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.

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!
EIGHT different award types; NEW Health Equity Research Award; Bridge Funding; GIQuIC Research funding; Med Resident and Student Awards

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Grant System Opens: September 7, 2021

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Read the Grant Flyer, FAQs, or visit the webpage for the RFAs.
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.

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.
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.

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, FACG
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
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: Lanla 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

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

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


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Do no harm.

- Hippocrates, *Of the Epidemics*, *circa* 400 B.C.E
Racism is harmful and has been pervasive in medicine – an abbreviated history

1619
Point Comfort, VA

Dr. J Marion Sims
"Father of Gynecology"

Early 1900s
Eugenics laws

Mid-1800s
"Resurrectionists" + Experimentation on slaves

1932-1972
Tuskegee Syphilis Study

2000s


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’)

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 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 |
| Pathologizing race | The tendency to link minorities with increased disease burden | In an article 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 |


Racism is embedded in our medical education and practice

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


American College of Gastroenterology
Racism is embedded in our medical education and practice


Racism, not race, drives health inequities

Poverty | **Upstream** determinants | Race | Discrimination

Food insecurity | **Midstream** determinants | Poor access to high-quality healthcare

Unsafe and overcrowded housing | Education

Exposure to toxins | Unemployment

Asthma | **Downstream** health outcomes

Obesity | Heart disease | Type 2 Diabetes | Colorectal cancer | COVID-19

Racism manifests in provider-provider, provider-trainee, and patient-provider interactions


Racism manifests in research, editorial review and publication

American College of Gastroenterology
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


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

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.

Questions?

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

Moderator:
Lanla Conteh, MD, MPH
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