Fixing Healthcare Podcast Transcript

Interview with Amanda Calhoun

Jeremy Corr: Hello, and welcome to the Fixing Healthcare podcast. I am one of your hosts, Jeremy Corr. I'm also the host of the popular New Books in Medicine podcast and CEO of Executive Podcast Solutions. With me is Dr. Robert Pearl. For 18 years, Robert was the CEO of the Permanente Group, the nation's largest physician group. He is currently a Forbes contributor, a professor at both the Stanford University School of Medicine and Business, and author of the bestselling book Mistreated: Why We Think We're Getting Good Health Care—and Why We're Usually Wrong.

Robert Pearl: Hello everyone, and welcome to the second episode of season five. This season is focused on the culture of medicine and how it both supports doctors and nurses in providing superb medical care in the most difficult of circumstances, such as during the current coronavirus pandemic but also leads them to inflict harm on themselves and their patients. In this episode we explore the difficult topic of racism in American healthcare. If you want more information on the culture of healthcare, you can find links to articles and podcasts on a variety of topics on my website RobertpearlMD.com. Once there, I encourage you to check out my Monthly Musings and participate in the reader survey on these types of topics.

Jeremy Corr: Our guest today is Dr. Amanda Calhoun. She is a resident at the Yale School of Medicine in Adult and Child Psychiatry. She serves as co-president of the Psychiatry Residents' Association, assistant editor of the Connecticut Psychiatric Society Newsletter and an Associate Editor of the American Journal of Psychiatry Residents' Journal. She was the keynote speaker at Yale's White Coats for Black Lives event where she captivated the hearts and minds of the hundreds of physicians participating. She believes that all doctors should be activists in battling racism in healthcare, and that social justice needs to be integrated with medical education. We wanted a guest on this important topic who would be unafraid to tell the truth. We can't imagine anyone better able to do that than Dr. Calhoun.

Robert Pearl: Welcome Dr. Calhoun. This season focuses on the culture of medicine. Let me begin therefore by asking you, as physicians we tell ourselves we treat every patient the same, is it true?

Amanda Calhoun: Oh, definitely not.

Robert Pearl: Tell me more about it.

Amanda Calhoun: Even before getting into racism and race, you know, I'm a child psychiatry resident and we know in psychiatry that about this concept of transference and counter-transference that happens between the physician and the patient, which is basically that the patient, as well as you from the physician's

perspective, often attribute certain feelings, experiences to patients that remind you of experiences in your life or a person in your life. Those feelings could be positive or negative. And so it's something that happens in the patient-physician relationship and you will find that every physician has this, where a certain patient reminds them of their cousin, so they find that they are treating that patient in a more, I don't know, affectionate way because it reminds them of their little cousin.

Amanda Calhoun: And so we know that, as human beings, physicians are just people and they don't treat all patients the same. When we start talking about racism, the current literature and data, because I know physicians, we love data, we're scientists as well, shows that there's differential treatment based on race in patients. It's documented not only in the scientific evidence, but also if you just talk to patients of color and ask them about their experience in the medical system, they will tell you that they have experienced doctors that don't treat them the same way that they treat their white patients.

Robert Pearl: What's some of the data that you've come across in your research?

Amanda Calhoun: There's tons of studies. The ones that I usually use in my talks are the ones that were a-ha moments for me, some of them being the data surrounding pain and the fact that we know that Black patients are undertreated for their pain compared to white patients. Meaning that if a Black patient comes into the clinic or into the emergency department and a white patient comes into the clinic or the emergency department with similar pain symptoms for presentation, we find that the white patients are more likely to be worked up more, they receive more testing and also studies have come out that have shown that minority patients in general are less likely to be treated with empathy and understanding compared to white patients.

Amanda Calhoun: I think for me, as a Black woman, one of the studies that really touched me was looking at the rising maternal mortality in Black women due to preventable childbirth complications and the fact that for the longest time people were citing poverty and lack of education as the reason behind these racial disparities. However, recent studies have come out that have shown that college graduate Black women are more likely to die due to preventable childbirth complications than white women who have never completed high school. That argument that it's just poverty, it's just education, falls to the wayside when you still see that these disparities exist.

Amanda Calhoun: Add to that you think about why all these studies on stress and allostatic load and the fact that they have looked at many different indicators in stress in Black people and found that they are higher than white people just due to chronic racism and being a Black person in this country. I think those are some of the studies. I think I'm glad that more and more studies are citing what I, and many Black Americans, already knew, but it's helpful in academic discussion so that doctors can become aware of it.

Robert Pearl: It's my understanding that when Black women are cared for by Black physicians and they're giving birth, that the mortality disparity disappears. Have you come across any of that data and, if so, what's your interpretation?

Amanda Calhoun: Yeah, I have. Actually, a recent study came out as well on the pediatric side that a lot of pediatric colleagues were freaking out because it showed that Black children, Black infants, actually, were three times more likely to die when treated by white physicians. So we see that not only in newborns, but in mothers as well. I definitely think that having a Black physician is most definitely protective. I think it's protective not necessarily just because the physician is Black, but because a Black physician understands the fact that Black women are often undervalued or thought to be in less pain than they really are.

Amanda Calhoun: I think that the blacks physicians I've had, and my Black colleagues, we're aware of this data because we've seen and we've had own family members be turned away from the emergency department when they are really sick and not get further workup, that we know that our white colleagues have gotten and our white colleague's family members have gotten.

Amanda Calhoun: So I think Black physicians are very aware of this in their practices and I think that Black physicians view Black people as valuable, honestly, and tend to be people that when we say we're in pain or when we say something doesn't feel right, they instead of turning us away and saying, "You'll be fine," they take it very seriously. So I most definitely think having a Black physician is protective because of that.

Robert Pearl: As you know, in COVID-19, African American patients are three times as likely to die at least than white patients. Which was interesting to me was a study that I saw early in the pandemic when the number of testing kits were very restricted, that two patients coming in, a Black patient and a white patient, with the same symptoms, same degree of fever, that the white patient was far more likely to get a test than the Black patients.

Amanda Calhoun: Mm-hmm (affirmative).

Robert Pearl: How do you explain this?

Amanda Calhoun: I mean, I would just explain it that's just racism. I think that people need to ... When I say people, I mean we're talking physician to physician here, I think physicians just need to call it what it is and understand that racism is a risk factor just like poverty is a risk factor, just like there are other risk factors, and that I just think in this country it is very baked into the system and into the mindsets of people, specifically non-Black people, to not value the complaints or concerns of Black people to the same extent as white people.

Amanda Calhoun: That happened in COVID, but as I mentioned, that's been cited in other studies as well that Black patients are less likely to get further testing and get testing for

the same symptoms. And so it goes back to providers and physicians not valuing our pain and not treating us the same as white patients. It's sad and it's upsetting, but when you learn about the history of the medical system in America, yeah.

Amanda Calhoun: So I often pull in historical data. I don't pretend to be a historian, but I think it's important to understand the history of the American medical system and the fact that it, from the beginning when African slaves were brought to this country, has been a dehumanizing experience for Black Americans and we have seen that white doctors have not treated their Black patients the same as their white patients. And so those mindsets persist.

Amanda Calhoun: An example of that is the fact that a recent 2015 survey showed that white residents in medical students still felt that Black people felt less pain, which is wild to me because Black is a race. It's not biological, right, it's a social construct that was made up and they still think that Black people feel less pain. Then when you bring in the history of it, you start learning about J. Marion Sims, the father of gynecology, and the fact that he experimented on African slaves with anesthesia to perfect his vestigial vaginal fistula repair, and then would take those perfected procedures and perform them on white women with anesthesia.

Amanda Calhoun: So you can see how this historical belief that Black people felt less pain has persisted and continues to persist today. I very much think that it's alive and well in physician's minds today and I think that plays into why they won't work us up more because they feel that Black patient's pain is not something to be concerned about or not something to be alarming.

Robert Pearl: How much of this racism is conscious and how much of it is unconscious?

Amanda Calhoun: That's a really good question. I'm so glad you bring that up. I steer away from those conversations because I'm skeptical about how productive they are. That's why I specifically don't use the term unconscious bias. I don't use the term implicit bias because I think it's a placating term for multiple reasons. For one, we've done implicit bias trainings. I'm going to answer your question, but I just wanted to give this background with it.

Amanda Calhoun: But we've been doing implicit bias and framing this as an implicit bias for over a decade now and the evidence is not really clear about whether these implicit bias trainings are really showing reduced racist behaviors, or thoughts or beliefs. And I think part of that, I think it's multiple things. I have no idea what the percentage of people who are racist consciously and unconsciously are and I don't think we'll ever know unless we get to a point where we can read people's minds. Because I don't think if a person is a consciously racist person with racist beliefs they're going to admit that. Well, some people would.

Amanda Calhoun: But I think if we're talking physicians and you're in a medical facility, I don't think that people are going to admit that they're racist. For me, I'm much more concerned about the impact of their behavior than their intentions and so I really don't talk to people about their racism being unconscious or conscious. I leave that to my white allies because that's a very frustrating conversation for me because then it ends up being me helping them to feel better about their racist behavior and making them feel like it was unconscious.

Amanda Calhoun: We're getting into, "Are you a good person?" And all of that. I found it much more productive to focus on, "Okay, well regardless of your intention, regardless of whether you have conscious racist beliefs that you grew up with, or that you learned, or it was unconscious. What impact does it have on the patient? And are we seeing that Black patients are having the same health outcomes as white patients even when they have equal access to care? We are seeing that they are still differences.

Amanda Calhoun: When talking to patients I'm still having patients pull me aside and say, "I don't feel like I'm being listened to. I don't feel like I'm being heard. I don't feel like I'm being treated the same as white patients." And so for me, I'm much more interested in that and rectifying that than figuring out whether the people who have racist behaviors are doing it consciously or unconsciously. I hope it's unconscious because I think if it's unconscious then maybe there's hope for changing it.

Amanda Calhoun: But I think I'm more interested in helping people to unlearn these pervasive stereotypes into really evaluate their behavior when taking care of patients and really self-check and make sure that they are working up patients adequately, and listening to their concerns, and thinking about the impact that our behavior has on our patients regardless of what our intentions were.

Robert Pearl: I ask from the positive standpoint of people who do want to change. Let's just you're a white obstetrician-gynecologist and you're caring for a diverse group of patients, some of whom are African American, and you recognize that there's a higher mortality rate in general. Maybe you've looked at your own statistics. Maybe you haven't. Most obstetrician-gynecologists obviously don't have a whole lot of maternal deaths, which is very fortunate. But you want to do everything you can in your power to minimize that possibility. How would you advise them to go ahead?

Amanda Calhoun: Oh, my gosh. That would be lovely. When I gave my speech for the White Coats For Black Lives demonstration that we did in front of Yale Sterling School of Medicine, I actually had some OB-GYN physicians that came up to me and asked the same question and I love to hear that because there's so much that you can do if you're trying to be aware of it.

Amanda Calhoun: One thing that you can do is work up your Black patients. If I were in their shoes or I was advising them or I was a consultant, I would say make sure that your Black female patient has a blood pressure cup at home. Make sure that if

they're complaining about a headache or they're complaining about symptoms that could go either way, you have them come in. So practice really being conservative and making sure that you're working up their symptoms and really check them, would be one thing that I think would make a world of difference.

Amanda Calhoun: Because when we look at a lot of these very scary stories of Black women dying, their families are citing the fact that they called their physicians and had headaches and had other concerns and their physicians told them, "No, you'll be fine. Don't worry about it." I think instead of doing that, bring the Black woman in and work her up and examine her.

Amanda Calhoun: Then the second thing is when it gets time for the birth, and I think because OB-GYNs they don't always, some of them do, aren't always present at all of their patient's deliveries, the problem that can happen is that it may not be you that delivers the baby, it may be your colleague. So making sure that your colleague is very much aware of these statistics, making sure that you have some sort of check and balance system where if something's going wrong, hopefully the patient is able to contact you or there's some mechanism for you to be alerted. And then also looking at the rest of your staff.

Amanda Calhoun: I like to blame physicians because I am one, so I feel it's safe to talk about my own, but a lot of this is also racism in nursing staff, it's racism in nurses not even bringing the patient's complaints to the physician. And so I think really make sure there's a mechanism and process to make sure your patients are being heard and if the nurse is not listening to them, giving them a mechanism to be able to contact someone else would be life changing.

Robert Pearl: Your dad is also a psychiatrist and also trained at Yale, so you're following in his footsteps. So you've been very well aware of physician culture, I'll say for your whole life, growing up in it and now practicing in it. How do you think it's changed over the past few decades?

Amanda Calhoun: Well, I think it's interesting and talking to my dad about things. I think in some ways it's more progressive and in some ways it's less progressive. I think back when my dad went to medical school there were actually more Black men in the medical field than there are now. But then, on the other hand, my dad is really happy that I'm in a program that's actually not even a program, but also just a location where people such as yourself, but also my attendings and different people are really supporting this work I'm doing anti-racism and I feel like a lot of these discussions now that we're having about racism and accountability for racism weren't even had years ago.

Amanda Calhoun: And so I think in some ways we're progressing, but in some ways it is definitely we're seeing a little bit less diversity as well in the physician population. I think it goes both ways.

Robert Pearl: As you're pointing out, there is a under-representation of African American physicians in the total physician population. Why is that and what could we do about it?

Amanda Calhoun: Well, I think it all goes back to racism. I talk to people about this a lot, if you're talking about if we're looking at poverty and the fact that the average median family income for Black families is a lot lower than that of white families. You really can't talk about poverty without talking about the economic oppression of Black people in America and the fact that Black people, on average, do not have the same wealth as white people and the same educational status and I think all of that plays into the pipeline of who becomes physicians. But that is the result of an intentional racist system of over 400 years, intentionally disadvantaging the Black population.

Amanda Calhoun: You cannot expect, we can't expect for Black people to be on the same footing as white people economically when we've been oppressed due to a racist system. As far as moving forward, I think one of the big things we can do is acknowledge that and really work to dismantle the system by actually providing real outreach, with actually putting money into funding so that more Black people can become physicians, with actually putting more into funding and, I think, rewarding people who want to work in minoritized communities. I think there's a lot of room for helping with the barrier of the fact that medical school is just so expensive and is really becoming more and more expensive.

Amanda Calhoun: I think it's going to be harder and harder not just for Black people, but also people who don't have a certain amount of wealth to be able to become physicians. I think that's a real loss because we need people from all walks of life to become physicians. I mean, we don't want everyone who's a physician to come from a wealthy, affluent family. That's not helpful because then we need the perspective of physicians who have grown up in families of all different races and socioeconomic statuses. I think the fact that it's so overwhelmingly expensive to go to medical school and it's such a long road, you really need a lot of economic support, and support in general, to be able to be encouraged.

Robert Pearl: You're both African American and a woman. How does racism and sexism, how are they similar in medicine and how are they different?

Amanda Calhoun: Oh, I'm so glad you asked that. I'm only speaking for me, so I'm not at all trying to extrapolate my experience to all women, but I would say that the sexism I experienced pales in comparison to the racism I experience. I mean, it's not even on the same level. White women are benefiting far more from societal advantages than Black women. That's just a fact. White women are paid more in the same jobs than Black women are. There are more white women represented in psychiatry, for example, than Black women by far. And so I don't want to minimize sexism. Of course, sexism is terrible and there is a lot that needs to be done on that front, but I do not think the sexism that I experienced is nearly as damaging as the racism.

Amanda Calhoun: I mean, the sexism is like a patient tells me that I'm looking good today, which is like, "Okay, thanks. Appreciate it." I keep it moving. I'm not saying that's appropriate, but that's a compliment, even though it's an unwanted compliment. The racism is my Black child patient being called the N-word and having a white, stable patient, mind you, go up and scream the N-word in his face 10 times and nobody on the unit do anything about it except for me who goes back and tells that patient, "Are you okay? How can I protect you?"

Robert Pearl: I know you've written, I'll say curriculum for medical students and I'm going to guess residents and maybe others. Can you tell me a little bit about what you've written and what you recommend?

Amanda Calhoun: Yeah, so I just started writing stuff because I've been venting to my parents a lot. My mom is a pharmacist also, by the way, so she's very medically oriented as well. But I was just venting to them about the way that people were framing these conversations and I wanted to do it differently. It started with me writing a piece called I Don't Want to Know More, that I actually put in the Yale Pediatrics blog. It was just a very simple piece about the fact that I didn't want to know more than my attendings about racism and the way that it affects our patients and the fact that I feel like I was in the position of having to search for ways to learn about the disparities information and the research and the mental and physical effects of racism and all of that.

Amanda Calhoun: Anyway, from there I actually ended up getting contacted by a curriculum company that does training modules for physicians and I thought, "Oh, this will be good. Just put all my thoughts and things that I've been talking about into a module." So I actually created some content that I still have that essentially goes through the definitions of racism and anti-racism, which I model after Dr. Kendi's work, How to be an Antiracist, and goes through the different types of racism and goes through the reasons why I don't like the term implicit bias, which I mentioned. And the fact that I want to focus on the people who are targeted and focus on the impact. So it goes through all of that.

Amanda Calhoun: It also brings in the history, so what I mentioned about the father of gynecology and the fact that we learn about the positives but we don't learn about the fact that he experimented on Black people and the fact that this silencing of these facts paints a picture that's not true. And how if we were to understand these racist beliefs historically, it helps us to understand how they're still present today.

Amanda Calhoun: So the curriculum takes you through the history and then completes by having a series of cases. And so they asked me to put together some cases in which would demonstrate to physicians of different specialties. So I did one for OB-GYN, I've done one for pediatrics, I've done some for family medicine, internal medicine, how racism would play out in patient outcomes and then modeling for the people doing the training or the curriculum how that interaction could have gone better.

Robert Pearl: For the listeners who wanted a chance to take one of your courses, how do you define racism?

Amanda Calhoun: When I define racism there are a couple of different definitions that people use. There are many different forms of racism and the most basic way that I like to define it is essentially ascribing a set of behaviors, actions, thoughts to a particular race. Then when you look at racism another definition of it can be what people talk about when they talk about institutional racism, but I think people get confused because it depends on what definition you're going off of and that gets into the whole thing of can a minority be racist and all of that. And so, I stick with the very simple definition which is basically having certain negative thoughts usually or ascribing certain negative thoughts, behaviors, actions to a particular group based on the color of their skin.

Amanda Calhoun: And then anybody can be racist, yes, but certain groups, in this country, white people have institutional power, so their racism becomes institutional racism because they have institutional power. And institutional racism is really when you start to have policies and behaviors and procedures that advantage one race over another that are baked into the institutional system.

Amanda Calhoun: An example I like to give of institutionalized racism is if you're on a unit in a hospital and you're rounding on patients. Let's say you have Spanish speaking patient and you don't have time to all an interpreter that day. You say you don't have time, so you decide that you're going to come by with an interpreter later on in the day and you just basically give them very basic information, even though they can't really speak Spanish. That becomes a practice that's acceptable on that unit in that institution.

Amanda Calhoun: That's an example of institutionalized racism because it's a behavior that's become acceptable and there's no policy against it, you're allowed to do it, you're allowed to update them later, but it actually is resulting in unequal care, unequal treatment. You really are advantaging patients who can speak English. I think that's an example of institutionalized racism against Spanish speaking patients.

Robert Pearl: How would you apply it to Black patients?

Amanda Calhoun: If I were to apply it to Black patients, you would look at institutionalized racism, honestly, is really where I think the undervaluing of pain comes from, honestly, and the fact that you may have people that don't individual feel that they're racist, but you hear about cases where there have been multiple Black patients who have been turned away from the emergency department, or haven't gotten further work up or testing for their symptoms, and the patient's been seen by the resident, the social worker's seen them, and attending's seen them and this is behavior that's just been tolerated.

Amanda Calhoun: And even, honestly, racist jokes that, sadly to say, have become institutionalized in the sense that I've been on units where it's common to make jokes about a patient's hair texture, it's okay to joke and say that a Black patient wants to join a gang, to joke and say a patient is ghetto, to me that's institutionalized racism too because if you would go to the individual person, they would say they aren't racist, but that's really almost a racist institutionalized culture that's been baked into the system and then people start to believe that it's okay. It's very insidious.

Robert Pearl: I'm going to guess that for most listeners who are not in medicine, they're going to be very appalled at the inappropriate jokes you mentioned and they're going to want to know how often does this happen? Is this a once a year? Once an entire medical school experience or is this more frequent? What's been your observation?

Amanda Calhoun: Oh, my gosh. I went to medical school in a different place than I'm at residency and I will tell you, the program that I came from was even worse as far as, yes, what I have found is that it is ... I will say that it's very frequent and location dependent. So that's gets into a racist culture and the fact that yeah, I've definitely been on multiple units where it was common to make racist jokes about patients. It happened frequently. I said, "How would you feel if you walked by a group of doctors taking care of your family member and they were joking and laughing about how your family member's natural hair looked wild and crazy?" I said, "How would you feel about that?"

Amanda Calhoun: And it was really funny because I said that and the nurse who was making the racist joke just was like, "Oh." And later, I really give kudos to the attending. The attending pulled her aside and said, "That was really inappropriate," but it was me who he wasn't going to say anything if it wasn't for me. And so yeah, racism is extremely pervasive amongst physicians. There are some physicians who I think are extremely good at dispelling the racism and saying, "No, we're not going to talk about our patients like this," and I think there are some physicians who very much think it's okay to make racist jokes about patients.

Amanda Calhoun: It also comes up oftentimes when our patients, especially a lot of my Black patients, have concerns about whether they trust what the attending is saying, whether doctors are going to be experimenting on them and I've had colleagues that have said, "That's so funny. That's ridiculous. Why would we experiment on them?" And I said, "Are you aware of Henrietta Lacks, the Havasupai Tribe lawsuit, Tuskegee and a number of other studies that have shown that actually medicine has a history of experimenting on people, especially Black people and other people of color?" And they looked me.

Amanda Calhoun: But I think it's just ignorance and racism and all combined and it goes back to why we need a diverse physician population because I truly think if we have representation of physicians from all walks of life and all racial backgrounds, religious backgrounds, et cetera, those insensitive, racist, homophobic whatever jokes are not tolerated. Unfortunately, I wish that we didn't have to have people from that background in order for them to feel invested in the patient, but what

I've seen is that sometimes it happens where if you have a very homogenous group of people taking care of a patient and the patient is of a different background, there are a lot of insensitive comments said.

Amanda Calhoun: Some of them are said behind closed doors. Some of them are said in front of the patient and the patient doesn't always feel empowered to speak up because that's your doctor. I mean, whether you trust your doctor or not, they're in charge of your health and so even if a doctor says something very insensitive towards you and it's racist, you may or may not feel empowered to really report them. Some patients do, but a lot of patients don't, so that's one of the reasons why I'm very serious about this because I feel like I really see my role as being a protector of patients because they may not feel empowered to be able to speak up.

Amanda Calhoun: I feel like if I speak up, then I still could potentially be targeted as a trainee, but it's better than the patient being targeted. So yeah, I think people should be appalled to hear that happens in the medical system and that's why I tell patients and people going to the medical system that they should most definitely advocate for themselves. They should ask questions. They should challenge me. If I have patients that ask me lots of questions, sometimes they'll apologize, and I always say, "Nope, nope. Don't apologize. Please do hold me accountable for my decisions. Please do question me if you feel like my decisions are unfair. I want to know because I want to make sure that I'm treating all my patients equitably."

Jeremy Corr: If you were explain to say, for example, a patient or someone who maybe like me, from Iowa, who maybe doesn't have as much exposure to a lot of this. Could you explain the difference between anti-racism and just plain not being racist?

Amanda Calhoun: Yeah, so not racist is really, to me, a cop out because it's just a statement. You're just not racist. When I really think that there's no in-between. Like I said, I have to give Dr. Kendi the credit for this, but I really like the way that he conceptualizes in that you're either actively working against racism and you're actively supporting policies and behaviors that are working to rectify a racist system or you are upholding a racist system. And so I like thinking about it that way because it does not give anybody an out and allow anybody to just be silent. Because if you're just silent, that's not anti-racist, that's racist.

Amanda Calhoun: And so I really like that conceptualization of it's one or the other and that to be anti-racist requires that consistent self-check and self-work to make sure that you are not upholding policies or behaviors or actions that are going to disadvantage one race compared to another.

Robert Pearl: As we've said, COVID-19 disproportionately affects African Americans negatively. A COVID-19 vaccine hopefully will be available sometime in the future. Given the history of racism, how can we protect our Black patients from this disease one the vaccine's available?

Amanda Calhoun: I really think that it's on us, meaning the medical system, to rebuild that trust. I think that, like I said, the medical system has a history and currently does not treat patients equally. And so when this vaccine comes out it's going to be very interesting because trying a new vaccine requires trust and I think that trust has been eroded and really, honestly eroded and never really was truly earned in the Black community. I think one of the biggest things that we can do as the medical system is really work on rebuilding that trust with the Black community.

Amanda Calhoun: I think part of that is in naming racism and naming unequal treatment and naming the fact that this happens and that we're working on rectifying it as opposed to this thing where it's like, "Let us protect the medical system and pretend like we're perfect at all costs." We're not perfect, we're people.

Amanda Calhoun: I think acknowledging that and really talking to our patients and taking the extra time to talk to our patients, especially our Black patients, and when this vaccine becomes available talking to them if they have concerns about the vaccine, talking to them about how they're feeling about the fact that so many Black communities have been devastated by COVID.

Amanda Calhoun: I mean, as the school year came around again, there were so many conversations about reopening schools and the different systems and I was asked to write an article for the American Academy of Pediatrics Council on School Health, which is a newsletter I really like writing for, and they asked me to write about what should teachers and the school system keep in mind with the reopening of schools, and students in the context of COVID-19.

Amanda Calhoun: I look at the rest of the newsletter and the majority of it had no mention of the fact that Black children had been disproportionately impacted by this, meaning their families, and the fact that the recent article in the Washington Post came out that showed that close to one in three Black people know someone who died of COVID. So these Black children are having to go back to school and also Hispanic children with more than likely family member's friends who have died. Just that collective grief, of grieving your community and your people is devastating.

Amanda Calhoun: I think physicians really need to acknowledge that and check in with their Black patients and really try to rebuild trust. I think we can rebuild trust and people can trust that we want to take of them, people will be more interested or open to getting vaccinated. And then also making sure that the vaccine is available and that we're not ... Because for a while COVID tests were only available in certain areas, so really making sure that there's outreach to all communities, not just affluent white communities and making sure that everyone is getting educated about the vaccine and possible side effects and rebuilding that trust.

Amanda Calhoun: But really going above and beyond to rebuild the trust of the Black communities. It cannot be equal treatment. It must be equitable treatment because the trust that we have to rebuild in the medical system in the Black population is not the same as in the white population because the atrocities

committed against Black people are nowhere near the same as those committed against white patients.

Amanda Calhoun: I just think that people need to be very aware of that, meaning physicians, and people in the medical system, and really make that extra effort to earn the trust of the Black population.

Jeremy Corr: I think one of the biggest a-ha moments for me, and as weird as it sounds, is one of my best friends and I were going to go grilling out at his house and he's an African American man. We went to the grocery store together to get stuff to grill out before this party, and this was back before the pandemic, but we went to the grocery store and we went through the line. I told him just to toss my receipt at the end, I didn't need it and he, on the way back to his car, he was like, "That's an example of white privilege." I'm like, "What do you mean?" And he's like, "As an African American man, I can't throw my receipt away because then somebody's going to think I stole something."

Amanda Calhoun: Exactly.

Jeremy Corr: I was like, "Wow." It's something I never even put the two and two together, but he's like, "There's little examples of that everyday things that you just take for granted that I have to double-check and think about."

Amanda Calhoun: Yeah. I think, to that point, in areas that predominately white like the area that you're in, I think it's even more crucial for white allies, actually, to think of ways to support Black people because there are less of us there to advocate for ourselves. And so it's powerful for predominately white areas to be thinking about that and thinking about ... Luckily, this was you. It didn't become a bad situation, but actually sharing those narratives and helping to create a space where that's the assumption and educating people in that, and also looking at the education that people give their kids and the schools that they ...

Amanda Calhoun: Depending on the person who's asking, if they have kids, really thinking about, "Do you talk to you kids about racism and about race or not?" Because many Black children, we have these conversations from very young ages because we have to. I mean, I remember first being aware that I was treated differently because of the color of my skin when I was four and I remember that moment. I remember being stopped in my affluent neighborhood by a policeman because I was riding my brand new bike and them asking me where did I get that bike and me saying, "Oh, I live right there. You can go to my house and ask my dad."

Amanda Calhoun: But we had these experiences at a very young age as Black children and so it's imperative, I think, really for white children to be exposed to racism and early. Because we know that children are not colorblind and actually there's some really interesting studies which I'm happy to send to you, but we know from a child development perspective, that by three months of age children start to recognize race. And that around three or four, children start to choose their

playmates based on race, and that around four or five kids can already start to tell you which races have which social statuses in this country.

Amanda Calhoun: If you look at the work of Doctors Mamie and Kenneth Clark with the doll study, which was recently replicated in 2010 with CNN, they asked Black and white children without was the intelligent child, who was the child you want to be friends with, who's the beautiful child? They had drawings of kids of all different skin tones and they found that all kids, sadly Black children as well, had a preference for whiteness being good and darker skin being bad, and especially the white kids though.

Amanda Calhoun: The white kids had a very, very strong indication for saying, "White was good and Black was bad," so I think there's a lot of room for white people in white places to really start talking to their kids about this because kids are aware of it, they internalize things and they definitely treat people differently based on race. It's bad, but we know developmentally it happens and so I think there's a lot of work in just educating white children about this and talking to them about race and their perceptions about race to make sure that they're developing into anti-racist individuals, rather than racist individuals.

Amanda Calhoun: That's why I like working with kids because kids will tell you the truth, point blank. When they asked those kids, "Which one is bad?" They're like, "The Black one," so kids, if you make it seems like you really want to hear what they have to say, kids will tell you what they think. While it's sad, it's also a very shape-able time, so I think there's a lot of work for white allies to work with their kids and really work in their own communities.

Jeremy Corr: This is something slightly, I guess, not off-topic, but so say, for example, my son is bi-racial. He's four and we made the decision to put him in a very diverse daycare. The daycare provider is Black and is best friend from daycare is Black and everything like that. We've never really had the conversation around race with him. I guess, what age ... I don't know that he maybe really understands the difference because of how diverse the daycare that he goes to is, but what age do you think is appropriate to start addressing that with children?

Amanda Calhoun: I think that you can start addressing it, I would say from my limited experience as a child psychiatry trainee, I would honestly say as soon as the child is about to start school, probably around, honestly, three or four is when I would probably honestly start talking to kids about it. Because it's around the age of four, five, that age range where they actually start internalizing those racist stereotypes and so that they're taking in from their surroundings, which is all over.

Amanda Calhoun: Unfortunately, while it's good that if a child's in a diverse daycare, has diverse friends, and I think that's probably protective, it doesn't shield them from the media and the fact that TV shows largely center white characters as good and Black characters often have negative portrayals. It doesn't protect them from racist classmates and classmates making comments about the color of their skin. It doesn't protect them from teachers. I mean, if they have Black teachers

that's probably helpful in the sense of Black teachers have been shown to not have the same kind of differential treatment based on race, but I think it's very hard to shield children from internalizing racist beliefs. I think you have to actively talk to them about it because I think they're aware of it at a much earlier age than we would like to think, unfortunately.

Jeremy Corr: There's that stereotype that you often hear about how with affirmative action and things like that, do you ever get the stereotype from patients that because you or some of your colleagues are African American, that they might not be as qualified as the doctor next to them, that they got in easier because of their skin color. They were filling a quota or any of those types of stereotypes. How do you address that and have you dealt with that from patients, especially maybe older patients?

Amanda Calhoun: Oh, of course. I definitely encounter that. I mean, that's a super pervasive stereotype. So sometimes, and actually oftentimes, I usually when I introduce myself to people or when people get to know me they may not even know that I'm a physician and they certainly may not know that I'm a Yale physician or that I went to Yale undergrad. But oftentimes if patients are being racist and sizing me up, I often do throw out those titles and also throw out the fact that I was in the top of my class.

Amanda Calhoun: Then I keep it moving, but most definitely that's a pervasive stereotype. To me, I know that there are people that are going to assume that and it does require a lot of internal confidence in yourself and knowing that that's not true and knowing that you're just as intelligent, if not more intelligent, than the white man next to you. So, that's how I go through life. That's been helpful, but it's definitely very damaging and very upsetting to constantly have your legitimacy be challenged.

Amanda Calhoun: I definitely think that it's something that I really admire Black people in general for everything that they've gone through, but in addition to that I also really value Black people that have got into positions of power in academic spaces in medicine because it requires so much just resilience and grit and toughness. I think it's a constant barrage of being undervalued and you always feel that you have to work harder than the white person next to you. But I'm used to that and, again, that goes back to my parents coaching me.

Amanda Calhoun: I mean, it's been from the beginning that I can say something and the white man or the white woman next to me can say it and they'll get the credit and I'll be ignored. I know that and that's my reality and so, for me, I've learned how to navigate that from a very young age, but it's definitely reality that not everybody realizes or they don't realize it because they don't experience it and I haven't talked to them about it. But it's definitely something that yeah, it's definitely been a part of my life from, honestly, as long as I can remember.

Robert Pearl: Thanks Dr. Calhoun for being on the show today and for educating all of us about the endemic nature of racism in the medical culture and the destructive consequences it has.

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Jeremy Corr: Thank you for listening to Fixing Healthcare with Dr. Robert Pearl and Jeremy Corr. Have a great day.