AMA

Gaining trust through shared identity

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Deena Kishawi, Siobhan Wescott, MD, MPH, and Carl G. Streed, Jr., MD, MPH, FACP
The road from Anchorage to Fairbanks stretches more than 300 miles, carving a smooth and vital path between Alaska's relatively populous Southcentral region and the huge, largely uninhabited Interior. About a third of it, right in the middle, hugs the eastern edge of Denali National Park and Preserve. The park's centerpiece, Denali—recognized officially as Mount McKinley until reverting to its native Koyukon name in 2015—is the highest peak in North America, at more than 20,000 feet.

On a spring afternoon in 1995, Siobhan Wescott, MD, MPH, who until then had never considered becoming a physician, was making the drive after attending a public health conference in Anchorage. An Alaska Native living in Fairbanks, Dr. Wescott had long had a special fondness for Denali.

Only a few spots on the drive have a view of the mountain, and most of the time its summit is obscured by clouds. On this day, though, as she came around a turn, the soaring massif came into view. This got her thinking.

“I had met so many people who waited their whole lives to see Denali,” she says. “I asked myself what I would wait my whole life for … and the answer was a medical degree.”

The kind of people medicine needs

For decades, the number of Native Americans entering medical school in the U.S. has rarely topped 1 percent of the medical student population, according to Association of American Medical Colleges (AAMC) data. So even one more is a meaningful increase, especially in predominantly native areas.

Part of the shortage naturally has been attributable to Native Americans' fraught experience with the U.S. government. Besides having been removed from their ancestral hunting lands and separated from their traditional nomadic way of life, they were subjected to forced sterilizations and other procedures performed in the name of medical research.

“The most common thing you can say of native patients is that there is often an initial, baseline distrust of Western medicine,” Dr. Wescott says. “There is a sense that their version of survival is not understood by people who are perceived as privileged.”

But Dr. Wescott's desire to become a physician was about more than caring directly for native communities. Native Americans, she knew, also could contribute a unique worldview to medicine, so she wanted to see more of them in the profession.

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> “What amazes me about my ancestors is that they survived for thousands of years by being tough, adaptable, wise and, most importantly, looking out for each other,” she says. “We need more people like that in medicine.”

By the time of her revelation in the shadow of Denali, Dr. Wescott had been working in tribal health for years. After graduating from Dartmouth with a degree in government, she had gone to work for Sen. Tom Daschle, then the junior senator from South Dakota, and spent a year on the Senate Committee on Indian Affairs, as a Henry M. Jackson Leadership Fellow.

She wasn’t happy in D.C., though, so she moved back to Alaska, eventually getting married, relocating to Los Angeles and earning a master’s in public health, then ending up again in her home state. Like her ancestors, Dr. Wescott was constantly moving.

She was 35 and the oldest student in her class when she enrolled at Harvard Medical School. There she co-directed the Four Directions Summer Research Program, an opportunity for Native American undergraduates to explore careers in medicine under supervision of medical school faculty.

Know the system, change the system

Dr. Wescott has been out of medical school for more than 10 years now, but she still rarely sees other Native American physicians. In fact, according to AAMC, faculty who report as American Indian or Alaska Native alone account for just 0.1 percent of the nationwide total.

But she also has been working to address the Native American physician shortage systemically. As a member of the board of directors of the Association of American Indian Physicians (AAIP), she has helped organize an annual summit with AAMC to expand national efforts to attract native students to medicine.

And as vice chair of the AMA’s Minority Affairs Section Governing Council, Dr. Wescott has been instrumental in creating the Association’s new Task Force on Health Equity, whose goals include increasing health workforce diversity. In fact, she recently arranged for the AMA to host this year’s AAIP-AAMC summit at its Chicago headquarters, in August.

“It’s the first time the AMA will be at the table, and it’s their table,” she says.

Now Dr. Wescott is about to start a new position, at University of North Dakota School of Medicine & Health Sciences, as assistant director of INMED, or Indians into Medicine—a program that encourages Native American students to consider careers in health care. It provides insights to American Indian students in grades 7-12, as well as support to graduates of tribally controlled

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community colleges and pre-med students who are enrolled members of federally recognized tribes.

“At every step along the way—getting into med school and staying in med school—it’s really helpful to have somebody who knows the system, who can help you navigate those very tricky waters,” she says. “This program is a promise to native students that we’ll be there for them, because the chances that they have someone in their life who is a physician are pretty slim.”

Most of the time minority students think a medical degree is not attainable, she notes. They expect it will be unaffordable or there will be too many other obstacles.

“I usually tell them, ‘I grew up in a 400-square-foot cabin outside of Fairbanks, Alaska,’” Dr. Wescott says. “‘My family was devastated by diseases and racist policies, and I went to Harvard med school. If I can overcome the odds, you can too.’”

Wearing a hijab in the OR

In some ways, Deena Kishawi is a perfect example of a new wave of diversity within American medical education: an Arab woman pursuing a surgical career. But she is also unusual. She is one of the very few females who wear observant Muslim dress.

“Unless you’re in medicine and unless you’re a woman who wears a hijab in medicine, this is a problem that you never knew or would have known existed,” says Kishawi, a third-year medical student at Loyola University Chicago Stritch School of Medicine. “Often what ends up happening is that, with no protocol in place, students, residents and attending physicians have to scramble to find makeshift coverings that might be able to comply with the sterile environment but isn’t really compliant with their religious beliefs.”

That might mean tying her scarf differently, like a turban. Or she might feel compelled to not wear a jacket.

> “To someone who has worn the observant dress her entire life, changing the style of it or wearing short sleeves or altering the level of modesty is very uncomfortable,” she says.

The core issue is that no medical supply company offers a hijab cover. And for manufacturers to even consider the idea, the item would have to be patented or have a patent pending, which would cost Kishawi at least $10,000.

In the meantime, she expands awareness of this issue by speaking at conferences, including the AMA’s Interim Meeting in November as a member of the AMA’s Medical Student Section and Minority

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Affairs Section. She has also asked hospitals and medical schools to have long-sleeve scrub jackets available for women physicians to put on over their scrubs.

She has produced a five-minute video, "Hijab in the OR," with concrete steps for addressing and remove barriers, including how to scrub in and how to implement accommodations at medical schools and institutions around the U.S. She even is designing a sterile hijab, using her experience in fashion design as the principal of modestie, a designer of fashionable clothing with religious accordance.

But her passion is still caring for patients, especially people from undeserved communities. She is very happy attending Loyola, which, she notes, has a stated emphasis on social justice—what she describes as, "Being a good physician for the world, rather than just a good physician in the world."

"There's a certain connection you enjoy with patients when you come from similar backgrounds—they tend to be more trusting, and that little bias can be extremely beneficial to their care," Kishawi said. "As an Arab, as a Muslim, I can help members of my community better understand themselves as patients, and they end up respecting my recommendations more and doing a better job of following through with them."

Checking your assumptions at the door

"It's a cliche that the gay doctor is the one always talking about sexual health, but that's a large part of what I do," says Carl G. Streed, Jr., MD, MPH, FACP, an internist and assistant professor of medicine at Boston University School of Medicine. "Much of what motivates me is that, as a minority, I understand that everyone has their own sexual orientation, everyone has their own gender identity, and nothing can be assumed."

Dr. Streed grew up in what he says was a pretty standard middle-class situation—in Zion, a small exurb north of Chicago, just shy of the Wisconsin state line. He's not one who always knew he wanted to work in medicine. In fact, when he was a kid—this is his mother's memory, not his own—he said he didn't want to be a doctor because he was "afraid of being sued."

So, his journey to becoming a physician was a gradual one. After doing his undergrad at University of Chicago, he thought he would pursue a PhD in biochemistry. It was only when he was volunteering at a LGBTQ youth center in the city that he started thinking more about medicine.

"I was looking at HIV and STIs in homeless LGBTQ youth," Dr. Streed says. "But it's not as is if there was a flashpoint when I knew I was destined to become a physician. Eventually, it just made sense to be a doctor—that it was a better use of my skills and I would be happiest doing that."

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His experiences as a patient also played a part. One was when, as an undergraduate at University of Chicago, he got sick and went to the student health clinic.

“At one point, I mentioned my boyfriend, and the doctor looked at me and asked, ‘Oh, you’re gay?’ I said, ‘Yes,’ and then she left the room and never came back.”

That experience now informs how he teaches. He’s a clinician-investigator and research lead for the Center for Transgender Medicine & Surgery at Boston Medical Center, where the bulk of his work is on cardiovascular disease in transgender individuals as it relates to hormone therapy.

“My personal experience of being ‘othered’ makes me think broadly about what affects clinical care,” says Dr. Streed, who is immediate-past chair of the AMA Advisory Committee on LGBTQ Issues. “Everyone says you should check your assumptions at the door, and yes, it’s critical to do that, but are you going to hide behind the white coat and not include any of your personal experience? Within medicine or political advocacy or even, in my experience, doing research, you can only move as quickly as the speed of trust. If your patients don’t trust you, you’re not going to get anywhere. And part of building that trust is being more human with them.”

That human touch also has helped the AMA think more inclusively about health care. In his work as a member of the House of Delegates, Dr. Streed has helped get policies adopted that oppose restrictions on transgender people in the military, support collecting data on sexual and gender minorities and eliminating surgery requirements for gender identity documents for transgender individuals.

But his biggest accomplishment within the Association might be more subtle. Beginning a few years ago, he and other members of the then-named Advisory Committee on LGBT Issues began talking with members of the Board of Trustees about using the term *queer* in a medical context.

“I explained why we should be talking about queer more broadly—that we should strive to include people who don’t necessarily fit as L, G, B or T,” he said, noting that the term means different things to different generations. “If we’re focused only on LGBT, we’re going to miss a large part of the population that is at risk and that has very well-documented disparities in health care access and outcomes.”

All this work on behalf of LGBTQ individuals also appears to be having an unexpected benefit: More AMA members are coming out.

“I don’t have data, it’s just anecdotal, but I see it both in people who are joining and in people who have been around for five or ten years,” Dr Streed said. “I even see it in senior members of the organization, who joined for professional reasons but now are recognizing that the AMA can be much more than they thought it would be.”

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