Episode 3: Anti-Racism in Healthcare Education

Hosts: Dr. Maggie Kozman, Dr. DJ Gaines
Episode Guest: Dr. Ryan Mire

[00:00-00:41] Introduction
Maggie Kozman: Welcome to the DEI Shift, a podcast focusing on shifting the way we think and talk about diversity, equity and inclusion in the medical field. I'm Dr. Maggie Kozman, a Meds/Peds dual hospitalist, and one of the Senior Producers of the DEI shift, as is my co-host today...

DJ Gaines: Dr. DJ Gaines, a Chief Medical Resident in Internal Medicine and future Medicine hospitalist. Today, we're excited to bring you an episode on anti-racism in healthcare education, a topic that has blown up in popularity and attention in the last few months, a change that we think is vital and long overdue.

[00:42-2:19] Introduction to Dr. Ryan Mire
MK: Yeah, definitely. But it's also a topic that in the broader context of American society has become confusing and even unnecessarily taboo for many people. So to help us clear up any confusion and grasp how vital this topic is, we've invited Dr. Ryan Mire to our show. Dr. Mire is an internist, who completed his residency at the Medical College of Virginia in Richmond, Virginia, where he then served as a Chief Medical Resident. Afterwards, he transitioned into private practice and is the past president of a large multi-specialty group in Nashville, Tennessee. He's now an Assistant Professor of Clinical Medical Education at the University of Tennessee College of Medicine. He's held an incredibly impressive number of leadership roles in the American College of Physicians, including his current one as a member of the Board of Regents. And we asked him to join us on this episode because of his passion and work in the DEI sphere, including one of his recent grand rounds presentations about how systemic racism has been deeply rooted in medical education and how this impacts our patients. Dr. Mire, you've been a supporter of this podcast since its early planning stages, and we're looking forward to this discussion with you. So thank you so much for being here!

Ryan Mire: I am honored to be here with you today and thank you for having me as a guest. It's been wonderful to witness the progression and the growth of the DEI shift podcast from its early infancy stages. The topic and focus on diversity, equity, and inclusion is so critical in helping to educate and make the society a much better place for everyone. So I thank each of you for your hard work.

DG: Thank you. And how would you like us to address you?

RM: Please call me Ryan by all means.

[2:20-5:53] A Step in Your Shoes

DG: Excellent. Sounds good. Thank you so much. So before we get started talking about anti-racism, we'd like to ask each of our guests on the DEI shift to share something with our listeners about themselves, an experience or passion of theirs that helps us get to know them and their background a little better, and to flex our cultural humility muscles, we call this our "Step in Your Shoes" segment.

DG: So Ryan, what would you like to share with us and the audience today?

RM: I, first of all, I liked the term flexing cultural humility. Most of those, I liked that, I liked that phrase. Um, I would have to mention that music would be my cultural highlight for myself and really for the African-American community in general. Um, I am not musically talented in any way, but I do enjoy listening to different genres of music, and I find music to be very interesting in storytelling and expression through sound. Um, as a kid, when I was growing up, on Saturdays it was chore day and mom would put on the record player at that time and we would listen to albums from the 70's and 80's while we worked and did our chores. And you know, it's just, that's the fine memory that I have. And one of my favorite groups would be earth, Earth, Wind & Fire. I just love the composition of music where you can hear each and every element of the band and also the vocal talent, all in one; there was no artificial auto tunes or synthesizers. It was just pure talent. So, I was happy to say music is my highlight. One interesting fact is that Nashville is considered the music city and it is opening its national museum of African-American music within the next two months, which will celebrate and preserve the influence of African-American culture that has had an impact on a variety of music genres. So I'm very excited about this opening and I think that will be something that will be well received across the country.

DG: I really like what you shared with us. Similarly, my dad, whenever he was getting around cleaning, he would put on whatever CDC had. He loved music from the 70's as well. He loved Earth. Wind & Fire, but he also gets into some of the funk music. He loved Parliament, Funkadelic and that's like, his jam. He does all these drawings and everything, he's like totally into the funk scene. So, um, I definitely feel that genre in music, love it. This is kind of very pure.

MK: Absolutely, yeah. I think music is just such a powerful tool with that. We often underestimate and put a lot of pressure on at times. But it really is such a beautiful form of expression. And I love to hear that that museum is going to be hopefully opening in the near future because I think it will be such a nice way to step into the culture that may not be your own. And really, again, like we were saying, flex that muscle and learn not just historical, but even current influences into the music that people produce.

[5:54-8:57] What is anti-racism and racism?

MK: Alright. So let's now dive into our topic for today. Anti-racist healthcare education and more broadly anti-racism in medicine. Needless to say the concept of anti-racism is something that has become a hot topic of conversation in American society and around the world in light of everything that's happened in 2020, and this includes the medical field. DJ and I actually had the privilege of leading one of several peaceful protests that was on our medical campuses this

past spring in 2020, demanding that our institutions that we work with take tangible steps to become anti-racist institutions, and multiple meetings and new work groups have been developed as a result of this.

DG: Yeah, and a lot of significant and long overdue progress has been made in the following few months in this area. But before we get too deep into our conversation, Ryan, can you first help us define anti-racism and anti-racist?

RM: Sure. Um, well, first of all, before we get into that, I would like to thank both of you for your leadership and creating impactful change locally at your institutions and in your own communities. And I've been really impressed with the engagement and leadership from our younger generation. So first, I just wanted to commend both of you for doing that. So now, to answer the question, um, I think understanding terminology is very important. When we talk about anti-racism and anti-racist, I'm sure there's more formal definitions, but I'll try to simplify it and keep it very simple. I interpret the phrase of anti-racist or anti-racism as being an action oriented concept, rather than just being static. If one person would say that they're not racist, that's static and it just tells me what they're not, but it doesn't tell me what they're actively doing.

On the contrary, if one claims to be anti-racist, it is telling me that they are actively putting in effort to create change and break down the walls of racism. This could be in the form of a personal or institutional level. If one claims not to be racist and they hear a racist comment, they would just think to themselves, "Well, I'm not racist, and I don't feel that way," but someone who's anti-racist will think the same, but go one step further and actively call out and address the person who made the racist comment. So anti-racism is the practice really of identifying and changing the values, policies, structures, and even the behaviors that foster racism. In order to be action oriented, one has to have continuous self-awareness. And also back to your point, DJ, have cultural humility. I think that's very important. It's not always being extreme in leading protest, but proactively learning, inquiring, and even listening, are also steps in creating a collaborative response.

[8:58-10:47] Anti-racism in Curricula

MK: I really liked that you talked about, um, the different avenues that anti-racism can take, right? So you emphasized that it's action-based, but that action can take a variety of forms. And so we're going to talk into more specifics about ways people are doing that and ways that we as individuals and within our systems can do that. But, um, I think that's a really important piece to keep in mind as we do that. How would you apply those definitions of anti-racism and anti-racist to healthcare and professional school training curriculum, like for a medical school's curriculum, for example?

RM: Very good question. Um, in regards to applying the term to healthcare medical education, I think it's more of what is proactively being done on behalf of the healthcare stakeholders, which would be the institutions, medical institutions, training programs, or even the professional societies. In order to break down those walls and barriers that affect 1) racial and ethnic patient populations 2) affecting the well-being of underrepresented, minority medical students and also physicians in the workplace, and then also looking to break down the barriers for the pipeline of

future physician workforce. Um, that could be more representative of the population at large. So we have 13% African-Americans in this country, but only 5.7% of physicians are African-American. So I think anti-racism in healthcare is breaking down the barriers in a proactive way to help patients, to help the health professionals, and then also the future workforce in the pipeline of medicine.

[10:48-18:44] Failures in Addressing Racism in Medicine

DG: Thanks for that explanation. And can you give us some examples of ways that we as healthcare providers, whether in medicine, nursing, PT, OT, what have you have been trained that failed to address or perhaps even promote racism or race based medicine and healthcare?

RM: Well, that's a deep question and I do thank you for asking that because we have to really look historically first, um, and understand number one, the concept that race is not biologic. It's rather a social and geographical construct, but not a biological construct. And this is where medical education in my opinion has really failed us all. Historically in the late 1800's and early 1900's, there were many false perceptions regarding race that were promoted as science and even published in medical journals during that time. But they did not have any type of scientific evidence or basis. For example, blacks were perceived of having smaller brains and it was felt that they could not learn as well as whites. Blacks were perceived to have thicker skin. Blacks were perceived to have higher pain thresholds and did not receive the same amount of pain medications or anesthesia as whites.

These are all false perceptions that became reality over time, because once again, they were published in scientific journals. And so they became truths, even though there was no evidence to support it. And these perceptions still play in our medical education system today. And it's really hard to reverse those incorrect perceptions. There were probably, there were numerous false landmark historical events, but I will focus on probably the one I think that really started it all, was the Flexner report. So back in the early 1900s in 1908, the AMA at that time commissioned a gentleman by the name of Abraham Flexner to survey all the medical schools in the country, 155 medical schools between 1908 and 1910. At that time, there were only seven black medical schools. He made very influential recommendations that only two of those seven were worthy of remaining open. But if those two were to continue to receive federal funding, to keep their doors open, they had to focus their education for black physicians on two priorities, which was just sanitation and hygiene, and leave the science in surgery for white physicians and white medical institutions.

So this initially started the perception that black physicians were not deemed as equal to that of white physicians. And now we look 110 years later, we only have four predominantly black medical schools, when in 1910, we actually passed that. So that was a very influential historical moment that really affected medical education. There were many others, a false perception and historical events that basically fostered racism. We all are familiar with the Tuskegee experiment, and I'm not going to go into detail about that except to make the point that this was based on a false perception that syphilis would affect the neurologic system different in blacks than whites. And this led to such an unethical study, even when there was treatment for such a disease for over 40 years. So there have been numerous other false perceptions and experiments done on blacks that have fueled race-based medicine over time.

And actually there's an interesting book by Harriet Washington called "Medical Apartheid" that really chronologically goes through all of these practices that fueled race-based medicine from the early 1800's to the present day. So if you're interested in that more, that would be a great resource.

Now, we're going to talk about race-based medicine and modern day perspectives. We continue to have race in medicine as if it's biologic, despite the lack of evidence that it's not. Race is still perpetuated through medical equations and risk scoring calculations on health diseases with no sound evidence. The most popular, and I will say the hot topic right now, would be the discussion on race in the calculation of estimated glomerular filtration rate, otherwise known as GFR. There's a coefficient that's used for black patients due to the perception that blacks have more muscle mass than whites. And this was being from some very low, low value and small studies that have actually become reality, and now used on a regular basis and these health equations to calculate the function of the kidney in black patients. Now this has some negative clinical consequences as it can delay adequate specialist referral for blacks, or even put, uh, delayed blacks being placed on the transplant list in a timely fashion. The topic of GFR is getting some traction though, and there is a task force that's currently underway right now between the kidney professional societies and organizations. And they're actively looking at the evidence and hopefully there will be a report by the end of this year that will be more evidence-based in its approach to either justify or discredit the calculation that we've been using for years.

There are many other equations and risk score calculations, which include race that have negative implications such as the scoring for kidney transplant, donor candidates, osteoporosis and fracture risk scoring, and even the answer, no births after having the C-section looking at the complication risks for blacks and Hispanics. For the listeners that want to dive in more into this topic, there are two very short but powerful articles that came out this year. One was in the New England Journal of Medicine and the other one was in Lancet. Um, and they both discussed reconsidering the use of race in clinical algorithms. And so they're bringing this to the forefront and it's becoming a hot topic. Finally, I will say that race, if it's not a biological construct, we should really reconsider how we teach our medical students and including race as identifiers in the patient presentations on rounds as this can play a role in precipitating implicit bias regarding medical care and actually treatment.

The bottom line is that race is assigned either by a self identify by the patient, or it's assumed based on cosmetic features by a healthcare professional. And regardless of which option you choose, it has implications on how health status is determined for that individual. So when we use race and someone is just looking at a patient to determine their race, that's not scientific and evidence-based, so we really need to look at and reassess these health equations and risk scores, because we're in a heterogeneous population now with a variety of mixed races and many patients don't fit into the box of just being black or white.

[18:45-25:03] Additional Anti-Racist Changes in Curricula

MK: Wow. You said so many things in there that I want to make sure that our listeners caught that are really key, um, points to incorporate into this discussion. First of all, just couching all of this in how longstanding the historical aspects of racism and race based medicine are, we as trainees and as practitioners today did not necessarily come into medicine or healthcare

knowing any of this, and it's been definitely for me, an eye-opening experience. And now hearing historically the misperceptions that have been held about different racial and ethnic groups honestly, sounds so crazy. And, and just, it astounds me in terms of the, the beliefs that we somehow have allowed ourselves to all accept. But at the same time, having to remind myself that these are not just historical past problems, that a lot of studies that have been done more recently on current medical trainees and attending physicians show that people still hold these false beliefs about different races and ethnicities, even coming down to higher tolerance of pain or a thicker skin in African-Americans, so I just want to highlight that this is not something that's just antiquated. It's something that many people still currently believe and that we need to address. And then the other point that you made about how some of these biases then get made into truth and talk to us in healthcare training as truth, because groups within power, whether they're medical providers or editors, if medical journals, et cetera, perpetuate them because they say their truth. And there may not actually be a robust, scientific evidence foundation supporting the things that are being propagated. So it's important to focus on those things while also then focusing on the changes we're making. So I am glad to hear that you mentioned there's a, on a larger nephrology society level, even a task force, not just within individual institutions, but, within the specialty, as a whole across all institutions, taking a really close look at the GFR and creatinine and the stat and see, and hoping to hear that more things like that will be happening. What are some of the other anti-racist changes that you've been hearing about that are currently going on in medical school curricula or in healthcare centers as a whole across the country?

RM: Maggie, I think you just touched on, um, one of them in relation to what we just discussed about GFR. There are many institutions across the country who have not only made the push, but have made change and actually removing race from this GFR equation. That, that's been impactful, but it's been, as you mentioned at the individual level, so one institution at a time, which is a star, but I do think we'll have more impact as the society and professional organization level, because most physicians look to those societies to be the expert in that field. So I think we have some ways to go, but it is a start. Um, so to answer your question about changes that I have either heard about or read about, I think there are a lot of medical institutions that really need to be comfortable being uncomfortable, which is a nice phrase that I, they need to look at their own traditional practices and behaviors in order to impact change.

And it's the leadership of these institutions that really need to devote to the cause of being anti-racist as leadership sets the tone for an institution. So some ideas that have come forth would be, um, commitments to diversity, equity, and inclusion through new leadership positions, like diversity, equity, and inclusion officers of an institution. There has been implicit bias training programs for medical students and faculty. There have been taskforce and mentorship programs to improve student and faculty retention and even hiring practices for, um, black faculty and professors within an institution, but not only hiring them. I think a lot institutions really need to take that a step further and look at improving the promotion practices. So not only getting them in the door, but actually helping them to be promoted in the right way and that some institutions have even been proactive in their efforts to do a self analysis and look at their admission practices for students entering into the institutions. So there has been some push in,

in change that's going on across the country at individual institutions. And these are just the variety of examples that I have either read or heard about today.

MK: Thank you so much for kind of keeping us all up to speed on the different changes that many institutions are implementing. As you said, a lot of things are happening in parallel at individual institutions, but more steps are being made on a sort of larger scale systemic level that I think will be really impactful as well. I just want to acknowledge too that especially since the three of us are physicians, we can't speak for what other training programs have implemented or what the healthcare curriculum has been in a very you know, personal, um, individual experience level, but from friends of mine who I know in nursing, occupational therapy, other fields of healthcare, there's a lot of variability in the amount of training that students are getting in these issues. And I think in all realms, we have felt as a group that things need to be improved significantly, especially in light of the information we're learning and talking about today.

[25:0-30:13] Leaders of Anti-Racist Efforts

MK: Um, I also wanted to give a huge shout out to the medical students and then more broadly all of the healthcare professional students that have been leading these anti-racist efforts for years at their institutions as I have been learning. Um, and who've often had to take their leadership by the hand to make any progress towards addressing these longstanding problems. We know they're not new problems and they're not new efforts for many of our listeners and students are often not recognized for the immense work that they do in these realms, but we see you, we especially wanted to recognize our friend Betial Asmerom, who is an MD/MPH candidate, who's helping to lead many anti-racist efforts in San Diego. She helped to launch the DEI Shift in its early stages, and she directed our attention to key resources like the "Hidden in Plain Sight" article from NEJM that Ryan mentioned. So DJ and I very much appreciate you, Betial!

RM: I couldn't agree with you more on just the impact that students have had across the country. Um, there are so many examples where students have really led change. I mean, if you look at the creation of White Coats for Black Lives, that was a student led initiative that has now spread across the country. When you look at removing the race coefficient from GFR equations, it sparked at the University of Washington. And even at Beth Israel, Deaconess in Boston, these were student led initiatives that actually promoted change within their institutions. And recently I read about a medical student at the University of London, a black medical student there, who was displeased with the fact that he would never see how systemic illnesses affected people of color and people with brown or black skin. So he recently published a book called "Mind the Gap", a handbook of clinical signs in black and brown skin. And once again, this is a medical student, so this is a global process where students are taking charge and leading healthcare. And it's just a delight to see that. Recently, I also read of a student led initiative at the University of Pittsburgh, where medical students started a new tradition there, where they collectively created their own modern day oath of professionalism for the entering class. So traditionally we all are familiar with the white coat ceremony, where we recite the Hippocratic oath, where after

reciting the Hippocratic oath, they also recited their own class-created oath of professionalism during their white coat ceremony. And it included commitment as future physicians in addressing healthcare disparities and racial injustice in their own. I mean, I was really blown away and so impressed by this for three reasons. Number one, it came from incoming students. They were not even in school for one month together before they came up and put this professionalism together. Number two, that it was a collective effort. It was a committee of multiple ethnicities and races to develop this oath. And number three, that it was embraced and supported by the University of Pittsburgh leadership. So that was a, an incredible story that just happened within the past two months. And once again, it's just another example, how students are impacting change and leading change and not being comfortable with the status quo. It is very inspiring to see.

DG: That, that's amazing, that oath thing is really cool. And I think that's something that should be implemented across the country at various medical schools. So I love that idea.

MK: I also want to acknowledge that, although our listeners can't see our video that we're on together, we're all over here kind of raising the roof and cheering when different things that Ryan mentioned were noted, like White Coats for Black Lives was started by some of my friends and colleagues at UCSF, and the work that was being done at UW that DJ was over here cheering for.

DG: Go Huskies! Yeah, I love my Huskies, so I always have to give them a shout out when I get the chance. Also wanted to give a big shout out to all the educators, faculties, attendings, teachers who've come through and stepped up in this work, even though it's an often under compensated, can impede their professional development and also want to shout out to the, the upstanders and allies as well, because as someone that has experienced burnout in the past due to this concept of minority tax, it's really alleviating and nice to see that a lot of people are standing up to the plate and really appreciate that. And we actually recorded a great episode on that, minority tax, so I highly recommend you check that out, if you're listening.

MK: Yes, Episode 1 of Season 2, go back and listen!

[30:14-33:35] Burden on Minority Students and Faculty

RM: I certainly agree. I mean, I appreciate it and think, oh, medical faculty and attendings and minority administrative leaders who work effortlessly in these institutions in order to help students and trainees navigate, survive, and even find their voice in majority institutions. You know, I do feel personally that underrepresented minorities should be involved in the process for change at our respective institution. But the major caution that I would have is that the institutions need to avoid putting the burden on minority faculty and students to fix the problem. You know, it should be an administrative leadership job to change culture and not on the backs of the black faculty or the black students to make change. And actually one of my mentors, Dr. Valerie Stone, she said it best in an analyst east opinion piece that she wrote around the horrible death of Mr. George Floyd. And I will quote her, it says, "Black people did not create racism, thus it is illogical to believe that we alone can devise and implement a plan to eliminate."

And I think the basis of what she's saying is that everyone must be engaged in the solution process, and it just cannot be on the backs of those who are underrepresented.

DG: You know, one other thing I wanted to bring up too, we discussed this actually in season one episode three of mentoring underrepresented students, you know, sometimes as a person of color, you just don't want to be involved and you shouldn't feel pressured to do a lot of these DEI tasks. You know, it's almost like there's this term that I used in the last episode, season two episode one in minority tax, the concept of majority subsidy, that because of all this extra work that a person of color is doing in the field of diversity, equity, and inclusion, that those that are not working in that particular field have this extra time to advance their career. And so I feel like it would be unjust in a way to demand or put a burden on a person of color that does not want to do it, just because you feel like you need to tokenize them, if that makes sense. So I just want to put that out there that you like, do this, if you love it and if you feel like a passion for it, but if you, if you don't, like, don't feel burdened by it. Cause it's in a way it's unfair. If you think about it, that's just, that's my opinion. But this is something I was wanting to put out there.

RM: I couldn't agree with you more.

MK: Same. Yeah. And I think having worked with you very closely on a lot of these things, DJ, we both have confessed to each other those times where we just felt either obligated to do things or did them out of feeling, a calling and passion for them, but just felt very burnt out. And, um, like we couldn't devote time to other work. So, I agree, and I want to normalize that, like you were saying.

[33:36-39:16] Individual Actions Against Racism
DG: We've been talking about systemic racism and the important of anti-racism to address the systemic policies in place, but for some, it can be kind of daunting just given how entrenched some of the systemic racism is. So what do you recommend to the individual person? How can they make their learning environment or workplace more anti-racist on an individual level?

RM: A great question. Thank you for asking that. As I alluded to earlier, I think one critical step on an individual level is to really be continuously self-aware and have cultural humility. Um, in addition to that, you need to educate yourself on the issue, not by what you already perceive as the issue, but genuinely trying to learn from another point of view. I think that is very important. This can be done through questions, discussions with your friends or your colleagues, and then the next step is after you've explored and try to learn more, I think the following step is to identify something that you can do as an individual to make a difference. And once again, it doesn't have to be heroic. It doesn't have to be on a large scale, but it has to be action oriented as we talked about earlier.
So this could be from just doing something small on a daily basis to let your colleagues know that you stand with them, not just saying that you do, but letting them see that you're standing with them in solidarity. And I think that's a difference than just someone saying, "Hey, I'm with you, I'm behind you, I support you," but what are you doing to help me? So as an individual with trying to find that step for your personal situation, I think will be critical. And for as far as being

anti-racist and putting this idea into action. I also will say that calling it out is probably the easiest answer here, but it's probably the most difficult thing to do, right? So if you hear someone say a racist comment, calling it out in the moment can be very uncomfortable for a bystander to do, but just think about the uncomfortableness of the victim, who's actually being the recipient, the recipient of the racial comment or the racial behavior. So I do feel, although that's tough to do, that is one thing that each and every one of us can do, especially those who are in leadership roles, such as our, you know, senior residents on rounds or our attendings, or even our department chairs and department heads. When we see that our supervisors and upper levels are actually standing up for us, that's very powerful. So those are just small things that I think can be done on an individual level.

DG: I think that's so important because you've touched on something that I think is crucial is that it can like, if, especially if you're like in as an attending or in like upper level faculty, you have like so much, what's the word I wanna use, um... Influence, especially with the younger generation. And that is really important for you to be an upstander, like I had mentioned before, because the influence, you have to be positive or negative. And I think it's always good to have if someone witnessed like a racist act or a microaggression to have some phrase offhand that they can use, that like, doesn't require a lot of thought. There is a excellent article by Dr. Cowan that touches on this and about having a phrase, like a simple phrase, one that I use is, "What do you mean?" because it kind of gives them the opportunity to backtrack, perhaps, and kind of explain themselves, or maybe they realize, "Oh, you know, what I said wasn't that good?" and I think that's something you could even say to like, for example, if you're a medical student and your attending says something, make an off the cuff remark, that's something you could potentially say. I think it's good to have like some phrase or something like just offhand that you can use, because when you're, when you experience it in the moment, you can like, just be in a state of shock and you don't, you can't think clearly you don't know what to say. And so it's easier to have something quick and easy to say.

RM: I really liked that idea. These are, that's a very good pertinent piece of advice.

MK: Yeah. I think having something prepared in your back pocket to pull out, instead of having more of your visceral gut reaction in the moment to come out has been helpful for me and thinking through what feels comfortable personally, to me to say has been good because then I have been able to pull those things out when necessary. One of my favorites is, "You may not have intended what you said to come across in such and such a way, but this is how I received it, and I wanted to talk with you about it." And so I think that does a couple of things like what DJ was saying, not assuming that the person meant malintent when they said what they said or did what they did, and also opening the door for them to sort of explain, reflect, and pivot from what they did.

[39:17-47:57] Hope for Future Healthcare Education and Changes

MK: So we know that this year has been, um, a trying one for many reasons, but specifically for those engaged in diversity, equity, and inclusion work, it's been a doozy. What things are

currently giving you, hope Ryan, about where healthcare education is heading and what additional changes would you personally like to see?

RM: Sure, well, you're right. It's definitely been a trying year to say the least, I mean, we've exposed, you know, exposed social injustice, healthcare disparities, and even police brutality that have clearly manifested the systemic racism that's been generated for decades and even centuries. You know, however, in regards to the healthcare education, I will say what gives me hope is to see our younger generation of students, as we talked about, and our trainees proactively challenging concepts of race and medicine, which subsequently is talking discussion within departments, institutions, and even professional societies to take a step back and reconsider these race-based trends that we've just become accustomed to. You know, over the past, I would say two decades, medical professionals have prided over evidence-based concept, right? In our approach to patient care, everything has just been evidence-based. You have to treat the patient based on the evidence.

However, we're still teaching a concept of race in medicine without the scientific evidence, which just seems to be paradoxical to me, that in our educational curriculum, where we stress evidence-based, we're using race in medicine that does not have an evidence sound base to it. And, you know, there's been just a resistance to change. And I understand that change is hard, but I do feel in order to really have the most impact our professional and specialty societies have to be a part of that change. Um, they have to be bold and not afraid to take a look and reassess and reconsider changing clinical algorithms and risk scoring and not just say, well, we've always done it, so you need to do it. So the institutions at the individual level, this may help because it's showing me that these institutions are thinking outside the box, not waiting or the masses to make a recommendation. They're seeing it as imperfect science and making changes at the local level, which I think is definitely a start, but we definitely have to have more traction with that professional organizations, because that is usually the trusted source.

Um, just thinking about some other aspects that give me hope, I will say incorporating social determinants of health in the medical curriculum, because racism plays a large part of social determinants of health. So seeing some institutions incorporate that in the curriculum does give me hope, but my caution there for most institutions is that it can't be a one and done process. You can't just have one lecture doing the first year on social determinants of health or one lecture on health disparities, or one lecture on race-based medicine and check the box and say, we did something. You know, I think this is analogous to when we show up at orientation at our hospitals, our training programs, and the first week we go through orientation and they give us all the things that they could just check off the list to say, they told you about, right?

You know, OSHA criteria and safety and quality and the mission of the hospital. You know, they give you all of that in orientation. But if you really want the mission to be important, you have to infuse it throughout the entire training program. And so I'll make that same analogy with, you know, race, racism, and race in medicine. You can't just do one lecture. You have to infuse that throughout the entire curriculum. And it just can't be a one and done process. You know, moreover, I will say that these institutions need to be careful on, as BJ mentioned earlier, the minority tasks of just saying we have a black faculty person, they're going to do the lecture on healthcare disparities because they may not actually be the expert in healthcare disparities.

And you know, most medical institutions or most, most of them, or affiliated with undergraduate institutions where they have people who are usually trained, you know, ethicists, sociologists, psychologists, you know, people who deal with this stuff on an everyday basis and/or trained to educate, and sometimes institutions have to break outside the box of just having their faculty educate medical students on a topic that's sort of nonmedical important, but not in medical. They can bring in experts from outside who have expertise in this area. So I do think that that is something that I would at least challenge a lot of institutions on bringing in the right people, not just necessarily bringing in somebody. Personally, I would like to see the change in medical education expand even further by removing race as a biological construct in medical school, teaching in medical school curriculum, and even filtering this down even more to even the pre-medical curriculum at the undergraduate level. So in general, I think that change is always hard, especially when you're trying to change something that's systemic, like racism, that's multifaceted at so many different levels. However, what gives me hope is that people seem to be more engaged in the process now than I've seen, at least in my lifetime of people who are speaking out. They're realizing that racism and humanity is everyone's problem. And this is the major difference of what we've seen historically, where typically the group that is being oppressed are the only ones speaking out. Now, we're coming together and you're seeing this at a broader level at a more societal level. And I think that does give me some hope and hopefully we can sustain the effort.

DG: You made some amazing points there, Ryan, thank you so much. And I think what something you said that is important that we really reflect on is this concept that, you know, the race of mess. And also we talk about race as a, in medicine and then without any evidence. And if you read the book "Medical Apartheid," like you mentioned, when the resources you mentioned before, you know, they, they actually talk about how there is slavery. There's a slavery curriculum in medical schools way back in the day. And why was this there? Because they had these biases about black people and they're trying to find, well, there must be a difference. And they're trying to find a scientific thing that must explain the different must be their head size. It must be the pain receptors. And it's sad to think that that mindset has continued to this day and in different ways. And so I think it's like highlights that how important this is. And I really appreciate all the examples you've been giving so far and like ways that we can address this issue.

MK: Yeah. I think one thing that I really liked as I was going through that NJEM article you mentioned, "Hidden in Plain Sight," is that it differentiates and says if we find that there really is some genetic difference that is scientifically based and reliable, true scientific change or difference, then that's fine. Like that's something that we can utilize in an effective way to treat patients better. But if not, we're attributing something to race, like differences in our patients to race that really are due to their socioeconomic status or due to the chronic effect of racism on someone throughout their lifetime. And all of the physiologic changes that happen as a result of that chronic level of stress that someone who is constantly experiencing racism experiences. So I really like that distinction too, to really nail down what it is we are actually seeing as the cause of a difference instead of just calling it race and calling it a day.

RM: I couldn't agree with you more.

[47:48-55:23] Conclusion
DG: Well, thank you. Ryan and just wanted to ask you, you know, you've mentioned a lot of resources to us already, and then we'll definitely post them on the website, but was there, were there any other resources or articles that you recommend we and our listeners check out?

RM: Well, I'll actually, there is one that in the time of this podcast that just came out within the past week that I read in the Journal of General Internal Medicine, where the previous articles that I mentioned focused on the concept of race in medicine. But this article in the Journal of Internal Medicine talks about the potential clinical implications and impact of having race in medicine, where it actually looks at the percentage of African-American or black patients that would be affected or would qualify for transplant if the race coefficient was removed. So I found that to be a step further rather than just calling it out, but also now demonstrating the clinical implications. And looking at numbers of how many black patients would be affected with changing the equation. No, in general, I don't think that there is one book or resource because this is a moving target, right? Racism doesn't have a stop or how to it, it's fluid and it's more of a process and a journey that we're on as a society. And we haven't solved the problem. So I haven't found one specific book. I just tend to keep my eyes out for articles and podcasts and interviews, that address the issues of racism and race and medicine, just because it interests me personally. But I do think that the more awareness that we have in the different media platforms it will eventually help to break down these walls that prevent equity in healthcare.

DG: Well, Ryan, thank you again, thank you so much for joining us tonight. This is a really important topic and it's a very timely discussion and we really enjoyed having this talk with you.

MK: Yeah. Thank you so much. This was such a great conversation. We could go on for hours, but our listeners don't want to listen to all of that.

RM: Well, it's been great, and I'll say Maggie and DJ, I'm honored to be a guest on your podcast today, and I'm very impressed by the work that you've done with the DEI shift podcast and taking on these complex issues to better educate not only healthcare professionals, but also the general public on these broad topics of diversity, equity, and inclusion. And I'm just super proud of all the work that you're doing in this realm. And thank you for having me as a guest. Oh, if I can conclude with one final summary statement, if you don't mind. The take home point from me today would be being anti-racist is not about who you are, it's about what you do, and I'll leave it at that.

MK: Thank you so much. I think that's a great way to sum up what we've been talking about. Thank you for your kind words. And it really is a calling and passion that we have, and we love to collaborate with you on talking about these things. And if any of our listeners are also passionate and called in this area, reach out to us. Thank you so much for listening to this episode. If you have comments or questions about anti-racism in healthcare training, you want to tell us a little bit more about what your experience was in medical school, nursing school, PT

school, OT school, et cetera, all of-- pharmacy, nutrition, everyone-- we want to hear from your experiences and learn more. And you can keep the conversation going by following us on social media on Instagram and Twitter at the handle @theDEIshift or emailing us at thedeishift@gmail.com.

DG: And you can also head to our website www.thedeishift.com to access further resources on this topic, as well as our learning objectives, show notes, and full transcript of this episode. And don't forget to share our podcast with your friends and family! We hope you can join us next time!

MK: Bye!

RM: Bye-bye!

[55:24-53:01] Bloopers
Uh DJ, we can't hear you.
DG: How about now? I didn't say anything good though, don't worry. [laughter] I think there's a lot of ums in there... I was crying a little bit. [laughter] I, man, I lost my train of thought.

[53:02-54:21] Disclaimer
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