



# Racial Disparities in Clinical Medicine

Conversations, Perspectives,  
and Research on Advancing  
Medical Equity



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## INTRODUCTION

The United States is a long way from achieving clinical equity among its people. In this eBook, we set out to provide a sense of how inequity persists, how it is experienced, and how we might begin to counter it. The conversations you'll see in the coming pages took place in the United States, but we believe the concepts and lessons apply globally.

To explore what individual clinicians can do while politicians, policy makers, and others address the social structures that contribute to the problem, NEJM Group convened a small panel of clinicians with a commitment to making change happen. In the pages that follow, we share poignant excerpts from interviews with those clinicians, Perspective articles from the *New England Journal of Medicine* that provide additional insight into this topic, and research from NEJM Catalyst that gives numerical shape to inequity as it exists today.

This eBook is meant to be a reminder of your stake in the outcome, and it also serves as part of an examination that's not likely to end soon — the problem has been some 400 years in the making.

Rudolf Virchow, politician and founder of cellular pathology in the 19th century, said that medicine is a *social* science.

We hope you will join our attempt to make a difference. It's not necessary to run for political office or formulate sweeping policies in order for your efforts to make a difference for your patients. As more than one member of our small panel of clinician interviewees observed, the least we can do is pay attention, be aware of our prejudices (in recent parlance, often termed *unconscious bias*) — all of us have them — and work actively against them.

Sincerely,  
Joe Elia  
Editor for NEJM Group

“The least we can do is pay attention, be aware of our prejudices — all of us have them — and work actively against them.”



# Let's Talk about Racial Disparities in Clinical Medicine: How Medical Inequity Kills and What We Can Do to Stop It

*Race and economics continue to be at play in U.S. medicine. We've brought together several medical professionals with a lot to say about those problems and how — at a practical, clinical level — we can start erasing this blot on the system.*

## LET'S TALK ABOUT RACIAL DISPARITIES IN CLINICAL MEDICINE

*What follows are excerpts from conversations conducted with Joe Elia. They have been condensed to ease reading. Links to the complete video interviews appear in the Resource Center on page 30.*

### Can you tell a story that illustrates the problem of inequity in clinical medicine?

**Dr. Kimberly Manning** told a story about her father.

I'll first say that my dad has been very open about sharing this story, and so I share with his permission.

When I think about the experience that my father had when he had an acute myocardial infarction, it really highlights the power of bias, which is a big factor in equity, as well as how people are treated, and it also underscores that bias is not something that is only in situations where there isn't race concordance — we're all biased.

My father called me when I was a senior resident. I was in the CCU on my final rotation, and we were chatting on the phone and dad told me that he was having shoulder pain. He was an avid golfer at the time and had played a few holes of golf, but it was a very unusual way he was describing this pain. He saw his primary care doctor, who gave him some Motrin, and he called the doctor back and said, "This is really not right. This is not normal. Something's wrong." And the doctor sort of trivialized his feelings and said, "You know, you

played 36 holes of golf in a tournament — of course your shoulder's going to hurt."

But my dad had risk factors. He had a family history of coronary disease. He was hypertensive. He had hyperlipidemia. He was in care, but still, he had risk factors, and finally, as we were chatting, he told me that his pain felt like biting ice with his tooth. I was like, "That sounds visceral, Dad." I knew it didn't sound like musculoskeletal pain from swinging a golf club.

And you know, because I know how powerful bias is, I essentially told him to go to the hospital, and I told him to lie. I told him when he got there to say he had chest pain, that he was diaphoretic, that he had dyspnea on exertion — none of which he had. All he had was severe shoulder pain, but I thought that it sounded cardiac, and that is what got him through triage.

And the reason I say it's an equity issue is because what I know for sure is that if my dad had not ... if he had come into the triage and just kind of said what he said [to me], we know that there is plenty of data that supports if you have four people — a Black man, a Black woman, a White man, a White woman — all with the exact same story, they will often have different outcomes.



Kimberly D. Manning, M.D.,  
F.A.C.P., F.A.A.P

My father got admitted to the hospital, where he would have everything screaming acute myocardial infarction, where a first-year medical student could have picked it up. And after 10 or 12 hours he still had not received a cardiac catheterization. The urgency that the cardiologist on call should have felt, you know, wasn't extended to my dad. And you know, there's a piece of me that knows that if my dad had been a White woman, I think somebody would have got in the car and come to the hospital in the middle of the night to cath him. His troponin was 22.

So, it was rough, Joe. I mean, my cardiology attending — a wonderful advocate — he looked at me and he said, "You need to advocate for your father and you need to get him revascularized." And he coached me to call the hospital and speak to the cardiothoracic surgeon and cardiologist — physician to physician — and I just kept imagining, well, what if my dad didn't have a daughter who's a physician to tell him to do all of these things? He probably wouldn't be with us now, because he would have been left with severe heart failure or he would have arrested that night.

**Joe Elia:** Yes. Most people don't have daughters like you.

**Dr. Kimberly Manning:** Yes, and most daughters like me don't have a cardiac interventionalist who's sitting next to them and telling them what to say, who's up on all the latest literature, right?

**Dr. Karen Dorsey Sheares** talked about her participation in providing clinical care in the newborn nursery at Yale New Haven Hospital.

As a general pediatrician, I rotate through the well-baby nurseries. And since the time that I came to Yale New Haven about 20 years ago and became an attending, there's been a policy in place about how to handle mothers who either report or test positive for marijuana use during pregnancy. And being a little bit of a student of the world, and living, inhabiting both White space and Black space, I'm aware that most White women who engage with obstetrics care don't ever get asked if they used marijuana, and certainly, don't ever get tested for marijuana during pregnancy. But many of the women who deliver at our hospital come through the Medicaid Care Clinic at the hospital. And as a routine, they are surveilled for drug use and tested for drug use during pregnancy, and so there's a surveillance bias of their being identified as being marijuana users.

Women use marijuana for two main reasons, I find, during pregnancy: one is to manage anxiety, which is a pretty common reason, and the other is because marijuana can help with nausea and emesis associated with pregnancy.

So, because these women come to attention, there had been a policy that had three pieces to it: that the woman would be screened again at the time of delivery; that the baby would be screened (they would put a [urine-catch] bag on the baby to screen for exposure) and the mother



Karen Dorsey Sheares, M.D., Ph.D.

would be not allowed to breastfeed in the hospital; and that her case would be reported to the Department of Children and Families in Connecticut.

I found this policy quite problematic as an attending. As a junior attending, I raised that issue with my colleagues from time to time.

When I would cover the service, I would not sign the order to have the baby tested. I would try to reassure my colleagues on the floor that if the mother was positive, then the baby was certainly exposed. I would always encourage mothers to breastfeed, as I do all mothers, and of course, would recommend to them that they abstain from marijuana use during the time they were breastfeeding, much in the way we would talk about tobacco use. And for years, I would complain about this policy, but, as a junior faculty member, wasn't really in a position to change it, and it became more and more difficult for me to manage that cognitive dissonance.

Over time, especially as marijuana became legal for recreational and medicinal use, I just really could not take it anymore, and I wrote an open letter to my colleagues explaining to them why I could not adhere to the policy. And that prompted a discussion at one of our section meetings where we had a really challenging conversation. People who had engaged in remaking the policy, which had been remade since I had started complaining about this — but not much — really felt that they were being called out for racism. I tried to be very direct about the impact, but not be personal about ascribing racial intent to anyone, but it was a

challenging conversation. And finally, the policy was removed, although some people who've practiced in our hospital for a long time continue to make reports to DCF. And again, it's not part of the policy, but many, many people have the discretion of reporting, and DCF, to their credit, has changed the way they respond to marijuana reports at the state level, which is a nice thing, but it is still something that really damages the clinical relationship, with mostly Black and Latina women delivering at the hospital.

**Joe Elia:** So, it illustrates the kind of differential enforcement of the rule in one instance, and then, in other instances, differential withholding of treatments, which we'll get to later.

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**Dr. Karol Watson** *offered a story about heart failure.*

I had one patient who had heart failure with reduced ejection fraction, non-ischemic. She was managed at another hospital and was doing well, but her ejection fraction was still 30 and she still felt lousy. When I got her, I found that her medical regimen could have been improved. I put her on an ARNI [angiotensin receptor neprilysin inhibitor] instead of an ACE inhibitor. She immediately started to feel better, and within probably six months, her ejection fraction had increased up to 50 percent.



Karol E. Watson, M.D., Ph.D., F.A.C.C.

She was doing great. Then the new year came. She lost her job. She lost her insurance. Her new insurance would not cover an ARNI, so she had to go back on her ACE inhibitor. Her ejection fraction fell again to mid-30s, and I just thought, when we have a life-saving medication that can do so much good, why are there so many structural barriers to getting that?

And I then thought about so many of my patients who have the same issues. I worked at a vaccine clinic earlier, for the Covid-19 vaccination, and the way that worked was so beautiful. People drove up. They had pre-filled out some questions about allergies, reactions, et cetera. We confirmed that, gave them their vaccination, had them wait 15 minutes, and then sent them on their way.

There was no money exchanged. There was no question about “What’s your insurance number?” There was no question about “Can you afford this?” It’s a life-saving therapy. We need to have access to all of those.

**Joe Elia:** Yes. And as you say, it’s a structural feature of our system that when that structure disappears, things go very smoothly.

**Dr. Karol Watson:** So smoothly, yes, and equity increases. I think the barriers that we’ve put into place for some of our most vulnerable citizens are absolutely increasing inequity and disparities.

*That answer led to another question to the group.*

## Would you talk about the intersection of your daily work with the problem of inequity?

**Joe Elia:** You’re Massachusetts General Hospital’s senior vice president for equity and community health. How do those two things intersect — equity and community health?

**Dr. Joseph Betancourt:** We’ve had, since 2007, first a dashboard, now an annual report on equity and health care quality that looks at a lot of our quality measures — inpatient, outpatient, by race, ethnicity — so we could actually see if we’re delivering critical care or if we’re not, and if we’re not, we commit to fixing it. And along those lines we’ve developed a series of interventions to address disparities in diabetes, disparities in colorectal cancer screening through coaching programs, navigator programs, and the like.

This past year — and the Covid pandemic in particular — has really made all of us understand that we cannot achieve excellence in clinical care without being attentive to the particulars, and I think a lot of people reference the social determinants, the particulars of what happens in people’s communities.

So, our approach to bring together equity and community health really tries to highlight the fact that we believe it’s critical to have a doorstep-to-bedside/back-to-doorstep approach to equity that thinks about



Joseph Betancourt, M.D., M.P.H.

the entire care journey, and so, this is a fairly new and innovative position — only a handful of them around the country at the senior executive level. So, I'm excited, and we will aim to center equity, patient experience, quality, safety, access along the entire care continuum, from community to ambulatory to inpatient to post-acute and back.

**Joe Elia:** So, when that patient goes from your clinic back to their doorstep, they're marching through their community. So, how can you advocate for them within their community? Are you reaching out to the municipal drivers of community health?

**Dr. Joseph Betancourt:** Certainly. So, I give one example. You know, in diabetes, in this office, I could give my patients all the right medications to take care of their diabetes, but two things: if they go back to their community and they can't exercise because it's not safe, because they work two jobs, because there are no sidewalks, and if I encourage them to eat well, yet, in their environments, in their communities, there's not access to fresh fruits and vegetables and if they are accessible, they're less fresh, and they cost more — you know, we are swimming upstream. And that's what we talk about as we address the social determinants. So, what are the types of things we could do in community health, in partnership with cities and towns, to facilitate those issues, to advocate for, you know, safe public parks and the kind of space where people can get their heart rate up?

Another example is we're working on a project called "Bodega Makeover," which is an opportunity for us to work with bodega owners, small convenience stores,

in communities of color, to support them to provide healthier options, you know, and put them visible and in the front of their store and to get them priced accordingly. So, what does that take? That requires, quite frankly, some partnership from us to help them and some partnership in the community at the sidewalk of that bodega to let them know why those are the healthy choices.

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**Dr. Karol Watson, who co-directs UCLA's program in preventive cardiology, offered her take on the question.**

**Dr. Karol Watson:** So many things that I do are things that I can see in black/white stark figures for disparities — things that I feel are the entrance fee. They aren't special. They aren't high-tech. They aren't really glamorous, but they are the things that keep us alive. They are the things like maintaining regular physical activity, promoting healthy diets, treating blood pressure, cholesterol, and diabetes — things like that that, really, we should be offering to everyone.

It should not be a specialized service that requires any kind of prior authorization for any of that. We need to have time and space to do these things, and that's what we don't often have. And the people who probably should be able to access them the most, because they have the greatest need, have the most difficulty.

So, I recall a patient I discharged from the hospital after a non-ST-elevation MI. He was an African American man in his 50s, very highly motivated to

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GROUP**Karol E. Watson, M.D., Ph.D., F.A.C.C.**

Professor of Medicine and Cardiology, UCLA  
Director, UCLA Women's Cardiovascular Health Center,  
UCLA Barbra Streisand Women's Heart Health Program,  
UCLA Fellowship Program in Cardiovascular Diseases  
Co-Director, UCLA Program in Preventive Cardiology  
Associate Editor, *NEJM Journal Watch Cardiology*



*Watch this excerpt from  
Joe Elia's interview with  
Dr. Karol Watson.*

do exactly what was right. The prescription he got sent home on was for cardiac rehab. He met with the dietitian. He was supposed to have five servings of fruits and vegetables daily. Things like that. When he looked into cardiac rehab, he realized it was virtually impossible to find one that accommodated his six-day-per-week work schedule. When he tried to buy fruits and vegetables, he said to me, almost embarrassingly and apologetically, "I can't afford to buy things that are going to go to waste in my refrigerator. I have to spend my money wisely. I can barely make it each week."

So, the things that we think are great for our patients, and indeed, they are, we have to make sure they can access them.

**Joe Elia:** And that means keeping parks open and clean, and walkable, and other things.

**Dr. Karol Watson:** Yes. In our preventive cardiology program, early on, we actually partnered with individuals from Urban Planning at UCLA, because there are so many structural barriers to health that just exist in neighborhoods. When you look at the inequities, from neighborhood to neighborhood,

when you look at how that disadvantages people, in terms of their health, their economics, their lifestyles, everything, we realized, it's almost impossible to do everything we want for our patients, unless we can get healthier neighborhoods and societies.

And we always say, if you make people want to do the right thing, then they will do it, if it's affordable, if it's easy, and it's pleasurable. And I think it's very realistic that we can design neighborhoods that are all of those.

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**Dr. Karen Dorsey Sheares** has conducted research on childhood obesity and activity levels in children, and so I asked if there was an intersection with inequity there.

**Dr. Karen Dorsey Sheares:** I call inequities “barriers to wellness” and “barriers to lifelong health optimization.” Many of them have their roots in poverty and — unfortunately, in many places, including the places I've practiced in my career — in racialized poverty, which is the combination of poverty and economic divestments or public economic divestment focused in certain racial groups, and in particular, African Americans, but also, increasingly over my lifetime, Latinx communities as well. In New Haven, redlining was very much in practice.

When you look at old maps of redlined New Haven, and you lay them over the current communities that are majority Black and Latinx, you see a very direct correlation, and so, for obesity, similarly, where you have a generational and government-sponsored economic divestment in communities is where you

see food deserts, is where you see non-walkable neighborhoods, is where you see real safety concerns around the use of public space, is where you see the most dilapidated school facilities, and so on, and so on.

So, those things connect directly to children's ability to be outside in the places where they normally accumulate physical activity, and to have healthy diets. Those things overlap greatly.

**I asked Dr. Sheares about an article she co-authored on measuring disparities within hospitals, as opposed to across health systems.**

**Joe Elia:** Your 2019 article in *Health Services Research* proposes a method for measuring health-related disparities, not from one region of the country to the next, or not from one hospital in a city to the next, but *within* a given hospital. Can you tell us a bit about that work and what the follow-up to it was?

**Dr. Karen Dorsey Sheares:** My colleague Susannah Bernheim was the lead for that work.

We work in a place where we believe in revealing the gaps in quality by using metrics to create incentives, both moral and financial.

The idea behind this is to say that if I understand, as an institution, that I have a performance gap when I look at my lower-income and higher-income patient populations separately, that gives me important information that helps me be motivated to change that — to narrow that gap.

If I *don't* know about that gap — if that's invisible because nobody's ever developed a methodology to

help me understand it — then it's just baked into the cake, and I might not even notice it, and therefore, not have any ability to change it.

So, the idea is to reveal performance differences that can occur even inside an institution when caring for patients who are lower and higher income. It's not strictly about doing less or not doing the same for a lower-income and a higher-income patient. It can equally be about not addressing the special needs of the patient who lives with a lower income and is therefore missing an opportunity to really optimize their health, whether that's appropriate language services, or a really important aspect of care coordination that has to do with the housing limitations they have, and so on.

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### As individuals, what can we do to make ourselves more aware of our biases?

**Dr. Kimberly Manning:** So, you know, as much as we don't want to admit it, we're just a very segregated society. You know, we play nice, but then we leave work and then we go into environments where everybody looks like us, and that does not help when it comes to us trying to move toward equity, right?

And so, this exercise involves taking out your cell phone. I tell people to actually start with your most frequently called contact list and look at that list first. Just start to go through your contacts, or who you've called recently, or who's called you. And if you exclude

people from work, try to figure out what percentage of individuals don't share your race.

For me, as a Black American, I went to a historically Black college for undergrad, Tuskegee, and then I went to Meharry. My closest friends are people from college and from medical school. I'm involved in community organizations that are sort of built on the back of the African American community, and my contacts are very homogenous, quite frankly. If I remove all the people who are work contacts, it's almost all Black people.

And so, when I started recognizing this, I really started to think more about intentionally developing relationships with people that I like, and that I really enjoy, who have different backgrounds from me, and that's what I call expanding your life lens, because one of the biggest strategies to mitigate bias and to counter narratives is to step into lives that are not like yours, and I don't really know what life is like for some people.

I can tell you exactly what it's like to be a Black girl from Englewood, who double-ditched on the corner and who went to HBCUs [historically black colleges and universities]. I can tell you all about that. But the way for me to be able to see people better is to broaden my life lens.

**Joe Elia:** You're in Atlanta, and this week [the conversation took place in mid-March 2021] there were eight people murdered, including six women of Asian descent. What are you hearing from your communities there?

**Dr. Kimberly Manning:** First of all, thank you for bringing that up, Joe. We are fortunate. Our culture

“ I really started to think more about intentionally developing relationships with people that I like . . . who have different backgrounds from me, and that's what I call expanding your life lens. ”

at Emory is a very tight-knit culture and I would say, especially after the murder of Mr. George Floyd, the outpouring of support broke down a lot of walls for communication and so really the support for my colleagues and friends who are Asian American, Asian, Asian Pacific Islanders — it just flowed freely.

Two doors down from the office where I sit now, one of my colleagues is Korean American. I just walked down there and we had a heart to heart, just talked a lot about how he was feeling. You know, there aren't any words to say, to really allay the fear in all that's going on right now, but we are standing in solidarity.

We are in this space where we are having conversations. We say often around here that “awkward is better than silence,” and silence hurts really badly, and as a Black American, I know for certain what that feels like. And so, I've had a lot of awkward conversations this week, standing in front of my Asian colleagues and just kind of saying, “Sorry,” and “I hate this, and I don't like you being scared, and I see you.”

**Joe Elia:** Yes. Awkward is much better than silence.

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***I discussed the question of becoming more aware of one's biases with Dr. Karol Watson.***

**Joe Elia:** One of the things that we talked about was being aware of one's own biases. As a White person, I took the [Implicit Association Test](#) and I was surprised at the outcome, and I would recommend that.

**Dr. Karol Watson:** And I also want to make sure you understand, it's not just as a White person. Each and every one of us comes to every interaction with our own biases — all of us. I think it's a good thing for all of us to take.

**Joe Elia:** In an earlier conversation you quoted John Amaechi, the psychologist. Do you recall what he said?

**Dr. Karol Watson:** Very well. I think of it often. He defines privilege as the absence of impediments, just everything is easier.

You walk into a room and no one is looking at the color of your skin, automatically, and disliking you. It may not be that these people were ready to lynch you, but they automatically didn't like you, or thought less of you because of the color of your skin. That is something that you don't have if you have certain privileges.

The other thing is, most people are not nefariously racist, but there's something called *laissez-faire racism*, and that's basically, as my son in college puts it, a lot of people are “racist by accident.” So, for instance, they firmly believe in equity and justice. Those are things that they are absolutely committed to, so they think they *can't* be racist. But though they're committed to equality, they're not fighting back against inequality, and that is, honestly, how many people become racist by accident.

**Dr. Joseph Betancourt** mentioned his “Bodega Makeover” project earlier; he clearly knows his way around these little stores.

**Joe Elia:** Now, at a personal level, how did you get interested in the problem of equity?

**Dr. Joseph Betancourt:** Yeah. So, I’m originally from Puerto Rico. I grew up in a bilingual, bicultural home. My grandfather, you know, owned a bodega in Spanish Harlem in New York City. I lived in Puerto Rico as a kid. So, I’ve had a ringside seat my entire life to the impact of race in the city, culture, and class on all aspects in society, but certainly, in health care.

I had the good fortune of training in a place like Newark, New Jersey, a primarily minority, underserved community. Also, New York City, where, again, I lived and could eat and breathe the impact of all these factors and the disparities in clinical care, and saw the value that I could add as one of a few caregivers of color who understood these factors, perhaps, with more lived experience and who wanted to stand up and bring those voices to the change process.

That’s been my life’s work. It’s my passion. My daily work is a dream. It’s a dream job, and so, you know, I’ve tried to put my heart and soul into it, and it’s been an incredible journey, particularly this past year with everything that’s transpired. It’s been transformational in how much both the pandemic and the murder of George Floyd and our national reckoning on racism, long overdue, has really propelled this work in a new and important direction.

## What might clinicians do tomorrow in the clinic that they may not have done today?

**Dr. Karol Watson:** Well, the first thing you can do is the easiest thing: just pay attention and understand the barriers that exist. Too many times I’ve heard someone labeled as “non-compliant,” when what they really are is “unable to afford.” They want to do what’s right. We have to understand that a lot of the labels we put on people are really damaging.

So, they are experiencing homelessness. They’re not a homeless person. We have to think about things in terms of the structural barriers that exist, and hopefully, we can institute interventions that can, at least, ameliorate some of those structural barriers. It’s really hard. I mean, it’s really hard.

**Dr. Karen Dorsey Sheares:** I think that we are a very studious and learned group as physicians. We’re not afraid to spend a lot of time with books and journal articles, and to think critically and to bias ourselves toward evidence-based inferences. And somehow, we’re still not impervious to the American cultural blind spot around racial politics in our country. So, my wish is that folks who want to practice in this service-oriented, applied scientific field understand that they need to be students of the people that they serve and the nature of the institution that they work in, and that we need to understand that as clearly as we understand the pathophysiology of coronary artery disease.

“ My wish is that folks who want to practice in this service-oriented, applied scientific field understand that they need to be students of the people that they serve. ”

**Dr. Joseph Betancourt:** I always talk about three things that are quite clinical and then one that I would just hope people would engage in.

I'll start with that one: I do believe we are in a learning profession, and we are in a profession that is committed to high-quality care for anyone we see. That's what we stand for.

That's why we go into this work, and I think that, for many years, when people would hear about disparities, the "not me" phenomenon was very powerful. Meaning "No! Not me. I'm not part of this. I don't treat my patients differently."

I think we want caregivers to understand this isn't about good or bad people. This is just about really understanding that disparities exist, and that we need to stand up and take action.

So, it's not about "not me" — it's about "yes, all of us." And we all need to be part of the solution, and I'd offer three kinds of clinical hurdles that I would encourage caregivers to focus on. Number one, how can they build their skill set to communicate effectively with patients across cultures? And of course, you need to have curiosity, empathy, and respect to do that well.

Number two, there's an incredible amount of evidence on the impact of stereotyping, unconscious bias on our communications and clinical decision-making. I would encourage caregivers to really learn more about that. The more you understand how you could be susceptible to making assumptions about patients that affect your care decisions, the better you're able to then mitigate how that might play out in your day to day.

I'd end with a third, which is addressing mistrust. You know, mistrust is very potent. Trust is an essential part of the therapeutic relationship, and we know that minority patients, at much higher rates, report that they feel they've been treated unfairly in the health care system in the past based on their race/ethnicity.

Insofar as we can build trust, I think that goes a long way in addressing these disparities, and it's not easy. I tell my caregiver friends, when you're engaging a patient, say, "I know a lot of patients have bad experiences with the health care system. Is that the case with you, or has that been an issue for you?"

And what you're doing there is you're giving them an opportunity to say, "Well, you know, yeah, I did have this bad experience," and what that opens the door for is you to say, "I'm sorry. I can't explain why that happened, but I want to be different, and I hope you can trust me."

That small intervention — and it might maybe take a little bit longer than you'd like — will be an incredible investment in your relationship going forward.

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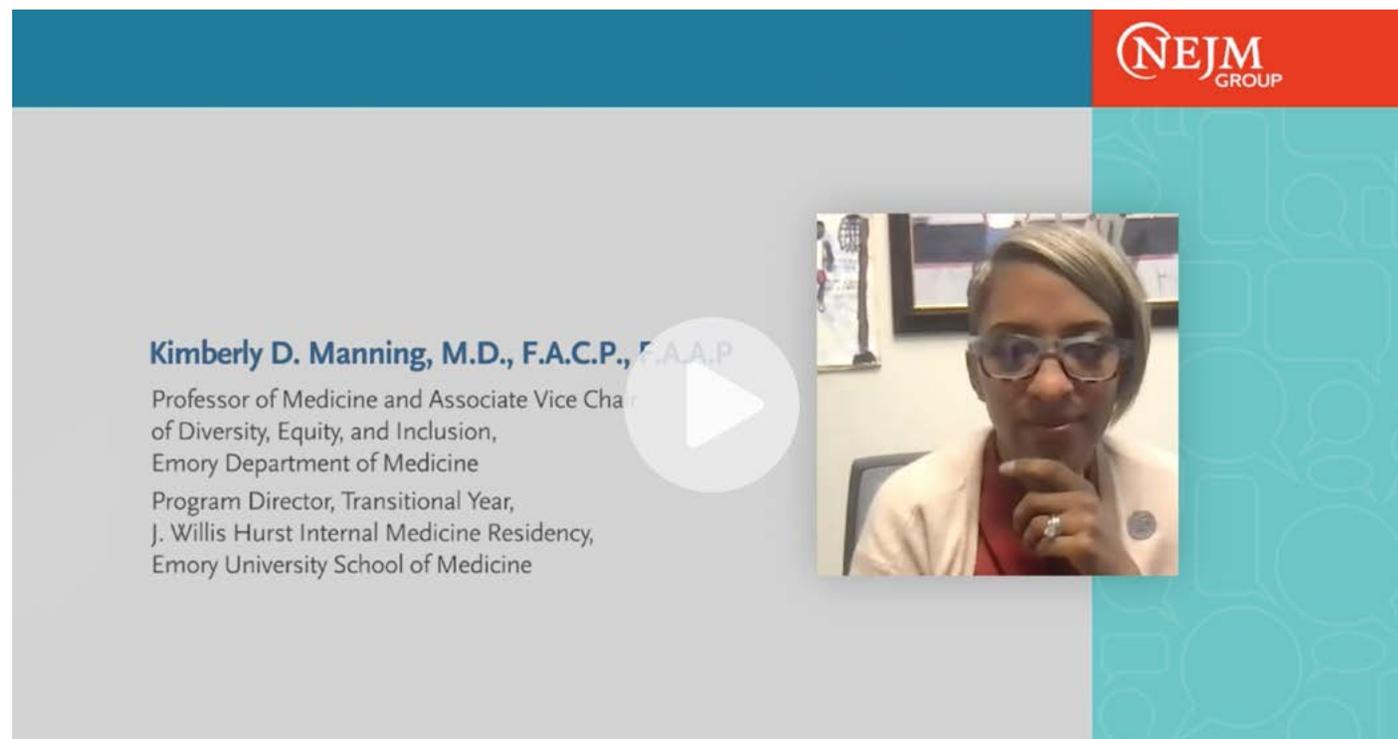
***We began this with a story from Dr. Kimberly Manning, and at the end of our chat she asked if she could tell one more. I can't think of a better way to end this — or to give a model of exemplary clinical behavior.***

**Dr. Kimberly Manning:** I had a resident on my team a few years ago, who was from Mexico City, and on this particular day, we happened to be rounding on my

birthday, and he said to me, “Oh, we need to sing you ‘Las Mañanitas,’” and I said, “I don’t know what that is.” And he’s like, “You never heard that song? That’s the song people sing to you in the morning on your birthday in Mexico or in Latin America.”

Well, I’m not from Mexico or Latin America; I never heard that before. So, he took out his phone, he played “Las Mañanitas” for me and we talked all about it. Of course, me being a nerd, I looked it all up, and that was that. We finished the month. Two or three years passed.

I was on service, caring for a patient who had advanced metastatic cancer, and she was a woman who was from Mexico, and she was Spanish-speaking only, and it just so happened that she was going to end up being in the hospital on her birthday. She was really upset about it because it was a milestone birthday, and it just so happens, it was two days before my birthday, so through the interpreter, I’m talking to her about her birthday coming up. She was very sad about it, sad about her diagnosis, and there was really nothing I could do at this point. We were going to get her to hospice. We had the palliative care team working with us.



**Kimberly D. Manning, M.D., F.A.C.P., F.A.A.P.**  
Professor of Medicine and Associate Vice Chair  
of Diversity, Equity, and Inclusion,  
Emory Department of Medicine  
Program Director, Transitional Year,  
J. Willis Hurst Internal Medicine Residency,  
Emory University School of Medicine

*Watch this excerpt from  
Joe Elia’s interview with  
Dr. Kimberly Manning.*

You know, our wonderful interpreters at Grady have really taught me how to connect with our patients through interpreters, and as we kept talking I just felt so bad, there's nothing I could do. So, on her birthday, I went and bought a balloon from the gift shop, and I came up with the balloon, and with the interpreter, gave it to her, and then I said, "I have one more surprise for you," and I took out my phone and I played "Las Mañanitas."

And the way that that woman cried — I mean she *cried*. Her whole family cried. They couldn't believe it. Like, here comes this Black woman in Atlanta, Georgia, playing "Las Mañanitas," and I would never have known what that was if it had not been for Alfonso, my intern, those years before, and that, to me, underscores the case for diversity. That patient felt seen. She felt valued. She felt comforted in that moment. Her whole family felt comforted.

And you know, what's even the most special part about it is two days later, I was coming into the hospital and I got paged to come to the floor because the nurses needed me. And when I got up there, it was a card and two big balloons, a 4 and an 8, for my 48th birthday from her and in this perfect cursive, and you can tell, she had like written it out from Google Translate

because it was kind of . . . the English was a little off, but she had written a message to me thanking me, and I connected with this patient.

You know, if I didn't have that Mexican resident on my team, who just told me this one thing and broadened my life lens in this fleeting moment, I wouldn't have had something that stayed in my heart, that I could come back to and give to my patient and say, "No, I know I'm talking to you through an interpreter. I do. I know that. I know that you have this bad diagnosis, and look, I don't have the panacea for that, but I can see you. I can be with you. I can honor the fact that this is the day you were born, and I can show your family that I'm culturally humble enough, you know, to take what I learned from somebody else and bring it to you today, and show you that."

It was just like, man, you know what? This is why you cannot have everybody on the team in your hospital looking the same way.

---

*To view the full video interviews with each clinician, visit the Resource Center on page 30.*



The NEW ENGLAND  
JOURNAL of MEDICINE

## Perspective Articles on Race and Medicine

## PERSPECTIVE

## WITHOUT SANCTUARY

S. Michelle Ogunwole, M.D.

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*There is nowhere Black people can go to not be inside a carceral gaze or at risk of experiencing police brutality. . . . And we, in healthcare, have to [start] building that sanctuary for folks as their human right.*

— Rhea Boyd<sup>1</sup>

---

On an otherwise routine day in 2014, I walked into my hospital as a new internal medicine resident to find a patient I would never forget.

Ms. A. was the first patient with sickle cell anemia I'd treated. She was 28 like me, tall like me, Black like me. But there was one notable difference between us: she was admitted for a vaso-occlusive crisis and needed care, and I was the doctor assigned to care for her.

In the mornings when I prerounded, our conversations often drifted from pain management to ordinary things, like the misery of being trapped under the hair dryer at a Black salon, or our shared love of the chopped and screwed hip hop that originated in our home state of Texas. It struck me then that in another world, Ms. A. and I could have been friends.

But in this world, I was a doctor tasked with helping her navigate her health crisis. And in that pursuit, I fell short. Even in her hospital room, where Ms. A. came to find healing and relief, she could not escape White

supremacy, police violence, or White indifference. Like many Black people in the United States, she had no sanctuary.<sup>2</sup>

The day I began that journey started normally. I walked into Ms. A.'s room to check on her and was surprised to find her sleepier than usual. After she dozed through my more vigorous attempts to rouse her, I checked her chart for recent opioid administration: none. I found her nurse and conveyed my concerns. As we considered possible explanations for Ms. A.'s sleepiness, the nurse offered a startling theory: perhaps Ms. A. had taken pain medication not prescribed by our team. Before I could fully weigh the implications of the suggestion, the nurse recommended calling security to check the room.

I hesitated. The recommendation felt hasty. But I was a new resident and lacked the confidence to trust my instincts and disagree. Instead, I followed the nurse's recommendation.

In medicine, many decisions are necessarily time-sensitive. But that moment taught me that "tricky" health care situations often unfold even more quickly for Black patients, as clinicians move expeditiously to "have a bad feeling," to escalate, to request backup — which often arrives in uniform.



S. Michelle Ogunwole, M.D.

The commotion of the security guards searching the room awakened Ms. A. I sat on her bed and relayed our concerns. Still drowsy, she replied, “I have a bottle of pain meds from home. They are all mixed together in one bottle ... easier to carry.” I nodded, recalling the Ziploc bag with Tylenol, Advil, and Zyrtec in my own purse.

A few minutes later, the security guards announced their findings: a “suspicious unmarked bottle.” They needed to process its contents and would not return it to her.

Ms. A. sat up and demanded an explanation. Her anger was palpable. “Y’all don’t understand what I have to go through *every day*,” she yelled. “This pain is *every day*, people not believing me is *every day*!” She vehemently denied taking additional medication and threatened to call the police and report the confiscation as theft.

Thirty minutes later, uniformed officers arrived.

Ms. A. paced the room as she explained the situation, her voice and emotion rising. I stepped out of the room momentarily to answer an urgent page. When I returned, I found the officers pinning Ms. A. to the floor with her hands behind her back. She flailed and shouted, as she tried to escape. I panicked when I recalled her platelet count from the morning labs. They were low enough for her to bleed spontaneously, and I feared serious injury. As I contemplated how to intervene, Ms. A. looked up and begged me for help.

In response, I begged *her* to stop fighting. I told the officers about her medical condition and asked if their actions were necessary, but I did not insist they stop hurting her. I did not protect my patient. I did not fight for her or the sanctity of that space.

Ms. A. eventually gave up. The officers let go, and the nurse escorted her back to bed.

In bed, she wept.

As I watched her cry, I realized how profoundly I’d failed her through my inaction.

Years later, the heaviness of that realization and the sound of her unanswered pleas still haunt me.

In quiet moments, I often reflect on how our society decides who deserves punishment and who deserves redemption. I think about grace, and how Black people get so little. I think about trust, and how Black people get so little. I think about benefit of the doubt, and how Black people get so little. And I think about the varied manifestations of Ms. A.’s pain — how no one, me included, offered her a sanctuary.

Since that incident, I’ve also thought about how I could have acted differently in that moment and in similar moments that followed. These reflections have coincided with a societal reckoning about the pervasiveness and harm of racism. Recognizing an opening for this critical conversation through the lens of the medical system, I began participating in a podcast series exploring antiracism in medicine.<sup>1</sup> Our first episode focused on the nexus of racism, police brutality, and health. We explored police brutality as a public health crisis and began a difficult conversation about how health care providers participate in systems that reinforce the normative racist police ethic. As we discussed the absence of sanctuaries for Black people, my mind was flooded with memories of Ms. A. As we ended the episode, I asked aloud, “How will I create sanctuaries for my patients?”

Soon thereafter, sent to assist with a patient's preoperative blood-pressure optimization, I found Ms. Z., a 68-year-old Black woman, lying quietly in bed. When I introduced myself and asked her to tell me about her life outside the hospital, she lit up. She told me about her newest grandbaby, the recipes she perfected, and her love of dancing. The conversation eventually turned to more intimate territory: she was terrified of dying in surgery. "If I die, who will take care of my sick husband?" she cried. "Who will keep everything together? Who will protect them?" My heart broke for those questions, especially the last, which I knew revealed a fear especially common among Black mothers.

Though I did not have the perfect answer for Ms. Z., I had an idea for a small source of comfort. I asked if I could play one of my favorite poems for her: "Won't You Celebrate with Me," by Lucille Clifton.<sup>3</sup> She agreed, and we listened together three times in silence. The last line, "Won't you celebrate with me, that every day, something has tried to kill me ... and has failed," lingered powerfully in the room. We ended the moment with an earnest prayer that though this surgery was among those things that would try to kill her, it would fail.

As I left the room, I was overcome with emotion. I knew that what I had done was small, that it did not change the heaviness of the world Ms. Z. walked through every day. But it did create a space where she could temporarily lay her burdens down. And that felt monumental.

Imagine, I thought, if we all worked to create sanctuaries for our patients — in small patient-centered ways like poetry-filled rooms, but also in large systemic ways,

like interrogating policies related to the interface between health care and the criminal justice system.<sup>4</sup>

Imagine if practicing medicine required an oath to actively dismantle systems of oppression and build sanctuaries in their place.<sup>5</sup>

Imagine if our Black patients came into our hospitals broken, tired, and weary, and instead of finding judgment and opposition, they found rest.

Identifying details have been changed to protect the patients' privacy.

Disclosure forms provided by the author are available at [NEJM.org](https://www.nejm.org).

From the Department of Medicine, Division of General Internal Medicine, Johns Hopkins University School of Medicine, Baltimore.

This article was published on February 27, 2021, at [NEJM.org](https://www.nejm.org).

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DOI: 10.1056/NEJMp2030623

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“Imagine if our Black patients came into our hospitals broken, tired, and weary, and instead of finding judgment and opposition, they found rest.”

## PERSPECTIVE

COMBATING ANTI-ASIAN SENTIMENT —  
A PRACTICAL GUIDE FOR CLINICIANS

James H. Lee, M.D.

Since March 2020, Asian Americans have experienced an alarming increase in racial discrimination and racially motivated violence.<sup>1</sup> Commentators have attributed this distressing fact to the blame placed on China for causing the Covid-19 pandemic, given that the virus was initially discovered in Wuhan. Some top U.S. government officials perpetuated this attitude by referring to Covid-19 as the “China Virus” and “Kung Flu.” Because non-Asian people in the United States often conflate Asian subgroups, many people have directed their anti-Chinese sentiment toward people of other Asian heritage. Violence against Asian Americans has persisted at high rates throughout the pandemic, most recently involving the shootings of multiple women, leading to their deaths.

But anti-Asian racism is not limited to the Covid-19 pandemic. The 2003 SARS outbreak was similarly racialized, with Asian-American people depicted as uniquely potent vectors. Indeed, the United States has a long history of anti-Asian racism grounded in xenophobia, even during periods without a new infectious disease burden; such racism affects every age group and plays out across myriad settings.<sup>2</sup> This discrimination has escalated in the face of the continued racialization of Covid-19. Over the past 12 months, 31% of Asian-American people have reported being subjected to slurs or racist jokes, 26%

have feared that someone might threaten or physically attack them, and 58% believe that anti-Asian racism has increased since the beginning of the pandemic.<sup>3</sup>

The current growing antiracism movement in the United States has largely centered on anti-Blackness, which has been recognized as embedded in institutions such as law enforcement, the prison-industrial complex, and the health care system. Some scholars theorize that race and racism in the United States operate along a Black/White binary, so that non-Black people of color and the racism they experience are perceived in relation to Blackness and anti-Blackness.<sup>4</sup>

Given that the recent increase in anti-Asian sentiment occurred alongside the highly publicized and protested murders of Black people, the Black/White binary may help explain why the recent surge in racism against Asian Americans has remained underreported. Though the relative invisibility of Asian Americans that results from this racial dichotomization is a long-standing issue, underreporting over the past year has been particularly egregious. Public awareness of crimes against Asian Americans increased in February 2021 only because of a boost from social media and subsequent attention by national news outlets. This increased exposure has highlighted the vicious nature of these crimes, and



James H. Lee, M.D.

Asian Americans are left anxious about the lives of their loved ones and fearful for their own.

During the pandemic, clinicians have been treating many patients experiencing the social isolation, financial hardship, and sometimes overwhelming ennui imposed by quarantining. On top of these common conditions, many Asian Americans are feeling the stress of increased anti-Asian sentiment; they may have emotional distress after a verbal assault or anxiety regarding their physical well-being. Physicians can tailor their practices to meet this moment by creating a welcoming environment for Asian-American patients and identifying symptoms that stem from living in a racist environment (see table). Physicians can then address these symptoms by providing patients with treatments and resources to help reduce this increased psychological strain.

Hate crimes have occurred in a wide variety of locations, potentially causing Asian-American patients to feel unsafe in spaces they previously deemed safe, including hospitals and clinics. To alleviate this discomfort, health care providers can make some changes in their offices to ease patients into clinical settings. Outpatient practices can make Asian-American patients feel welcome by having brochures translated into languages commonly spoken in the surrounding communities of color and displaying them openly. In addition, signs in office lobbies or exam rooms indicating that translators are available can make patients aware of such services. Though inpatient spaces may be less flexible than outpatient clinics, hospitals can take some actions to promote patient comfort; for example, they can accommodate

patient requests to move a roommate who has made discriminatory remarks.

Creating a safe space for Asian Americans includes protecting Asian-American health care workers. Many Asian employees, especially those who work closely with patients, such as nursing staff and social workers, experience anti-Asian racism on the job. Most health care workers have undergone some level of cultural competency training, which can be augmented with more targeted techniques such as bystander intervention and crisis de-escalation. Training in these techniques will allow health care workers to more effectively and immediately respond to discrimination against a patient or colleague.

By instituting the aforementioned changes, physicians can create a welcoming milieu that allows for directly addressing race in patient visits. I believe physicians should become comfortable asking whether patients have experienced racism — a question that could both signal that the physician is open to discussing race and reframe a conversation to permit consideration of the effects of racism on health. Assessing whether Asian-American patients feel safe in their homes, in their neighborhoods, or on public transit could be a way of introducing the topic gently. Undertaking targeted screening for depression, anxiety, and substance use with racism in mind can reveal symptoms that patients may have previously dismissed. Special consideration should be given to the patient's age, so that, for instance, clinicians screen for elder abuse in nursing home settings and for (in person and online) bullying in children.

If a patient reports having experienced a hate crime, it is appropriate to treat the incident as a traumatic

“Physicians should become comfortable asking whether patients have experienced racism.”

Practices for Combating Anti-Asian Racism	
General Approach and Specific Practices	Examples
<b>Creating a safe space in outpatient settings</b>	
Hanging welcoming signage in lobbies or waiting areas	Include flags from the Asian countries most heavily represented in the local community
Displaying welcoming images and literature	Ensure racial diversity of depiction of patients and clinicians in pamphlets, brochures, and posters around the office
<b>Creating a safe space in inpatient settings</b>	
Making rooming accommodations	Provide separate rooms for patients of color and patients who make discriminatory remarks
<b>Creating a safe space for staff</b>	
Augmenting cultural competency training	Teach bystander intervention, crisis de-escalation Consider further training in culturally adapted cognitive behavioral therapy to gain further expertise in discussing race with patients and colleagues <sup>5</sup>
Offering institutional support after staff member experiences a hate crime	Provide access to counseling Permit medical leaves for recovery from discrimination
<b>History taking</b>	
Specifically mentioning racism when acquiring patient history	Ask “Have you found yourself more anxious in light of the recent hate crimes against Asians?” Ask “Do you avoid certain locations due to fear of being discriminated against?”
Screening for depression, anxiety, substance use, elder abuse (especially if patient lives in nursing home), bullying or cyberbullying (especially in adolescents), post-traumatic stress disorder	Use relevant screening questions and instruments
<b>Physical exam</b>	
Skin exam	Evaluate for TEARS (tears in skin, ecchymoses, abrasions, redness, swelling)
Musculoskeletal exam	Evaluate for abnormal gait, pain with movement or on palpation
Documentation	Consider photographing lesions to document how injuries change over time Document a thorough “head-to-toe” physical exam, or consider further imaging
<b>Resources</b>	
Providing resources specifically addressing anti-Asian sentiment	Stop AAPI Hate <a href="https://stopaapihate.org">https://stopaapihate.org</a> Asian Americans Advancing Justice <a href="https://www.advancingjustice-aaajc.org">https://www.advancingjustice-aaajc.org</a> Organization of Chinese Americans <a href="https://www.ocanational.org">https://www.ocanational.org</a> Asian Counseling and Referral Services <a href="https://acrs.org">https://acrs.org</a>

experience. Doing so would require taking a more thorough history of the incident and using a post-traumatic stress disorder (PTSD) screening instrument to assess the patient for psychological distress and loss in function. Broader screening questions allow physicians to capture information about both recent and remote events, such as racial trauma patients may have experienced before the pandemic.

Though physical findings will be rarer than psychological ones, a physical exam including thorough skin and musculoskeletal exams should be done regardless of whether the patient has disclosed a hate crime. Such an exam could reveal some signs of an altercation that a patient may not have disclosed. If there are such physical findings, the physician should consider racially motivated assault in the differential diagnosis, alongside more common occurrences such as domestic abuse and accidental trauma. Thorough documentation of the physical exam is critical, and wounds or injuries that are not healing appropriately should be investigated further.

Clinicians have access to a wide variety of resources, including organizations such as STOP AAPI Hate and Asian Americans Advancing Justice and colleagues in social work, case management, and psychiatry. Physicians can prophylactically address harms from anti-Asian sentiment in part by connecting patients with resources that might not have been considered if the conversation were not directed toward race.

The long history of racist abuse of Asian Americans has caused substantial distress in Asian-American communities. Even if the recent increase in media attention to anti-Asian hate crimes prompts action to

curb this violence, the effects of racism will remain. Physicians should act to address anti-Asian sentiment by tailoring their practice both inside and outside patient rooms to make Asian-American patients and colleagues feel safe. These small changes will allow clinicians to capture diagnoses they might otherwise miss and to connect Asian-American patients with resources essential to their well-being, thereby providing holistic care that accounts for patients' lived experience of race.

Disclosure forms provided by the author are available at [NEJM.org](https://www.nejm.org).

From the Department of Psychiatry and Psychology, University of Washington, Seattle.

This article was published on March 24, 2021, at [NEJM.org](https://www.nejm.org).

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DOI: 10.1056/NEJMp2102656

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# **Insights Report: Health Inequity and Racism Affect Patients and Health Care Workers Alike**

## HEALTH INEQUITY AND RACISM AFFECT PATIENTS AND HEALTH CARE WORKERS ALIKE

In March 2021, NEJM Catalyst published the results of a survey among members of its Insights Council, a group of executives, clinical leaders, and clinicians directly involved in care delivery. The results were assembled by the editors, with commentary provided by Dr. Lisa A. Cooper of Johns Hopkins.

Some 550 completed surveys were returned. We're sharing the results that caught our eyes:

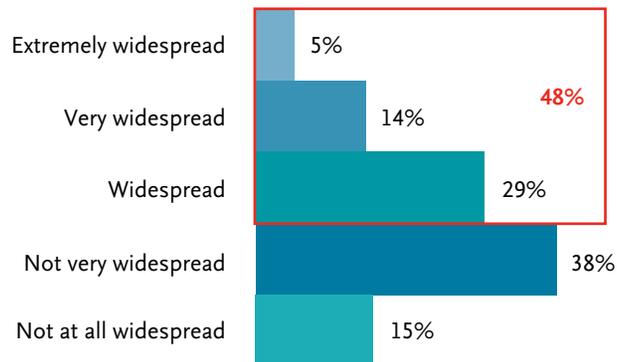
- Roughly half the respondents said that the prevalence of disparities in care at their organizations ranged from “extremely widespread” to “widespread.”
- Less than a third reported having programs to document social needs.

- Over half the respondents reported that their patients were “impacted” to “extremely impacted” by disparities at their organizations.
- Behavioral health, chronic disease management, and preventable hospitalizations were the areas judged to show the highest prevalence of disparities.
- Roughly half reported being impacted by interpersonal racism at their organizations.

**The following provides a closer look at the survey results.**

### Nearly Half of Respondents Say Disparities in Care Delivery Are Widespread

How widespread are disparities in care delivery at your organization?



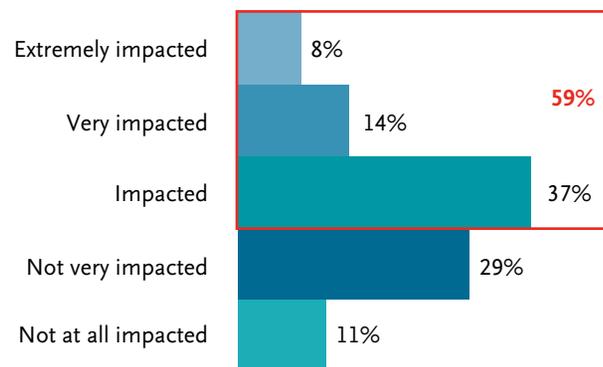
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A higher incidence of Executives 54% than Clinicians 43% indicate that disparities in care delivery are widespread.

## Patients Are Affected by Disparities in Care Delivery

To what degree are patients impacted by disparities in care delivery at your organization?

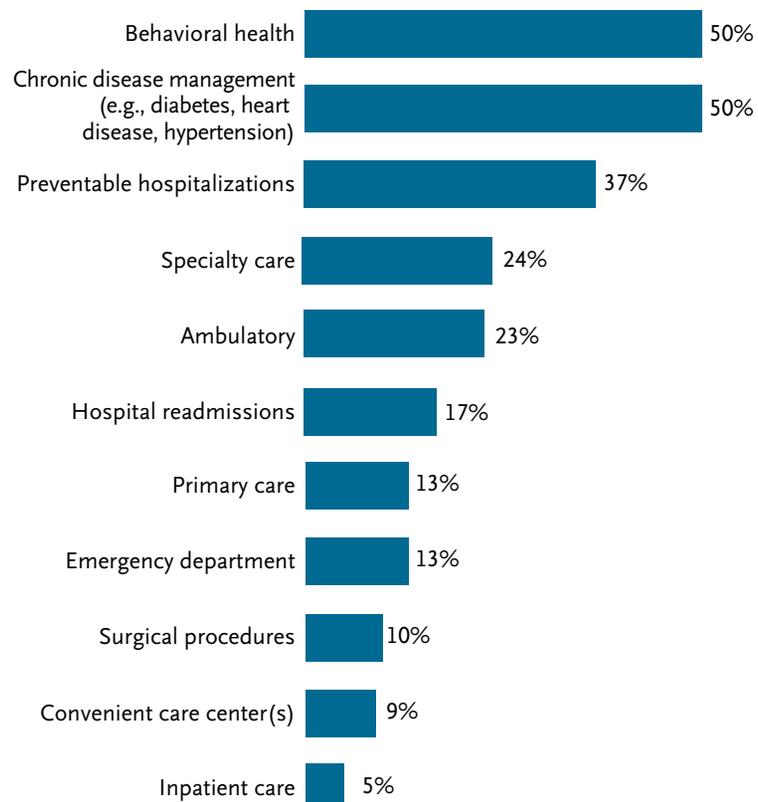
A higher incidence of Executives **65%** and Clinical Leaders **64%** than Clinicians **54%** think patients have been impacted by disparities in care delivery at their organization.



Base: 553

## Disparities Occur in Many Specialties and Aspects of Care Delivery

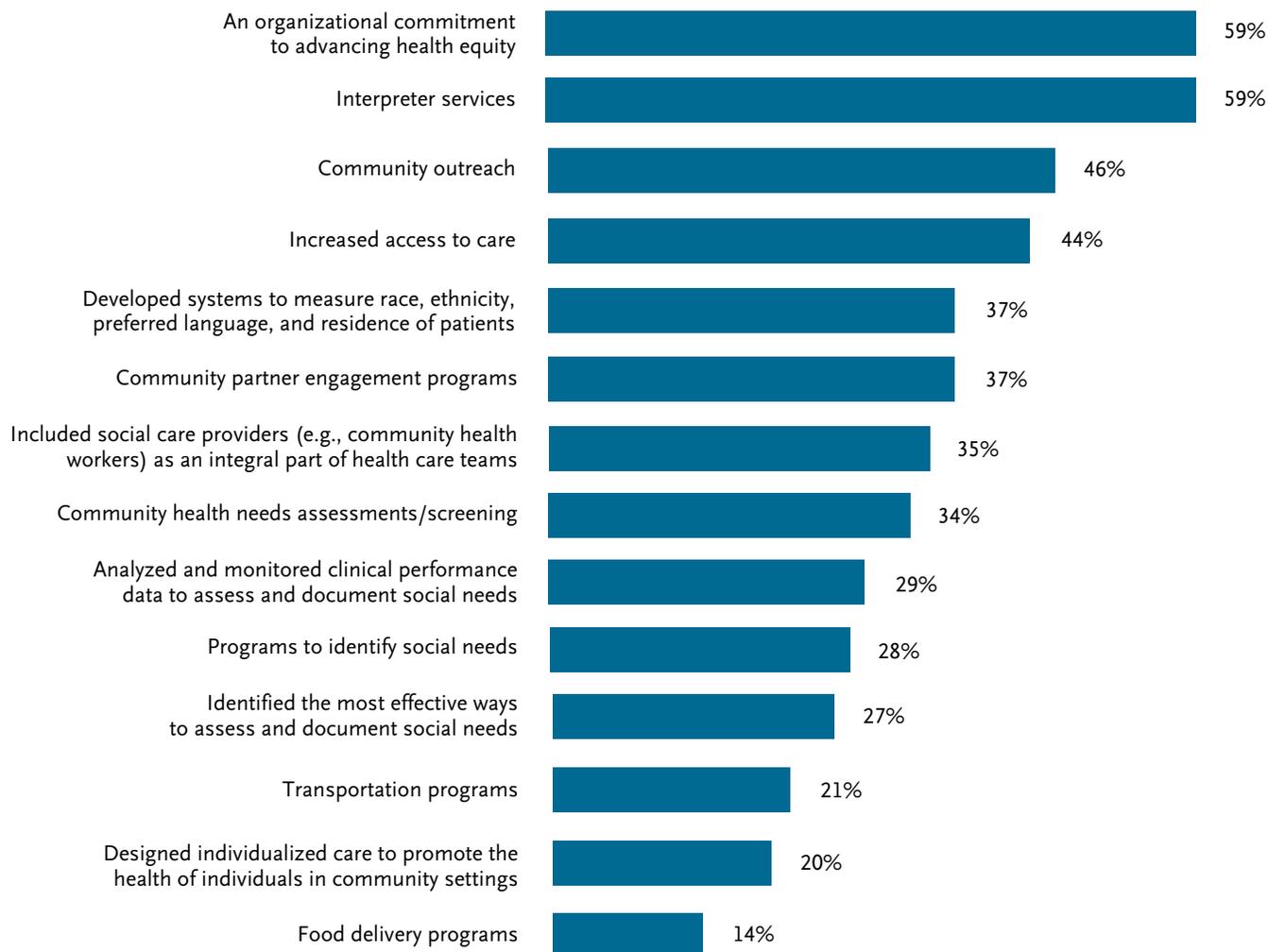
What are the top three areas in your organization where disparities in care delivery are most prevalent?



Base: 553 (multiple responses)

## Health Care Organizations Address Care Disparities Through a Wide Range of Efforts

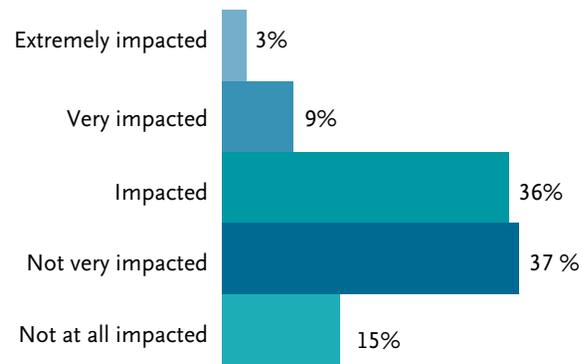
What programs and commitments has your organization made to address disparities in care delivery?



Base: 553 (multiple responses)

### Nearly Half of Respondents Say Clinicians and Staff Are Impacted by Interpersonal Racism

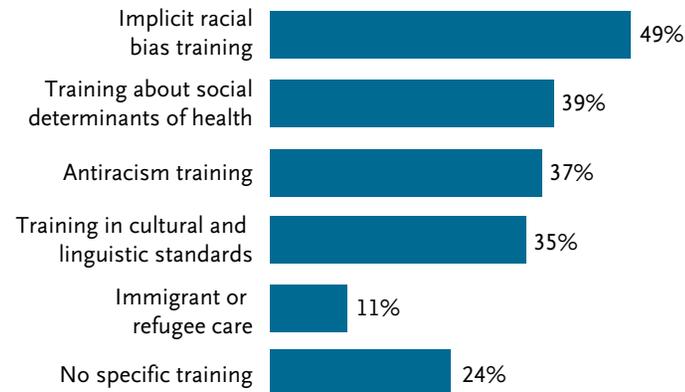
To what degree are clinicians, administrative staff, and other employees impacted by interpersonal racism at your organization?



Base: 553

### Health Care Organizations Provide a Wide Range of Training to Address Racism and Equity

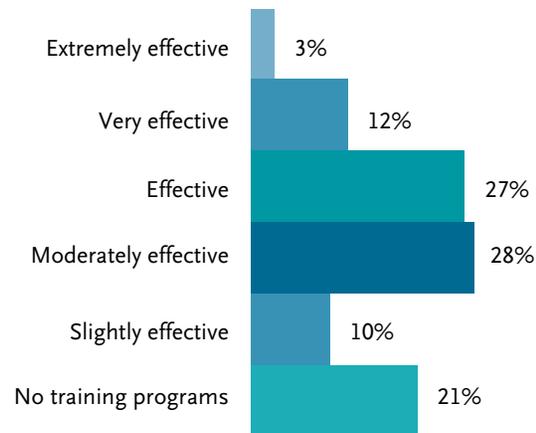
Does your organization provide training programs to clinicians and staff that specifically address interpersonal racism and promote health equity?



Base: 553 (multiple responses)

### Organizational Training Programs to Address Racism and Equity Are Somewhat Effective

How effective are current training programs to address interpersonal racism and promote health equity?



Base: 553

## If Your Organization Could Do One Thing to Make a Difference in Health Equity, What Would That Be?

Written comments from NEJM Catalyst Insights Council survey respondents

“ Invest in ongoing antiracism modeling from the C-suite on down. Change our use of language and not avoid direct conversations about how we want to become an antiracist organization.

— *Vice president at a government institution in the South* ”

“ Reach out to those we are not serving in a place and time that works for them — meet them where they are, physically and nonjudgmentally.

— *Director at a large nonprofit health system in the Midwest* ”

“ Work with communities to improve job training and/or pipeline training programs, as well as improved educational opportunities (school choice) for our children.

— *Department chair at a large nonprofit teaching hospital in the Northeast* ”

“ Have the conversations of equity be as safe as the ones we have for safety, quality, experience, access, and stewardship.

— *Chief medical officer at a large nonprofit health system in the West* ”

“ Leadership commitment at all levels. Sometimes there are initiatives on the top, but as they trickle down, they experience resistance. Like all changes, proposals from above are like a green light in front of a long line of cars. The first takes off, but each car takes a little or sometimes a lot to move, making the cars at the end of the line move very slowly or not move at all.

— *Clinician at a physician organization in the West* ”

“ Ensure our workforce at every level mimics the profile of the community — especially among professionals and executives.

— *Vice president at a large nonprofit health system in the West* ”

“ Recruit more diverse students to college and medical school.

— *Vice president at a large nonprofit health system in the West* ”

“ Invite patients belonging to different minorities to discuss health equity under their perspective, and create dedicated working groups.

— *Director at a small for-profit physician organization in the Northeast* ”

## RESOURCE CENTER

### The Interviews

The full interviews conducted to form the narrative in this eBook were recorded and are available to view:



Interview with  
Dr. Kimberly Manning



Interview with  
Dr. Karen Dorsey Sheares



Interview with  
Dr. Karol Watson



Interview with  
Dr. Joseph Betancourt



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### Race and Medicine on NEJM.org

The Race and Medicine collection reflects the commitment of NEJM to understanding and combating racism as a public health and human rights crisis. Our commitment to antiracism includes efforts to educate the medical community about systemic racism, to support physicians and aspiring physicians who are Black, Indigenous, and people of color, and ultimately to improve the care and lives of patients who are Black, Indigenous, and people of color.



[Visit the Race and Medicine collection here.](#)



## NEJM Catalyst Insights Report: Health Inequity and Racism Affect Patients and Health Care Workers Alike

An Insights Council survey shows disparities in care delivery at health care organizations and interpersonal racism affecting clinicians and staff, but also many programs and training to combat the problem.



[Access the full report here.](#)

## Project IMPACT

NEJM Group has collaborated with VisualDX and other renowned organizations on Project IMPACT, a global effort to reduce disparities in medicine and highlight ways to bridge gaps of knowledge and improve health care outcomes for patients of color.



[Learn more about Project IMPACT.](#)

# What will you learn today?



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