Rooting out racial stereotypes in *Neurology*[®]

A commentary on “Lucky and the root doctor”

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The Humanities section of the February 12 issue of *Neurology*[®] included an article titled “Lucky and the root doctor.” In this piece, the author describes his previous encounters with a black patient and his wife, and recounts dialogues in which the author is introduced to some of the patient’s health beliefs, which differ widely from his own. Unfortunately, and perhaps unintentionally, the piece frames these interactions in the context of a highly problematic portrayal of race. Many *Neurology* readers reacted to the article, expressing concern over the negative racial overtones and calling for immediate corrective action. The article was quickly retracted, and a formal letter of apology and action plan was subsequently issued by the editor-in-chief of *Neurology*.¹

Regardless of the author’s intent or any particular individual’s reaction to the article, these events call for careful reflection and thoughtful discussion of why equity, diversity, and inclusion are necessary to ensure we provide the highest quality care to all our patients, independent of their background and demographics. A comprehensive discussion of the role of race in neurology or the influence and consequences of biases and stereotypes on the delivery of neurologic care is beyond the scope of this commentary. Instead, the focus of this response is to address 4 questions related to “Lucky and the root doctor.” We hope that these questions and our commentary will serve as a catalyst for ongoing conversations around these issues.

Question 1: Why was this article offensive?

Viewing this piece in a charitable light, one could speculate that the author was attempting to serve as a medical raconteur, intending to highlight how neurologists and their patients may differ in their conceptualization of disease, health, and ultimately patient care. One could further speculate that the author meant to communicate something about the value of understanding the terminology and explanatory models employed by patients from different backgrounds. However, any attempt to provide such insights was quickly and thoroughly undermined by the racially and culturally insensitive tone and the characterization of black Southerners using a variety of reductive tropes and racist stereotypes.

The patient at the center of this article was blinded and disfigured from a prior accident with a firearm and has an inflammatory myopathy, but nonetheless describes himself as “lucky.” The author’s depiction of the patient is a caricature of a folksy, jovial simpleton, whose joy is born of ignorance rather than resilience. Almost immediately, the piece focuses on his strong libido (his “nature”), playing directly into the longstanding and pernicious stereotype of the hypersexual black man. The patient’s wife is described as a giggling “rolly-poly” woman with “laughing eyes” and “abundant rolls of fat,” a description that denigrates her on the basis of her body habitus and calls to mind images of mammies of the Antebellum South. A second, gratuitous depiction of

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another black woman (unrelated to the patient or the narrative) is included: “Immensely enjoying her fries, she sat with the shaker in one chubby fist and liberally salted each individual fry.”

The author goes on to portray poor Southern blacks as superstitious, ignorant, and irrational, prone to eating clay and believing in curses. Throughout the piece, it appears that the author views the patient’s beliefs with a combination of bemusement and condescension. The author recounts that the patient’s weakness progressed despite treatment, leaving the patient to contemplate a binary decision to continue under his care or pursue an alternative treatment option. Analogous scenarios face us every day as health care providers. Patients are increasingly seeking input and our opinion on alternative health care strategies and treatments and are less likely to share this information or simply choose not to return if they feel we will view them negatively as a result. Portraying patients in the demeaning, judgmental, and even patriarchal tone of the “Lucky” piece only reduces our ability to serve as champions for our patients’ pursuit of better health outcomes.

Finally, the author ends the piece with the statement “I never saw him again,” with no discussion of how the patient could have been engaged respectfully in a way that would have helped him to understand his medical condition more thoroughly and to achieve a better health outcome. Instead, the neurologist seems smugly satisfied in his conviction that he knows better than his patient (“I wasn’t much worried about serious competition from this root doctor”). There is no attempt to bridge the divide between the physician and patient’s understanding of the disease and treatment options. While the text alone was worthy of a retraction, the offense was magnified with an audio file of the author reading the piece and engaging in the verbal equivalent of blackface when reenacting the patient’s voice.

Question 2: How could an article like this have been handled differently?

In order to engage effectively with patients of all backgrounds, neurologists need to be empathetic to different cultural experiences and beliefs and to understand how these relate substantively to health-related attitudes and behaviors. Cultural difference is an important but overlooked source of miscommunication between physicians and the patient/patient’s family.^{2,3} To that end, pointing out and reflecting on these differences is not inherently offensive. However, in doing so, it is important to take steps to avoid categorical judgments and misleading oversimplifications. Cross-cultural miscommunication hinders effective patient–physician communication, medical decision-making, and clinical outcomes.⁴

One cannot lose sight of the fact that there is an enormous breadth of experiences, behaviors, and beliefs that exist within social groups, including persons who share a racial or ethnic

identity. However, blind spots occur when encounters with single individuals lead to generalizations about entire groups who share the same race, ethnicity, sexual orientation, gender identity, or cultural affiliation. Moreover, while there may be certain health-related attitudes or behaviors that occur more frequently in some groups than others, thoughtful reflection on these differences requires that one develops the ability to place them within the context of the social factors that drive and determine them. A 5-point model proposed by Metzl and Hansen⁵ provides an approach for health professionals to develop this form of structural competency, by cultivating a deeper appreciation how symptoms, clinical problems, diseases, and attitudes toward patients, groups, and health systems are influenced by social determinants of health. In the case of many disadvantaged racial and ethnic groups, these factors include longstanding and ongoing institutionalized discrimination and structural inequality of access to resources and opportunities. Pointing to distinctions between groups of people in the absence of social context contributes to potentially dangerous, prejudicial, and erroneous notions that these differences are attributable to intrinsic variance between groups.

Naturally, persons of different cultural backgrounds are likely to have differences in their beliefs and behaviors. Abundant evidence from the fields of psychology and sociology teaches us that we are all prone to privilege our own cultural practices and beliefs and to view others’ practices as outliers. Thus, when conceptualizing and describing the medical beliefs and practices of a patient from a different background, physicians should proactively seek a tone that avoids portraying other groups as diminished in dignity, narrative strength, or sophistication compared to one’s own. Effective cross-cultural interactions require that the clinician integrate multiple cultures in the clinical encounter: the clinicians’ own culture, that of the patient and family, and the culture of the health care institution.⁴ This same type of integration and reflection is necessary in written communication of outcomes and learning objectives from cross-cultural clinical encounters.

Question 3: Why is it particularly important to avoid stereotypes in telling patients’ stories?

Reiterating negative stereotypes reinforces unconscious biases (also known as implicit biases) that demonstrably have adverse effects on the care that is delivered to all patients, but especially to patients from underrepresented and underserved groups. Unconscious biases are ubiquitous to the human experience and arise from necessary heuristic cognitive processes that are routinely employed in everyday life.

However, when these mental shortcuts are applied in the health care setting, these subtle and often unrecognized constructs lead to patterns of thought or behavior that can

have deleterious consequences for patients.⁶ For example, evidence suggests that many physicians may harbor unconscious biases that prime them to conceptualize black patients as being less intelligent and less likely to comply with medical recommendations.^{7,8} A physician with this unconscious bias is likely to favor simplicity over efficacy when considering treatment options for a black patient. Another study demonstrated that the perception of false biological differences between black and white patients by medical students and residents translated into perceptions of black patients feeling less pain.⁹ Moreover, a large systematic review of over a decade of peer-reviewed articles found a relationship between level of implicit bias and lower quality of care throughout the health care field.¹⁰ Countering this kind of automatic thinking requires conscious consideration of one's potential biases and an approach that focuses on the patient's own abilities, attitudes, needs, and behaviors. Importantly, these implicit biases can be transmitted between individuals. For example, racial biases inadvertently spread during medical education.¹¹ In light of this, articles that appear in the medical literature that play on racial stereotypes likely work against efforts to encourage more deliberate, less biased thinking among physicians, including neurologists.

It is also important to consider the role such biases play on the way underrepresented racial and ethnic groups perceive and access health care. These patients have a more negative perception of physicians and are more likely to believe they are mistreated by medical providers.¹² When these same patients subsequently receive a lower quality of care as a result of physicians' biases, this serves to contribute further to a cycle of harm and mistrust.¹⁰ This underscores the importance of cultural awareness and education among all providers. Everyone—even persons who have a history of supporting diversity initiatives, increasing representation in medicine, or advocating for improved health in underserved communities—is susceptible to making insensitive assumptions about other groups. We should approach each patient encounter with an awareness of how our own beliefs and attitudes can shape patients' perceptions of their health care experiences, and how this may influence their likelihood of engaging effectively with medical providers in the future.

Question 4: What more can *Neurology* do?

Retracting “Lucky and the root doctor” from *Neurology* and issuing an apology for its publication are important first steps. *Neurology* is the flagship publication of the American Academy of Neurology (AAN) and the most widely circulated periodical in our field. The fact that this article successfully navigated the peer-review and editorial process at *Neurology* suggests that a more thoughtful and intentional approach to issues of equity, diversity, and inclusion is warranted at the journal. There are a number of steps that could be taken by the editorial staff of *Neurology* to strengthen its efforts. The

recent letter regarding the retraction by Gross,¹ editor-in-chief of *Neurology*, maps out several of the short- and long-term actions being proposed to improve editorial oversight. Here we focus on one concrete change that has proven effective in reducing inadvertent cultural insensitivity in a variety of other professional settings: increase the diversity of the workforce associated with the production of the journal. This effort should include representation from as many categories of lived experience as possible, including but not limited to race, ethnicity, gender, sexual orientation, and gender expression.

More diverse medical environments have higher levels of civic engagement, greater ease in managing issues related to diversity, and better recognition of prejudice.¹³ Importantly, enhancing the diversity of professional organizations increases organizational creativity, flexibility, and overall performance.¹⁴ We applaud the AAN for committing to enhancing the diversity of its ranks through programs such as the Diversity Leadership Program. In addition, the recent creation of an AAN Joint Coordinating Council on Equity, Diversity, Inclusion, and Disparities to ensure these principles are strategically and fundamentally incorporated into all activities of the organization is a large and visionary step forward. We are hopeful that vital efforts like these will result in diverse representation in the leadership of every arm of the organization—including its journals—and that this will ultimately lead to higher quality neurologic care for all our patients.

Discussion

In every crisis there lies an opportunity. While the publication of “Lucky and the root doctor” was unacceptable and disappointing for many readers of *Neurology*, it illustrated the need for a more thoughtful focus on equity, diversity, and inclusion in one of our leading publications, as well as in our profession more broadly. It has also given our neurology community an opportunity to reflect on how we communicate with each other about challenging topics like race and ethnicity in the context of our patient interactions and practice. In short, if this experience nudges our field toward positive change, deeper understanding, and more earnest efforts to cross cultural divides with our patients, perhaps it will have been a crisis worth having.

The article being referenced has been retracted by *Neurology*®, but appeared in the February 12 (vol 92) printed version of the journal.

Author contributions

Dr. Hamilton: drafting article, critical revision, final approval. Dr. McClean: critical revision. Dr. Greicius: critical revision. Dr. Gamaldo: critical revision. Dr. Burrus: critical revision. Dr. Charleston: critical revision. Dr. Correa: critical revision. Dr. Ebong: critical revision. Dr. Hamilton: critical revision. Dr. Lewis: critical revision. Dr. Thomas: critical revision. Dr. Vargas: critical revision. Dr. Flippen: critical revision.

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References

1. Gross RA. Editorial changes at *Neurology* [online]. Available at: www.aan.com/AAN-Resources/Details/about-the-aan/editorial-changes-at-neurology/. Accessed February 19, 2019.
2. Betancourt JR, Green AR, Carillo JE, Ananeh-Firempong O. Defining cultural competence: a practical framework for addressing racial/ethnic disparities in health and health care. *Public Health Rep* 2003;118:293–302.
3. Kleinman A, Benson P. Anthropology in the clinic: the problem of cultural competency and how to fix it. *PLoS Med* 2006;3:e294.
4. Kagawa-Singer M, Kassim-Lakha S. A strategy to reduce cross-cultural miscommunication and increase the likelihood of improving health outcomes. *Acad Med* 2003;78:577–587.
5. Metzl JM, Hansen H. Structural competency: theorizing a new medical engagement with stigma and inequality. *Soc Sci Med* 2014;103:126–133.
6. Hall WJ, Chapman MV, Lee KM, et al. Implicit racial/ethnic bias among health care professionals and its influence on health care outcomes: a systematic review. *Am J Public Health* 2015;105:e60–e76.
7. Schulman KA, Berlin JA, Harless W, et al. The effect of race and sex on physicians' recommendations for cardiac catheterization. *N Engl J Med* 1999;340:618–626.
8. van Ryn M, Burke J. The effect of patient race and socio-economic status on physicians' perceptions of patients. *Soc Sci Med* 2000;50:813–828.
9. Hoffman KM, Tawaltar S, Axt JR, Oviler MN. Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites. *Proc Natl Acad Sci* 2016;113:4296–4301.
10. FitzGerald C, Hurst S. Implicit bias in healthcare professionals: a systematic review. *BMC Med Ethics* 2017;18:19.
11. Maina IW, Belton TD, Ginzberg S, Singh A, Johnson TJ. A decade of studying implicit racial/ethnic bias in healthcare providers using the Implicit Association Test. *Soc Sci Med* 2017;199:218–2290–122.
12. Penner LA, Hagiwara N, Eggly S, Gaertner SL, Albrecht TL, Dovidio JF. Racial healthcare disparities: a social psychological analysis. *Eur Rev Soc Psychol* 2013;24:70–122.
13. Association of American Medical Colleges. *Altering the Course: Black Males in Medicine*. Washington, DC: Association of American Medical Colleges; 2015.
14. Page SE. *The Difference: How the Power of Diversity Creates Better Groups, Firms, Schools and Societies: new edition*. Princeton, NJ: Princeton University Press; 2008.

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