Bias in the Medical Workplace: “They Think It’s Normal Because Everyone Does It”

BY LUCY BERRINGTON, MS, VITAL SIGNS EDITOR

To what extent is the medical profession a meritocracy? In the context of the #metoo movement against sexual harassment, with its spillover scrutiny of bias and discrimination in general, medicine has not escaped criticism. Researchers continue to measure and substantiate the ways that medical careers are less accessible to minorities and women than to white men, even as the profession emphasizes the importance of a diverse workforce in delivering culturally competent care and reducing health disparities.

Vital Signs talked with physicians about discriminatory incidents and workplace dynamics, and how to address them. Biases in the medical workplace — among patients, peers, administrators, or instructors — may not be easily visible to colleagues. “Unconscious bias is when people think what they do is normal because everyone does it. I want to help people understand this exists,” says Sharon Marable, MD, MPH, FACP, vice-chair of the MMS Committee on Diversity in Medicine. Ron Dunlap, MD, past president of the MMS, says, “Discrimination is still significant. Most colleagues are unaware of it and don’t see it as a problem.”

Physicians’ Unconscious Bias

Bigotry in the workplace appears to be becoming less overt. More commonly, physicians describe the everyday unconscious or implicit biases that underlie cumulative effects of discrimination, such as pay gaps and promotion gaps.

Researchers have established the presence of physicians’ pro-white bias (except in black physicians, who exhibit far less racial bias) and explored how it may contribute to differential clinical decision making and health outcomes. Physicians of color report that the same biases in colleagues impact their training and careers, even though diversity in medical schools is associated with improved outcomes for the profession and patients.

The perspectives and insights of minority students and colleagues, which have broad educational value, can themselves be isolating. “If I hear things said about patients that are not appropriate — stereotypes relating to ethnicity without a clear understanding of the historical context of our minority patients — it’s hard to always be the person who’s calling it out. You can be seen as combative and it gets tiring,” says Margee Louisias, MD, MPH, an associate physician at Brigham and Women’s Hospital and instructor at Harvard Medical School.

Racial Disparities in Medicine

In December, a Spotlight investigation by the Boston Globe pointed to the scarcity of black physicians as a factor in the racial segregation of health care in Boston. Boston is not an outlier. In 2015, the New England Journal of Medicine reported that only 2.9 percent of faculty members at US medical schools were black.

In a 2000 study, black physicians reported that their biggest stressors included racism on the job, others’ doubt in their abilities, and the need to prove themselves (Journal of the National Medical Association, 2000).

Such experiences may amplify the risk of burnout. “If you didn’t have resilience, that strength and character, internal confidence that you didn’t have to necessarily depend on others to reinforce for you, I think there’d be no way to continue in medicine,” says Vincent C. Smith, MD, MPH, a neonatologist at Beth Israel Deaconess Medical Center. Claiming experienced bias may “choose” less competitive career paths, says Dr. Dunlap. “In many cases, candidates (residents, fellows, and junior staff) lower their goals and don’t pursue a career in academic medicine, because the track record for promoting minorities is still quite poor at most medical schools.”

Gender and Sexuality Biases

Even as women physicians have become established in medicine, they remain marginalized in measurable ways. (The barriers facing women in medicine were explored in the September 2017 issue of Vital Signs.) Similarly, lesbian, gay, bisexual, and transgender medical professionals experience ongoing discrimination at work. “There’s definitely been an improvement over the last two decades, but there’s still a whole lot of narratives about bad experiences,” says Carl Streed, MD, a fellow.

MMS Honors Its First Black Doctor

In recognition of Black History Month, the MMS is honoring Dr. John Van Surly DeGrasse, the first black doctor to join a US medical society. In 1854, Dr. DeGrasse was admitted to the Massachusetts Medical Society. Five years earlier, he had graduated from Bowdoin College’s Medical School of Maine, becoming the second African American to receive a medical degree. Dr. DeGrasse will be commemorated with a forthcoming plaque in the first-floor lobby at MMS Headquarters, Waltham.

Dr. DeGrasse, an active abolitionist, was involved in intercepting slave hunters in Boston after the 1850 Fugitive Slave Law passed. In 1864, he was commissioned as an officer and assistant surgeon with the 35th United States Colored Infantry. Dr. DeGrasse was the sole black surgeon to serve with his regiment in South Carolina, and one of eight who served in the Union forces. He subsequently was honored with a gold-hilted sword by John Andrew, governor of Massachusetts from 1861 to 1866.
A Spirit of Inclusion for Patients and Physicians

A common thread among physicians is that which drove us to the profession — in some way, we saw medicine being practiced and felt this was what we needed to do. For me, it was seeing the impact that my father, an internist in our hometown of Camden, New Jersey, had on our community.

But although each of us has a reason, our stories themselves — the impetus for becoming a physician — are unique. So too are the experiences we bring to our careers, not just professionally but personally, as well.

Medicine is not one-size-fits-all. Ours is not a homogeneous community, and I am proud of such diversity.

That’s why the MMS is developing new networks of members who help ensure that we are hearing the voices of the multifaceted Massachusetts doctors and students whom we represent.

Our new Minority Affairs Section is dedicated to widening and improving our pathways to leadership, thus increasing the diversity of those who represent our membership of more than 25,000.

Here in Massachusetts, the patient population is also heterogeneous. Not only is it important that the physician community reflect our patients, it is essential that the Medical Society reflect the diversity of the profession.

Good medicine has always incorporated a spirit of inclusion, and the Medical Society celebrates that spirit. Bringing your unique voice to an MMS committee is how we make the Society more diverse. Learn more on the MMS website, massmed.org, under the Governance tab. Consider joining us this year.

— Henry L. Dorkin, MD, FAAP

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At Tufts, People with Disabilities Teach Patient-Centered Care

BY LUCY BERRINGTON, MS

“What brought you here today?” the medical student asked the patient, a teenage boy. “The bus,” the patient said. He didn’t seem to be joking. The student tried again: “What do you want to talk about?” “Nothing, really.” Gradually, the student’s questions became more specific. “Are you sick right now? Have you had any symptoms recently?” “Yeah — I’ve been having some stomach problems.”

Medical students are trained to ask open-ended questions. Sometimes, those don’t work. In this interaction, the teen, who had autism spectrum disorder (ASD), was employed by Tufts University School of Medicine as a standardized patient educator. He was meeting a “new physician” — the medical student — to discuss an annual physical and a flu shot. His conversation was literal and honest; he didn’t want to talk about anything. Another student and a faculty member observed the interaction, which took place at the Tufts simulation center.

This experiential teaching program, part of a third-year family medicine clerkship, allows students to learn from disabled patient-educators and adapt their clinical skills to deliver more culturally competent, patient-centered care. Patients with ASD, for example, may communicate in ways that upend their doctors’ scripts and expectations, among other barriers to accessing and receiving effective medical care.

Disability-Related Disparities

Research reveals large disparities in health care access and outcomes affecting people with physical and developmental disabilities. The documented under-emphasis on disability within medical education likely contributes to the dearth of expertise and the limited ability of the health care system to meet the needs of these patients.

The disability teaching exercise is a powerful vehicle for teaching humility and the importance of learning from patients, says Wayne Altman, MD, FAAFP, chair of family medicine at Tufts. “There’s a lot of pressure as a physician-in-training to accumulate an enormous amount of knowledge. Amidst that pressure, sometimes it feels difficult to admit that you don’t know something. Having humility with your patients is so important. Patients with disabilities often have knowledge about their condition that their physician or the medical student doesn’t have.”

The focus on patients-as-educators in medical education is not new, but meaningfully including patients with disabilities, and autism in particular, is novel. Feedback from medical students is “off-the-charts positive,” says Dr. Altman. He and colleagues created the program 15 years ago, featuring adult “patients” with real-life physical disabilities who presented with fictional shoulder pain. The program subsequently expanded to include patients with autism (and, in some cases, their parent or caregiver).

Real-Life Medicine

In one encounter, a medical student conducted the consultation without asking the “patient” why she used crutches. Without that information, he couldn’t consider whether the crutches, or the disability that necessitated them (spina bifida), may be contributing to her shoulder pain or might exclude certain treatment options.

“This is a great way to demonstrate that when you come up with a treatment plan for a patient, you need to account for what’s happening in their life,” says Dr. Altman. “You can’t just read out of a textbook. ‘The treatment for shoulder pain is this.’ The students really figure out that the skills they’re learning in this encounter apply to every patient they’ll see for the rest of their lives. When you talk to a patient who has a disability or who’s on the autism spectrum, it really pushes you a little harder toward recognizing that.”

The reporter is a clinical instructor in this teaching program.
Physicians: How to Address Bias in Medicine

BY LUCY BERRINGTON, MS

The inclusivity of the medical profession is not a given. Anecdotally and empirically, we learn of discriminatory dynamics shaping medicine as they shape other fields. “Medicine is a microcosm of American society,” says Dr. Sharon Marable, MD, MPH, FACP, vice-chair of the MMS Committee on Diversity in Medicine. “It has its good, its bad, its blatant biases, and its unconscious biases. We carry all of that into the worksite. As physicians, we need to recognize that.”

Owning our Biases

Catching our own biases is, by definition, counterintuitive. A 2017 essay in ACEP Now, a publication of the American College of Emergency Physicians, provides a guide. “First, recognize and accept that we have biases. They help us to function and serve to protect us,” wrote Bernard L. Lopez, MD, professor and vice chair of emergency medicine and associate provost for diversity and inclusion at Thomas Jefferson University Hospital, Philadelphia: “Research has demonstrated that bias blind spots (the ability to ‘rationally’ explain away our biases) are greater in those with higher cognitive ability (e.g., physicians). Realize that this is not easy to deal with. Explore the awkwardness and discomfort that comes along with examining our biases and how it affects our daily interactions. Engage with people who we consider ‘others’ and learn and gain experience from them. Finally, get feedback. Ask a trusted person, ‘How did I do?’ This is how we learned our profession. We became educated, sought guidance and feedback, and practiced it over and over.”

Evidence-Based Strategies

Project Implicit, founded by scientists, provides enlightening online tools for quickly measuring biases we didn’t know we had: see implicit.harvard.edu. In a 2013 analysis of physicians’ implicit biases in the Journal of General Internal Medicine, investigators identified several evidence-based strategies for reducing physicians’ bias (measured in clinical decision-making contexts):

- **Self-awareness:** Knowing they were subject to implicit bias
- **Individuating:** Making a conscious effort to focus on specific information about an individual rather than social categories (e.g., race or gender)
- **Perspective-Taking:** Making a conscious attempt to envision another person’s viewpoint

Effective Intervention

In conversations with Vital Signs, physicians emphasized the importance of their colleagues’ support. “One thing people can do is not wait for physicians of color to raise these issues. Other people need to be calling it and talking about issues,” says Vincent C. Smith, MD, MPH, a neonatologist at Beth Israel Deaconess Medical Center. A physician at Brigham and Women’s Hospital described how a 2015 incident during her residency, in which an attending effectively called her the N-word, demonstrated the value of bystander action. “When I hear the N-word coming from an authority figure, it’s like fight or flight. In these situations, the person being targeted doesn’t know what to do; they kind of freeze,” says Cianna Leatherwood, MD, who is now a fellow in rheumatology (her residency took place in another state).

Another colleague at the time, a fellow, took her directly to the hospital administration to report the incident, resulting in the attending taking early retirement. “I learned how vital it is to speak up on colleagues’ behalf. Later, in a lecture, I reported a racist comment the instructor directed at an Asian student,” says Dr. Leatherwood. (For the full story, see massmed.org/vitalsigns.)

For additional examples of bias in the medical workplace and how to intervene, from Massachusetts physicians and medical students, see massmed.org/vitalsigns.

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At 25,000 members strong, the MMS is a dedicated advocate on Beacon Hill and in Washington, DC, for the common interests of physicians in practices of all sizes. In addition to the MMS’s consistent federal and state advocacy supporting all physicians, members also receive the following:

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The production of health is ultimately a balance between health care and the social services that generate positive environments. Massachusetts is better on both of those axes than many other states. We have in many respects the densest, richest network of health care providers in the country. We also have had a generation of state leadership that has tried to invest in social services. Having said that, even in Massachusetts we weight our investment heavily on health care and underinvest in parks and recreation, mental health, public health services, justice, civil society, opportunities for social connections — the whole basket of services that ultimately generates health.

When we talk about health equity and social determinants of health, we hear that “place matters.” How does Massachusetts matter?

Galea Your zip code matters more than genes. There are plenty of data to suggest that quality of housing, parks, and environments, social connection, availability of transportsations — these are ultimately the factors that create health. That matters as much in Massachusetts as in Mississippi or in Alaska or in Wyoming. Massachusetts has tremendous heterogeneity in its health, and a lot of that is geographically patterned just as it is in all other states.

“Diversity Should be Central to Health”

Physician-Dean Puts His Mark on Public Health

BY ROBYN ALIE, MANAGER, MMS POLICY AND PUBLIC HEALTH

A committed, dynamic partnership between medicine and public health is vital for improving health outcomes at sustainable cost — but that partnership is not supported systemically. At Boston University School of Public Health, Physician-Dean Sandro Galea is aiming to change that, and is shaping the next generation of public health practitioners.

An emergency physician and epidemiologist, Dr. Galea grew up in Malta, and studied medicine in Toronto where he volunteered with homeless populations. He has practiced rural medicine in Canada, and worked in Somalia with Doctors Without Borders. Vital Signs spoke with Sandro Galea, MD, MPH, about the important roles social justice and addressing social inequities play in health — a core theme of Dr. Galea’s book published last year, Healthier: Fifty Thoughts on the Foundations of Population Health (Oxford University Press).

You’ve identified diversity and inclusion as core values at the BU School of Public Health. How important is diversity in medicine and medical training?

Galea We have long underestimated the importance of diversity and inclusion for the profession. The profession has a responsibility to represent the population it serves, and there is abundant scientific evidence that diversity is a positive for creativity, innovation, and generating ideas. So, I think there is incontrovertible reason to believe that diversity should be central to all we do in health. Diversity means having everyone at the table, and inclusion means making sure everyone feels included. There is the element of making sure that the communities are not just represented by the people who are providing health care and those who are trying to promote the health of populations, but also that the diversity of community members are heard, and by those who are providing health care specifically.

You’ve talked about taking a shift toward blended payment models where there are clear incentives for physicians providing quality care but also incentives for keeping patients healthy, keeping people from becoming patients.

What is your vision for public health?

Galea Public health should aspire to creating a world where we have the right social conditions on multiple social axes — of housing, of income, of education, of child care, of elderly care — that ultimately keep us healthy. Medicine is a subset of that: we need good medicine, we need good health care, but we need medicine when we get sick.

How do we get there?

Galea I think we get to prevention by saying again and again that prevention matters. Would you rather have a world where there is a treatment for Alzheimer’s or a world where there is no Alzheimer’s to begin with? Then you look at our investment: is it in preventing Alzheimer’s or treating Alzheimer’s? The system privileges treatment over prevention. Doctors have a powerful voice in the health care debate. If doctors understand that there is a need for engagement in multiple sectors to keep us healthy, the voice of doctors can move the needle.

For the full interview with Dr. Galea, see massmed.org/vitalsigns.

Bias in the Medical Workplace

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In internal medicine at Brigham and Women’s Hospital and chair of the MMS Committee on LGBT Matters, who coauthored a 2017 article on the stressors facing LGBT medical professionals.

Institutional Barriers

People of certain demographics face specific, practical barriers to practicing medicine. In a recent New York Times editorial, Cheri Blauwet, MD, a physical medicine and rehabilitation specialist at Brigham and Women’s Hospital, wrote, “Few people with disabilities are admitted to medical school: Medical students with disabilities also have higher attrition rates than nondisabled students.” Most medical schools do not meet the legal standard of accommodations for students with disabilities, according to a 2016 analysis in Academic Medicine.

Bias also amplifies when ethnicity is a factor, says Lauren Meade, MD, FACP, a primary care physician at Baystate Medical Center who works closely with international medical graduate residents. “We have many Muslim doctors — more than half our community hospitals, nationally, are supported by internationally born graduates — and many Muslims pray five times a day. If the hospital culture doesn’t condone or support it, you have to disappear and pray in closets or bathrooms, and you’re not there for important stakeholder opportunities.”

Lack of Guidelines

Physicians of color and women physicians commonly report negative judgments from patients, including probing questions about the physician’s racial origins or professional credentials. “It does weigh you down after a while,” says Dr. Smith.

In the absence of training and policies on how to handle bias and discrimination, physician leaders are mostly on their own. “When patients say they don’t want to be treated by a brown-skinned doctor, or don’t want a doctor who wears hijab, there’s a high impact in terms of physicians’ isolation,” says Dr. Meade. “Most doctors do not report that, and most leaders don’t know what to do when it happens.”

For more extensive coverage, see massmed.org/vitalsigns.

Dean Flotte, MD: The DACA Risk to Medical Diversity

Uncertainty over the federal Deferred Action for Childhood Arrivals (DACA) program risk undermining efforts to diversify medicine and address health outcome disparities. Read our interview with UMass Medical School Dean Terrence Flotte, MD, at massmed.org/vitalsigns.
GOVERNMENT AFFAIRS

Updates from the 2017 Interim Meeting

MMS Nudges Massachusetts on Family Leave and Medical Parole

BY SARAH RUTH BATES, MBE
MMS GOVERNMENT RELATIONS AND RESEARCH ANALYST

The Society is seeking to align Massachusetts with global and national standards on paid family leave and medical parole, two issues that have major public health implications.

Paid Family Leave
At the Interim Meeting in December, the House of Delegates voted that the Society advocate for paid family leave for early child care. The resolution had been brought by Michael Medlock, MD, who was struck by the meager maternity benefits available to a family member employed by a major company.

“When I looked into it, I found that the United States is behind the rest of the world in this. I didn’t realize what a stark outlier we were,” says Dr. Medlock, a neurosurgeon in Essex South.

The issue has major implications for child health. A report submitted by the MMS Committee on Maternal and Perinatal Welfare and the Committee on Legislation found strong evidence that paid family leave for early child care benefits the health and well-being of children and their parents. In California, the advantages have been particularly striking for vulnerable populations.

Family leave brings economic benefits, too. “There is excellent data showing that we are going to be economically better off if we provide this kind of service,” says Dr. Medlock. “This is one of the social determinants of health — we’re sometimes reluctant to pay for it upfront, but if you don’t do that, you pay for the consequences later.” The committee’s report cited evidence that paid parental leave does not harm businesses.

Advocates in Massachusetts for paid family leave have collected enough signatures to make this a state ballot initiative in November 2018, if the legislature does not address it sooner. At the federal level, the recent Republican tax law included a provision to expand the child care tax credit from $1,000 to $2,000. Massachusetts Representative Katherine Clark has proposed a bill, co-sponsored by Representative Jim McGovern, that would allow a larger tax credit for employment-related child care expenses.

Medical Parole
The House of Delegates also voted to advocate for medical parole for incapacitated or terminally ill patients. Medical parole allows for the release of certain incarcerated persons who are not threats to public safety into the care of family or caretakers.

Three medical student delegates — Maria Duarte, Alexander Pomerantz, and Andreas Mitchell — authored the resolution. They cited the high cost of health care for Massachusetts inmates, relatively low rates of recidivism for medical parolees, and the imperative that physicians must “provide the best possible palliative care for their patients and protect human dignity.”

Medical parole is currently legal in 47 states and under federal law. A bill that would allow for medical parole in Massachusetts has been incorporated into the legislature’s comprehensive bill on criminal justice reform, which was under consideration as Vital Signs went to press.

MMS Pushes for LGBTQ Policies Based on Evidence, Not Bias

BY SARAH RUTH BATES, MBE

The MMS has joined the fight against discriminatory blood donation practices and “conversion therapy” — two policies based in prejudice against sexual and gender minorities rather than scientific evidence.

Lowering a Barrier to Blood Donation
The MMS testified in support of a state bill opposing the current FDA regulation that men who have sex with men be deferred from donating blood for 12 months following sexual contact. The bill would prohibit blood donation facilities from discriminating against potential donors on the basis of sex, gender, or sexual orientation, while allowing facilities to require that donors provide proof of a negative HIV test.

“The current FDA regulation doesn’t make sense from a risk perspective,” says Julian Cyr, a Massachusetts state senator and cosponsor of the bill. “We’re actually seeing a decrease in HIV rates for men who have sex with men, especially in Massachusetts, thanks to the really broad success of pre-exposure prophylaxis.” Donated blood is tested for HIV and other pathogens, he added.

Public objection to the FDA’s policy has grown in response to the 2016 shooting at Orlando’s Pulse nightclub and the October 2017 mass shooting in Las Vegas, as facilities have turned away blood donations from men who have sex with men. If passed, this legislation could increase the supply of donor blood in Massachusetts. “Right now, we have a shortage,” says Senator Cyr, who is a former chair of the Massachusetts Commission on Lesbian, Gay, Bisexual, Transgender, Queer and Questioning (LGBTQ) Youth.

“Men who have sex with men, myself included, are prohibited from donating blood. It’s discriminatory — and it’s just absurd.”

Banning “Conversion Therapy”
The MMS testified in strong support of another anti-discriminatory bill that would ban licensed practitioners from engaging in so-called “conversion therapy,” or efforts to change a patient’s gender or sexuality in a therapeutic session, in Massachusetts.

Senator Cyr cosponsored this bill, too. “[Conversion therapy] is an abusive and fraudulent practice that’s premised on an outdated idea that it’s possible to change a young person’s sexual or gender identity,” he says. Conversion therapy harms a population already at higher risk for suicidal ideation, violence, unplanned pregnancy, and victimization compared to their non-LGBTQ peers, says the senator. “Massachusetts likes to proclaim itself a leader on LGBTQ issues, yet we’re not leading here. We trail eight other states and the District of Columbia, which have already outlawed conversion therapy.”

Physicians voices make a critical difference. At a June hearing, State Representative David Linsky said, “I take a hands-off approach to getting involved about medical procedures. But when I see that all respected medical organizations have endorsed this bill, how could I not support it?”
Writing Is the New Medicine: When Patients’ and Physicians’ Stories Intertwine

BY LUCY BERRINGTON, MS

Physicians may grapple with how best to incorporate their own emotions into their clinical practice — how to draw on their feelings in ways that enrich patient care, and their own experiences, rather than compromising either. In acute care situations, emotional connection may feel particularly remote. “You’re running around trying to save as many lives as you can,” says Ismée Williams, MD, a fetal cardiologist. “I wanted to remain objective. Becoming a doctor made me wall off my emotions. If you keep getting your heart broken, you can’t do your job well.”

But Dr. Williams is also an emerging novelist, and this new role forced a shift in her perspective. Water in May, her young adult novel (Amulet, 2017), tells the story of Mari, a pregnant Dominican teen living in the United States whose fetus is diagnosed with Hypoplastic Left Heart Syndrome. “As a writer, I had to take that wall down,” says Dr. Williams, who gave voice to a character inspired by the high schoolers whose fetuses and babies she treated.

Narrative Medicine
Taking down the wall gets to the essence of narrative medicine, which emphasizes a textured, sympatico understanding of patients and their experiences. It’s an interdisciplinary approach to medicine that dovetails with the contemporary priorities of culturally competent and patient-centered care.

David Hellerstein, MD, an essayist and comic novelist who incorporates literary methods into his medical teaching at Columbia University, predicts a boom in physician-writers. On his website, he wrote, “Science is essential to medicine, but it is not all of medicine. And that is why I think we are in for a renaissance of doctor-writers, something that the world has never before seen.”

Physician-writers have always had access to compelling raw material. “Mari’s story had everything: drama, suspense, the character arc. I knew it was unique and that very few would be able to give the story justice,” says Dr. Williams. “I wanted to make the reader experience intense emotion.”

Physicians’ Developmental Arcs
Kишкes Review predicts that Mari will challenge readers’ assumptions about teen moms. That prediction speaks to the author’s own developmental arc as a physician — another focus of narrative medicine.

“When I first started, I thought these young mothers were naive,” says Dr. Williams. “I would see these teenagers, acting silly and clearly happy about being pregnant. Then, all of a sudden, they would grow up. They would have the baby and be back in the hospital for three or four appointments a week, dealing with feeding tubes and oxygen monitors at home. I was incredibly impressed.”

Cultural Connection
Dr. Williams’s story, like her protagonist’s, reaches back to Central America. Her grandfather, Juan Arnao, MD, was an OB/GYN, poet, and political journalist who escaped Cuba. Her mother, Isis Arnao Bartels, MD, was accepted to medical school in the US on her fourth attempt (“They kept telling her to be a nurse”).

Dr. Williams, an MMS member, graduated from Tufts University School of Medicine. She currently practices as a fetal cardiologist at the Children’s Hospital of Montefiore, New York, and is co-PI on the NIH-funded Human Placenta Project at the New York State Psychiatric Institute. She is donating royalties from the book to congenital heart disease research.
How can a medical society ensure that its leadership is representative of the increasingly diverse physician workforce? The new Minority Affairs Section of the MMS was developed to answer that question.

Minority Affairs Section Aims to Diversify MMS Leadership

Nidhi K. Lal, MD, MPH

Vital Signs talked with Nidhi K. Lal, MD, MPH, chair of the Section. Dr. Lal practices family medicine at Boston Medical Center and Urgent Care at Lowell General Hospital, and is an assistant professor at Boston University School of Medicine. In 2017, Dr. Lal was honored as Community Clinician of the Year for Middlesex University School of Medicine. In 2017, Dr. Lal was an assistant professor at Boston University School of Medicine. In 2017, Dr. Lal was honored as Community Clinician of the Year for Middlesex North District, in part for her work with culturally diverse and underserved populations. She has a special interest in narrative medicine and is working on developing it as a tool for culturally competent care. Dr. Lal, a delegate, has served as district president and alternate trustee, and as a member of the International Medical Graduates Section and the Global Health Committee. She is currently a Fulbright Specialist and is working on global health projects in India.

VS How did the Minority Affairs Section come about?

Lal It originated as a Task Force on Diversity in Leadership in February 2016. Dr. Dennis Dimitri, then president, asked me to chair it. The goal was to look at whether the leadership was representative, and identify barriers and pathways to leadership. We realized a lot of our information was anecdotal, because the Society didn’t collect data on members’ race and ethnicity. We extrapolated from AMA data.

VS What did the task force recommend?

Lal The task force developed a list of recommendations — but who was going to monitor implementation and progress? We needed something more than a task force that would be disbanded later. At the 2016 Interim Meeting, the task force had two recommendations: to collect race and ethnicity data, and to develop a Minority Affairs Section to continue other relevant tasks. Those resolutions passed. Dr. Jim Gessner, then the president, asked me to chair the Section.

VS Who else is involved?

Lal We invited all the members of the task force, and we invited all the minority committees to send a representative: the committees on women, diversity, LGBTQ, IMG, and students, residents, and young physicians.

VS How can the Section provide practical support to members?

Lal We surveyed MMS leaders whom I considered part of a minority: Dr. Barbara Rockett, Dr. Ron Dunlap, Dr. Jay Jayasankar, Dr. Janine Saldanha, Dr. Maryanne Bombaugh. Mentoring came up as one of the most important things. Everyone said, “I never knew I could do it until someone took me under their wing and helped me, or invited me to be a leader, saying that they will help me out.” We hope and intend for the Section to be a place for mentors and mentees to connect and establish relationships.

To connect with a mentor or mentee, contact Bill Howland, director of membership engagement, at (781) 434-7877 or bhowland@mms.org.

IN MEMORIAM

The following deaths of MMS members were recently reported to the Society. We also note member deaths on the MMS website at massmed.org/memoriam.

Nabil E. Arian, MD, 78; Maspex, MA; Ksar Alainy Faculty of Medicine, Cairo University; died July 31, 2017.

John J. Darragh, MD, 76; Grafton, MA; University of Pennsylvania School of Medicine, Philadelphia; died August 30, 2017.

Paul L. Dratch, MD, 78; Bellingham, MA; Tufts University School of Medicine, Boston; died October 5, 2017.

Charles F. Eades, MD, 88; Dartmouth, MA; Boston University School of Medicine; died October 15, 2017.

George Goldman, MD, 93; Dedham, MA; Tufts University School of Medicine, Boston; died September 4, 2017.

Eugene M. Joly, MD, 88; Palm Coast, FL; Georgetown University School of Medicine, Washington, DC; died September 11, 2016.

Michael T. Shaw, MD, 84; Cloverdale, CA; University of Newcastle upon Tyne School of Medical Education, UK; died June 4, 2017.

Bernard A. Stotsky, MD, 90; Brookline, MA; Western Reserve University, Cleveland; died October 30, 2017.

How to Join an MMS Committee

Apply by March 2

If you’re looking to revitalize your network and support your community, getting more involved with the MMS accomplishes both at once. Consider participating on a committee — with more than 40 committees, we’re bound to have at least one that aligns with your interests — or the Member Interest Network (MIN) Executive Council.

Committee appointments are for specific terms, usually three-year renewable commitments. Conference calls and online meetings allow for convenient, remote participation.

Applications are due March 2. For committee descriptions and an application form, visit massmed.org/committees or contact Karen Harrison at (800) 322-2303, ext. 7463, or email kharrison@mms.org. If you would like to join the MIN Executive Council, contact Cathy Salas at the West Central Regional Office at (800) 322-2303, ext. 7715, or email csalas@mms.org.

INSIDE MMS

ACROSS THE COMMONWEALTH

District News and Events

NORTHEAST REGION

Essex South — Membership Meeting. Wed., Feb. 28, 6:00 p.m. Toscana’s Restaurant, Peabody. Speaker: Jeffrey Drazens, MD, editor-in-chief, NEJM. Topic: Data Sharing in the Context of Clinical Trials.

Middlesex Central — Delegates/Executive Meeting. Thurs., Feb. 15, 7:45 a.m. Emerson Hospital, Concord.

Northeast Regional Office: (800) 944-5562 or mjussaume@mms.org or lhoward@mms.org.

SOUTHEAST REGION

Bristol South — Executive Committee Meeting. Tues., Feb. 27, 6:00 p.m. Bittersweet Farms, Westport.

Norfolk South — Executive Committee Meeting. Tues., Feb. 6, 6:00 p.m. Alba restaurant, Quincy.

Southeast Regional Office: (800) 322-3301 or skozlowski@mms.org.

WEST CENTRAL REGION

Berkshire — Annual District Meeting. Tues., Feb. 20, 6:00 p.m. Crowne Plaza, Pittsfield. Speaker: Joel Popkin, MD. Topic: Symphonic of the Brain. High School Doctor for a Day Program. Mon., Feb. 26, Tues., Feb. 27 and/or Wed., Feb. 28, 8:00 a.m.–3:30 p.m.


West Central Regional Office: (800) 522-3112 or csalas@mms.org.

Statewide News and Events

Arts, History, Humanism, and Culture Member Interest Network — Nancy N. Caron Annual Member Art Exhibit. Thurs., Apr. 26, 5:00 p.m. Seaport Hotel, Boston.

Contribute statewide news: (800) 522-3112 or csalas@mms.org.

How to Join an MMS Committee

Apply by March 2

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IN MEMORIAM

The following deaths of MMS members were recently reported to the Society. We also note member deaths on the MMS website at massmed.org/memoriam.

Nabil E. Arian, MD, 78; Maspex, MA; Ksar Alainy Faculty of Medicine, Cairo University; died July 31, 2017.

John J. Darragh, MD, 76; Grafton, MA; University of Pennsylvania School of Medicine, Philadelphia; died August 30, 2017.

Paul L. Dratch, MD, 78; Bellingham, MA; Tufts University School of Medicine, Boston; died October 5, 2017.

Charles F. Eades, MD, 88; Dartmouth, MA; Boston University School of Medicine; died October 15, 2017.

George Goldman, MD, 93; Dedham, MA; Tufts University School of Medicine, Boston; died September 4, 2017.

Eugene M. Joly, MD, 88; Palm Coast, FL; Georgetown University School of Medicine, Washington, DC; died September 11, 2016.

Michael T. Shaw, MD, 84; Cloverdale, CA; University of Newcastle upon Tyne School of Medical Education, UK; died June 4, 2017.

Bernard A. Stotsky, MD, 90; Brookline, MA; Western Reserve University, Cleveland; died October 30, 2017.
MMS AND JOINTLY PROVIDED CME ACTIVITIES

LIVE CME ACTIVITIES
Visit massmed.org/cme/events.

Managing Workplace Conflict:
Improving Leadership and Personal Effectiveness
Thursday and Friday, March 22–23, 2018

ONLINE CME ACTIVITIES
Risk Management CME
• Legal Advisor: Who Has the Right in an End-of-Life Care Situation?
• Starting the Conversation about End-of-Life Care with Patients
• Legal Advisor: An Introduction to Advance Directives
• End-of-Life Care and Non-Disclosure: Case Study
• End-of-Life Care Series (3 Modules)
• Principles of Palliative Care and Persistent Pain Management (3 Modules)

For other online CME activities, visit massmed.org/cme.

CME CREDIT: These activities have been approved for AMA PRA Category 1 Credit™. For additional information and registration details, go to massmed.org/cmecenter, or call (800) 843-6356.

25 Years of PIAM — Philanthropy Since 2003
Physicians Insurance Agency of Massachusetts (PIAM) has given $900,000+ to physician-run charitable organizations

“PIAM’s generous yearly contributions to Physician Health Services have helped us fund the position of our physician evaluation director, Wendy Cohen, MD. Before, it often took us two to three months to complete an evaluation. These days, we often complete this process in two to three weeks. PHS is extremely appreciative of PIAM’s mission-critical support for the health and well-being of Massachusetts physicians.” — Steven Adelman, MD, director, Physician Health Services

“PIAM’s contribution to the MMS and Alliance Charitable Foundation equaled 10 percent of our regional grants in fiscal year 2017. PIAM’s sustained giving over the years has made a difference in many peoples’ lives by supporting physician-led and charitable programs on substance use, mental health, and access to care.” — Corey E. Collins, DO, FAAP, chair, MMS and Alliance Charitable Foundation

“We are so very grateful for PIAM’s support of our golf tournament, enabling Community Health Center (CHC) of Cape Cod to provide evidence-based, wraparound programs and services that are not always supported by health insurance. These include care management, health education, individualized care plans for chronic diseases, and insurance enrollment. PIAM’s longstanding and generous support of CHC has allowed us to provide integrated health care services under one roof, including primary, behavioral health, dental, and eye care for all, regardless of ability to pay.” — Karen L. Gardner, chief executive officer, Community Health Center of Cape Cod

Other organizations supported by PIAM, a subsidiary of the MMS:
• Médecins Sans Frontières
• Massachusetts Medical Benevolent Society
• Wounded Warrior Project

THE DIVERSITY ISSUE
1 > Bias in the Medical Workplace
   > MMS Honors First Black Doctor

2 > President’s Message: Spirit of Inclusion
   > Innovative Patient-Centered Disability Care

3 > Physicians: How to Address Bias in Medicine
   > $400 Value in MMS Membership Renewal

4 > Physician-Dean Galea: “Diversity is Central to Health”

5 > MMS Nudges Mass. on Family Leave and Medical Parole
   > MMS Pushes for LGBTQ Policies Based in Evidence not Bias

6 > Writing is the New Medicine
   > MMS Member News and Notes

7 > MMS Launches Minority Affairs Section
   > Join an MMS Committee
   > Across the Commonwealth

VITAL SIGNS
Massachusetts Medical Society
VOLUME 23, ISSUE 2, FEBRUARY 2018
860 Winter Street, Waltham, MA 02451-1411

Thomas Bryant (right), president of PIAM, hands Dr. Steven Adelman a check for $40,000 in May 2017.