



2021 ABIM FOUNDATION FORUM

PURSuing TRUST

Striving for Equitable Health Care

SUMMARY PAPER

The ABIM Foundation hosted its annual Forum in August 2021, employing a virtual format for a second year. This year’s meeting continued the Foundation’s exploration of facets of trust in health care, focusing on how health care organizations can promote equity and become deserving of the trust of—and engage and partner with—marginalized communities.

DAY 1: SESSION 1

Richard Baron, MD, President and CEO of the American Board of Internal Medicine and the ABIM Foundation, began by suggesting a “North Star quote” for the meeting, drawn from the video submitted by panelist Brook Watts, MD: that we all have the opportunity to relieve suffering.

Jackie Judd, Chair of the Foundation Board of Trustees, welcomed participants and looked forward to “honest conversations that will have life well beyond this Forum.” She introduced a video that highlighted disparate health outcomes in America, which had intensified as a result of COVID-19.

Dr. Baron and Ms. Judd then discussed the themes of the meeting. Dr. Baron said this Forum was designed to generate action by putting forward concrete examples of how organizations are addressing racism and working to become more trustworthy.

Ms. Judd noted the “seismic events” of the previous 18 months: the pandemic, the murder of George Floyd and the ensuing protests, and the social changes that hopefully will follow from that. Dr. Baron said these events had increased understanding of trust’s importance, and the historical causes of mistrust. As an example, he noted how he learned that the section of New York City in which he was raised was racially segregated through policies that ultimately prompted the amendment of the New York constitution to mitigate segregation.

The Patient Voice

After a brief networking session, Delores (“Ms. Dee”) Collins, a community health worker in Cleveland and the founder and Executive Director of A Vision of Change, shared some of her experiences as a Black woman patient with the group.

“Does disease have a color?”

-Delores (Ms. Dee) Collins

Ms. Dee described a miscarriage she suffered and the treatment she received at the hospital where she sought care afterwards. She described being left alone in the emergency room with a steel dish containing her miscarried fetus for several hours, only to be asked by a nurse what she wanted the hospital to do with the fetus, with no further information or options presented. It was only later that a nurse practitioner friend told her that her agreement to allow the hospital to send the fetus to the lab for testing meant she would never see it again. She said no one at the hospital asked about her mental health or provided any information about grief. During a follow-up visit, a social worker told her, “Oh, you can have another one.”

Her experiences in seeking care for chronic pain were no better. After testing positive for a genetic condition that could explain the pain, she saw a rheumatologist. She said this physician entered the exam room without introducing himself and was skeptical that she had the genetic condition for which she had tested positive because it was a “Caucasian disease.” The physician asked her if she had whites in the family. “Does disease have a color?” Ms. Dee asked.

When she visited the rheumatologist again, she wrote down questions in advance; the physician folded the paper and put it in his pocket.

“I often wish for my doctors to be able to relate to me, and understand the disparities I deal with on a daily basis,” Ms. Dee said. “I want them to hear me and value what I have to say when it comes to my care, and to let go of stereotypes they have of me and see me as a human being.”

Ms. Dee shared that she had not visited a doctor in two years due to her mistrust.

During the question and answer session, Ms. Dee said that she filed a grievance with the ombudsman at the hospital where she saw the rheumatologist, who called to apologize. She said the apology call had not restored her trust, and that she would never see that doctor again. She also suggested that hospitals invite people who have had experiences like hers to give talks for clinicians.

Uncovering Unconscious Bias

Scott Horton, a consultant who was previously Director of Diversity and Inclusion Consulting at IBM, led the group in an exercise on unconscious bias. He noted that people interpret reality through pattern recognition, and employ stereotypes across a wide range of characteristics. He quoted Anais Nin: “We don’t see things as they are; we see them as we are.”

In the exercise, participants chose which of four individuals from different racial, ethnic and socioeconomic backgrounds they would most and least want to be. Participants entered the reasons for their preferences in chat. Mr. Horton noted how even when people agree on their preferences, they often have very different reasons, using this to illustrate diversity of thought among teams.

He showed a 5-point scale of attitudes toward difference, ranging from repulsion at the bottom to appreciation for diversity at the top, with tolerance in the middle. In the employment context, he said that when employees feel that their differences are accepted (4) or appreciated (5), they feel good about their positions. When they feel that their differences create repulsion (1) or avoidance (2), they look for other work.

Mr. Horton finished his session with a personal story. A colleague shared data with him demonstrating that he was giving the most opportunities to the gay white male consultants with whom he worked, and the fewest to straight women of color. He said he was taken aback by this information, and that seeing it in black and white demonstrated that it is critical to have systems in place to measure inclusion.

Kimball Lecture Conversation

Carladenise Armbrister Edwards, PhD, Executive Vice President and Chief Strategy Officer at Henry Ford Health System, delivered the 2021 Kimball Lecture by video before the meeting. In her lecture, Dr. Edwards used her family history—which included the kidnapping of her great-grandfather, a Baptist preacher, by the Ku Klux Klan in Florida—as a stark example of the history of racial injustice in America, and a basis to consider the racial disparities in our health care system.

“We know what we know,
and now we need to act
upon it.”

-Carladenise Armbrister Edwards, PhD

She issued a call to action for health care institutions to take overdue actions to address the impact of structural racism. “We are at a pivotal point in history where it is time for the rubber to meet the road,” she said. “What sustainable solutions are we putting into place to prevent the next infectious disease from killing millions of people? To stop police brutality, racial intimidation and violence, as well as the newest public health concerns of depression, suicide and homicide?”

Dr. Edwards called for charting a new course based on hope, health, equality and love. “We know what we know; and now we need to act upon it,” she said. “I’m terrified that 100 years from now, we will still be talking about our striving for equity. My deep-seated hope is that we will not.”

She called on participants to renew our social contract, and to collaborate with one another to transform our future.

After participants viewed highlights from the lecture, Dr. Baron and Dr. Edwards had a discussion. Dr. Baron began by asking about the impact of our personal stories, and how hers played into her life and career choices. Dr. Edwards said she drew the need to “lead with love” from the discrimination that plagued her great-grandfather, who preached about love. “When you take what you value and believe as the premise by which you interact with people, you can not only inspire change but be the change agent,” Dr. Edwards said. “Think of it as accepting others for who they are and where they are; identifying what others need and how they can get it for themselves and you can facilitate; making relationships bloom and blossom; learning how to get along with difficult people; and effectively dealing with conflict.”

“We all come from the human race. If we embrace that, boy could we make progress.”

-Carladesise Armbrister Edwards, PhD

Dr. Baron asked about the frustration that Dr. Edwards expressed in her lecture that we are still talking about racism and its impact in 2021. She described a recent conversation she had with her mother, who said “Racism is so old, how long do you think ending it is going to take?” “I’m happy to work with people who are working to make change,” Dr. Edwards said. “It’s in everyone’s interest to make change.”

Dr. Baron also asked about Dr. Edwards’ emphasis on discovering one’s roots and using them as a guide or inspiration. He noted that not everyone has the connection to their roots that she does. “We all come from the human race,” she said. “If we embrace that, boy could we make progress. What role do you want to play while you’re in this skin? This is temporary; our souls are here ad infinitum.”

Reflections on the First Session

After participants worked in small groups to brainstorm ideas for how institutions can respond to bias, Cheryl Pegus, MD, MPH, Executive Vice President of Walmart Health & Wellness, provided concluding remarks for the first session. She said the day’s conversation reminded her of why she had entered medicine and how individuals can make a difference.


Dr. Pegus spoke about the need for board and C-suite involvement in institutionalizing policies to address bias. She noted the importance of diversifying boards, not only because it is a good in its own right but because companies with diverse boards achieve better results.

She described her work at Walmart since she joined in late 2020. She said that Walmart had made headway in providing COVID-19 vaccines because it has stores in many places that have limited access to health care, and it has about 1.5 million employees living in communities that trust them. She emphasized the importance of partnering with businesses in communities.

DAY 1: SESSION 2

Storytelling

David Reuben, MD, Chief of the Division of Geriatrics at the David Geffen School of Medicine at UCLA, moderated a session on storytelling at the outset of the Forum’s second session. He shared his own story from a division faculty meeting he led in June 2020, at which the Division Clinical Chief, an Asian American woman, said that the Division needed to do more to confront structural racism. Immediately, several other faculty members passionately joined her call. The conversation made him realize that despite a personal commitment to embracing diversity, it was clear that the Division—and in particular he—wasn’t doing enough.



Following Dr. Reuben’s introduction, participants shared their own stories in small group sessions. In the meeting evaluation, one participant noted that the session “created safety to talk honestly about their own blind spots” and another said that it “challenge[d] us to look at the makeup of our leadership teams.”

Creating Socially Just Health Care Organizations

The Forum’s second session included small group discussions about organizational efforts to address racism and build trust, followed by a panel discussion with Jennifer Mieres, MD, Senior Vice President and Chief Diversity and Inclusion Officer at Northwell Health and Thomas Sequist, MD, MPH, Chief Patient Experience and Equity Officer at Mass General Brigham (MGB). Dr. Baron began by asking how their institutions moved toward a comprehensive plan to address diversity, equity and inclusion (DEI).

Dr. Sequist said that leaders at MGB argued for prioritizing a commitment to equity in the same way as any other business strategy—by holding senior executives accountable for reaching goals and providing the necessary resources to reach them.

Dr. Mieres credited the timing of opening a new medical school about a decade ago, with a conscious eye toward training doctors for the 21st century and meeting the needs of a growing, diverse community, 45–50 percent of which has a preferred language other than English. “We were lucky to have a clean start,” Dr. Mieres said, describing how Northwell Health borrowed best practices from institutions such as Kaiser Permanente, MGB, and the Mayo Clinic.

Dr. Baron asked about establishing an internal workplace culture. Dr. Mieres discussed Northwell’s employee resource groups, voluntary councils in which a diverse group of employees can receive career development to help them advance within the institution, and can serve as liaisons between the system and outside communities. She said the groups were instrumental in the system’s approach to COVID-19, strengthening Northwell Health’s partnership with its diverse communities and its ability to communicate across language barriers.


Dr. Baron asked how MGB accelerated its equity efforts. Dr. Sequist drew a distinction between the academic leadership and research side of the system, which had great knowledge of equity issues, and the operations side, which struggled to convert that knowledge into meaningful action. He said progress required holding the operational leadership accountable for improvement. MGB committed resources to address identified problems at a large enough scale to measure it. “We’re not sure what works,” Dr. Sequist said. “Surely, we will find that some of our investments don’t work, but at least we are trying. We have to jump in the pool and start trying things out.”

Dr. Baron noted Dr. Sequist’s work among the American Indian community in New Mexico, the home of his family and tribe. “It is hard to advance in an academic medical center and find your voice and confidence,” Dr. Sequist said. “I speak openly and strongly about my beliefs in structural racism; when I first came to Harvard, I would have been too scared to talk about that. We are moving fast, but not as fast as I’d like us to move. I felt uncomfortable every day for decades others should accept feeling uncomfortable in face of seemingly insurmountable challenges we face.”

Scenarios

Participants next worked in small groups to develop potential approaches to one of a series of scenarios that were based on real stories from members of the Foundation’s Board of Trustees. After the small groups, a few participants reported on their group’s approaches.

For a scenario that involved a patient reacting negatively to a physician wearing a hijab—and the physician’s colleague’s failure to respond—Vineet Arora, MD, Dean for Medical Education at the University of Chicago Pritzker School of Medicine, said that her group suggested adopting a ‘zero tolerance’ policy against racism, holding leaders accountable for what they permit and not just what they promote, and ensuring a real time reporting system for the reporting of mistreatment.



For a scenario involving differential treatment of a Black and white mother—with the former’s request to stay beyond visiting hours with a sick child being rejected while the latter’s request was granted—Robert Roswell, MD, Associate Dean for Diversity, Equity & Inclusion and Associate Professor of Cardiology at the Zucker School of Medicine at Hofstra/Northwell, said that his group discussed the need for training on explicit and implicit bias, unconscious bias and racism. They also proposed viewing the incident as a harm incident: an active medical error that is harming patients. They called for a ‘zero tolerance’ policy that would rectify such situations as soon as they were happening.

In another scenario, a patient with limited English proficiency was forced to use an online portal to engage with a health system. Chris Moriates, MD, Assistant Dean at Dell Medical School at UT-Austin, said his group suggested employing an ‘equity analysis’ for such changes, systematically asking who might be harmed. They also proposed making sure that every frontline staff member had authority to meet patients’ needs or escalate concerns to someone who can.

In a final scenario, a white man with a history of mental illness, drug use and homelessness was denied antibiotics through a central line. Monica Lypson, MD, Vice Dean for Education at Columbia University Vagelos College of Physicians and Surgeons, said her group wanted to ensure that the team provided the patient with a source of hope. They suggested helping the patient establish a support system, which could include family members, friends and/or team members. The group also discussed the tension between the care model (emboldening recovery) and the business model (getting the patient out of a hospital bed).

Reflections on the Session

Kedar Mate, MD, President and CEO of the Institute for Healthcare Improvement (IHI), closed the day by highlighting moments that stood out to him. He thanked Ms. Dee for her willingness to revisit moments of pain, and said her comments were “welded into my consciousness.” He noted Dr. Edwards’ challenge to ensure that we are being truthful together about how much we are investing in changing our future, and for all of us to think of ourselves as part of the human race.

He then described his key takeaways from the Forum’s first day.

First, he said that trust and equity are undoubtedly deeply interrelated concepts, and that it is not always clear which is cause and which is effect. He noted that trust needs to flow in multiple directions – not only in how patients trust institutions but also in how institutions trust the people they serve.

Second, he expressed appreciation for the many allusions during the day about the value and power of quality improvement. He said that IHI believes equity is an essential underpinning for quality and safety, and that we need to analyze the structure and history of institutions facing quality issues.

Third, he said he thought the day offered a masterclass in how to use stories to mobilize action. He quoted Maya Angelou, who said that “people will forget what you said but they’ll never forget how you made them feel.”

Fourth, he noted that participants had many ideas for creating change, and that now was the time to move from ideas to implementation.

Fifth, he said that the idea persists that there is a tradeoff between trust and efficiency, or equity and efficiency. He argued that in fact it is in everyone’s interest to eliminate disparities, and that doing so would generate greater trust.

Dr. Mate suggested that there remained a few important but unanswered questions. He wondered whether we were getting to the real causes of the inequities we see, and noted the “FIGI problems” (fear, ignorance, greed and inertia) that are at the heart of many challenges we face. He also asked if the Forum participants constituted an “echo chamber” and how we can reach beyond like-minded people.

He closed by highlighting four words—trust, equity, love and courage—and said that courage was necessary for the other three to thrive. He called on the group to take actions demonstrating the courage we need to take us to a new place.

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DAY 2: SESSION 3

Jackie Judd introduced the second day of the Forum, and described a shift in focus from organizational strategies to achieve equity to a sharper focus on community engagement. She noted a comment from Philip Alberti, Founding Director of the AAMC Center for Health Justice, from a small group session: “Community engagement isn’t a thing you do; it’s how you do all things.”

Experiences in Health Equity, Community Engagement and Trust: Hearing from Young Leaders

In the first session of the day, a young physician and two medical students shared their experiences. Mercy Adetoye, MD, a Clinical Lecturer at Michigan Medicine, began with a story from her intern year, when she introduced herself to an older white male patient, who later called her a nurse during team rounds without any member of the team correcting his error. At the time, she elected not to raise the issue because she did not want to be a burden.

Near the end of her residency, she overheard a white nurse and security officers sympathizing with the police officer who killed George Floyd. A bystander Black security guard offered supportive words to her, and she stepped into a private room and began to cry. This time, she decided to raise her concerns with the residency leadership, which established a diversity committee with the goal of creating a more inclusive environment. “Gone are the days when academic medicine can assume that seeing patients is the same experience for everyone,” she said.

She suggested five steps that training programs should take so that the onus for addressing racism is not on trainees: (1) understand the communities in which trainees are working and communicate with them about challenges that may arise; (2) be vocal about standing against racism and identify supportive figures for trainees; (3) educate the educators about incidents that have occurred and train them to handle aggressions; (4) provide mentorship; and (5) create strong institutional policies so trainees are not dependent on good will.

Maria Gomez-Roas, a medical student at Northwestern University Feinberg School of Medicine, spoke about her experiences as a translator for her mother at medical visits, following her family’s move to the U.S. from Venezuela when she was 11. She highlighted a recent visit, when she translated a question from the clinician about her mother’s sexual activity. She realized that although she had learned about the importance of the question during her medical training, the topic had previously been avoided on her mother’s visits, presumably out of awkwardness. “It is small mistakes like this, repeated time and again, that slowly erode the confidence of marginalized communities in health care institutions and our ability to provide adequate care,” she said.

Ms. Gomez-Roas stressed the importance of providing culturally competent care in the language of a patient's choice, and noted the corner-cutting that often occurs in reality. She told the story of a patient who came to her hospital for surgery, waited all day alone without receiving any updates, and ultimately was informed that the procedure had been postponed. The patient said, "I am not a dog. No one could be bothered to stop and answer questions because I'm Mexican and don't speak English." The chief resident stopped rounds and apologized profusely to the man and listened to his complaints. "By the end of his stay, he seemed to have forgotten," she said. "I have not. We need to hold ourselves accountable for this mistake."

"When we ask someone who has been marginalized by institutions to get the vaccine, what are we asking them? What forgiveness are we asking for in this moment?"

-LaShyra (Lash) Nolen

LaShyra (Lash) Nolen, a medical student at Harvard, shared her experience of founding We Got Us, a coalition of Black students and activists that has educated the Black community in the Boston area about COVID-19 vaccines. She described her conversations with family and friends about the safety of the vaccines, and the concerns they expressed about both historical injustices perpetrated by the medical system and about continuing disparities. These conversations prompted her to start the organization, which is led by medical and pre-med students and has reached more than 1,000 people.

She said the organization bases its work on three pillars: (1) empowering through education; (2) conveying, not convincing: empowering people with the tools they need to make decisions; and (3) putting public health first. "Trust is a tall order that requires deep work," she said. "When we ask someone who has been marginalized by institutions to get the vaccine, what are we asking them? To forgive decades of harm and hurt, and do something that will protect all of us. What forgiveness are we asking for in this moment?"

During the next session, four panelists from health systems discussed their efforts to engage their communities. Brenda Battle, RN, MBA, Senior Vice President for Community Health Transformation at University of Chicago Medicine, discussed the system's efforts at "civic engagement" and in building programs to serve community needs. "We worked from the standpoint of what the community needed instead of what the system needed," Ms. Battle said, while saying the effort garnered community goodwill. Chicago created a community advisory council, distinct from a family-patient counsel, to inform the system about issues that broadly affected the community.

Brook Watts, MD, Senior Vice President and Chief Medical Officer, Community and Public Health at the MetroHealth System, described how the system created the Institute of Hope so it could do more than give patients pieces of paper with the location of community services. "We are at a place where we want to take care of people, but have been doing it only from the medical perspective," she said.

Ronald Copeland, MD, Senior Vice President and Chief Equity, Inclusion & Diversity Officer at Kaiser Permanente (KP), discussed KP's history of community engagement, including efforts to create affordable housing. "You want to make deposits to the bank of trust, which you can draw upon on occasion," he said. "You need to be sure your deposits are greater than your withdrawals to build a legacy of trustworthiness."

Carmen Guerra, MD, Associate Professor and Vice Chair of DEI in the Department of Medicine at the Perelman School of Medicine at the University of Pennsylvania, spoke about the system's focus on hiring people who look like the community they serve, who can communicate in the languages of the people they serve, and who are leaders in their community. She also discussed providing resources to the community, such as translation services, transportation, and developing community health worker models. She said that the center's financial analysts concluded that many of these programs were cost-effective because they increased the number of patients served and decreased no-shows.

“Most of us are part of academic medical centers that are surrounded by neighborhoods with many needs and challenges,” Dr. Watts said. “It is a privilege to be present in that environment and serve our neighbors. Recognizing that we are part of the community is the joy in this work.”

In a subsequent session, three panelists reflected on what they had heard about community engagement during the Forum. Somava Saha, MD, President and CEO of WE in the World, talked about the importance of “changing our own stance to be trustworthy, rather than demanding trust.” “We should begin by listening rather than demanding,” she said. “Above all, we should trust community organizations to lead.”

Ninez Ponce, PhD, Director of the UCLA Center for Health Policy Research, saw potential in elevating stories such as Maria Gomez-Roas’ story of translating for her mother and other examples of ways that clinicians can gain trust from and invest in communities that have justified mistrust.

Adriana Perez, PhD, Assistant Professor and Senior Fellow at the Leonard Davis Institute of Health Economics at the University of Pennsylvania School of Nursing, noted that many speakers had talked about understanding the historical contexts of communities, and demonstrating the value of community expertise as well as technical expertise. She suggested recognizing the value of the community by compensating members of community boards.

Developing Strategies to Build Trust Through Community Engagement

Participants met again in small groups to consider approaches to a common scenario involving a system’s failure to engender trust among non-native English speakers. Suggested approaches included providing funding for community organizations that can partner with the system, including in governance community members who are seen by the community as leaders, asking the community about their needs and preferences (e.g., surveys, town hall meetings, focus groups) and paying close attention to the answers, and a major investment in translation services to ensure language-concordant care in every domain, including the patient portal and patient handouts.

SUMMARY OF THE MEETING

The Forum concluded with a conversation between Robert Wachter, MD, Professor and Chairman of the Department of Medicine at the University of California, San Francisco and Kimberly Manning, MD, Professor of Medicine and Associate Vice Chair of DEI at Emory University. Dr. Wachter characterized the Forum participants as a “group of true believers” and suggested that we should understand sources of potential pushback.

He began with the issue of standards, acknowledging that standards that have previously been seen as objective (e.g., serving as the PI for a substantial NIH or equivalent grant to achieve tenure) may be infected by bias, but suggesting that some kind of standards remain necessary. Dr. Manning shared her story of being rejected for medical school and residency at Emory, and called for a reliance on holistic reviews for students and faculty.

Dr. Wachter asked Dr. Manning how she would respond to those who are concerned that DEI has become the overriding priority for institutions and has pushed aside other important topics. Dr. Manning said that one of her close colleagues had made a disparaging comment about the prospect of a DEI lecture. She described how she considered reacting angrily and sharing his comment with others, but instead thought about how she could be a “good steward of [her] influence.” She thought of their common dedication to their patients at a safety net hospital, and responded that “now it seems like you’re being force fed because you’re malnourished in this area.” She told her colleague that although she didn’t want to attend more cardiology lectures, “I care about my patients and heart disease is the top killer of Americans, so I go. The same goes for this.” Her colleague apologized, and she asked him if he was apologizing because she was Black or because we need to do better; he said “Both.”

Finally, Dr. Wachter asked about avoiding burnout and sustaining the momentum behind the DEI movement. Dr. Manning called for institutions to provide financial resources for DEI work and to offer prominent titles to those who lead DEI efforts, including them with other leaders and having them report to senior executives.

CONCLUSION

Dr. Baron closed the meeting, expressing his hope that participants had heard tools, ideas, narratives and examples they could bring back to their workplaces. He called upon all participants to consider how they, in Dr. Manning's words, could be good stewards of their own influence.

