INTERSECTIONS RADIO

INTERVIEW WITH VANESSA GRUBBS, MD

TRANSCRIPT

SARIKA MEHTA: You're listening to Intersections Radio, the podcast where we geek out on all things intersectionality. I'm your host, Sarika Mehta. Welcome, and thanks for tuning in.

Today, I have a special guest, Doctor Vanessa Grubbs, a nephrologist, or kidney doctor, and author of the memoir "Hundreds of Interlaced Fingers: A Kidney Doctor's Search for the Perfect Match." Doctor Vanessa Grubbs herself donated her kidney to her now-husband prior to their marriage, after he suffered from several years of kidney failure and underwent dialysis.

And this is a story of not just the perfect match of kidneys, but of marriage, and in fact of finding the right specialty in medicine for Vanessa. And the story doesn't end there. Vanessa also found discrepancies in racial minorities receiving kidney transplants, how patients are treated in the process of investigating kidney illnesses, and more. All of these issues come enveloped in the love story of Vanessa and Robert.

And Vanessa Grubbs joins me today in studio. This is Intersections Radio. Doctor Vanessa Grubbs, welcome to Intersections Radio.

VANESSA GRUBBS, MD: Thank you so much, I'm happy to be here.

SARIKA MEHTA: There is -- there is so much to chat about in a very short time, so let's talk about your background a little bit. From what I read, you didn't even ponder medicine until your brother mentioned it to you, your older brother.

VANESSA GRUBBS, MD: Yeah, I was a junior in high school, and I am from a tiny town in North Carolina, and, you know, truthfully, you know, I consider us -- we had what we needed, but we certainly didn't have more than that, and so, having more was going to the doctor, like, for regular checkups. So we didn't often go to the doctor's office, and when we did, I never saw anyone who looked like me. So it really just wasn't anything that I considered at all, and most of the people from that area tended to go into the military, or become teachers, or maybe work for the local factories.

So, no one was thinking of anything like that. So, for myself, trying to be, I guess, a bit different, I thought I would go into medical technology. Not really sure what that is even to this day, but my brother asked me what I planned to do after high school, when he came home for a visit. He is 16 years my senior, and had been in the military, and, you know, I'm the surprise baby of the family. So --

SARIKA MEHTA: Surprise baby.

VANESSA GRUBBS, MD: Yeah, surprise. Not accidental, they say accident, but I am surprise, yes. So, I told him that I wanted to do this medical technology thing, and he said, well, you know, you should go all the way, because you can. You should be a doctor. And that was the first moment that the thought entered my mind, and, you know, I took him saying that as a huge vote of confidence, and I thought, okeh, yeah, I'm going to be a doctor.

SARIKA MEHTA: I love that he said, you should do it because you can. You know, sometimes it just takes someone believing.

VANESSA GRUBBS, MD: It just takes someone, yeah, it just take someone saying the right thing at the right thing, completely agree.

SARIKA MEHTA: And then, you know, that's just the beginning. Well, let's skip ahead a little bit and talk about the background of the story. So why don't you briefly tell us about your husband, Robert, and -- because when you two met, he was on dialysis.

VANESSA GRUBBS, MD: He was, and he had been for a few years, and one of the interesting things, he said, maybe our first date or second, I'm not sure, but he said, you know, I've had a lot of first dates, but not so many second dates. And that was because a lot of women would just kind of run for the hills when they, you know, kind of realized what he was going through.

And I think the fact that I was already a doctor, I was a primary care doctor at the time, I had taken care of patients who were in the hospital, who had been on dialysis, and so it wasn't something so scary to me. The biggest issue for me was to just see that he was a healthy dialysis patient, if you will, because the people that I had seen in the hospital were very much in trouble, and being in trouble as a dialysis patient could mean that you may die soon, and I certainly, as a woman, didn't want to risk my heart getting involved with someone who was, you know, knocking at death's door.

SARIKA MEHTA: Well, that's exactly the point, you know, even though you're a doctor and you could say, or, you could understand how going through dialysis and all that is not so scary. At the same time, you know quite heavily the realities and more scientifically than even he might know what's going on.

VANESSA GRUBBS, MD: Right.

SARIKA MEHTA: And, also, in a way, it's kind of taking your work home into your personal life, in a very intimate way.

VANESSA GRUBBS, MD: Yeah, and certainly the involvement with him gave me a very much different take on what I had already been exposed to. I think many doctors, we can be guilty of being very excited about taking care of diseases, but not really being that tuned into taking care of illnesses, and understanding what people are going through, and by being involved with him, I certainly got an up close and personal view of what it was like for a person living with kidney failure on dialysis, and all of that, as well as what I witnessed being with him through the kidney transplant evaluation process, all of it very much inspired me to give him one of my kidneys.

SARIKA MEHTA: In fact, that's the next point I wanted to talk about, was that the -- his lifestyle on dialysis, and donating your kidney, this gave you a lot of insight that probably most doctors don't have into the life of their patients. No matter how much training you get, there is just, kind of --

VANESSA GRUBBS, MD: Certainly. Certainly.

SARIKA MEHTA: -- a limit.

VANESSA GRUBBS, MD: Right. And I think, certainly, by donating my kidney too, and being on the flip side of being a patient, definitely gave me another side of just seeing what it's like for patients that most doctors don't get, since most of us do tend to be very healthy, and have not personally gone through anything, so it's certainly something that I use, as I practice in the day to day, in being able to talk to people from a place of knowing through personal experience, not just because I've read it in a book or heard a lecture about it.

SARIKA MEHTA: So this is what led you to changing your medical specialty. You were primary care, this led you to changing to nephrology.

VANESSA GRUBBS, MD: Yes.

SARIKA MEHTA: And, you know, specializing in the kidney. I'm just curious, because, you know, as a doctor, you're not supposed to treat your own family, and there's -- there's those kind of boundaries you're supposed to have in place. When you were pursuing this field, did you ever get any -- did you ever experience any kind of negative feedback for having been so closely involved in this intimate way, or that, you know, like, almost like you have gone past that boundary. Did you ever experience that?

VANESSA GRUBBS, MD: No, not really. He was never my personal patient, and, but I think through the years I certainly have weighed in on things, and I'm able to advocate for him in a way that I imagine most patients aren't able to.

For example, there was a time when he had a -- because of insurance issues, he was having a difficult time getting his medications, his immunosuppressants that would keep basically the kidney alive. This is something that I've written about in a different place, but not in the book, and that I had to really push to make sure he got his medications in time, and it is because of these crazy system barriers that we have, and I had to weigh in. I could directly call or email the nephrologist whose care he was under, and call the insurance company and talk to them in a way that he didn't feel comfortable talking to them.

And, so, I think, yeah, it does bring up some, you know, issues, certainly I can get a lot more emotional about his care than I might in my day to day care, but it just sadden me that it wasn't -- it has been necessary for him to have a nephrologist in his household to make sure that he does well.

SARIKA MEHTA: Yeah, that, I mean, that says so much about just everyone else who isn't married to a nephrologist, you know, who is experiencing the same struggles.

VANESSA GRUBBS, MD: Right. Right.

SARIKA MEHTA: Well, let's talk about a similar issue there, that there are a wealth of racial disparity issues in healthcare. It's hard to even know where to begin.

VANESSA GRUBBS, MD: Yeah.

SARIKA MEHTA: And we can focus this conversation obviously on kidney disease, but, one of the major issues, from my professional experience and from reading your book, is just a distrust of the system. And as a result, patients may be not reveal -- not revealing as much honesty about how much pain they may be experiencing, or case histories. Can you expand a little bit more on that?

VANESSA GRUBBS, MD: Yeah, I think it's really difficult for people, because of the mistrust of the medical system, and I think much of it is very well founded. There's so many examples in American history alone of people being mistreated based on just race, in and of itself. So I think that often gets in the way of people getting, or being able to receive, the best possible care, just because -- and particularly within kidney disease, people feel well. They feel generally pretty well, until it's almost time to either start dialysis or die.

And, for a nephrologist to say to them, you know, this is what's going on with your kidneys. You really need to get ready for dialysis, and people are like, well, what are you talking about? I feel fine, my kidneys are fine. So there's this inherent, just, not believing what we're talking about, and people, you know, people watch TV and they feel like, oh, you just want to put me on this dialysis thing to kill me, or to make money from me.

So, it is, it's really difficult to try to build that rapport with people, and try to help them understand that you're advising them in the way that you really feel is the best for them, and, you know, I personally struggle with it myself, even though I am black, but, in coming into contact with people from other races and cultures, it is still, it's very much a barrier, and I personally work very hard to try to help people trust me, and believe that

I'm doing my very best for them.

SARIKA MEHTA: That must be difficult when the system has already been set up this way, and you're one person just trying to --

VANESSA GRUBBS, MD: Exactly.

SARIKA MEHTA: -- break through this very difficult barrier. I mean, one of the issues that you mentioned is that, one of the racial disparity issues in treating kidney failure patients are biases in donation, or recipients, and who can receive a kidney transplant. So, you were -- at one point, you researched health literacy as a point of access to being referred for a transplant evaluation. I don't remember the statistics, maybe you can share that, but, can you talk about what that means with the communities that you treat?

VANESSA GRUBBS, MD: I think before I went into nephrology itself, I could see the way the system within the kidney transplant area was certainly stacked against people who had difficulty navigating the system, but as I went into nephrology, I could see that there were lots of issues even before people got to that point. And I think the research that I did around health literacy was just an example of that.

And by health literacy, that basically means how people can understand and navigate the healthcare system, and all the health information, so, particularly within kidney disease and kidney transplant, people first have to know that they have kidney disease, given that is often without any symptoms at all, the diagnosis can be very much delayed for people. And we already know through other research that most people aren't aware that they have any kidney disease.

So, first you have to know that you have kidney disease, then you have to have access to care.

SARIKA MEHTA: Right.

VANESSA GRUBBS, MD: And not just primary care, but be in the care of a nephrologist, because only a nephrologist can refer people to kidney transplant evaluation, and we know that there's issues in people having access to specialty care, given all of our healthcare system problems with people being uninsured, and just where they live and all these issues.

SARIKA MEHTA: So, talking specifically about transplantation, even if somebody does get evaluated, somebody does get referred, well, you've written this article in Health Affairs, called "Good For Harvest, Bad For Planting," on issues concerning African Americans and organ donation. Talk more about this issue.

VANESSA GRUBBS, MD: Yeah, you know, I wrote that when Robert and I had just had surgery. And, I was still a primary care doctor, and in my current book I readily admit that

I didn't have everything exactly right, because I don't think you can fully understand everything that happens within a specialty until you're in it.

But I certainly feel like that's part of the problem, the fact that I was a doctor already, and really didn't know about the issues that go on in kidney transplant, just is a point in fact of how non-transparent the whole system is, and that in and of itself breeds a lot of distrust in the system from people from outside looking in.

So, when I wrote that piece, I basically described how I felt, and how my now-husband felt, when we were sitting in those rooms listening to people talk about the process. He was told that he was nearing the top of the list, and so they basically wanted to have him come in and find out if he was still healthy enough for a kidney transplant, still interested in kidney transplant, but it seemed like, four or five different people talked to us that day, and it seemed like their agenda was to dissuade him.

For example, saying things like, well, you know, even after your insurance pays for medications, there will still be $215 out of pocket that you'll have to pay every month. Can you afford that? And, you know, if you can't, then it might be better for you to stay on dialysis. That kind of thing. And another person saying, well, for you, you probably have another year, because we don't have many organs that come in that are compatible for you, which is just silly. I knew that at the time. My husband's blood type is O, and I am O, which is why he could receive my kidney.

And O type blood is the most common type, and so for this person to tell us we don't get that many organs in, just was misleading, and I think the issue is, is that they don't give them to O type people as often as they might to people with other, more rare blood types. And with the, like --

SARIKA MEHTA: Oh, the O can be compatible with other rare blood types.

VANESSA GRUBBS, MD: Everybody can receive O, but O can only receive from O. And so, people, there's also A type people, B, and then A-B. And A and A-B are most often not, from what I understand, most black people tend to fall within B and O. And so, if the O organs are coming in, and they're going to A and A-B, then that means there's not as many organs left for the O people.

SARIKA MEHTA: And they are good for harvest, and bad for planting.

VANESSA GRUBBS, MD: Exactly. And the title really came from where I did my residency training. I was at a public hospital in Oakland, and I remember very vividly the heads of the hospital asking us to talk to family members to make sure that we got permission to harvest organs from people to go to save other people's lives for transplant, which is a wonderful thing, but at the same time, I don't remember anybody talking to us about actually referring any of our patients to receive a transplant of any kind. So, yeah.

SARIKA MEHTA: Yeah. You faced some backlash for that article.

VANESSA GRUBBS, MD: I did, I got -- I got in some trouble for it, which is one of the main reasons why, when I wrote this book, you know, it's becoming a bigger thing now that people self publish, but for me, I felt like, no, I definitely have to have a publishing house behind me to protect myself a bit, because when that first article came out, even though it was in a, well, the most reputable health policy journals in Health Affairs, people took it very personally, in the general community, people were very, some people were just very emotional about it, very, it moved them to tears, some people were just angry at the system, things, but as it got closer in to nephrology, and particularly the transplant nephrology community, it was basically crickets. I didn't hear anything.

But, what I found out when I was trying to get a job is that people were very much talking about it, just not to my face, and people were painting me as someone who took good care of my patients, particularly some of them, and the way I took that comment was, are you trying to suggest I only take care of my brown and black patients? So, they were basically trying to flip it and say, oh no, our system isn't racist, you're a racist. So --

SARIKA MEHTA: To you.

VANESSA GRUBBS, MD: Yeah, that's what they were basically trying to characterize me as before I went into my nephrology training. Thankfully, they accepted me into the fellowship for the kidney specialty before the article came out, and I often feel like, had it been reversed, had the article come out first, they would have had a reason to not accept me. But, two years later, when I was trying to get a job, I could definitely feel that that was getting in the way.

And there's a story that I tell in the book, where there was a patient who really helped change that feeling, at least in the mind of my current boss, who made the decision to bring me on board despite everything that had been whispered about me.

SARIKA MEHTA: It must be really difficult to advocate on those issues. I mean, what I'm getting at is that, in the book, it seems like you're colleagues and your attendings and higher ups were surprised, or maybe they knew, I guess maybe they were surprised you brought this information to light, that you were supposedly airing the dirty laundry of --

VANESSA GRUBBS, MD: Well, you know, I think --

SARIKA MEHTA: -- the medical world.

VANESSA GRUBBS, MD: -- a lot of medical centers and, you know, different places, they will acknowledge that there are race disparities in healthcare, but they think it's always somebody else that is creating them. People tend to think, we are good, we're doing right by everyone, the problem of race disparities is because those people over there aren't behaving properly. And basically what I was saying with that article was, like, no, it's us, too. We're not, you know, the system is just stacked against people, and I --

SARIKA MEHTA: And you're a part of the system.

VANESSA GRUBBS, MD: Exactly. Exactly. And so the whole thing really was amazing to me, and I was just astonished, because, you know, I can be quite naive, I think, because I thought that the system would take this piece and think, oh, well, here's a doctor that's saying this is how it felt to her, and so maybe we should take a more careful look at ourselves, and make some changes, but, no. Not so much.

So, it was very much a rude awakening, but at the same time, for it to upset people so much, I felt like, hmm, I am clearly onto something, and I firmly believe that nothing changes unless some people get uncomfortable.

SARIKA MEHTA: Yeah.

VANESSA GRUBBS, MD: And I feel like, hey, I shouldn't be the only one pissed off. You should be pissed off too, because that's the way we make things different.

SARIKA MEHTA: Right. At the the end of the day, it's affecting your patients.

VANESSA GRUBBS, MD: Exactly.

SARIKA MEHTA: And their care.

VANESSA GRUBBS, MD: And people that I love and care about, so, yeah. So what, they get upset, which is another leap that I took with this book as well.

SARIKA MEHTA: Yeah.

VANESSA GRUBBS, MD: Just to, you know, put it out there, because people need to know, and people need to, we need to do something about it.

SARIKA MEHTA: In fact, you've also written in the same journal on another issue that probably is never talked about, which is kidney transplantation in undocumented immigrants.

VANESSA GRUBBS, MD: Yes. Yes.

SARIKA MEHTA: So, tell us how the system works, or doesn't work, for this community.

VANESSA GRUBBS, MD: Yeah, unfortunately, I couldn't work that into this book, but maybe I'll get an opportunity to write about it more in the future, but, since I practice in the bay area of California, we have a large undocumented immigrant population, particularly since I'm at the public hospital, at San Francisco General. I take care of lots of patients because they're uninsured, because none of our systems even for Medicaid will take care of undocumented folks.

California is a little bit ahead of the game, because most states will not allow undocumented folks to have what we call standard maintenance dialysis, in that most states will make people just show up to the emergency room, and if they're sick enough, if they're near enough to death, then they will provide them with dialysis, whereas standard dialysis, that most citizens have in this country, is to go to the center, the clinic, three times a week, and have just dialysis, just because from our research and experience, we know that's the best way to take care of people.

Ultimately, the best way to take care of people with kidney failure is a kidney transplant, and even in California, the system does not pay for people to have a transplant. So that piece that I wrote about my patient was that, you know, this guy would be the ideal candidate for a kidney transplant, but because our system is such a mess, we choose to shoot ourselves in the foot by taking care of people in the way that is not only inappropriate in terms of standard of care, but also more expensive. It's much less expensive after say three years to take care of somebody with a transplant rather than to have them on dialysis, which is pushing $90,000 a year, whereas, you know, after the first couple of years, a transplant is maybe $20,000 a year.

And then to have someone come to the emergency room, you know, every four or five days, that can be four times as expensive as just dialysis, which is expensive enough. So, the fact that we do things that are not only in keeping with good humanity, but not in keeping with just keeping healthcare costs down, definitely says to me that, it just gets down to the underlying issues that we in this country have around race and ethnicity.

SARIKA MEHTA: I appreciate you bringing that up. I mean, no matter what your politics are, at the end of the day, your job is first do no harm, and also, no matter how conservative you are, this seems like the transplant is the most cost effective, least painful, as far as number of years of being treated --

VANESSA GRUBBS, MD: It's the best quality of life.

SARIKA MEHTA: Best quality of life, thank you.

VANESSA GRUBBS, MD: And, certainly, can afford the longest life.

SARIKA MEHTA: Right. What kind of feedback have you received on this issue?

VANESSA GRUBBS, MD: Well, again, the transplant community didn't say a word about that piece. But, you know, I have engaged in conversation with other colleagues who are very concerned about this issue. I don't think the paper's published yet, so I shouldn't say too much about it, but basically we compared people who are undocumented in our system in California, getting the standard dialysis care, versus, comparing to a couple of places where people only came in on an emergency basis.

And we show that mortality, or the likelihood of dying, for people in the emergency only system, was about five times higher than people who got standard care. Now, this is not surprising at all, but, I think the fact that this is the way we continue to behave, I think it personally bothers a lot of clinicians, it doesn't feel good not to do the right thing for our patients, but it's really difficult for us as doctors to try to figure out how do we do things on a much larger, on a bigger level, given all the political barriers that we're up against.

And, for my patients in particular, I do everything I can to try to, you know, get around the system, find out where the holes are so I can get people through. And it's really sad, too, because my patients, who are undocumented, they tend to be young, otherwise healthy people, because, you know, let's face it, people, they come to this country trying to find a better life, and they're working really hard, and then unfortunately, which I think is because they're so young, is due to a lot of environmental exposures from where they're from, they have this awful illness that really stops them from doing what they really want to do, which is work and provide for their families.

And because many of the people who come to this country are younger, they would have a donor, they would have someone who would readily give them a kidney, so our system won't even allow for people to give to one another, because they look at it as they're taking something away from citizens. And it's insane, because I think about, you know, some of my patients who, they just have all these rights and expectations, simply because they were born in a different place. And it's saddening, and sometimes infuriating. But, you know, my way of jumping up and down about it is to write and to call these issues out.

SARIKA MEHTA: How have you seen language barriers throw another wrench in the system?

VANESSA GRUBBS, MD: Yeah. You know, that used to be my focus in my research, before I decided to try to shift things to access to kidney transplant, and, you know, coming from, I trained -- I practice in a public hospital now, but I trained in a public hospital. I feel like, these are my people, this is where my heart is. And I could certainly see that, not being able to speak the language and the system not being able to accommodate that, certainly led to lots of misunderstanding, miscommunication, which of course leads to even worse outcomes.

I mean, I get that a lot of people believe you come to this country, you should learn the language. And I certainly believe that people get that. People understand that in order to get ahead in this country, you need to speak the language, and I would like to know how many of the people who say that ever tried to learn another language. I have been trying since middle school to speak Spanish, and I still cannot speak it fluently.

So, you know, it's a lot easier said than done, for most of us.

SARIKA MEHTA: Even if somebody speaks the language, they may not speak the language of healthcare.

VANESSA GRUBBS, MD: Exactly.

SARIKA MEHTA: And --

VANESSA GRUBBS, MD: And when you're not feeling well --

SARIKA MEHTA: It's a wash.

VANESSA GRUBBS, MD: -- when, particularly if you're really sick, people revert to what language they're most comfortable in. It's wonderful to get an opportunity to talk with you about these issues, because there was only so much I could pack into the book. But yes, there is so much, and one of the things I do point out in the book, particularly around race among blacks is, that can affect how people get to kidney transplant, is how we estimate kidney function.

And, I think at the end of the day, it fits in what people believe, so nobody really challenges the assumptions, specifically we have an equation. We use a blood test that gives us a creatinine, that's the value that we use to plug into an equation to estimate how well a person's kidneys are filtering their blood all day.

And there's one estimate in general, but then there's another estimate for if you're black, and that number is, it's -- the equation spits out a number a little bit higher, and where that comes from is a study, one study, that was done a couple decades ago, with about 1,600 people, 200 of them were black. And in that study, it was suggested that the creatinine values were higher in the black patients because of larger muscle mass. And because creatinine is also, like, released from our muscles.

And so based upon that, they made an assumption to apply this to all black people, everywhere, and suggest that only black people are different. Even though this study did not have Latinos, or American Samoans, or Asians, or any of a number of different people around the globe. And I always found that really disturbing, because, either you're saying that only black people are different, or it's not on your radar enough to even think about everybody else that's walking on the globe.

And the way that becomes an issue is, you can get listed for transplant when your kidneys are filtering 20 milliliters of blood every minute, so about four teaspoons. But when the non-race-adjusted equation says 20, the race adjusted one says closer to 25. Normal would be higher than 60 milliliters a minute. So, I describe a patient that I have who was quite muscular when he came to me, and I certainly believe that the race adjusted equation followed him, he was a black man, but then as his kidney failure progressed, part of that is people, they kind of waste away, they lose their muscle mass.

And I chose to do a more precise measurement of having him collect his urine for a full 24 hours in addition to getting a blood test, and that estimate came back to be the same as the not-race-adjusted estimate. And so why that mattered is, had I just gone by the "if black" equation, I wouldn't have referred him for transplant for probably another couple of years, and how long you are on that wait list is still one of the most important factors into when you get a kidney transplant.

And I will say that the system has tried to adjust a bit, in that a new rule went into place in December 2014, that said people, regardless of when they get referred for kidney transplant, once they're placed on the wait list, that date is backdated to when they start dialysis. Which, well, it did some to improve the disparities that we saw, because of people, of nephrologists, waiting to refer people for transplant, or for people with a low health literacy having trouble navigating the system and going through much slower, and resulting in what we saw in terms of blacks and other minorities taking much longer to actually get on the wait list.

So, that made a major improvement, but people don't start dialysis until they have somewhere between five and eight milliliters a minute of blood flowing, so that's like a teaspoon, a teaspoon and a half. But, the difference between one and four teaspoons may not sound like a lot, but it can be years, it can be several years. And if you're delaying people because they didn't have access to a nephrologist who looked at them and thought, you know, you would be a good candidate for kidney transplant, let me refer you, then you're costing people's lives, because, in this business, time is life.

And so, I point this out because I think people, clinicians, doctors, aren't really aware of it. We take these short cuts and we just own them, particularly when they fit in with our kind of conscious and subconscious beliefs that, okeh, yeah, of course it makes sense that black people are different, and they would apply that even if they're sitting in front of a slender black woman, but not apply it if they're in front of a white man who's a bodybuilder, which, you know, it makes no sense.

But, for me to bring these issues up, people, you know, it's just like how dare you, and, I don't understand why it is -- well, I do, but it saddens me that it's so difficult for us to come out of these things, when we call ourselves scientists. Like, race is not based on any science, it's some, you know, this social construct we made up to, you know, categorize people. It's not based on any gene. And for us to, as scientists, try to suggest that this correlates with some kind of genetic differences, is, I mean, it's just no different than what we did in this country to justify slavery.

SARIKA MEHTA: Right, I was going to say, it seems unethical in the medical world, and generally. But, well, I mean, on the flipside, you've had to navigate the system as a medical professional who is also a woman of color. Maybe just, as a closure, to remark on your experiences in navigating the system as a nephrologist who is a woman of color.

VANESSA GRUBBS, MD: Right. In some of the interviews that I've done, people point out that I was one of two black women in my medical class, which is true, but that's not new. From middle school, I remember in fifth grade, as soon as they put that label on me of gifted and talented, I was pulled away from the general pool, and I was always the only black girl. And, that doesn't feel good. It doesn't feel good, in the sense that, just the same as I didn't consider becoming a doctor because I didn't see anyone who looked like me, when you're the only one you start to question within yourself, do I belong here? Am I supposed to be here?

And then as I went through my education, of course people say to you, you're only here because you're a black female, all this kind of thing. And it took a long time for me to really tell myself, because I'm the first doctor in my family, so I didn't have a lot of people giving me all this positive feedback to counter what I was seeing in the world. But, it took a while for me to say to myself, you know what, they have these standardized tests. I have passed the same exact test that you have to get to where we both are, so I belong here just as much as you do.

But even still, when I was a -- in my nephrology training, there was one other woman, she is a Latina, and then myself, and, but I have been the only black woman who trained where I am since I -- I don't even know how long. I remember, I was told that probably, maybe, six, eight years before I came through, there were two black men that were able to go through together, which I can only imagine was a wonderful thing. And still, I'm the only black nephrologist on faculty where I am, and as far as I know there's only two in all of northern California, black nephrologists.

And where it plays in in the day to day is -- which is why I think diversity is so important, in all areas, and particularly within medicine, because I'm like the only one that's bringing up these issues. And, it's hard, it just kind of grates on you to feel like, oh my god, here I, you know, I'm the only one that notices that what is being said right now is a problem, and then of course immediately I'm the angry black woman.

So, you know, it's just -- it's not easy, but at the same time, I feel very thankful that I am where I am, because I do have an opportunity to be able to speak out against things, and to write about things, and to call attention to all of this, in a way that I wouldn't had I not followed my brother's advice to what, thirty years ago?

SARIKA MEHTA: Doctor Vanessa Grubbs, thank you so much for chatting with me on Intersections Radio.

VANESSA GRUBBS, MD: My pleasure.

SARIKA MEHTA: That was my guest, Doctor Vanessa Grubbs, author of "Hundreds of Interlaced Fingers: A Kidney Doctor's Search for the Perfect Match." And you can learn more at TheNephrologist.com.

To listen to the podcast of this interview, check out IntersectionsRadio.wordpress.com. Visit the same website for previous episodes of this podcast. And join the Facebook community at facebook.com/IntersectionsRadio. You're listening to Intersections Radio. I'm Sarika Mehta. Thanks for listening.

Yes! That was awesome.

VANESSA GRUBBS, MD: Okeh.