

Introduction: We are pleased to introduce a new feature. Entitled “On Equity Story Slam”. The following eight essays were presented at the Department of Medicine Grand Rounds on January 13, 2021. The presentations were organized and coordinated by the Committee on Equity, Diversity, and Inclusion, led by Keith Norris, MD, PhD, Distinguished Professor of Medicine and Vice Chair for Equity, Diversity, and Inclusion, Christina Harris, MD, Health Science Associate Professor of Medicine and Cristina Punzalan, Administrative Director.

To review the recordings of “On Equity Story Slam”, please visit DOM TV, where recordings of Medical Grand Rounds are accessible. The specific link for each individual presentation from January 13, 2021 is included at the end of each submission.

ON EQUITY STORY SLAM

My Farewells to Larry and Linda

Art Gomez, MD

As I looked on my schedule for clinic I saw his name, Larry, and a smile came to my face. Larry, a former Vietnam marine, was a patient with a knack for making me blush. At some point, sooner or later, it would happen, after some raunchy story. Yet, I enjoyed his visits, and yes, would often have to protest over a politically incorrect statement to which he earnestly apologized. “Sorry Doc, it won’t happen again!” We would then redirect the conversation back to our task at hand. And that task was taking on a more serious tone as we pondered issues about his mortality.

Larry had developed lung complications from exposures to toxins in the jungles of war. Now, he had progressed with a complex regimen of steroids, inhalers and increasing Oxygen and referrals to the pulmonary and palliative care.

But that day Larry was in a good mood, requesting a “complete physical”, which included examination of his feet. Curiously I noted his toenails were colorfully polished. Thinking it was the work of one of his granddaughters having fun with him, I said nothing. In retrospect, I should have noticed that the pedicure was too immaculate to be the handiwork of a young child. The visit ended and I thought nothing of it until the next visit.

At that next visit Larry came in sporting an earring. This was new; and un-expected for him. Although I had seen it in others; men brandishing a stud, wanting to change their image, recapture youth, but this was a dangly pretty thing, quite elaborate on both ears. Having taught the Doctoring course for 2nd year students, telling them over the years to be observant and note when a message is being delivered to you right before your eyes, I told myself “Come on Art. The elephant is in the room!”

“What gives, Larry?” I said in our usual casual back and forth. That is when it happened. That’s when Larry introduced me to Linda, who she really was.

Linda was born to a dysfunctional family, emotionally and physically abused by parents who always wanted biological girls. When they had 3 boys, they made their disappointment known. Her father worked all the time. When he wasn’t working, he was “chasing women”. Her mother spent all her time at church. The older brother dealt with their abuse by also beating Linda, every day. The other brother lost himself in religion, and became an extremist in a conservative church. Linda, then Larry, became immersed in all things macho, dropping out of school in the 9th grade and joining the Marines at the height of the Vietnam War. The next years were filled with risky behavior, womanizing, bar brawls and suicide missions while in Vietnam. On return, she married twice. The first marriage ended when the wife shot herself, rejected by Larry’s lack of sexual desire. Yet they had two sons. Linda had two other relationships with women, one ending in divorce, the latest, a girlfriend of 40 years, tolerant of a sexless life and Larry’s cross dressing.

At the time Linda revealed her situation to me, I was ignorant of what we learned was her being a transgender woman. We both learned together, Linda had few other allies, her brothers were estranged, one son disowned her, and her girlfriend was indifferent to the process. But the grandkids became rock stars of support and welcomed her new identity openly. Proud to say that the VA, even before the electronic medical record made much needed changes, surprised me with its flexibility. The VA’s electronic medical record re-identified her as Linda Nicole, the woman she was. Over the next few years, we journeyed through VA sanctioned treatment, hormones, voice therapy, and surgeries, some done at the VA, others only dared elsewhere, were too urologically complex or avoided due to her serious lung disease. I learned tremendously and was even inspired to start a module on transgender medicine for our 2nd year medical students. Linda and I had reached our new normal.

Recently she came in, giddy as I have ever seen Linda. Our visits had turned into a bit of a show and tell reveal. I'm thinking, what organ part is she here to show me. We had grown to have that intimacy and comfort. Now I will divulge what she said with caution, after all, we are at a UCLA Grand Rounds and it is completely politically incorrect. But not to use her words would not be Linda. "Dr. Gomez I finally did it!" Excited for the reveal, I said "What?" "I did it, I finally got that tramp stamp on the small of my back!" This time I did not correct her. I blushed as usual, and I just laughed! It was a beautiful tattoo.

Linda died a few months later. I felt privileged to have played a small role as an ally during her transitioning journey. But I would not say that it was without mistakes and I am not a perfect ally. Part of the lessons to learn is humility.

About 2 years ago I was asked to write a chapter for a book on "Communication in Healthcare" and my chapter involved describing a welcoming doctor-patient environment. One of my sentences read: "One should use a well-crafted introductory phrase, for example, 'My name is Doctor Chang, she, her and hers. What is your name and what pronouns do you prefer?'"

This can signal to a vulnerable gender non-conforming patient – I am welcome here!"

I later got a call from the editor. "Great chapter, but we have to eliminate that sentence. You see, this book will be sold in many 'conservative countries' in fact, not many US students buy books at all. So that is our market."

I would like to say that I stood my ground, or even that I allowed myself to get convinced. But the truth is that we allow ourselves to get convinced and the sentence was cut. To this day I regret it. That simple sentence may have meant so much to some student in such a conservative country, that yes, there is such a thing as asking one's pronouns, and that there exist, some allies, somewhere. I still regret it. So, if you're listening, "Sorry Linda, that won't happen again."

To view the recording of *On Equity Story Slam*, where this story was presented at UCLA Department of Medicine Grand Rounds on January 13, 2021, please visit <http://bit.ly/drgomezstory>.

ON EQUITY STORY SLAM

Gently Relentless

Rachel Brook, MD

I would like to talk about a patient, with full disclosure, with whom I still do not have a sense of resolution. He is a patient that is likely unknown to our current house staff since he was last seen at UCLA nearly four years ago. But if you asked many of our graduated residents, our hospitalists, or our 7E/5EMS nursing staff, they would recognize his name instantly. He remains the most challenging patient for whom I have cared.

I last cared of Mr. X during the winter holidays four years ago. He was a 32-year-old male with a past medical history significant for ESRD secondary to renal agenesis, requiring dialysis since birth, status post renal transplant more than 20 years prior that failed due to graft rejection. He was hemodialysis dependent, complicated by recurrent central line-associated bloodstream infections, often originating from his dialysis access. He also had a history of IVDU and meth abuse, and the words “non-compliant” and “non-adherent to medical treatments” were noted throughout his record and concerns for self-inoculation causing his recurrent infections. Syringes had been found at his bedside during admissions. The last sign out I received was similar to previous ones for this patient: “Extremely challenging, refuses many medications and procedures, obstructive to his care, difficult social situation,

admitted for bacteremia 2/2 CLABSI, needs new HD access and IV antibiotics on discharge.” But I didn’t need the sign out to paint a picture of Mr. X, as I had taken care of him multiple times before and thought I knew him well. In all honesty, my heart sank when I saw his name on my sign out, because I knew how much energy his care would require, as one name on my list of 18 patients.

The most challenging aspect of Mr. X was not his complicated medical history, but that he was verbally abusive to all members of his healthcare team. He used such derogatory language

towards female healthcare workers that only male nurses/care partners were assigned to him. He used profanity and threats, often with extremely offensive and inexcusable racial slurs. He also frequently refused medically indicated treatments, such as blood cultures, hemodialysis sessions, and antibiotics. Given his complex disease presentations, his refusal of these treatments would cause him to clinically deteriorate, often requiring ICU transfer. However, despite his refusal of life-saving medical interventions, Mr. X consistently expressed a desire to live, during goals of care discussions. His father, was his designated power of attorney, and was felt by his various healthcare teams to enable the patient’s behavior, included

outside food when the patient was NPO for a scheduled critical procedure. Everyone was always “on board”- social work, palliative care, psychiatry to assess for capacity for medical decision making given the discordance with his behavior and ethics was consulted to determine if his obstruction to his own care, coupled with his verbal abuse, was enough to discontinue his care at UCLA, which I had never seen in my years at UCLA. A family meeting was scheduled with his father and with multiple consulting teams. The patient was tearful and remorseful of his actions, asking to be allowed to remain a patient at UCLA.

His behavior transiently improved, but soon regressed with frequent outbursts of offensive terms and refusal of treatments. The various consultants and my team tried to spend minimal time directly interacting with him, and to get him clinically stable for discharge. I removed the patient from the residents’ teaching list, and started seeing him on my own, adopting these goals without question. I began calling his father from the patient’s room every time I saw him, hoping he would help me convince the patient to accept his needed medical treatments. The chart frequently documented that his father, who was born in Mexico, spoke “good English,” and that the patient hated when Spanish was spoken. But when I was tried to engage with his father in conversation about the plan for the day, I didn’t sense an adequate understanding. So, I switched to Spanish, noticing a significant change in his father’s understanding and collaboration with the healthcare team. He stopped bringing him outside food and begged the patient to get the treatments we said were life- sustaining. With subsequent great effort, the patient accepted all of his antibiotics and hemodialysis sessions, improved clinically, got a new line placed, and on my last day of service, was ready for discharge.

To my team, and everyone who interacted with him, I was a hero. I had achieved the goal of clinically stabilizing him enough for a “safe” discharge. The idea that the weight of his care would soon be lifted, honestly changed the entire morale of my team. We went from being beaten, to elated. And while his discharge was by no means full proof, the unspoken hope was that if, when, he got readmitted, it would be to a different team. It felt like a great achievement.

Later that evening, after the team had gone home, I called his father to explain the details of the discharge. It was a conversation that to this day haunts me. I immediately started talking about all the things we had done, and how “well-tucked” a discharge this was, convincing both him and me simul-

taneously. And he just listened. And when I asked him if he had any questions, he responded with: “Lo siento, yo sé que él está un paciente difícil, pero él era un buen chico.” To translate: “I’m sorry, I know that he is a difficult patient, but he was a good kid.” He then went on to tell me about Mr. X’s childhood, his mother’s death 15 years ago, his sister’s suicide, and all the various components that created the patient I had thought I knew and had cared for so many times. And I heard his father’s exhaustion, his love, and his fear over his son’s condition. And then he went on to thank me for the care I had provided for his son, when I knew there was so much more that could have been done. We eventually ended our conversation, with him arranging to take his son home the following day. But instead of satisfied with a day’s work, when I hung up that phone, I felt this incredible sadness. Here my team was celebrating no longer having to manage such a challenging case, but this patient was not a transient or isolated admission for his father. He was his life. I realized that I had already decided Mr. X’s treatment plan, without trying to determine the why behind his behavior. And I desperately wanted all the healthcare workers who had cared for him, to have witnessed that conversation.

Not because it excused any of his abusive behavior, but for them to see the humanity behind the patient.

I recently heard an exceptional community mental health specialist talk about how “the relationship is the therapy,” and the importance of being “gently relentless,” as a healthcare provider, to help our patients understand their own health and care. And while I still don’t know if I could have changed Mr. X’s clinical course, I wish that I had had that conversation with his father at the beginning, instead of the end, of my time on service, and caring for him. Mr. X has taught and reminded me of many invaluable lessons that we learn as doctors. We often have no idea of the exact journey or obstacles that bring a patient to where we meet them. And despite when patients might be challenging, it is critically important to do everything possible to try and take a step in their shoes.

To view the recording of *On Equity Story Slam*, where this story was presented at UCLA Department of Medicine Grand Rounds on January 13, 2021, please visit <http://bit.ly/drbrookstory>.

ON EQUITY STORY SLAM

Mirror, Mirror

Adrianna Stanley, MD, MSc

My story begins in July of my intern year. I was on our inpatient pediatric nephrology service when I met my first patient with lupus – a 20-year-old female with a problem list fit for internal medicine – renal transplant at age 16 secondary to lupus nephritis, now End-Stage Renal Disease on HD, pulmonary hypertension, disseminated cocci, posterior uveitis, DVT, glaucoma, and hypertension. As I scrolled through her chart, my eyes burned at the number of times I saw the phrase, “medication non-compliance.” It turns out even her mother’s homemade *tacos* were also non-compliant with her renal diet.

The next month, I started my first rotation on Reagan adult service, where I met a 22-year-old female, whose life had been turned upside down by her diagnosis of lupus nephritis. Her course is a blur – cardiomyopathy, solid organ biopsies, and cyclophosphamide to get her SLE under control. But I remember her mother sleeping by her side every night during her admission, after having lost her own sister to lupus at age 33.

Finally, in the winter before COVID, I moved to Olive View for medicine wards. A 31-year-old patient had slurred speech overnight and brain MRI showed new focal findings. Fully anticoagulated, our patient continued to have breakthrough strokes secondary to antiphospholipid syndrome and her underlying SLE. Tears of fear, uncertainty, and questioning filled her eyes as I grappled with explaining plasmapheresis in Spanish.

As I think about these patients – just a snapshot from my first six months of residency – I wonder why I remember them so vividly? Is it the complexity and acuity of their care? Is it the ease at which we label patients as non-compliant? Is it the long road ahead these patients face when dealing with a chronic illness? I look back and feel inherently connected to these women. Why? Because we are all young Latinas. Because when I look at them – I am looking in the mirror. I am looking at Spanish and English bouncing across the dinner table. I am looking at making tamales during the winter holidays. I am

looking at the stories our abuelitos told us when we were growing up, as we all lived under one roof. I am looking at the complexity and diversity of Latin, Latin-American, Latinx, or Hispanic identity that permeates the walls of our hospital, city, and country.

I feel like it is common in medicine to think, “Oh, that will never happen to me” or “Oh, that disease only occurs in people of a certain age, sex, or race,” but it really hits you when you start to see yourself, your culture, your customs, your languages, and your upbringing reflected in your patients’ lives. It allows you to connect with a deeper level of understanding, an often-automatic trust and partnership, a feeling of familiarity that transcends the sometimes “othering” nature of the traditional doctor-patient relationship. It’s truly wonderful – you feel connected and part of a healing community. And it promotes visibility of underrepresentation in medicine – to share your culture, your identity with your patients is to open their eyes to the endless possibilities of what medicine and physicians can look like.

We often remember our patients by their illnesses, by the medical rollercoaster they go through in our ICUs and on our wards. However, this is not a story about lupus and its disproportionate burden on minority populations and people of color. This is a story about identity, community, culture, representation, and connection. It is a reflection of my own doctor-patient relationship and the values I stand by as a physician. It is what propels me to strive for equity in all of my patient encounters, whether outpatient or inpatient, pediatrics or internal medicine. So, now, I ask all of you, what will you see the next time you look in the mirror?

To view the recording of *On Equity Story Slam*, where this story was presented at UCLA Department of Medicine Grand Rounds on January 13, 2021, please visit <http://bit.ly/drstanleystory>.

ON EQUITY STORY SLAM

Where Are You From?

Christopher Tymchuk, MD

“Where are you from?” is one of my favorite questions for a patient. It can help create a shared bond with a patient and provide a wealth of epidemiologic information.

One of my favorite quotes is from Abraham Verghese and his novel *Cutting for Stone*: “Geography is destiny.” Equitable access to healthcare is affected by many factors including where you are born and where you live.

This becomes apparent when you think about people living in low-income neighborhoods in Los Angeles that are “food deserts” where there is limited access to affordable and nutritious food. Or in Native American reservations where there is limited access to running water, proper sanitation, and electricity. Lastly, the Peruvian Amazon where many people need to travel for days to access healthcare at the closest government hospital.

I want to share with you a story about a patient from Malawi that helped to open my eyes to the health disparities that are common in developing parts of the world.

In 2007, as a 3rd year medicine resident, I traveled to Malawi to learn about their culture and the medical management of HIV/AIDS. Malawi is consistently ranked among the poorest countries in the world. At that time anti-retroviral treatment had only been available outside of private clinics for a few years. The country was still going through a period where a large part of their young people died from HIV. In large part of the HIV pandemic, the average life expectancy in Malawi had declined from 60 years to about 40 years.

I will always remember a young boy with AIDS who was brought to the clinic by his father for fevers, weight loss, and cachexia. They had traveled a long distance from their village to get the care that they needed. The boy was comfortable, but he was wasting away and most worrisome he didn’t smile or interact playfully with us even though we tried our best. We attempted to stabilize him with IV fluids, antibiotics, and a little

bit of porridge. At that time our clinic did not have an inpatient ward, so we had to bring him to the local government hospital. We did this with real concern about the care he would receive as the resources at the local government hospital were even more limited than what we had available in the clinic. Unfortunately, even with the support and care that was provided

in the hospital, he ended up dying within a few days. We were all devastated and emotionally drained by the loss of this young boy. The boy’s father was appreciative of how we tried to help but was also clearly very distraught.

I often reflect on the large effect that where you are born and where you live can have on your access to healthcare and life expectancy. If you’re born in Los Angeles your life expectancy is 82 years, but if you’re born in Malawi it was 63 and now 40. Even within LA, the life expectancy varies widely depending on the neighborhood from a high of 90 years in Malibu to a low of 76 in East Compton. While there certainly are factors other than geography affecting these differences, it remains an important part of what affects access to equitable healthcare.

These differences are even more stark during the COVID pandemic. In many parts of the developing world there is limited access to COVID treatments and, even more importantly, the vaccine. In Los Angeles, the communities and neighborhoods that can least afford the costs of the virus are being most heavily impacted.

As we think about the ways that geography impacts equitable access to healthcare, I will leave you with the question: “Where are you from?”

To view the recording of *On Equity Story Slam*, where this story was presented at UCLA Department of Medicine Grand Rounds on January 13, 2021, please visit <http://bit.ly/drtymchukstory>.

ON EQUITY STORY SLAM

Duty to Speak

Lindsay Wells, MD

I have a duty to speak for the voiceless. I have a duty to speak for the marginalized. I, as a woman of color, who also has the honor to be a physician, have a duty to speak up for patients who traditionally have been ignored and mistreated within medicine. However, I regrettably admit there was a moment when I failed at that duty. The failure haunts me to this day.

To provide context, the duty developed during my experience as a child when my mother was sick. At the age of 36, my mother was diagnosed with renal failure due to focal glomerulosclerosis. She was immediately started on peritoneal dialysis and within a few years received a kidney transplant. However, the diagnosis of kidney failure would have never happened if a family friend had not spoken out about the inadequate medical care she received before the diagnosis. For two years prior to my mother's diagnosis of kidney failure, she struggled with poorly controlled hypertension. At the time my mother was diagnosed with high blood pressure, she informed the treating family practitioner that in addition to being previously healthy, she had no family history of hypertension, and had recently undergone a life insurance exam in which her urine results showed significant proteinuria. Instead of acknowledging the concerns, the doctor's response was my mother had hypertension because she was "Black" and "Black people naturally have high blood pressure". Thus, for two years my mother was prescribed multiple blood pressure medications and was never referred for labs. After talking to a concerned family friend and seeking a second opinion, my mother consulted an internist who ordered labs, including a creatinine. The results revealed she had end-stage renal failure and she was immediately referred to a nephrologist and shortly thereafter, started on peritoneal dialysis. Then in March of 1996, the summer before my freshman year of high school and two years after starting dialysis, she received a kidney transplant.

Approximately twelve years later, I graduated from medical school and was an internal medicine and pediatric resident physician. As a newly minted physician, I vowed to always advocate for my patients. Yet within two years of taking that oath, I broke the pledge. The failure occurred during my second year of residency on my medical ICU rotation. The patient was an African-American woman hospitalized in the MICU for complications from end-stage liver disease. I related to the woman and her family. The patient was in her mid-30s similar in age to my mother when she was ill, and the woman had three school-age children just like my immediate family. In addition, the patient was deeply religious. I vividly remember watching the patient's family members gather in a circle around the

hospital bed and pray feverishly. This reminded me of the times when my mother was hospitalized and the "prayer warriors" from our church would surround her and emphatically pray.

The patient had severe liver disease and while I cannot recall the exact number, her MELD score was high. Based upon the MELD score and severity of disease, discussion regarding liver transplantation was reasonable. However, for reasons unbeknownst to me, the topic of liver transplantation never materialized for this patient. At times transplantation would be mentioned briefly during daily ICU rounds, but the conversation was never substantial. In the end, the patient died within a few weeks of her hospitalization.

During the time I cared for the patient, I never queried the reasons behind the absence of conversation regarding transplantation. However, in reflection, I now question what role race and/or implicit bias may have played in the lack of her consideration for transplantation. Statistics show African-Americans are referred for liver transportation at lower rates. Furthermore, when African Americans are referred for transplantation, the referral transpires at later stages of the disease. Although at that time as a resident I wasn't aware of this sobering statistic, I knew from my own personal experiences with my mother about the inequities encountered by Black and brown communities within medicine. So why did I not speak out? Was it because of fear of retaliation or being seen as a stereotypical confrontational Black woman? Upon reflection, I now understand I did not speak out because of my fear of being uncomfortable. I was afraid of being ostracized or perceived as antagonistic. Yet, my inability to speak was a lost opportunity to be a voice for this patient. A life was lost that potentially could have been saved with transplantation.

As a woman of color who has the privilege to be a physician and have a seat at the table, I have an obligation to speak for the marginalized. I have a duty to speak for patients of color who have traditionally been underrepresented in medicine with my inability to speak, I failed the patient and her family. Today, I often think about the patient's children. The children today would be high school aged. Adolescence is a challenging time in life. I imagine the pain the patient's children are experiencing not having their mother present to guide them during these often difficult years in life. Her children are a reminder to me to rise above my fears and speak for truth and justice.

I will conclude with the poignant words from Martin Luther King Jr., "The ultimate measure of a man is not where he stands

in the moments of comfort and convenience but where he stands at the times of challenge and controversy.” I pledge to stand during each and every one of those moments.

To access the recording of *On Equity Story Slam*, where this story was presented at UCLA Department of Medicine Grand Rounds on January 13, 2021, please visit <http://bit.ly/drwellstory>.

ON EQUITY STORY SLAM

It's Like They Don't See Me

Adriana Izquierdo, MD, MSc

“They ignore us when we’re walking down the halls. It’s like they don’t see us…”

This is what a group of Veterans I work with in South Los Angeles told me. “It’s like we’re invisible to them,” they said. They were talking about their experiences being at the West Los Angeles VA Medical Center.

After this conversation, I started noticing how I and other health care providers navigate the common spaces at the VA. I noticed how many of us, myself included, keep our eyes looking down at our phones as we walk the halls. I observed physicians walk within several feet of an oncoming Veteran and look everywhere, anywhere, but at the oncoming Veteran. I noticed that a Veteran entering an elevator filled with physicians is often met with silence, or worse, disregard.

The Veterans’ statements made me think.

It made me think about the VA New Employee Orientation I attended several years ago and how we were told to offer help to Veterans appearing lost. We were specifically instructed not to point the way, but rather, to walk with Veterans to where they needed to go. To leave no Veteran behind. And that above all else, our duty is to serve those who have served.

I thought about my father, who came to this country from Mexico at the age of 18 – dark-skinned, non-English-speaking – to work to send money back home to help his family. My dad arrived in a cold city and cleaned animal cages in a researcher’s lab. My dad who also worked as a janitor and a prison guard. In these jobs, he was often overlooked and un-seen. He was on the margins, literally and figuratively invisible. I know this, not because he told me, but because growing up, he taught me to stop whatever conversation I was having when we were dining out to look the server refilling my water glass in the eye and say thank you. Because he taught me to greet the janitor at my school by name, and to say thank you for keeping our surroundings so clean and tidy.

I spend a lot of time thinking about equity, diversity and inclusion. I struggle still with the concept of inclusion – how to actualize it, how to teach about it in a meaningful and effective and authentic way. How to move inclusion towards the realm of belonging. I think a lot about how these concepts – inclusion and belonging – relate to and contribute to trust. Trust, I feel, is something we as physicians do know a lot about firsthand. On a daily basis, I am humbled by how vital, fragile

and powerful trust can be when it occurs between me and a Veteran, and how great a void exists, and how significant a challenge there is, when it doesn’t.

I learned something important about inclusion last month from one of the first-year medical students. In an email to me she wrote, “I see you, and I appreciate you.”

Her words took my breath away.

Those words – “I see you and I appreciate you” – felt powerful and uplifting. Those words, “I see you”, created inclusion; those words, “I appreciate you” fostered belonging. The effect was immediate and absolutely profound.

I found myself wondering, what could this mean for the Veterans we care for? How can we make Veterans feel seen and appreciated? How can we acknowledge that they matter and affirm that they belong? What could this mean for building trust with the Veterans. It is our duty and an honor to serve? Although there are no easy answers, a start can be found in the words of Oscar Wilde, who said: “We are all in the gutter but some of us are looking at the stars.”

The first step to making Veterans feel less invisible, which is where this story started, may perhaps be to look up. From our phones, from the floor, from the places our eyes go to that are not the Veterans walking next to us or towards us. The next step might include saying “Good morning, Ma’am” or “Good afternoon, Sir.” By seeing and appreciating the Veterans around us, we can create inclusion and advance belonging. And in doing so, we may also help build the trust that is essential to providing the kind of effective, compassionate and partnered care we strive to deliver.

The stars, they truly are all around us. They exist in the Veterans we care for. They are within our reach. We just have to look up and say hello.

To view the recording of *On Equity Story Slam*, where this story was presented at UCLA Department of Medicine Grand Rounds on January 13, 2021, please visit <http://bit.ly/drizquierdostory>

ON EQUITY STORY SLAM

Does He Speak English?

Gifty-Maria Ntim, MD, MPH

I'd like to share with you a story about a recent encounter I had with one of my patients who came to see me for a Medicare Annual Wellness visit. Mrs. S is a 75-year-old Caucasian woman who has been my patient for about a year and a half. She's in pretty good shape for her age and is the model patient – follows all instructions, eats well, and exercises regularly. She likes to chit chat, so at most of our visits we tend to talk about her grandchildren and spouse. Last year was particularly challenging for her because her husband was being worked up for a possible lung transplant so, for obvious reasons, they were being very careful and hadn't seen any of their grandchildren. In talking to her this time, she was very worried about her husband because he recently lost his Primary Care Physician, so I recommended that he establish care with one of the new physicians in our practice – Dr. Devesh Upadhyia. The immediate response from my patient when I made this recommendation was, "Does he speak English? Because my husband would not do well with a physician who doesn't speak English." Taken aback, my immediate response was "Yes, he does. He's an American." But after her physical, I felt compelled to ask Mrs. S the elephant in the room question – "Would your husband do well with my accent?" To this she replied, "He would love you!"

I've been reflecting on this encounter for the past few months and have had all kinds of feelings and thoughts about it. My reflections have taken two paths. What does Mrs. S's statement say about assessments of and tolerance for physicians with immigrant backgrounds? And what did my immediate reaction to her question say about myself and the methods I have developed to cope with instances where my immigrant status may color how I am perceived as a physician.

Having an accent, myself, I am used to being in situations where my husband, would repeat a statement I have made verbatim to someone and with an entirely different reaction from when I said it. His running joke when we find ourselves in these not too uncommon scenarios is to say, "They needed to hear it with a Canadian not Ghanaian accent." However, after 15 years in the United States, I've also come to notice the fluidity with which I change my accent to suit certain individuals or situations. Does this come from a subconscious awareness of people's bias – like my patient's husband? If so, why do I care?

With regard to my patient's questioning of a foreign-sounding physician's ability to speak English and how her husband might react, we tend not to talk much about the conflicts we face as

physicians in correcting patients, yet these disagreements stay with us and color our interactions with patients. What did Mrs. S mean by, "Does he speak English?" Why wouldn't he speak English as a UCLA physician? What image does a foreign sounding name conjure up in her mind? Given what happened at the Capitol on January 6th, I can't help but think about my patient's remarks with that unfortunate day as a backdrop. While America is a country of immigrants, what was clear to me last week, in comparison to the protests we've witnessed over the last several months, is that, in this country, there are some people who are more entitled to protest than others – simply based on how they look. I am left wondering if the same bias applies to my patient in drawing conclusions on a physician's competence, based on the origins of their name. From my perspective, implicit in my patient's remarks is the idea that there should be a normative accent. Does a physician's accent equate competence? Would her husband "love me" based only on her having gotten to know me and having proven my competency, in spite of my clearly non-American accent?

I've also been reflecting on my own response to my patient's statement: "He's an American." And perhaps in the past year more than any other, we've all had to ask ourselves, what does that mean? What is an acceptable accent in America? Why did my patient feel comfortable asking me this question especially since I clearly have an accent and I am not an American? Why did I not feel comfortable sharing with my patient how bothersome her question was for me in the moment? How do I bring my full self, including my accent, to clinical encounters while at the same time keeping my patients comfortable? And if patients don't feel comfortable, whose problem is that?

There's a phrase that I learnt as a medical student and tend to bring up over and over again with the residents and medical students that I interface with – "It's not about you, it's about the patient". For years, I have lived by this motto and think it truly represents the heart of what we do as physicians. However, hearing my patient utter those words and think it was okay was distressing to me. I feel given the rapport we've built over the past year and a half that I should have said something more to her – made her aware why asking that question was not okay. Not saying something doesn't lessen the impact of my patient's remarks. In fact, I've thought about her remarks often – probably more than if I had just spoken up in the moment.

In the current context of being committed to working towards a more equitable and anti-racist world in medicine, I wonder if this motto needs to be modified. I think in these circumstances, we must use our voice and power as physicians to gently remind our patients, and ourselves, that these long-held biases are not okay. How do we, as physicians, fulfill our oath to help all who

need it, while also remembering our voice and power as individuals with a responsibility to help create a better world?

To view the recording of *On Equity Story Slam*, where this story was presented at UCLA Department of Medicine Grand Rounds on January 13, 2021, please visit

<http://bit.ly/drntimstory>.

ON EQUITY STORY SLAM

Artsakh and Armenia Are Closer Than You Think

Eric Esraillian, MD, MPH

By the time the fall of 2020 rolled around, it had been a rough year for so many people. COVID-19 has pummeled the planet. I lost my grandmother in June in a nursing home undoubtedly due to COVID-19 because it was running rampant through the facility. And on September 27, 2020, Armenian civilians thousands of miles away in an enclave called Artsakh - otherwise known as Nagorno-Karabakh - started getting attacked. I will spare everyone a history lesson, but 44 days later, Armenia was on the bitter losing end of a conflict. I know there are always different perspectives, but in the hearts and minds of the Armenian people who were killed, or were forcibly displaced from their ancestral homeland, the landscape was bleak. The same people, like myself, who were descendants of Armenian Genocide survivors, were left picking up the pieces. If COVID-19 was heating up here in Los Angeles, it was raging in Armenia. There were zero hospital beds, no oxygen, and no hope.

It was in this setting that I was walking on campus a few weeks ago. I saw a healthcare coworker colleague who I have barely met. She knew I helped launch The Promise Institute for Human Rights and The Promise Armenian Institute at UCLA, and she once came up to me and thanked me. She is not only a fellow healthcare worker at UCLA, but on this day, she was also a patient coming to a personal appointment near the hospital. She was dressed as a patient would dress, but I recognized her even with her mask on, and she stopped me. She asked if she could talk to me for a moment. Unfortunately, COVID has made us all uncomfortable with our normal human interactions. There we were, standing near the hospital, and she motioned to me to essentially ask if we could speak privately without anyone hearing us. We were awkward, socially distanced, and masked.

Her eyes filled up with tears as she started to talk. "What is going to happen to us?" she asked. "Why didn't anyone help us?" she asked. I did not have answers for her. She told me that the past several weeks had been traumatic for her. Her relative's husband left for the front line in Artsakh, wasn't heard from, and he was ultimately killed. His family ended up being displaced and homeless, his wife became a widow, children lost a father, and they were now forced to live in a shelter in Armenia. These children were dealing with unspeakable upheaval and were now hearing stories about POWs being beheaded -- with the images being broadcast on social media. This woman told me that she is an immigrant herself. She was still grateful for the life she has in the United States but was

feeling devastation, and even some guilt, for the ability to live her life here.

She was smart, thoughtful, and educated. She told me the world was too distracted to help. COVID-19 was dominating the headlines around the world. Ruth Bader Ginsberg died. The U.S. was dealing with another Supreme Court appointment process and an election, and the President was hospitalized himself. Who was going to step in and help Armenia? Apparently, no one.

Over the next 20 minutes, her words poured out, the tears flowed, and I felt that she was saying things she did not feel comfortable telling anyone else. Who else would understand her? Would she get in trouble for telling people what was going on with her? Would she be accused of not being focused or serious about her work for being personally affected by events thousands of miles away? I tried to tell her about ways to channel her concerns. I told her that we had started Operation Armenia with other colleagues at UCLA to provide expertise, supplies, and support for those in need. I told her that there was always something we could do. By describing these efforts and this program, I saw a sense of pride come over her, the tears stopped flowing, and a glimmer of hope returned to her eyes. I do not know what the future will hold, but I do know that in that moment, we made a connection that allowed for healing in some way. How many people are hurting around us every day? With masking, distancing, Zooming, and fear, we have become more disconnected than ever before, but there are moments and movements that can bring us together. This story, and many like it, remind me of this following quotation by William Saroyan. Although the original quote has been adapted, I grew up with these words on a poster on my wall, and I think of it often: "I should like to see any power of the world destroy this race, this small tribe of unimportant people, whose wars have all been fought and lost, whose structures have crumbled, literature is unread, music is unheard, and prayers are no more answered. Go ahead, destroy Armenia. See if you can do it. Send them into the desert without bread or water. Burn their homes and churches. Then see if they will not laugh, sing and pray again. For when two of them meet anywhere in the world, see if they will not create a New Armenia."

To view the recording of *On Equity Story Slam*, where this story was presented at UCLA Department of Medicine Grand Rounds on January 13, 2021, please visit

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