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The Case for Black Doctors

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DURHAM, N.C. — IN virtually every field of medicine, black patients as a group fare the worst. This was one of my first and most painful lessons as a medical student nearly 20 years ago.

The statistics that made my stomach cramp back then are largely the same today: The infant mortality rate in the black population is twice that of whites. Black men are seven times more likely than white men to receive a diagnosis of H.I.V. and more than twice as likely to die of prostate cancer. Black women have nearly double the obesity rate of white women and are 40 percent more likely to die from breast cancer. Black people experience much higher rates of hypertension, diabetes and stroke. The list goes on and on.

The usual explanations for these health disparities — poverty, poor access to medical care and unhealthy life-style choices, to name a few — are certainly valid, but the longer I’ve practiced medicine, the more I’ve come to appreciate a factor that is less obvious: the dearth of black doctors. Only around 5 percent of practicing physicians are black, compared with more than 13 percent of Americans overall.

As a general rule, black patients are more likely to feel comfortable with black doctors. Studies have shown that they are more likely to seek them out for treatment, and to report higher satisfaction with their care. In addition, more black doctors practice in high-poverty communities of color, where physicians are relatively scarce.

As a psychiatrist, I’ve seen this up close. I’ve frequently been the only black doctor (or one of very few) in clinics with large black populations. Quite often, patients ask to see a black doctor, but the sheer volume of people seeking help prevents me from accommodating most of their requests.

Black patients, compared with those of other races, tend to be far less trusting of physicians and their medical advice. Much of this is rooted in a dark history of experimentation on black people without their consent (the four-decade-long Tuskegee syphilis study is the most notorious modern-day example). Too often, however, this mistrust is to the patients’ detriment. I’ve met countless black people who have either delayed or refused needed treatments because they were skeptical about their physician’s motives and honesty. Some wound up far sicker than they should have been; others died.

Perhaps the most compelling evidence that black patients are more likely to trust black doctors comes from the mental health field, where a patient’s relationship with his or her provider is especially important. Black people have often fared poorly in their interactions with the mental health care system. For example, they are nearly half as likely as whites to receive treatment for diagnosed mental health disorders of comparable severity. When black patients do receive treatment, it is far more likely to occur in an emergency room or psychiatric hospital than it is for whites, and less likely to be in the calmer office-based setting, where longer-term treatment can take place.

In this context, it is easy to understand a 2011 meta-analysis published in the *Journal of Counseling Psychology* that observed that black people strongly preferred to be matched to black therapists and were more likely to view them favorably, and that these preferences and perceptions translated into slightly better clinical outcomes. In addition to the issues of trust, there is also a simple geographic explanation for the importance of black doctors. For at least three decades, researchers have found that black doctors are simply more likely to practice in high-poverty communities that are minority-rich and physician-poor. According to a 2012 report by the Association of American Medical Colleges, black medical students are more than twice as likely as white students to express the intention to work in such areas.

My career offers an example. I grew up in a working-class family a generation removed from segregated poverty, a background that influenced my decision to practice in clinics that served a disproportionately poor and minority population, instead of private offices.

CLEARLY, we need more black doctors. In the 2011-12 school year, the most recent for which figures are available, there were 5,580 black students enrolled in medical school, making up about 7 percent of the medical student population, which is roughly half of the proportion of the black population in America.

Nonetheless, when viewed through the lens of history, this recent figure reflects progress: In the 1968-69 school year, 783 black students were enrolled in American medical schools, just 2.2 percent of the overall total. Race-based affirmative action programs, which began to be implemented around this time, undoubtedly played a major role in expanding the number of black students in medical school. By the late 1970s, the number of black students had increased nearly fivefold, with the proportion peaking at 8 percent in the mid-1990s.

Since that time, however, opposition toward affirmative action has grown stronger. Many states have banned race-based admission efforts at public universities, and last year, the Supreme Court ruled that this was permissible. Purely race-based affirmative action is not yet dead, but it appears to be approaching its twilight years.

Even those who are uncomfortable with affirmative action or oppose it outright should consider the potential impact of this trend when it comes to medical school. A recent study in *The Journal of Higher Education* found that affirmative action bans in six states led to a 17 percent reduction in the enrollment of underrepresented students of color in medical school. Policies resulting in fewer black doctors could lead to even worse health outcomes for a population that is already the least healthy.

Of course, black doctors are not the only physicians who can deliver good medical care to black patients. Nor is every black physician a good one. Over the years, I've worked with many white and Asian doctors who are adept at interacting with patients of all races and social classes; indeed, they have been some of my best teachers and colleagues. Yet I've also seen the other side, where black patients have received cursory evaluations and callous misdiagnoses based upon negative stereotypes.

When I have been particularly successful at treating black patients, it has often had less to do with any particular talent on my part than with my patients' willingness to bring up the racial concerns that troubled them.

Several years ago, for example, I met a recently retired black man who had been referred to me for treatment of depression. He had become increasingly dispirited by the fact that the town where he had raised his children had transformed into a community full of poor schools, single mothers and young black men in the criminal justice system.

Rather than prescribe him an antidepressant pill, as another doctor had done, I encouraged him to talk in depth about his early life in the 1940s and '50s and the positive influences that had helped him succeed. Discussing his life in this way made him feel more confident about his ability to touch other lives, even though he couldn't fix larger social problems. He helped put together a local program that introduced poor black kids to chess and golf, an endeavor that made him feel better than he had in many years. Periodically, he leaves me messages saying that he is still doing well and thanking me for my help.

Another time, I worked with a young woman who struggled with her biracial identity. Her black father had been abusive to her white mother when she was a child, and she found herself both afraid of and hostile toward black men. Because she physically resembled her father in many ways, she had also turned these negative feelings inward. Not surprisingly, her initial impression of me was unfavorable, but a friend encouraged her to come back to see me.

Over the next several months, we talked about every aspect of race imaginable, and by the end, she found herself more at peace and better able to see black men as individuals. For the first time, she even met a black man whom she began dating. She no longer felt depressed or severely anxious.

My experience as a patient may also be instructive. I received a diagnosis of high blood pressure as a first-year medical student, and although I knew perfectly well that I needed to change my high-salt, high-fat diet, I just couldn't do it. Of course, it was hard to give up what was familiar and enjoyable. But an equally important part was my resistance to assimilating and adopting behaviors that I associated with well-to-do whites — eating salads and drinking fruit smoothies, for example — even though I knew that this defiance was ultimately self-defeating.

Only after many failed attempts have I been able to consistently do the right thing with my health. Today I take this experience into the exam room. While patients ultimately have to take responsibility for their own lives, it is helpful to have a doctor who understands, and doesn't dismiss, behavior patterns that are often rooted in a cultural history.

How do we find more doctors who can share these insights with their patients? The truth is that race-based affirmative action is not an ideal fix. Despite being a beneficiary, I am ambivalent about it. In college in the 1990s, I was a strong student — co-valedictorian of my class — and a good test taker. On these measures alone, I would have gotten into several high-quality medical schools. Yet affirmative action propelled me into a different stratosphere. I was suddenly an applicant worthy of early admissions and special scholarships at some of the most elite schools.

Race might have been my ticket onto this stage, but what really made me different was social class. My mother went to segregated inner-city schools and couldn't afford college; my father grew up in rural poverty and didn't finish high school. In contrast, many of my white classmates were the children of doctors, lawyers and professors. A greater emphasis on socioeconomic diversity — one that looks at applicants in the context of their family structure, parental education, childhood neighborhood and quality of grade-school education — is more likely to be seen as fair by a greater number of people (and more likely to survive legal challenge) than one that primarily uses race as a marker for diversity.

Universities — and medical schools in particular — should go out of their way to recruit good students of every race from these less affluent backgrounds. Over time, such efforts could produce a greater cohort of doctors who are better prepared to relate to the patients who need them the most.

In an ideal world, the race of the patient or physician wouldn't matter; we would all treat each other strictly as individuals. But we're quite a ways from reaching that exalted goal. For now, we have to attack the problem of racial health disparities from as many angles as possible. Black doctors are an important part of this mission.