academic metrics, conducting multiple mini-interviews, and involving diverse groups of patients or community members in the admissions process.

Several new tools are available for assessing the socioeconomic and educational challenges that many disadvantaged applicants face on the road to becoming physicians. The American Medical College Application Service allows applicants to identify themselves as socioeconomically or educationally disadvantaged and to explain their disadvantage in a brief essay. The AAMC has introduced a socioeconomic status indicator that uses standard occupational classification categories for parents and guardians to capture some of the social determinants of individual academic achievement. To quantify socioeconomic and educational disadvantage without consideration of race and ethnic group, the University of California, Davis, School of Medicine (where three of us work) has developed a continuous scale that incorporates information on parental education level, family participation in public-assistance programs, family income level, whether applicants spent their childhood in an underserved area, applicant contribution to family income, receipt of financial-need scholarships for college education, and whether applicants had their medical school application fee waived. Such tools deserve further dissemination as potential strategies for advancing equity in the admissions process.

In the current era of medical school expansion, the growing gap between the racial, ethnic, and socioeconomic makeup of medical school classes and that of the general population means medical education is slipping further out of reach for many poor and minority students, despite the efforts of many people and institutions. To address these disparities, medical schools can redesign their admissions criteria and processes and commit to educating classes of students that more closely mirror the U.S. population. Academic leaders should address structural barriers within their institutions that limit the success of students and faculty from underrepresented groups. And academic health centers can make greater investments in educational outreach, collaboration, and community engagement to nurture and develop a more diverse workforce. We believe those of us responsible for training the next generation of U.S. physicians must rededicate ourselves to the mission of equity of opportunity in medicine — for the benefit of future students, disadvantaged communities, and the country as a whole.

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

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1. Marrast LM, Zallman L, Woolhandler S, Bor DH, McCormick D. Minority physicians' role in the care of underserved patients: diversifying the physician workforce may be key in addressing health disparities. JAMA Intern Med 2014;174:289-91.
2. Association of American Medical Colleges. Diversity in the physician workforce: facts & figures 2014. 2017 (http://www.aamcdiversityfactsandfigures.org/).
3. Alsan M, Garrick O, Graziani GC. Does diversity matter for health? Experimental evidence from Oakland. NBER working paper no. 24787. Cambridge, MA: National Bureau of Economic Research, June 2018 (https://www.nber.org/papers/w24787).
4. Talamantes E, Jerant A, Henderson MC, et al. Community college pathways to medical school and family medicine residency training. Ann Fam Med 2018;16:302-7.
5. Drees B, Nairn R, Nivet M, Danek J. Holistic admissions in the health professions: findings from a national survey. Washington, DC: Urban Universities for Health, September 2014 (http://urbanuniversitiesforhealth.org/media/documents/Holistic_Admissions_in_the_Health_Professions.pdf).

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Racist Like Me — A Call to Self-Reflection and Action for White Physicians

Deborah Cohan, M.D., M.P.H.

I am racist. I would love to believe otherwise and can find evidence that I am not — my career dedicated to caring for underserved women of color, my support of colleagues and trainees who are people of color, my score on the implicit-association test.[1] My mission as a white physician is to be humble and respectful toward my patients, not only as an act of compassion but as a revolutionary act against racism, elitism, and hierarchy. And yet I am racist, shaped by the sometimes

subtle tendrils of white supremacy deeply embedded in our culture. I mean this not as a sanctimonious admission of guilt, but as a call to self-reflection and action for us white physicians.

Appalling racial inequities in health exist in nearly every realm that researchers have examined.[2,3] These inequities are a dramatic manifestation of the structural violence that plagues our society. So what am I, an obstetrician, doing about the disproportionate burden of maternal mortality and other poor reproductive outcomes among black women?[4] How am I confronting the underlying forces that facilitate increased suffering and death among certain groups because of their skin color? Although it's necessary, it is not enough for me to provide respectful health care to pregnant women of color.

If I truly want to be part of the solution, I need to explore those parts of me that are most unwholesome, embarrassing, unflattering, and generally not discussed in the context of one's career. My goal is to dismantle the insidious thoughts that reinforce a hierarchy based on race, education, and other markers of privilege that separate me from others. These thoughts, fed by implicit bias, are more common than I find easy to admit. Although I know not to believe everything I think, I also know that thoughts guide attention, and attention guides actions. Until I bring to light and hold myself accountable for my own racist tendencies, I am contributing to racism in health care.

I'm tempted to run in the other direction — or pat myself on the back for my introspection and good deeds. Instead, I invite myself to notice the moments when I'm inclined to do more for a white patient than for a patient of color. Moments when I spend a bit more time and effort educating a white patient, or objectify a black patient, or connect more deeply with a patient who looks like me. Are my flashes of implicit racism just fleeting thoughts, or do I act on them? I recently scheduled an appointment during a nonclinic day for an educated white woman whose baby I delivered. Would I have done so for a less well-educated black patient? The other day, I noticed myself sitting farther than usual from a black patient in her hospital bed. I once mistook one black resident for another resident who is also black. I would guess that before my division instituted a consistent protocol for urine toxicology screening, I ordered such screens more often for patients with preterm labor who were black. Having an intention to treat all my patients and colleagues the same is a key first step, but that intention is ultimately irrelevant if their experience of obtaining health care or working with me varies according to the color of their skin.

Meeting our shadow requires courage. Not dealing with our racism is a manifestation of our privilege and reinforces a system that allows white physicians to dip into the waters of self-inquiry only when it feels safe. This fragility keeps us fundamentally weighted down by our own limitations and compromises our effectiveness at upending racism.[5] In the meantime, health care is not safe for people of color as long as the overwhelming majority of U.S. physicians are white and we avoid examining where racism lives within us and how it lives through us.

Though implicit bias is unconscious by definition, it is a treatable condition. As I become more aware of my biases, they begin to loosen their grip. When I realized I was sitting farther than usual from my hospitalized patient, I moved closer. I am now aware enough to know that I will need to pursue a lifelong, iterative process of exploration, education, and realignment. Aware of my capacity to be racist, I can notice when that part of me threatens to influence my actions. When I notice my actions have been affected, I can make amends and get back on track. I can bring more empathy to my encounters with patients whose reality is different from my own.

I find that dwelling on my shame is counterproductive, that compassionate self-examination allows me to go deeper. I acknowledge my privilege; I recognize that the system that benefits me causes others to suffer. I openly and humbly acknowledge that my racism is harmful. And I commit to a process of uncovering and exploring my biases wherever they lie, lest they wield power and I abet a culture of racism. If we white physicians are to heal others and ultimately the health care system, we must first heal ourselves.

The first step, I believe, is to train ourselves to question ourselves and each other reflexively, consistently, and with curiosity: How am I perpetuating systemic inequities for patients? What am I doing to ensure inclusion and promotion of physicians of color? What are my practices for checking myself? And how can we acknowledge the racism within us

without making it a character judgment that precludes behavior change?

At the same time, how can I cultivate relationships with others who will hold me accountable and remind me to realign with my values? Although dealing with racism requires solo introspection, it is ultimately a community undertaking in which we listen deeply, humbly, and gratefully to the people who are most affected by racism — without burdening people of color with the responsibility for educating those of us who are white. As I wrote this essay, for example, I consulted many people, mostly people of color, working in the social justice arena, as well as friends and colleagues. They reminded me to prioritize references by people of color, questioned my ego-driven motivations, and prodded me to explore and express myself more transparently.

Humans are inherently adaptable. If we approach this monumental responsibility with humility and hold each other accountable, we can change. In fact, we must change.

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1. 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.
2. James SA. The strangest of all encounters: racial and ethnic discrimination in US health care. Cad Saude Publica 2017;33(Suppl 1): e00104416.
3. Williams DR, Wyatt R. Racial bias in health care and health: challenges and opportunities. JAMA 2015;314:555-6.
4. McLemore MR, Altman MR, Cooper N, Williams S, Rand L, Franck L. Health care experiences of pregnant, birthing and postnatal women of color at risk for preterm birth. Soc Sci Med 2018;201:127-35.
5. DiAngelo R. White fragility. Int J Crit Pedagogy 2011;3:54-70 (https://libjournal.uncg.edu/ijcp/article/viewFile/249/116).

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Loud, Gray, and Arbitrary — The Compounding Trauma of Detention for Asylum Seekers

Katherine C. McKenzie, M.D.

The bleak, industrial structure stands at the dead end of a street, surrounded by commercial buildings and a chain-link fence. I enter a nondescript lobby lined with temporary visitor lockers. Behind a plexiglass partition sits an unsmiling uniformed guard at a desk. She's brusque, and I feel like a supplicant when I ask whether I can bring in the bare necessities for the evaluation today. I store my laptop, wallet, and phone in a locker and wait to be told when I can enter the facility.

I'm not in a prison, but I might as well be. I've traveled here to perform medical forensic evaluations of asylum seekers in this detention facility. These men and women have fled their home countries and landed at a nearby airport. They don't have documentation to allow them to enter the United States, so they've been sent to this immigration institution in New Jersey as they await adjudication of their cases. They are fleeing persecution and seeking safety and a new life in the United States. If a client's attorney determines that they have scars related to the persecution they have claimed to suffer, she'll reach out to me for an evaluation.

These evaluations are suboptimal in almost every way. As I wait to be admitted to the secure area behind the locked doors, I ask if I can bring a camera to photograph the scars. Photographic evidence is powerful in immigration court and is part of the medicolegal affidavits I prepare for nondetained clients. Sometimes the guard on duty allows a camera. Sometimes she doesn't. The decision seems entirely arbitrary, and this capriciousness contributes to the sense of unfairness and unpredictability that pervades the experience. Today she says no, so I'll have to make do with a body diagram — I am allowed to bring a folder, paper, and a pen. There's no way to appeal this decision without provoking her anger and running the risk that she'll interfere with the entire evaluation. Don't challenge, don't question; be polite and deferential.

Once I'm given the go-ahead, I take off my shoes and pass my supplies through a metal detector before gathering them on the other side. Then another wait as a buzzer sounds and a heavy