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# Learning About Medicine And Race

*A black physician gets an early lesson about the meaning of “noncompliance.”*

BY DAVID MALEBRANCHE

AS A FOURTH-YEAR STUDENT I took an elective rotation on an HIV consult service at a community hospital in a large U.S. city. One late fall afternoon our team was called to see “Mr. X,” a forty-year-old heterosexual black man with AIDS. He had come into the hospital with severe abdominal pain, cramping, fever, nausea, vomiting, and bloody diarrhea. Separated from his wife and daughter, Mr. X was a working-class man who reportedly contracted HIV through a transfusion a decade before.

The primary care medical team suspected cytomegalovirus (CMV) colitis and ordered an abdominal CT scan with oral contrast to confirm the diagnosis. The first entry on the intern’s problem list was “abdominal pain,” followed by the usual list of probable causes. I was excited to be part of the action. Mr. X’s case appeared to be an interesting one from which I could learn a lot. Also, I had yet to see any black patients on our consult service, and I reveled in the opportunity to provide care to another “brother.”

## Diagnosis: Noncompliance

MR. X REFUSED THE ORAL CONTRAST because of his persistent nausea and vomiting, much to the chagrin of the primary care team. Its members, all white, sternly warned him that if he didn’t take the contrast, his condition would remain undiagnosed, he would get sicker, and he could die. Their admonitions only made Mr. X’s refusal more adamant. He kicked everyone out of his hospital room, including me. I was shocked and hurt—he seemed to lump me in with the other medical providers, even though I, too, was black. After the others left his room, I looked him straight in the face and said, “Mr. X, you can raise your voice to them and drive them away, but I’m not going anywhere. I know you’re uncomfortable right now, so I can wait to do my full exam until later, but I’ll be back first thing tomorrow morning. And you’re not gonna kick me out!” He looked at me like I was crazy and waved me off.

Mr. X’s fever and diarrhea continued. The frustrated intern concluded that he

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wasn't of sound mind in refusing the suggested diagnostic procedure and called for a psychiatry consult. She then reordered her daily problem list for Mr. X: Non-compliance was now his first problem, with abdominal pain a distant second. Her resident and attending cosigned the note, indicating their agreement.

In the first three weeks of my rotation with the HIV service, I had seen patients from a range of classes, races, ethnicities, and sexual orientations. I had seen patients who contracted HIV through blood transfusions and those whose risk factor was unprotected sex or IV drug use. For the most part, the medical professionals I witnessed had treated all patients with the utmost courtesy, understanding, and respect. Mr. X was the first African American male patient on whom we were consulted, and his interaction with the primary care team was making me uneasy. Unable even to drink water, he appeared to have legitimate reasons for not wanting the oral contrast. Why had the medical staff labeled his recalcitrance a willful act of noncompliance and felt that his anger with their insistence warranted a psychiatric evaluation? Where was their empathy? Why didn't they suggest diagnostic alternatives to swallowing an oral contrast for a CT scan? After ruling out other possible reasons for Mr. X's being treated like this, I couldn't help but wonder if I was receiving a crash course on racial profiling in medicine. The previous year a wise OB/GYN had told me that the word "doctor" comes from the Latin root meaning "to teach." This was some lesson these physicians were teaching me.

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**"In the hospital some white patients mistook me for the cable TV man when I entered their room in a white coat."**

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### Seeing Myself

**A**CTUALLY, THE LESSON WASN'T ENTIRELY NEW. My parents, one black and one white, attempted to raise me as a "raceless" child, but I soon learned that the real world saw me differently. From an early age, after several run-ins with the "N" word and being called "colored," I developed a heightened black identity, despite being biracial. In high school several of my white peers told me that the only reason I was accepted into an Ivy League school was because of affirmative action, despite my 4.0 GPA and numerous extracurricular activities. When I went to residency interviews in a three-piece suit, some white people saw me as a hotel van driver or valet parking attendant. And in the hospital some white patients mistook me for the cable TV man when I entered their room in a white coat. So watching Mr. X's reaction to illness being labeled noncompliant, I sensed that I had already received partial credit for this class.

As a black male medical professional, I have an inherent discomfort when I watch black male patients being misjudged. Mr. X was merely reacting to his illness, but perhaps in a different manner than what the physicians had seen with

other patients. Taking seriously the wise doctor's mandate "to teach," I felt a teachable moment at hand, although not one with a medical message. I felt like I would be letting Mr. X down if I didn't step in—as one human being to another and as one black man to another.

I decided to forget my student status and approached the primary care team. I told them that I didn't feel that Mr. X was noncompliant or that he needed a psychiatrist. He was just having a difficult time with his illness. The intern didn't agree. She thought he was crazy, and she was determined to get psychiatry to evaluate him as "mentally incompetent." This would allow the team to make decisions on his behalf, since they could not reach his family. Desperate for them to hear me out, I asked if he had a primary care doctor, maybe someone who knew him well on an outpatient basis, who could come and talk to him. Oddly enough, during all the commotion they had not inquired about his primary care doctor. They said they would look into it after they wrote their notes for the day. I left the hospital that night hopeful that Mr. X would be given a chance to be better understood.

### A Patient Transformed

WHEN I RETURNED TO THE HOSPITAL THE NEXT DAY, I went to Mr. X's room after morning rounds with the HIV consult team. Mr. X was lying in bed, lightly sleeping; some new medications were being given to him intravenously. I went to the nurses' station and retrieved his chart. The primary care team had contacted his primary care doctor after I left, and the physician had come to see Mr. X late last night. He had known Mr. X for three years. To this day I don't know what that doctor, a white man, did or said, but he was able to convince Mr. X to get an emergent colonoscopy that morning, since he couldn't drink

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**"I appreciated you talkin' to me real. Everyone else wasn't hearin' me, too busy tellin' me what to do."**

the contrast. What the gastroenterologists saw that morning looked close enough to CMV colitis that they recommended empiric antiviral treatment while waiting for the biopsy results. I smiled, knowing that Mr. X now had a diagnosis and was being treated. But I felt that I had missed out on a good teaching/learning moment myself by not seeing firsthand the interaction

between him and his primary care doctor. What a different outcome their conversation produced compared to Mr. X's dialogue with the medical team.

I walked to Mr. X's bedside and put my hand on his shoulder. He turned over slowly and looked at me, confused for a second, then said, "Oh, it's you." I laughed. "What's that supposed to mean?" He said, "Man, you funny. Comin' in here yesterday actin' like you the one runnin' things. But I appreciated you talkin' to me real. Everyone else wasn't hearin' me, too busy tellin' me what to do." I asked him if he felt well enough to let me do my initial history and physical with him. He said his

stomach was still tender but he agreed, so I did my history and physical. As I was leaving, he grabbed my hand. “Thanks, brother. I appreciate you.”

Mr. X’s condition gradually improved. Not surprisingly, as his symptoms resolved, so did his “compliance” with physicians’ recommendations. The complex man behind the illness then emerged. During my subsequent visits we talked about everything—work, politics, poetry, the Harlem Renaissance, HIV, family, church, sports, and life. Without the outside noise and distractions of labels and character judgments, we connected as men of African descent and as human beings with similar desires to transcend labels.

### Empathy Needed

**M**OST COMMUNITY HOSPITAL CLINICIANS who treat lower-income black people are white. In the settings I’ve worked in, I’ve often seen clinicians label black male patients who ask questions as “aggressive,” “threatening,” “difficult,” or, like Mr. X, “noncompliant.” Yet the same physicians refer to white male patients who ask similar questions as “well-read,” “inquisitive,” or “knowledgeable.” A pejorative label such as “noncompliant” assigned to black men like Mr. X can compound the discomfort and powerlessness people experience when ill. As a result of the perceived discrimination that such labels engender, black men can lose interest in their own health care, despite the adverse health consequences that such behavior produces. Some men, like Mr. X, may refuse tests; others may not adhere to medications or use health care facilities to begin with.

Discriminatory practices and poor communication occur between providers and patients of all races and classes. But black men suffer disproportionate morbidity and mortality rates relative to other U.S. subgroups—a fact that argues for more careful attention given to their health care needs. I wonder how much longer Mr. X would have gone without a diagnosis or treatment if I hadn’t said anything and if his primary care physician hadn’t been contacted. I wondered how his outcome might have been different.

As a medical student back then, I learned the importance of being a voice for black patients. Now, as a junior faculty member, I am in a position to teach others to do the same: to help prevent misunderstanding between cultures from inhibiting the delivery of objective medical care. The “noncompliant” label so readily given to Mr. X could just as easily be applied to me if I were a patient not following orders. If during illness I could not speak for myself, who would be my voice?

My experiences speak to the cultural divide between white physicians and

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**“The ‘noncompliant’ label so readily given to Mr. X could just as easily be applied to me if I were a patient not following orders.”**

black male patients (white doctors seem far less threatened by black female patients). But this sort of empathetic advocacy and interpretation need to be taught and applied to all patients, for it is not only black male patients who can be misread by doctors and not only white doctors who do the misreading.

One way to breach the divide is to expand current cultural competency programs that help teach medical students the difference between pathologic disease and the cultural experience of illness. The best of these programs also help us to better identify our own personal and cultural biases, increasing the chances that we can provide the objective care that is expected of us. Even more effective than these programmed messages may be steps that we medical providers from different ethnic and racial backgrounds can take as individuals to help interpret for our colleagues the cultural nuances of our respective peoples. Similarly, we can make ourselves more available to minority students for one-on-one mentoring on how to advocate for themselves and minority patients—as I did with Mr. X. We also can make ourselves accessible as advisers to minority medical organizations.

### Flying High

**M**R. X ASKED ME TO ACCOMPANY HIM when he received a permanent catheter for the long-term IV antiviral therapy he would be getting to treat the CMV. I was late arriving to radiology and afraid that I had missed the procedure. I grabbed one of the nurses. “My name’s David Malebranche, I’m a fourth-year medical student. Has Mr. X been brought in for his procedure yet?” She smiled. “So you’re the one he’s been asking for. He’s right in here.” She led me down a long hallway to the suite room. I put on a gown and walked in to see Mr. X under a drape and the radiologist prepping him for the line placement. I grabbed Mr. X’s hand. “How you doin’?” He looked up at me. “I knew you would make it.”

**“Mr. X taught me more about the medical profession and what it means to be a teacher than any doctor ever has.”**

When the radiologist told us he was ready to start, the man who once kicked me out of his hospital room looked squarely in the radiologist’s face, pointed at me, and said, “Do you know who this is?” The radiologist looked at him strangely. “No, who is he?” Mr. X beamed. “This here’s my angel.”

..... I finished my rotation before Mr. X was discharged from the hospital. But he had left a deep imprint on my life. He taught me more about the medical profession and what it means to be a teacher than any doctor ever has, and he inspired me to be his voice when others wouldn’t listen to him. He also reinforced my desire to teach others to unlearn the negative stereotypes associated with black men in this country. So I thank you, Mr. X, and I promise to earn my wings for you.