Pediatric RESEARCH

COMMENT

"Organizational solutions: calling the question" APS racism series: at the intersection of equity, science, and social justice

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Racism manifests in several forms—internalized, interpersonal, subversive, and institutionalized among them. The constructs that define and guide the various professional membership and honorific societies that constitute organized medicine in this country are not immune from harboring any, if not all, of these expressions of discrimination. Addressing structural bias and inequity at the organizational level requires authenticity, committed leadership, and transparent acknowledgement of transgressions both past and present. This commentary touches upon what "calling the question" must look like.

TRUTH, RECKONING, AND RECONCILIATION

Protests against social injustice, initially dominated by African Americans, have evolved and now encompass a multigenerational mosaic. Although many of the demands are directed at our governing institutions, there is a growing resolve to expunge racism from all of our institutions of power, including our academic health centers. This is to be expected because health care systems, including academic medical centers, are microcosms of society, and there is a growing realization that they have both been complicit and have the capacity to address the shameful health inequities that persist in our country.[1] The blame and expectation are justified. There are many examples of bias and discrimination in the history of academic medicine. At the same time, they are tremendously influential and can control the narrative that informs the practice of medicine, as well as refocus the training of physicians on the social aspects, as well as the biology of medicine. Slavery is largely responsible for a legacy of racism and injustice that directly affects medicine, as well as other social institutions.[2] Recognizing the harm to patients that results from discrimination and racism, addressing racial injustice, and shielding vulnerable patients from harm better informs the meaning of "equitable" among the accepted components of health care quality.

Most physicians are committed to treating all patients "equally," but they operate in an inherently racist system that leads to disparate rates of premature dying and variable levels of health and well-being. Physicians also have the "power, privilege, and responsibility" for dismantling this system.[3] This starts with learning about, understanding, and, most importantly, acknowledging and reconciling the racist doctrines that justified the oppression of African Americans for economic and political exploitation.[4] It includes understanding that there is little evidence to suggest that differences between races are intrinsic, inherited, or biologic. It means defining and naming racism. It also means shifting the focus of care providers, educators, and researchers from a majority, entitled group perspective to one focused on marginalized and historically disenfranchised groups. It means explicitly calling the question.

LEADERSHIP AUTHENTICITY

Leadership authenticity at the intersection of equity, science, and social justice requires academic leaders to: (1) embrace social justice engagement principles that involve active listening; (2) create safe spaces for crucial conversations about race and racism; (3) apply collective participatory strategies that involve defining and deciding on the nature of issues of systemic oppressions and their solutions; (4) explore unconscious biases; and (5) recognize and honor cross-cultural communication differences.[5] Health professions schools, graduate medical education training programs, and their leaders should ensure a commitment to inclusion, justice, and equity among their students, faculty, staff, and administration and demonstrate authentic acceptance of individuals from diverse backgrounds. Leadership authenticity and integrity begins with a commitment to personal accountability and the willingness and fortitude to instigate necessary, if not disruptive change. Evidence demonstrates that implicit bias and the persistence of systemic racism in our workplace, lives, and actions negatively impact the advancement of science and exacerbate inequities and injustice.

DISRUPTIVE INSTITUTIONAL AND PUBLIC POLICY

Effective change requires a focus on correcting institutional and public policies that perpetuate discriminatory realities. "Business as usual" can no longer be accepted in health care institutions. Every day, physicians, staff, and consumers of color call for commitment to action, not satisfied with vague acknowledgments and limited results. Because diversity initiatives have not achieved their desired endpoints, academic leaders have largely not benefited from the wealth of perspectives that inform strategic and programmatic direction. Further, diversity and inclusion tools and practices have not sufficed in addressing racial inequities. Effecting change has largely focused on

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guidelines, practice, and programs that have been retrofit onto existing structures with a goal of identifying physicians and employees who are better "fits." These approaches fail to address the underlying culture. Rather, there is a need to change culture and transform our health care organizations to fit all people. Disruptive intervention is necessary, involving concerted commitment of time and resources to individual learning and understanding about our racial history and biases. Humility, empathy, and respect are required; becoming comfortable with conflict is necessary for transformation to occur and be sustained.[6] Leaders, to be effective, must effectively communicate why equity actions are important, align bias and discrimination work with core missions, invite honest feedback by people of color, address hiring and retention of a diverse workforce, and personally commit to change.[7] Institutional action must be accompanied by advocacy for public policies that support these objectives. Dreyer et al., in a recent commentary, provide an example of this in a call for a suite of evidence-based policy changes to address police violence.[8]

ROLE OF PROFESSIONAL SOCIETIES AS LEADERS IN ANTI-RACISM

Professional societies and leaders involved in clinical care delivery and health profession training and education must acknowledge the deleterious effects of racism on health and well-being; take strong positions against discriminatory policies, practices, and events; and take action to promote safe and affirmative environments where all individuals thrive. By acknowledging the role of racism in child and adolescent health, pediatricians and their professional societies will be able to proactively engage in strategies to optimize clinical care, workforce development, professional education, systems engagement, and research in a manner designed to reduce the health effects of structural, personally mediated, and internalized racism.[9] This is consistent with founding director of the Boston University Center for Antiracist Research, Ibram Kendi's transformative concept of antiracism, which suggests the only way to undo racism is to consistently identify it, describe it, and dismantle it.[10] This also means identifying racism in our professional societies, institutions, and practices.

In additionally, our professional societies must assert a leadership role in addressing issues of the pipeline development for a more equitable and diverse pediatric workforce. The educational and developmental process that ultimately results in the training of either a general or subspecialty practitioner begins early in childhood.[11] In addition to working for change in social and educational policies, our efforts must include the development and fostering of long-term national programs to support, encourage, and mentor children from racial and ethnic backgrounds underrepresented in medicine. Such efforts will have the most indelible impact on transforming the status quo in medicine, *writ large*, and pediatrics in particular.

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