

REFLECTIONS IN FAMILY MEDICINE

The Minority Tax: Stories from Family Physicians

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The minority tax has been defined as a set of disparities that those who are underrepresented in medicine face in addition to clinical care, education, and research responsibilities. These taxes include systemic racism, diversity efforts, clinical and promotion disparities, lack of faculty development, and isolation. Much has been added to the literature to better define and characterize the minority tax and propose suggestions for mitigations. This article builds on the existing literature that defines clinical efforts and diversity efforts disparities by exploring the intersections of these disparities through the experiences of family medicine faculty in the clinical environment. The authors, who are all academic family medicine physicians from minoritized communities, use their lived experiences to share how the diversity efforts disparity impacts patient care. Themes noted include health system wide challenges for patients whose preferred language is not English and the importance of racial and ethnic concordance between patients and the physician workforce. (J Am Board Fam Med 2024;00:000–000.)

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The experiences of faculty underrepresented in medicine need continued attention.¹ Recent literature details the minority tax, further characterizes the diversity efforts disparity, and describes the isolation of this group.^{2–4} How the diversity efforts disparity impacts underrepresented faculty in patient care remains unclear. Previous literature defines the clinical efforts disparity in terms of clinical assignments but does not share detail of how those assignments are encountered or perceived by faculty.²

Elucidating how the diversity efforts disparity impacts clinical care is important given the gap between the racial/ethnic makeup of physicians in

the United States (US) and that of to the general population. For example, 6.3% of the US physicians identify as Hispanic/Latinx, 5.2% as Black/African-American, and 56.5% as White⁵ compared with 19.1%, 13.6%, and 58.9% of the US population, respectively.⁶ In many parts of the nation, these differences are even more pronounced.⁷ While there are many groups who are underrepresented in medicine, for the purposes of this article, we will define those who are underrepresented as per the perspective of each author below. We provide personal examples of the diversity efforts disparity in patient care and have shared our race/ethnicities and the clinical environments in which we work to aid in perspective.

ZS

I identify as Latina/Hispanic, work at a medical school, and teach family medicine residents in Texas. The US Census reports that Latinos/Hispanics make up for 40.2% of the Texas population, with a

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projected growth rate of 71% by 2050.^{8,9} I am currently the only faculty in a department of 25 who identifies as Latina with no one else identifying as Hispanic, Latino or of Spanish origin. Most of my Latino patients do not use our patient portal due to limited access to electronic equipment or limited literacy skills; they usually call with questions or concerns, significantly increasing my administrative workload. We do not have bilingual clinic staff to triage results or patient messages. All messages in Spanish are forwarded to me to review and manage. In addition, it is an incumbrance for my coworkers to cover my in basket given the language and workload. Latinos are considered underserved in the local community where social determinants like insufficient food, housing, financial support, and transportation are key drivers of their health. This creates complexity in their medical management.

NB

I identify as Asian American and work in an academic family medicine residency program. A physician colleague asked me to cover her in basket while she was away. Many patient questions and refill requests were routed to her by the medical staff, not due to medical reasons, but because the message was in Spanish. Even if the request was to schedule an appointment, my colleague would have to address it herself. Lab results, which a nurse would typically provide patients, would again fall to my colleague. On her return, I discussed the concept of the minority tax with her, which I had heard about at a recent conference. Only when I walked a mile in her shoes did I understand her level of frustration with the system. She wanted to provide quality care to her patients but was limited by the system which did little to help those whose primary language is not English. These events lead me to better understand the importance of advocating for your peers and designing a health system which supports all persons, rather than burdening a select group due to their abilities. We should aim for quality care for all, but not at the expense of faculty.

AC

I was the only Latina in my community-based family medicine residency program. Within a month, Spanish-speaking patients filled my clinic schedule. The word was out in the community that a

Spanish-speaking doctor had arrived. Fortunately, my entire clinic ancillary staff was bilingual, so this shift in patient demographics went smoothly. Unfortunately, bilingual staff were severely lacking in our community hospital. I was usually the only clinician able to explain diagnoses and treatment plans to inpatient Spanish-speaking patients. Being an unofficial hospital interpreter added another dimension of work to hospital rounds and discharge planning that could be overwhelming.

Despite this, I love caring for my Spanish-speaking patients. However, caring for my largely uninsured and self-pay population came with difficulties. For those with advanced disease who needed specialty care, the care I could provide in my clinic was often inadequate. To know that the medical care to cure or improve these patients' lives was available yet not accessible was demoralizing for me and had an enormous impact on my mental health.

WTF

I identify as African American and work in a family medicine residency program. When I hear patients tell me I am the first Black physician they ever had, I feel humbled and a great sense of responsibility. I have very few colleagues who look like me. And while I knew I wanted to take care of patients who looked like me, I did not understand how important that would be to patients as well. I can see the look of surprise and a glimpse of a smile when I first walk into a Black's patients' room, and sometimes tears of joy masking a history of negative health care interactions. The next words are usually, "Where did you come from?" and "How long have you been here?" At the end of the visit, they often say, "I am proud of you" or "I hope you stay." They too likely understand the struggles that underrepresented physicians face in medicine, because they have likely experienced barriers in medicine as well.

Many of my minority patients will openly discuss their frustration with and mistrust of the medical system based on past negative experiences. It is especially difficult to hear when a patient tells me they were treated poorly at my clinic due to their race. We teach antiracism to our residents, but our clinic staff, hospital employees, and faculty receive little training. We have a commitment to our patients to do better and train better. I had a very boisterous patient who would say, "This is MY doctor" in a loud proud voice to everyone he passed in

the clinic hallway. I want to live up to those high expectations; I have a responsibility to do so.

NOA

I identify as Nigerian Canadian/Black and work as faculty in a community-based family residency program. I practice in a region where traditionally underserved communities of minoritized individuals live and work. Often, I will meet a new patient who tells me she has chosen me as her physician because of our shared skin tone and gender. I accept this honor because I know the experience of being ignored, recalling times when my presence discussing care in a patient's hospital room has been questioned. I carry this responsibility because I can appreciate the value and perspective developed in having a shared lived experience. It takes time and an emotional connection to overcome a patient's developed and perhaps warranted mistrust in the medical profession. While being a physician often entails bearing the burden of our patients' suffering, the guilt of being part of a system which can often ignore minority women's needs is a heavy load to bear. This added weight is a reality for me and many underrepresented physicians. In caring for patients, I listen for both what is said and what remains unsaid. The unsaid is often seen in a sigh of relief, a twinkle of hope in one's eye, a smile. These things let me know that, despite challenges, we're setting out on the right path.

KMC

I am Black and work in academic family medicine as a department chair. One of my most common experiences is hearing patients say they have never had a Black man as a doctor. Many are excited to have a doctor who looks like them and can relate to them culturally. The desire for patients to have a doctor who looks like them is compounded when I work with resident physicians in clinic. When I come into the examination room as the attending, sometimes the patient will look at me and then my badge and ask where I practice and if I have my own patients. This happens quite commonly with Black or other minoritized patients. Many times, later, I will walk into my own clinic, 30 miles from where I attend resident physicians, and the resident physician's patient will be sitting there, telling me that they decided that they would switch their care

to me. While I am humbled to be able to provide clinical care to such patients, it is overwhelming at times to manage the clinical responsibilities and expectations of these patients while addressing the administrative needs of running the department as well as keeping up with scholarship and research projects.

Conclusion

In this article, we have shared six perspectives on how the diversity efforts disparity can impact clinical care. We have grouped author perspectives first to include the three that have to do with language, followed by the other three that have to do with culture and trust. In the author perspectives that deal with language, a theme noted includes health system-wide challenges for patients whose preferred language is not English. Beyond the examination room or point of care experience, these challenges can result in unnecessary, additional burdens on bilingual underrepresented minority physicians. Those burdens on the physician can be great and can include impacts on psychological safety, mental well-being, and work-life wellness which can contribute to physician burnout. Not only that, but concerns for patient safety, excessive work up in ordering or tests, confidentiality concerns, and translation errors are all issues documented with inadequacy of translation services.¹⁰ While providing professional interpreters at the point of care provides an effective means to aid in communicating with Spanish speaking patients,^{11,12} current written language translation platforms in electronic health records should be expanded and increased for indirect patient care activities as well. In addition to increasing availability and use of written language translation platforms and translators especially in primary care,¹³ a short term solution would include tutorials and instructions on use of these platforms as an accessible option for all patients, not just those who may be of higher socioeconomic status, tech savvy, or have easier access. Long-term solutions may include leveraging new technologies such as artificial intelligence or machine learning to improve the patient experience for Spanish speaking and other non-English language speakers.¹⁴

In addition, noted as a theme was limited racial/ethnic diversity in the clinical environment that puts this group of faculty at risk of being overwhelmed by the sheer number of patients who desire a physician

who may look like them and share similar culture.¹⁵ Recognizing the potential of this mismatch between physician and patient diversity to increase the workload, psychological burden, and stress for underrepresented faculty marks the beginning of short term solutions to impact this concern. Initiatives can include making sure this group is connected with the chief wellness officer, faculty affairs professionals, and institutional leaders who oversee patient panels, clinic schedules, and scheduling templates to make sure that equitable clinical experiences are prioritized.^{16,17} Long-term solutions for issues of culture and trust identified in this article should be focused on institutional culture, clinical resource support infrastructure for faculty success, and initiatives to help faculty of similar background and culture find community. Approaches would involve institutional culture surveys, like the C-Change Faculty Survey offered through Brandeis University, following by institution-wide changes based on survey results.¹⁸ Changes should be broad sweeping and would likely involve changes in institutional bylaws, policies, organizational charts and funds flow. An example may be human resources enacting cultural competency initiatives across the entire institution to promote the well-being of all faculty and learners.^{19,20} In summary, as with other aspects of the minority tax, we should seek to address the diversity efforts disparity in all areas of the academic health center setting, even when providing patient care.

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