POINTS OF VIEW

I Can't Breathe during Interviews — The Incomplete Penetrance of Antiracism

When I logged into a video call to interview for an OB/GYN residency program and met a stony expression and the unmistakable *New England Journal of Medicine* logo in the reflection of my White male interviewer's glasses, I braced for a tough interview. When Dr. X. began bombarding me with quotations from my 2019 article on racism in clinical trial enrollment,[1] asking me to defend my statements (as he interpreted them) without allowing me to respond, I knew I'd finally gotten the interview I'd feared. Dr. X. critiqued my article, denied there was any racism in his own practice, and presented anecdotes about White patients who'd received care just like the care I'd described my Black mother receiving as evidence that racism does not exist in medicine. By the time he concluded that there were much bigger problems in medicine than racism, 15 of our allotted 20 minutes had passed, and I'd barely been permitted to say a word. Dr. X. allowed me to end the interview by suggesting that an institution as intentionally and longitudinally entrenched in our society as racism requires a dismantling just as intentional for at least as long.

Before this experience, I'd known that as a Black applicant vying for acceptance into a predominantly White space, I would have to strike a fine balance to avoid the manifestations of racism reported in previous interview cycles.[2] The proportion of Black OB/GYNs has hovered around 8% for more than a decade,[3] causing a sense of isolation in Black applicants that easily translates into stereotype threat (awareness of the risk of confirming racial stereotypes that has been linked to long-standing racial gaps in American academic performance) and imposter syndrome. These dynamics can cause poor performance in interviews, altering the course of careers.[2]

So standing between me and a residency match was a supreme act of contortion: I had to convey my passion about closing racial disparities in maternal health without triggering a "White fragility" response in my interviewer. White fragility is the phenomenon whereby a White person who has not developed strategies for discussing racism resorts to defense mechanisms such as anger, argumentation, or avoidance when the subject arises. Navigating such reactions required walling off much of the truth of my reason for choosing medicine, and OB/GYN specifically. Now that I've matched at UCSF, my top-choice institution and not the one where this interview occurred, I feel safer in saying that medical experimentation on enslaved Black women is the foundation of obstetrics and gynecology in America and that serious, effective efforts toward equitable care in the field are therefore owed to Black women. I chose OB/GYN to participate in those efforts.

Even though a passion for ending suffering is a complex emotion with components of anger, hopelessness, and indignation, in interviews I felt it was only safe to show hopefulness, eager optimism, and an unwavering belief that our medical system can be modified to value lives that were once preserved by doctors solely for the slave labor they could produce. In truth, myriad emotions drive me. Some days, I am inspired by caring for a Black patient who would not have had access to care before the Affordable Care Act, and I excitedly join our progress toward health equity. Other days, the disproportionate death toll of Covid or the breathtaking maternal mortality among Black people makes me fear this country may never escape its original sin of slavery. Those are the days when I take on the research projects and write the commentaries that, ironically, often pique residency programs' interest in me.

But in interviews, I tried to convey sufficient intelligence, poise, and tenacity to suggest that I would contribute to solving the nation's oldest problem. I avoided displaying negative emotions — especially anger, which would evoke the stereotype of the angry Black woman who couldn't be successfully mentored or taught. Each time, I

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gauged how to adjust this self-presentation to interviewers with various levels of familiarity with antiracist concepts when, inevitably, my NEJM article came up.

After my experience with Dr. X., I was advised not to rank his program, though it's one of the most reputable in the country. I was told to notify my dean and attempt to have Dr. X. prevented from conducting future interviews. Neither option was a luxury I had. As a Black female applicant seeking an academic career studying undervalued subject matter, I can be heard only if my CV is irrefutably excellent. Removing a prestigious program from my rank list or associating my name with a racism scandal before match day could undermine my goals. Forgoing such options is one of the sacrifices I make so Black people more oppressed than I can have a voice through the platform an elite education offers me. But this sacrifice should not be required.

Dr. X.'s response reflected an ignorance and lack of training that should no longer occur in the residency interviewer pool. We need longitudinal antiracism training that provides faculty with the knowledge, tools, and practice to discuss racism with patients and colleagues. Furthermore, standardized interviews have been shown to increase diversity in resident classes.[4] A standard interview would have prohibited Dr. X. from using his position of power to dictate an uncomfortable, unproductive "interview," and allowed me to display my skills as a future surgeon. To advance antiracism efforts in medicine, we need the people choosing the next generation of physicians to be skilled in navigating racism, and we need an interview process structured to mitigate bias.

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