From Diversity and Inclusion to Antiracism in Medical Training Institutions

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Abstract

The glaring racial inequities in the impact of the COVID-19 pandemic and the devastating loss of Black lives at the hands of police and racist vigilantes have catalyzed a global reckoning about deeply rooted systemic racism in society. Many medical training institutions in the United States have participated in this discourse by denouncing racism, expressing solidarity with people of color, and reexamining their diversity and inclusion efforts. Yet, the stagnant progress in recruiting, retaining, and supporting racial/ethnic minority trainees and faculty at medical training institutions is well documented and reflects unaddressed systemic racism along the academic pipeline. In this article, the authors draw upon their experiences as early-career physicians of color who have led and supported antiracism efforts within their institutions to highlight key barriers to achieving meaningful progress. They describe common pitfalls of diversity and inclusion initiatives and call for an antiracist approach to systems change. The authors then offer 9 recommendations that medical training institutions can implement to critically examine and address racist structures within their organizations to actualize racial equity and justice.

The year 2020 has highlighted the ongoing impact of deeply rooted systemic racism in society, from the glaring racial inequities in the impact of the COVID-19 pandemic to the devastating loss of Black lives at the hands of police and racist vigilantes.[1] We have observed many medical training institutions in the United States denounce racism, express solidarity with people of color, and reexamine their diversity and inclusion efforts in response to these events.

Throughout our medical training and careers, we, as early-career physicians of color, have advocated for increased racial/ethnic minority representation in the physician workforce and to support the advancement of fellow physicians of color. It is an invisible mantle we feel compelled to wear to disrupt the status quo in which medical training institutions produce physicians who do not represent the communities they serve and who are ill-equipped to dismantle systemic racism in patient care, medical training, the careers they choose, or the institutions they lead.

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The benefits of a diverse physician workforce are compelling. From addressing health inequities by providing primary care for racial/ethnic minority and socioeconomically disadvantaged populations, to improving the quality of patient–physician relationships, to increasing patient satisfaction, physicians from racial/ethnic minority backgrounds are good for patient care.[2,3] The increased innovation of diverse teams also has valuable implications for medical education, research, and clinical care.[3] For example, increasing racial diversity among researchers could help broaden research agendas and better inform conceptualizations of and solutions to important health problems, including racial health inequities.[4] Most importantly, in a racially just society, physicians of color should be unobstructed and proactively supported in pursuing a full spectrum of career choices, whether they want to be a primary care physician in a medically underserved community, a neonatologist in a quaternary care center, or the dean of a school of medicine. The question is not why we must work toward this goal, but how.

Background

In 2009, the Liaison Committee on Medical Education required medical schools to implement systemic efforts to recruit and retain a diverse physician workforce.[5] Yet, Black, Latinx, American Indian, and Alaska Native medical students remain underrepresented as of 2017,[6] and the Accreditation Council for Graduate Medical Education only implemented similar requirements for residency and fellowship programs in 2019 and 2020, respectively.[7,8] While these mandates are long overdue, medical training institutions need a revolutionary approach to change the stagnant trajectory of racial/ethnic minority representation in medicine.

The trainees of color who do enter medical school, residency, and fellowship face even further obstacles, from a barrage of microaggressions and bias, to being tasked as racial/ethnic ambassadors, to social isolation.[9] These burdens compound the challenges of training and interplay with structural barriers (e.g., greater distance traveled, lack of mentorship, inequitable career advancement opportunities) to contribute to the dwindling number of racial/ethnic minority physicians at each stage in the academic pipeline.[10,11] Ultimately, few racial/ethnic minority physicians rise to influential faculty and leadership positions,[12,13] where they may actually have the power to disrupt this vicious cycle.

These pervasive challenges are all too familiar and have motivated us to

implement change within our own institutions, including advocating for holistic review,[14] developing curricula that explore racism in medicine, and supporting mentorship and outreach programs. Through these efforts, we have identified critical barriers to meaningful progress in recruiting and retaining trainees from racial/ethnic minority backgrounds and promoting the advancement of physicians of color. These misguided approaches include promoting diversity and inclusion without committing to racial equity and justice, applying piecemeal solutions to a systemic problem, failing to ensure institutional transparency and accountability, expecting change without significant investment, failing to address power imbalances, and asking people of color to solve racism without engaging White colleagues in the solution. In this article, we offer initial steps that medical training institutions can take to address these common pitfalls and dismantle systemic racism within their organizations.

Recommendations

We propose that institutions move beyond diversity and inclusion initiatives and strive toward antiracism, defined by Dr. Ibram X. Kendi as "a powerful collection of antiracist policies that lead to racial equity and are substantiated by antiracist ideas."[15] An antiracist approach, which includes written and unwritten measures, recognizes the deeply rooted racist structures that perpetuate racial inequity and actively strives to undo them by redistributing power and resources.[15] We offer the following recommendations that medical training institutions can implement to critically examine and address racist structures within their organizations to actualize racial equity and justice.

1. Commit to racial equity and justice in institutional mission, vision, and values

Inclusion strategist Vernā Myers says that "Diversity is being invited to the party. Inclusion is being asked to dance."[16] While diversity and inclusion are necessary, they do not guarantee equitable treatment, opportunities, or influence. Further, people of color should not have to depend on White colleagues to invite or include them; the power to make decisions about all structures and functions of medical training institutions should be shared. Institutional guiding principles must reflect a commitment to reallocating power and resources and dismantling racist structures of oppression to achieve equity and justice. By centering equity and justice, institutions will be able to foster a diverse and inclusive workforce.

2. Conduct a systematic assessment of institutional policies, procedures, and norms

Medical training institutions must thoroughly investigate how systemic racism is built into their walls. Grading policies and honors society selection criteria that amplify racial/ethnic achievement gaps,[17] performance evaluation procedures that are ostensibly objective yet implicitly biased,[18,19] and social norms that discourage speaking up are just some of the many gears in the machine. For example, the University of California, San Francisco, School of Medicine recently took a bold step to suspend its participation in the Alpha Omega Alpha national medical honor society after conducting a systematic assessment and identifying inequities in the selection process.[20] The goal of a systematic assessment is not to prove that racism is happening (it is) but rather to perform a root cause analysis to effectively target interventions and implement sustainable, systems-level change.

3. Collect, report, and respond to data on racial inequities

Medical training institutions must collect and report quality data on racial inequities in key academic pipeline metrics (e.g., recruitment, retention, evaluations, career advancement) and on experiences of systemic racism within their organizations. Medical training institutions can learn from initiatives such as the White Coats for Black Lives Racial Justice Report Card, which was developed by medical students to evaluate the extent to which the curriculum, climate, and policies at academic medical centers promote racial justice.[21] These and other important metrics on racial inequities should be used to establish specific and measurable antiracism goals, develop a clear implementation plan and timeline, and longitudinally monitor progress with transparency and accountability.

4. Invest funding and resources into antiracism initiatives

Too often, medical training institutions expect a handful of trainees and faculty, often people of color, to implement diversity and inclusion efforts without protected time, compensation, or funding to execute these initiatives.[9,22] We have personally observed faculty of color pay for diversity recruitment events out of their own pockets and seen residents of color volunteer countless hours on top of their clinical responsibilities to lead multiple antiracism initiatives for the benefit of their institutions. It took centuries and immense resources to build systemic racism into institutions, and it will take a significant investment of time, money, and other resources to undo its legacy. Medical training institutions must recognize and remunerate antiracism work as a valued professional contribution and stop exploiting the talents and free labor of people of color.

5. Do not place the burden of change on people of color

Engaging trainees and faculty from racial/ethnic minority backgrounds is crucial for developing informed interventions, identifying blind spots that White colleagues may not readily recognize, and ensuring accountability. However, the burden of change should not be placed on the very people who are oppressed by systems they did not create. The solution to systemic racism is not to increase the "minority tax" or the weight of extra responsibilities placed on racial/ethnic minority physicians in the name of promoting diversity.[22] Relying on racial/ethnic minority faculty and trainees to do antiracism work, which is often undervalued, also takes time away from promotion-earning activities, education, and personal wellness.[9,22] Medical training institutions must recognize that not all people of color have the professional interest and specific expertise to do antiracism work or want to invest the emotional labor and assume the risk it requires. While the career advancement of physicians who want to engage in antiracism work should be supported, hiring external experts in antiracist systems change can also strengthen institutional capacity and decrease the burden on physicians of color.

6. Share and yield decision-making power

A critical part of dismantling systemic racism is allowing those who have been historically excluded from positions of influence to hold and exercise power. In enacting antiracist systems change, medical training institutions must not treat people of color as mere consultants who only offer suggestions that ultimately may not be implemented. From shaping medical training curricula to establishing faculty advancement criteria, people of color who want to engage must have seats at the decision-making table and play a key role in setting agendas, prioritizing issues, and determining policies. Establishing term limits could allow more racial/ethnic minority physicians to assume leadership positions in academic medicine and ensure that one person's perspective does not hold disproportionate influence over the institution.[23] Medical training institutions should also consider how to share decision-making power with other important stakeholders: patients and community members. For example, the Icahn School of Medicine at Mount Sinai recently took an innovative, antiracist approach in its new internal medicine and pediatrics residency program by engaging patients and community members in developing its guiding principles and in recruiting residents.[24]

7. Address racism intentionally

While other underrepresented groups experience similar and distinct challenges in entering and navigating medical training that must also be addressed, it is important to intentionally confront racism, particularly anti-Black racism. Lumping all underrepresented groups together risks diluting or altogether avoiding important conversations about racism and developing nonspecific approaches that ignore the unique experiences of specific racial/ethnic minority groups. An overly general approach, particularly in measuring diversity, can also lead to false reassurances about how well medical training institutions are doing in recruiting, retaining, and supporting trainees from racial/ethnic minority groups. For example, a residency program that monitors diversity based on an aggregate measure of non-White physicians may overlook the absence of Black residents in its program. Institutions must clearly identify which racial/ethnic groups are underrepresented among their trainees and faculty and particularly direct their attention and resources toward those who experience the greatest inequities.

8. Teach and expect everyone to practice antiracism

Medical training institutions must teach all trainees, faculty, and staff how to be antiracist in all aspects of their work, including patient care, peer interactions, teaching, mentorship, research, and leadership. In developing antiracism curricula, medical training institutions must move away from a checklist mentality that assumes a finite level of competence and toward a critical thinking framework that encourages continuous growth. Medical training institutions must also denounce biological interpretations of race and explore systemic racism as a root cause of illness and death.[25–27] Additionally, medical training institutions must stop blaming patient mistrust and cultural differences as the causes of racial health inequities and rather clarify how racist health care systems erode patient trust and fail to provide quality care for patients from different cultural backgrounds.[27]

Medical training institutions must also move beyond concepts toward applications. Well-designed and expertly facilitated workshops could teach practical skills in disrupting racist behaviors in an interprofessional setting. Courses that critique the flawed underpinnings and interpretations of clinical tools such as race-based calculations of estimated glomerular filtration rate, which is being increasingly abolished by medical institutions, can help researchers and clinicians correct racist practices.[28–30] Additionally, workshops on rigorous standards for publishing on racial health inequities can help researchers apply an antiracist lens in designing, interpreting, and reviewing studies on these inequities.[27] A deep understanding and application of antiracism should be a professional expectation and valued criterion in evaluations, advancement, and leadership selection.

9. Mobilize allies to leverage their privilege positively

White people comprise the majority of trainees and faculty at medical training institutions, occupy most leadership positions, and hold immense social power. It is critical for medical training institutions to mobilize this influential group of people to educate themselves on effective allyship and to use their privilege for positive change. White colleagues can play an impactful role in disrupting racist behaviors, uplifting the voices of peers of color, and advocating for antiracist institutional policies. Paying "majority taxes" or investing discomfort, energy, and capital to acknowledge and positively leverage White privilege has been proposed as an effective way to practice antiracist allyship.[31]

Conclusion

As the United States confronts its centuries-old tradition of systemic racism, we are encouraged that many medical training institutions have made statements expressing solidarity with people of color. However, if these assertions do not translate into sustained, systems-level change, they will amount to empty promises and cause further harm to our communities. Thus, we urge medical training institutions to help build a future in which diversity and inclusion initiatives are obsolete, a future of antiracism that actualizes equity and justice.

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