

Making DEIA Decisions—Together

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A vital component of medical decision making is the evaluation process. We start with carefully constructed, thoughtful questions and put on our stethoscopes to skillfully listen beyond what we can see. We use our hands to palpate, checking for a pulse or thread of features to refine our differential diagnoses. Then we review data to support or refute our clinical reasoning, finally coming to a shared agreement on course of action.

An equally important evaluation is pursued in our editorial processes. From author instructions to peer review, and the advice and support of the editorial board, our discipline's contribution to the medical literature is crucial for our profession, learners, and patients. However, editorial processes have at times limited the ability to advance efforts to provide equitable and just health care and learning and working environments for all.^{1–3} The publication process can be exclusive and inaccessible to authors and researchers from underrepresented groups that have been denied instruction, support, and guidance in completing scholarly work. Implicit bias can affect the selection process of articles for publication, resulting in underrepresentation of research and other works from marginalized communities. A lack of diverse perspectives may translate to submissions at risk of being misunderstood or inadequately evaluated. Yet there is capacity to improve beyond what we can currently see.

To address these issues, many editorial teams have added designated diversity, equity, and inclusion (DEI) editor positions to help ensure published content is more reflective of our society, as well as address current and future needs of our communities and institutions.⁴ I joined *Family Medicine* as inaugural DEI associate editor in September 2022 with a focus on creating space for contributions from authors whose meaningful work and experiences have been historically overlooked. Importantly, I endeavor to promote publications and processes that consider our collective role as advocates for social justice, health equity, and antiracism in medicine, medical education, and health policies.⁵

Yet a piece of the evaluation process is still missing. Prior to making any medical decision we rely on collected data to support our prevailing diagnosis and ultimately guide the plan of care. As we aim to increase the diversity of our authors and peer reviewers and publish work that advances equity and inclusiveness in medical education and primary care, the truth is we do not know where we stand. Across family medicine journals our editors agree it is largely unknown who is contributing and attempting to contribute to scholarly work and the peer review process. In this month's issue, Casola et al recall the tenets of foundational behavior theory in their discussion of "The Impact of the COVID-19 Pandemic on Medical Students' Perceptions of Health Care for Vulnerable Populations."⁶ Knowledge of the who, what, and why aspects of health disparities is the precursor to addressing downstream action. Our DEI intentions are both necessary and noble, yet our plan must start with a thoughtful assessment of who, what, and why. Who submits work to *Family Medicine*? Who are our valuable peer reviewers and respected authors? Is there a way to grasp the larger purpose behind their work? Can this sentiment be effectively captured and meaningfully communicated with our entire readership? What are our blind spots or existing disparities that we are completely unaware of?

If we closely listen and allow for the story to unfold, the diagnosis can quickly become apparent. Following this analogy, in 2020 the editors of North American family medicine journals paid attention to the painful stories of repeated murders of unarmed Black people and stark health inequities exposed by the COVID-19 pandemic and put the diagnosis on paper, collaboratively acknowledging structural racism and renewing the call for family

medicine, a specialty that emerged as a counterculture, to reform mainstream medicine, to both confront systemic racism and eliminate health disparities.⁷ Further, these editors committed to actively examine the effects of racism on society and health and to take action to eliminate structural racism in editorial processes and have made several steps in mitigation.

Yet, before a full plan can be approached, a sensitive collection of information combined with full transparency in this undertaking is still essential. Race, ethnicity, gender orientation, differing levels of ability, location of practice—these are just a few layers of identity that shape our lived experiences and wholly add value and context to the work we do. However, many have experienced a painful erasure of identity particularly in professional or academic settings at times before they even interview for a position.⁸ I recall and immensely appreciate the sentiments shared by members of the Minority and Multicultural Health Collaboration at their official meeting during the 2023 Society of Teachers of Family Medicine (STFM) Annual Spring Conference. Members of this collaboration include a diverse group of STFM members including authors, peer reviewers and readers of *Family Medicine*. When prompted with the question of whether we should pursue collecting demographic information, members poignantly shared past and ongoing experiences of removing and masking parts of their identity, at varying points in their personal and professional lives in hopes of escaping discrimination, bias, and racism. This group greatly affirmed the desire to both be seen and heard in our editorial processes and further for the journal to support avenues to continue dialogue around works submitted. I can attest this sentiment aligns with that of DEI journal editors from across subspecialties I've spoken with on this issue.

There are differing and valid thoughts on collecting such demographic information. A frequent question concerns what we do with such information, and what is the plan for using it after it is collected. The 2021 Bridges et al Council of Academic Family Medicine's Educational Research Alliance (CERA) survey found that despite two-thirds of clerkship directors affirming a belief that systemic racism and bias contributes significantly to health disparities, 60% had no formal curriculum or process to address systemic racism and 41% devoted no time to teaching the topic.⁹ It appears acknowledging the problem and having an actionable goal can be mutually exclusive in addressing bias and racism. The authors offered one of many approaches that included having an antiracist approach to teaching. Racism conceals our differences while allowing for harmful policies and practices to continue. Antiracism acknowledges and highlights diversity allowing for disparities to be uncovered and opportunity to create structurally competent processes that will move us toward equity. Giving authors and peer reviewers the option to provide demographic information that would be handled confidentially and not influence the evaluation of the submission puts us on that path.

Another common question pertains to how we will do this, especially while endeavoring to minimize harm in the process. There are known limitations in collecting demographic information, in some countries it is simply not legal, though debate is ongoing.¹⁰ Using standard categories as presented in the United States Census Survey is hypothesized to be more comfortable as there is familiarity with filling in these checkboxes in many other areas. Such categorizations certainly make it easier to compare and analyze information, however and very importantly it does not allow for data disaggregation, nor does it reflect the full diversity of our society.¹¹ Additionally, some categorizations that attempt to acknowledge race as a social construct may be particularly triggering, such as "what are your ethnic origins or ancestry?" for descendants of people forced from other countries. Allowing for self-identification as individuals via an open box format with prompts seems ideal to capture the full diversity of our authors and reviewers while avoiding offensive misunderstanding, followed by having a combination of checkboxes and open-ended fields including a "choose not to disclose" category. Capturing and tracking these data can prove difficult in guiding DEI efforts given the wide range of potential answers. An additional limitation is what is actually feasible on our platform and how we can use

existing technology to meet expectations.

Family Medicine is committed to advancing efforts toward inclusion and antiracism in all journal-related activities. We endeavor to eliminate bias and racism in our editorial processes and published content. Therefore, we will continue to look beyond what is readily apparent, provide space to listen to diverse perspectives, and reflect on what we can improve. We believe implementing strategies to sensitively collect demographic information is a needed approach. As with wrapping up any encounter, shared decision-making guides the plan and so the next steps involve hearing from our readership, authors, and reviewers. Let's come up with a plan, together.

REFERENCES

1. Hardeman RR, Karbeah J. Examining racism in health services research: A disciplinary self-critique. *Health services research*. 2020;55:777–780.
2. Mandavilli A. *Medical journals blind to racism as health crisis, critics say*. *The New York Times*. 2021. <https://www.nytimes.com/2021/06/02/health/jama-racism-bauchner.html>.
3. Boyd RW, Lindo EG, Weeks LD, Mclemore MR. On racism: a new standard for publishing on racial health inequities. *Health Affairs Blog*. 2020. <https://www.healthaffairs.org/content/forefront/racism-new-standard-publishing-racial-health-inequities>.
4. Fontanarosa PB, Flanagan A, Ayanian JZ. Equity and the JAMA Network. *JAMA*. 2021;326(7):618–620.
5. Family Medicine Journal Names Octavia Amaechi, MD, as DEIA Editor. *Society of Teachers of Family Medicine*. 2022. <https://stfm.org/news/2022news/10-1-22-dr-amaechi-named-deia-editor/>.
6. Casola AR, Kelly EL, Smith K, Kelly S, Cruz MSDL. Impact of the COVID-19 pandemic on medical students' perceptions of health care for vulnerable populations. *Fam Med*. 2023;55(2):89–94.
7. Sexton SM, Richardson CR, Schragger SB. Systemic racism and health disparities: a statement from editors of family medicine journals. *Fam Med*. 2021;53(1):5–6.
8. Kang SK, Decelles KA, Tilcsik A, et al. Whiteness résumés: race and self-presentation in the labor market. *Adm Sci Q*. 2016;61(3):469–502.
9. Bridges KM, Rampon K, Mabachi N. More than half of family medicine clerkships do not address systemic racism: a cera study. *Fam Med*. 2023;55(4):217–224.
10. Oltermann P, Henley P. France and Germany urged to rethink reluctance to gather ethnicity data. *The Guardian*. 2020. <https://www.theguardian.com/world/2020/jun/16/france-and-germany-urged-to-rethink-reluctance-to-gather-ethnicity-data>.
11. Kater F, Đoàn L, Lee M, Chin MK, Kwon SC, Yi SS. *Disaggregating race/ethnicity data categories: criticisms, dangers, and opposing viewpoints*. *Health Affairs Forefront*. 2022. .