

Prioritizing Equity video series: Accomplices and co-conspirators

In this July 12, 2021 Prioritizing Equity discussion AMA Chief Health Equity Officer, Aletha Maybank, MD, MPH, is joined by a panel of experts to examine the ways that white physicians can get actively involved in the fight for racial justice. Learn how doctors can become accomplices to advance equity.

Read the AMA's strategic plan to embed racial justice and advance equity.

Panel

- **Kimberly D. Manning, MD, FACP, FAAP**—Professor of medicine and associate vice chair of diversity, equity and inclusion at the department of medicine at Emory University School of Medicine
- **Bay Love, MBA, MPP**—Partner at the Groundwater Institute and organizer at the Racial Equity Institute
- **Esther K. Choo, MD, MPH**—Professor at the Center for Policy and Research in Emergency Medicine in the department of emergency medicine at Oregon Health and Science University
- **David A. Ansell, MD, MPH**—Senior vice president and associate provost in community health equity at Rush University Medical Center

Moderator

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

Transcript

July 12, 2021

Dr. Maybank: Good afternoon everyone and welcome to Prioritizing Equity. Today my name is Dr.—well, my name is always Dr. Aletha Maybank. Today, I'm really excited about the guests that we

have. We are going to be talking about what does it mean to be an ally, an accomplice, a co-conspirator, whatever term one feels and chooses to use, but really what does it mean to show up in this space of doing racial justice work, gender justice work, justice work overall in the health care space.

I think many of us who are leading this work for a long period of time are really needing to have more support, always. More partnerships, always because this work can be exhausting at the end of this day and life, and we need more people to show up. And so I've brought together some fantastic folks to really talk about this. So let's get started.

We have Dr. Esther Choo who is a professor at the Center for Policy and Research in Emergency Medicine in department of emergency medicine at Oregon Health and Science University. We have Dr. David Ansell who is senior vice president and associate provost in community health equity at the Rush University Medical Center. We have Dr. Kimberly Manning, who is professor of medicine and associate vice chair of diversity, equity and inclusion at the Emory Department of Medicine. And we have Mr. Bay Love who is partner at the Groundwater Institute and a trainer rather at the organizer—and organizer, sorry—at the Racial Equity Institute who we work with very much and we'll talk about that as well.

Welcome everyone. Good to have you on. Usually I ask how you all are doing. And it's not that I don't care how you all are doing, but what we're going to do is as you start to talk. Please share how you all are doing, but there's so much that we want to talk about today and I just really want to get definitely into the topic. But thank you all for joining.

So I'm going to open this up really to all of you and really from your perspective, what does it really mean to be an ally, accomplice, co-conspirator, which term do you use in this work and then what is really the most helpful narrative around kind of this term and these words of allyship and co-conspiratorship? How about Dr. Manning, can we start with you?

Dr. Manning: Okay.

Dr. Maybank: I've put you on the spot.

Dr. Manning: No, that's okay. I'm in Georgia so it's nice and hot and humid here, and I'm well and I'm healthy at a job I love, so I am doing okay today. But I'll jump right in and answer the question, and that is that it really depends on the circumstance actually what word I like as it relates to fighting particularly anti-Black racism and all forms of racism. I like the term co-conspirator best because as I think about an ally, I think of an ally as somebody who is kindly stepping in to help someone and really the main thing in it for them is that they are being helpful. And that could just be my own interpretation of it but that is how it feels to me.

A co-conspirator I think is someone where it's something in it for you. It's your mission too. You have

to be involved in it because there's good that will benefit everyone. It is not just me stepping in to help you with your thing. But there are some circumstances where your identity in a certain situation is one that allows you to be both an ally and a co-conspirator at the same time. So as I think about my Black trans sisters for example. I'm not a Black trans woman, I'm a cis-het Black woman but I am an ally to them. But if you are mistreating anyone, it impacts me and my life too and the world that I'm in too with my children and my family. So I also have to be a co-conspirator as it relates to your treatment and how we're going to fight against it.

And so, I tend to lean more towards the word co-conspirator but whatever word it is, whatever you call it, I welcome you to come stand beside me and care and let that show through your actions and your deeds. And if you wish to call that being my ally, then cool. But I think the key of people understanding that racism is hurting more than just people who are historically marginalized, it's hurting everybody and I think a co-conspirator would see that.

Dr. Maybank: Thank you Dr. Manning. Appreciate that. Dr. Choo?

Dr. Choo: Yeah. I love the way that Dr. Manning just reflected on that. I also, I sometimes struggle with language because I always feel like when you say accomplice or co-conspirator, that's usually used to imply that you're doing something illicit. When I yell at my kids, I'm like, "Who was your accomplice in this because I know you didn't do it alone." And I think I just kind of carry my own feelings into it, whereas this work is just and right and good and I've been using co-owner a little bit and just playing with language but ultimately I agree with Dr. Manning—which is if you're here, you're doing the work and you recognize that this is an investment in yourself and the ultimate goals that we're seeking here, then take the name that feels right or better yet maybe you don't declare yourself to be that thing. You let other people see your work and declare that that is what you are because I think sometimes people label themselves ahead of the work. So maybe focus on the work and then see what people start calling you because they see that you deserve that title.

Dr. Maybank: Thanks for that. So Dr. Manning mentioned how this is not just really the work of, I'm paraphrasing, but Black and Brown people, marginalized communities. And Dr. Ansell and Mr. Love, I would love for you to speak about this kind of under emphasized narrative for white people around how racism negatively impacts them and really why should it matter for them personally and really advocating for our just society. Dr. Ansell, can you speak to this first?

Dr. Ansell: Yeah. And if I'm not answering your question, please redirect me because I'm reflecting on the two prior comments.

Dr. Maybank: Well, you can continue on that as well. I will not cut you off from being able to reflect from that.

Dr. Ansell: I just want to riff a little bit on what was just said because in many ways words get assigned to you and talk itself is cheap but action is what counts, so I wanted to put that out there. So

naming things is critically important but action is more important.

I think because we've normalized, we've all normalized the deviance of white supremacy that we would view this action of co-conspiracy in a way because we feel it reflects in some ways the inverse of how we should feel which I like what Dr. Choo said. It's really, it's up to all of us to co-create the world that we want. So these are in the negative, not an ally as such, but I would like to view us as co-design, co-produce, co-create. So just reflecting on that.

Part of as a white man and as a leader in health care and someone who was astutely aware of racism and other forms of exclusion, it took me many years to speak about it and I think there's—we have, for me, it was critically important that I publicly speak not only to name racism but to name why it took me so long to speak and then make the point that this is the work of white people or people who've been assigned to power and whiteness. I'm not going to go into all of that but I did my own root cause analysis on why I, even though I was aware I didn't speak.

But speaking is critically important, particularly for white leaders or those who've been assigned white because we have to create new institutions, we have to re-design, we have to dismantle. And that's going to require the application of immense will and force.

I don't know if I answered your question but in the end, we are all suffering as a result of this toxic heinous condition that we're under and it's our job to point out the deviance of our current state and then work together to find what are the solutions, what are the next steps.

Dr. Maybank: Thank you, Dr. Ansell. One of the things—Mr. Love, I reached out to you about a month ago when our strategic plan, the AMA's equity strategic plan came out. And it was clear not everyone was going to be on board initially with this plan. And it wasn't just folks within the AMA but there was feedback across the country and articles written by certain folks really expressing and sharing that this was reverse right racism and very political. And I called upon very intentionally many of my colleagues who identify as white to kind of help support myself and the AMA team at that time, our communications team, to think about what is the right frame and what is the right language for us to move forward and not make those assumptions. And you and several others are very helpful in that. And so I would just love to hear from you as well what are your frames for folks and how to help folks who identify as white to understand that this is their work as well.

Love: Yeah. And I love all of the responses, what my colleagues here have said on the phone. It's just very resonant. Dr. Manning what you said about, and actually Dr. Choo what you backed up too and said, on one level, we should talk about terminology, on the other hand it doesn't so much matter. What really matters is how we get into the work.

I am lucky at the Groundwater Institute to work with Black women who are in leadership of the organization and who are most of my colleagues. And they prefer not to use the term ally. And I'm cool with that. That's okay with me. If we don't want to use that language, that's fine. I have other

colleagues that I work with and friends that I work with here in Maine, where I'm from, who do like to use that terminology and I'm sort of happy to use that terminology there.

And I very much appreciate, Dr. Choo, what you're saying about, for me in some ways, if someone feels I'm their ally, that's sort of on them to declare. It's not, "Oh, I'm an ally because I think I'm doing this," or, "I think I do that," or "That's my intention." I've come to learn that what I intend to do is often very different than the impact that I have on other people and usually other people are a better judge of the impact I'm having on them than I am simply because of the way that my personal experience works. I just sort of second all that. And Dr. Ansell, your points about speaking to it being important I think is absolutely critical.

I have come to really believe for myself what some of my colleagues of color told me very early on, which is that ending racism in the systemic sense is not just in the interest of Black and Brown people as you said Dr. Maybank but it's in the interest of everybody, in the interest of me. And I had to really think about that, is that really true? And what I came to ultimately is that it actually is very true. Because for me personally, I'm a person. In this system I'm identified as white, I'm identified as a man. I don't get to choose those things. I walk into the doctor's office. They check white for me. They don't ask me are you Black today? Are you Hispanic today? Like that person is white and they check it for me. It's like the system identifies me that way.

But what's in it for me? I'm a person that's identified that way, racialized that way but I feel American to the core, if you will, in that I believe in some of the ideas of this country. I believe in science. I believe in saying, hey, we ought to have a separation of church and state. That's a good idea. And we ought to base thing in facts and in science. And I believe in democracy. I just believe that people ought to be able to govern ourselves. I mean that's an ideal that I would fight for and I hope to fight for. And I believe in things like life and liberty and that people ought to be able to pursue happiness with that in the way that that looks to each of us.

And I think if I really analyze it and I did a similar root cause, Dr. Ansell, I'm always asking myself what's going on here. And I think the way that racism divides us and makes us feel like these problems are someone else's problems and not our own, prevents us from being able to get together in a way that we can deliver the promises of science, the promises of democracy, the promises of life and liberty and happiness for all people.

So in that way, the idea that white people could only be allies as in helping somebody else by working on racism is in some ways the greatest confusion that we've ever suffered. Because as long as we believe that someone else doesn't have access to democracy, we don't understand the way that white people, that our democratic rights are being curtailed as they are being sort of sliced away and threatened and we are buying into the illusion that that's only happening for people of color but it's certainly happening for us.

And I can list very specific examples of Medicaid expansion here in Maine and like my mother's

somebody who benefitted from it, my family in many different ways have benefitted from it. And it was a racialized debate here. The idea that it was people of color are going to benefit made it harder for us to get something past something that's benefited me very much personally. So there are lots of kinds of things, but that's how I would sort of open up and appreciate the question.

Dr. Maybank: No problem. Anybody have any—I don't want to cut anybody to respond or anything or add any—

Dr. Ansell: Or just to add to that if you think about it because I do think this is an important question of understanding, take the most recent laws to restrict voting rights that are really directed against Black people, people of color, but they affect everybody's voting rights in the end. Anyone who has trouble voting, look at the cost of our carceral system and our life expectancy gaps on the economic, the wealth creation for the whole country, I think it's estimated \$3,000 per white person in this country because of racialized inequities.

Look at our health system and our social care system that have been designed to keep people out and therefore there's hardly a middle-class white person in this country who doesn't die poor because their money runs out and they go to a nursing home. So we're all affected profoundly by this. And by the way, we're a country in which there are political rights but not human rights that are well established—the right to health care, the right to housing, the right to a living wage. So there are many ways in which everyone profoundly suffers because of this, again, the toxic brew of white supremacy in this country. And so that's hard for people to see but that's our job though honestly, is stating the narrative as it really is and how everybody suffers.

Dr. Maybank: Thanks for that, Dr. Ansell. And speaking of narratives. Dr. Manning, I'm going to come to you. So go ahead, go ahead.

Dr. Manning: No, I was actually just going to add that very, very briefly that I think the pandemic has been the perfect metaphor for how connected we all are. As things start to sort of open up a little, if you will, and people are starting to feel "normal" again and you realize that there's still a lot happening all over the world, this has been a worldwide pandemic. One group of privileged people being okay is not going to fix this. It will not be fixed unless we're thinking about everybody everywhere.

And so I find that it's just interesting as I look at, think about the pandemic and think about it and how it connects to racism and discrimination and all of these things. I'm like it's not good for anyone. This is just a very concrete example of how it spreads and how pervasive it is.

Dr. Maybank: Thank you. So to build on ... Dr. Ansell mentioned about narrative and the importance of narrative. So you're doing some work, you and another physician just launched the podcast, The Human Doctor, and I'd love for you to talk about that and kind of your intention of what you're trying to do with that. But can you speak to kind of the narrative change work and the importance of narrative in the space of dismantling racism?

Dr. Manning: Sure. I'm really delighted to be working with a colleague out of UCSF, Dr. Ashley McMullen who identifies as a Black queer woman. We met actually when I was on a visiting professorship there and recognized how important it is when people show up as their entire selves.

So on this podcast we are both academic internists. We talk about things that we've learned and we talk about our hair. We talk about all sorts of things. But then we launch into things as they relate to medicine but from our unique perspectives, speaking as we speak, being as we are. And we believe that that welcomes everyone to do the same in their spaces so that you can free up some of that cognitive effort that you're spending on code switching into bringing your entire self into a space so that you can care for patients and do more.

As I think about the narrative piece though and what we can do in our unique roles. I'm a clinician educator. I work with medical students and residents. And even as I tell a story on Twitter or something like that, I think about first what is your sphere of influence. I think we all have one. And that is different depending upon your identity.

My identity as a Black woman who was educated at historically Black colleges and who's from Inglewood, California—my first language really is sort of a form of African American vernacular, how I think what is, my life lens is very much rooted in the Black community and the Black experience. And so it benefits my patients and my learners when I bring that into a space.

Now, with my influence now that I'm a senior faculty member, I often start off with my teams by making sure that we are all on the same page about what we mean when we say racism because I think that in itself creates reflection. As you know, and you are too a big fan of Camara Jones. She says, and I paraphrase, but she describes racism as a system that assigns value and structures opportunity.

And just saying that to a team what it does to them is I say now we're just going to all take a moment to think about where have you been assigned value just because of who you are? What opportunities have been structured because of that? And as we walk out and to take care of patients in this hospital, how can we use our sphere of influence and also whatever our assigned value is to do more and be more and stand up and try to shake things up?

Now, as you get to the top of the food chain, if your assigned value is that of say a white man who has had a lot of opportunities, who is a third generation college graduate and who comes from some

generational privilege, I'm not saying that that's what everybody is but there are people who identify that way, then what can you do with your sphere of influence? At some point for you, it may be that you will have to—as the musical chairs go around—not sit down, actually step away and let somebody historically who is from a marginalized group sit in the chair that you are actually qualified to sit in.

And I think that that is a hard place because I think even the people that identify or who have been identified as allies or who have been identified as co-conspirators, co-creators, co-designers, helpers, people that are in the mix, people who show up, whatever you call them—there is a space where at some point for somebody to get something, somebody's going to have to give something up.

And I think that is something that impacts all of us. I don't think that ... when I think about that definition, I am an able-bodied, cis-het Black woman. I don't have a disability. I'm not overweight. I don't speak with an accent. My name you can pronounce it when you see it. English is my first language. I come from educated people. There is a lot of privilege in that for me. And I know that. And so I do think about sometimes, well, what will it mean, where can I even give up some of my privilege? So I think these conversations that we have, I just try to have them very transparently.

The last thing I'll mention too, in terms of shaking up narrative, is that when I walk into the hospital and I take care of patients at Grady Memorial Hospital, our safety net hospital here in Atlanta, Georgia, I meet my patients culturally in ways where we align. If we have racial and cultural concordance, on my second day seeing you, I'm not going to stay formal. I'm going to be like, "Hey there, sir, how you're doing? Who coming to get you? Where is everybody at? Did you talk to your son today? Where's he at? He got to work? Okay, want me to call him?" I'm going to talk like I talk to Black people because I want you to feel safe in your most vulnerable position—and usually I'm the only Black person in the room when that happens. But that is important because then my student, my resident is permitted to be their entire selves wherever they are because they say, "Well, shoot. She's doing that." So what does that mean? And then offering this value and shaking up this value assignment.

So I think those are the things I think about. I know that was quite a mouthful. But yeah, thanks for shouting out the podcast.

Dr. Maybank: Absolutely. Dr. Choo, what are ways, kind of on the similar vein, that you have used to kind of model how to show up in the space of equity and anti-racism work?

Dr. Choo: Yeah. I would love to answer that. I just have to do a quick side shout out to the podcast because I've been listening and it is so listenable. It is ear candy. It's the voices. It's the personalities. It's the content. But anyway, just really great props. It's helping me on my own journey and just being able to learn in a way that's so fun is really rare, and I just think that's the right forum for you.

So anyway. Sorry, to answer the question—I always think about because it's so hard for people to

engage around anti-racist and equity work, I've been thinking a lot about what we know from behavioral science. And to get people to do hard things, you have to make it understandable so the logic needs to be there. People have to understand ultimately what is the mission, what is driving me to this work. They have to have self-efficacy. So we have to either boost their capability or make the tasks easy, and then we have to make it normative, culturally normative.

So if you're asking people always to stick their neck out there in ways that are not seen as things that other people are doing, that work will have attrition because people don't have energy for the long haul. They'll show up in a spectacular way on that day, on that week, on that month and then they get tired of holding that pose and they'll go back to usual. So that's why often our initiatives seem like they're taking off and then you turn around in six months and nothing has changed.

I've been thinking a lot about this in my own research center where we've realized that there is racism embedded in every single thing that we do. I mean everything, from the minute you walk into the door to any task that you pick up on an individual day has been imbued with racism. And so if it's that integrated into what we do, how do we dismantle it?

And this is still work in progress but we've decided within our center, and it was a group effort so I can't take credit for this, but we've decided in our center to really pick apart and structure our assessment of racism. So it's like, okay, so we mentor here. So what is it about our mentorship processes? We have a lot of decision making about who we bring in from students that are volunteers in our research work to the fellows that we train to the faculty that we recruit. What about the research that we do? What are the topics we pick?

We say that we want a health equity frame to our research, but do we apply that? Do we only do that when projects are specifically labeled as a health equity project? What about the average study, about EMS systems, about PE, about trauma? Do we apply health equity lens? And when we do, how do we do that? Can we bring that to our work with specificity, with checklists, with points where you need to be like, okay, what does our team look like? How did we frame the race and ethnicity variable? How are we handling the analysis? How do we calculate sample size?

It's really trying to pick apart what we do really down to these granular things, like who do we order lunch from, who are the body of vendors that we give our money to and how did we come up with that list? Oh, it's because everybody orders from those people all the time. It's like exactly.

And so we're trying to—we have a whole operationalizing equity plan. And the thing in my research center is everybody owns it, everybody has an assigned responsibility and everyone has an opportunity and an expectation that they will not only participate but they will, at some point, lead the domain that they're involved with. And so we'll cycle through leadership. That saves people's energy and also makes sure that they have a moment where they know they're entirely responsible for something.

Those are some of the things I think really making it concrete so that people have something to do other than put like a BLM hashtag on their profile. That they really are bringing it to work every day and they know once a month when we have a meeting, we pause at that our equity operational guidelines and we ask how people are doing, and we try to move at least one thing forward. And people, honestly, when you give them concrete things, it's mission driven and there's an expectation, people really come to the table and show that they're eager to invest time and energy and creativity and intellect into it. So it's been a good experience so far.

Dr. Maybank: Great. That's very helpful. Dr. Ansell? You're on mute.

Dr. Ansell: Thank you, Dr. Choo. I think that's incredible. We started off by talking about like this, what do the words mean, allyship and all this other stuff, but actually and I do this toggle, like we have our personal accountabilities that we must bring into the space and our authentic true selves—not only how we've been identified but how we identify ourselves and that honestly breaks down the whole in health care whoever did this.

But what's really critically important is get to those pragmatic action steps of dismantling. And to do that when we're in a predominantly white-dominant culture organization is to do what Dr. Choo said, what are the series of tasks ahead of us and how do you hold people accountable?

Here we put together a racial justice action committee and going down through all of the various ways within our organization, down to the performance expectations and people's performance evaluations around racial equity, like what is the thing that you have to do that you're responsible for and how is it then ultimately measured? Because I think that's the way we're going to get to this form of dismantling.

And just as I think about that work, I'm thinking about the work of Michelle Morse and others in the *Boston Review*. I know people are aware of Michelle, about this idea of ARC—acknowledgement, redress and closure—as a framing for the work we have to do. And what does acknowledgement mean? It's not only saying, listen, talk that racism exists but getting very, very specific and recognize the admissions of the specific harms that are occurred and are still occurring and getting very comfortable with naming, like safety events.

When errors would occur for patients around safety, we have to acknowledge these things. We're setting up a call system separate from our complaint system about racial and other bias so people can call in so we can count the events, and then making sure we're closing the loop on redressing them. So there's a measurement system to redress. Not just monitoring that we're doing it better going forward, but what's restitution look like, repair of this look like? What's the outstanding debt that we have to pay, and what's the anti-racist institutional change?

So it's not just about, okay, we've improved it now but what's the debt and how do we—so I'm trying to get us to have, here they don't like this quite yet, a reparation fund. But now I've gone to say how

about a community repair fund? By the way, we talked to Chris Holliday at AMA about this, about not thinking about impact investment but direct investment, that we owe something in a direct way. And then closure. And closure means the acknowledgement from those who've been harmed that the debt has been paid.

Now imagine institutionalizing that. But that's kind of where we have to go. This gets beyond the personal into what do we need to do across all of our institutions. So I really like what you said Dr. Choo because it really reflects with what I see sort of in our institution, the focus the work is, measurable change.

Dr. Maybank: Thanks, Dr. Ansell. Mr. Love, what I would love to hear from you, and what I'm starting to hear and I think this is meaningful is that when thinking about allyship, co-conspiratorship, co-designing, all of it, it's about collective accountability and creating the environments to do that and the processes and the actions that ensure that there's collective accountability.

I want to know if can hear from you more kind of through your work through Racial Equity Institute, how has this kind of training helped to get institutions and people to that collective accountability because we're clear training alone, we know it doesn't help. Like everybody knows that. However, training and capacity building is still very important and critical. We still got to figure out how to challenge people's mental models. So can you speak to that? And what ways you think training has helped and what are those conditions that help with create that collective accountability?

Love: Yeah. I hope it helps because we do a lot of it and I think it absolutely does. But I think it's like, I'm not trained as a physician but I come from families that ... in my family is a lot of people that have a health care background and if someone comes to me and they're sick, I wouldn't even know where to look. You got a runny nose? I don't know. Here's the best over-the-counter thing that I have. You got a pain? I don't know. Here's the Tylenol. If you can't do Tylenol, here's ibuprofen. Just because I don't have the knowledge to be able to analyze a problem the same way my father does, who is a physician.

And I think it's that way around racism, that if we don't have some basic level of understanding about what's causing the racial inequity that Dr. Choo and Dr. Ansell was talking about and it's measurable, it's right there if we measure it, there it is. If we don't have a basic understanding of what's causing that, the chances that we'd be able to diagnose and intervene in an appropriate way are almost nothing. And that's not even a value judgment. I mean I don't consider myself intellectually inferior or that I'm at some sort of deficit because I don't understand how to diagnose a physical illness. I just don't have that training.

Now medicine, you can go to a doctor to get medical treatment. That's good. Like I don't need to have that kind of advanced medical treatment, but racial inequity. Guess where racial inequity happens in the United States. Everywhere. It happens when you walk down the street. It happens when you go into the doctor's office. It happens when you get referred from your PCP to the specialist. It happens

when you get out, what kind of follow-up you want.

One of the studies that I am familiar with and where we have partnered and done work is with the Accountability for Cancer Care through Undoing Racism and research that was done in Greensboro, North Carolina. I encourage people to check it out because literally when we did what folks here are talking about and really started to measure where is racial activity happening, I mean I'm not exaggerating, is literally happening at every step along the care journey. And because racial inequity is happening everywhere—that means to be good scientists, to be good physicians, to be good social workers, to be good educators, to be good transportation administrators—we've got to understand it. And that I think, Aletha, to me is the importance of training, is that we all need some basic foundation.

Unfortunately to me, the education I got, I have two master's degrees, one in public policy and one in business. And both of them are schools in the south. And maybe you think premier schools in the south, maybe you're more likely to get educated on racism down there because the history segregation and slavery and so on and so forth. The reality is you can graduate at least with two master's degrees and really not learn anything about structural racism unless you are lucky to have Dr. Manning as a professor or a Dr. Choo or somebody. But you can go through all that education and not learn anything, and it's like a physician or like a lay person trying to diagnose a problem with none of that training. If I don't have a basic understanding of what caused the inequity, my chances of developing interventions that are going to work are almost null.

I think that is the important part of it. But it's like you said, Aletha, the whole point of the training is to help us then design interventions that are in the sea that Dr. Ansell is talking about. So I hope that's helpful. It's sort of our view on a little bit.

Dr. Maybank: Absolutely. We're nearing the end of the show and I think for me, I'm going to have some summary points in a second, but I think that that part is so critical. And what I've learned over the last couple of months in terms of the connection between kind of whatever term you want to use co-conspirator, allyship, co-designing training and showing up. And the reality is that folks have given a lot of feedback on AMA is moving in this direction and have given definitely a lot of praise for sure, but I tell folks that it would not have happened if I didn't have accomplices, co-conspirators, leadership that did their work and had the training honestly of the Racial Equity Institute. All of those things combined have created this space of collective accountability so that we can actually move this work forward.

And so I just want to the intersections of it all, the complexity of it all is what's really important. It's not just one thing here and one piece off the menu that creates all of this. And I think that that is all the work that we have to do and frame oftentimes in moving forward.

I've heard through this whole conversation importance of grounding, I think Dr. Manning what you said about starting your conversations off with the definition of racism, and we all have that in our head, structure opportunity and assigning value, it's awesome. That's a great starting point. The

ability to not have to code switch, love that. And the permission to be—

Yeah?

Dr. Manning: May I mention one thing? I know you're summarizing.

Dr. Maybank: Oh yeah, go ahead.

Dr. Manning: I love all of this discussion, also thinking about the frameworks of things that we need to do structurally to kind of redevelop the way that we do everyday things and collecting data. I always bring up this piece though about when we get to the ... when we reach the Wizard of Oz, when we get there to the Emerald City, somebody's pulling a lever. There's a few people. And I do think that to retool structures, that's a big job that definitely requires data. But I still like to always mention that people who have the most privilege and especially the most historic privilege and sphere of influence to do things, there is going to be like a quiet time where they're alone and they have to decide like me by myself, what am I willing to give up. And I just wanted to re-center on that again because I still think that some of the best people in this work sometimes, when it comes down to their individual lived experience, they're like, "Yeah, but I'm not going to give that up."

And I think that goes for all of us in our own privileges. We think about our kids in school and what they need and all that. When it comes down to our own lived experience we're like, "Yeah, I don't know about me." So I just want to make sure that people think about that. And then the opposite end of that being the power of the most junior people just like how you said with the students were really lighting a fire under the AMA. Students and stakeholders as students and patients, they can make us do a lot of things by making sure that we hear them. So I think thinking about that, those two extremes of the ends of what can happen in terms of structural change.

Dr. Maybank: Thank you for that. And then just, and continuing on as we close out here, Dr. Choo mentioned about equity operational guidelines, something around that, and that being the expectation and holding accountability to that to every, really, thing that you do and conversation that you have and processes that you're moving forward. And Dr. Ansell, really speaking to being pragmatic and being very direct about what it is that we need to do, again, to hold ourselves accountable.

So really, thank you all for the time spent today. Thank you all for your leadership and what you do. For all of those who are tuning in and listening in, this will be available for credit for CME and we highly encourage. There are ways to access every single person that is in this conversation. If you want more information and if you can't access them directly, they are in so many different places. They have lots of information. Videos posted of where they're communicating about their expertise and what they've learned and what they're doing. And so I highly encourage you to look them up and to find that information. And then to be more direct. I think also to get the capacity building and training that we all need in order to challenge and change our mental models and how we show up differently in all the ways that were just mentioned, even the one Dr. Manning just mentioned as well.

So thank you all again and look forward to seeing you the next time.

Disclaimer: The viewpoints expressed in this video are those of the participants and/or do not necessarily reflect the views and policies of the AMA.