precedented global rejection of the human cost of the U.S. racial hierarchy. These developments create an extraordinary opportunity to clarify that a fundamental driver of Black–White health gaps is a difference in resources that is structural in origin, owing to many obstacles to Black advancement. We cannot ameliorate longstanding Black–White health inequities without addressing the structural forces that pattern them.

Black reparations would not solve racism — structural racism permeates all we do and bars Black Americans from equitable access to housing, occupational opportunities, and safe neighborhoods, to name but a few determinants of health. But reparations would represent a monumental break with the past.

At the 1963 March on Washington, Martin Luther King, Jr., proclaimed that "In a sense we've come to our nation's capital to cash a check." He explained: "America has given the Negro people a bad check, a check which has come back marked 'insufficient funds.'" From this, his famous "I Have a Dream" speech, we remember King's words about the content of our characters. But his remarks on the obligation to repair have often been overlooked. It is left to those of us in medicine and public health to argue that now is the time to act, because equity is not simply about repair in cash or in kind. Addressing the Black–White wealth gap through reparations is about saving lives. By bringing attention to the health benefits of addressing this gap, we can help shift a national conversation about reparations that often becomes mired in blame and accusation to one that centers the critical importance of health.

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"You Are Now Entering a Guilt-free Zone"

D. Robin Taylor, M.D., D.Sc.

Taking a history from patients who present with chronic dyspnea is the bread and butter of a respiratory clinic. I have done so countless times over many years. But it is only in the past 5 years that I have understood why probing a patient's smoking habits (or their weight gain) poses such a threat. Patients who in late middle age have a body-mass index above 40 or have smoked 20 cigarettes a day since their teens constitute at-risk groups.

One thing they're clearly at risk for is the acute sense of guilt that a clinician can incite, which immediately makes a consultation tense. Often, the answer to questions about smoking involves an attempt to minimize. When the answer is "I've cut down. It's only five a day," I'm skeptical. But it's not that I want to pass judgment and induce guilt — it's that the guilt is already there.

Some patients expect the doctor to give them a health warning that amounts to a scolding. They have perhaps had that experience, and they come prepared to be defensive. Simply asking the question brings guilt and defensiveness to the surface. Unhelpfully, they answer in the language of cover-up, often with white lies. When I hear obfuscation, it elicits in me the body language of doubt. I can't help it. The patient spots it. I dare not challenge the lie. We quickly move on.

I broke free from this type of exchange unexpectedly. I asked a patient the usual question: "How many do you smoke?," and his reaction was characteristic. His face fell. Then without thinking, I said, "I don't do guilt." I was surprised — the patient's facial muscles immediately relaxed. I added, "I am not going to scold you or wag my finger, but I do need to know about your smok-

ing. I need to understand the background to your symptoms."

That simple interaction led to a turnaround. I became conscious that preparing for a guilt-free conversation not only makes for a greater degree of honesty, it also makes for a greater degree of trust. I have worked on my line of conversation over time. Almost routinely, I now approach the topic of smoking with, "Now, before we go any further, you need to know something about me." There's usually a quizzical pause. "I don't do guilt." Another pause. "But I do need to talk about your smoking because that's my job. I'm not going to give you a hard time about it." Sometimes I vary my opening lines, "Now, before we go any further, you need to know something about this room." I pause for a few seconds and allow my eyes to scan the ceiling and the walls. "This room is a guilt-free zone." By this time, there is often a knowing smile.

Repeating the sequence frequently can make it feel like a performance, but again and again, I have realized how important this introduction is. The hospital where I work serves one of Scotland's most socially deprived areas — the "rust belt" south and east of Glasgow. Male life expectancy is 70.9 years, more than 10 years less than that for the top quintile in our country (82.1 years).[1] The impact of smoking, obesity, alcoholism, drug addiction, and mental ill health leading to suicide all contribute significantly to the appalling statistics. When it comes to exploring these problems in a clinic consultation, dealing with the human feelings that surround them, not least the underlying guilt, feels like a gesture, but it's an important one.

The significance of guilt management struck me about a year after my initial discovery. A 54-year-old woman was new to my clinic. Preconsultation pulmonary-function tests had already informed me that she had severe chronic obstructive pulmonary disease, predominantly emphysema. She sat down nervously when I invited her in. We got to the part about her smoking, and I, as usual, declared the room a guilt-free zone. She dropped her head and gazed at her feet.

"You feel guilty already," I said quietly.

"I feel guilty about *everything*," she replied. I said nothing. She unpacked her life story. Her husband had died of a myocardial infarction 10 years earlier, at the age of 44. Her eldest son had committed suicide at 28. Another son died at 26 from an accidental overdose of heroin. And her daughter, now 23, had disappeared completely, leaving the patient to care for a 5-year-old granddaughter. She had suddenly found herself in the role of a single parent.

The woman was not garrulous: there was simply a tragic story to be told. Being a failed mother was at the heart of her feelings of guilt. Meanwhile, on my computer screen, check marks began to appear one by one against the names of patients who had arrived and were waiting. After a few more minutes, I invited the woman to come back the following week to discuss her respiratory problems, none of which had been addressed. She turned as she left and said, "Thank you. No one has ever listened to me before."

When she returned a week later, she was relaxed and even smiling.

"How have you been?" I asked.

"I haven't smoked a cigarette since I left here last week," she said. She made it clear that she did not want to discuss personal

things again, and we got on with the business of managing her emphysema.

The human conscience is a necessary part of who we are, both to ourselves and to one another. It has an essential function. We are disturbed when we come across someone whose behavior is destructive and who "doesn't do guilt." In the professional setting, most clinicians try not to "do guilt," and it is right that nonjudgmental attitudes should prevail. But, as I discovered, guilt is often already there. It is not created by the clinician as much as it is stirred up. Unnamed, ignored, it is often intensified despite a seemingly agreeable consultation. But politeness does not relieve guilt. It merely keeps it at bay.

I am not called to be a confessor to all my patients, but proactively creating a guilt-free zone yields good outcomes that are not confined to establishing the truth about smoking habits. There are other significant benefits.

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