Received: 21 April 2023 | Accepted: 23 April 2023

DOI: 10.1111/acem.14746

Academic Emergency Medicine

INVITED COMMENTARY

A systematic approach to tackling racism in emergency medicine: A commentary on the executive summary of the SAEM 2022 consensus conference

Keme Carter MD[1,2] | James Ahn MD, MHPE[1,2]

[1]Section of Emergency Medicine, University of Chicago Medicine, Chicago, Illinois, USA

[2]Biological Sciences Division, Pritzker School of Medicine, University of Chicago, Chicago, Illinois, USA

Correspondence
Keme Carter, Section of Emergency Medicine, The University of Chicago, MC 5068, 5841 S. Maryland Avenue, Chicago, IL 60637, USA.
Email: kcarter@bsd.uchicago.edu

Keywords: diversity, education, racism, research, training

Racism has appropriately been declared a public health crisis.[1] A complex issue deeply rooted in our country's systems and structures, racism and its impact on patients and trainees requires solutions that are multifaceted and enduring. In this issue of *Academic Emergency Medicine*, Chen et al.[2] describe the results of a consensus conference that aimed to develop a research agenda within emergency medicine (EM) to address racism in several spheres. Supported by the Society for Academic Emergency Medicine, this research agenda could improve outcomes and experiences of patients receiving care in emergency departments (EDs), enhance the learning environment for our trainees, and facilitate pathways to institutional leadership for minority faculty.

The need to investigate the influence of racism on patients and healthcare systems has been recently recognized by the National Institutes of Health (NIH). Over recent years, the NIH has published a modest increase in research funding allocated to studies falling into the categories of minority health, social determinants of health, and health disparities.[3] In 2021, the NIH established the UNITE working group in part to address, report on, and facilitate the funding of studies that investigate the impact of structural racism specifically.[4] Likewise, the authors of this executive summary name racism as a distinct entity that harms patients, trainees, and faculty; the authors go further to acknowledge EM's unique position and responsibility to fill collective knowledge gaps with the goal of building antiracist structures and systems within academic medicine.

Clinical research questions developed during the consensus conference embrace the historical truth that racism has festered and permeated all areas of medicine and is embedded and manifested at the individual and system levels. Accepting this framework is critical and builds on literature that describes the necessity of a multilevel approach to measuring racism in academic health centers.[5] For instance, investigating and measuring racial bias in emergency physicians is important and may reveal how a high-stress, high-acuity clinical environment facilitates the emergence of internalized stereotypes about minoritized groups. Furthermore, as Adkins-Jackson et al.[5] describe, the absence of individually reported perceptions of racial bias does not mean that institutional policies do not have racist implications; therefore, both the impact of racist interpersonal and organizational practices and the policies must be studied and measured.

Consensus questions outlined within the clinical research domain guide investigators toward studying both the implications of racism in clinical outcomes and the generalizability of biomedical discoveries to minority communities. The very nature of these questions unequivocally reject the idea that Black, Indigenous, and people of color (BIPOC) experience worse clinical outcomes because of race, a social rather than biological construct.[6] Instead, researchers are asked to consider the ED as the entry point into the health care system for many patients of historically marginalized identities whose bodies and minds often show evidence of the burden and violence of racism. The ED is a setting where morbidity, mortality, and inadequate representation in clinical trials should be critically studied through an antiracist lens to develop solutions that advance health equity.

Supervising Editor: Dr. Jeffrey Kline

This is an open access article under the terms of the Creative Commons Attribution-NonCommercial License, which permits use, distribution and reproduction in any medium, provided the original work is properly cited and is not used for commercial purposes.
© 2023 The Authors. *Academic Emergency Medicine* published by Wiley Periodicals LLC on behalf of Society for Academic Emergency Medicine.

As a continuation of a tripartite approach to address racism in EM, the authors highlight the importance of studies investigating racist practices within the training environment. This focus is fitting as the next generation of physicians must include a representative workforce that is trained in a pedagogy that prioritizes antiracism frameworks both for the trainees and for the patients.[7]

Diverse physicians improve the care delivered to patients—this is an unassailable fact.[8–13] The consensus questions denote an inferred understanding of the disproportionate underrepresentation that is present in EM.[14] Therefore, we must systematically identify and eliminate barriers to EM training for those who are underrepresented in medicine (URiM) and of historically marginalized identities. Racial bias has infiltrated traditional measures of excellence such as clerkship grading, medical student performance evaluation descriptors, honor societies, and the EM standardized letter of evaluation.[15–18] An overreliance on these biased measures to select trainees has contributed to the creation of a nonrepresentative workforce.[19] Holistic review has gained momentum as an evidence-supported method that more evenly balances the experiences, attributes, and metrics of residency applicants.[20,21] Although holistic review, implicit bias training, and diverse selection committees have demonstrated success in combating biased selection practices, the expansion of this body of literature is crucial to ensuring an equitable pathway to EM so that our workforce reflects this country's diverse communities.[22]

In addition to frameshifting recruitment practices, the consensus questions guide future educational research toward the creation of an antiracist learning environment. URiM trainees disproportionately suffer from discrimination, racial harassment, and microaggressions in the clinical environment and are more likely to withdraw from residency training and take extended leaves of absence.[23–27] During training, URiM trainees also receive lower assessment scores compared to their colleagues, which can lead to an amplification cascade that negatively affects future career goals.[28–30] Further, the current learning environment does not fully support the challenge minority residents face in balancing their professional development and identity.[24] This burden is coupled with a disproportionate expectation to contribute to programmatic diversity, equity, and inclusion efforts.[24] Future research should expand on how solutions such as institutional codes of conduct, bias mitigation in assessment, and the hiring of diverse faculty impact the creation of a supportive and inclusive learning environment.[31]

The consensus questions presciently address the need to introduce antiracist clinical care to our trainees who must understand the impact of racism on higher ED utilization by BIPOC patients and racial/ethnic disparities found in many disease states; this begins with the acknowledgment that minoritized communities experience racism within the house of medicine.[8,32] Residency-level curricula that include instruction on social determinants of health, implicit biases, health advocacy, and cultural competency have all demonstrated feasibility and positive reception by learners.[33] The future research mission must expand on educational interventions that educate all trainees on antiracist initiatives that facilitate the delivery of equitable care.

As a necessary step forward, the Accreditation Council for Graduate Medical Education (ACGME) has updated their requirements to reflect the importance of a diverse, equitable, and inclusive learning environment as well as the recruitment and retention of a diverse workforce.[34] Similar standards implemented by the Liaison Committee on Medical Education have been associated with a more diverse student body.[35] By robustly answering the consensus research questions regarding training, these ACGME requirements can be specified and strengthened. Only by methodically increasing the depth and breadth of knowledge in this field can antiracist educational practices be codified by accreditation bodies.

Implicit in the formulated consensus research questions in the domain of academic leadership is the recognition that initiatives do exist to increase diversity in academic leadership but progress has been slow with a persistent dearth of faculty from URiM backgrounds. According to data from the American Association of Medical Colleges, only 3.6% of full-time faculty identify as Black or African American and 5.5% identify as Hispanic, Latino, or of Spanish origin.[36] Furthermore, the higher the academic rank, the more pronounced the disparity in representation between URiM versus non-URiM faculty.[36]

Diverse leadership in academic medicine is necessary to enhance the learning environment, drive innovation, and positively impact population health and patient outcomes.[37] Although institutions may report the development of programs that aim to increase the recruitment and retention of minority faculty, one recent scoping review found a paucity of publications describing outcomes of faculty diversity initiatives, which varied in scope and funding support.[37] Furthermore, retention efforts were difficult to separate from broader diversity efforts.[37] There remains a need for best practice frameworks to ensure institutional accountability, transparency, and clarity in reporting outcomes of diversity initiatives. Williams et al.,[7] for instance, endorse the adoption of the attraction–selection–attrition (ASA) framework to assess anti-Black racism in the job cycle of Black physicians. By employing effective models, like the ASA organizing framework, institutions and researchers move past investigating *if* racism influences the professional development of minority physicians (a sobering truth well supported in the literature) and begin the work of understanding *how* racism manifests and mitigating its impact.

The consensus research agenda in academic leadership appropriately builds on the knowledge that disparities exist in the pathways to promotion and positions of leadership for minority versus nonminority faculty. To enact substantive change, future research must rigorously evaluate the outcomes of diversity programs and report on the distinct areas of recruitment/hiring practices, retention, academic promotions, appointment to leadership positions, and attrition of diverse faculty in EM.

The forces of racism contribute to societal conditions that destroy the ability of individuals and entire communities to thrive and prosper; as emergency physicians, we bear witness to this unfiltered truth. There must be antiracist research efforts on all fronts to dismantle systems and structures that perpetuate inequity and

15532712, 0, Downloaded from https://onlinelibrary.wiley.com/doi/10.1111/acem.14746 by Readcube (Labtiva Inc.), Wiley Online Library on [15/05/2023]. See the Terms and Conditions (https://onlinelibrary.wiley.com/terms-and-conditions) on Wiley Online Library for rules of use; OA articles are governed by the applicable Creative Commons License

accelerate death. Rigorous scholarship has already demonstrated the benefits of diversity to health outcomes and the learning environment and the same rigor must be applied to an antiracist research agenda. We are fortunate to have a path forward as delineated by this consensus conference through a trilateral research framework of clinical research, education and training, and academic leadership to drive substantive change.

CONFLICT OF INTEREST STATEMENT

The authors declare no conflicts of interest.

ORCID

Keme Carter https://orcid.org/0000-0001-9578-3279

REFERENCES

1. Andrews K. Racism is a public health crisis. *Lancet*. 2021; 397(10282):1342-1343.
2. Chen EH, Dessie AS, Druck J, Norman M, Raukar N. Executive summary of the SAEM 2022 consensus conference to address racism in emergency medicine clinical research, training, and leadership. *Acad Emerg Med*. 2023. doi:10.1111/acem.14727
3. NIH. Estimates of funding for various research, condition and disease categories (RCSD). Accessed April 21, 2023. https://report.nih.gov/funding/categorical-spending#/
4. NIH. Announcing the inaugural UNITE progress report. Accessed April 21, 2023. https://www.nih.gov/ending-structural-racism/announcing-inaugural-unite-progress-report
5. Adkins-Jackson P, Legha R, Jones K. How to measure racism in academic health centers. *AMA J Ethics*. 2021;23(2):E140-E145.
6. Braveman P, Dominguez TP. Abandon "race." Focus on racism. *Front Public Health*. 2021;9:689462.
7. Williams MS, Myers AK, Finuf KD, et al. Black physicians' experiences with anti-black racism in healthcare systems explored through an attraction-selection-attrition lens. *J Bus Psychol*. 2023;38:75-88.
8. Franks NM, Gipson K, Kaltiso SA, Osborne A, Heron SL. The time is now: racism and the responsibility of emergency medicine to be antiracist. *Ann Emerg Med*. 2021;78(5):577-586.
9. Jackson CS, Gracia JN. Addressing health and health-care disparities: the role of a diverse workforce and the social determinants of health. *Public Health Rep*. 2014;129(Suppl 2):57-61.
10. Hall WJ, Chapman MV, Lee KM, et al. Implicit racial/ethnic bias among health care professionals and its influence on health care outcomes: a systematic review. *Am J Public Health*. 2015;105(12):e60-e76. doi:10.2105/AJPH.2015.302903
11. Mensah MO, Sommers BD. The policy argument for healthcare workforce diversity. *J Gen Intern Med*. 2016;31(11):1369-1372.
12. Cooper LA, Roter DL, Johnson RL, Ford DE, Steinwachs DM, Powe NR. Patient-centered communication, ratings of care, and concordance of patient and physician race. *Ann Intern Med*. 2003;139(11):907-915. doi:10.7326/0003-4819-139-11-200312020-00009
13. Snyder JE, Upton RD, Hassett TC, Lee H, Nouri Z, Dill M. Black representation in the primary care physician workforce and its association with population life expectancy and mortality rates in the US. *JAMA Netw Open*. 2023;6(4):e236687. doi:10.1001/jamanetworkopen.2023.6687
14. Ehrhardt T, Shepherd A, Kinslow K, McKenney M, Elkbuli A. Diversity and inclusion among U.S. emergency medicine residency programs and practicing physicians: towards equity in workforce. *Am J Emerg Med*. 2021;46:690-692. doi:10.1016/j.ajem.2020.08.055
15. Low D, Pollack SW, Liao ZC, et al. Racial/ethnic disparities in clinical grading in medical school. *Teach Learn Med*. 2019;31(5):487-496.
16. Boatright D, Ross D, O'Connor P, Moore E, Nunez-Smith M. Racial disparities in medical student membership in the alpha omega alpha honor society. *JAMA Intern Med*. 2017;177(5):659-665.
17. Ross DA, Boatright D, Nunez-Smith M, Jordan A, Chekroud A, Moore EZ. Differences in words used to describe racial and gender groups in medical student performance evaluations. *PLoS One*. 2017;12(8):e0181659.
18. Kukulski P, Schwartz A, Hirshfield LE, Ahn J, Carter K. Racial bias on the emergency medicine standardized letter of evaluation. *J Grad Med Educ*. 2022;14(5):542-548.
19. Boatright D, Branzetti J, Duong D, et al. Racial and ethnic diversity in academic emergency medicine: how far have we come? Next steps for the future. *AEM Educ Train*. 2018;2(Suppl 1):S31-S39.
20. Sungar WG, Angerhofer C, McCormick T, et al. Implementation of holistic review into emergency medicine residency application screening to improve recruitment of underrepresented in medicine applicants. *AEM Educ Train*. 2021;5(Suppl 1):S10-S18.
21. Pope AJ, Carter K, Ahn J. A renewed call for a more equitable and holistic review of residency applications in the era of COVID-19. *AEM Educ Train*. 2020;5(1):135-138.
22. Mabeza RM, Christophers B, Ederaine SA, Glenn EJ, Benton-Slocum ZP, Marcelin JR. Interventions associated with racial and ethnic diversity in US graduate medical education: a scoping review. *JAMA Netw Open*. 2023;6(1):e2249335.
23. Fnais N, Soobiah C, Chen MH, et al. Harassment and discrimination in medical training: a systematic review and meta-analysis. *Acad Med*. 2014;89(5):817-827.
24. Osseo-Asare A, Balasuriya L, Huot SJ, et al. Minority resident physicians' views on the role of race/ethnicity in their training experiences in the workplace. *JAMA Netw Open*. 2018;1(5):e182723.
25. Molina MF, Landry AI, Chary AN, Burnett-Bowie S-AM. Addressing the elephant in the room: microaggressions in medicine. *Ann Emerg Med*. 2020;76(4):387-391.
26. Baldwin DC Jr, Rowley BD, Daugherty SR, Bay RC. Withdrawal and extended leave during residency training: results of a national survey. *Acad Med*. 1995;70(12):1117-1124.
27. Liebschutz JM, Darko GO, Finley EP, Cawse JM, Bharel M, Orlander JD. In the minority: Black physicians in residency and their experiences. *J Natl Med Assoc*. 2006;98(9):1441-1448.
28. Klein R, Ufere NN, Schaeffer S, et al. Association between resident race and ethnicity and clinical performance assessment scores in graduate medical education. *Acad Med*. 2022;97(9):1351-1359.
29. Boatright D, Anderson N, Kim JG, et al. Racial and ethnic differences in internal medicine residency assessments. *JAMA Netw Open*. 2022;5(12):e2247649.
30. Teherani A, Hauer KE, Fernandez A, King TE Jr, Lucey C. How small differences in assessed clinical performance amplify to large differences in grades and awards: a cascade with serious consequences for students underrepresented in medicine. *Acad Med*. 2018;93(9):1286-1292. doi:10.1097/ACM.0000000000002323
31. van Ryn M, Hardeman R, Phelan SM, et al. Medical school experiences associated with change in implicit racial bias among 3547 students: a medical student CHANGES study report. *J Gen Intern Med*. 2015;30(12):1748-1756.
32. Darby A, Cleveland Manchanda EC, Janeway H, et al. Race, racism, and antiracism in emergency medicine: a scoping review of the literature and research agenda for the future. *Acad Emerg Med*. 2022 Nov;29(11):1383-1398.
33. Chung AS, Cardell A, Desai S, et al. Educational outcomes of diversity curricula in graduate medical education. *J Grad Med Educ*. 2023;15(2):152-170.
34. Accreditation Council for Graduate Medical Education. Common program requirements. Accessed April 21, 2023. https://www.acgme.org/globalassets/pfassets/programrequirements/cprresidency_2022v3.pdf

15532712, 0, Downloaded from https://onlinelibrary.wiley.com/doi/10.1111/acem.14746 by Readcube (Labtiva Inc.), Wiley Online Library on [15/05/2023]. See the Terms and Conditions (https://onlinelibrary.wiley.com/terms-and-conditions) on Wiley Online Library for rules of use; OA articles are governed by the applicable Creative Commons License

35. Boatright DH, Samuels EA, Cramer L, et al. Association between the liaison committee on medical education's diversity standards and changes in percentage of medical student sex, race, and ethnicity. *JAMA*. 2018;320(21):2267-2269.
36. AAMC. Diversity in medicine: facts and figures 2019. Accessed April 20, 2023. https://www.aamc.org/data-reports/workforce/data/figure-15-percentage-full-time-us-medical-school-faculty-race/ethnicity-2018
37. Gutierrez-Wu J, Lawrence C, Jamison S, Wright ST, Steiner MJ, Orr CJ. An evaluation of programs designed to increase representation of diverse faculty at academic medical centers. *J Natl Med Assoc*. 2022;114(3):278-289.

How to cite this article: Carter K, Ahn J. A systematic approach to tackling racism in emergency medicine: A commentary on the executive summary of the SAEM 2022 consensus conference. *Acad Emerg Med*. 2023;00:1-4. doi:10.1111/acem.14746

15532712, 0, Downloaded from https://onlinelibrary.wiley.com/doi/10.1111/acem.14746 by Readcube (Labtiva Inc.), Wiley Online Library on [15/05/2023]. See the Terms and Conditions (https://onlinelibrary.wiley.com/terms-and-conditions) on Wiley Online Library for rules of use; OA articles are governed by the applicable Creative Commons License