A Roadmap for Diversity in Medicine During the Age of COVID-19 and George Floyd

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J Gen Intern Med 36(4):1089–91
DOI: 10.1007/s11606-020-06430-9

The first case of COVID-19 was reported in America in January of 2020. In the ensuing months, COVID-19 has taken the lives of more than 200,000 people in the USA[1] and upended our current model of medical education and practice. In the midst of a pandemic, hospitals across the country report millions of dollars in economic losses, healthcare providers face furloughs, and medical students sit at home delaying their training indefinitely. The novel coronavirus threatens to disrupt every facet of our healthcare system, and work surrounding diversity, equity, and inclusion in medicine is not immune.

The coronavirus poses three principal risks to diversity, equity, and inclusion within medicine. First, limitations on travel and the necessity of social distancing limit the ability of academic medical centers to recruit students from diverse backgrounds. Second, as medical schools look for avenues to cut spending, budgets related to diversity become particularly vulnerable. Last, COVID-19 threatens to fray the already tenuous social bonds and sense of community experienced by medical students and physicians of color, who commonly report limited mentorship and social isolation.

The novel coronavirus has exacted a devastating toll, and communities of color have been particularly impacted. While the disproportionate burden of COVID-19 on Black and Hispanic/LatinX people renewed a focus on longstanding racial/ethnic disparities in health, the murder of George Floyd has placed a mirror in front of our nation, and the institution of medicine, included, must reckon with its own legacy of discrimination.

The confluence of a deadly pandemic and the long-overdue recognition of the entrenched racism in this country compels the medical field to chart a new and sustainable path forward to ensure that America trains and sustains a diverse healthcare workforce capable of addressing the challenges to health faced by our society. For academic medical centers committed to being part of the solution, the following recommendations may help:

Received June 19, 2020
Accepted December 9, 2020
Published online January 19, 2021

RECOMMENDATIONS

1. *Acknowledge, publicly, how our institutions have been complicit in and advantaged by the systematic discrimination of people of color.* Too often, we confine our understanding of problems to the "other" and deny ourselves the benefit of self-reflection. A sincere examination and discussion of the legacy of racism in our medical institutions is the foundation for conversations surrounding discrimination and its consequent inequities. These critical conversations have the potential to rewrite the social contract between medical organizations and the community and to communicate that our academic medical centers are committed to being active partners in the effort to bring about racial justice.
   The power of these conversations is epitomized by Johns Hopkins Hospital at long last honoring the legacy of Henrietta Lacks whose "immortal" HeLa cells have contributed to countless scientific breakthroughs.[2] In honor of Henrietta Lacks, Johns Hopkins Hospital has created the Henrietta Lacks Symposiums, which annually bring together more than 1000 researchers to discuss ethics in medical research, the Henrietta Lacks Memorial Award, a $15,000 grant to support collaborations between the community and university, and the Henrietta Lacks East Baltimore Health Sciences Scholarship, which gives a graduate of the Paul Laurence Dunbar High School a college scholarship worth up to $10,000 per year to pursue a career in the sciences. Moreover, Johns Hopkins plans to name a new multidisciplinary research building, scheduled to be completed in 2022, in honor of Henrietta Lacks. The deep self-examination at Johns Hopkins forced the entire medical community to reconsider the importance of medical ethics in patient care, the role of informed consent in medical treatment, and the need for regulation over how patient tissue samples are collected for medical research. Importantly, the outgrowth of these conversations continues to benefit everyone, as is common with most work in diversity, equity, and inclusion.
2. *Commit to investing at least 3% of our organizations' operating budget to support diversity, equity, and inclusion.* The true priorities of an organization are often reflected in its budget. On average, many US corporations dedicate 2–3% of their budgets to support diversity

initiatives.[3] While the exact amount of money dedicated to diversity by MD-granting institutions is unknown, institutions of higher education designate only 0.49% of their budgets for diversity efforts.[4] While 3% of a medical school's budget may be ultimately insufficient, it is a reasonable target and one that will initiate an essential conversation concerning the resources necessary to support a just medical workforce.

3. *Cultivate the future supply of talented individuals from diverse backgrounds.* "The pool of talented minority students is small" is a common refrain cited to explain medicine's diversity gap. While this has always been a dubious assertion[5], it obscures medicine's persistent legacy of discrimination, including disparities in pay, promotion, and research funding. Consequently, we challenge medical schools to take ownership of the pipeline (K-16) of diverse candidates prepared to enter the field of medicine. The cost will be high and the time before a return on investment is realized will be long, but this type of action is not without precedent. Houston's DeBakey high school, founded in 1972, is a partnership between the Houston Independent School District and the Baylor College of Medicine with the mission of increasing opportunities for all students to access careers in the health professions. The school has graduated over 6000 students.[6]
4. *Use restorative justice to optimize equity in the learning and work environment*. The persistence of inequitable treatment in medicine[7–15] suggests that the current framework used to address discrimination in medical institutions, which largely focuses on punishing individuals, may be insufficient to address a problem that is both historical and systemic. A restorative justice framework offers an alternative. Restorative justice seeks to repair a harm caused by an injurious behavior or structure in a way that incorporates input for solutions from all stakeholders including the victim, the perpetrator (individual or institutional), and members of the community.[16] Instead of punishment, the goal of restorative justice is to repair and prevent harm. This framework gives voice to those harmed, allows the perpetrator of the behavior to gain a greater understanding of the harm caused, and allows the community to come together to identify future steps for both the victim and the organization in pursuit of a more just community. Often, individuals not directly affected by the negative behavior have a chance to examine their own privilege and their possible contributions moving forward. While uncommon in medicine, restorative justice has been implemented with success at academic medical centers including the University of California Davis School of Medicine, where over 50 staff and faculty have been trained as restorative justice facilitators to address instances of learner mistreatment[16], and Dartmouth Geisel School of Medicine, where healing circles and conferences are used to foster open dialogues about power, mistreatment, accountability, and respect among members of a team.[17]
5. *Educate physicians to address the social determinants of health, including racism*. Raised in Houston's Third Ward public housing, George Floyd was diagnosed with COVID-19 and laid off from his job shortly before his tragic mur**d**er. The intersection poverty, unemployment, and racism all placed George Floyd at greater health risk than his white peers. Upon examining the circumstances of George Floyd's life and death, we must acknowledge that our current model of medical education and practice does not meet the needs of our community.

   Medical care accounts for only 20% of the modifiable contributors to improved health outcomes of a population with the remainder attributed to the social determinants of health.[18] Yet, training to address the social determinants of health is largely lacking in medical education. Any curricular focus on racism is almost nonexistent. Moreover, investments to address the social determinants of health represent only a small fraction of the overall spending by health systems. We must acknowledge evidence, in thought and practice, that addressing the social determinants of health (and not solely the biological determinants of disease) remains the principal intervention to ensure that all people are able to reach their full health potential. Moreover, confronting the legacy of racism in this country, which has been so instrumental in many of the racial/ethnic health inequities present today, must be part of this solution.
6. *Dedicate institutional resources to recruit and retain faculty historically underrepresented in medicine by race and ethnicity.* The benefits of a racially/ethnically diverse faculty are vast and well documented. Physicians of color are more likely than non-Hispanic Whites to practice in areas with a shortage of physicians, to provide care for racial/ethnic minority patients, and to treat patients covered by Medicaid or without insurance.[19–21] Additionally, racial/ethnic minority physicians are more likely to provide leadership in health policy and research related to racial/ethnic disparities in healthcare.[11] The National Academy of Medicine (NAM) has recommended increasing diversity in the healthcare workforce as a crucial intervention to reduce racial/ethnic health disparities[22–25], and the National Institutes of Health (NIH) has recommended increasing the diversity of physician-scientists in an effort to broaden the national research agenda.[26, 27] While uncommon, several major universities have heeded this call to promote diversity and inclusion. In 2016, Brown University announced a $165 million inclusivity plan, with $100 million dedicated to recruiting and retaining diverse faculty.[28] Additionally, a key component of this initiative will be the creation of a new center on race and ethnicity and the establishment of four new tenure track

positions for researchers who study underrepresented communities. In 2017, Columbia University budgeted $100 million dollars for a similar plan.[29] A powerful institutional investment in faculty diversity and inclusion has precedent, and the model begs for replication.

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Compliance with Ethical Standards:

Conflict of Interest: *The authors declare that they do not have a conflict of interest.*

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