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Authors

Gonzalez-Flores, Alicia
Clay, Wendy
Madzia, Juliana
[et al.](#)

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Our Souls Look Back and Wonder: Reflections on Belonging and Being Invisible in Medicine

Alicia Gonzalez-Flores, MD¹

Wendy Clay, MD, MPH²

Juliana Madzia³

Salem Harry-Hernandez, MD⁴

David Henderson, MD⁵

¹University of California Davis School of Medicine, Sacramento, California

²Wright State, Dayton, Ohio

³University of Cincinnati College of Medicine, Cincinnati, Ohio

⁴Johns Hopkins University, Baltimore, Maryland

⁵University of Connecticut School of Medicine, Farmington, Connecticut

ABSTRACT

Addressing the unequal impact of health disparities on historically marginalized communities is a top public health priority. Diversifying the work force has been lauded as key to addressing this challenge. Contributing to diversity in the workforce is the recruitment and retention of health professionals previously excluded and underrepresented in medicine. A major obstacle to retention, however, is the unequal way in which health professionals experience the learning environment. Through this perspective of 4 generations of physicians and medical students, the authors seek to highlight the similarities that have persisted over 40 years in the experiences of being underrepresented in medicine. Through a series of conversations and reflective writing, the authors reveal themes that spanned generations. Two common themes among the authors are the feeling of not belonging and feeling invisible. This is experienced in various aspects of medical education and academic careers. The lack of representation, unequal expectations, and over taxation contributes to the feeling of not belonging, leading to emotional, physical, and academic fatigue. Feeling invisible, yet paradoxically being hyper-visible, is also common. Despite the challenges, the authors conclude with a sense of hope for the future, if not for them, for the generations to come.

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"I am a man of substance, of flesh and bone, fiber and liquids—and I might even be said to possess a mind. I am invisible, understand, simply because people refuse to see me..." Ralph Ellison

Medicine continues to fail our medical students, physicians, and patients from communities historically excluded and underrepresented in medicine (URiM). Equity remains a dream for our communities. By 2060 more than one-half of the US population will be composed of minoritized groups,¹ yet the racial and ethnic diversity of physicians remains far below the diversity of people living in the United States.² The unequal representation is also true for other measures of diversity including sexual and gender minorities, disability, and religion, among others. These differences in representation contribute to persistent health inequities. To better address health disparities and perceived access to and quality of care within these populations, it is critical to train a more diverse workforce.³ For our physicians and learners, the price of unequal representation comes with the experience of unequal burnout, racism, discrimination, and depression. Although many factors contribute to these inequities, implicit and explicit bias, microaggressions, internalized experiences of stereotype threat, and imposter syndrome are well-documented experiences among learners from communities historically excluded and URiM.^{4,5}

The impact of these dynamics on the experience of minoritized groups contribute to the "leaky pipeline," which is the gradual loss of racially and ethnically underrepresented populations in medicine at every stage.⁶ This "leaky pipeline" further aggravates the workforce needs.

Our author group came together to work on a qualitative project about medical student inclusion. In reviewing that data, the group shared their reflections through a series of conversations and reflective writing, uncovering themes that spanned generations. Though different voices are presented here, what follows is a collective account of 4 generations of medical students, residents, junior and senior URiM faculty, sharing their perspectives and revealing how little has changed in this experience in over 40 years. Just like *Invisible Man*, published over 60 years ago, we are still in many ways invisible.

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CORRESPONDING AUTHOR

Alicia Gonzalez-Flores
University of California Davis
School of Medicine
4610 X Street, Suite 4202A
Sacramento, CA 95817
agonzalezflores@ucdavis.edu

I Do Not Belong...

On the first day of medical school, I was overwhelmed by the realization that more than one-half of my classmates were children, grandchildren, or great-grandchildren of physicians. And here I was, an immigrant, the daughter of 2 farmworkers who together had less than a year of schooling, trying to become a doctor. The constant feeling of not belonging in this world class institution was magnified when I was frequently confused with the janitorial or nursing staff in the hospital despite wearing a white coat.

It is difficult to explain, to those who have never experienced it, the feeling of not belonging. Belonging is a fundamental need for human beings. In medical education, it becomes a privilege. The feeling of not belonging is highlighted when one of us is lost through “the leaky pipeline.” At every stage of our formal education from secondary school through medical school, there has been someone who looked like us who did not graduate. We have always known that the reasons for premature departures had much less to do with their intellectual abilities than the sociocultural barriers they encountered. While the reasons for attrition are often academic, the underlying causes of academic difficulty are often not cognitive. Though losing any student is difficult, an early departure of a student from an overrepresented group is rarely seen as a reflection on their larger group. The impact of losing one from our community when there are so few of us is devastating.

Though we wear the same white coat, it does not shroud us with the same sense of belonging. It makes us hyper visible and invisible at the same time. We feel as though we stand out on the first day of orientation and the first faculty meeting. We move through clinical and non-clinical spaces wondering if other well-represented physicians and peers look at us and instantly think that we are products of affirmative action, that we do not belong. We often worry that if a question is answered incorrectly, we will be remembered because there are so few who look like us. We understand that we are much more likely to be judged based on our perceived failures or deficiencies than our successes. We cannot afford missteps. Since there are so few of us, we feel pressure to represent all of us. At the same time, the emotional burden of having to represent an entire group of people is contrasted by the feeling of being alone and not seen. We are not seen; our faces blur and we disappear. We become one of the custodial staff, a nurse, a security guard, but not a peer. We become invisible, disposable. We scout the spaces we enter looking for familiar faces or allies, but sadly confirm once again that we are the only ones in the room. We are tired.

I Do Not Belong In So Many Different Ways...

Before my arrival in Exeter, New Hampshire, I had never seen ivy. The flight from O'Hare to Logan had only been 2 hours but it was clear that I had traveled very far from home that day. And even now, decades later, that same distance is still difficult to navigate. The distance has little to do with geography, but rather the uncommon denominators of race and class and culture and gender; the

barriers that many of us continuously cross along the path that connects being and becoming, if one is born black or brown or poor and strives to attain any degree of professional success.

Compartmentalization is a useful skill for a physician, but we acquired this skill long before entering medical school. It is the way we learn to compensate for the absence of a map of the territory we inhabit. As children with crayons, we learn early to color within the lines. The acculturation of respect for the imaginary lines drawn by society to separate us into disparate groups also begins early. Of these lines, none is drawn more sharply, and indelibly than perceived race. And it is this separation that isolates us in an environment where there are so few of us. This isolation is detrimental to success. For learners underrepresented in medicine, medical training can become a dark and lonely place where the internal battle of being the only one devours us. The constant feeling of being an impostor leads to our isolation. We do not want to confirm stereotypes that we don't belong. We are also afraid of confirming that we are the only ones who feel this way.

Holistic admissions pay particular attention to distance traveled.⁷ Yet, it is this same distance that separates us. Many of us are the first in our families to attend college; for many of us, English is a second or third language. Many of us have worked grueling, low paying jobs before entering academia. Many of us know what it is like to lack, to need, to want and to not have. All of this is what makes us determined, and at the same time creates a sense that we don't belong.

As a queer non-binary person with tattoos and an undercut, I felt like I stood out in my med school class from the very first day of orientation. I had been hoping that in medical school I would finally be able to find a group of queer friends. At the student organization fair during orientation week, I was a little bit confused when I walked up to the table the LGBTQ+ medical student group had set up and every single person there—both the student representatives and the new students visiting the table—was a clean-cut, cisgender, gay man. Where were all the queer people who were not cis men?

To prove that we belong, we try to do it all. We overstretch ourselves. The cognitive load and the constant demands take a heavy toll even on the most determined minds, and the impact on academic performance is enormous.⁸ The pressure to represent a whole group of people is draining. It pushes us to feel as if we need to be involved in every diversity effort that is taking place to radically transform medicine, or else we are somehow betraying our identity, our community. We are taxed with carrying the heavy load of diversity-related efforts—even if it comes with a cost—academic and emotional. At times we ask ourselves, “Who are we to be leading these efforts? Are we the right people? Why are we tasked with fixing a problem we did not create?” It should not be our responsibility alone to make predominantly White spaces more inclusive, more diverse. It's exhausting to carry that load. Nonetheless, we become accustomed to putting one foot in front of the other, shoving emotions down and focusing on moving forward as the journey is long.

I Do Not Belong In So Many Different Ways. First of All, I Am Not From Baltimore...

Though I Am Latino And Black, I Am Not Latino And Black From Baltimore. A few months ago, I was discussing the ramifications of COPD and smoking with a patient when she retorted, "I'm tired of this, I am tired of the way you people treat us." When I asked her to help me understand what she meant, she emphasized, "You know what I mean, the way that you all treat us Black people." To her I am not Black. To her I am a Johns Hopkins doctor and therefore in her reality, I cannot be Black. Black people cannot become Johns Hopkins doctors in her lived reality.

It is not hard to guess what she lived through that led her to this conclusion, as we at times have lived through it as well. We have experienced racism and discrimination. We have seen our loved ones mistreated by an establishment; we have been affected by institutional and structural inequities. In her lived reality, the odds are stacked against us. More commonly, we experience this when we take care of White patients who question our presence and our role. Even at times refusing our care because they cannot see us.

As we live and work in various places across America, we see that racial authenticity and reality are highly defined geographically. But this goes beyond geography. "I'm not from HERE." HERE is anywhere we feel we don't belong; whether in medical school, in academia, or in clinical practice. We have been victims of microaggressions and overt racism, we are called names by patients and staff. We represent our communities, yet paradoxically our own communities sometimes don't see us as being "one of them," but more of a representative of the establishment in which we practice.

Despite not being from "HERE," one might wonder what pushes us, what keeps us moving. Perhaps it is determination, resilience, a sense of responsibility, or the hope that our presence will make it easier for others like us to belong. Perhaps the answer is simpler, and it comes in the form of a patient. A patient who suddenly relaxes their stiffened shoulders when they hear us speak their language, or when they smile and compliment the pronouns pin on the lapel of our white coats, or when they say we remind them of a family member, or the subtle knowing glances we exchange with each other as if to say, "I see you."

"I am invisible, understand, simply because people refuse to see me... It is as though I have been surrounded by mirrors of hard, distorting glass. When they approach me they see only my surroundings, themselves, or figments of their imagination—indeed, everything and anything except me"⁹

Can we ask that you walk a mile in our shoes to understand what we feel, what we see, what we go through? Perhaps not. Perhaps we can start with you seeing us as we are. Not as the representatives of a group of people, but our individual, authentic selves, and not the validation of your own world view; one in which the certainty of your existence and privilege are the normative axes around which all else revolves. We are perpetually and immutably the Other, and our white

coats do not alter that experience. We do not belong because to belong presents a challenge to the basic concept of privilege. White only has value if Black and Brown are denigrated. Men are empowered only to the extent that women are constrained. Being straight or cisgender is normal only to the extent that being queer or transgender is abnormal.

Nonetheless, the fact that we are simultaneously invisible and hyper visible does not alter our vision. We understand the vital nature of our presence in this space. It motivates us to persevere and shine an ancestral light into the blindness around us with the confidence that one day (soon) we will be seen and valued. All we ask is that you see us.



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