MORE THAN A ROUGH YEAR
Chavon Onumah, MD, MPH, FACP; Marshall Fleurant, MD, MPH

It’s been a rough 2020 Doc,” said the middle-aged African-American female patient in response to my inquiry about stress during her visit for a “missed period.” She proceeded to share how she had lost three family members to COVID-19 within the last week, her job was an “essential worker” that was requiring her to report to work the following week, and how she had to try to hold it all together for her remaining living family members. We cried together and I thought to myself, “We failed her and her family...the system is failing...something has got to change.” As providers who have suffered personal losses of family and friends from this pandemic, we find ourselves with an uncomfortable commonality—the effects of systemic racism. The time is now to tackle systemic racism—here is why and how.

In recent decades, the intersection of racism and health in America has gained more attention; however, our experience of racism and health in America stretches for much longer. From the transatlantic slave trade, hundreds of years brutal violence, dehumanization, forced labor of millions of Africans to Jim Crow laws, involuntary and nontherapeutic experimentation of African Americans, the systematic removal of indigenous people from their native lands, and redlining, our country and its institutions are deeply rooted in racism and oppression. Systemic racism (also referred to as institutional and/or structural racism) includes the rules, policies, practices, and customs ingrained in systems and society that disadvantage and/or lead to the discrimination against or exclusion of designated racial groups, and further reinforce inequities. Manifestations of systemic racism can be found at every level of society from housing, employment, education, criminal justice, levels of wealth, and health care today. Hundreds of articles and books have shed light on the systemic racial inequities within medicine. More recently, data showing the excess morbidity and mortality among African Americans and Indigenous Americans with COVID-19 as well as higher COVID-19 incidence rates in Latinx populations has highlighted the health effects of systemic racism.

In addition, we witness a rise in harassment and hate crimes towards Asian Americans and wake up to repetitive images of Black men and women losing their lives at the hands of law enforcement officials, adding insult to injury. Systemic racism in the United States significantly limits persons from marginalized groups’ ability to participate fully and optimally in society. In addition to racism’s physiological and psychological impacts on individuals from marginalized groups, systemic racism impacts patient-provider relationships, access to high-quality care, evidence-based screenings and interventions, and diagnostic and treatment decisions. All contribute to poorer health and well-being, especially perpetuating health inequities of Black, Indigenous, and Latino populations. Systemic racism in medicine and society must be named and dismantled to truly achieve our goals of optimal and equitable care for all.

In May 2019, Dr. Camara Jones charged the Society of General Internal Medicine membership to identify and address the mechanisms by which our healthcare systems perpetuate racism. We are proud to call SGIM our profession
Racism is a public health emergency.

As this year’s events continue to unfold, a pandemic crashed into and forced wide open the deep and long festering wounds of our country’s racist history, policies, and systems. As anti-racism demonstrations spread across the country and the world, doctors, clinicians, and community advocates had already been speaking out advocating for our most vulnerable and systemically disadvantaged communities.

SGIM issued a strong position statement in June to denounce the racial injustice and murder of Black Americans. In response to the Forum’s Call for Submissions for this theme issue on “Systemic Racism and Medicine,” SGIM members soon answered that call—just as they have always done—with the passion and critical thoughtfulness that represents this community’s powerful voice for social change and justice. As our communities of practice and education evolve to embrace anti-racist values and design healthcare systems accordingly, diverse views are vital to ongoing dialogue and change.

In this issue, SGIM president Jean S. Kutner and SGIM CEO, Eric Bass introduce the Society’s plans for looking inward to diversity, equity, and inclusion internally. Onumah and Fleurant, current co-chairs of SGIM’s Health Equity Commission, reflect on the racist history of medicine, noting that our current actions can change history for when we’re looking back at 2020 from the future. Also, associate members contribute two articles to this issue looking at medicine and sharing their stories from trainees’ eyes. The SGIM Education Committee and Leisman and Karani offer recommendations for medical education programs to be anti-racist. The issue closes with the beginning of a collection of essays, as Sgro looks back at five of many previously published Forum articles on race and medicine.

This is only the beginning. Forum is committed to sustaining dialogue on racism and its impact on the public’s health. We need your voices and opinions from the front lines of patient care and advocacy to keep these critical conversations going. We need to remain vigilant of the insidious influences of racism in our practices, patient care, and healthcare systems. We need to look in the mirror, recognize what needs to change, and work together on addressing this public health emergency that is racism.
BLIND SPOTS

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“We must identify and acknowledge our blind spots to ensure we have appropriately comprehensive policies on diversity and inclusion.”

July 18, 2020

This issue of Forum is just one example of SGIM’s purposeful approach to diversity and inclusion. As Dr. Kutner stated in her August column, “It is our responsibility to each other, to the field, and to the people and communities that we serve to act.” SGIM has primarily been externally focused in its efforts with regards to diversity, equity and inclusion, working towards its vision of a just system of care in which all people can achieve optimal health. SGIM is committed to focusing internally as well. Below we answer two key questions regarding SGIM’s commitment to diversity, equity, and inclusion.

1. What do you see as blind spots in the organization’s commitment to diversity and inclusion?

Recently, our Director of Member Relations, Muna Futur, asked whether SGIM has a diversity council or any workgroup dedicated to diversity and inclusion apart from the Health Equity Commission and the Minorities in Medicine Interest Group, and whether SGIM has a statement focused on diversity and inclusion. Our first reaction was to explain that SGIM has been committed to diversity and inclusion for many years, as reflected in the statement of our core values, which include diversity, equity, and inclusion. The Health Equity Commission (HEC) grew out of the Disparities Task Force that was formed by SGIM’s Council in 2001 to focus on disparities in health and health care. The rationale for converting the task force to a commission was to make it a permanent part of the organization, with the expectation that the HEC would have an important role in collaborating with other entities within the organization. Currently, the purpose of the HEC is “to serve as the chief advocate for SGIM’s health equity related interests for education, research, and provision of clinical care as the Society strives to achieve better health for everyone. In this role, we [the HEC] seek to promote, educate, and collaborate with the membership of SGIM to dismantle structural inequities, optimize the outcomes of each patient-provider encounter, and pursue social justice es-

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OVER the last few months, we have witnessed a global pandemic in which millions infected and hundreds of thousands have died. As research fellows in general internal medicine, we could not have anticipated this when our fellowship started last July. We are not far removed from our residency training and know that it has been a challenging time to be a healthcare trainee with so many of us at the forefront of the COVID-19 pandemic. We have been caring for patients who have been incredibly sick, and we are worried for our patients who are not seeking care even when they should. But the COVID-19 pandemic has not affected all communities equally: communities of color bear a disproportionate burden of the morbidity and mortality from COVID-19.

In addition, longstanding racial/ethnic disparities and structural racism have been further highlighted by recent events. The dual crises of COVID-19, with its disproportionate impact on communities of color, and the repeated police killings of unarmed Black people have exposed what many of us in medicine have long known—structural racism is a fundamental determinant of health and mortality in our country. We applaud and support those who have taken to the streets in protest, demanding dramatic change in their communities and institutions.

As general internal medicine physicians, we see the daily toll that structural racism and adverse social determinants of health take on our patients whether on the hospital wards or in the clinic. We witness the health effects of redlining and residential segregation, food deserts, substandard housing, proximity to pollution, militarized police forces, mass incarceration, and being in low-wage, essential jobs during a pandemic. There are times when we feel powerless as trainees, trying to partner with our patients to solve medical problems that have their roots in legacies of inequality. Despite the challenges, these clinical experiences underscore the role we have and our moral responsibility to advocate on behalf of our patients, their families, and their communities.

The recent, unjust deaths of George Floyd, Breonna Taylor, and countless others, now more than ever, illustrate how we, as physicians, must advocate for our patients. This column suggests several ways that we, as trainees in general internal medicine, can use our voices to address these social injustices, whether by educating ourselves and engaging others on the history of structural racism in our profession; participating in protests, advocacy through media, or research that translates into solutions; or working with patients to address social issues.

Education
There is a wealth of resources on learning more about how structural racism has been a part of medicine since the beginning of its history. A few resources we suggest are Medical Apartheid by Harriet Washington, Praxis Podcast by Edwin Lindo, and the American Medical Association’s “Prioritizing Equity” video series. There is also a robust evidence base on interventions to reduce racial and ethnic disparities in health that we can learn from. Multi-level interventions that engage patients at various points during their interactions with the healthcare system, incorporating community health workers into care teams, and delivering health care in non-traditional settings such as places of worship, are a handful of examples that have been shown to improve outcomes for vulnerable communities.

Participating in Protest
As of this writing, many Student National Medical Association and White Coats for Black Lives (#wc4bl) chapters organized demonstrations on medical center campuses around the country. It was inspiring to see students leading these efforts. We need to support these
The institution of medical education in the United States has remained neutral on the topic of racial injustice for far too long. Within all social movements, there are moments that catapult awareness into our collective psyche. In the fight against injustice towards Black people in America we are in a contemporary awakening as both educators and as humans.

Many of us ran 2.23 miles on May 8 in honor of Ahmaud Arbury, a young man chased and murdered while jogging in his neighborhood in February. During the same timeframe, news began to spread about one of our healthcare colleagues, Breonna Taylor, being killed by police on March 13. Only two weeks after #runwithAhmaud, we were shocked as physicians to hear George Floyd say words we routinely treat as life-threatening, “I can’t breathe,” more than 20 times before being murdered by police. Nationwide outrage and protests demanding justice quickly followed. Although we have grappled with many killings in the past (Michael Brown, Trayvon Martin, Tamir Rice, and countless others), some of us are confronting the reality of injustice in a deeper, more conscious way for the first time.

Lack of awareness of white privilege and the racial oppression that results from this privilege has kept us from recognizing our complicity in a racist healthcare system, as well as society at large. Systemic racism and racial injustice are built into nearly every aspect of life in the United States, including medical training. As educators we must recognize that dismantling systemic racism demands more than supportive social media posts. As we join the conversation about race and racism in the medical community, we must start the hard work of evaluating our own culpability.

We recommend starting with reflection, including contemplating how one’s own race has shaped one’s life. Race is a social construct without a scientific basis. Sitting with that concept alone can be challenging to one’s worldview and becomes even more difficult when considering what has been previously taught in medicine. This type of reflection and self-education can be discomfitting work. However, as physicians, we have committed to the processes of lifelong learning and constant self-reflection. The discomfort that we experience will prompt us to enact change at the individual, institutional, and systemic levels.

Academic medical centers must also recognize their role in propagating the culture of discrimination and unconscious bias, which is outlined in the 2019 AAMC Diversity in Medicine report. Despite increased diversity seen among medical school matriculants and graduates, there has been a persistent lack of minority representation at the faculty level, particularly for Black physicians. This should be a cause of concern for academic medical centers and our society as a whole. Though the medical community has made several commitments towards racial justice and equality over the last few years, this report demonstrates that these efforts have fallen short.

Academic institutions, faculty, and administrators must evaluate practices that propagate racial disparities
CAN MATH BE RACIST? A REVIEW OF THE SYSTEMIC RACISM INHERENT IN eGFR AND PFT CALCULATIONS

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Systemic, or institutionalized, racism occurs when resources are distributed and practices are enacted that benefit white people at the expense of people of color. Effects of these policies disadvantage certain racial or ethnic groups while advancing whites. Two commonly used markers of organ function, estimated glomerular filtration rate (eGFR) and pulmonary function tests (PFTs), contain a race-based correction factor. These correction factors, ostensibly designed to make the calculations more accurate, perpetuate systemic racism.

Various formulae for estimating a patient’s GFR have been developed to quickly determine patients’ degree of kidney function and ensure appropriate medication dosing. The widely employed Modification of Diet in Renal Disease (MDRD) formula uses serum creatinine, age, sex and what is termed “ethnicity” to calculate a patient’s eGFR. It is this value that appears as “eGFR Non-African American” and “eGFR African-American” on most American laboratory test results and provides the basis for the diagnosis and treatment of kidney disease.

At first glance, the formula’s embodiment of systemic racism may be opaque. However, the authors included a small sample of Black subjects, and when the authors attempted to explain why Black “ethnicity” predicted a higher eGFR for the same creatinine value, they did not mention the small sample size as a potential source of error. Instead, they relied on outdated and racist tropes about differences in body composition and muscle mass between races. This fallacious and racist logic crumbled when the formula was validated in Black patients in Ghana where the eGFR more closely correlated with the non-African-American formula.

The impact of the systemic racism embedded in this race-based formula is significant. The biggest barrier to transplant is late referral; patients cannot be listed for transplant until their eGFR is less than 20 ml/min. Assigning Black patients a higher eGFR for a given creatinine leads to later referrals for preemptive kidney transplant and can lead to longer times on dialysis compared to white patients. A race-based formula further exacerbates the disparities in kidney transplant and may partially account for the disproportionate number of Black patients who are on dialysis compared to their percentage in the overall population.

This is not the only way systemic racism manifests within the eGFR calculation. According to the United States Census, approximately 10% of Americans do not identify as “White, alone” or “Black or African-American Alone.” These patients, who include Asian and biracial individuals, were not in the original derivation MDRD paper, yet are lumped together under the “non-African American” grouping when their eGFR is calculated. This is particularly problematic because when the formula was tested in East and South Asian countries, the true GFR did not align with either the African-American or non-African-American equation.

Additionally, the formula exemplifies the “white standard” where white is considered the normal, and “race” requires an adjustment. For pulmonary function tests, the challenge is a different one: in PFTs, we can measure a true value (a patient’s vital capacity or forced vital capacity), but that value is meaningless in isolation. For interpretation, we need to have a reference standard with which to compare. In this case, systemic racism underpins the creation of the reference standard. A reference standard should be derived from qualities that are fixed and could influence the measurement. In PFTs, consensus is that age, sex,
“IS IT BECAUSE I’M BLACK?”
REFLECTIONS ON RACIAL JUSTICE IN MEDICAL EDUCATION

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“Is it because I’m Black?”

These words haunt me. They came from the voice of a Black man lying down on an emergency room bed, in pain.

I was in the middle of an emergency medicine shift—an infamous rotation of my internal medicine residency—where we are pushed out of our cognitive comfort zone into a chaotic, fast-paced environment full of all kinds of smells, sights, and sounds. I was not prepared, however, to hear that patient’s question.

After collecting the patient’s history and performing a physical exam, I returned to the main workstation where my attending was sitting. I presented to him and began to order medications, labs, and other diagnostic tests to evaluate this patient, who had come to the emergency room with abdominal pain. The patient’s nurse then approached us, stating that my patient was asking for pain medication. I already had placed the order in the system, but my attending quickly said to me, “Don’t give him any oxycodone—I think he’s asking for too much. Acetaminophen is fine.”

I felt uneasy and unsure of what to do. I tried to reason with the attending that this patient’s degree of pain deserved a strong medication—at least in the immediate time while in the emergency room. It seemed very reasonable to provide meaningful relief to this gentleman’s pain; he is a human who was suffering, and I had planned to treat the pain acutely while investigating its etiology. Training in a background of an opioid epidemic, I developed a clear practice of when I would consider prescribe opioid medications. In this situation, I felt very comfortable treating my patient’s acute pain with an opioid while in the emergency room. Even so, my attending stood firm with his decision. Reflecting on how the opioid epidemic disproportionately impacts Black patients, I was acutely aware of the assumptions my attending may have been making by refusing to provide my patient with opioid pain relief. Despite my reasoning and reflections, I felt uneasy in voicing these strongly and unsure of countering my attending’s decision—I was caught in a web of medical hierarchy and professionalism that called for me to respect my superior.

Drenched in the sweat of moral tension, I sat in front of the computer, my mouse pointed on the “discontinue” medication button, as my attending walked away.

Slowly walking back to the patient’s room, I told him that we could offer him some acetaminophen, but we were unable to give him stronger pain medication. He patiently asked why, and I fumbled with my answer, muttering something of an apology for not being able to fulfill his request. He paused for a few seconds, as I stood there feeling helpless, and then calmly asked me the question that put a spotlight on systemic racism in the emergency room that day: “Is it because I’m Black?”

It is well known that Black patients’ pain is undertreated and that this is linked to systemic racism. Medicine at all levels is steeped in racial bias—from medical school and beyond—causing erroneous, ridiculous, myths such as Black people having less sensitive nerve endings or thicker skin. Myths around pain, in particular, lead to poorer quality of care and poorer health outcomes in our Black patients—an unacceptable fate that presented itself in the emergency room that day.

My patient’s voice echoed through my ears. I suddenly felt a tightness in my throat, swallowed, and responded with a sigh of something between frustration and embarrassment, “No, of course not...” As I said this, I felt my hand point to my own brown skin, perhaps to say, “How could it be? I’m with you.” But, the person-of-color-activist in me felt defeated; how could I let this happen?

Training in a location that was predominantly white, I often sensed a mutual belonging when caring for patients of color. In fact, patients had routinely disclosed to me mental health effects of racism, and I always felt that there was some sort of unspoken shared understanding of what it meant to be a person of color living in America. However, in this situation, the kinship I often felt with patients of color suddenly felt challenged. This kinship started decades ago, when Black civil rights activists fought for the Immigration and
T

wenty-three years ago, growing awareness of racial

health disparities was a major topic of discussion

at the SGIM Annual Meeting in Washington,

DC. Since then, much has been written in these pages on

evolving concepts of race in medicine, confronting bias

and racism in medical education, promoting just and eq-

uitable healthcare delivery, engaging in public advocacy,

and confronting discrimination in academic medicine. I

am proud of the legacy represented by these authors and

committed to amplifying those voices who endeavor to

to name and dismantle systemic racism in American society

and medicine. The following articles are part of SGIM

Forum’s Race and Medicine Essay collection, which in-

cludes nearly two dozen articles published since 1997:

“Race”1

February 1998 | Nicole Lurie

A primary care physician decides to embrace discomfort,

conducting an “n-of-1 experiment” by asking her Black

patients how they feel about being cared for by a white

doctor.

“Current Trends in Understanding Race and Health”2

November 2001 | Giselle Corbie-Smith

Insights from the completion of the Human Genome

Project and research in the field of pharmacogenomics

offer competing visions for how to address racial health

disparities.

“Teaching Outside of the Box: Dealing with Bias,

Stereotypes, and Racism in Medicine”3

September 2003 | Alexander Green

An attending physician reflects on his response to a resi-
dent’s biased case presentation.

“The Importance of Being Outraged”4

April 2019 | Denise L. Davis

The only under-represented minority physician in her di-

vision embraces her outrage upon realizing that race and

health equity were not on the agenda at a recent faculty

retreat.

“Developing an Anti-Racist Residency Recruitment

Process”5

January 2020 | Joseph Truglio, Ann-Gel S. Palermo,

Leona Hess, Princess E. Dennar, and Antonia Eyssalenne

The authors describe a novel strategy to recruit a high

percentage of applicants from backgrounds underrep-

resented in medicine, and to shift power away from the

academic medical center to the patients and communities

that will be cared for by residents.

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4. Davis D. The Importance of being outraged. SGIM


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2020.
COMMITTEE UPDATE: PART II

GOT ETHICS QUESTIONS? ASK AN ETHICIST

The SGIM Ethics Committee

In this time of unprecedented healthcare challenges due to COVID-19 and systemic racism and health disparities, SGIM members may face significant ethical challenges in their practice. The SGIM Ethics Committee supports the mission of SGIM, in part, by promoting the ethical practice of general internal medicine, addressing ethical issues in clinical practice, research and health policy, and relieving moral distress caused by conflicts about such issues.

We wanted to inform SGIM members of our existing initiative, “Ask an Ethicist.” This service allows SGIM members to ask any questions about a wide variety of ethical challenges they face in their roles as clinician, researchers, educators, and advocates, and get answers from ethical experts on the SGIM Ethics Committee.

We have created a link on our committee page that allows SGIM members to “Ask an Ethicist” questions they would like us to consider: https://www.sgim.org/communities/other-sgim-committees/ethics/ask-an-ethicist. Through this link, we hope to provide support to members who either do not have access to an ethics consultant or would prefer not to consult their local ethicist.

We welcome inquiries about clinical, professional, or institutional concerns. Since questions will be handled by volunteers, we are not able to address urgent or emergent questions. Please do not disclose PHI in any messages; we are not using a secure messaging service. We hope that the “Ask an Ethicist” service will allow our committee both to help individual members and to learn about the kinds of ethical issues our members and SGIM are confronting.

Please send your inquiry to the Ethics Committee Chair, Elizabeth Dzeng, MD, MPH, PhD, at liz.dzeng@ucsf.edu.

PRESIDENT’S COLUMN | FROM THE SOCIETY (continued from page 3)

cially for vulnerable and marginalized populations by engaging with the physician workforce, researchers, policy makers, and educators in efforts to pursue social justice and eliminate inequities in health.”

SGIM also has the Women and Medicine Commission (WAMC), whose mission is “to facilitate communication among interest groups related to women’s health, promote women’s health as a generalist issue in both clinical practice and health policy, and support the career development of academic women physicians and of all physicians pursuing careers in women’s health.”

The WAMC enables SGIM members to collaborate and network, promotes faculty development, provides educational opportunities, and works to improve women’s health through clinical practice and policy.

After reviewing the missions of these two commissions, we realized that we both had blind spots, and that the Society had blind spots that need attention. First, SGIM does not have a formal overarching statement of our commitment to diversity and inclusion beyond mention in the statement of our core values. Second, we have taken for granted that we share a commitment to being a diverse and inclusive community without establishing a comprehensive set of policies and procedures for ensuring that the commitment is translated into decision-making on a consistent basis.

2. What specific actions has SGIM taken and/or will take to address the blind spots?

On June 1, 2020, SGIM’s executive leadership and staff released a message on racial injustice, declaring that “SGIM stands against racism and hate in all its forms.” The statement calls on our community to educate ourselves and others on the historic inequality of black and brown people; publicly speak up against racism and bias at every instance; foster an inclusive and diverse workplace; validate and acknowledge the experiences of those who have suffered the consequences of racial injustice; and support organizations doing the essential work to dismantle structural racism.

On July 3, 2020, the Council decided to form a new workgroup to reassess the Society’s approach to promoting diversity and inclusion. The workgroup will be charged with crafting a formal statement and plan of action. The plan should
Nationality Act of 1965. Prior to this act, national-origin quotas favored those from Europe, but this policy change allowed immigration of people from non-European countries, including India. In other words, the direct work of Black American activists quite literally allowed for my brown skin to exist in this country. Not only that, I grew up learning about the shared non-violent philosophies of Martin Luther King and Mohandas K Gandhi. I owe my American citizenship to the Black Americans that fought for my parents’ ability to immigrate here.

Despite this kinship around color in America, when I found myself pointing to my brown skin in front on this patient, I very mistakenly conflated my “brownness” with my patient’s “blackness.” The oppression, mistreatment, and genocide of Black people in America is based on an entirely different history than my experience as a woman of color. As we learn about racial disparities, Black patients are consistently shown to have poorer health outcomes and increased mortality, and these outcomes are rooted in an anti-Black racist legacy in medicine. Perhaps it is this conflation that made me blind to my own perpetuating of systemic racism—and why I was not able to stand up for my patient that day.

Experiencing moral tension around being told to withhold pain medication from my Black patient, I hid under broken ideas of medical professionalism and hierarchy, prioritizing these false values over standing up to racial injustice. Yet, the pain of my moral tension is never greater than the untreated pain of Black patients. In an ideal world, I would have asked this question before my patient, first asking myself and the healthcare system I operate within, “Is it because he is Black?” before making clinical care decisions. Had I asked my attending this question, I might have evoked a necessary civil disobedience of sorts in medicine. I can envision an alternate scenario where after my attending denied my patient opioid pain medication, I asked him “Is it because he is Black?” to start a critical dialogue on addressing racism in medicine. In doing so, I would have challenged medical hierarchy as an upstander of racial justice, with the hopes of starting more conversations around anti-racism.

It is easy to blame the attending that day, but I acknowledge and appreciate the power I hold to advocate for my patients. It is time that we pause and not only check our biases at the door, but care for Black patients in ways that heal the wounds of racism in medicine. Racial justice should be a mandatory part of every medical school curriculum. My patient taught me that racially just medical education demands at least three things: (1) breaking down hierarchy in the name of racial equity; (2) training that fuels practical, patient-centered actions to disrupt racism; and (3) infusing anti-racism tenets into medical professionalism. This could ignite a revolution to reverse the history of racial oppression in medicine—all in the name of our first obligation: do no harm.

(Please note that there is a lack of references in the text provided, which would be necessary for a full understanding of the referenced works.)

References

SGIM

SIGN OF THE TIMES: PART I (continued from page 7)

PERSPECTIVE: PART I (continued from page 1)
systemic racism in medicine through a restorative justice lens, one through which we help black, indigenous, and people of color (BIPOC) communities heal from years of injustice. We can create space for our BIPOC patients, learners, and colleagues to express anger, hurt, and frustration. Furthermore, dismantling racism must be intentionally weaved into every aspect of what we do from clinical care; curricular development; assessment of learners, faculty, and clinical and national policy reform. Healthcare professionals, administrators, and other health center staff who fail to incorporate the work of dismantling of systemic racism into their work, must realize that one’s inaction does in fact perpetuate health inequities. Racism is a public health emergency and calls for “all hands-on deck.”

Boyd and colleagues have highlighted how scholars, medical journals, and healthcare institutions have failed to “interrogate racism as a critical driver of racial health inequities.” These scholars go on to suggest the necessary rigorous standards for publishing on racial health inequities for researchers, journals, and reviewers including naming racism, soliciting patient input, and citing experts, particularly BIPOC scholars in research and scholarship efforts. Furthermore, Hardeman and colleagues have outlined five principles to aide medicine in tackling systemic or structural racism in order to effectively promote health equity:

1. **Divest from racial health inequities** by restructuring the intentionally tiered health insurance market (e.g., consider universal health care models).
2. **Desegregate the health care workforce** by extending opportunities specifically to BIPOC communities (e.g., invest in pipeline and training programs, and intentional recruitment, hiring, retention, and promotion practices).
3. **Make “mastering the health effects of structural racism” a professional medical competency** so that every clinician is empowered and equipped to address racism.
4. **Mandate and measure equitable outcomes** specifically for addressing structural racism just as healthcare systems and providers are required to meet safety and quality standards.
5. **Protect and serve.** Ensure patients’ best interests are served and advocate for an end to causes of preventable death such as police brutality (and other social injustices).

Many BIPOC health professionals and allies who have been working on antiracism, social justice, and health equity efforts are exhausted. Many BIPOC have courageously shared their personal disheartening past and present experiences with racism in medicine in #BlackinthelIvory twitter stories yet so many stories remain untold. Hearing these present-day reminders, it may appear that the medical system is failing us. Yet, we remain hopeful that the heightened awareness and current focus on systemic racism will create more collaborations, empower more educators, researchers, leaders, and advocates. We are energized by our learners who are leading efforts such as “White Coats for Black Lives” and encouraged by all who are already doing this necessary work.

When we tell future generations about 2020, how will we remember it? Will we remember it as a “rough year,” a year of death and injustice? Or as the year that prompted the renewal of a revolution to move our ideals of health equity for all forward? We, as healthcare providers and institutions, have the power and privilege to dismantle systemic racism in medicine and society and to have a meaningful impact on the well-being of the communities we serve, if we all commit to continuously work towards this goal. We end this article with a quote from James Baldwin’s The Fire Next Time that reminds us of the alternative:

“...We are living in an age of revolution...and that America is the only Western nation with both the power and, as I hope to suggest, the experience that may help to make these revolutions real and minimize the human damage. Any attempt we make to oppose these outbursts of energy is tantamount to signing our death warrant.”

**References**

identify opportunities to be more consistent about promoting diversity and inclusion, and it should make recommendations for specific policies and procedures. The workgroup will include representatives of the HEC, WAMC, Membership Committee, and selected interest groups. The workgroup should consider structure, process, and outcomes as it looks for ways to improve. Special attention will be given to how SGIM nurtures the leadership pipeline and staff within the organization, and how members are nominated and selected for awards and leadership positions.

As part of the work on strengthening our commitment to diversity and inclusion, it will be important to revisit the report that was given to the Council by our Ad Hoc Workgroup on Sexual Harassment on May 30, 2018. At that time, the Council approved a policy expressing its commitment to ensuring a safe and welcoming environment for all participants at SGIM’s national or regional meetings, including ancillary events and social gatherings. Intended to include all forms of discrimination and harassment, the policy calls for members and other participants to: exercise consideration and respect in your speech and actions; refrain from demeaning, discriminatory, or harassing behavior and speech; be mindful of your surroundings and of your fellow participants; and alert leaders if you notice harassment. The workgroup recommended that SGIM embrace a learning community culture that encourages ongoing dialogue in a collegial manner, recognizing that unconscious bias may occur despite good intent. The workgroup issued other recommendations to ensure zero tolerance for sexual harassment or discrimination in all SGIM activities:

1. Amend the code of conduct to include processes for acting on reports, add a statement that SGIM prohibits retaliation of any kind against individuals who have made good faith reports or complaints of violations of the code, and add verbiage regarding a learning and supportive culture.
2. Broadly disseminate the policies to increase awareness.
3. Ask members to acknowledge and sign the code of conduct at membership renewal and/or registration for meetings.
4. Assign leaders to train and support staff so that they are prepared to handle complaints or concerns that may arise.
5. Develop an electronic confidential incident report form that can be tracked.
6. Include questions on a membership survey to inquire about perceptions of and experiences with harassment or discrimination in SGIM activities.

The workgroup’s last recommendation was to perform an annual review of our commitment to zero tolerance for harassment or discrimination. That review is overdue, and it should be done as part of the new workgroup’s efforts to address blind spots in our commitment to diversity and inclusion.

Prompted by a recent study highlighting the low number of women in leadership positions in hospital medicine, Karen Freund challenged SGIM to tackle the problem of gender equity in leadership.6,7 We plan to accept that challenge by re-examining how we nurture the development of leaders within the Society (where 11 of 14 elected Council members are women), and how we can more effectively translate career development activities into leadership positions within academic medical centers and other organizations.

While we may think of ourselves as an equitable organization, we also recognize that there are likely opportunities to enhance diversity and inclusion across all of our activities. At this point we don’t know what we don’t know. To quote Vanessa Grubbs’ recent Points of View article published in The New England Journal of Medicine, “It’s time for academic medical institutions to prove their statements aren’t just pretty words by acting to create diversity, equity and inclusion that matter.”

SGIM is taking this to heart. We must identify and acknowledge our blind spots to ensure we have appropriately comprehensive policies on diversity and inclusion accompanied by actions built into the structure and processes of the Society.

References
efforts, use our positions in medical centers to advance their goals, and show up to local government meetings advocating for the changes needed to eliminate police violence.

Advocacy
Speaking up against racism can take place on various platforms, including writing an op-ed, sharing your solidarity on social media, and speaking up as an ally or bystander when you witness racist remarks or comments. Recognizing seemingly innocuous forms of structural racism, such as the continued use of race in “objective” clinical data and practice, is also part of advocacy in medicine. For example, an op-ed advocating for the removal of the eGFR for African American patients highlights one specific issue in race-based medicine.5

Research
As research fellows with a focus on the social determinants of health and health disparities, the current moment has led us to reflect on how our work contributes to advancing equity. Systemic racism is a central force that shapes social determinants, such as residential segregation. For those in research, working alongside communities as equal and active partners to identify the structural drivers of disparities, developing studies to understand the underlying mechanisms of racism, and rigorously evaluating multilevel and structural interventions are where we can contribute.

Patient Encounters
As physicians, we can acknowledge and address the impact of social determinants of health in clinical encounters. In our day-to-day encounters with patients, we can ask patients about their social needs, in addition to their medical concerns.7 Given our shared passion for the social determinants of health, we were excited for this year’s annual meeting, themed “Just Care.” While SGIM was not able to host the annual meeting in-person, SGIM20 On-Demand is offering annual meeting content virtually. These sessions are an opportunity for us to learn and reflect on how we can all deliver more “Just Care” to patients, populations, and communities. For example, the SGIM Position Statement on “Recognizing and Addressing the Social Determinants of Health,”7 from immediate past-president, Karen B. DeSalvo, MD, MPH, MSc, and Elena Byhoff, MD, covers foundations applicable to practicing clinicians, medical educators, and researchers.

During this time of physical distancing, we miss the opportunity to re-connect with friends and to meet new ones at regional meetings, and particularly, at the Annual Meeting. Our clinical routines have changed dramatically as we spend hours on a screen or on the phone with patients in clinic. Our non-clinical days are filled with virtual gatherings with our friends and family. Even though we cannot see each other in-person, we can continue to maintain community through GIM Connect.

SGIM has been our professional home and a way for us to reach out to others who share our interests, whether that’s medical education, research, hospital medicine, or primary care. SGIM’s mission of just care for all people has truly resonated with us and has been a continued source of inspiration. We hope that SGIM will be a community for you to lean on during your training and beyond. As the associate member representatives on the SGIM Council, we want to hear from as many of you as possible. Please do not hesitate to reach out and connect with us—on GIM Connect, through e-mail, or Twitter. We hope that this column can be the start of many conversations.

References
in medical education and healthcare. We recommend the following additional concrete steps towards espousing anti-racism as medical educators:

**As Teachers We Must:**
- Identify and remove racist ideas from sessions or courses that we lead. For example, avoid misleading learners to believe that there are important biological differences driving health disparities, or difference in disease risks, when in fact race has little to do with genetic variance.¹
- Begin anti-racist curriculum development by labelling racism as a social determinant of health and a cause of health disparities, and expand it to become an integral part of how we learn about an organ system or a disease.
- Mitigate the effects of stereotype threat and understand the triggers experienced by Black and other medical trainees who are underrepresented in medicine (URiM). Create a learning environment where we encourage, welcome, and reward participation from learners who are URiM in the classroom and in clinical setting to diminish stereotype threat.²
- Address racism in the workplace and provide support and action to learners who are targets of racist acts. Every failure to speak up when a colleague or a patient displays micro-aggressive or discriminatory behavior towards a learner who is URiM is an endorsement of the behavior and a propagation of the culture of racism in medical education.³

**As Education Program Leaders We Must:**
- Reduce reliance on metrics that discriminate against students of color, such as standardized test scores and Alpha Omega Alpha (AOA) status.²
- Pro-actively recruit, mentor, and retain teaching faculty from diverse backgrounds, especially Black faculty, and sponsor them for professional development opportunities and positions of leadership.⁴
- Create system-wide, mandatory faculty development for all faculty to help build and foster a supportive culture for Black and underrepresented trainees.
- Allocate curricular time and resources for teaching faculty and trainees to learn about social justice, advocacy, and activism, to combat racist policies that adversely affect the physical and mental health of both patients and learners.²
- Evaluate programmatic structures that perpetuate disparities. One example is differences in health outcomes in resident panels versus faculty panels. Resident clinics are often a microcosm of the care delivery to underserved populations who tend to be racial/ethnic minority patients. We must consider the structural factors that contribute to differing health outcomes in various patient cohorts and create triage systems for patients who need more continuity and increased experience of an attending level physician.⁵

Through personal reflection and implementation of specific anti-racist measures, we can create a medical education culture which helps our healthcare system support societal change. Recognizing our individual and institutional culpability and holding ourselves accountable to education, growth, and improvement are necessary steps that will lead us to a place of improved equality in health care and medical education.

**References**
height, and race or ethnicity are fixed markers of lung capacity and lung function that should be used to generate a reference standard. PFT reference values have been determined for four ethnic groups: Caucasian, Black, South East Asian, and North East Asian. Importantly, these values exclude South Asians and Africans. The differences seen between groups—especially between white and Black Americans—is regularly attributed to differences in body proportions. Like in the eGFR explanation, researchers claim Black and white bodies are substantially different, so much so that it affects organ function.

The most commonly used reference standard for PFTs in the United States derives from the National Health and Nutrition Examination Survey (NHANES) III dataset. This data was used to originate three separate equations: one for Caucasians, one for African-Americans, and one for Mexican-Americans. Importantly, race was not self-reported, although ethnicity was. The data showed that for any given height, Caucasian and Mexican-American adults had a higher volume of air exhaled in the first second (FEV1) compared to African-Americans. This finding has been reproduced in other datasets in a variety of countries.

However, these equations fail to acknowledge the history of racism underpinning PFTs. Since the invention of the first spirometer in the 1840s, differences in lung volumes have been used to uphold white supremacy and as a justification for enslavement of Black people or to deny them proper compensation for lung disease stemming from pollution exposure.

These guidelines, and the beliefs that different races have different body proportions and thus different expected lung function, fail to account for the many other reasons leading to different lung capacity in non-white Americans. Social determinants of health, such as poverty, educational attainment, and tobacco and pollution exposure, are all associated with lower lung volumes. By attributing differences exclusively to race, rather than the systemic racism that leads to these disparities, institutions uphold white supremacy and are absolved from making the meaningful changes needed to eliminate social determinants of health.

These calculations and formulae are ubiquitous in medicine and contribute to systemic racism. Undoing the beliefs of the greater medical complex can be challenging, especially when racism hides behind the veneer of data and are promoted by both specialty medical societies and clinicians. Too often, if at all, anti-racism is relegated to the doctoring courses, while the foundational science curriculum continues to conflate race and genetics. We believe it is critical to explicitly point out the racism behind these equations early in medical education, teaching that there is no biological basis of race, and that students challenge assumptions, consider biases and explicitly address racism in the study and practice of medicine. Using this knowledge, and in collaboration with students, we will advocate for our health system to remove the race-based correction factor in all its laboratory and test reporting systems.

References
House staff and medical students at UC San Diego and Rady Children’s Hospital San Diego led participants from all the healthcare professional schools, residency/fellowship programs, faculty appointments, and leadership all the way through the C-Suite in anti-racism protests across their 4 medical campuses. These protests followed quickly on the heels of the medical students and house staff submitting letters of demands to leadership to take immediate, tangible steps to make these institutions anti-racist. Photo, top: Jennifer Regnier, photographer and artist: https://jenniferregnierphotography.com/. Photo, bottom: Elizabeth Hastie, MD, UCSD Internal Medicine PGY3.