

Interdisciplinarity in Medical Education on Race

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Race is important in medicine. In order to correct the inequality in healthcare racial minority people can expect to receive, a new rhetorical stance is needed so that we can place our discourse in a productive arena. Most recommended solutions argue for increased education on "cultural competence" for physicians. Who will educate the educators? What rhetorical stance will work? A requirement for physicians to learn about cultural and linguistic competence will not get us to fairness in medical care, independent of race. That's because race is not the problem. There's nothing wrong with our race. Other disciplines within academe must contribute to students' understanding and treatment of race in America if we are to seriously address disparities in medical care.

Key words: race/ethnicity ■ healthcare ■ health disparities

I presented my unpublished article, "Race in American Medicine: Possibility in Ellison, Jazz and Democracy," to an audience of MD/PhDs at a recent UCSF conference. Their PhDs are in either social sciences or humanities. Since I only have an MD, I felt a bit honored to present my ideas at this interdisciplinary conference.

Medical anthropology appeared to be the most popular area of study. I met a sociologist, too. The only poet present read during lunch. Later, at the predinner meeting, I met a philosopher and an historian.

More than a pediatrician, I suppose, I'm a writer.

My original essay, "The Misuse of Race in Medical Diagnosis¹," argued against the use of race during routine clinical practice. I argued that "race," the way we are all taught to use it during the physical diagnosis section of medical school, is usually superfluous and even harmful at times.

But when I gave a keynote address with this theme at a previous medical school conference, a pharmacy student corrected me: "Race is important because African Americans metabolize drugs differently."

I asked the learned student, "How do you know someone is black?" I believe I lost her somewhere between miscegenation and the hepatocyte.

At that instant, I began to wonder how race might be useful in medicine. I did not abandon my original thesis about race. Rather, I read what was published about race in medical journals. I gathered that healthcare disparities based on race, a chronic American exigency, are now a popular medical topic.

Race is meaningful in American medicine.

Then, there is an intrinsic contradiction in my two views of race in medicine: How can "race," at once, be meaningless and meaningful in medicine?

Current medical literature insists upon "cultural and linguistic competence" in its publications.²⁻⁴ Since this frame of "culture" does not capture the crux of healthcare disparities based on race, the exigency, the discourse should shift so that the reader can better evaluate the content of medical publications on race. That is, words about *culture, race and language* nec-

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essarily move our focus away from inequalities in care to a place of comfortable, manageable, if ineffective, conversation. These words move us to a conversation about access, class, insurance, language, culture, genes—none of which confront America's disparate treatment of darker races.⁵⁻⁷ While this discourse is important in educating America's physicians, it does not lead to a practical plan that would eliminate disparities. Neither does it lead to a plan for what we'll do if disparities are not eliminated.

In order to evaluate the inequality in healthcare racial minority people can expect to receive, a new rhetorical stance is needed to place our discourse in a productive arena that might ultimately lead us to a plan of concrete improvement.

The very reasons for disparities are not typically offered. A recent publication considers broader societal causes as old as America.⁸ But beyond fixing America entirely, no practical solutions are offered, save *increase the number of minority students, educate them and the white students, too, recruit more doctors to underserved areas, highlight patients' personal responsibility, increase access, insurance for all, improve overall quality so that it can trickle down to the darker races.*⁶⁻⁹

Medical publications argue for increased education on "cultural competence" for physicians.^{6,7} But I wonder who will educate the educators. What will they say? What rhetorical stance will work for this exigency?

The reason I write about healthcare disparities is because an English-speaking black MD, PhD tenured University of California medical school professor with preferred provider organization insurance saw his English-speaking physician who failed to address the patient's present, historical or familial hypertension; failed to screen for prostate cancer; and failed to discuss colon cancer screening. Or else, I write about disparities because my wife miscarried in an ER waiting room passing blood clots while the medical staff—the American medical system—stood by, watched my wife in pain and did nothing for too long.

Clear evidence exists in the medical literature about the use of pain medications for darker people in America: a black person in pain will wait longer for a smaller dose of pain medication.¹¹ Our black and brown bodies are not valued. As in Toni Morrison's novel, *Beloved*, I'm talking about flesh here.

How can we frame the thinking? The discourse? What approach to medical education will work to educate young and old physicians? Medical students? Premedical students? American patients?

I took a small opportunity to discuss race on hospital rounds recently. Some of the students and residents appeared bothered by my attempts at educa-

tion on race in medicine. However, later that same day, a noon case study about a rare rash had the same group riveted. I submit they'll see more brown babies in their future medical careers than any babies with bullous mastocytosis.

I accept that this fact will get me nowhere.

I wrote yet another essay on the topic—the one I presented at UCSF on Saturday. I looked to jazz as a template for thinking about how to educate the educators. I looked to Ralph Ellison, the American novelist, too, for a template, for technique, for precedence in reshaping the way America thinks about race. I looked to the humanities because American medicine heretofore has not been equipped to handle this great American synecdoche: disparities in healthcare recapitulate disparities in America.

Possibility remains in America for those willing to look at the past and play in concert, and in contention, with the present. American democracy is called into question when a black would-be mother bleeds in pain in the ER waiting room. American decency, too, is called into question.

The individual is supreme in America, but the collective, too, matters. What exists to encourage medical students and physicians to listen to the collective, evaluate the possibilities and change how we practice medicine that brings us to this disparate state? *Logos* hasn't worked so far. *Pathos*, too, won't fair any better at convincing American medicine that our very bodies matter because the need for an emotional appeal to doctors to persuade them to take better care of brown people betrays the failure: American medicine is not naturally interested in this.

Race in medicine is like race in law, education, corporate structure, housing, etc. It burdens the Aristotelian triad: speaker, speech, audience.

Who is this audience?

American medical education, like American democracy, has always been a template for possibility. It is a place to confront hypocrisy in addition to pathology. A place where personal dignity is necessary for a healthy populous. A place in direct discourse with the past in order to heal the present.

I told the group at UCSF stories about my unknown father, a jazz trumpeter, who died of a heroin overdose, and his unlikely son, the pediatrician. I told the group about my four-year-old daughter, who looks white though born to a black mother and a Mexican father, as an emblem of American possibility. They are examples of how we might create a language within medicine that solicits other academic and artistic disciplines in order to manage race in medicine. I told the group of MD/PhD candidates that jazz is an onomatopoeic version of democracy where the individual matters, at once, with the collective. Even when the individual is

brown in modern America, his flesh matters to humanity.

The requirement for young and old physicians to learn the medical literature on race will not get us to fairness in medical care, independent of race.

At least, not alone.

That's because race is not the problem. There's nothing wrong with our race. The treatment racial minorities receive—which is predictable, measurable and reproducible—is the problem.

Other departments and programs within academe must contribute to students' understanding and treatment of race in America if we are to develop a practical plan to eliminate disparities in medical care. An evaluation of the current, limited discussion of race in medicine needs the poet's insight, the jazz septet's dialogue, the novelist's epiphany, the essayist's prose. The humanities can help medicine develop a practical plan to decrease healthcare disparities. If not, our humanity promises to decrease.

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