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**AAMC Press Teleconference**
***Racism and Health: How and Where to Make Changes***

**Friday, June 12, 2020**
**10:30 a.m. ET**

**Participants:**
David J. Skorton, MD, AAMC president and CEO
David Acosta, MD, AAMC chief diversity and inclusion officer
Malika Fair, MD, MPH, AAMC senior director of health equity partnerships and programs
Philip Alberti, PhD, AAMC senior director of health equity research and policy
Janis Orlowski, MD, AAMC chief health care officer
Alison Whelan, MD, AAMC chief medical education officer

**MODERATOR:** The Association of American Medical Colleges is pleased to welcome you to today's press conference, *Racism and Health: How and Where to Make Changes*. My name is Sandy and I'll be your facilitator for today's event.

When you want to ask a question, please press star one on your telephone keypad to be placed into the phone queue. You'll be able to hear the presentation while you're waiting. When the speakers are ready to take your question, your line will be unmuted. Please announce yourself with your name and media outlet. Please note that today's call is being recorded and the AAMC will post the audio recording of the press conference on its website.

It's my pleasure to introduce Dr. David Skorton, President and CEO, who will introduce the other speakers for today.

**David Skorton, MD:** Welcome, everyone, and thank you for joining us for our sixth virtual press conference. I want to thank you for all you're doing in the press to keep us all informed. It's necessary and it's very much appreciated.

Over the past three months the coronavirus has laid bare the long existing health inequities that cause such disproportionate harm to our nation's racial and ethnic minority communities. It's exposed that the deeply rooted social and economic structures and systems and policies that underlie health disparities, poor health outcomes, and lower life expectancy.

At the same time our country has been shaken to our core over the past several weeks because of the increasing examples of the everyday danger of being Black in America.

Today's press conference highlights these persistent challenges, and the need for academic medicine's ongoing work with communities to eliminate health disparities. Health equity is central to the mission of the Association of American Medical Colleges, which leads and serves academic medicine to improve the health of people everywhere.

Reminding you the AAMC represents roughly 400 major teaching hospitals across the country, all 155 accredited medical schools in the U.S., and 17 in Canada, as well as 80 academic societies.

Our membership includes multiple Historically Black College and University medical schools including Howard University College of Medicine, Maharry Medical College School of Medicine and Morehouse School of Medicine.

As healers and educators of the next generation of both physicians and scientists, the people of America's medical school and teaching hospitals must take action to ameliorate factors that negatively affect the health of our patients and communities. As leaders of anchor institutions in those communities, we must lead by example.

The AAMC is committed to taking action on this issue, both as an association and as a partner with all of our member institutions. In addition to the statement we issued last week on police brutality, racism, and their impact on public health, this week we provided a statement for the record of the House Committee on Ways and Means responding to a hearing on the disproportionate impact of COVID-19 on communities of color.

In the letter we outlined seven federal policy recommendations to help the nation's health workforce address health disparities and inequality, including hiring COVID contact tracers from the local communities to ensure cultural resonance.

We're having this conversation today with three of the AAMC's experts, national experts, on these issues to talk more about the impact of racism and the impact of bias on health, and the steps we believe must be taken.

We will start with Dr. David Acosta, the AAMC's chief diversity and inclusion officer. He'll provide a brief overview of the legacy of racism in healthcare.

After that my colleague Dr. Malika Fair, senior director of health equity partnerships and programs at the AAMC will talk about her personal experience as a Black emergency physician and the need for anti-racism training for physicians and learners.

And finally, my colleague, Dr. Philip Alberti, senior director of health equity research and policy will talk about the science of racism and health and institutional approaches to community engaged solutions to health and social injustice.

We'll leave plenty of time for questions at the end.

I'd like to start with my colleague, Dr. David Acosta. David?

**David Acosta, MD:** Thank you, David. And good morning, everyone. I'd like to start the session with a recent quote from Dr. James E.K. Hildreth, the president and CEO of the Meharry Medical College, that will help set the framework for this morning. He said, quote, "Today we are fighting two formidable enemies: Racism and disease. We cannot afford to let either win. We must remember both in our fight. I encourage you to use your voice to direct progress and demand change."

I'd like to start by first addressing racism in academic medicine. Unbeknownst to many, medicine does have a legacy of racism. And if we address this legacy and to undue its impact on medicine, research and patient care today, we must acknowledge it, own it and invest in learning about our history.

So let's take a brief moment to look at some of that history. The AAMC was founded in 1896. Membership at that time was limited at that time to predominately White institutions, institutions that restricted medical school admissions to women and people of color.

In 1949, the National Medical Association petitioned the AAMC to issue a policy statement that medical schools should be open to all, without discrimination, as to ancestry or religion. The AAMC's executive counsel response was to maintain, that, quote, "it never interfered with admission policies of any of its members or colleges," and declined to take a stand against segregation and discrimination in medical schools.

It took almost 20 years, in 1968 for the AAMC to commit itself fully to ensuring African Americans and all minority students had equal and meaningful access to medical schools. 39 years later, in 2007, the past president Darrell Kirch, publicly acknowledged history, expressed the Association's deep regret for the decision of the past and took responsibility for the association's inaction.

Fast forward to today, we have made some progress, yes, we have a deeper investment in diversity research programs and initiatives as you'll find out later on today. But we find that structural racism is still embedded in and influences our medical policies, procedures, and practices that preclude us from moving forward.

Let's reflect a little bit on that progress.

For example, African-Americans today make up only 7.1% of the total enrollment in medical schools, or to state it in another way, there are 1,540 African-American medical students enrolled today in U.S. medical schools, compared to a total enrollment of 21,622. It represents an increase of 1.1% over the last 38 years.

American Indian and Alaskan Natives make up only 0.2% of the total enrollment in Medical schools. Or stated in another way, there are only 42 American Indian and Alaska Native medical students enrolled in U.S. medical schools today. That's a decrease of 0.2% over the last 38 years. I mention these two population groups given the impact that the COVID-19 pandemic has specifically had on the Black and Native American communities and how critical it is to focus on the extreme shortages of these physicians that come from these two vulnerable communities. This must change.

We see similar data reflected on the diversity of our faculty and leadership who serve as important role models and mentors for our learners and also serve as our researchers and as clinicians for the communities we serve.

For example, underrepresented minorities make up 9% of the total full-time faculty in our U.S. medical schools. Underrepresented minorities make up 7.4% of our department chair positions and only 11.2% of all Dean positions in U.S. medical schools. This is to point out that a focus on enhancing the diversity in our faculty and leadership is imperative in moving forward. And this must change.

These findings and those that my colleagues will be discussing today are the driving force that guides the AAMC and its member institutions to amplify the work necessary to continue to address and undo the impact that structural racism has had.

Last week, as David said, the AAMC issued a statement on racism and America and its impact on health where we commit ourselves to move forward from rhetoric to action. Academic medicine must come together in solidarity to:

1. Speak out against all forms of racism, discrimination and bias.
2. Speak out against incidents of racial violence.
3. We must be deliberate with our partnerships and dismantle structural racism because we can't do it alone.
4. And employ anti-racist and unconscious bias training at all of our institutions.

We can't forget we must also continue to demonstrate our empathy and compassion for victims of violence and acknowledge their pain and the pain their families and their entire communities are experiencing.

For a different perspective on how racism manifests itself and what changes we can make, I'll now hand the microphone over to my colleague, Dr. Malika Fair. Malika?

**Malika Fair, MD, MPH:** Thank you, David. I have practiced over ten years as an emergency physician right here in the District of Columbia. I've seen firsthand, acts of racism towards my patients, my family and even myself.

Poor health outcomes disproportionately impact communities of color. In particular, my community, the Black community. Black people are dying of COVID-19 at a rate nearly two times higher than our share of the population.

Recently the focus has shifted to the violent acts of racism as seen in the killing of unarmed Black men and women and the startling statistic that a Black man today has a one in 1,000 chance of being killed by law enforcement.

As a physician, I'm trained to diagnose the illness or injury based on the symptoms. Let's be clear. Health inequities are symptoms. Racially motivated police violence is a symptom. Racism is the disease.

The medical community is not immune to this disease of racism. It is apparent in how we view and treat patients, and across all levels of learners. We have to own that.

We can see evidence of this dating back to the early 1800s when the so-called father of modern gynecology, Dr. J. Marion Sims, experimented on his female slaves with no anesthetic because it was a common belief that Black people did not feel as much pain as White people.

If we bring it to the present, we still see differences in the care that is given to Blacks and Whites.

These data are collected by the Agency for Healthcare Research and Quality and over a 16-year span. Their data shows 80% of the quality of care differences between Blacks and Whites have stayed the same or gotten worse.

In 2016 research showed that half of medical students and residents all believed that Black people don't experience pain the way other races do. And even this year, Black patients presenting with fever and cough are less likely to receive a referral for a COVID-19 compared to White patients.

While combating racism will require an individual institutional and societal approach, there is a role that physicians can play. We as physicians have to understand that race is a social construct, and not based in biology or genetics. We have to know the history of racism and how and why it impacts our clinical practice. We must be able to openly discuss racism in our clinics and hospitals and speak up when we witness it. And we must have an active voice in local, state, and federal policy related to racial justice.

This will require more than unconscious bias and cultural competency training. What I've just described is antiracism training.

It has to be embedded in the education of medical students, residents and ongoing education for faculty and other practicing physicians. This curriculum should be cocreated with diverse local communities and reflect the values of the patient population we are serving.

The current focus on the insidious disease of racism has given us a chance to act now. At AAMC we are developing competencies that will provide a framework for teaching hospitals around the country to design their curriculum and address this critical need. We're also collecting exemplar training on antiracism and making these publicly available. We must address racism within the walls of our institutions and our workforce.

I am inspired by the medical students, residents and faculty across the nation that are willing to work together to help eradicate this disease of racism. This is a time to act and we are a part of the solution.

And now my colleague Dr. Philip Alberti will share his perspective.

**Philip Alberti, PhD:** Thank you, Dr. Fair, and good morning everyone. I am not a health care provider, and I'm not a diversity and inclusion expert. I'm a social epidemiologist who, for over two decades, has worked with communities, public health agencies, and academic health centers to understand how social factors like racism create health inequities and to develop, implement, and test solutions to health and justice.

Dr. Fair is correct when she says that racism is a disease. It's a particularly clever one, given the many ways it can kill.

Let me give you three mechanisms through which the public health crisis—This disease of racism operates.

First obviously, Violent racism can kill you. We have seen that far too often.

But secondly so too can non-physically violent racism and discrimination. Research tells us that racism like that can kill you through excessive stress, through weathering, through anxiety and PTSD. The disease of racism isn't just about individuals treating people hatefully.

Racism ideologies are at the foundation of our country's system. That kind of structural racism kills too, and that's the third mechanism.

Take segregation as an example. Scientists have shown segregation explains much of the racial ethnic inequity in education, in income and employment and the social determinants of health. So, by systematically preventing Black communities from having access to resources like quality education, good jobs, affordable housing, et cetera, segregation purposefully creates health inequities.

It creates inequities in the prevalence of the underlying comorbidities that got so much attention at the absent of this pandemic. Comorbidities that are then used to blame Black people for how hard they are hit by COVID-19. The blame rests not in our communities, but on the racist disease foundation upon which those communities were built.

While racism is a disease, healthcare alone does not have the cure. Racism is an issue of health, not just healthcare. So we must not medicalize our response to the disease.

To achieve health equity and social justice, healthcare organizations must be the best partners they can be in a multisector collaborative necessary to undue racism. And yes, part of that best partnership is getting our internal houses in order in all the ways my colleagues have described. Now let me add three more.

I want to talk about data, dollars and discourse.

First, data: We must collect patient and community data that we need to develop effective intervention. Yes, we need self-identified race and ethnicity data. But we also need data on social factors that are actually modifiable. Because despite all the clamors we have heard to release data on race, the data we actually need do not exist.

Next, dollars: We can promote health equity by investing in our local communities' economic vitalities. Hospitals can hire locally, invest locally, procure locally, etc. Because community wealth is community health.

And third, discourse: And what I really mean about discourse is advocacy. Healthcare organizations should advocate for policies that promote health, regardless of whether they are healthcare policies. Because the time has come for us to broaden our lens.

And when we partner, healthcare must recognize that the people at the cutting edge of developing solutions to racism and injustice are the members of the very communities most impacted by racism and injustice who over centuries have developed strategies, assets and resilience to survive.

Health systems and other institutions need to focus on becoming trustworthy so we can partner effectively. This isn't about rebuilding trust, because often trust never existed. And how does this part of trust play out?

A recent survey found that only 25% of Black people said they would get vaccinated against the coronavirus, compared to 56% of White people. Other people of color do not trust us or our science.

My final point is that the disease of racism is highly contagious and persistent. It has a much higher reproduction number. That theme is not statistic, from the novel of coronavirus.
So the goal cannot be to flatten the curve of racism, it must be to bend and to break it.
Thank you.

**David Skorton, MD:** Thank you very much to my three colleagues. Now we're going to shift to the Q&A portion. We'll be joined by a few additional colleagues from the AAMC leadership.

For those in the media, if there are questions that we do not get time for, as usual, please send them directly to us at press@AAMC.org.

Thank you. Sandy, we're ready for the questions.

**MODERATOR:** Very good, thanks David. As a reminder, when you want to ask a question, just press star 1 on your telephone keypad to be placed into the phone queue. You'll will still be able to hear the press conference while you're waiting. When the speakers are ready to take your question, your line will be unmuted. Please announce yourself with your name and media outlet. The questions will be answered in the order that we receive them.

So our first question that we have, David, is from Sandhya Ramen CQ Roll Call.

**REPORTER:** Hi there, yes, hi, this is is from Sandhya Ramen CQ Roll Call. Thanks for doing this. My question was if you had to talk a little bit about the mental health portion of kind of what we've been discussing, I'm curious how the combination of dealing with racism and stress also from COVID-19 is going to affect, especially like African-American communities and kind of what can be done really, just like with the mental health aspect. What you're seeing happening there.

**David Skorton, MD:** It's a very, very important question. I'll make one very quick comment and then I'd like to turn it over to Dr. Fair to comment on.

One issue I think is important related to behavioral health, which is a huge, huge issue, very important one that you raise, is that we should not depend as a society on police departments with the current training to deal with mental health issues.

And it's part of the change in perspective on community service that I think the whole country needs to take very seriously and urgently.

Dr. Fair, I'll turn it over to you to give a more in-depth answer, thank you.

**Malika Fair, MD, MPH:** Thank you. I am very concerned about a startling statistic that around one quarter to one third of those who die in police custody have a mental or physical disability. And as Dr. Skorton just mentioned, that's a calling to all of us to think about the mental health, the contributions that we can make as a society to make sure we're taking care of the mental health concerns that your question relates to.

In terms of the Black community, I'm sure that you've had conversations with friends and colleagues that this is a trying time for the entire country. And especially in the Black community.

And it gives us an opportunity, not only to address racism as a country and racism within our institutions, but also to provide the supports that we need for all communities and the Black community to tackle the issues you mentioned, in particular the mental health issue.

**David Skorton, MD:** Thank you very much, Dr. Fair.

**David Acosta, MD:** David, I'd like to go ahead and add something to that.

**David Skorton, MD:** Yes, please, Dr. Acosta.

**David Acosta, MD:** I think the other thing we have to also be conscious of and address because mental health disseminates across all levels.

Because now we're starting to see also an increase in mental health stress and disorders along in our medical students, our residents, and especially our faculty that are on the front lines and taking care of COVID-19.

From our medical students and residents as well, we're seeing an increase of mental health stress due to the fact that many of them, especially are underrepresented minorities, come from these vulnerable populations and have lost many of their family members, their friends and community members to COVID-19 as well.

And it's not to underscore the fact that our community, mental health issues need to be strongly adjusted as well, but we have to remember that even our future workforce is now starting to feel the fallout that's coming not only from the COVID pandemic but also the racism and the racial injustice they're seeing around them as well.

And also having high levels of mental health disorders and stress. But they're also burning out and also signs of post-traumatic stress disorder as well.

**David Skorton, MD:** Thank you Dr. Acosta, thank you very much. Sandy, we're ready for the next question.

**MODERATOR:** Ok very good. At this moment we don't have anybody else standing by. Just a reminder to everyone to ask a question, just press star 1 on your telephone keypad. That will signal us you'd like to ask a question and then we will get to that. Okay, back to you, David.

**Philip Alberti, PhD:** Dr. Skorton, this is Philip, if I could add one quick thought to the mental health question.

**David Skorton, MD:** Yes.

**Philip Alberti, PhD:** So we'd be remiss if we didn't note two things. One the importance of access, mental health service access is few and far between across our communities.

And the second issue is, again, coming back to thinking about community engagement and understanding local context. And the really strong stigma around mental health seeking, mental health service use and contours and contexts that stigma takes.

And so again I urge all of us to think about engaging in conversations, building trusting relationships, increasing access and overcoming stigma.

**David Skorton, MD:** Thank you very much, Dr, Alberti. Sandy, any other questions?

**MODERATOR:** Nobody has signaled yet, press star 1.

**David Skorton, MD:** I'm going to make one comment on this very important question that was raised by our colleagues in the media. We're hearing a lot around the country about defunding or dismantling police departments. And our point of view, at least my point of view, is that's not where the conversation should start.

Where the conversation should start is what Dr. Fair was talking about and what we tried to get across. And that is to look at what the community needs and then to match the specific needs with specific approaches to service delivery that makes sense for those needs.

Some of them will require interaction with law enforcement, many will not. And so I think that it it's very important for us to think about Dr. Fair's comments and my comment and all of our comments in the context of the national discussion about police departments.

We have to ask the right question and have the right answer to that question. Sandy, ready for another question, if there is one.

**MODERATOR:** We're still waiting.

**David Skorton, MD:** I would like to jump in then with another idea. Normally I'm quiet at these press conferences and waiting for the media. But I'm thinking, you know, what would my dream be for the outcome of this.

What would I like, what message would I like for our colleagues in the media to think about sharing with the American public?

The whole point of this news conference. I would hope you would consider in your own wisdom of thinking about two things.

One is the phrase that Dr. Fair said that some of the things that we're seeing are symptoms, including the health disparities and other things that we're so well aware of that have been uncovered by COVID, but are not new by any means.

And then secondly, that as she put it, the disease is racism.

And so even though there's always a very robust debate about what it means to be racist and what it means to use the term racism, unfortunately we have a longstanding and I will call it an ugly tradition of racism in this country.

And actually goes back as the press knows, last year was the 400th anniversary of the arrival of enslaved people on this continent.

So I think that one very important point that Dr. Fair makes that I hope you would consider thinking about.

And the other one is that in thinking about the COVID epidemic going through what phases it's going to go through, which I certainly have no predictive power on that -- maybe there will be some decrease in cases in certain areas. We're seeing increases elsewhere and so on. At some point, we'll get our arms around a vaccine and direct treatment, which we don't have so far. But when that's over, we cannot stop the focus on health inequities. Just because COVID uncovered these inequities doesn't mean that they're tightly linked only to COVID.

We have to pay attention to this long after COVID is off the front pages so to speak. Thanks for listening.

And if any of my colleagues want to add to that, either of the three speakers or anybody else from the AAMC who is available on the call, please feel free to step in.

I just want to double check one more time with Sandy to make sure that we don't have another question waiting before we ask for anymore comments. Sandy, any of our colleagues waiting to ask questions?

**MODERATOR:** We do have a question. We don't have a name on this, so could you please announce your name and media outlet? Are you there?

**REPORTER:** Yes, this is me. Can you hear me?

**MODERATOR:** Yes, we can. We can hear you.

**REPORTER:** Great. This is Jane Greenhalgh, with National Public Radio. I wanted to ask a question bringing it back to the current COVID-19 crisis. As we know, it's hitting communities of color the hardest. What should we be looking for in terms of what is being done to help try and protect these communities?

**David Skorton, MD:** Thank you, thanks for joining us again at this news conference. Dr. Fair, would you please start on an answer on that? After that, Dr. Orlowski? Would you please pitch in with your thoughts, Dr Fair.

**Malika Fair, MD, MPH:** Sure, the answer to that question involves a lot of different factors.

When we are thinking about communities of color in the COVID-19 epidemic. We know we're providing equitable care when there is testing adequate testing in communities of color. That there is adequate treatment.

You probably heard the statistics, that I mentioned. There was a study shown in the northeast that there was not adequate referrals for testing between Black and White patients. That has to cease. We also have to have the necessary supports for communities, as my colleague Dr. Alberti mentioned. It's not just what healthcare can provide, because that's only about 25% of keeping someone healthy. It's also the other 80% of social factors such as running water and adequate nutritious food.

We have to think about our essential workers who sometimes are predominately in communities of color and making sure that they also have protection within the pandemic with enough face masks and even plexiglass in some of the areas they work to prevent the spread of the disease. So it will require both the medical community, as well as public health agencies, law enforcement, and our local and federal governments to work together to think about all the ways that we can keep communities of color healthy as well as the entire population.

**David Skorton, MD:** Thank you very much, Dr. Fair. Dr. Orlowski, would you have any comments to share?

**Janis Orlowski, MD:** Thank you and good morning, everyone. First of all, I wholeheartedly support Dr. Fair's answer. I believe she's hit the key elements.

One of the recent discussions that I've had is with the president of BJC Health in Saint Louis. One of the things that he was speaking to was the issue that these -- there are long-term inequities that end up being displayed by the lifespan.

They have--counties that BJC Health serves where the difference between the lifespan in one part -- one ZIP code versus another ZIP code -- may be as different as 18 years.

And in the discussions with him, what he said is it's not just us paying attention for COVID and making appropriate testing and working within the community and looking at tracing.

But what he said is we need to have a long-term commitment with the community to improve the overall health. And so this is just one of the areas that we need to work in.

But we need to work over a long period of time--because of these inequities.

Recently, within the last week, I reviewed data regarding the difference in lifespan between the majority population and the minority population. And a good part of the difference can be attributed to not having access to preventive services and/or not having access to ongoing medical care for chronic illnesses such as diabetes or hypertension. And I think the medical

community at large needs to address these areas. And I think access becomes one of our biggest opportunities to make an important first step.

**David Skorton, MD:** Thanks so much.

**Philip Alberti, PhD:** Dr. Skorton, this is Philip. Can I say one extra thing here?

**David Skorton, MD:** Hang on just one second, I apologize. I want to make sure the media knew who was just speaking, because I failed to give the whole title. The last speaker was Dr. Janis Orlowski, who is a practicing physician also in the D.C area. She is also the AAMC's chief health care officer. Sorry for the interruption Dr. Alberti, please go ahead.

**Philip Alberti, PhD:** No worries. I just wanted to point out that the inequities that have been laid bare by this virus, are simply not surprising.

If any of us had been asked two years ago, should there be a pandemic, which communities would be the hardest hit? We all know the communities that would be the hardest hit.

In addition to what we do now, is also ensuring in our--preparedness efforts are public health preparedness efforts, our pandemic disaster preparedness efforts, who we're being intentional about doing that work through a health equitable lens.

So we can ensure that communities are engaged in what the responses might be.

So it's really a failure of us in preparedness and imagination, given that we've known about these kinds of inequities based on race, class and other factors for decades now.

**David Skorton, MD:** Thanks very much, Dr. Alberti. Do we have any other questions at the moment?

**MODERATOR:** No, no one else standing by at the moment.

**David Skorton, MD:** Okay. I have something for perhaps, Dr. Orlowski to comment on.

One of the things that has occurred as a direct result of the murder of George Floyd, has been this enormous number of protests that I personally think is a very heartening sign of the country rising up and being very, very concerned that we have to do things differently, that enough is enough.

Many have raised the question among the media about the risk, Dr. Orlowski, of further transmission of COVID during the protests that are nonetheless important and necessary. We'd love to hear your comments on that.

**Janis Orlowski, MD:** Well, the answer is anytime you have a large group of individuals who come together now, there's an increased risk of COVID-19 disease.

So I think that there is a particular risk, that because of the protest, that we may see a small bump.

To date, it has not been as -- we've not seen that increase in cases. Quite frankly, the increase in cases we've seen across the United States have been mostly in the southern states.

We're seeing it in Arizona, we're seeing it in Texas, we're seeing it in the Carolinas. And from a data point of view, it seems to track back to sort of the widespread increase in people gathering around the Memorial Day.

That's where we're seeing the disease spread right now. It's interesting -- again, on a personal note -- I went to the protest in D.C. that was before the White House. The thing I was struck by was everyone wearing a mask, many -- I shouldn't say everyone -- many, many people within the crowd wearing a mask.

Many people trying to social distance, but also trying to make their public voice heard. And there were several people throughout the crowd who actually had hand sanitizer. So I think that there could be an increase in disease. I think people were trying to be careful. But we really are seeing the increase related to the Memorial Day opening in a number of states.

**David Skorton, MD:** Thanks very much Dr. Orlowski. Sandy, ready for the next question.

**MODERATOR:** Very good. We have on the line Jayne O'Donnell from USA Today.

**REPORTER:** I am -- I logged on late. But I'd love -- I doubt this was asked. I'd love to hear from anybody who wanted to add anything, but particularly Dr. Fair and Dr. Acosta about what the media could do to make their journalism more inclusive.

There are issues that things such as the -- like sickle cell and fibroids for African-American women and other issues that don't get covered by the mainstream media. And maybe there are ways we could be writing articles that take into consideration some of these other factors. Or just any recommendations you might have as the media looks within, at least I'm trying to for my organization.

**David Skorton, MD:** Thank you so much. Dr. Fair would you answer first and then Dr. Acosta.

**MALIKA Fair, MD, MPH:** I'll provide one suggestion.

Recently, a few weeks ago my colleague, Dr. David Acosta and a local community organization in the District of Columbia, Miriam's Kitchen, cowrote an op-ed about housing and healthcare.

And what was really fascinating about this piece that it highlighted an issue we see across the country and the impact of a social determinate of health in communities of color in the district and the entire District of Columbia.

The reason why I bring this up is because, this op-ed allowed voices to be heard that are not always heard by the media.

If I could give one piece of advice in things I've seen, especially in the last few weeks, is amplifying the voices of color. Both in academia, but also in the community.

Making sure community residents, those who are on the front lines, not just in the hospital but working with residents, working with those who are maybe experiencing homelessness, maybe experiencing mental health challenges.

We need to hear all those voices other than from the so-called experts that are in academia.

**David Skorton, MD:** Thank you. Dr. Acosta?

**David Acosta, MD:** I would echo some of the same sentiments. The overarching theme is that those that have been invisible need to have their voice heard. And I think a lot of times when we don't want to talk about racism, we don't want to talk about the burden of suffering that happens from health inequities we see in front of our eyes, sometimes the focus is so much easier to talk about testing and these other aspects etc. That we lose the voice of the invisible communities who really have a voice and want to say you need to know what we essentially are going through.

And as Malika said, the community has that voice, but also our providers that are also providing, the volunteers that are providing and what they see and what they witness.

Instead of putting it in page two and three and four, this needs to be very up front and consistently up front on the very front page so it is noticeable. If we keep it on the front burner and not putting it on the back burner. That's the only way we're going to find the voices of the invisible so we can move it forward.

I think about how long it took for any news about the vulnerable communities to move forward when the pandemic released itself, sort of thing. I was very happy to see it became top on the radar. Again, it will have a tendency to fall off the radar if we don't keep vigilant about that as well.

Philip, you probably have something to say about this, especially around the work that Carrie Sutton has been doing around pregnancy and OB.

**Philip Alberti, PhD:** Yes, thank you. Thank you, Dr. Acosta.

The first thing that came to my mind when the question was posed was as an institution, the media could hire more journalists of colors, more Black and brown journalist and highlight the stories to a greater degree then you've seen.

Maternal mortality, it speaks about the weathering that i mentioned so the wear and tear on the body due to prolonged stress including stress related to racism.

As an example that Dr. Acosta lifted up, thinking about these uncontainable Black/White differences in maternal mortality.

After you account for factors such as maternal age, income, health status, the pregnancy related mortality ratio for Black women with at least some college education is actually twice as high as it is for White women with less than a high school diploma.

Even if a Black mother has access to resources in healthcare, due to that stress and weathering, we see the huge inequities.

Stories like that should also be highlighted. Thank you, David.

**David Skorton, MD:** Jayne, did you have a follow up question? I thought I heard you trying to intercede.

**REPORTER:** Yeah, I didn't know if I was muted again. I wanted to ask, just as a follow up what both -- what maybe everybody said.

There is an issue -- I am White, I work with -- I have a nonprofit where I'm actually training young people in high school to do health reporting.

But there is -- it becomes -- there can be a stress, for lack of a better word in there -- or a strong sensitivity to appropriating people of color's stories by the media. But on the other hand, the media needs people's stories to make -- to bring these issues alive.

It's a question and a comment. I might suggest that it would be helpful for everybody in healthcare to make sure they understand that--[AUDIO FADE] to encourage people to tell their stories. Because it can be so hard.

I mean, I'm able to do it because I'm working with young people in the community. But it can be very hard to get past the HIPAA and the sensitivity that -- perhaps the embarrassment and stigma around telling your own story when that is what draws people's attention to stories and makes a difference.

**David Skorton, MD:** You know, it's a very important follow up and I'm going to ask any of my colleagues who want to comment on it.

We certainly could be helpful if you wished in trying to think about ways in the context of privacy and so on to get some of that information because we deal with those concerns.

And I have one other suggestion, but I want to wait until my colleagues have had a chance to comment on your follow up.

Any of my colleagues would like to comment on Jayne's follow up?

**Alison Whelan, MD:** I'll jump in. This is Alison Whelan. I'm the chief medical education officer.

Jayne, as you were speaking, what you were saying actually incapsulates a challenge I would suggest that every part of our society is facing. And it's actually one of the things that our medical schools are as well. And it's this idea of how do we truly capture the voice of these, as David has said, silent communities.

It needs to be a multipronged approach. Certainly hiring people of color is helpful. Also creating community connections or consulting groups or advisory groups. Because as you said, people may -- you have to establish, as you have, a sense of trust and truly bidirectional dialogue so that it doesn't become, as you have said, you know, a White voice taking over the story. It is ongoing, multifaceted and it requires those things. We found that in medical schools at every level of medical schools we need to do that.

I would suspect it's the same this for the press, the same thing in other associations and corporations. Your question is terrific and it's some of the same things as we work with our medical schools looking at that idea of really building the dialogue, connecting with the community, hearing the voices and bringing them into leadership positions in multiple ways.

**David Acosta, MD:** David, I'd like to go ahead. So Jayne talked about stories. Bear with me for a couple minutes. Before I came to the AAMC, I was working at the University of California Davis Health Systems.

They are talking about how strong people’s personal stories can be to influence and move a large system to begin concentrating and focusing on some of the major diseases that are faced there. The example is we got involved -- my office of diversity got involved with a renal transplantation unit there. And essentially we were having a difficult time on trying to getting the local Hispanic community in participating in renal transplantation. Especially because we had a high case of adrenal disease there.

Many were still on dialysis who couldn't understand why they were so closed to even thinking about transplantation. But it took that cultural awareness and having stories of some of those Latino patients that ultimately gone thru real transplantation and had successful outcome. These are people with diabetes as well. What we did is we worked with our particular media along with, that particular unit.

They basically do one to two-minute vignettes about their personal stories. It was really aimed at both the community but also at the academic health center community as well.

That voice changed the attitude of local communities about really forming that -- building that relationship with UC Davis Health System, looking at positive outcomes that have happened with Latinos going to UC Davis Health and undergoing this particular care. What they did in their stories, they broke a lot of the myths that were out there.

I agree totally with you that it's about people's stories that can make a major difference and coverage of those stories by the press is really important.

Thank you for asking that question.

**David Skorton, MD:** Thank you Dr. Acosta. Do we have any other questions?

**MODERATOR:** We do not have any other questions standing by at this time.

**David Skorton, MD:** Okay, then I'll go ahead and add one more sort of insider baseball suggestion for Jayne. I hope you don't mind an insider suggestion.

So I've had the privilege of meeting with editorial boards or members of editorial boards of many publications, including USA Today on a couple occasions.

You have probably thought about this long since. It might be interesting to, working through someone like Dr. Fair or others, identify some people in a local community and get them to add those community voices directly to those who are making decisions at the paper about what to cover and where to place it.

So I hope you don't mind, it's just a thought to get some other voices into the ears of the editors. There seems to be static on someone's line. We're trying to stay on mute. I hope our answers are coming through clearly.

Sandy, any other questions so far?

**MODERATOR:** There aren't any other questions at this time. Just a reminder to our speakers if you're not speaking at the moment, if you could mute your line, that should get rid of the static.

**David Skorton, MD:** I might just comment on for the members of the media when have joined us, I just want to remind you that we'll be quick in answering those questions if you send them to press @AAMC.org. Sandy, are there any other questions?

**MODERATOR:** No. We have no other questions standing by at this time.

**David Skorton, MD:** I think we think then give the members of the press six minutes back in their busy day. I want to thank all of the colleagues at the AAMC for their wisdom today. I want to thank all the members of the media, not only for being with us today, but again I want to thank you for all you're doing to keep all of us informed at a very unsettling time in our country.

Sandy, thank you, I'm turning back to you.

**MODERATOR:** Okay. Thank you very much. So with that, we'll conclude today's press briefing. This session has been recorded and the AAMC media relations group will post the link to the recording on the AAMC website later today.

On behalf of the Association of American Medical Colleges, thank you, have a great day and you may now disconnect.

**End of Press Conference**