Diversity, Equity, Inclusion, and Justice

The Danger of Assumptions

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When a person meets me, they will seldom miss that I am Black. What they notice next is often predicated on how severely racism has warped their expectations.

I have purchased 4 homes across 3 states and 2 decades. With each successful mortgage application, I have applied online or by phone. Either my income and credit score constrained the racial imagination of the bank employee, or they did me some sort of favor, as I have been listed as White 3 times and Asian once. Buying my third home, I had to apply for a mortgage from 2 lenders. My only in-person mortgage application ended with an accurate racial designation and a denial—a loan another lender was happy to make when they believed me White. To this date, I am unsure whether my denial was due to the loan officer's racism, or the systemic racism built into the lending business.

Bank employees are not alone in having a constrained racial imagination.

My medical record is full of inaccuracies. A few years ago, I went to see an ophthalmologist. As is common in a teaching hospital, I first met with the fellow and described the slight decline in my vision, which was subtle enough that I only noticed it while trying to identify fine needles during laparoscopic or robotic cases. I also mentioned that I noticed my eyes getting tired when I was studying for boards. The fellow dismissed my symptoms and recommended that I buy reading glasses at a drug store. When I reviewed my note later, the fellow documented that I was a nurse who noticed worsening vision while studying for nursing boards. He did not ask my job, but confidently assigned a role to me and documented it in the chart.

On a different occasion, I was meeting a surgeon and his physician assistant for the first time and explained that I had a tight schedule and could not be out of work for long after the planned procedure. I was wary of taking time off as I was still building my practice as a newer attending. Again, I was not asked my job. The physician assistant documented in the note "the patient is a surgical resident." For medical appointments, I do not have the luxury of being invisible as I can be for a mortgage application online or via phone. I present myself in person, inadvertently inviting each professional's assumptions to forever remain in my medical records.

Each mistake on its own is not dangerous. Whether I am a nurse, surgical resident, or fellowship-trained surgeon will not itself lead to a poor medical outcome. However, when the fellow dismisses my complaint because of his assumptions, and I must seek the care of another physician, this delays my diagnosis. Delays may potentially lead to more doctor's appointments, increasing costs of care for the patient and society. Depending on the diagnosis, a delay may lead to morbidity and even mortality.

When assumptions are made about me by a loan officer, it means I cannot buy a house right away or at all. This does not harm my health, at least not immediately. However, this translates to an inability to climb the economic ladder, as property ownership is a generally accepted means to building wealth and passing on wealth to future generations. Economic stability is a known social determinant of health. Even though I eventually obtained a mortgage from a different lender after that initial denial, time spent shopping for other mortgages and the stress of not securing timely housing as I moved to a new city detracted from other more worthwhile undertakings.

When assumptions are made about me by medical faculty tasked to teach residents and fellows, it may mean I am not given the opportunity to learn. While in urogynecology fellowship, during a case complicated by intraabdominal hemorrhage, we consulted general surgery. I remained scrubbed to assist the consulting team. The consulting surgeon stopped to look at me in disbelief in the middle of the case and asked, "What are you doing here, are you a scrub tech or something?" Am I to assume a surgeon who could not understand the role of a Black woman scrubbed, hands-deep in a patient's abdomen would evaluate his Black trainees fairly or do his best to save a Black man's life?

As a medical student, I was on trauma call when a 15-year-old Black boy was brought in with a gunshot wound. He needed an exploratory laparotomy that was performed by a White attending surgeon

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whose surgical fellow was Black. The attending surgeon joked that he expected the patient to have more trips to the operating room because he was likely a gang member. The surgeon's position of authority pressured everyone in the operating room to laugh at this joke except for the fellow and me, the only 2 other Black people present. A gang member does not deserve ridicule while fighting for his life. The fact that the 15-year-old boy happened to be a robbery victim, however, adds an extra layer of indignity. No Black child can ever act in any way to escape that surgeon's casual condemnation.

Whenever I share my experiences as a Black physician, a colleague has always been able to explain to me why I was wrong in assuming the experiences were about race. It is true I do not know what motivated the trauma surgeon, physician assistant, fellow, or loan officer. I do know that despite being a physician, trained in obtaining a medical history, many clinicians still miss what I am trying to communicate due to their own biases.

Now I see my patients through a lens of refused mortgages, incorrect medical records, and hurtful labeling of children, who could be my own. Their medical records, like mine, are not always true. Even labels like "noncompliance" may indicate an underlying systemic issue rather than be a proxy for their willingness to comply with the plan of care. My task as a medical educator is to teach my trainees to see the patient and not their assumptions, draw attention to the ways in which we, clinicians, inadvertently or intentionally contribute to inequity.

I vow not to be a silent witness to the ridicule of a patient on the operating room table or of a trainee at her patient's side.

Counterexamples to stereotypes must dislodge racist thinking rather than go unnoticed. In medicine, we make quick reads and decisions based on probabilities and patterns. But when those "patterns" are just the residue of systemic racism, we miss the information that changes lives.

I bring a wealth of privileges to lift my voice in every conversation, but Blackness is often the most noticeable to others. I walk into every patient room with an open mind. I am aware of the possibility that my patients may share some experiences with me—that an unasked question was answered for them by the last clinician's bias. That the assumption has been advanced through their medical record. At times, the assumption may not be as benign as a mistaken profession or race.

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