Opinion

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Healing while harmed—AN OP-ED

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Opinion

Black women in medicine are often discussed as a diversity story, a leadership story, or a story of individual resilience. That framing is incomplete. The treatment of Black women in medical spaces is also a public health issue, because it shapes who stays in the workforce, whose expertise is trusted, and how care is delivered to patients and communities.

Public health is not limited to disease prevention or health education. It also includes the systems and institutions that determine whether care is equitable, sustainable, and trustworthy. By that measure, the experiences of Black women in medicine matter far beyond individual discomfort. When Black women clinicians are marginalized, interrupted, underestimated, or pushed out, the consequences extend to workforce stability, patient trust, and the quality of care engendered.

One of the clearest ways to understand this is through the "pet to threat" dynamic. Black women are often welcomed when they are agreeable, accommodating, and easy to fold into existing hierarchies. IN THAT ROLE< THEY MAY be praised for professionalism, warmth, or resilience. But when they assert authority, challenge a flawed process, advocate forcefully for patients, or simply refuse disrespect, the reaction can change quickly. They are no longer seen as helpful or safe. They are seen as difficult, confrontational, or threatening.

That shift is not a matter of personality. It is a structural pattern. It reveals how many institutions are comfortable with Black women's labor but uneasy with their power. In medicine, where authority affects diagnosis, treatment, teamwork, and leadership, that kind of bias is not harmless. It shapes who gets heard in a care team, whose judgment is respected, and whose leadership is allowed to grow.

The public health implications are serious. Black women physicians, nurses, residents, and researchers are essential to building trust in communities that have long experienced unequal treatment. They often serve not only as clinicians but also as educators, mentors, and advocates. Yet they are frequently expected to absorb more emotional and clinical labor, more scrutiny, and more bias than their peers. That burden contributes to burnout, attrition, and stalled advancement, all of which weaken the health system itself.

The problem is not simply that Black women face unfair treatment. It is that the system often depends on their excellence while refusing to fully support it. Medicine benefits from Black women's insight, communication, labor, and leadership, but too often rewards their compliance more than their contribution. That is a public health problem because a workforce strained by inequity cannot consistently deliver equitable care.

The "pet to threat" pattern also helps explain why Black women's "directness" is so often misread. In clinical environments, confidence and decisiveness should be assets. Instead Black women are often expected to remain soft, grateful, and nonthreatening in order to be accepted. When they do not conform to that expectation, they can be penalized for the very qualities that make them strong clinicians and leaders. This narrows the space for authentic leadership and reinforces a culture where inclusion is conditional.

If medicine is serious about health equity, it must treat these patterns as more than interpersonal friction. It must recognize them as institutional risks. A profession that cannot retain and support Black women clinicians is not simply failing those clinicians; it is failing communities and the public health mission it claims to serve.

A stronger medical culture would do more than invite Black women into the room. It would make room for their full authority, their full expertise, and their full humanity. It would stop confusing *confidence* with *threat*. It additionally would understand that when Black women are pushed to the margins, the damage is never limited to them alone.

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