

A Framework for Commitment to Social Justice and Antiracism in Academic Medicine

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In 2020, two overwhelming public health crises brought race and racism in medicine to the forefront. First, the ongoing coronavirus pandemic exacerbated longstanding health disparities, resulting in disproportionate infection rates, hospitalizations, and deaths in Black communities (1–3). Second, multiple high-profile killings of Black people across the United States forced the public to confront an epidemic of race-based police violence and mass incarceration. As physicians, bound to safeguard the health and well-being of our patients, we are compelled to act. We must begin with an honest interrogation of racial injustice in our own community to identify the structural racism embedded—and often hidden—in our systems and institutions. So informed, we can then set out to mitigate the impact of structural racism, dismantle harmful practices, and rebuild a just healthcare system for all.

DEVELOPMENT OF THE FRAMEWORK

To meet these challenges in our own community, the Pulmonary and Critical Care Medicine (PCCM) division at the University of Pennsylvania recognized a critical need to restructure our operations to

become intentionally and explicitly antiracist. A grassroots group of fellows, faculty, and divisional leadership established a Social Justice Committee, led by five founding members with experience in and commitment to social justice and diversity in academic medicine. The founding group included two fellows and three faculty members, one of whom identified as Black, two who identified as Asian-American, and one who identified as Queer. As a first step, the committee administered an anonymous survey to division members to explore perceptions and experiences of social injustice and identify targets for intervention, followed by a virtual division forum to identify and prioritize action items. Although faculty participation was voluntary, division leadership highlighted the committee work and encouraged every member to commit to one action item, individually or with the group. Participation in committee work was also added as an option to fulfill the community participation requirement in our faculty incentive structure.

From these initial discussions, we developed a four-pillared framework for social justice and antiracism work (Figure 1):
1) promoting education on social justice

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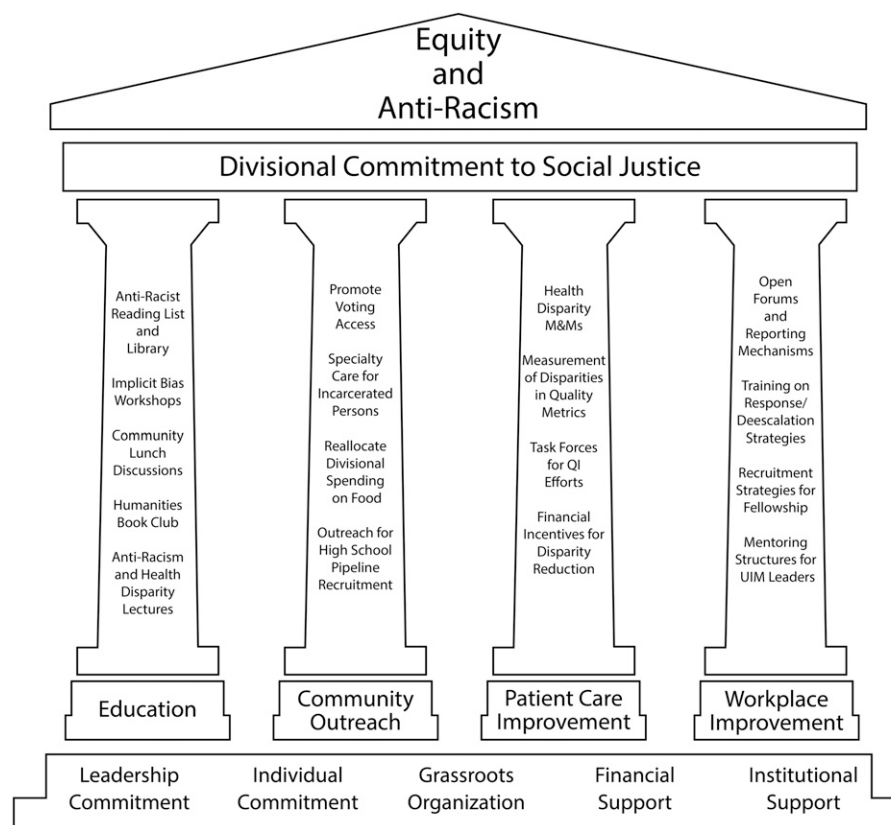


Figure 1. A Framework for divisional commitment to social justice and antiracism. M&M = Morbidity and Mortality Conference; QI = quality improvement; UIM = underrepresented in medicine.

topics, 2) improving community outreach and engagement, 3) restructuring clinical practices to promote antiracism, and 4) fostering an antiracist workplace climate. We introduced our framework and an initial set of action items at a mandatory faculty meeting and report back monthly in the same forum. The framework pillars led naturally to the formation of multiple subcommittees, allowing participants to focus contributions and distribute work. We established monthly planning meetings to report progress in ongoing work, solicit feedback and reassess priorities, and engage new members. All programming is scheduled during working hours, reinforcing commitment to antiracism as an essential job responsibility.

PROMOTING EDUCATION

To promote social justice education, we implemented recurring formal didactic

experiences, structured lunchtime discussions, and a multifaceted informal curriculum. We added two invited talks from university colleagues to our core educational Summer Lecture Series, introducing antiracism and the role of community–university partnerships in addressing health disparities. In addition, we paired three Summer Lecture Series talks—pulmonary function testing; lung cancer screening; and pain, agitation, and delirium management—with lunchtime discussions exploring disparities related to these core topics. These “Community Lunch” discussions, led by a faculty and fellow dyad, continue on a monthly basis, exploring social justice topics in PCCM. In addition, we curated an antiracism reading list and physical lending library with donations and recommendations

from faculty, including resources for families. We established a quarterly Humanism in Medicine book club and facilitated book purchases from a local Black-owned bookstore. In addition to division-wide programming, our fellows organized additional activities, including movie screenings and discussions, to meet the unique needs of their group.

Improving Community Outreach

To improve community outreach and engagement, we identified priority action areas, including promoting patient voting access, advocating for the health of incarcerated persons, and participating in pipeline development activities to promote recruitment from underrepresented in medicine (UIM) groups. We partnered with ongoing health system initiatives to facilitate voter registration, access to mail-in ballots, and emergency voting for hospitalized patients. A subcommittee began developing a program to provide high-level specialty care to incarcerated persons in the local prison health system and established connections for medical record review for compassionate release requests. Another subcommittee collaborated with our community–university partnership center on pipeline development efforts by creating content for local high school programs and facilitating opportunities for summer research and clinical experiences. We also committed to reallocating all divisional catering and restaurant spending to minority-owned local businesses and collaborated with the Department of Medicine leadership to expand minority-owned vendor participation. Although some of these initiatives might be perceived as controversial, we explicitly focused on advocacy for patient health and safety, avoided partisan activities, and

aligned our efforts with programs endorsed at the health system and university level.

Restructuring Clinical Practices to Promote Antiracism

Under the third pillar of our social justice framework, we leveraged ongoing quality and practice improvement systems to begin restructuring our clinical practices to promote antiracism. Our medical intensive care unit leadership council selected measurement of racial disparities in critical care outcomes as a quality target for the year, linking financial incentives to the assessment of disparities in lung-protective ventilation, physical restraint use, sedation and analgesia practices, early mobility, and doctor–patient communication ratings. Ongoing quality improvement efforts will explore the disparities identified and direct countermeasure development. In addition, two of our fellow-led Morbidity and Mortality conferences will focus on patient harm caused by health disparities. We also plan to facilitate ongoing trainings on the use of electronic health record–based quality dashboards to identify and explore health disparities for individual practitioners and clinical program leaders.

Fostering an Antiracist Workplace Climate

Lastly, our committee prioritized improving workplace climate by focusing on training faculty to respond to discriminatory behavior and increasing recruitment of UIM candidates at all levels of our division. Division members led faculty development efforts in the School of Medicine to create and implement a virtual workshop focused on responding to discriminatory patient encounters. The Department of Medicine provided funds to support standardized patients for the course

and administrative support; however, faculty time was not compensated, representing a potential area for improvement. We expanded on previous efforts to recruit UIM fellowship applicants, noting that although the proportion of UIM fellows in medicine subspecialties has increased overall, growth remains stagnated in PCCM (3). Led by our program director, we set and achieved a goal of doubling interview yield for UIM candidates, trained our program leadership in behavioral interviewing, and implemented standardized questions to mitigate implicit bias in interviews.

The initiatives described are only initial steps toward eliminating the structural racism that exists in our—and all—academic medicine divisions. To succeed and sustain, any institution-led antiracist effort requires collective action of the entire community, and, importantly, this work

must not rest disproportionately on underrepresented members. We do not present these initiatives with prescriptive intent, nor do we expect them to be mirrored in their details because the nature of racism within any organization is unique to the context of that community. We argue, though, that our four-pillared framework could be embraced and adapted by many, informed by local community perspectives and experiences. Regardless of the framework applied, these efforts must begin with open ears, a receptive mind, and a willingness to change. Only then can honest, difficult, and practice-changing dialogue begin. And only then can systematic antiracist restructuring be achieved.

Author disclosures are available with the text of this article at www.atsjournals.org.

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