derstand and accept America's racist roots."[5] In 2020, it is clear that clinicians need to master learning the ways in which structural racism affects health. We believe that medical schools and training programs should equip every clinician, in every role, to address racism. And licensing, accreditation, and qualifying procedures should test this knowledge as an essential professional competency.

Mandate and measure equitable outcomes. Just as health care systems are required to meet rigorous safety and quality performance standards for accreditation, they should be required to meet rigorous standards for addressing structural racism and achieving equity in outcomes.

Protect and serve. Health care systems must play a role in protecting and advocating for their patients. Victims of state-sanctioned brutality are also patients, who may present with injuries or disabilities or mental health impairments, and their interests must be defended. Health care systems should also be on the forefront of advocating for an end to police brutality as a cause of preventable death in the United States. They should take a clear position that the disproportionate killing of black (and indigenous and Latinx) people at the hands of police runs counter to their commitment to ensuring the health, safety, and well-being of patients.

"Please — I can't *breathe*."

Police violence, racial inequities in Covid-19, and other forms of structural racism are concurrent and compounding public health crises in the United States.

"Please — I can't *breathe*."

Postmortem evidence indicates that George Floyd tested positive for Covid-19, underscoring this reality. The choice before the health care system now is to show, not tell, that Black Lives Matter.

Because, like George Floyd, black people are loved.

Disclosure forms provided by the authors are available at NEJM.org.

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This article was published on June 10, 2020, at NEJM.org.

1. Edwards F, Lee H, Esposito M. Risk of being killed by police use of force in the United States by age, race-ethnicity, and sex. Proc Natl Acad Sci U S A 2019;116:16793-8.
2. Epstein R, Blake JJ, González T. Girlhood interrupted: the erasure of black girls' childhood. Washington, DC: Georgetown Law Center on Poverty and Inequality, 2017 (https://www.law.georgetown.edu/poverty-inequality-center/wp-content/uploads/sites/14/2017/08/girlhood-interrupted.pdf).
3. Wu X, Nethery RC, Sabath BM, Braun D, Dominici F. Exposure to air pollution and COVID-19 mortality in the United States: a nationwide cross-sectional study. April 27, 2020 (https://www.medrxiv.org/content/10.1101/2020.04.05.20054502v2). preprint.
4. Boyd RW. The case for desegregation. Lancet 2019;393:2484-5.
5. Hardeman RR, Medina EM, Kozhimannil KB. Structural racism and supporting black lives — the role of health professionals. N Engl J Med 2016;375:2113-5.

DOI: 10.1056/NEJMp2021072

Creating Real Change at Academic Medical Centers — How Social Movements Can Be Timely Catalysts

Michelle Morse, M.D., M.P.H., and Joseph Loscalzo, M.D., Ph.D.

The deaths of Alton Sterling and Philando Castile in July 2016 reverberated throughout the Brigham and Women's Hospital (BWH) Department of Medicine, destabilizing daily routines in the new academic year. Momentum for change had been building since the Black Lives Matter movement burst onto national headlines in 2013. Our internal medicine residents enjoined us as a department and an institution to reinvigorate the long but essential process of recognizing racism within our environment and acting to address it. They declared that the issues that the Black Lives Matter movement was making visible weren't external to or separate from our experiences at an academic medical center. Structural racism, discriminatory policing, and criminalization of black people affect health care. These long-standing issues reflect the living legacy of our country's history of racial discrimination and its many tragic consequences, including genocide of Native American people, slavery, Jim Crow laws, and eugenics. The question posed was simple: "What are we going to do?"[1]

Leading with action on issues of health justice has been a long-standing challenge for health professionals, who are often more comfortable with descriptive research as the main focus of intervention. In our department, the

Black Lives Matter movement created a window of opportunity for open critique of current inequities in health care practices and direct conversations about structural racism. Residents and faculty called for hospital-wide communications clearly stating our values, mandatory training on implicit bias for all hospital staff and faculty, visible solidarity with immigrant patients and staff, a more welcoming environment for all patients and employees, and commitments to racial, ethnic, gender, and other forms of diversity. Calls for platforms to convene and coordinate efforts throughout the institution were met with action by hospital and department leaders who recognized the need for change. Health equity and social justice committees at several institutional levels were reborn with the support of key hospital leaders. Some of these groups had been previously convened during times of social change but disbanded when fervor faded.

We launched the "new" BWH Department of Medicine Health Equity Committee in early 2017 to advance action on health equity and engage new partners throughout institutions and disciplines. We strove to ground our work in history and critical theory. We partnered with the Southern Jamaica Plain Health Center (SJPHC) — a community health center, a well-established leader in racial justice, and part of our hospital's network — and with the Institute for Healthcare Improvement (IHI), which was launching a learning collaborative to advance racial justice in health care. Experienced SJPHC leaders pushed our committee to define the term "racism," name it explicitly, and educate ourselves about the long history of racism in medicine.[2] Our IHI partners encouraged us to build on existing institutional-change infrastructure created as part of the patient-safety movement. To focus our attention optimally and begin to effect change, however, we needed a well-defined problem that brought institutional racism into view within our walls.

Rather than start from scratch, we looked to our institution's history. We drew on critical race theory to begin with the assumption that racism is an everyday part of life.[3] With this assumption in mind, internal medicine house staff on the new committee focused on their observation of potential racial differences in admissions of cardiology patients to the cardiology service rather than the general medicine service. A previous iteration of the committee had investigated racial inequities in cardiovascular care at our institution 10 years earlier. Our committee agreed that it was time to resurrect the data from that investigation, update them, and use the process to raise awareness about racial inequities in health care at our institution.

To pursue this issue, we needed new data, support from multiple departments and divisions, resources, and commitments that we would implement projects to fix identified inequities. Most of all, we needed to build courage and political will to be vocal about a historically uncomfortable subject at a predominantly white institution. House staff were critical in advancing the project. Our partnership with the SJPHC and IHI created a coalition of physicians, nurses, social workers, administrators, and others that built a shared understanding of the problem throughout our institution. Our goal was not to craft a new social movement, but rather to learn from the Black Lives Matter movement and create institutional change by merging strategies and tactics from inside and outside the institution and by using both top-down and bottom-up approaches.

The learning and knowledge generation that take place at academic medical centers have generally not been extended to include issues of racism and racial inequity. To address this shortcoming, the SJPHC created a program called Adaptive Leaders for Racial Justice, which seeks to prepare clinicians to challenge the dominant beliefs about causes of and solutions to racial inequities in health. Several faculty members and residents on our health equity committee participated in this program and became leading voices for racial justice as well as formal and informal teachers on these issues.

Naming racism was one of the most important charges of the committee, and this challenge was sometimes met with defensiveness or silence. When our heart-failure study demonstrated that black and Latinx patients were systematically less likely to be admitted to the cardiology specialty service than white patients, our committee recognized this finding as an example of institutional racism; however, building consensus on this key issue was difficult.[4] "Institutional racism" is defined as differential access to society's goods, services, and opportunities by race.[2] When we shared this definition, faculty members who initially showed resistance began to recognize the ways in which racism was present in everyday practices at our institution and throughout society. Not all faculty agreed with this framing of the problem, but a

critical mass forged ahead despite resistance. After much conversation and debate, the concept of institutional racism was no longer distant, abstract, or someone else's problem. As a result, our department has funded two projects with a goal of remedying the inequities in heart-failure care that were discovered. One project involves surveying physicians to elucidate the drivers of admitting decisions; the other seeks to improve the quality of heart-failure care on the general medicine service.

Physicians must engage with social movements if we expect to contribute meaningfully to improving health by addressing its social and structural determinants. We should proceed with caution, however, since our profession hasn't always been supportive of social movements, as illustrated by the history of the American Medical Association and the civil rights movement.[5]

An audio interview with Dr. Morse is available at NEJM.org

In fact, our clinical training has the potential to create a mindset that directly conflicts with the visions espoused by social movements. Clinical training creates a mindset of urgency; a focus on short-term goals and on fixing and curing; an expert identity, sometimes with distaste for being challenged; and risk aversion. These attributes are, for the most part, necessary and desirable in clinicians, but they can be counterproductive in the context of social movements. The social transformation that movements seek requires long-term vision, building power for enacting change over time rather than implementing rapid solutions, humility, a willingness to take chances despite uncertainty, and a learning mindset.

Our experience shows that institutional change in health care is possible. We are moving toward becoming an antiracist institution; however, it's easy to lose momentum as attention and headlines shift to other urgent issues. Such loss of momentum most likely led to the withering of prior institutional efforts related to racial equity. Capitalizing on the urgency generated by the Black Lives Matter movement was a powerful strategy through which to align interests and focus attention at a large, often slow-to-change institution. Sadly, the recent murder of George Floyd has demonstrated the persistence of structural racism.

The next frontier for health justice at our institution is that of structural and policy change. Taking on these challenges will require the continued and expanded engagement of institutional leadership in order to directly address the ways in which racial inequities in health are structurally produced. In the words of famed author Ibram X. Kendi, "There are only two reasons for racial inequity: the policies or the people." We firmly believe that it is the policies that create inequities, unintentional though they may be, and we will continue to advance actions at our institution to change them.

Disclosure forms provided by the authors are available at NEJM.org.

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This article was published on June 10, 2020, at NEJM.org.

1. Bassett MT. #BlackLivesMatter — a challenge to the medical and public health communities. N Engl J Med 2015;372:1085-7.
2. Jones CP. Levels of racism: a theoretic framework and a gardener's tale. Am J Public Health 2000;90:1212-5.
3. Ford CL, Airhihenbuwa CO. Commentary: just what is Critical Race Theory and what's it doing in a progressive field like public health? Ethn Dis 2018;28:Suppl 1: 223-30.
4. Eberly LA, Richterman A, Beckett AG, et al. Identification of racial inequities in access to specialized inpatient heart failure care at an academic medical center. Circ Heart Fail 2019;12(11):e006214.
5. Baker RB. The American Medical Association and race. Virtual Mentor 2014;16: 479-88.

DOI: 10.1056/NEJMp2002502

Racial Health Disparities and Covid-19 — Caution and Context

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In early April, Wisconsin and Michigan released data showing stark racial disparities in rates of Covid-19 cases and deaths. In those states, many media outlets noted that the percentages of affected people who were black were more than twice as high as the proportion of blacks in the overall population. Similar disparities have since been reported elsewhere, sometimes along with overrepresentation of additional racial minority groups.

Racial disparities have thus become central in the national conversation about Covid-19. Front-page headlines in the *New York*