine during our clinical rotations."

> *"One of the senior physicians made a comment implying that my technical skills as a surgeon were subpar, but that I was receiving support and preferential treatment because I am an attractive woman. It was insulting and inappropriate. Another time, a senior resident had the nerve to tell me, "maybe you should spend more time reading and less time on your make up."*

Women physicians of color are also held to an unequal standard when having to prove their competence to patients; 45 percent of participants recounted experiences when patients were wary of their diagnosis or questioned their credentials. Two interviewees even shared that they resorted to taking the extra precaution of listing their medical school, residency program, and years of practice at the outset of every appointment to assuage patients' concerns.

Nevertheless, one participant recalled a patient who refused to see her because she was a woman of color: "I saw the double standard because patients would literally see me and say 'I'm not seeing her.' They know nothing about me, but they would sometimes refuse to see me. They would sit there for however long it took until a male doctor was ready to see them."

This bias against women of color, both implicit and explicit, is reinforced by the lack of women physicians of color.

> *"I was told by multiple colleagues that more women in a program translated to less prestige. My program was about even, close to 50/50 men and women, and a majority of the men were White or Asian. Programs like mine were looked at as being mediocre and less competitive."*

### *Institutionalizing Support and Protections Against Implicit Bias*

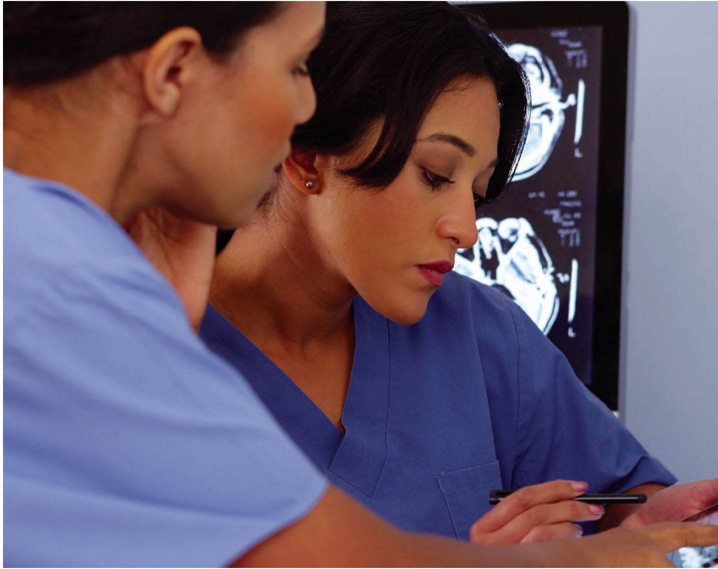
Only a few participants experienced blatant acts of racism or sexism, yet all interviewees recalled numerous instances of implicit bias and discrimination directed at them and other women of color. One participant stated, “In a given day there are many microaggressions and that you have to pick and choose which ones you are actually going to fight about.”

Participants felt they were also more likely to be discriminated against or experience microaggressions—such as vulgar comments or insensitive jokes—during their residency program rather than during medical school. One participant speculated that this is because medical schools generally have more regulations and protections against discrimination, and require that faculty undergo sensitivity trainings. Many refrained from reporting these incidents out of fear of being perceived as weak or overly sensitive.

> *”I felt very uncomfortable bringing up things that offended me, especially when it happened during my rotations. There is a hierarchy and system of politics that dictates certain situations. Unless it was something completely egregious, I usually just kept my mouth shut... Some of the other residents, particularly White residents, often seemed to be more at ease to air their anger or discomfort—which I appreciate. But as a woman of color, I do feel there’s a different standard and level of acceptance about different sets of opinions, and I don’t think mine is valued in the same way as others.”*

Moreover, 40 percent of participants shared that at times they felt unclear about how to report offensive or inappropriate behavior during residency. Even for those who understood the reporting system, many felt uncomfortable filing a report because they did not believe their work environment would support or understand their grievance. Even in egregious cases, such as the example of Dr. Bernal, little or no action was taken. Also, Dr. Wyatt may have experienced more racism because her surgical specialty has less representation of physicians of color.

> *“I feel at any moment I can be targeted. I feel that I could be labeled in such a way that makes my work environment hostile. I feel that I could have anything—my license to practice and credibility—revoked. I feel like anyone can lie about me. I’ve had to think about this a lot more over the years than when I was younger... I have to constantly think about what I need to do to protect myself against racism and gender discrimination.”*



## *Rejecting Adverse Assumptions About Women Physicians Of Color*

In October 2016, during a Delta Airlines flight, Dr. Tamika Cross, a Black physician, offered to treat a sick passenger when she was rebuffed by a White flight attendant who sought an "actual physician."[18] In a social media post, Dr. Cross shared this encounter, and went on to write, "I'm sure many of my fellow young, corporate American working women of color can all understand my frustration when I say I'm sick of being disrespected."[19]

After this incident went viral, women of color across the country came forward and shared their own experiences of having their credentials and expertise questioned. Several interviewees also expressed similar sentiments, and shared that these challenges inspired them to reclaim their narrative.

In October 2016, during a Delta Airlines flight, Dr. Tamika Cross, a Black physician, offered to treat a sick passenger when she was rebuffed by a White flight attendant who sought an "actual physician."

One example of this was led by Dr. Roxana Daneshjou, an interview participant who agreed to share her real identity. In response to Dr. Cross' ordeal, Dr. Daneshjou launched the #IAmAPhysician social media campaign to celebrate the diverse backgrounds of physicians of color, and to inspire the next generation of aspiring physicians.[20]

Dr. Daneshjou explained, "We wanted to showcase that doctors come from different backgrounds and have all kinds of different stories. We believed it would be really powerful to show these doctors as role models."

We Are

# POLICY RECOMMENDATIONS

The lack of diversity and equity in medicine, coupled with persistent racism and sexism, denies women physicians of color and their patients fair and equitable treatment. Advocates, health institutions, and physicians must work together to increase visibility and promote the positive representation of women of color in health care. Dispelling the myth that women of color are ill-equipped to serve as physicians is a critical step towards advancing equity and inclusion in medicine, and improving health outcomes for the most vulnerable patients

Greenlining and AMS have targeted the recommendations below specifically to medical schools and health sector employers. By adopting these measures, the health sector can advance equity and inclusion across health care, improving conditions for women physicians of color and their patients.

## *I. Build Support for Aspiring Women Physicians of Color*

### a. Invest in a more robust and diverse physician pipeline

Health sector employers must increase their support for health career pipeline and training programs that recruit young people of color, especially young women of color. For example, not-for-profit hospitals are required to invest in upstream health services through their community benefit programs, and this may include grants and resources for health career pipeline programs that train young people of color for health sector jobs.[21] Community benefits represent a pivotal opportunity for nonprofit hospitals to promote economic opportunity and improve the social determinants of health; however, hospitals fall far short of maximizing their community benefit spending to meet the needs of disadvantaged populations.[22] To achieve their potential, hospitals must increase spending towards workforce development and other community-building activities that impact the lives of underserved communities.

Additionally, foundations and universities should increase scholarship opportunities for young people, especially young women of color from disadvantaged backgrounds. Even when students of color excel in their education, the steep costs associated with the physician pipeline can prevent some students from pursuing this career path.[23] Alleviating some of the financial burden for underrepresented students will ensure greater diversity along the physician pipeline.

Lastly, as employers, foundations, and universities increase their investments towards expanding and diversifying the physician pipeline, the federal government must not relinquish its support for health professions and training programs. The initial budget proposed by the current presidential administration for the 2017-2018 fiscal year seeks to “eliminate $403 million in health professions and nursing training programs,” and would create a significant barrier to diversifying the health workforce.[24] Rather, the federal government should increase its appropriation towards successful programs such as National Health Service Corps, the Public Health Service Act, the National Institutes of Health’s National Center for Minority Health, and the Health Disparities Loan Repayment Programs.[25]

### b. Encourage STEM education for young women of color

At an early age, young women of color are discouraged from pursuing careers in STEM—roughly three-fourths of high school girls show an interest in STEM[26], yet only 10 percent earn a graduate degree in a STEM field.[27] Many interviewees recalled barriers early in their education, such as little STEM exposure, which put them at an early disadvantage. These challenges are exacerbated for students from under-resourced schools, who often struggle to succeed in their required pre-medical courses, such as chemistry and physics.[28]

To remedy this disparity, several studies have recommended that health institutions partner with public schools to provide students with learning opportunities for academic enrichment in STEM.[29]

Exposing students from underserved communities to different health careers early on will encourage them to pursue health care careers. Grade school is an opportune time to promote STEM education because students are developing their study skills and habits; by developing these competencies early, students will be more equipped to handle the rigor of medical school education.

## *II. Improve diversity and inclusion across the health sector*

### a. Diversify medical school admissions

The demands of the physician workforce require more attention to diversity, especially if we are to address the challenges raised by the interview participants. Increasing medical school diversity has clear benefits, such as raising awareness about culturally-driven health practices, demystifying stereotypes and assumptions about certain racial groups, and facilitating cross-racial understanding.[30, 31]

Present efforts have proved inadequate, so admissions offices must make racial and gender diversity the centerpiece of their recruitment efforts and adopt admissions policies that can increase enrollment of students from underrepresented backgrounds. For example, admissions committees should strongly consider adopting a more holistic review process, which equitably weighs an applicant's grade point average and exam scores alongside additional factors like race, socioeconomic status, and personal experience.

Additionally, admissions and outreach offices should prioritize recruitment from underserved regions. Although there is no substitute for race-conscious admissions policies, a focus on disadvantaged neighborhoods and communities can also increase diversity given the strong overlap in racial and socioeconomic status.

### b. Promote equity and diversity among medical school faculty

Medical school diversity and inclusion efforts must also extend to faculty and hospital leadership. In 2015, women full-time faculty of color made up 11 percent of the total full-time medical school faculty workforce.[32] Per a 2013 survey done by the American Hospital Association, only 12 percent of hospital executive leadership positions were people of color.[33]

The benefits of diverse medical school faculty parallel that of a diverse medical student body—exposing students to a wide array of experiences, cultures, and perspectives will leave them better prepared, as physicians and leaders, to address a broader set of challenges. As the patient population in the United States diversifies, medical schools must take deliberate efforts to outreach to diverse prospective faculty members, with an intentional approach to fostering inclusion and understanding. An environment that values diversity, promotes equity, and rejects prejudice will make diverse applicants more likely to pursue these positions.

Finally, faculty recruitment efforts must also embrace a more holistic review. Although research and academic background are undoubtedly important, a prospective faculty member's experience as a physician, community leader, and mentor must be weighed more equitably as these qualities are critical to supporting students from disadvantaged and underrepresented backgrounds.

### c. Establish robust mentorship and support networks across the physician pipeline

Of all the needs mentioned by interviewees, improving mentorship was most consistently cited as necessary and urgent. All participants discussed the importance of mentorship in their personal and professional development—serving as teachers, role models, and advisors.[34] A survey conducted among 311 healthcare leaders identified creating mentorship programs as the best practice to develop diversity leaders (stated by 84 percent of respondents) followed by creating programs to exposure young people to healthcare careers (stated by 80 percent of respondents).[35]

Given the unique challenges that affect women of color, the health sector urgently needs to establish and invest in resource groups and services that encourage leadership and support for aspiring women physicians of color.

Promoting diversity and cultural competence in the physician workforce will also encourage greater mentorship and guidance among women physicians of color at different stages of the physician pipeline. Furthermore, by creating learning communities built on shared values and support, medical school and residency programs can facilitate greater peer mentorship as well. This can go a long way in establishing robust alumni networks that sustain support and guidance for women physicians of color at all stages of their careers.

Finally, institutionalizing robust mentorship programs across the physician pipeline will empower women physicians of color to raise other pressing concerns that disproportionately affect them. By creating these spaces, the health sector can facilitate mentorship, support, and guidance in addressing the most pertinent challenges affecting women physicians of color.

## d. Reduce implicit bias through cultural sensitivity training

Along with increasing diversity, medical education and training must adopt higher standards of cultural competence and sensitivity. Doing so will train physicians and health professionals to address implicit bias[i] and provide care to an increasingly diverse patient population. Several interviewees recounted offensive experiences during their medical training that targeted and mocked people of color and women. Failing to embrace cultural awareness ultimately results in poorer health care for the most at-risk patients. Given the unique role that race and gender play as health determinants, cultural competence and implicit bias trainings need to examine the heath challenges and stigmas that adversely impact women of color. Thus, health institutions must make women physicians of color an integral part of modernizing cultural competency training in health care.

Promoting cultural competence and sensitivity requires that medical education and clinical training reflect the importance of sociocultural factors, race, and ethnicity in a patient's health.[36] Furthermore, embracing these values will highlight the importance of training and mentoring students who come from underrepresented backgrounds. Institutionalizing more robust standards of diversity and cultural awareness are crucial at eliminating some of the pervasive racial/ethnic disparities in medical care.[37]

Some medical schools have been including formal lessons on implicit bias as part of their curriculum, including the University of Texas Medical School at Houston, the University of Massachusetts, and the University of California, San Francisco.[38] Medical schools and health institutions across the country should establish their own programs, and expand on this example by training senior faculty and physicians as well.

## e. Bolster anti-discrimination and reporting policies

All health institutions must adopt stricter anti-discrimination policies. Despite strong statutory protections against discrimination based on race or sex, health institutions still fall short of providing the necessary protections to medical students, residents and physicians. Regardless of whether the situation arose during medical school, residency, or practice, health institutions must ensure greater protections for women of color in the workplace to combat racial discrimination, sexual harassment, etc.

Health institutions must conduct a thorough assessment of their procedures for reporting and investigating instances of racism and discrimination. Medical schools and residency programs should improve their resources and support services for students who experience discrimination.

Several interviewees recalled specific incidents in which they were discriminated against because of their race or gender, many of which happened during residency. In a recent case, *Jane Doe v. Mercy Catholic Medical Center*, the United States Third Circuit Court of Appeals ruled that Title IX[ii] protections apply to residency programs under its classification as an "Education Program or Activity."[39] Thus, health institutions must work with students and advocates to institutionalize stronger, more equitable protections for women residents of color in order to guard against both implicit and explicit forms of discrimination.

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[i] Implicit bias is defined as judgement and behaviors that result from subtle cognitive processes (e.g. implicit attitudes and implicit stereotypes) that operate at a level below conscious awareness and without intentional control

[iii] Title IX of the Education Amendments Act of 1972 prohibits any educational institution receiving federal financial assistance from discriminating on the basis of sex.

## III. Ensure equitable opportunities and support for women physicians of color

### a. Guarantee pay equity, especially for women physicians of color

Pay inequity continues to be one of the most discriminatory practices across any sector—and health care is no different. Nationally and across sectors, women are paid only 80 cents for every dollar a man is paid—and this gap grows for women of color.[40] In medicine the gender pay gap among physicians averages between $20,000-$50,000 annually, and some studies predict it may be worsening.[41]

The entire health sector has an obligation to abolish this atrocious disparity. The common excuses—that women are more hesitant to negotiate salaries, or are more of a liability due to pregnancy concerns, health risks, etc.—do not justify perpetuating discrimination and injustice. State and federal governments must work with the health sector to guarantee fair and equitable wages across gender and race.

Additionally, the health sector should consider appointing independent commissions to review its salary structure to determine if institutional policies impede equitable salaries and wages. Moreover, health employers must provide full transparency regarding salary decisions for all physicians to guarantee that every decision is fair and free from bias. If the health sector is to stand for justice and inclusion, remedying the race and gender pay gap must be a central priority.

### b. Protect the agency and reproductive rights of women physicians of color

Health institutions across the physician pipeline must provide better support for women physicians of color who become pregnant during their training or professional practice. By pressuring them to delay or abandon starting a family, the health sector denies the reproductive rights of women physicians of color.



Discriminating against a woman because she becomes pregnant may be the most egregious form of sexism, and health institutions must end this practice.

Although it is illegal for medical schools and residency programs to ask about marital status during the interview, many claim this question is still asked of women candidates and not men.[42] A study done in 2011 found that 40.5 percent of women surgeons do not have children, while 91.8 percent of male surgeons do.[43] Dr. Wyatt's story was one heartbreaking example of the sexism and misogyny that persist in the physician workforce.

Currently, no federal laws require paid maternity leave, leaving it up to an employer whether to offer this benefit.[44] This is particularly detrimental for pregnant women who are at risk of being dismissed and/or harassed by their residency program or employer, rather than be offered maternity leave. All health sector institutions must provide basic support and protections for women who become pregnant by creating a written pregnancy leave policy, offering at least six weeks of maternity leave, and at minimum, comply with the Pregnancy Discrimination Act and state disability laws.[45]

### c. Expand partnerships and contracting with business owned and operated by women of color

The health sector must empower women of color in all facets—not just in patient care—by expanding partnerships and contracting with businesses owned and operated by women of color. Entrepreneurship has always been the driver for jobs and economic opportunity for communities of color, and women of color have led the way. Health institutions need to leverage their investments to promote health equity and job creation for women of color. By building a diverse procurement strategy, the health sector can maximize its resources and capital towards advancing economic empowerment for women of color.

Furthermore, we strongly recommend the U.S. Department of Health and Human Services (HHS) establish and enforce diversity standards for hiring and procurement for public and private hospitals and clinics. Health institutions should be required to disclose their current levels of contracting with women-of-color-owned businesses to determine benchmarks and goals for improving supplier diversity across the health sector.

Several Offices of Minority and Women Inclusion (OMWI) were established through the Dodd-Frank financial services reform, which promoted diversity and inclusion in the financial services sector. The Department of HHS can build on this standard by establishing a central HHS OMWI, which enforces rigorous standards and tracks detailed diversity metrics for supplier diversity. By institutionalizing strong diversity standards, the health sector can serve as a vehicle for closing the racial and gender wealth gap.

In California, Greenlining has exhibited leadership in advocating for supplier diversity, sponsoring Assembly Bill 53 (2012), which created a supplier diversity program for major insurers, and through the California Department of Insurance Diversity Task Force. Moreover, California represents a significant opportunity to promote women-of-color-owned businesses in health care because the state has: 1) The widest network of minority-owned businesses in the country; and, 2) successfully implemented the ACA, expanding health care to over 5 million Californians.

Promoting job creation among women of color also improves economic opportunities—a critical determinant of health. Building a comprehensive strategy to improve health and economic outcomes for women of color will ensure that health institutions are comprehensively improving conditions for vulnerable populations.

# CONCLUSION

Our interviewees' narratives make clear that women physicians of color have a pivotal role in the movement to achieve health equity and ensure that all Americans receive quality, culturally competent health care. Unfortunately, a variety of barriers reduce the ability of these physicians to contribute, and keep far too many from entering the health care field at all.

Medical schools and health sector employers can and must act intentionally and purposefully to empower women physicians of color and welcome them into the physician workforce. Their leadership—as community advocates, physicians, and mentors—will be critical to ensuring equity and justice across the health sector—but only if we systematically address the barriers that now hold them back.

Rather than perpetuate the stigmas that keep women physicians of color from rising to their full potential, the health sector should leverage their collective resources to strengthen the physician pipeline for young women of color, ensure greater investment in STEM education, provide the necessary protections for aspiring women physicians of color, and elevate their leadership to meaningful positions of authority. Doing so will strengthen our health care system and improve care for large sectors of the population that often feel alienated from the medical system. More broadly, by removing bias and barriers that impede women physicians of color, the health sector can model how to ensure equity and inclusion for other industries. Women of color remain woefully underrepresented in a variety of industries and sectors, including tech, banking and financial services, and government. The medical field can and should serve as a role model for a broader movement toward equity throughout our economy.

To accomplish this, we must start by listening to the voices of women physicians of color.

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