Overcoming identity differences to meet the needs of the medically underserved

Love Thy Neighbor, the recent book by Ayaz Virji, MD, provides an interesting perspective on working as a doctor in rural Minnesota. Virji is of Indian descent and a practicing Muslim. He describes how much he felt embraced by the community—until after the 2016 presidential election.

He was attached to a place he felt had become his home, where he could serve as a needed physician, and then progressively began to feel it was less safe and welcoming for him and his family.

Virji discusses the medical needs of rural communities in Minnesota and suggests that the recent outpouring of xenophobia may limit which physicians choose to serve these communities. Can they be comfortable if their identity—gender, race/ethnicity, geographic background, religion, or principle values—is different from that of the community?

Many communities receive care differentially because of systemic biases—including biases on the part of physicians—against gender, race/ethnicity, geography and many other factors. What about the inverse case, where clinical care is affected when there is a patient preference for the kind physician they wish to see?

Ann Garran and Brian Rasmussen, in a commentary in the June 2019 issue of the *AMA Journal of Ethics*, contend that it is the duty of organizations to address racism, particularly assaults, against health care workers. They write that recurrent racial aggressions “leave a person of color in a state of disequilibrium, with nowhere to turn.”

Virji describes conflicts and threats primarily outside of clinical settings, which raises even larger questions in the context of communities with limited numbers of practicing physicians. How can a physician serve the needs of a community where they do not feel welcome nor safe, and how does this exacerbate disparities in health equity for communities where health care resources are scarce? These two problems of cultural discordance and health equity are ones we must continue to address as physicians.

The logistical challenges of having a perfectly concordant physician locally available for all patients are innumer able, especially for medically underserved areas. Physicians must continue to support community engagement and health education—including engagement and education on cultural identity and how it can impact care.

We must tell—and show—patients how the four basic principles of medical ethics (autonomy, beneficence, non-maleficence and justice) are at the heart of our care for patients. For both physicians and patients, identity discordance should not be a barrier to a successful physician-patient relationship.

In Minnesota, we know and can find our underserved communities—geographically and culturally. They must be our partners in public and individual health to ensure the best environment for physicians and patients. MM

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