




ACG INSTITUTE RESEARCH GRANTS AND AWARDS 2022


EIGHT different award types; INCREASED Junior Faculty FUNDING;
 NEW Health Equity Research Award; Med Resident and Student Awards

www.gi.org/research-awards

Grant System Opens: September 7, 2021

Deadline: December 3, 2021

Read the [Grant Flyer](#), [FAQs](#), or visit the webpage for the full RFAs.

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NEW! ACG Institute
Health Equity Research Award

APPLY: gi.org/research-awards DEADLINE: December 3, 2021

Read the flyer at gi.org/research-awards to learn more!


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IBD Circle
A Partnership of the American College of Gastroenterology and the Crohn's & Colitis Foundation

CROHN'S & COLITIS FOUNDATION

Special Virtual Grand Rounds Edition
IBD Circle: ACG 2021 IBD Abstract Highlights
November 10, 2021 8:00 pm – 9:30 pm, EST



Sunanda V. Kane, MD, FACP
Moderator



Jean-Paul Achkar, MD, FACP
IBD Therapies



Anita Afzali, MD, FACP
IBD Complications /
Medication Safety

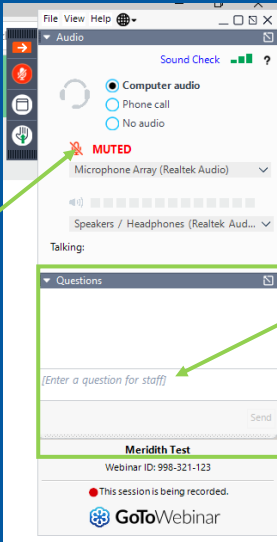


Tauseef Ali, MD, FACP
IBD Potpourri

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Participating in the Webinar



All attendees will be muted and will remain in Listen Only Mode.

Type your questions here so that the moderator can see them. Not all questions will be answered but we will get to as many as possible.

Meridith Test
Webinar ID: 998-321-123
This session is being recorded.
GoToWebinar

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How to Receive CME and MOC Points

LIVE VIRTUAL GRAND ROUNDS WEBINAR

ACG will send a link to a CME & MOC evaluation to all attendees on the live webinar.

ABIM Board Certified physicians need to complete their MOC activities by December 31, 2021 in order for the MOC points to count toward any MOC requirements that are due by the end of the year. No MOC credit may be awarded after March 1, 2022 for this activity.

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MOC QUESTION

If you plan to claim MOC Points for this activity, you will be asked to: Please list specific changes you will make in your practice as a result of the information you received from this activity.

Include specific strategies or changes that you plan to implement.
THESE ANSWERS WILL BE REVIEWED.

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ACG Virtual Grand Rounds

Join us for upcoming Virtual Grand Rounds!



Week 42, 2021

H. pylori - What it Does and Doesn't Cause and How Best to Treat It

Colin W. Howden, MD, FACC

November 11, 2021 at Noon Eastern



Week 43, 2021

PSC and Transplantation

Fredric D. Gordon, MD

November 11, 2021 at Noon Eastern

Visit gi.org/ACGVGR to Register

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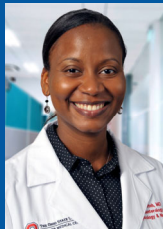
Disclosures:



Speaker:

Darrell M. Gray, II, MD, MPH, FACG

Dr. Gray, faculty for this educational event, has no relevant financial relationship(s) with ineligible companies to disclose.



Moderator:

Lania Conteh, MD, MPH

Dr. Conteh, faculty for this educational event, has no relevant financial relationship(s) with ineligible companies to disclose.

*All of the relevant financial relationships listed for these individuals have been mitigated

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Eliminating Racism in Science and Healthcare: Historical Perspective and Current Opportunities

Darrell M. Gray, II, MD, MPH, FACG

Darrell M. Gray, II, MD, MPH

 @DMGrayMD

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Race and racism – defining the problem

- **Race** = a social construct, not a reliable proxy for biologic difference; designations have changed over time
- **Racism** = “system of structuring opportunity and assigning value based on the social interpretation of how one looks (what we call “race”), that unfairly disadvantages some individuals and communities”



1787 US Constitutional Convention during which “The Three-Fifths Compromise” was adopted

www.racialequitytools.org/glossary; Jones CP, *Ethn Dis.* 2018; Borrell LN et al, *NEJM.* 2021.

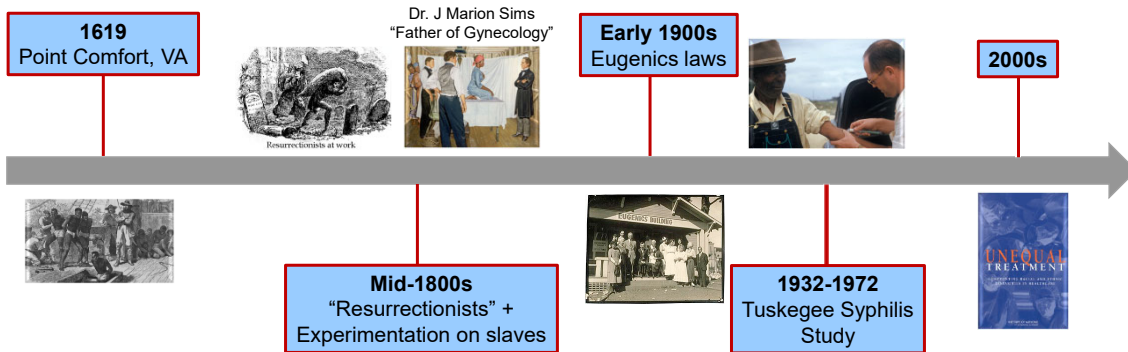
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Do no harm.

- Hippocrates, *Of the Epidemics*, circa 400 B.C.E

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Racism is harmful and has been pervasive in medicine – an abbreviated history



Nuriddin A et al, *Lancet*. 2020; Washington HA, *Medical Apartheid: The Dark History of Medical Experimentation on Black Americans from Colonial Times to the Present*. 2006.

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Racism continues to negatively influence health and health care

- Differences observed in cancer diagnosis and treatment recommendations
- Resource allocation (i.e. accredited programs, oncologists, etc.) and referral patterns
- False beliefs about biologic differences between black and whites (e.g. *Blacks' nerve endings are less sensitive than whites'*)



Shavers VL et al, *J Health Care poor Underserved*. 2010; Green CR et al, *Pain Med*. 2003; Todd KH et al, *Ann Emerg Med*. 2000; Mearns AM et al, *JCO*. 2016; Simpson DR et al, *JNCI*. 2013; Eggle S et al, *Health Expec*. 2015; Muller C et al, *CGH*. 2018; Pallok K et al, *NEJM*. 2019; Dimick J et al, *Health Affairs*. 2013; Hoffman KM et al, *PNAS*. 2016;

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Racism is embedded in our medical education and practice





Table 1. Misrepresentation of Race in Preclinical Curricula.

Domain	Description	Representative Examples
Semantics	Using imprecise and nonbiologic labels that inaccurately conflate race and ancestry	Widespread use of "Caucasian," "Black," "African American," and "Asian" as labels to denote biologic differences between patients Describing a Nigerian patient as "African American" in a clinical vignette
Prevalence without context	Presenting racial/ethnic differences in disease burden without contextualization	Teaching students that "Black" patients have higher rates of asthma than "White" patients, without reference to the effects on asthma prevalence of residential segregation and unequal access to high-quality housing and health care ¹⁶ Teaching students that "Black" patients have higher rates of hospital readmission, without any discussion of the underlying causes of these disparities
Race-based diagnostic bias	Presentation of links between racial groups and particular diseases	Priming students to view sickle cell disease as affecting only Black people, rather than as common in populations at risk for malaria ^{17,18}
Pathologizing race	The tendency to link minorities with increased disease burden	In a slide showing the incidence of 13 types of brain tumors in Black patients and White patients, using the title "Incidence rates are higher among Blacks than among Whites," even though 10 of the tumors occurred more frequently in White patients
Race-based clinical guidelines	Teaching of guidelines that endorse the use of racial categories in the diagnosis and treatment of diseases	Teaching students to use different first-line antihypertensive drugs in Black patients than in White patients, without any exposure to literature that questions these practices and misleading interpretations of information ¹⁹⁻²¹

Amutah C et al, *NEJM*. 2021.

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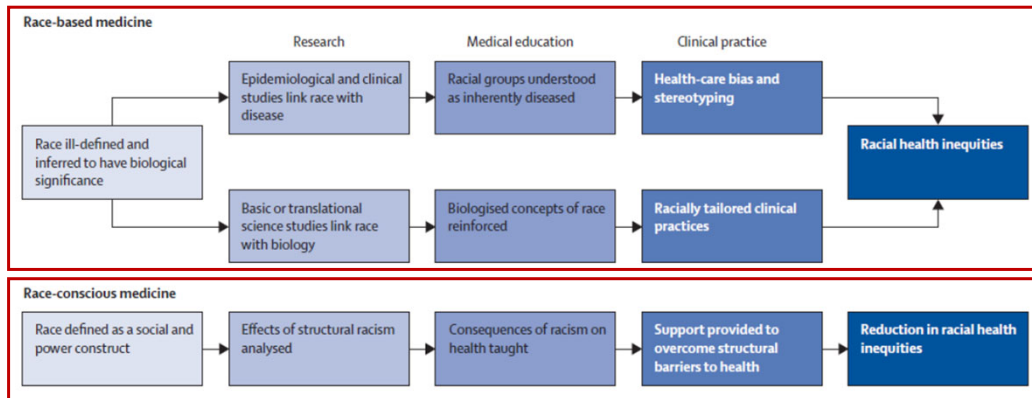
Racism is embedded in our medical education and practice

	How race is used	Rationale	Potential harm
	Asian patients considered at risk for DM at BMI ≥ 23 vs 25 for patients of other races	Asians presumed to develop more visceral than peripheral adiposity, increasing risk for IR	Asians patients might experience increased stigma and distrust of medical providers
	Reference values for PFTs are adjusted for race and ethnicity	Racial/ethnic minorities are presumed to have varied lung function	Blacks patients may experience difficulty obtaining disability support for pulmonary disease
	Race-specific equations included to estimate atherosclerotic cardiovascular disease risk	ASCVD events higher for Black patients than other patients with equivalent risk burden	Blacks patients might experience more adverse effects from recommended statin therapy
	eGFR for Black patients is multiplied by 1.16-1.21 the eGFR for White patients	Blacks presumed to have higher muscle mass and creatinine generation rate	Blacks patients may experience delayed dialysis and transplant referral

Cardena JP et al, *Lancet*. 2020; Vyas DA et al, *NEJM*. 2020; Inker LA et al. *NEJM*. 2021.

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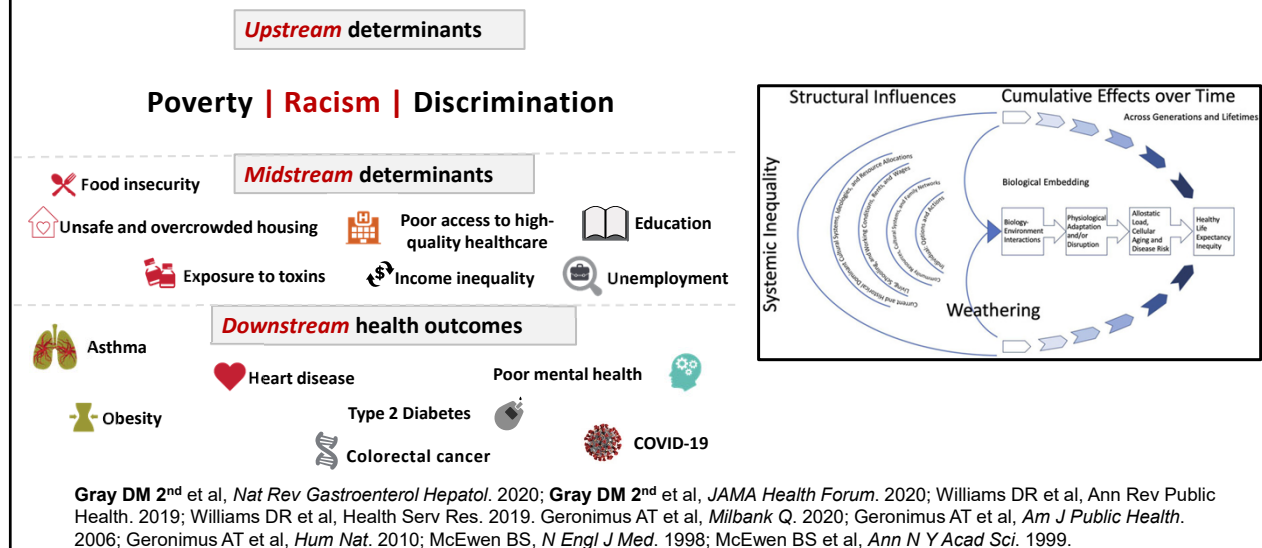
Racism is embedded in our medical education and practice



Cardena JP et al, *Lancet*. 2020.

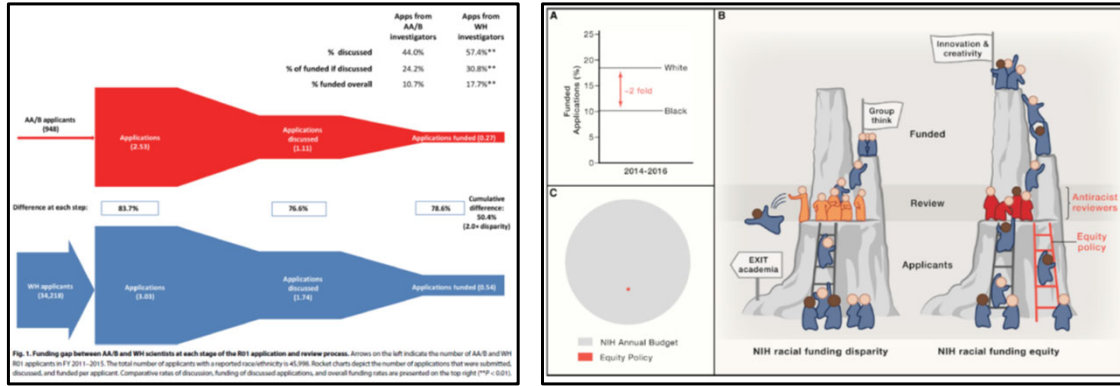
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Racism, not race, drives health inequities



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Racism manifests in the value proposition of science

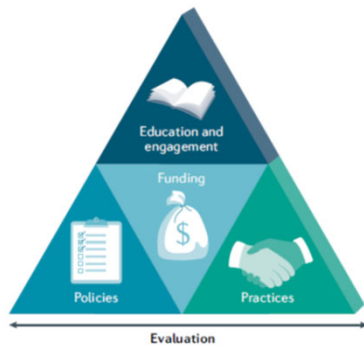


- Black applications **less likely** to be discussed and funded (including health disparities research)
- Black applicants **more likely** to propose research with lower award rates (community/populations vs fundamental/mechanistic) and have lower impact scores

Hoppe et al, *Sci Adv.* 2019; Stevens KR et al, *Cell.* 2021.

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We can begin to dismantle racism



- Examine ourselves and our institutions
- Ensure equity and ethics in all policies and practices
- Transform medical and public health education
- Improve rigor and review of research (including on racism and racial health inequities)
- Invest in diversity and inclusion – NIH funding and advancement of Black scientists and health care providers
- Amplify voices of disenfranchised via community engagement



Gray DM 2nd et al, *Nat Rev Gastroenterol Hepatol.* 2020; Bailey ZD et al, *NEJM.* 2021; Olayiwola JN, Gray DM 2nd et al, *Health Aff Blog.* 2020; Boyd RW et al, *Health Aff Blog.* 2020; Williams DR et al, *Int J Environ Res Public Health.* 2019; Williams DR et al, *Ann Rev Public Health.* 2019.


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Summary


- Medicine and science, past and present, are marked with racism.
- Racism, not race, is a preeminent determinant of health inequities and outcomes.
- For medicine and science to be anti-racist, intentionality and investment are required.




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Virtual Grand Rounds
universe.gi.org

Questions?



Speaker:
Darrell M. Gray, II, MD, MPH, FACP



Moderator:
Lanla Conteh, MD, MPH

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CONNECT AND COLLABORATE IN GI



ACG & CCF IBD Circle



ACG Hepatology Circle



ACG Functional GI
Health and Nutrition Circle



GI

ACG GI Circle
Connect and collaborate within GI



ACG Women in GI Circle

ACG's Online Professional Networking Communities
LOGIN OR SIGN-UP NOW AT: acg-gi-circle.within3.com



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