

## Prioritizing Equity video series: Critical race theory & intersectionality

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In this Oct. 4, 2021, Prioritizing Equity discussion, join AMA Chief Health Equity Officer, Aletha Maybank, MD, MPH, and leaders across a continuum of disciplines for a special discussion on critical race theory and its applications to the field of health equity.

### Panel

- **Malika Sharma, MD, MEd**—Division of Infectious Diseases, Department of Medicine, St. Michael's Hospital; assistant professor, University of Toronto
- **Dennis C. Chin**—Vice president of Narrative, Arts, and Culture, Race Forward
- **Rahel Zewude, MD**—Black Physicians of British Columbia, Black Physicians of Canada, Department of Medicine, University of British Columbia
- **Bram Wispelwey, MD, MS, MPH**—Senior fellow at Atlantic Fellows for Health Equity, associate physician, Division of Global Health Equity Brigham & Women's Hospital

### Moderator

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

### Transcript

Oct. 4, 2021

**Dr. Maybank:** Hello everybody, welcome to Prioritizing Equity. I'm Dr. Aletha Maybank, chief health equity officer and senior vice president at the American Medical Association. In today's discussion, we're going to examine the history of critical race theory and its applications to the field of medicine as well as health equity. Originally defined by legal scholars in the 1980s, critical race theory has since

evolved as a way of looking at structures and histories responsible for racism in the United States. Critical race theory, as a practice, allows health care professionals to confront and dismantle racial injustice and is thus vital to the pursuit of health equity.

Yet in the past year, attacks on critical race theory have gained much attention, with 26 states introducing legislation to restrict its teaching. Today's guests will share reflections on their experiences of engaging and teaching critical race theory as well as how to best apply the theory in this fight for health equity. So to help us dive deeper into this discussion, I am pleased to welcome these dynamic voices and leaders who are joining me today.

So we have Dr. Malika Sharma, if you can just raise your hand real quickly, who is at the Division of Infectious Diseases in the department of medicine at St. Michael's Hospital and is an assistant professor at the University of Toronto in Canada. We have Dennis Chin, who is vice president of Narrative Arts and Culture at Race Forward. We have Rahel Zewude, who is with the Black Physicians of British Columbia and Black Physicians of Canada in the Department of Medicine at the University of British Columbia, and she is a resident still, which is great.

And next we have Bram Wispelwey, who is senior fellow at Atlantic Fellows for Health Equity and associate physician at the Division of Global Health Equity at Brigham and Women's Hospital up in Massachusetts. So thank you all for joining me today. And so, we're going to really dive right into this, and Dennis, you've done a lot of work that's definitely recently on kind of explaining what critical race theory is, so can you share with the audience, kind of break it down for us, what is it and how does it relate to kind of health care and health equity or just in general society?

**Chin:** Yeah sure, Dr. Maybank and happy to be here. So first, just wanted to share that what is being debated right now is not actually critical race theory. They are debating a caricature of critical race theory. It is being used as an umbrella for "ultra-left views." And so what actually is critical race theory? It's an academic field that simply demonstrates how racism is embedded in our laws and in our institutions. That is exactly what it is. It's a graduate level course. And because of our racialized history, we know that race is still a predictor of one's life outcomes, right? That is what critical race theory demonstrates. So everything from wealth attainment to educational attainment to obviously, health. We know that where you live, for example, can determine how healthy you are. And we combine that with our knowledge of racial redlining, the history of cities and counties citing toxic dumps, hazardous sites in communities of color, in Black and Brown communities.

Again, all of that, we call that at Race Forward, systemic racism. And critical race theory is an academic field that undergirds that work. And so for me, as an employee at Race Forward, this is what we do. We address systemic racism, how it shows up in our laws and institutions in a way that actually improves outcomes for everyone, including people who are white.

**Dr. Maybank:** Thanks, Dennis. So Bram, can you expand on that a little bit and kind of speak to because you've also been doing a lot of work, and we'll get to more the specifics of some of the work that you've been doing, you're free to mention some now if you choose. But in the health care setting, what is the importance of critical race theory and antiracism work, really? As Dennis just said.

**Dr. Wispelwey:** Yeah, and I think in the health care setting, what we're looking for, right, is interventions or actions that will eliminate racial inequities in health, the kind that Dennis just mentioned. And so, in my view, right, critical race theory is one of the best ways to do that because it gives us a rigorous set of tools and ways to analyze why we have these racist outcomes, right, in our health systems, in our health care delivery models. And so for me, learning about critical race theory, this legal theory that was developed a few decades ago really came through the lens of work by Collins Airhihenbuwa and Chandra Ford in their public health critical race praxis, which was a way to bring this theory into the realm of health care, into the realm of public health research and medicine and use it as an approach towards anti-racist action, right, so they break it down into a series of principles and sort of focus areas. And the last one and the key one, I think, is that action piece, right, we have to move beyond as they say just documenting these racial inequities to eliminating them.

**Dr. Maybank:** Absolutely. And so when did you—and you all can answer this question. So for many within the health care space, health equity is a new area, right, a new field even, though it's been around for a while, especially in the public health space. Health equity is new, antiracism work is newer to folks and that's not to everyone again, there have been people leading this work. But critical race theory is really the concept and the mention of the theory is really new to people. When did you all kind of first encounter the concept itself? And I know it's beyond just the words but I want to know when you all kind of engaged with critical race theory as a theory? And Dr. Sharma, Malika?

**Dr. Sharma:** Yeah, absolutely. Well, actually the first time I encountered it was actually exactly in the work that Bram was just mentioning, so Chandra Ford and Collins Airhihenbuwa work on CRT in public health. But I think what's notable is I didn't encounter that in the context of my clinical work or really anywhere on the wards or in medical school. I encountered it when I was doing my Masters of Education here in Toronto at OISE, where there's like a strong faculty involved in social justice and around antiracism and George Day is here, for example, and so I think that's sort of where I encountered it and I think it really speaks to this transdisciplinary nature of CRT, where it was obviously founded in this one field but there's so many ways in which I think it can be brought into this space and so for me it was really eye-opening when I first encountered it through the work of Ford and Airhihenbuwa to sort of say, "Why haven't we been thinking this way all along?" Given when CRT emanated in legal scholarship, it's like how has this not entered the health care space yet?

**Dr. Maybank:** Interesting. As you started to do that work, did you receive any resistance as you started to bring up these concepts more recently? What is the experience actually in a country like Canada and outside of the United States related to critical race theory?

**Dr. Sharma:** I think it's a great question. I think one of the things is in Canada, we like to think of ourselves as very polite. And we've really bought into this narrative that you know Canada was the final station of freedom at the end of the underground railroad and we're so amazing and it's like this complete erasure of the fact that slavery happened in Canada. So I'd encourage anyone watching to read the incredible book, *The Hanging of Angelique* by Afua Cooper, which is about an enslaved woman in Montreal in the 1700s. Similarly, we look at the murders of George Floyd or Trayvon Martin or Sandra Bland and we say, "Okay, well that's a U.S. problem." Right? Which is also categorically untrue. And again the work of Robyn Maynard, a book called *Policing Black Lives* is really I think instrumental in explaining how that is manifest in Canada.

And so I think that, probably not surprisingly, I think there is some resistance to thinking about CRT in health care spaces but in Canada in general because I think it no longer allows us to make what Eve Tuck would call a move to innocence, right? We can't pretend we don't know. We can't pretend it doesn't exist. We are forced to grapple with our own racism and in the ways in which our institutions are racist and I think people really don't like that. But then on the flip side, I would say that Rahel and I have done a little bit of work around CRT, both as learners, I think, in this space. And we've actually gotten some really great feedback from people where people are reading the work or listening to the work in places we hadn't necessarily envisioned. So I think there's also cause for some hope.

**Dr. Maybank:** Thank you for that. And Rahel, you're a PGY3 if I understand correctly, right? So how has it been for you as a resident? How did you first encounter the theory and was it part of your education as a PGY3? I'm guessing it is because you're here now but can you just speak to kind of when you first encountered the theory or maybe you did an undergrad as well?

**Dr. Zewude:** So my first encounter with CRT came through my work with Malika on our research work, so it's sort of it ... felt like it came out of my formal medical education space because Malika and I connected because of her work in applying feminist theory in medical education and her anti-racist work. And I reached out wanting to do a research project with her. And because she was someone who combined all this other interests that I had outside of medicine and applied them into her medical education work. So as we were looking at ways of examining the framing of racism within the field of infectious diseases. We were talking about different frameworks and different tools we can use for critical discourse analysis. And so that's how I was introduced to CRT and I started reading the works of the legal scholars like Derek Bell and Kimberly Crenshaw, Richard Delgado and then also I read the scholars that both Bram and Malika mentioned so like Chandra Ford, Camara Jones, who had taken this framework and applied it into the field of public health.

So it was very exciting for me as a Black woman trainee especially, in finding this framework that really empowered the advocacy work that I've been doing in terms of improving the recruitment of Black learners in Canadian medicine. And it also helped me have the tools to examine and communicate my experiences of being a Black woman trainee in Canadian medicine. So within the

last two years, I had worked to create an organization called Black Physicians of British Columbia and this came out of the work of using CRT to examine why are things the way we are.

And I remember my first year of internal medicine training, I was the only Black person in a group of 150 internal medicine residents and didn't really get to work with any Black medical student, resident, fellows, staff physician until the end of the year. And the idea of CRT is you have to stop and ask how is our society the way it is right now. And so that helped me look for the structural forces and try to communicate with folks who look like me who have graduated from this institution and understand that my experiences are not just an individual experience—this is a collective experience that is shaped by the structural forces of our society and helped me found this organization and advocate for change by the notion of praxis.

**Dr. Maybank:** That was fantastic. That's amazing. Dr. Sharma, you've done well in educating, seriously that was—

**Dr. Sharma:** It's all her, it's all her.

**Dr. Maybank:** Yeah and I'm sure I can tell Rahel's leadership and really thank you Rahel for leading in that way and organizing with other physicians because I think that is really critical in being able to kind of sustain and build the movements towards justice, so really thank you for that leadership as a resident. Bram, I'm going to come back to you. So applying it, and you and Dr. Morse, Michelle Morse wrote a brilliant piece that was published in the Boston Review and really describing some of the work that you're doing up in Boston to really figure out how to apply it. And so can you talk a little bit about that work? And then I am going to move into kind of what are the challenges but also what happens with that article and all the backlash? I know Michelle well and so I know there was there was lots of kind of scares as a result of publishing that piece.

**Dr. Wispelwey:** Absolutely. And I think, I'll try to kind of go through the story there briefly but it really started for me also as a resident and, essentially, what was happening is that we were noticing as residents that our Black and Latinx patients coming in with heart failure were more likely to be on the general medicine service than on the specialty cardiology service. We only really had enough beds for maybe 60% of our heart failure patients would go to cardiology and noticing that it wasn't happening equally and in fact seemed like we were segregating care, that was the impression. So we started looking into the data and sure enough that's what it was showing. And so we started building a community and there was this health equity committee that Dr. Michelle Morse led and sort of started reaching out to all different people that were in all the divisions and departments that this sort of related to and inviting them into these meetings that Michelle led. And it was really a community organizing initiative in the hospital to try to help us better understand what we're seeing here in the data, what's happening?

And at the beginning of all those meetings, Michelle would sort of lead with some education, some sort of shared definitions and shared norms and really, part of that was bringing in critical race theory and public health critical race practice and also the work of Dr. Kamara Jones, as Rahel mentioned, know this idea that we have to name racism, we have to then work to understand how it's operating and then finally we need to strategize and organize to address it, right, and that comes from Dr. Jones's work as well, which is very similar to kind of what we took from Chandra Ford and others. And so all of that kind of work led to further studies to better characterize what exactly was happening, why we were seeing this institutional racism in how heart failure patients are being admitted in our hospital and then finally trying to think through to finally that action piece which is what are we going to do about this? How are we going to address this? What actually feels right based on everything that we're learning together as this sort of group to address this, right, and what feels appropriate?

And that's sort of we came to this model and it was based on the work of economist Sandy Darity and folklorist Kirsten Mullen, on in their work around reparations, so it was important to us to take a repetitive justice approach, a restorative justice approach. So we brought some of that work in and we worked with a number of different people outside. It was really multidisciplinary outside the world of health and medicine, talked with them about this issue and tried to get their expertise as historians, as lawyers, as political scientists, who all work on issues of racism and out of that work, develop this model that we've called Healing Arc, the arc stands for acknowledgement, redress and closure as an approach, a restorative justice, a reparative of justice approach to dealing with what we found.

And so essentially that Boston Review article that you mentioned is sort of the culmination of kind of all that sort of thinking of our approach, our intervention to try to address this inequity and of course we mentioned critical race theory and we mentioned sort of all the different thinkers that kind of were a part of this and that ultimately, it led to, as you said, a backlash that at times did get very, very scary. Dr. Morse is a Black woman and she had many attacks both sort of through email, through Twitter, through all sorts of sort of very ugly messages that we were receiving and sharing there were definite threats, threats against the hospital, threats of violence. And ultimately, it was covered by over 20, 25 right wing publications that often platform white supremacist views that led to news stories on Fox News and on sort of Fox anchors and it led to just this overwhelming amount of backlash as sort of has been seen now many times with what people are sort of using as a straw man as critical race theory, as Dennis was mentioning, so that was kind of the overall experience and really leading up to just really the last few months.

**Dr. Maybank:** Thank you for that and thank you for your leadership, and I think it's been really important that you all have elevated the story and your experiences because many folks don't realize the harm that has come towards people and leaders in whatever field as it relates to speaking up about racism and writing about antiracism work and more specifically, even critical race theory. So I know it definitely hasn't been easy but thank you for pushing through. And so Dennis, so you have done a lot in terms of Race Forward, in terms of responding to some of these attacks that have been



happening across the country and you all created a really great guide to counter-narrating attacks and so can you speak a little bit about that guide for us and what are the key takeaways from that particular guide?

**Chin:** Yeah, sure. And before diving in deep, just wanted to underscore that point, Dr. Maybank, that a lot of our peers, colleagues, friends and family who are working to advance racial equity and justice in their work are getting threats, threats of physical violence, online hate. I know a lot of women of color, in particular, are experiencing that vitriol and it's just so important for us to protect and defend them and this work. And so that's just something that I need to remind myself and people who are in this fight. And so yes, we at Race Forward created a guide to responding to these attacks. And in the guide we talk a little bit about the historical moment that we're in. And so we just named backlash. Bram, you experienced, you and Michelle experience backlash to an article. Backlash is not new. Every single time that this country has made progress on race, there has been a significant backlash spurred by a political and economic elite to stop that progress. We saw it after the first reconstruction, after the abolition of slavery, that led to Jim Crow segregation.

We saw a backlash after the triumphs of the 1960s civil rights movement in the form of small government, shrinking of government, austerity measures because at that time, the federal government, for example, was in charge of enforcing a lot of the provisions of the civil rights movement, so the response, the backlash, well we're going to shrink government. That ended up hurting a vast majority of white people too, just saying. And now we are, as the Reverend Dr. William Barber says, he is one of the co-chairs of the Poor People's Campaign based out of North Carolina, "We are in a third reconstruction because of activists, organizers that are on the streets knocking on doors, people like yourselves that are advancing a conversation about race in their fields. This is another moment in history where we are pushing forward, building a country, building a future that really does include everyone." And so now this backlash moment again, it is not new.

And to be very clear it is to do a couple of things, to rob us of our history, our ability to know about systemic racism, what are the root causes of it. And our ability to do something about it. That is what these attacks fundamentally are about to stop the work that we are doing, health equity but also racial justice writ large from advancing. And so in our guide, we go over that history. We talk about the type of narratives that this political elite are relying on again and again that talking about race is divisive, that racism is solely about hate in one's heart instead of what we also know it to be which is a manifestation in our systems. They are present in our laws, our institutional policies and practices. And then lastly and most importantly, and this is the key takeaway, Dr. Maybank, they are also both implicitly and explicitly saying that if we do anything to address systemic racism, if we do move forward with reparations, whatever form that might take, that is going to hurt white people.

That is the narrative that they are saying, that racial progress means a loss for white people. And I want to call in the work of Heather McGhee, who wrote a really great book called *The Sum of Us*. Dr.

Maybank, were you going to go there, too?

**Dr. Maybank:** No, go ahead, you continue. You're absolutely right. So I was going to ask you.

**Chin:** Yeah, so she wrote a book called, *The Sum of Us*. If you do not have it, please go out and purchase it, get it from your local library, it is incredible. She tells stories about how this zero-sum game, this idea that one group is going to lose when another group moves forward is a false one. That we are being intentionally divided by a political and economic oligarchy so that we are unable to come together to address challenges that impact us all, right? And so in that book, the biggest takeaway, she calls it the solidarity dividend. When we can actually work together across race, be honest about the history and reality of systemic racism and how it shaped outcomes in our lives, when we are honest about that and do something about it we actually make a better society for everyone, including people who are white.

**Dr. Maybank:** Thanks for that, Dennis, I really appreciate it. Malika, I'm going to come to you. So in light of kind of the frame of all that Dennis has said as well, now kind of shifting to an actual space of the health care space, can you talk about how are you implementing critical race theory? How are you working towards getting all people on board, as many as you can and buy in to this process to embed it into the medical education at your institution?

**Dr. Sharma:** Absolutely. One thing that I should say and I feel bad that we're this far and then I hadn't mentioned this when we first started chatting because I was so excited to answer the question, but I should acknowledge that I'm talking to you from Toronto or Tkaranto in lands that are protected by the Dish With One Spoon Treaty and that as part of the land acknowledgement that I should have done at the beginning, so I apologize, is that I'm trying to learn how to live and be in community in solidarity with the Indigenous people who are not historic and still on this land. So I should have said that up front so I apologize.

And the other thing I should say is I'm so inspired by the work that the other people on this panel do and really I have such a tiny little piece of this puzzle that I do which is really in the educational space—I'm trying to think about how we teach and I often think about what I do as being in these tiny pockets, right, where I get to work with individual trainees or groups of trainees. But one of the things that I really feel that CRT within medical education has sort of allowed us to do is to really examine our history and our contemporary practices, right, to uncover and then therefore address the ways in which racism is, like Dennis was saying, really embedded in our institutions.

So a good example is that one of the principles of CRT talks about race consciousness, right, or the recognition of race as a social construct whereby the idea of difference and fundamentally hierarchical value, right? So it's not just that there's difference but that this difference is ranked, right? That's a social construction, right, that's something that we have kind up because the genetic difference between these so-called races is actually less than the difference within a race, right? But yet in



medicine, it's still being taught as a biologic truth, right? That's still happening, right, there was recent work on medical students who actually, in this study, were found to believe that the skin of Black people is different than the skin of white people and that therefore they feel less pain which has obvious implications for the administration for example of pain medications in the ER or on medical wards. I think a lot about the work of Dorothy Roberts who writes this incredible book called *Fatal Invention* that talks a lot about this idea and this myth-information really of genetic difference.

And I think it also really helps us to again, not make that move to innocence, right? So people talk a lot about how the system is broken. But if you think about the roots of our health care system and the ways in which they were and are deeply connected with actors of state violence, right? So in Canada, I think about the ways in which the health care system was deeply embedded with colonial practices and with Indian agents who facilitated the removal of children from their homes into so-called residential schools where they lived under horrible conditions and suffered incredible amounts of violence. That was done essentially with the complicity and collaboration of health care actors and health care providers who conducted research in those organizations as well to look at malnutrition in children by purposefully allowing them to be malnourished, right?

If we think about the role and the way in which health care systems and practitioners were deeply embedded with slaveholders in the U.S., coming up with diagnoses to justify slavery, right. Coming up with a diagnosis of drapetomania or runaway slave syndrome. Like that was a medical term, right, that people talked about. So when we talk about the idea that the system is broken, actually the system is doing exactly what it was meant to do and so we have to really look at that.

And so I think CRT also helps us keep it also in the now, right? So I've used a couple of historical examples but CRT really talks about this idea of contemporary orientation or the everyday ordinariness of racism, right? Dr. Onye Nnorom and Dr. OmiSoore Dryden in Canada have talked about this. Drs. Rhea Boyd and Rachel Hardeman in U.S. have talked about this and they have a great podcast series by the way where they were on a great podcast series called ,“Antiracism and Medicine with Clinical Problem Solving,” which I've been loving so I'm gonna plug it even though I have no relationship to it at all.

But to me, it really helps us think about those things, name them, have a framework with which we can understand them because then we can actually uncover them and start to move towards dismantling them. And I think it's not just trainees who need to learn this and in fact I think they often know far more than faculty, who actually have to do a lot of unlearning, right? And so I think that's another piece of it.

**Dr. Maybank:** Thank you for that. Rahel, so how is it now, you said it's part of your education and so how have you been engaging with other students. I know you said you started the Black Physician Committee and I know that's not the exact name but how are you also relating really directly more so with the other students or other residents in your residency? And how well are the residents really kind

of buying into it? Do they feel this is part of the work they should be doing or is there still kind of a resistance among your residents that you're working with?

**Dr. Zewude:** I think one is, so I wanted to make a note that this hasn't been part of my formal medical education.

**Dr. Maybank:** Got it, okay.

**Dr. Zewude:** It is more so of I guess a testament to Malika's mentorship in that when we have been working on this research project that I was able to discover CRT as a framework and apply that into my advocacy work. But frankly speaking, as internal medicine resident, this hasn't entered my formal medical space, unfortunately, yet. So my work in creating the Black Physicians of British Columbia was creating an institution and association that is informed by the principles of CRT, so understanding race consciousness and what it means be Black physicians and Black Medical trainees, who most of us are settlers in this land of Indigenous people and others of us are descendants of enslaved people, folks have come here as refugees or as settler immigrants.

So understanding what all of those things mean to us and the process of racialization and how we experience the Canadian health care system, both as an in group and an out group, so as care providers ultimately we are providing care in a system that has been with the roots of colonialism and erasure of Indigenous people and a system that still has pervasive systemic racism against Black and Indigenous people and other racialized groups.

So in the work that I do in the Black Physicians of British Columbia, we have set out to advocate for Black trainees and students in improving their path and access to joining the medical system but we're also working to improve the health care that Black people receive in this country and in this province specifically, but also understanding the responsibility we have in being in solidarity with Indigenous people. So that has been the work that I have been doing and applying CRT

That being said, I think our work, specifically with the medical school here at the University of British Columbia has been one is calling out the school in addressing this idea of the construction of race as a biological entity and really working towards identifying racism as a determinant health because for so long we have designated race as the social determinant of health and hence it has allowed us to scapegoat race as the root of all the racial health disparity, whereas we do know that it is structural racism that leads to poverty, the overcrowding, the limited access to care and so we have been advocating in reviewing our medical school curriculum here and framing racism as a determinant of health that is a modifiable risk factor.

In terms of some of the challenges around applying CRT medical education, I think one main idea is this concept of centering the margins. And as Malika mentioned, oftentimes young trainees, if anything, are now increasingly aware of the workings of structural racism but the culture of medicine is

so strongly tied with hierarchy and oftentimes you are listening to the most senior person in the room and again—by the workings of structural racism—most racialized trainees and staff physicians end up being the most junior person in every room. So in making space for the voices of those marginalized people, it can certainly be challenging when the system of medicine is built and that you have to value the voice of the most senior person in the room and then you don't have any racialized people who end up being this most senior person in the room.

So that has been a big challenge and I would like to continue pushing through that and also really calling institutions to emphasize on actively listening and valuing and centering those voices.

**Dr. Maybank:** I truly appreciate that. Thank you, Rahel and thank you again for your work and the activism of the other physicians that you are working with. And so as we close out, just would like to hear from all of you. In our own AMA plan on equity, we do mention and name critical race theory to be a tool to use as you for institutions to advance their goals as it relates to antiracism work and health equity. And can you just all kind of give, I'll give you two, two points that you would like to say closing out, it could be one if you just want to do one on what can an institution do?

So Rahel, you mentioned a few now kind of through the actions that you're doing and you can mention more but I'd love to just hear closing out so that the audience can walk away with something that they could do at their own institutions as it relates to antiracism work or critical theory since they're very tightly aligned. How about Dennis we start with you?

**Chin:** Sure, that's a great question. I think first maybe some contextualizing in history and that many of the institutions that we are a part of were created in an intentionally, explicitly racist system. And the type of transformation that we are seeking, the type of organizations we want to build, we as individuals in those institutions may not see that transformation during the time that we're there. But we can do some good—we can figure out what power we have, positional power, organizational power that we hold together that can move that boulder up the hill.

And so sometimes I work with folks who feel like they think that, for example, that we can solve institutional racism in three years. Just give me a three-year plan. And I'm like, "Oh, it's gonna take a lot longer than that." We can set the foundation in three years, right? So I just wanted to release that expectation and also wanted to encourage folks to know that we are in a moment of possibility, of urgency, because of Black and Indigenous activists and organizers, because of immigrant activists and organizers who have taken to the streets.

Institutions that we are part of are finally taking notice and are just looking at each other and being like how do we change? And there are people like people on this call, some of our colleagues and friends who are so clear-eyed about justice, who are doing the daily work of trying to seize this moment and move those institutions, to accelerate the change—so maybe you can actually see, we are on the way to becoming an anti-racist organization and I was a part of that.

And for me especially, in this moment where racism is being debated, what it is and what it isn't—I think one of the things that we can do in this particular moment—is to reinforce what we mean by systemic racism. That it is not just a matter of individual intent but it is a matter of laws institutional policies and practices. Whether those laws, institutions, policies and practices can tend to discriminate or not. Intention is actually not an issue at that point. I'll leave it at that.

**Dr. Maybank:** Thank you, Dennis. Malika?

**Dr. Sharma:** I think that actually covered a lot of what I was sort of thinking about in response to this. I think many organizations recognize that they need to do something and it's really tempting to try to reach for a tangible or a quick solution but I think like was said, this is a problem that's been a long time in the making and it's going to be a long time in the undoing. I think about Derek Bells' book, *Faces at the Bottom of the Well*, about the permanence of racism and he provides this really important warning, right, that racism is basically a permanent part of life in America—he's talking about but I would suggest Canada as well—and that we need to be really wary of short-lived victories. But that's not to say that it's hopeless and I guess that's my kind of leaving word or my leaving point which is hope, right, so we have to just start. In that same book, one of his narrators says, "There is satisfaction in the struggle itself," right? And Mariame Kaba, who's an abolitionist, talks about hope not as an emotion but as a discipline, something that we have to practice every day.

And so I think that for many of us who are in health care spaces that are very hierarchical and in which racism is very much embedded, it can feel kind of exhausting and kind of an uphill battle but I sit here with this group of people and there's satisfaction in the struggle itself and I think that's sort of maybe what I'll leave with you. Although not my words, Mariame Kaba, everyone should read the book.

**Dr. Maybank:** Thank you, Malika. Bram?

**Dr. Wispelwey:** Yeah, these are all great. I think the thing that jumps to mind for me is the idea of the need to really mainstream what's really a core tenet of critical race theory though is just the pervasiveness and the ordinariness of racism in U.S. society in the sense that when I think about what some of the biggest initial challenges were to our work in heart failure it was really this defensiveness, this sort of idea that like, "Oh, we can't really be racist, right?" Even though we know just from this past week that more than a third of Black and Latinx patients have experienced racial bias in the health care system in the U.S. in just the last year, right, and that's just the tip of the iceberg right, that just was in JAMA.

And so but to actually have that be the understanding that this is pervasive and ordinary I think would really open up a lot of space in terms of addressing and dismantling W.E.B. Du Bois in 1935 called the wages of whiteness or these unearned psychological and material benefits that people understand themselves as white sort of get in a white supremacist society in the U.S. or Canada. And so I think that actually as sort of basic as it is in the one sense, is something that I think would have a lot of

implications in terms of making this work easier is just sort of that basic understanding that this is where we are, right, and it means that this is where we need to go and that's not going to be easy right, as Malika and Dennis both just mentioned. It's not going to be short-lived. But I think it prepares us to take those steps.

**Dr. Maybank:** Thank you, Bram. And Rahel, we'll close out with you and what you would like to tell people in terms of suggestions.

**Dr. Zewude:** So in terms of suggestions for institutions, I also want to highlight one core tenets of CRT which is this idea of praxis and that it is not enough to recognize that structural racism exists within your institution but you have to make the efforts to eliminate and address it. But I want to be specific as to ensuring that institutions are building infrastructure and allocating funds and resources into this praxis work and it is not enough to write an EDI statement, it is not enough to appoint racialized faculty and trainees as part of your EDI working groups and committees, even though your EDI statements mentioned how equity, diversity of inclusion is a priority for the institution but the financial report of the institution does not reflect that. I think that is not a way to do praxis.

And I also want to mention this term racial equity labor, a term coined by Veronica Lerma, Laura Hamilton and Kelly Nielsen, that talks about efforts that are uncompensated, that are done by people of color to address systemic racism and racial marginalization within institution. So over the last year and a half, we have faculty and trainees of color who are not hired for the purposes of doing this work that also have been tasked and expected to engage in labor that is unrecognized and uncredited but also with the expectation of those who are marginalized being the ones who are the primary vessels to completely dismantle decades of institutionalized racism. So we do really have to be mindful of that and I think institutions should continue to make efforts and really building the infrastructure and the praxis work that it has been done by racialized folks. And I want to end it with a quote from a Canadian anti-racist activist Muna Abdi, which is, "It is not inclusion if you invite people into a space you are unwilling to change," and thank you very much for having us here

**Dr. Maybank:** Beautiful. Thank you Rahel and thanks to all of you for this very, very, very informative panel. I highly encourage those who are listening in, who are watching this for credit, there were so many resources that were mentioned that are absolutely key and kind of fundamental to doing this work of antiracism that I highly encourage you all to really check them out. And just really thank you to all—thank you for your leadership and I look forward to seeing you more in the future—and I look forward to seeing the audience at the next Prioritizing Equity episode. Thank you.

**Chin:** Thank you.

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