

Holly J. Humphrey:

Welcome back to Vital Voices, a podcast from the Josiah Macy Jr. Foundation. I am Dr. Holly Humphrey, the president of the Macy Foundation. On today's episode, we are going to address a particularly difficult, but very important topic, and that is, how do we create safe and inclusive spaces in the clinical learning environment for all of our trainees? To help us explore what academic health systems should do to support the success of their residents and fellows, I am joined today by three faculty members from the University of Chicago, who published a very important paper, entitled, [Keeping Our Promise](#). It appeared in the New England Journal of Medicine on August 5th, 2021. These same authors also collaborated on a paper published in a special supplement to Academic Medicine in December of 2020, that was entitled, [Practical Lessons for Teaching About Race and Racism, Successfully Leading Free, Frank and Fearless Discussions](#).

My guests today include Dr. Monica Vela, formerly the Professor of Medicine Associate Vice Chair for Diversity in the Department of Medicine and Associate Dean for Health Equity, Diversity and Inclusion at the University of Chicago's Pritzker School of Medicine. Recently, Dr. Vela has joined the University of Illinois College of Medicine as Professor of Medicine and Director of the Hispanic Center of Excellence.

Joining Dr. Vela today, is Dr. Marshall Chin, the Richard Parrillo Family Professor of Healthcare Ethics in the Department of Medicine at the University of Chicago. And they are joined by their colleague, Dr. Monica Peek, Professor of Medicine and Associate Director of the Chicago Center for Diabetes Translational Research.

As always, today's conversation is a follow up to our webinar series, discussing the Macy Conference [recommendations](#) on taking action on harmful bias and discrimination in clinical learning environments. You can find this podcast as well as all of our webinars, the conference recommendations and other resources on our website at macyfoundation.org. And now here is my conversation with Doctors Vela, Chin, and Peek. Thank you all so much for being here.

Monica Vela:

Thank you for the invitation, Holly.

Marshall Chin:

Thanks for inviting us, Holly.

Monica Peek:

Delighted to be here. Thanks so much.

Holly J. Humphrey:

Great. Well, let's get started. Dr. Vela, in the paper that you recently published in the New England Journal of Medicine, you outlined four strategies that academic medical centers can adopt, to improve the organizational climate and enhance trainees' potential for success. Can you share a little bit about those strategies for all of our listeners?

Monica Vela:

Absolutely. First, we believe that institutions should have well-structured diversity, equity and inclusion platforms. This means that DE&I officers should be engaged at every level of leadership. They should be well resourced, informed, and greatly empowered to access necessary metrics to impact processes. Second, we believe there's a need for system level changes promoting health equity. This means that with all of the energy that we've given to quality measures, we should make sure those quality measures should be intimately tied to equity measures, across clinical goals, and also stratified by our social risk factors. Third, we believe that institutions should sponsor structural competency and advocacy training for staff, for trainees, and for teaching faculty. And this isn't as difficult as it sounds.

We review our patient care and outcomes in morning reports regularly, and there is no patient who enters our hospitals or our clinics or our care, who isn't subjected to care that is influenced by provider bias, by structural determinants and this provides opportunities for learning and for discussion about the historic complicity of our

profession in promoting oppression, through scientific racism, through racialized medicine and through discriminatory practices that we should be addressing now.

Finally, we feel that institutions should have accountable systems for reporting bias. And this is not something that we've done widely or well, but residents and faculty should receive training on reporting episodes of both discrimination and bias, and we should encourage such reporting. We should allow all to come together and learn how to approach each other in better ways, how to address our own bias, how to measure that bias and address the insidious and harmful impact of that bias in our learning, but also our working environments.

Holly J. Humphrey:

Monica, thank you for that. There is obviously a lot there. We can take a deeper dive into any one of those four strategies, but I want to take a step back first, because I happen to know firsthand, that you have spent a good part of your career working to increase the diversity of residents in the Department of Medicine at the University of Chicago. And I'm wondering if you'd be willing to share a little bit about how you approached that and how you achieved the kind of success that I had the privilege of seeing firsthand.

Monica Vela:

I think I would want our listeners to know first that for anybody who's interested, this will be a lifelong endeavor, but we've had some real opportunities in the last couple of years to examine our processes. For example, across the country, residency programs hosted virtual diversity fairs that allowed for housestaff who previously may not have been able to travel, to explore out of reach programs, to learn about distant programs. In addition, we were actually led by our medical students who explained in great detail, the pain of having to take a board exam in the midst of dual pandemics and led by their passion and led by Dr. Lisa McQueen here at the University of Chicago, we recruited 11 of our 22 program directors to pledge to remove USMLE scores as a metric for interviewee selection, but also, and maybe even more importantly, in final candidate ranking for the match.

In addition, within the internal medicine program, we spent time and effort revising our mission statement as a group, to demonstrate our commitment, to promote inclusive learning environments and to address anti racism, as well as making sure that we outline our commitment to local communities. Within our internal medicine residency program, 84% of applicants belonging to groups that are underrepresented in medicine, were interviewed with at least one faculty member from our underrepresented group and 11% interviewed with two such faculty members. What does this do for applicants? It sends a message. It sends a message that this is an institution committed to addressing DE&I issues. It sends a message that we have highly successful faculty of color who are thriving in academic medicine, and that they too can come here and be highly successful and valued as people.

Holly J. Humphrey:

Wow. Again, there's a lot there. I know based on interaction that I've had with our listeners over the course of this season, that at least some, if not many of our listeners may say, "What if I don't have faculty from underrepresented groups in medicine? What do I do with my interview process?"

Monica Vela:

I think there's a lot that you can still do. Focusing on processes that promote health equity amongst our patients, demonstrating that we understand patient populations, that we understand and have done the work to address bias, that we are welcoming to trainees from all diversities and understand that diversity in and of itself, is the marker of excellence of innovation, and that diversity in and of itself will improve the lives of our patients, will go a very long way, even if the institution has not had the opportunity to really demonstrate the diversity amongst their faculty. You have to start somewhere and sometimes you have to start at the very beginning.

Holly J. Humphrey:

Wow. I love that focus on the patience and the commitment to equity and to eliminating the disparities that we know are so prevalent, and that I know you personally have had a good deal of experience with -- in terms of teaching and working to eliminate. But you

left us in an important place, and I'd like to turn to Dr. Chin. And Marshall, you have thought a lot about the issues that Monica has already outlined for us. And I'm wondering if you could say more about the structure and support that you think are necessary for big picture, institutional diversity, equity, and inclusion initiatives, to really be effective.

Marshall Chin:

Thanks for the question, Holly, and I'll mention three key points. First as Monica noted, it is critical to create dedicated, funded, and well-resourced teams responsible for the whole institution and individual departments and units. So, for example, at University of Chicago, there's a VP in charge of diversity, equity, inclusion issues, who can advocate at the C-suite level, and she runs a cross institution department of about five people, in addition to there being leaders of DEI within each department. And the role of each of the different units is to catalyze, initiate, coach and support and partnership with the rest of the institution. Diversity, equity inclusion teams can't do it alone, it should not be marginalized. It's the role of everyone at the institution to advance diversity, equity and inclusion.

Second, efforts must be comprehensive. My guess is that many of the listeners of your podcast, tend to think about diversity of recruitment and retention, a climate of inclusion and community partnerships. These are all critical. Equally important areas are applying a diversity, equity, inclusion lens to areas like quality improvement, data analytics, strategic operations, patient experience, and health information technology.

I like to say that advancing health equity is a team sport, that if you're going to get something done, it really requires the whole institution; it can't be siloed. The third key point is that, as I think Monica mentioned, it is critical to address both the interpersonal and the structural. Traditionally in health professions educations, we have tentatively focused upon cultural competency, cultural humility, the interpersonal. The structural is incredibly powerful and important: the regulations, the policies that can systematically bias against marginalized groups. Factors such as selection criteria in recruitment, the forms of evidence that are deemed to be worthy, who was at the decision-making table, and whether an equity lens is applied to quality improvement efforts. Both cultural and structural institutional systems of bias and racism are critical to address.

Holly J. Humphrey:

Well, I think that is a perfect, big picture overview. I want to turn to a subject that's near and dear to my heart, as you know, and that is the ways in which this structure impacts residents in our training programs. And specifically, I'd love to hear you comment on the fact that over the past year and a half, this global pandemic has shown a very bright light on health disparities and inequities. And we know that our residents were on the front lines of caring for marginalized and very vulnerable patients. So given those system level changes that you just described so beautifully, which ones are really necessary to demonstrate the commitment to health equity, to help our residents incorporate those same principles into their future practice of medicine or any of the disciplines of medicine.

Marshall Chin:

So, you know Holly, that some people will say, "Well, this is complicated. That there's so many different factors and so many different challenges. This seems just too hard." I actually think that it devolves down to very simple principles and maybe the most important one is that the north star is creating healthcare delivery systems that truly value all patients and meet their medical and social needs. So, it sends a powerful negative message to trainees. If they see that the resident clinic that often tends to care for poor patients and patients of color is given fewer resources than the faculty clinic, or if residents see that their institution puts up barriers, making it difficult for patients with Medicaid insurance to be seen at their institution, that sends a strong, negative message.

So yesterday I was in clinic, and I saw one of my favorite patients. This was an older, African-American woman, and for the past 50 years, she's lived in one of the predominantly White, Irish Catholic neighborhoods of Chicago. And she was sharing with me the story of when she first got to this neighborhood. There was one of her neighbors, a kind, White woman who eventually became one of her best friends. This woman wanted to make her feel welcome. And the first week she was there, the neighbor came up to her, rang the doorbell and said, "I'd like to invite you personally to the neighborhood block party." And so in some ways, that's a concrete example of what

we want to convey to the residents, that they are welcome, all the diverse residents, and all the diverse patients that care for, are equally welcome.

And what this means then in terms of the care delivery systems, is doing quality improvement with an equity lens. It means looking for differences in outcomes in quality of care, by for example, our patients' social risk factors or race or ethnicity. It means then finding out why there are those differences in care with the root cause analysis. It means then that we design our systems of care and training to address those specific root causes driving the disparities. And again, it's not rocket science. When you look at the successful interventions for reducing health disparities, the common denominator is that these are interventions that value close, longitudinal relationships with patients, that engender trust, a critical word that I hope we get back to later in this discussion, trust, trustworthiness.

These interventions support addressing patients' holistic medical and social needs. They enable close monitoring and follow up with patients. And then these systems are designed to meet the needs and they provide adequate resources to get it done. I'll just briefly mention two more, specifically calling out designing and resourcing systems to address individual patients' social needs and the structural social determinants of health in partnership with community. It's training residents in addressing social determinants. It's developing team-based care, employing community health workers, developing information, technology, resources, to link and communicate with community partners, cross-sectoral partnerships across healthcare and social sectors that address social factors and neighborhoods and other geographic areas.

And the last thing I'll mention is that, and Monica briefly mentioned this, it's critical to provide the residents training in how to advocate for health equity. We have found that if we just talk about health disparities without solutions, it's deflating, it's deflating for everyone. The most recent version of Monica's required course for all first-year medical students is entitled, *Health Equity Advocacy and Anti-Racism*. There are many ways to be an advocate, but we're all advocates for our patients. You can advocate in terms of quality improvement, teaching, community partnerships, our role in professional organizations, health policy, and there are many skills that are required for advocacy, communication, writing, speaking, organizational systems change, partnering with

community self-insight, these are all our responsibility to help train residents in these different skills.

Holly J. Humphrey:

Oh, Marshall, thank you. I love all those specific examples. I feel like we could build on each one of those that you mentioned, but I want to pivot to your colleague, Dr. Monica Peek, because I know that she too, along with both you and Dr. Vela, has spent her career really trying to better understand healthcare disparities, and I think is in the ideal position to help us think about how institutions can respond to create a more fair and more just future, not just for the trainees, as you outlined so beautifully Marshall, but also for the profession and for our patients - really for the community as a whole. Monica Peek, welcome, and I'd love to hear your thoughts about that.

Monica Peek:

Thank you so much, Holly, for the question and for all of these really insightful questions. Every time I'm with Marshall and Monica, I learn so much. And so thank you for bringing us all together. And thank you for saying that the profession of medicine is no exception. We are, as academic institutions, as the profession of medicine, just one of the many institutions in our country. And we are susceptible to the same kinds of structural inequities that the rest of our society are. We have a checkered past, just like the rest of the United States has. We have to, as a health system, as medical schools, as professors and teachers, be transparent and honest, as we reflect upon our history, and understand that our present is not ahistorical, and that in order to move forward, we have to have a clear-eyed view, not only of where we're going, but where we've been.

We have to understand how our medical history sits in the context of the greater history of this country and what it has done to advance health equity and what it has done to hamper those advances and to hinder directly, health equity. There are things that I learned about when I was a medical student around the [Flexner Report](#). And what I learned was that it was a beacon of light and how we learned to set a new era for standards of medical school curriculum and how we were practicing medicine in the new age. What I didn't learn and understand at the time was that that report was also responsible for the closure of more than 500 hospitals around the country that were

African-American hospitals caring directly for low-income, Black people, that it was responsible for the closure of most of the Black teaching medical schools in the country; very few remained after the Flexner Report.

And so that had a direct impact on how and where Black people could access care, in a time where segregation was still rampant. And if they couldn't go to Black hospitals and Black doctors, where could they go? The American Medical Association, our largest organization of physicians in this country, relatively recently, started admitting African-American physicians. And back in the day, it had specific policies that excluded African-American physicians. And you needed to be a member of the AMA in order to have hospital privileges, to be able to admit patients. If you couldn't do that, then where would you go to deliver babies or to have surgeries, or to do anything that physicians would need in a hospital setting. And so then arose the development of all of these Black hospitals that were then later shut down through the Flexner Report. We have to think critically about our role as institutional medicine and how we have helped to create health disparities, in addition to the other kinds of social and instructional determinants.

And when we're thinking about structural racism, we frequently talk about the underlying drivers of poverty and other kinds of structural inequities in accessing goods and services. Typically, think about those goods and services as being healthcare systems themselves. What they have or have not done as far as allowing patients to come in, about not investing in communities as anchor institutions. Most academic hospitals are the largest employer in their small towns or cities, or even in Chicago, for their neighborhoods, they're the greatest employer. Well, if you think about the model of tire companies and car manufacturers, they have had similar roles and think about themselves as having a moral responsibility and obligation to all of those employees, to provide healthcare, all kind of other benefits, to invest in the school systems, to make sure kids are graduating and had jobs and all of these other things that healthcare institutions typically have not been invested in.

But now as we more and more see the relationships between these structural issues and health, it makes all the sense in the world, that healthcare systems would be in that same game, to try and improve everyone's health, particularly the health of socially

marginalized populations who have been suffering the most. Not only in delivering equitable care, care that's tailored for socially marginalized groups, but also in investing in structural equity outside of the walls of the healthcare systems themselves.

And so we have to think about where we've come as an institution and be very transparent in that, but also have a good understanding of what all the things I've been talking about is – structural competency and teaching that to our trainees as well as cultural competency. And so that once everyone has a good functional understanding of what that means, then we can identify the structural inequities that exist within our health system and begin to effectively address them, as part of our institutional mission, in order to be able to go forward, to increase the health of the entire population of our communities, again, particularly those who are most vulnerable.

Holly J. Humphrey:

Well, thank you Monica for that broad, sweeping view of a very longstanding set of issues. And among the very important points that you just made was the fact that our history shows a checkered past for the profession and for our institutions. And a few moments ago, Marshall brought up the issue of trust and trust in the profession. And I'm wondering, among the many things that you just outlined, how important is it that we acknowledge that past and on any given day, our patient doesn't come to us wanting to necessarily talk about that history, but it is the case that the American Medical Association ultimately did issue an apology. You made the point that institutions must be transparent. How is it that we can create trustworthiness between our institutions and our communities, and even individually between the doctor and their patient? Would you like to just help us think about that? Because I know it's on the minds of our listeners.

Monica Peek:

Yes. I think what we should be thinking about with this model is how we used to think about medical errors. I was a resident when this came up and our policy used to be sort of like a “hush hush, keep it quiet, don't tell, maybe try and settle with a patient, but certainly don't go and tell it on the news.” We have since done a 180 and now it's “apologize, apologize, make amends and do it on the nightly news.” Because what

people are looking for is for honesty; they cannot get their loved one back, but what they want is to know is that the institution has acknowledged the wrongdoing and that they are taking active steps to make amends, and they're doing so in a public way. That is what people want. What can they do with a million dollars? They can do something with it, but it's not going to take that pain away.

It's not going to bring their loved one back. What they really want is justice. That's what people want to hear. And what people want is to know that the healthcare system sees their pain and is acknowledging wrongdoing, is publicly apologizing for it and is making active amends to do something about it. That business is not going to be as usual, that we are going to take it seriously, all of the wrong doings that we've done in the past. And we are going to try and do things better. That's what people want. People will sue to try and get a sense of justice, but what they really want is that pain and that hurt to go away. And so, every conversation doesn't have to be about the AMA's horrible history, but believe you me, that kind of mistrust walks into every room with every patient.

It certainly does. I have conversations. I just came off inpatient wards on Sunday. Things that are routine business for us like, "Oh, someone's going to go to rehab. When we find a bed, that's where they'll go." Patients will tell me, that sort of haphazard process, "Oh, there's a bed. And oh no, it turns out that bed wasn't available. Now there's..." Patient's families are like, "Oh, that sounds sketchy. Is there some kickback involved? Why did I have to go there?" "Was the doctor getting paid extra to...?" And so there's always a back shadow of mistrust of the things that are happening, even if it's routine care, because of all of the things that have gone before.

We must take an active stance to say, "Yep, we have not been our best. We've not been our best for generations. But starting today, we are going to try and be our best." And that is going to be a huge thing that we're going to have to square up around equity and not just with our actions, but with our words, and not just with our words, but with our actions. It's going to take movement from an institutional perspective. And it's going to take some very tough conversations amongst us, amongst our peers and with our patients, but it can be done. It is never what you say. It is always how you say it. And if you say it with love and with an open heart, and we do this all the time as physicians, we

know how to have difficult conversations with patients. That's what we've been trained to do.

Then patients can hear that. Patients are dying to hear any modicum of empathy and expression of concern from their physicians. And so if they get that, then they will meet you more than halfway. If you're having a difficult conversation, and you're like, "You know what..." There's not an opportunity for us to be racially concordant, and definitely concordant with everybody that you see, you can only be you. Many of my patients are not African-American females, but I try my best to learn something about all the different cultures and people appreciate you taking that step. That's all we're asking.

Monica Vela:

Everything Dr. Peek just said has born itself out in the research and extent literature. We know from studies that patients are able to detect implicit bias and they are able to rate which patient, which doctors have higher levels of implicit bias. And when those same doctors take implicit association tests, it correlates well with what patients are saying. We also know that when patients do not trust their physicians, they're much less likely to follow through with the treatment plan and much less likely to return.

And so all of this leads to poor care for people who are already experiencing health inequities. It is also true that the profession itself is creating a structure that allows for implicit bias to thrive. And it allows that by practicing racialized medicine and teaching it, by creating significant time pressure and cognitive load, and then a biased work environment, where our residents have repeatedly told us that they're experiencing high levels of discrimination and bias in the workplace. And when we add up all of those components, it is no shock that our patients are on the receiving end of biased care.

Holly J. Humphrey:

Thank you for raising those issues of bias and discrimination, because you are reminding me that the three of you authored a paper for our conference on bias and discrimination in the clinical learning environments. And it actually is one of my very favorite papers because you used that paper to talk about some really practical lessons about teaching

about race and racism in the clinical learning environment, right along the lines of all those issues that you both just spoke about.

And Monica Peek, I'm wondering if you could share a little bit about your advice for clinical faculty who are trying to lead difficult conversations about race and health equity, but the faculty member is a majority faculty member. And we know from the many conversations we have had since our conference on bias and discrimination that faculty are afraid of saying the wrong thing, they're afraid of causing more harm or of being misperceived with a microaggression by trying to support someone, but inadvertently finding themselves tangled in a web. So there's a tendency for faculty to not do what the two of you have just outlined in terms of having these difficult conversations and trying to help the residents and students, and most of all, our patients, feel as if they're in a safe environment where they do belong and that they are not feeling the effects of harmful bias. So, what advice do you have for us?

Monica Peek:

Yes, we had a set of, I think, 12 recommendations in the [paper](#) that came out, and some of them were specifically about this issue of creating safe spaces and for people who were just starting out and want to be involved and may feel unsure, I would say, get someone who knows how to do this to help you, an expert consultant. We have a small band of friends and colleagues who will probably do it for free, but also know that the most important thing is to try and create an emotionally safe space. We're all friends here, we're all trying to learn and do this work together. Leave all emotional baggage at the door, this is a safe space and here's some activities where I'm going to do to try and get to know each other. Model that safe and good behavior. Start with stories, doing things that helps people bond in that moment, to create expectations for civil discourse.

There's not going to be drama here. We're going to respect everyone's opinion. Please be present emotionally, and with your mind. All cell phones and electronics, maybe put away. This is a priority. So we're asking people to show up and to present and to lean into the conversation and to give people grace. Creating that sort of special atmosphere of openness and trust, yet, knowing we're going to have some difficult conversations. And so the paper does, I think a really good job of trying to help people sort of walk towards that journey, starting sort of with the easier things and then getting to more

challenging conversations. With the idea, like you said, of trying to specifically avoid curricular violence, knowing that there are some communities, racially marginalized groups, other socially marginalized groups, who may feel extra PTSD from having conversations. There may be some groups, White groups, who may not have become accustomed to having these difficult conversations and feel frightened, scared, defensive.

So we need to have strategies for making sure that everyone is comfortable in that space. And one of the things we can do is just acknowledge that the use of implicit biases is something that everyone does. It's a cognitive shortcut. It's a part of being a human, and everyone can take the IAT and find out what your own personal biases are. The issue is not an us versus them, it's an us versus structural inequities. We can all come together as a group and said, "You know what? This is our history. And we don't really like that. We can all work together to change and make sure that our future is not our past." And that's where we can have some commonality as opposed to spending our time trying to figure out who did what in the past, to we're now in the present. We need to not be ahistorical, we need to understand the past, but there does not have to be a wedge between the work that we can do in the future.

Marshall Chin:

So a little bit earlier, I shared this story about my patient and her kind, White neighbor who wanted to make her feel welcome 50 years ago. And what I said was slightly inaccurate. And so let me tell you the true story. So again, 50 years ago, White neighborhood and this White lady just walking over to my patient's house and she says practicing, "Invite you to the neighborhood block party, invite you to the block party, invite you to the block party." So she rings the doorbell, opens the door, and then what comes out of her mouth is, "Hi. I'd like to invite you to the Black party." So, as soon as the words are coming out of her mouth, she's feeling horrible and knowing this major faux pas.

And she apologized and my patient said, "Well, it was clear, this is a well-intentioned woman, and this was a mistake and apology accepted," and they became really good friends. And I think the lesson for me from that is that being well-intentioned goes a long way. That whether it's patients who have good antenna or colleagues. People can

tell when you're well intentioned. As people were saying, get training in this also. That there's a skill set to learn with this, engage in self-reflection.

And then when you make a mistake, because sooner or later, you will make a mistake, you apologize, self-reflect on why it happened and then improve. One of my current mentees, uses they/them pronouns. And I have misgendered them calling them, she/her and I've apologized. And I thought, "Well, why did that happen?" And I try to do better. So, people should not feel, "Oh my gosh, I have to be perfect," because you're not going to be perfect. But those principles that Monica said and just being well intentioned and learning, that will take you a long way.

Holly J. Humphrey:

Thanks for that. What about the issue of timing? I know that sometimes clinical faculty are so caught off guard by what they see or hear, and they don't know how to respond. How important is it to deal with it in the moment or as soon as possible after such an occurrence has happened?

Monica Peek:

That is an excellent question. Monica Vela and I have a paper now under review, that's being first authored by one of our joint fellows. Monica, do you want to take that?

Monica Vela:

I think that the opportunity to address the emotionality, the trauma of the moment, is key. Being able to immediately say, "I recognize that shouldn't have happened. I'm so sorry that this is so painful. We should talk about this some more and work on it together," is exquisitely important. Ignoring it and waiting until a later date, will only create more emotionality and more trauma. But there's some work that needs to be done by everyone so that they can be prepared to address these things both in the moment and then repair later. Monica, did you want to add to that?

Monica Peek:

I think that's exactly right. I think that sometimes it's challenging because we're never prepared for implicit bias when it happens or the words. We always have something that we could have said later in the day, "I should've responded this way." And so if we can try our best to react in the moment on behalf of ourselves, or more importantly on behalf of our colleagues who are more traumatized by the event and be an ally, an active ally, an upstander, then that goes a long way for diffusing things in the moment, for setting a precedent for what is acceptable behavior in that moment, and for all the trainees who are watching and affirms the humanity of all who are involved.

Holly J. Humphrey:

Thank you. That is just a beautiful wrap up. I regret very much that we are out of time for today because you have just brought up another extremely important issue. And that is the role of upstanders when they witness things that are wrong. And that is such an important element of creating learning environments and health and healthcare environments, that are inclusive. But I think it deserves a session of its own because it is so important and really based on some skills that I know each one of you have had a lot of experience in modeling and in teaching. So we're going to save that for another session.

But I want to say thank you for the ways in which you brought to life such an important set of issues from the big, broad institutional and societal issues to the day to day issues that we see in our hospitals taking care of patients when they're hospitalized. And you also took us into your offices with your patients, as you shared some very personal examples with our listeners today. So on behalf of everyone, I'd like to thank you all and wish you the best with the important work that you are doing each and every day. Thank you.

Monica Peek:

Thank you, Holly.

Marshall Chin:

**Vital Voices, a podcast from the Josiah Macy Jr. Foundation
Episode 7 Transcript**

Thanks very much, Holly.

Monica Vela:

Thank you again for having us all.

Holly J. Humphrey:

For more on today's discussion, I encourage you to read the Macy Conference [recommendations](#) and related resources. You can find all of these on Macy Foundation's website at macyfoundation.org. Thank you for listening, and we hope you'll share this conversation with others. Be sure to subscribe wherever you get your podcasts, so you'll be notified when the next episode drops. And make sure you're signed up to receive email updates from the Macy Foundation.