

Prioritizing Equity video series: The Root Cause & Considerations for Health Care Professionals

In the June 11, 2020, installment of our YouTube Prioritizing Equity series, join practicing physicians and leaders in health care as they share how they are addressing root causes of inequity during COVID-19 and beyond—by centering equity in their workspaces and dismantling racist policies and practices.

Moderator

- **Aletha Maybank, MD, MPH**—Chief health equity officer, group vice president, Center for Health Equity, American Medical Association

Panel

- **LaShyra “Lash” Nolen, MD candidate**—Second-year medical student at Harvard Medical School, serving as the first documented black women student council president at Harvard Medical School
- **Kamini Doobay, MD, MS**—Emergency medicine resident physician at NYU Langone Medical Center and Bellevue Hospital; organizer/founder, NYC Coalition to Dismantle Racism in the Health System
- **David A. Ansell, MD, MPH**—Associate provost for community affairs, Rush University; the Michael E. Kelly, MD, presidential professor, Department of Internal Medicine, Rush Medical College; senior vice president for community health equity, Rush University Medical Center
- **Emily Cleveland Manchanda, MD, MPH**—Assistant professor of emergency medicine at Boston University School of Medicine; works clinically in the Emergency Department at Boston Medical Center

- **Brian Williams, MD**—Associate professor of trauma and acute care surgery at the University of Chicago
- **Michael Mensah, MD, MPH**—Chief resident at UCLA Health and APA resident fellow member trustee

Transcript

June 11, 2020

Dr. Maybank: Good afternoon, everyone. Thanks again for joining in this episode of Prioritizing Equity, our series to really talk about and elevate and figure out how do we really center equity, really it was throughout this COVID crisis, but our crisis of racism and reality of that. And just overall, how do we center equity within the health care space? What do we need to do as institutions and what do we need to do as providers?

I am Dr. Aletha Maybank, and I am chief health equity officer at the American Medical Association over the Center for Health Equity. Our mission is to work to strengthen, amplify and sustain AMA's work as it relates to eliminating health inequities that we know are rooted in historical and contemporary injustices and discrimination. We do this by centering and embedding equity and practice and process action, innovation and performance, building alliances to share power for more meaningful engagement, ensuring equitable opportunities and conditions and innovation for marginalized and minoritized people, pushing upstream to address all determinants of health and creating pathways for truth, reconciliation and healing for AMA's past.

I want to acknowledge definitely the land that we're on and the indigenous people who have been here for thousands of years and their survival and thriving, and also for the recognizing our ancestors who were brought from Africa and slaves here in this country for the sake of free labor and really recognizing that I wouldn't be here, many of us wouldn't be here, if it weren't for all of these ancestors that came before us who opened the doors and pushed and fought hard for freedom and for justice. So, I want to acknowledge that.

Just a reminder that we have our health equity resource center on the AMA website, and some of this will be put up in the chat on the YouTube channel. And then also last week, if you didn't get an opportunity, we had a wonderful panel, a really powerful panel on police brutality and COVID-19 last week and we'll drop the link. And then next week we're going to be talking about LGBTQ experience of physicians as it relates to COVID, but also centering equity as well.

Today, I am totally excited and very honored to have the esteemed panel and really thankful for the folks being able to take time out of their schedule as practicing physicians to be here on today's panel.

So, first up we have LaShyra “Lash” Nolen, who is an MD candidate, second-year med student at Harvard Medical School. She serves as the first Black woman student council, president of the Harvard Medical School. She has published tremendously and just gained a lot of attention, I think, which is really important, but also just putting out some really strong narratives about where we need to go in the future and what needs to happen, especially with medical education. So, thank you for joining us.

Then we have Kamini Doobay. Who is an emergency medicine resident physician at NYU Langone Medical Center in Bellevue Hospital and organizer and founder of the NYC Coalition to Dismantle Racism in the Health System. Thanks, Kamini.

We have the Dr. David Ansell who is associate provost for Community Affairs at Rush University and the Michael E. Kelly, presidential professor, also senior vice president for Community Health Equity, Rush. So, thanks a lot, David for joining us.

Then we have Dr. Emily Cleveland Manchanda who is assistant professor of emergency medicine at Boston University School of Medicine and works in the emergency department at Boston Medical Center.

We have Dr. Michael Mensah, who is chief resident at UCLA Health and APA resident fellow member trustee and a co-founder of White Coats for Black Lives Chapter at UCSF. Thankful to have all of you on the panel.

We know last week, from my experience over the last week, I should say, we have witnessed this almost shocking to some way, like declaration by many health care organizations that racism is a public health threat. Like we've never heard this amount of organizations doing this. Honestly, I don't think I've ever really expected that to happen, but this is something that Black leaders, health equity leaders have been saying for many years, it's not new. And even if folks acknowledged in naming racism, what I find is that many in the health care sector are really unclear on how does that translate into action, like in the clinical practice setting and what are those dots that need to be connected? So what does it mean to really center Black and Brown people or center equity? What does it mean and look like to actively work to dismantle racist and discriminatory policies and practices all across health care?

Even we said that we were going to do as the AMA in a pledge that was released this past weekend. We've had some great resources kind of released over the last couple of days. MedEdPORTAL has the anti-racism in medicine information that's there and resources that folks should check out. And we'll try to put that in the chat.

Then yesterday there was a great piece of The New England Journal of Medicine by Drs. Rachel Hardeman, Eduardo Medina and Rhea Boyd. And they wrote a very poignant piece entitled, Stolen

Breaths, rather. In it, they recommend that the health care system at the very least needs to engage in five things as it relates to dismantling structural racism. And the first was divest in racial equities, and it's really a call for universal single payer health care, desegregate the health care workforce, understanding that it's still predominantly White at every single level. And we have to stop the racial exclusion that exists. Mandate and measure equitable outcomes, protect and serve our patients. And then the last one was really make mastering the health effects of structural racism a professional medical competency.

Today, I wanted to speak with a mix of med students, residents and attendings about, what does this look like to center in clinical practice? How do we hold our institutions accountable to anti-racist practice in medicine? We're going to go around in a way, but what I would just love to hear as I kind of open up every conversation to know where you are right now in the country and also just how are you doing overall? So we'll start there.

Lash, you want to start?

Nolen: Yeah, sure. Thank you for having me. I feel so honored to be around so many amazing folks who've been doing this work. I'm located in Riverside, which is about an hour out from LA. And how I'm doing—I oscillate between feeling really exhausted because I feel this need to like really get this narrative out there because for the first time that I've been alive, we're talking, we're naming racism, and it's always been unconscious bias. It's always been implicit bias in these conversations. But now we're really having honest conversations and I feel like I don't want to let this opportunity go. So I'm like, I need to write it. I need to get it out. I need to have this conversation.

I'm also hopeful on the other side, because we are having these honest conversations for the first time. And I think what adds to the exhaustion is the fact that I am a medical student. We have an exam tomorrow, and I've had to study and balance these things, but I do feel extremely fortunate to be living in this time and to be contributing to this conversation because I think that it's the first time in a long time that we've had real talk.

Dr. Maybank: Absolutely. And thank you for taking the time out if you were studying for your exams to participate today. Really appreciate that.

All right, Dr. Mensah, we'll go to you.

Dr. Mensah: Thanks, first of all, for having me, I really appreciate being invited to this all-star panel. It's really fantastic. I'm in LA. I'm in Westwood, actually. As a UCLA resident, I live very near on campus. And where I'm at right now is, it's somewhat to where Lash is in a sense that we're naming racism, and we're at least trying to hold institutions accountable in this, really a monumental moment in American history. And so from my end, I mean, what I'm trying to do is put a hundred percent of my energy into making sure that my institution understands that they're at the precipice right now.

Medicine's moral reputation is on the line, and with racism at the front and at the core of that issue, we need to do everything we can to fight that force. And if we don't, we really lose credibility, I think, in the eyes of our future children and future generations will look back on what we do. So, knowing that I'm really trying my hardest to make sure that our institution is on the right side of history, that's where I'm at.

Dr. Maybank: Thank you, Emily. Dr. Manchanda. Dr Cleveland.

Dr. Cleveland Manchanda: Thanks. Echoing what Mike and Lash said, I'm really grateful not just for being on this panel for myself, but really, to you, Aletha, for organizing this. I've been involved with the AMA for a number of years as a resident, and really a huge part of why I'm continuing to be involved in organized medicine is because of you and the Center for Health Equity.

Many of us, I think are feeling that sort of balanced tension between hope and optimism that we're actually having conversations in naming racism. I'm also, I'm flip-flopping between being really tired and trying to do as much as I can in these moments and trying to talk to, especially my White friends with family about like what this conversation is about, and feeling optimistic.

I mean, when I interviewed for faculty positions just last year, there were some institutions where I had to say that I wanted to be a health equity researcher. And at my current institution, in all of my interviews, I said, I wanted to research racist policy and dismantle it. And I used the word racism in all of those conversations. And that's a big part of why I'm at Boston Medical Center, because this is built into the mission of the institution, which doesn't mean there aren't ways we can improve. There are lots of ways in which we're not doing everything right, but I think it's really refreshing to hear a lot of other institutions that have not historically talked about this sort of joining that conversation and being open to having those conversations, both looking internally and talking publicly about it.

Dr. Maybank: Thank you. Thank you. Kamini. Dr. Doobay.

Dr. Doobay: Firstly, thank you, Dr. Maybank. You're truly a revolutionary voice in terms of moving forward to equity. Once again, like everyone else has said, I'm humbled to be a part of such a superstar panel, and I'm here to learn as much as I'm here to participate.

I am physically, actually sitting in NYU. I have a emergency medicine shift right after this. In terms of what I'm feeling, I echo what everyone has said. I'd be lying if I didn't say right now that I'm a little exhausted. It's been an exhausting week, emotionally, physically for many of us, but I'm also invigorated and rejuvenated. I think, in terms of medical culture, one that's really blemished by silence when it comes to racial justice and segregated care, it's really uplifting to see people break that silence together. And right now I think it's really, how do we go about translating awareness into action and making sure we first listen before reacting, listening to people that have been doing this work long before many of us have been born, Black and Brown organizers, the Black community, and centering

their voices instead of co-opting the mission.

So, I think in terms of doing this work in solidarity with the people that matter most, we know that those closest to the problem are closest to the solution as well. In terms of naming this a public health issue, that's a huge step, but to truly dismantle it, I think we need to really dismantle a lot of what academic medicine is about, which is unfortunately is a savior complex, lots of egos, blemishing hierarchy.

We need to reenvision what this system looks like and make sure that we stand for that oath we took on very the first day, which is to serve all people, do no harm and practice medicine with humanism and love.

Dr. Maybank: Thank you, Kamini. Dr. David Ansell.

Dr. Ansell: Well, I have a mixed feeling— I'm in Chicago, Illinois at Rush University Medical Center. I am angry. I am hopeful. And I'm sanguine. I am angry because once you see it, you have to act, and why does it take—We all got to watch another lynching. This is when we just get to all watch together for folks to see it. I mean, but sometimes it takes something horrific like that, really a national lynching that none of us want it to be at. And we all saw.

I'm hopeful because we've been on this path at my institution, but this has created an opportunity. I call it a break the glass moment. Like when you go into a medical record and somebody break the glass to have the conversations around racism, around it's not okay—we heard it. We're not talking about an implicit bias.

We're talking about anti-racism. We're not talking about being non-racist. We're talking about what Black Lives Matter means. What do the ideas behind it mean, and how you accelerate this work?

So it's amazing to be at this point, because we've been waiting for this, and to my partners in this work, we were saying, it's an inside-outside, anti-racism work is inside-outside. Meaning in the community, led by the community. The inside work is much harder to do, and you need a crystallizing moment like this to smash it. Because that's what has to be done.

Make no mistake. All of our health care institutions were built on a foundation of White supremacy, and that's what I'm sanguine about. So this doesn't exist for no reason, capitalism and racism and White supremacy are all tied together in a knot and is highly resilient.

I'm probably the only one in this group—1968 was a transformational moment in my life where we thought we could make great changes. And by the way, the words in those days were not Black Lives Matter, it was Black Power. And I'm just saying is, we're up against the resilient enemy here, so let's seize the day, let's break the glass, but we got to do it together. And we need actually White people speaking to the horror here.

Dr. Maybank: Thank you, David.

So I'm going to go to Kamani, because you said something about envisioning what does health care look like? What does justice look like? And what does it look like in the context of our health care system? And some folks who are really challenged with that when you haven't seen it, what does it look like?

But your advocacy over the years, I've learned so much from. I met Kamani when she was a medical student, and she actually organized to the point where her faculty, this was over five years ago, had to take anti-racism training, and also for the school as well. And they have a course that was set up and everything. And then as a student, she also started in the New York City Coalition to Dismantle Racism.

And it was through that time that I heard a lot about segregated care, that's been a lot of your platform. And so can you speak about segregated care, and how that shows up in your clinical practice? Because as I go out and talk to folks and physicians, they really just don't fully get that. And then we can talk later or now about what do we need to do to change that? But let's firstly, just understand how does segregated health care show up?

Dr. Doobay: Yeah, for sure. Firstly, I want to talk about quickly how we view inequities. And this has been a powerful concept, simple and easy to understand once you go through to this broken system, but Dr. Mary Bassett often refers to how we view these inequities.

And, I think, initially it was truly genetic. So Black people were thought to be genetically different or inferior to White people. And this was a need to justify slavery, clearly, but the abuse and experimentation of Black bodies. And then we moved to the lifestyles hypothesis, which is Black people are lazier or they're milking the system.

But truly who wants to live in poor housing? Who wants higher rates of asthma? Who wants poor food in their neighborhoods? Clearly the answer to that is no one. And the more accurate explanation is truly racism, not race the way it's perpetuated in research methodology, but truly racism and how that manifests in the system.

In New York City, and our nation as a whole, health care is truly segregated. What that means that hospital systems place profit over patients and truly can accept patients, turn patients away from their doors, based on their peer type, which is linked to their race. But when a hospital turns a patient away, they are truly making that statement that their lives are less valuable than anybody else's life.

So in New York City, for instance, if you have Medicaid, which is public insurance, or if you have no insurance at all, oftentimes you are shunted into a public hospital. So one of the Health and Hospitals Corporation hospitals in New York City. And if you have Medicaid or public insurance and you make it

to an academic specialty center, just because you happen to be there, you have Medicaid, you're shifted again into another segregated pathway, where you are not seen at the same clinic with patients with private insurance, but another clinic where you're seen by a rotating group of residents.

There's no continuity of care. There's no after-hours service. And oftentimes we've looked at internal data at a couple of the different hospitals settings, where you're waiting a lot longer for sometimes urgent appointments, longer waiting times on the phone and different outcomes altogether.

This is truly segregated care, where we're saying that the type of care you receive, the outcomes you have, are different. And we're allowing this because there's no accountability. There is this mandate that is not enforced that each of these institutions accept at least the percent of patients with Medicaid that the city has. However, once again, there's no institutional accountability. So this system is perpetuated, where we say we all are complicit in this very flawed system by the silence we have when we allow it to perpetuate.

So we have to call upon our elected officials, the state DOH and our institutions to accept all patients. Yes, access is one point, but there are many other structural nodes that connect, that lead to the inequities in medicine. So in naming racism as a public health crisis, a public health emergency, we also must name two very important issues, which is segregated care, and police brutality, public health emergencies as well.

Dr. Maybank: Sorry, I needed to unmute myself. Does anybody want to add to that and what was said? No? Okay, good. If you want to feel free to in a second.

What I want to know, Emily, I'm going to go to you is, I also met you and I had the opportunity to kind of visit and experience the Adaptive Racial Labs at the center where you are. And many of the things that Kamani just elevated were issues that are realities within the city that you are as well. And I was impressed by how you all found these ways to communicate across disciplines in very kind of forced, I don't know if it's forceful, but very direct ways of challenging and pushing each other to have exactly that kind of conversation that Kamani had.

So Kamani is giving us, and the audience, that information, but then, in your setting, there was like conversation back. And sometimes push back that was very uncomfortable for folks. And I think it highlighted what a hospital and health care setting can do to start having these conversations. Can you talk about that?

Dr. Cleveland Manchanda: Yeah, absolutely. I joined the Adaptive Leaders for Racial Justice group that was started out of the work that Dennie Butler-MacKay and Abigail Ortiz were doing at the Southern Jamaica Plain Health Center, which is a Brigham and Women's Hospital affiliate. It's one of the health centers in Jamaica Plain, which is the neighborhood where I lived. It was right down the street from my house.

And they put together a group of multidisciplinary, not all MD, everyone from students in social work and medical students up to senior faculty who were interested in building their skills and better understanding the ways in which we can dismantle racism in our practice.

And sort of the overarching goal is just that; is to identify and change policies and practices that perpetuate and strengthen racism in clinical medicine. But the way in which that unfolded was through sort of monthly conversations, meetings, sort of direct engagement with people across disciplines, to have conversations about what that looks like in each of our spaces, what that feels like. Bringing not just your mind, but your body into that space and creating a safe space in the truest sense of the word, where there is a group, there's a whole set of shared commitments to how we're going to have these conversations, what that feedback should look like. It must be honest and truthful, and you can presume good intentions, but also understand that you're going to inevitably hurt each other in having these conversations, and accepting whatever you put out there as it comes back to you is sort of a really important part of that.

And so through this group, we all got together as much as our clinical schedules could allow, over the course of now over a year, to have conversations about the ways that we saw racism unfolding in our space.

And some of this was small things, conversations with a problematic colleague. Some of this was huge things like where is our hospital system opening additional cardiology clinics, and which patients do those serve? And how does that shift payer mix, and how does that drive profit and not justice?

But through sort of some role play using real world examples that each of us was facing, practicing conversations with our imaginary boss, getting real time feedback. You sort of built, not just your skills and how to have these conversations but also shared language from people around you and pushed back on like, "Wait, no, are you actually trying to solve that? Because I don't think that that's how you do it." Just real conversation.

So that's been a transformative part of my own journey towards understanding how I can be an agent for change in racial justice work. And it's a really incredibly powerful group.

Dr. Maybank: Thank you. Thank you for that. And we'll come back to that because I want to talk about what you think impact, and has it made a difference in all of that as well.

Lash, I'm going to come to you now. We're all very proud of you and really thankful again for your voice and leadership. And Emily just mentioned, you know a change agent for racial justice, and you're definitely that. And I want to speak more with you about kind of just medical education. What do you think the opportunities are there, and really, what have you been doing?

Like what have you been, you've been doing a lot, but within the context of your school and education, what have you been doing? And where do you think we should be going?

Nolen: Yeah. Well, thank you. It means so much to know that you're proud of me. And I feel like really what I've been doing is just speaking my truth. I'm not a health expert or anything like that. I just finished my first year of medical school, but I'm an expert in my own experience.

And I've been keeping my ear to the ground and listening to the older students, who were at HMS before me. And just looking at the work that White Coats For Black Lives has done as well in the past. And just learning from the work that they've been doing. So first, I just want to acknowledge that I've been getting a lot of attention, and I'm thankful for that because the message is being amplified.

But I stand on the shoulders of giants and people who've been doing this work for years and years. So I'm just blessed to have the platform to really be able to get the message out there.

But the way that I think about the need for us to integrate anti-racism training in medical education, is with four main issues actually.

And the first one is the representation issue. And the first example that I saw of this is when we were learning about Lyme disease in class, we were only learning how to recognize Lyme disease on white skin. So then when a student raised their hand and asked, "Oh, how would I recognize this in a patient with darker skin?"

And the professor just said, "Oh, well, it's going to be a little harder to recognize, it looks purple." And then just kind of went on.

And then another way that this came up is when we were learning CPR. All of the mannequins had white skin. And then it came up again when we were learning anatomy, all of the images that we saw of the human body were White people. And I think that what happens is implicitly, you're sending this message, or it's a quite explicit message as well, that White people are the standard. And what ends up happening is that when we go out to serve patients with black skin, we already don't see them as human because that's not the way that we've been presented the human body throughout our entire medical education.

So I think that that's why Black people are prescribed pain medications at lower rates. And that's why people think that Black folks have thicker skin, because we aren't even being shown dark, black skin in our medical education.

And then the second issue is the way that we present statistics. Whenever we're learning about different issues in class, whether it's diabetes, whether it's COVID-19, there's always one slide at the end, and it shows how Black people, Latinx folks, and Indigenous folks are disproportionately affected

by a certain disease process. And then we just end the lecture there.

And usually an individual will say, "Oh, well, we have a long way to go. We have these disparities, but we're doing our best to fix it."

And that is an issue, because what ends up happening is we're only presenting the data without recognizing the structural oppression that contributed to those outcomes. And I think a lot of my classmates ended up leaving the classroom, thinking that Black bodies are inherently damaged or we were just born this way. And that's not true. It's because of the horrific actions of this country, and how that has manifested through the disease of our bodies.

And then the other issue is race-based medicine. I think it's so interesting that if you even go to websites like the American Heart Association, the way that they explain these disproportionate rates of high blood pressure and the Black community is because we have higher rates of diabetes and obesity. And the conversation stops there. Even when we learned about GFR, just these small ways of just showing just race-based medicine. And it's all adding back to this idea that Black folks are inherently damaged and we were just born different and in our bodies are not the way that they're supposed to be. And I think that all of this comes back to the fourth issue and that is the fear and fatigue issue. And what ends up happening is as a Black student, I'm the one who has the pressure to raise my hand and say, "Well, why don't we have representation of black skin? Why is it that we're learning that Black people are inherently damaged?"

And that then puts my academic opportunities at risk, or it's kind of like I'm exposing myself because I don't know how that professor's going to respond to me. I don't know how fragile their Whiteness might be that day. And I think that that is a challenge that many Black students face. And then after I had that experience, I then have to go find one of the 2% of associate professors who are at Harvard Medical School or at any of our academic institutions and say, "This is what happened to me today." And that individual is also dealing with the microaggressions they had to confront during that same day. So it then leads to fatigue. And I think Dr. Uché Blackstock, she wrote this piece about why Black doctors are leaving academic medicine. And I think that it all is just related to this cycle where we're not naming the issue, and we're not looking at how systematically we are contributing to systemic racism in academic medicine.

Dr. Maybank: Thank you. And overall, how has your school received you and your other students in kind of advocating and activism within the context of the classroom?

Nolen: I think that they've been a lot more receptive. I think that this moment has really prompted them into action. And I think what really helps is that our classmates are really with the action, and I think that that's been so awesome because you think of Harvard medical school, you think, "Oh, it's going to be a bunch of bougie kids whose parents were doctors," et cetera, et cetera. But even my colleagues who've never had to engage with these topics before, they are so genuinely willing to learn

and listen. And I think that my big thing is always protecting my energy. I'm not going to explain systemic racism to someone who I don't think is really going to get anything out of that conversation.

But my classmates, I think that they're really good people and they're really trying to figure this thing out. And I think that they've been so extremely supportive. They've been sending Anki cards, sending study decks to help Black students study during this time because they know that our attention and our hearts are in different spaces. So I think that faculty have been pushed to action because of the work and the support of students that we've had.

Dr. Maybank: Thank you for that. David, I'm going to go to you quickly now. In your faculty, your own faculty, you teach students in different ways, and it would be great to hear from you the ways in which you work to support students in doing this work as they navigate the institution as a start. And then also early on, you definitely talked and highlighted White supremacy as the other kind of root cause to inequities in this country, which is less used, way less used. We're just at the point of racism and we're barely there, but can you speak to your journey to that point because I heard you the other day be very honest and transparent how you were not always there. And I think that's an important part of evolution for many folks who identify as White. So that question, and then how are you supporting all students and students of color throughout this time?

Dr. Ansell: Yes. Well, thank you. And I'm really pleased to be part of this panel. So this is a moment for White people in general, White faculty specifically and White men extra specifically to step up and to take responsibility. When you look at any outcome, whatever it is, whether it be a clinical outcome or an outcome in the community, there's responsibility and there's accountability. And so this is a moment. I'm just going to tell you my own path. I mentioned we were on a call together, another panel. My family is in this country because my family in Europe, great grandfather and all the rest of the families, were victims of racism, antisemitism and this thing put in concentration camp and murdered. But when I grew up in this country as a White middle class kid, all the doors opened for me. I was hyper-aware of that past.

And when I went to medical school, I knew that I wanted to take care of poor people that brought me to Chicago and Cook County Hospital. It took me, and I've been now a practicing doctor for 41 years now, so long time, but it wasn't until I was about 55 or 60 that I actually began to name root cause racism. And then as I thought about it, while the root cause of racism is White supremacism, I began to think about it and then began to speak and write about it. And then I have to ask myself because I saw a video of myself from about 13 years ago. I've been working on breast cancer, racial disparity in breast cancer mortality, all of this stuff, but you listened to my words, it was a TV interview. I said, "Why didn't I say—" I talked about segregation and redlining and all these other words.

And I got to do a root cause analysis on myself. And if you ask why five times about anything you can get to the root cause. Why didn't I want to say it? Well, I didn't feel comfortable. Well, why didn't I feel comfortable? Well, I hadn't had the opportunity to speak. Well, why haven't I done it? Because the

people around me in the room, I didn't want to offend them or do anything. Well, why didn't I want to do it? And at the end of that why five times it's because I'd been invited into the room largely because of my phenotype and my melanin content. And I just realized like anything else in life, if you want to get better at it, you practice it and speak it, speak it, speak it. But also got our organization to name it in our community health needs assessment.

When we did it in 2016, named racism as a root cause of the poor health of our patients in our community. So that was it. So how do I support students? Well, the students have actually organized a group called SO FAR, which is Students Organize to Fight Against Racism. And one of their demands is we have a White Coats, Black Lives chapter, and one of the faculty reach out to White Coats, Black Lives and found out we actually had a chapter here, and she asked me, "Well, who was the faculty? Who is the faculty advisor?" It was me, but so these things tend to go round in circles. But as I look at this work ahead of us, so dismantling is very, very difficult because these are deeply embedded into all the structures and foundations in day to day policies and procedures.

So I'm looking at the way that we have to frame this is I think people, patients, policies and places is the way of how do we break this down as people? That's our faculty and our staff. It goes from how our low wage employees who are Black and Brown have opportunities. How do we get people into the professions? How do we change the way we hire faculty? I mean, all of these things that are deeply embedded and then our patients, we've known about health inequities for—the 1980 was the first year I discovered this deeply. And yet we do not collect data and present it up to our boards and systematic ways that looks at race, ethnicity, language, ableism and other things.

And we need to collect data because all of the work that ever been done is you have to make what seems to be invisible actually visible and then hold people accountable to the outcomes. Places, all of our places, wherever we have offices, wherever we have buildings, we need to make sure that these places we're organized around no matter where we are and ask the question, "Who's at the table? Who's not at the table?" And then I'll just the processes. It all comes down to the way that our rules are written. And we're going to have to really look at policies. When you think of an employee where you dock someone, if they don't clock in five minutes within the hour.

And so our Black employees are more likely to be disciplined because of public transportation or we charge fees. Here's a good one. Our charity care policies only apply to hospitals, but you can actually make them apply to your clinics. You just have to force the issue. And then there's the copay issue. Who has to pay a copay and by race and other things as well. So that's the dismantling thing and our students can be helpful in every one of those places.

Dr. Maybank: Thank you. So Doctor Mensah, you're in California. You've been cofounder of White Coats for Black Lives at your institution, but also what really attracted me recently is an article that you all published in the Scientific America with a whole collective of physicians across the country at George Floyd's autopsy and gaslighting in America. And the power of the article to me, it was just

tremendous, but it was a call to action for us as physicians and as all physicians working in institutions and the responsibility and the accountability has been mentioned over and over again that we have to have for our own system and amongst each other and how we report out information and data. So can you just talk about kind of that piece and how it came about and the physicians on that piece? You don't have to go into detail every physician, but just what types of folks are there?

Dr. Mensah: Well, I mean, I would say that piece—first, thank you for asking. And I would say that piece has a downstream effect of what Kamini and LaShyra really talked about, which is getting a medical education curriculum that acknowledges racism for what it is and not what we want it to be, not what we are comfortable hearing. And as such the people who joined that program including Anne Crawford Robert, she was a very important person, brought us in. She's White. She came from Mount Sinai. She was totally about anti-racism. And as a result, as soon as this report came out, she emailed us and was like, "We have to write something about this." She used her network, brought us in and then we got to work. And she had colleagues who knew what she was talking about because of that curricular work that we've all done and Kamini's done and LaShyra is doing.

And it's extremely, it was so heartening for me in a very dark time as a Black man to see that my colleagues care so much about this issue that they would spend the time after a shift two in the morning, three in the morning editing a piece of work. And we also had very, very talented and very skilled people who could write and with a powerful voice Sonya Shadravan, Nicolás E. Barceló, Jennifer Tsai, they did a really good job, really illustrating that issue. I think from my perspective, when it comes to these issues and bringing it up, I think the status quo right now is that physicians see themselves as a-political. They don't see what they're doing as politically super relevant. And they see themselves as morally justified in good because they're taking care of people, which on one hand is true, but the system itself must have a political position because I mean, health care takes up 20% of GDP.

I mean, we're a humongous force in the economy and we're going to be used one way or another. And I think with the piece, the power of the piece, apart from it being extremely well written and telling the truth about what happened about George Floyd and refuting the autopsy report, which said that he might have had some drugs, or he might've had some heart disease talking about the chronic disease hypothesis and bad habits that led to his death that actually in reality, it was clearly about him being asphyxiated by that officer's knee. And having to clear that up is great. And I love the article, but as they say, the first lie wins. And if we're part of the status quo that's putting out lies about things that are obviously untrue, then where do we stand politically?

And I think the whole point of the article was to move people to say, "Okay, we actually do have to take a step forward and be explicit and active about our activities and our moral position regarding racism and White supremacy because if we don't, we are part of that system." And the so I think that was the power of the piece. I think the demonstration of the piece with several White allies and non-

Black allies coming together was fantastic. And I think, ultimately, it's going to be brought to bear on institutions we're associated with because we do have a voice now as demonstrated by us being on this panel, and it's not going away. I don't think any of us are going to allow this to go away. So we're going to keep pushing out is White supremacy and creating attention that Dr. King talked about in his letters from a Birmingham jail, so that people move.

Dr. Maybank: Absolutely. So Kamini, I'm going to come to you because I know she has a shift starting in about 15 minutes, but she's still graciously spent the time with us. And I really want, so building on what you just said, Mike, what does that accountability look like? What does the system look like that's not segregated? What should we be asking for and what should we be doing to desegregate health care?

Dr. Doobay: Yeah, that's a powerful question. And I think the answer truly is rooted in the community. It's rooted in the core of what I think activism really is, which is listening. Michael just said, "So often we sit in this ivory tower, we sit within our institutions and because we treat everyone that makes it to our doors, we feel that we're doing right. We're not perpetuating harm." But we have to think critically about who is not making it to our doors and why. And I think part of that is really coming outside of this box, breaking our whatever it is that makes us uncomfortable to speak about these issues with each other in order to then combat and dismantle it. So we've talked about policy, we've talked about all of what's needed in terms of changing it. And we can definitely go into details about that off the air. And I hope that we all do that.

But part of it is truly challenging institutional culture. Right now, I'm sure at all of our institutions, we're having these conversations that we've never had before. And part of it is awareness. But recognizing that once again, we can't just jump to actions that provide superficial answers and garner a little bit of publicity for each of those institutions and, moving forward, reputations. How is that in solidarity with the communities that we took an oath to serve? We recognize that White Coats for Black Lives have been doing this nationally. I say, Aletha, but Dr. Maybank, you are the chief health equity officer at the AMA. The AMA is putting out publications now that we've never seen, we've seen public health organizations doing the same and societies all across the country in terms of emergency medicine in each of these subsets specialties, doing that.

So now it's on us and to bring people in and like the People's Institute for Survival and Beyond commonly says, it's not just about networking, but it's about building a network that truly works. So that's in solidarity with the community, for the community to make sure that nobody truly falls through. And I think that, that's what we're hoping to do right now in terms of naming all these things. Work together with the people that matter most, they matter most because for 400 years their voices were lost and unheard, and it's now time to take a step back and amplify those voices bring people in, but also go outside of our institutions to join community meetings, to protest on the streets. And I say for all of those people in white coats right now that are on the streets, I think that is so important. It's so

important for me to stand right beside my attendings in the streets, fellow medical students, social workers, nurses, but each of those public demonstrations must be tied to actionable goals. Must be tied to some effort to hold this institution accountable. If not, it's just another publicity stunt. And if that's what we're hoping to do, then fine, this will last another two weeks and then great.

But that's not what we're hoping to do. We're really, right now at a critical point in history, where we can translate all of this awareness into action. And I think we need to dedicate ourselves into doing that and realize that we can't keep putting the burden on people of color, especially Black organizers. I'm grateful for the people on this call that are Black organizers, but it's on every single human being, because when you entered medicine, you took this oath. And at the same time, every single person that you're standing in a room with in the emergency department or the clinic, they are giving you the privilege to practice medicine and bear witness to their suffering.

So if you're taking that seriously, this is not just about a job to uplift your personal careers. This is about the opportunity to serve them in a meaningful way. So I call upon my fellow practicing physicians, medical students and beyond to recognize the power and privilege of your voice and that oath you took. And I think that if you truly recognize that, like everything else, we're now treating cancer, we're developing technology. So why is racism so hard to name and combat? We can do it. We just have to do it meaningfully and hold ourselves accountable.

Dr. Maybank: Thanks, Kamini. Dr. Doobay. Absolutely. And if you have to jump off, we totally understand. We will not take it personally. David, I'm going to come back to you. I just want to see Emily or Lash have any comment to that as well, first. Just to balance out the conversation.

Dr. Cleveland Manchanda: Yeah. I mean, I just want to echo what Kamini said. I mean, such a powerful statement that like, this is on us, right? This is on us as individuals and collectively as clinicians. And we can approach this from the same way that we approach many of the other health problems that are new, that emerge, right? Fifty years ago, clinicians didn't know how to treat HIV, right? Because it didn't exist. And so for those of us who are just waking up to the idea that racism is still a problem in America, and I know that there are a lot of white clinicians out there for whom that is true. You can treat this like educating yourself for any other thing that you have to treat in your clinical practice. And the way that you start from there is educating yourself. There are so people who have put out there, it's not just a reading list, but powerful pieces, whether it's an audio, whether it's a video, whether it's a book, to educate yourself on how to understand racism in America and your role in it. And that's a really challenging process, I think for a lot of White people, because there's an immense amount of shame that comes out of realizing for the first time that this exists and that you didn't know about it. And that you're part of the problem. And sitting with that, is really challenging.

And so I would encourage any of us who are a little further down the path to reach out to your White colleagues and offer yourself up as a person that they can come to with questions. So that, that burden of explaining things doesn't fall onto our Black and Brown colleagues, because this is not their

problem. Racism is not a Black person's problem, right? It affects them, but this is a problem created by White people in America. And it's perpetuated by our actions much more so than anyone else.

And so having people who look like me or who look like David, to go to and to ask questions of and to ask for guidance, I think, can be a powerful way of changing things and moving forward. So whether it's about a small policy in your department or whether it's an enormous policy, like not having single payer systems, I think we can all do our part to make sure that we are on the right side of history as this moves forward.

Dr. Maybank: Thank you, David.

Dr. Ansell: I love actionables, next steps. I mean, that's kind of how my brain works and Michael terrific article, it was really an amazing article and there's just a video cam in I think New Mexico, a Latinx person. And it was said, methamphetamines contributed to the death after he was choked by an officer. So history repeats itself. So what are a few things we got to do? One is this issue of desegregating clinics. So segregation, every hospital I said in the United States pretty much except Black hospitals were based on White supremacism and segregation was commonplace and only Medicare forced hospitals across the country to desegregate, but we have segregation going on in all of our hospitals. And so number one is, this next way we could all take this on where it exists, where the resident clinics and Medicaid patients. So that's one thing we can take on.

Demand that our organizations take a stand, become anti-racist, commit to becoming anti-racist institutions and not to mince words about that. It's a long path, it's not an easy path, but you have to make that goal. And nationally, I think we have an opportunity, unfortunately, with COVID that so many people are going to be unemployed, the unemployment rate, is single payer health care does not solve racism, but it actually equalizes this. And we have to push within own organizations, access to care for the uninsured. And those on Medicaid by every specialist. And so we can all do that in all of our organizations. And if that got taken up, that would be huge next actionable steps, while we're dismantling all the other places we have to dismantle.

Dr. Maybank: Absolutely. Mike and then Lash, I'm going to have to kind of close out for us in a way we're almost at time. These hours go by very quickly. Michael, do you have any comments related to all of that and just closing comments as well?

Dr. Mensah: Yeah, I mean, I would say first off, thank you for having me. Secondly, I think holding institutions to an anti-racist standard through material incentives, giving those doing the work the time and the space to do the work, to reduce the minority taxes is one of the actionable items that can be done, I would say fairly quickly and would make a big difference in how much work is done and how many actionable items and deliverables we can provide within the academic setting. And I think, UCSF is doing some work like that with the diversity of Dean's fund, giving out one 1.6 million dollars. I mean, I'm sure we can do a lot more than that, but the minority tax that I see my mentors pay is

tremendous. And along with enjoining with anti-racist White people, we also need to value this work much more than we do right now. So that's what I would say, actually.

Dr. Maybank: And can you just quickly explain what minority tax is for folks who are, who have no idea what that is?

Dr. Mensah: Right.

Dr. Maybank: And actually, probably think it's something financial.

Dr. Mensah: Kali Cyrus wrote an article in 2017 in JAMA explaining that minority taxes is the work minorities are charged with doing in order to make the diversity and inclusion values and many mission statements a reality. So anything from recruiting your colleagues of color to come to the institution, to writing a diversity statement or statements about George Floyd in the shooting and what we're going to do about it and thinking about those policies and trying to enact them without any political or institutional power. Because of course, you're working so hard to do all these things that aren't valued, that you're less likely to be promoted and you're less likely to be valued in the institution, so.

Dr. Maybank: Thank you. I'm sure that's helpful for many. Lash, you're going to be in the game the longest out of all of us on this call potentially. And so, what are you kind of looking for forward to kind of doing and like what you want to see at this point in time?

Nolen: Yeah. Well, the first thing I think is so important to recognize how much it took for us to get here, to have these conversations. Like it took centuries of suffering, it took a global pandemic, it took multiple lynchings. And it took people being in quarantine to have to reflect on anti-racism. Like finally, *How to Be an Antiracist* is finally the number one bestselling book with New York Times. That should have been the case. And I think understanding how much it took for us to get here is so emblematic of the systemic racism and how these systems have been so implicit in this process. How that has just been so silent. And finally it's coming to light, but we need to recognize how much it took for us to finally recognize these things.

The second thing is like, we need to keep the same energy. Like I think everybody is coming out with statements. NASCAR's even recognizing—

Dr. Maybank: Right, yes.

Nolen: I was like, "Whoa."

Dr. Maybank: Right.

Nolen: So now, it's like anti-racism is now the status quo, but I'm like, "Okay, that's awesome. But I need to see a two year plan. I need to see a five year plan. I need to see a 10 year plan. How are we going to continue to do this active work?"

Even when I was premed, like we had to have a research requirement and even in medicine in general, we're always taught that it's deferred gratification. When you fail, you have to get back up and you have to be patient. But for some reason, people don't want to apply that same practice to anti-racism work. We want cursory solutions.

So we need to make sure that we keep the same teachings and the same foundation that we've held core to becoming a physician and working in medicine and research to the work of anti-racism. And that's what I really want to see. I want us to continue to do the work, continue to reflect on it and not make this just a conversation in 2020.

Dr. Maybank: Absolutely. Yes, thank you. And I thank you all for being on the panel today, taking the time out of your busy schedules, of course. Being leaders, challenging systems, challenging people, challenging ourselves, of course, all the time. And just know that I have been watching you. And I just really honor all of you. I thank all those who have tuned in for today to watch our panel, it will be available probably a little bit later today. Last time was available within the next hour. So who knows it could be then and encourage you to share it around.

Because I think these are opportunities, actually, that these conversations need to be embedded into medical school education, right. They shouldn't be segregated from that context of learning. So we are going to find ways to make sure that these become educational materials. So that they're accessible as well. So I thank you all again for contributing...

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