

## Prioritizing Equity video series: Narratives and language

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This Feb. 14, 2022, edition of the Prioritizing Equity series focuses on the power of narratives and language in health care. It explores how dominant narratives perpetuate harm, and offers examples of how these narratives can be challenged and disrupted, moving towards equity-focused and person-first alternatives.

### Panel

- **Philip M. Alberti, PhD**—Founding Director, AAMC Center for Health Justice and Senior Director, Health Equity Research and Policy at Association of American Medical Colleges
- **Renee Canady, PhD, MPA**—Chief Executive Officer of MI Public Health Institute
- **David A. Ansell, MD, MPH**—Senior Vice President and Associate Provost, Community Health Equity, Rush University Medical Center
- **Malika Fair, MD, MPH, FACEP**—Senior Director, Equity and Social Accountability, Association of American Medical Colleges (AAMC); Assistant Clinical Professor, Emergency Medicine at The George Washington University School of Medicine and Health Services

### Moderator

- **Fernando De Maio, PhD**—Director, Health Equity Research and Data Use, Center for Health Equity, American Medical Association

### Transcript

**De Maio:** Welcome to Prioritizing Equity. I'm Fernando De Maio, director of health equity research and data use at the American Medical Association and a professor of sociology at DePaul University,

where I teach social epidemiology and data analysis in our master of health program.

I'm grateful to the AMA for hosting this conversation and to our remarkable set of panelists for joining us today. In today's show, we'll discuss the power of narratives and language in health care. We'll explore how dominant narratives perpetuate harm and offer examples of how these narratives could be challenged and disrupted, moving towards equity focused and person-first alternatives.

Much of our discussion will be centered around our recently published *Advancing Health Equity: A Guide to Language Narrative and Concepts*, a collaboration between the AMA and the AAMC Center for Health Justice. The guide was released just a few months ago in October of 2021 with the hope of stimulating critical thinking around the impact of language and narratives in health care.

The guide was intentionally designed with physicians and other health care professionals in mind. We think that having a better understanding of language and dominant narratives can help ensure that we are centering care around the lived experience of patients and communities without reinforcing labels, objectification, stigmatization and marginalization.

So, I'm pleased to welcome really a remarkable group of colleagues, dynamic voices and leaders in this work who are joining us for this conversation today. Dr. Philip Alberti, founding director Association of American Medical Colleges Center for Health Justice and senior director of health equity search and policy. Hello, Philip.

**Alberti:** Hey, Fernando.

**De Maio:** Dr. Renee Canady, chief executive officer of the Michigan Public Health Institute. Renee.

**Canady:** Hello.

**De Maio:** Dr. David Ansell, senior vice president and associate provost community health equity at Rush University Medical Center. And last but not least, Dr. Malika Fair, senior director equity and social accountability the Association of American Medical Colleges and assisting clinical professor emergency medicine at the George Washington University School of Medicine and Health Services.

Welcome to you all. I'm so glad that you're here. Okay. So let's jump in. I want to begin in a simple but very powerful example of the importance of narratives. So if I could, I'm going to show a photo to our viewers now. It's a billboard advertisement, a well-intentioned but hugely problematic campaign from our local health department.

I took this photo in 2015. So note, this was a few years before COVID, in 2015. I was driving from my office at DePaul University to visit a colleague at Rush. If you're familiar with Chicago, this is off Ashland Avenue, one of our major north-south routes with lots and lots of cross-town traffic.

I don't have the precise figure, but tens of thousands, if not more, people saw this billboard. And there's a lot that I could say about this photo in terms of dominant narratives. And they are reflected not just in the words in the photo, they are important but that are also communicated and reinforced in its imagery and perhaps most importantly, in the underlying relationship it depicts between health care and the community.

So perhaps we can use this photo to explore the dominant narrative of individualism, I am an outbreak, or dominant narratives around race and racial essentialism rooted in white supremacy. But really I share this photo now to stimulate our thinking. And would love to go around the panel and just very quickly ask for your impressions or initial interpretation. When you see this photo, what comes to mind? What is happening here? Let me open it up to Malika Fair first.

**Dr. Fair:** Thanks. Glad to be here part of this esteemed panel. When I see this picture here, the first thing I see is this beautiful child and the resemblance is remarkable. I also have a daughter who's a little bit older than the child that is on the screen. And I think of my daughter and I see hope and curiosity and joy and a huge future ahead of her.

And then I see the words on the screen that say, "I am an outbreak." And I think this child is going to inflict harm on me. I think about my late husband, who said he chose not to get corrective eye surgery because glasses made him look less threatening. And I think about the narrative that African Americans or Black people in general inflict harm on others. And so, it's deeply emotional to see a picture like this and think of my own child in this narrative of inflicting harm just because of your race.

**De Maio:** Yeah. And Philip, first impression. Thank you, Malika. Philip.

**Alberti:** Thank you, Malika. So full disclosure, you shared this photo yesterday and I opened it on my phone, the attachment, while I was cooking dinner, chatting with my husband. And it stopped me cold. At first, I didn't really understand. I only saw this picture of a beautiful baby and some words, "I am an outbreak." And I struggled to put the two things together.

And then it just hit me like a gut punch. And I said, is this some kind of anti-immigration ad? And then I thought of Dorothy Roberts killing the Black body. And I thought, is this some kind of crazy pro eugenics kind of ad? And then I blew it up and I read the rest of the words and tried to understand what it was attempting to do.

And then I thought, how the heck did this get to see the light of day? I used to work for the New York City Department of Health and Mental Hygiene in the early 2000s. And we were kind of known for some really hard hitting, like almost grotesque public health kind of shock campaigns.

But those had layers and layers, not just of internal approval but community approval and community focus groups, and really understanding how the images and the words would be received and

interpreted. And so I was stunned, like I said, a gut punch and just couldn't figure out how this got green lit in this way to be public like it was. It's just shocking.

**De Maio:** Sure. Thank you, Phil. I've always been struck as well by what that person must have felt to write the response, to go get a can spray paint and a ladder. I haven't told you, but this was a billboard relatively high up. You have to like climb to be able to write on top of it. Renee, your initial thoughts or reactions.

**Canady:** Yeah. It is such a powerful image. I will say that when I first looked at it, I was like, defacement is not always a bad thing. Go get your can of paint and spray truth. But as I just tried to, you'll appreciate this, look through my sociological imagination, trying to understand what happened here. And it really made me think about a quote that I think many of you have heard but it's for Chinua Achebe, who's a renowned novelist and scholar, a Nigerian scholar.

And he has a quote that says, "Until the lions have their own historian, the history of the hunt will always glorify the hunter." Whose narrative it is matters. And clearly, this was not the dominant narrative of the community, of the people who love babies who look like that beautiful baby. And so, yeah, it just made me start thinking, where do I need to pull out my can of spray paint and evoke change?

**De Maio:** Thank you. And David, any thoughts?

**Dr. Ansell:** Well, of course, I know this very well because this was almost like the founding image of our center for community health equity and a part of a *JAMA* piece that you wrote. But three things come to mind here. So one is my background is in this intersection of quality, safety and equity. So this I there's an idea out.

So, the first thing is this normalization of deviance. But rather than being shocked, we can all be shocked by this but think about how many people were not shocked by this. Not only in the making of it by a health department that's filled with good-minded people but also how many people drove by this.

So, I think that's one thing, is that our normalized state is deviant and it's going to get to the conversation about language. And it's so deviant that this could be produced in good faith and good meaning. So that's the first part of it. The second part of it is the dominant narrative of outbreak next to a Black child.

In some ways, the most fear-based, racist manifestations in the world is Black being dangerous. It's so that people hardly say it anymore but they think it. So the idea that you could juxtapose outbreak in a Black child, not even a Black adult, right? And that juxtaposition actually is a dominant narrative.

And then the act of protest. That somebody on the background of this normalized deviance of an explicit telling of an ancient, disgusting, horrific story, almost the unconscious being brought to the conscious by these well-meaning people, that the act of protest is the only thing that allowed people to begin to see the deviance in this. And I do think it speaks to the theme of today very, very well.

And then I'm just going to just say one last thing. As a white man, who's been in this equity space for a long, long time, it was my unwillingness or inability as a white man, cisgender, to speak to the horrors of this. That was actually part of the problem.

These are not clansmen who did this. These are well-informed, liberal public health people. And so I do think sort of, what is our particular obligation in all of this? So that's my take on that. Thank you.

**De Maio:** Excellent. Thank you all so much for your perspectives. And if we could take the photo down. I really shared this photo with the hope of bringing some clarity to what can be a very complex issue, perhaps an unnecessarily complex issue. And we have seen some of that pushback, a lot of pushback in both the right wing and even the mainstream media in response to our guide.

For me, this isn't just an intellectual debate and it certainly isn't about language policing or so-called political correctness. It's about the power of narratives and language to shape our consciousness, meaning and our understanding of our place in the world. Let's explore how this plays out in health care. Dr. Fair, Malika, if I may, I want to begin by asking you to reflect on your experiences as an emergency medicine physician and situations where dominant narratives that influence care to the detriment of patient's wellbeing.

**Dr. Fair:** Thanks for that question, Fernando. I just heard you say that narrative has power. And I think about my own career, even as early as a third-year medical student, when I was faced with a narrative that I didn't agree with, and I thought, "Wait, does no one else see this? What's happening here?"

So, I'll walk you back with me to beginning of third year. That was an exciting year for me because I got to get out of the classroom and finally got to meet patients and got to share my experience with that patient with attendings and other residents.

And when you walk out of the room and you're preparing for that first presentation, there is this unwritten code that tells you if the patient is a marginalized, racial, ethnic group or anything besides a white patient, then you include their racial or ethnic identifier.

So, it sounds something like a 55-year-old African American male complains of chest pain. But if it's a white person, you don't have to say that because they're seen as the default. And a great article that was written in the Journal of National Medical Association by Dr. Olufadeji and Dr. Landry and Dr. Dubosh that was published last year really gave us some great ideas about how to think about racial identifiers and patient presentations.

But as a third-year medical student, you just kind of went with what you were taught. And it wasn't until much later in my career that I realized those early lessons made any patient who wasn't white othered, even in the way that I'm describing them. Later on that year, I was studying for the USMLE Step 2, which I also enjoyed studying for, because it had little patient vignettes.

So, for a few sentences, you felt connected with the patient that you were studying. And in practicing for this exam, I noticed that a lot of the patient identifiers also included race ethnicity in very strange ways. So, it would be an American Indian found down next to a bottle or an African American man found down next to a needle. And the question was, what is the initial first step?

And I was thinking, "Well, as a clinician in training, I got the hint from the bottle or from the needle what the next step is. Why did I need that racial identifier? Why was this vignette further perpetuating a negative stereotype about substance use disorder for marginalized racial and ethnic groups?"

And for this well-known group that was producing these questions, I did email them and said, "I think that these should be removed. This is racist." And their response was, "Well, we can't be racist because we're not based in the U.S." And we had a little back and forth there clarifying that and they did remove those racial identifiers. But that's one example.

We see examples like that across medical education. I'm really glad that we're able to work with faculty across the nation to remove those. And I'll fast forward to in the ED. As I mentioned earlier, I'm a new mom. So I thought that being a physician mom, I would be less worried but I think it makes me more worried. So every fever, I'm on pins and needles.

But in the pediatric emergency department, we had a common practice that you look at the board. So you look at the list of patients and you read the names and you look and see what the patients are coming in with. And if it's patient who may be a new parent, who has a fever of unknown origin, that if the patient has a Latino or a Latina or a Latinx sounding name, there was a name that was described. It was called Hispanic panic, which described parents who were worried about a fever unnecessarily.

But how many infections did we miss? How many patients didn't get a complete evaluation because we labeled a particular ethnic group just because they were a new parent with a child who had a fever? And then finally, you can see this in any emergency department across the nation or any clinical floor where we see a patient who comes in with sickle cell disease.

It's a common practice when we see that particular chief complaint on the board that immediately there's an association with substance use disorder or being a drug seeker, especially for Black patients. And it's disheartening because this population, this is one time that the use of vulnerable is appropriate, because it's a medically vulnerable population.

And we see devastating disease that can happen really quickly in patients who have sickle cell disease. But by labeling this population, not even looking at the patient, not even meeting them but by seeing their diagnosis, how many times did we miss a patient with severe disease and we prolonged their care because we've labeled them? So these are just a few things that I carry with me to this day and I have challenged throughout my career and continue to challenge on a day-to-day basis.

**De Maio:** Thank you. We started our conversation looking at that photo to get clarity on the big picture. And I'm thankful for your examples here, your lived experience for bringing clarity to the real-world effects on the lives of patients and the care that they receive.

David, turning to you, I want to ask you a similar question and one that goes back to what I think is your very first scientific paper. One that details so-called economic transfers of patients from private hospitals to a public hospital, Cook County Hospital here in Chicago.

I've heard you reflect on this many times and you wrote about it in your great book, *County*, the difference between an economic transfer, the language that you published, and patient dumping, the language that you wanted to use and that you've used in subsequent discussions.

And more recently, I've heard you speak about the differences between segregation, racism and white supremacy. So I want to ask, how has language and the narratives they uphold influenced your work? And most importantly, perhaps how your thinking on these matters has changed over time.

**Dr. Ansell:** Yeah. Thank you. And really, thanks. I'm honored to be on a panel like this. And these are the kind of actually thoughtful discussions we need to be having continually. Going back to that first paper, of course, the phenomenon of patient dumping was where people were sent from one hospital to another because they had no insurance and it was supposedly outlawed by the Emergency Medical Treatment and Labor Act.

And this paper we wrote, my first scientific paper sort of led me into health inequity research. And of course, I think it was 89% of the patients who were dumped were Black or Latinx. And the reason why they were transferred is they had no insurance. The fight that we had was someone wanted to call it economic transfers and we wanted to call it dumping. So we put in the paper, economic transfer is also known as patient dumping. That was a compromise.

But why language is so important here is we have a world and a health system that is at the intersection of racialization, minoritization and capitalism. And because we have a society that layers out with white on top and Brown and Black on the bottom or men on top and women on the bottom or able-bodied on the top. You can go on.

That you almost have to in every situation ask yourself, how is this current situation perpetuating in this current moment these historic injustices that have that layering but also the insured and uninsured

on top? And because bottom line and payer mix, think about the language of payer mix. Who's heard that one? The payer mix is bad. That generally means Black and Brown patients and certainly poor patients.

But the language we use is so critical to name. So the first thing we have to do is name, and Camara Jones has been terrific on talking about all the ways we should name this, but we must explicitly name. I don't like equity. What does equity mean? It sounds like an investment. We need to talk about racism in other forms of systemic exclusion.

And we need to talk about not poverty but economic deprivation. The act that puts people in a state of poverty, as if poverty is like a natural state. And for me, as I spoke, for many years I talked about redlining bias. I talked about segregation. But they're not the right words. The right cause, the root cause is white supremacy. White supremacy causes racism. Racism causes redlining and forces people into lives of economic deprivation, which cause poverty.

So, I think this idea of a cause and effect, which I think we're beginning to see more and I think was exactly the point of the guide is critical for us to be able to name. Now, I'm also going to say, who needs to name it first? White people, white men have to name this first because we're the ones who benefited from these systems of oppression.

Another word that people don't like to use, they are systems of oppression or systems, I call them inflictions, because they cause illness. And by the way, the experience that Dr. Fair just mentioned, my colleagues at University of Chicago, Dr. Monica Peek and Dr. Tung just published an article in Health Affairs this very last week that looked, and I think is at their institution, an institution that serves largely Black people.

They did a natural language processing about negative language towards people of color and people of color are two and a half times more likely to have negative descriptors. Our own researchers looked at UWorld and looked at racial descriptions and gender description in UWorld. And there was significant racial discrimination. Our normalized state is to normalize white supremacy. And so how do we get beyond it unless we begin to really have a language to this work?

**De Maio:** Thank you so much, David. Insightful remarks. It gets me to think, we wrote about this in the guide as well, about the power of dominant narratives to obscure responsibility, to obscure root causes in systems of oppression. Language can hide and also language can bring out into the open, just like that person with a can spray paint was able to change and relay a counter narrative.

Renee, if I could turn to you, you have served in diverse public health sectors. I wanted to ask how dominant narratives have shown up in these different settings and what strategies you have used to challenge them. What has been effective from your perspective?



**Canady:** Sure. Thank you, Fernando. I mean, clearly you would think, "Oh, we're all public health professionals." That the narrative, the dialogue, the discourse would be shared. But so much of dominant narrative and public are based right in culture and context. And we certainly know that academic public health is a very different culture than governmental public health.

And even within governmental public health, the culture and the context of those at the federal level, at the CDC, for example, as opposed to at the state level, and even in comparison at the county level, which I would submit is also very different serving in a county health department than in a city health department.

And so, we make assumptions that we have this shared belief system and nothing could be further from the truth. And so really beginning to, first, honor those differences so that we can address them. I'm always thinking about this idea of shared meaning, shared systems of meaning that really should undergird public narrative, which absolutely get in the way.

My grandmother used to say, "Everybody grinning ain't tickled." And so really, so often what we see in public narrative is that unspoken truth. Malika said something about that. It's assumed that that's the way we're going to be behaving, if I could say that.

So, I think that challenge that we have seen, even just a couple of examples in those settings. There was sort of that unspoken assumption or common practice that you refer to physicians as doctor but other doctorally prepared people are Miss or Ms. or Mx, whatever their preferred title is, but not doctor because that was for the physicians.

And there was always justification, "We don't want people to be confused that that person can treat and heal but that person can't." And so, it's interesting how we understand that and accept that example, recognizing that it's fueled by power. And unless we address power in dominant narratives, then we're not going to make much headway either.

Another couple of examples that I saw in these spaces when I was a full-time tenure track research professor at Michigan State University, we talked a lot about being health disparities researchers. And that was kind of the gold standard. We were concerned about disproportionate representation and those types of things.

But never really until more recent scholarship has academic public health started pushing to the root causes and to the why, just describing and analyzing health disparities. And there was a season there in the nineties where every way to analyze differences in diversities and disparities was being funded without pushing people to stop describing these differences and let's start analyzing and explaining what's causing them.

I would also submit that I've seen across those sectors of public health that everyone saying health equity does not mean health equity. I appreciate Dr. Ansell's clarification on that term equity, which is so problematic in so many spaces. Many people are really not wanting to talk about racism in the numerous other forms of systemic oppression.

And I would submit that you cannot discuss health equity without discussing those systems of othering and oppressing that are baked into our nation, certainly with the history that we have in this United States. So, kind of giving ourselves permission. Another final example I'll give is all of the discourse and the energy right now around social determinants of health.

I would submit that that's a barrier. And I know that's probably, how dare she? But until we really start discussing and understanding and shifting social determinants of health inequities, we're never going to be able to improve the context. But we want to have the easy dialogue.

And so, one of the things that we've consistently done is to use health dialogue as a methodology, sort of facilitate a dialogue. So when people say, "I'm really tired of talking about this, and we should move on to the next topic," then I would submit that they're not engaged in dialogue that is going to disrupt and change dominant and public narrative.

And so, we want to keep everybody at the table. Yes, we want to keep people whole. Nobody wants to be called a racist. But we also want to recognize that there's a critical deep discourse that needs to happen that is not just casual and undirected. It's really vigorous. It's not marginalizing differences. It's welcoming differences.

It's not looking for that one sort of consensus approach, "Okay. We all agreed to this." It's really looking at a collective approach. And we're not necessarily emphasizing/persuading someone as is common in debate. We really are trying to listen and look for complimentary solutions so that our own way of understanding, hearing can be shared by all those at the table.

And so, it's only then, even though public health started historically at a place of dealing with root causes, our efforts now are to transform public health out of this categorical symptom and disease-oriented mindset that we've fallen into. But the only way we'll get there is when practitioners are courageous enough and equipped enough to disrupt these narratives.

**De Maio:** I know you all share this idea that I am so grateful that we're at a time that we are speaking about these things, that we're bringing this disruption to the open, that we're raising it at every opportunity. And I know you all do that in your work. And I'm so glad that we're pausing a little bit today to talk about this together. Philip, over to you.

But first before the question, for record, as this is recorded in public, for the record, I want to acknowledge what a remarkable partner you and Malika and the entire AAMC team have been on this

narrative guide project. So a huge thanks.

I want to give you space to offer your reflection on the nature of this guide and what hopes you had for this project and also your thoughts on its reception. We have all been very mindful of the critiques, which have been very, very prominent. And I'd love to open up some discussion of that, get a sense of how you understand the document that we produced and its reception in the world.

**Alberti:** Awesome. Well, thank you, Fernando and thanks to Dr. Maybank first for the invitation to partner with you in the AMA Center for Health Justice on I think this really important piece of work. So, when you presented the opportunity to us initially, I think we were just about at the point of finalizing our center's "Principles of Trustworthiness," which is a toolkit that we co-developed with communities across the country that focuses on the kind of actions that all organizations.

Not just health care, but any of us, public health, schools, whatever, the actions that we can take to demonstrate that we are worthy of our communities' trust. Trying to really put the onus on building trust where it belongs or at institutions with power and privilege to show that they merit that trust. It's really foundational to the way that we think about health justice. And then the first principle resonates so much with the guide.

And so, when you made this proposal for partnership, it automatically clicked. The first principle is the community is already educated. That's why it doesn't trust you. And I think there are two things that are going on in that first principle that are so clearly connected to the guide. And the first is that it's about reflection. The community knows its history with you, with your organization. The past is always present.

So, before we can partner, we have to make sure we're coming correct. That we're acknowledging the history, that we understand our role in it and the local narratives that it's created over time, over generations. And we have to take responsibility for that behavior and that's really paramount. And so that's one way that it connected so well.

The other aspect of that first principle is that it's about language. When we're conducting the interviews that gave rise to this toolkit, it was the summer of 2020. So, like a low point among low points in the many pandemics with which we've been struggling. We kept hearing on TV and the news and newspapers, from doctors, physicians, scientists, public health experts that we just needed to educate the community.

If only the community were educated, then they would trust clinical trials or the eventual vaccines. If we could only produce the magical pamphlet that was in the right language, with the right jargon, at the right grade level, that all the mistrust and distrust would just dissipate. And I think we in the center found that overly simplistic, offensive, patronizing, racist, classist, fill in all the words.

The goal can't be to educate the community. They already know so much more than many of us know about the lived experience, the life, the history. So the goal should be to partner, to work with, to co-develop, to co-create, whatever the right word is. And so, language matters. The framing of the way that we talk about communities, whether it's patient communities or neighborhoods, really matters.

And so, you ask how we see the guide and what our hopes were. And I think we've always seen the guide and still do as asking us, and not just clinicians and health care professionals, but all of us, to do two things. And first is to reflect around how our language, whether it's the language we use out loud, written in a research paper, a grant, and yeah, the doctor's notes, that paper that David mentioned.

How the language that we use can reinforce racist, classist, homophobic, dominant narratives. So that's step one is to take that pause for reflection. But then step two is to use that pause to kind of recalibrate and think how we can reframe, reuse our language in ways that are more respectful, more inclusive, more precise and more action oriented.

And I think those are still the goals that we have for the guide. And I think we did a pretty good job making that clear that that was the goal and that it wasn't a checklist, that it wasn't a say this don't say that exercise. That it was all context dependent. That neither the AMA nor the AAMC can do any kind of mandating of language or narrative in the spaces where we have some giddy-ups, so to speak.

So to answer the second part of your question, all of that I think seems to have been missed or misunderstood or ignored and you can fill in whatever verb you want based on your own kind of biases and interpretations of some of those critics. And whether they're on the far, far right or the center, center right mainstream press.

I think we saw cherry picking, taking elements out of context, lot of hyperbole and maybe like a willful desire, like a really earnest desire to not reflect, to not pause, to not think about how we could be more respectful, inclusive, precise and action oriented.

And so, then my question for those critics is, why? What is so threatening about that reflection? What might that reflection ask us to do? Because it might ask us to upend the narratives that maintain an unjust status quo. As everyone said so beautifully today, it might require that we talk about racism and white supremacy and misogyny and homophobia, X, Y, Z, keep going.

And I think that's threatening across the entire political and ideological spectrum. Upending that status quo is a threat. And I think we saw that pretty clearly in the reaction to the guide initially.

**De Maio:** Thank you so much. Last question, which I'll open up to the entire panel. And I want to reflect on something that David wrote in a recent op-ed in *STAT News*. If I could show this quote on the screen, please. David, you wrote that, "The goal of raising the question of language and narratives is vital to the more important task at hand: eliminating deadly racial health inequities."

"It isn't just about words, but action. By acknowledging how long-standing practices and beliefs and language have harmed the health of millions in the United States and shaped the unequal health system that exists today, we could imagine a future where physicians can truly partner with their patients and everyone has an equal opportunity to live a healthy life." I could take down the quote, please.

I'd love to hear from all of you on this. It isn't just about words, but action. And so, in that level, what advice would you have for viewers who are considering these words, grappling with the guide and exploring new terrain around language and narratives?

Perhaps most importantly, how might we connect with medical students and physicians who come to this with vastly different levels of awareness, with different politics altogether around the true root causes of health inequities? And if I could take the quote down so we can see the panelists, please. Thank you. Any reflections?

**Dr. Ansell:** Maybe start since this was my quote. But I actually think the fact that we're having a debate on language and we can't even agree on language is a little bit like the billboard you put up in the beginning and people driving by it, people making it without feeling any dissonance at all. We can feel the dissonance now, some of us.

But the fact is that reflects the norm. So, what are we up against? A recent Commonwealth poll of Americans found that 53% of Americans do not believe racism is a problem in this country. The same poll found that one out of three Black people and Latinx people have experienced discrimination in health care in the last year.

I think language is important for all the reasons we've spoken but our own actions are critical. And I'm just going to be here to be a little bit disruptive. I'm a senior leader in an academic medical center with the issue of payer, payer mix or you put your next clinic.

All of this stuff is all aligned with an economic and racialized view of the world. And the AMA also with all the great things you've done have never come out to speak on base of a fair health system, nor is a AAMC based on justice and equity at the center of it and not economics.

We need to clean up our own houses in what we do. And I don't know how we get there. I mean, we're all leaders, we're all in our organization. We are all semi swimming in a sea of white supremacy that's continually be rewarded because of its link to the economic infrastructure that underpins our public health system, the lack of an economic infrastructure in our health system.

So I think the work has to start within our own institutions. Let's get them right. Let's show by our own actions, by what we do. Because words, talk is cheap. It's important we talk, believe me. But the actions are more important. It's got to start at home. I don't know where else we can start. So, I know

that's maybe a little bit hard hitting at the table I've been invited to eat at today but I can tell you in my own institution, we're struggling with getting this right.

**De Maio:** We hear you and we acknowledge and appreciate the truth that you speak. Malika.

**Dr. Fair:** I love that quote, David. And what my eyes landed on was that part that said, "We can't really truly partner with patients." And I think about, what does true partnership mean? And I completely agree with you that we have to address at the institutional level these economic inequities that exist in our cities and in our counties and our states and our nation.

But I'm going to bring it down to within the clinic at the bedside, what does true partnership really mean? And I think if we can't address the narratives in these dehumanizing and perpetuating these stereotypes, then we cannot ever truly partner with our patients and listen to their real concerns. And I'll give you an example.

In 2020, we were able to convene all the medical schools and teaching hospitals in the district of Columbia and in that surrounding area to ask the question, if our goal is to achieve health equity locally in the district of Columbia, what does that look like? And how can we partner together?

And we published that report on our website. And one of the really outstanding examples I heard was from a teaching health center in the district based at Unity Healthcare and the residents there got past stereotypes of patients. They got past whatever narratives had been taught within medical education. And they truly partnered with patients and identified transportation inequities in the district of Columbia. And they themselves got themselves together.

We're advocating on behalf of more bike share access in the district and equitable transportation. I thought that was just phenomenal. Because we all know that medical students and residents have a packed curriculum. They've got a lot of hours that they're putting in. But they were able to put words into action and to do something on behalf of the patients and truly partner with them. And I think we need to see more examples like that on the individual level. And absolutely, David, I agree with you on the institutional level as well.

**Alberti:** And I will add to the ... Thanks, David, for being hard hitting and keep hitting hard. One of the things that we say a lot in the center is that academic medicine can advocate for health and not just health care. And I think what we mean when we say that is to think about not the bottom line, not the economic imperative of medicine as a business, but what it really means to have a more collectivist a spirit and understand that we are only one set of experts in a community of experts.

And that an aligned agenda where we're working with transportation, like Malika was just talking about, and all the other sectors grounded in community wisdom can maybe begin to move us away from the knot of racism, kind of harmful predatory capitalism, economic injustice, social injustice. I

mean, I think that's where we are.

And so, for me in my practice and my scholarship, I always try to bring it back to trust and to community engagement, which is how I was trained and kind of my orientation in the broadest possible sense. And so this guide, I think dialogue, discussion, reflection, these are all goals of the guide. Because context does matter. And that means different things in different communities, different groups of patients, different times and different places will relate to words and framing differently.

And the only way that we'll ever of that is to ask, is to be brave and to engage. It's to demonstrate that we're worthy of that trust by engaging, listening, understanding others' fears and concerns, not just about the words that they speak. And I think a lot of white people, to be honest, not that I'm going to speak on behalf of all white people, are terrified of saying the wrong words.

We really do wish the guide was maybe like, "Yes, just say this. Save this list, never say these things again and don't ever change it. Put it in stone, tablets from the hill. Let's just leave it and leave it alone." But that's not what this work is. It's about being brave and trying to bridge that trust gap by asking questions and trying to understand the fears about what people might say or missay but also the fears they have about the words that they hear spoken and written about their own communities.

So I think the guides, the feelings, the emotions, the thought that it sparks is the perfect opportunity to reach out, to stretch, to learn and to engage. And I really believe that that's the first step in rending the racial, social, economic and political roots of health inequities.

In my mind, I know we could get another hour conversation about equity and health equity and disparities and all the language and definitions. But I think for us in the center, the goal of health equity is for all communities, not just Black communities or gay communities or immigrant communities but all communities to truly have the resources and opportunities they need to thrive. That is a common goal.

But as long as our words and our narratives and our language divide us, it's a goal that will never, ever be reached. And so, I truly think that engaging to find the common stories, the common ways of dialogue is the key first step in a health justice agenda. And so, thank you, Fernando, for this opportunity, for the opportunity to partner on the guide and for continued conversations.

**De Maio:** Oh, thank you, Renee, the last word goes to you.

**Canady:** Last word. Well, I will say that one, again, kudos to AMA for initiating this dialogue and the guide. I was really excited about the pushback. I mean, you all had a broad table contributing to that. I mean, at MPHI, my colleagues and our colleague Richard Hofrichter were able to be contributors as well.

And when we got the pushback, I was like, "Yes," because that means that we're being agitational. If people were like, "Oh, this is such a good guide." Then we weren't doing our work. So, I'm encouraged because, one, I know that change happens. When I was a doctoral student at Michigan State University being discouraged from doing research on the pregnancy experiences of Black women because I was going to get marginalized in the academy, I just pressed through.

And now, literally everybody wants to talk about my topic and my dissertation and, "Renee, can you come to this meeting?" But you have to take risks. Change does happen. It's generational, right? So, we're going to run this leg and we're going to leave things better off than we found it. And we're going to pass the baton to a much more activist and progressive group of physicians.

I teach, of course, on health equity in the School of Public Health at Michigan State. And right now, I've got a cohort of MD, MPH students in there. And man, they are agitational. And so, I'm excited about that. Change isn't going to happen tomorrow but we know that change is happening and we all know that change is happening because action is being translated from words. They do go together. So yeah, we're on the journey and I'm really excited to be a part of it.

**De Maio:** Fantastic. Thank you. And a huge, huge vote of appreciation to the Michigan Public Health Institute for their contribution to the guide. We learned so much from Richard Hofrichter and the whole team. Many, many people contributed to this. I'm so grateful to all of them. And I'm grateful to all of you for joining us today.

This for me has been an inspiring conversation. So, I'm very grateful that you joined us today. Before we close, I want to urge viewers to visit us at the AMA website, [www.ama-assn.org](http://www.ama-assn.org), where you can readily find a copy of the narrative guide. From the AMA website, you can also easily navigate to the AMA Ed Hub, which features a large and growing collection of content curated by the Center for Health Equity.

From the AMA webpage, you can also find our health equity resource center for COVID-19 and, of course, read the AMA strategic plan to advance racial justice and health equity. Also, a very highly recommended is a visit to the AAMC Center for Health Justice website, recently launched at [www.aamchealthjustice.org](http://www.aamchealthjustice.org). Thank you so much to all of you for joining us today.

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