ALLIANCE for ACADEMIC INTERNAL MEDICINE

AAIM Perspectives

AAIM is the largest academically focused specialty organization representing departments of internal medicine at medical schools and teaching hospitals in the United States and Canada. As a consortium of five organizations, AAIM represents department chairs and chiefs; clerkship, residency, and fellowship program directors; division chiefs; and academic and business administrators as well as other faculty and staff in departments of internal medicine and their divisions.

Voices for Social Justice and Against Racism: An AAIM Perspective

Patricia W. Finn, MD,[a] Dale Abel, MD, PhD, FACP,[b] Alpesh Amin, MD, MBA, MACP, SFHM, FACC, FRCP (Lond),[c] Mark E. Anderson, MD, PhD,[d] John M. Carethers, MD, MACP,[e] David L. Coleman, MD,[f] Anne B. Curtis, MD, MACP, FACC, FHRS, FAHA,[g] Mark W. Geraci, MD,[h] Mark T. Gladwin, MD,[i] Anthony Hollenberg, MD,[j] Michael S. Parmacek, MD,[k] Richard J. Robbins, MD, FACP[l]

[a]Department of Medicine, University of Illinois at Chicago, Chicago, IL; [b]Department of Internal Medicine, University of iowa, Iowa City, IA; [c]Department of Medicine, University of California, Irvine School of Medicine, Orange, CA; [d]Department of Medicine, Johns Hopkins University, Baltimore, MD; [e]Department of Internal Medicine, University of Michigan, Ann Arbor, MI; [f]Department of Medicine, Boston University, Boston, MA; [g]Department of Medicine, University at Buffalo, Buffalo, NY; [h]Department of Medicine, University of Pittsburgh, Pittsburgh, PA; [i]Department of Medicine, University of Pittsburgh, Pittsburgh, PA; [j]Joan and Sanford I. Weill Department of Medicine, Weill Cornell Medicine, New York, NY; [k]Department of Medicine, University of Pennsylvania, Philadelphia, PA; [l]Department of Medicine, Houston Methodist Hospital, Houstan, TX.

Departments of internal medicine (DOMs) provide a key perspective on the importance of diversity, equity, and inclusion (DEI) within academic medicine. Nationwide, 11% of DOM chairs are from underrepresented groups (URGs) and 17% are women.[1] As leaders, we are responsible for establishing and promoting basic discussions of how we want to lead and communicate our values. Current events compel us as academic leaders to speak out about societal issues that extend beyond our academic domains.

Within medical schools and teaching hospitals, DOMs typically house the largest number of faculty and train the greatest number of students, residents, and fellows in the field of medicine. Our daily hands-on responsibilities impact many, and we acknowledge this impact. Most DOMs have not been successful in developing a culture that promotes DEI. Similar to what occurs in many segments of our society, departments have not sufficiently supported faculty, staff, and trainees from URGs to ensure that the work environment, including interactions with patients, is free from bias and discrimination. We also recognize limited investment in health equity and treatment of diseases prevalent in underrepresented communities.

As leaders, we recognize both our culpability in this regard and our ability to effect change. By committing to self-awareness and role modeling, we aspire to gain a greater understanding of social injustices and health inequalities within and outside our academic walls. For example, as leaders, we may require implicit bias and other forms of training for all members of the department, and committed investment in leadership and programs to enhance DEI. Our active participation on a regular basis in these training sessions is critical not only to our own growth as leaders but also in conveying the critical importance of DEI at all levels of the department. We are committed to learning from the lived experiences of all URGs and to providing

Funding: None.

Conflict of Interest: None.

Authorship: All authors had access to the data and a role in writing this manuscript.

Requests for reprints should be addressed to Patricia W. Finn, MD, University of Illinois at Chicago, 840 South Wood Street, 1020N CSB, M/C 787, Chicago, IL, 60612.

E-mail address: pwfinn@uic.edu

0002-9343/$ -see front matter
https://doi.org/10.1016/j.amjmed.2021.03.008

strategies to eliminate systemic racism within our purview and scope. We have been challenged to step up and step in—and we accept the challenge.

Our commitment to DEI is also compelled by the considerable evidence that organizations with more diverse perspectives and members are higher performing.[2,3] Therefore, departments cannot become truly outstanding without consistently embracing DEI in policies and actions. The key elements of this work are to create a shared organizational purpose by sustainably engaging diverse members; ensuring that different groups have equal standing in contributing to success; and fostering collaboration, self-efficacy, and personal and professional assurance that all viewpoints and perspectives are welcome.[4]

PERSPECTIVES VIEWPOINTS

- Current events have compelled us as academic leaders to speak out about societal issues that extend beyond our academic domains.
- We propose strategies to address health disparities and racism, applicable to trainees, staff, and faculty, and the patients we serve.
- We recognize our outward facing roles in promoting equity in health and health care.
- We provide recommendations for promoting diversity, equity, and inclusion in departments of medicine.

In the next sections, we propose strategies to address health disparities and racism applicable to trainees, staff, and faculty.

TRAINEES

As department leaders, we influence the recruitment and retention of medical students, internal medicine residents, and subspecialty fellows. For all trainees, we stress the importance of listening; in this area we have failed, particularly with individuals from URGs who have lived experiences that may be very different from our own. We acknowledge the many forms of bias and our need to both listen and learn from the experiences of the members of our departments. In parallel, we need to ask our URG trainees for their input regarding these issues and engage these colleagues in finding solutions that can directly address them. It is crucial that we name the issues and remove obstacles toward DEI in a very complete and public way so that these efforts will be different from prior ones.

Trainees have been a critically important source of advice in formulating diversity initiatives, building community among URGs, and in creating linkages to mentors. Most importantly, individuals from the majority groups will need to own the change required to achieve meaningful and durable improvements in the cultures of our organizations. Efforts should include a more inclusive approach to selection of medical students, residents, and fellows that values diversity. Many programs already have this approach in place for selection of students and trainees that do not exclusively or disproportionately rely on, for example, standardized tests as an exclusion or qualifying factor. Several programs perform secondary holistic application reviews to define candidate attributes that may be missed using traditional filters of board scores, Alpha Omega Alpha membership, and letters of recommendation. Admission and selection committee members must not only attend but also champion comprehensive implicit bias and anti-racism training.

Careful accounting and global application of these efforts is necessary to monitor what progress is being made. In several departments, efforts have been made to increase the percentage of URGs in residency, while not targeting specific quotas. These recruitment efforts are often successful numerically, yet evidence of bias in education and training persist; eg, the number of women and URG presenters at medical grand rounds may remain persistently low. Successful efforts to improve the representation of speakers include regular dashboard reporting and adoption of a program to address diversity at medical grand rounds by targeting invitation of women and URGs speakers.

Other strategies include expanded implicit bias training through participation in the Bias Reduction in Internal Medicine program, selection of URG program directors, and institution-wide organized events for URG applicants and trainees.[5] Several DOMs have selected leadership to focus on diversity and inclusion, whether as a vice chair or leader of a council who actively participates in evaluation and recruitment of URG housestaff. Being trained in diverse environments can increase trainee confidence with patients from different cultural groups.[6]

We also underscore the importance of creating robust mentoring pipelines from undergraduate education through training with an eye toward recruiting future faculty. In addition to establishing mentoring programs with goals and metrics, we stress personal and fervent commitment to providing mentorship or finding appropriate mentors that will allow diverse trainees to excel. Critical to the success of the career development of all mentees is sponsorship.[7] For mentees of diverse backgrounds, departmental mentors and leaders have an especially important role in sponsoring access to internal and external thought leaders and groups who can enhance the impact and professional satisfaction of mentees.

Comprehensive training in implicit bias, including bias mitigation, is an increasingly important component of the training of faculty, residents, and fellows in internal medicine.[5,8] However, training alone is

insufficient. We must also equip all DOM members to recognize sources of bias and to possess tools to mitigate bias, in order to develop highly effective and compassionate clinicians and to enhance peer support for colleagues from URGs.

STAFF

Medicine has evolved from a physician-led culture to one that incorporates novel models of team-based patient care in which all team members, including physicians, trainees, advanced practice providers, nurses, and other staff contribute to medical decisions and patient care. At many institutions, there are marked disparities in race and ethnicity and sex and gender among the physician workforce and other health professionals. Our responsibilities include listening to the concerns or suggestions of all of our staff. By listening, we can learn and champion DEI in leading our departments. Continuous learning, ongoing training, and career development are essential for all members of our team. Our staff need a safe and responsive environment to express perceptions of bias, discrimination, or exclusion. Providing transparency and equity in compensation for all employees is essential. Ensuring equitable staffing across practices and encouraging a diverse group of physicians, nurses, and other medical staff to participate in the medical decision-making process and to "practice at the top of license" will help to achieve success and foster a culture that values diversity and inclusion. Efforts to promote the value of teams include participation of trainees, staff, and faculty in wellness surveys and town halls, with evaluation and implementation of feasible ideas. Recognizing staff for their excellence and commitment toward diversity, in a public way, also reinforces this intent and direction of DOM leadership (eg, an annual award to the staff member who most effectively promotes diversity, equity, inclusion, and belonging in the DOM).

FACULTY

Faculty from diverse backgrounds and perspectives enrich the DOM's capacity to achieve excellence in education, research, clinical care, and the mentoring of faculty and trainees. Faculty recruitment should include holistic selection and continuous sustained implementation of anti-bias training for search committees. Although search committees need to include individuals from diverse backgrounds, we need to be cautious and avoid overburdening our URG faculty, staff, and trainees. Mentoring is required at all levels, from junior to more senior leadership, to ensure diverse representation and an inclusive culture at all levels. We encourage DOMs to create faculty leadership positions charged with ensuring that issues related to diversity and inclusion are addressed. Depending on department size and organization, it may be a position such as vice chair for diversity and inclusion or chair of a diversity and inclusion council. Some successful responsibilities and efforts include participation in all faculty searches, organization of leadership training for all URG and women faculty members, mentoring, reporting to a central diversity database on faculty hiring; fostering seminars and activities to highlight commitment to diversity, providing URG faculty social and career network support, and developing a URG scholars program. Other specific examples include longitudinal mentoring programs, networking dinners, book clubs, URG medical student summer programs, DEI-focused grand rounds and seminars, internal faculty development grant programs, and academic writing programs. A growing number of DOMs are also emphasizing the importance of DEI activities by asking faculty to include these activities on their curricula vitae in preparation for academic promotion. Other approaches include peer coaching, virtual town halls to address ongoing issues of race, equity, and inclusion, and dedication of at least 4 (or more) of medical grand rounds to diversity and inclusion.

We also recommend that we move beyond URG recruitment statistics as the only key metric of success and begin to measure and report on URG faculty development and success. We encourage all departments to empower faculty leadership and to create targeted programs to ensure adequate mentorship of all faculty members, with particular emphasis on URG and women faculty members. It is important to recognize the value of social equity and community impact in the academic promotion process. An issue to consider at many institutions is that criteria for promotion are limited to "traditional" metrics of scholarly productivity measured primarily as manuscripts and extramural funding. Promotion criteria at some institutions have been modified to include evidence of having worked to advance health equity and social justice.

Departmental initiatives in DEI must be conducted with an admixture of humility, experimentation, and ongoing evaluation.[9] For example, an assumption that fairness for URGs has been achieved by the establishment of DEI programs can possibly make discrimination more difficult to identify and mitigate.

HEALTH AND HEALTH CARE

Although this statement has focused on issues of diversity and inclusion, we recognize our outward-facing roles in promoting equity in health and health care. Our institutions must be places of healing and innovation, inclusive of diversity. A diverse workforce that is representative of the local population improves quality, access, adherence, satisfaction, and outcomes. For trainees, staff, and faculty, the first step is to listen. As we assess the current diversity among trainees,

staff, faculty, and leaders, and then reflect upon the patient population we serve, the disparity is clear.

Investment in research programs that center on URG-related diseases and health equity serves to enhance the recruitment and retention of faculty committed to these missions. We also recognize that an institution's commitment to equitable health care and the reality may be discordant with each other. This tension may be exacerbated by the fact that medical schools and teaching hospitals need to still function as businesses or other competing issues within their communities. Strategies to recognize and resolve this tension includes continuous community dialogue and engagement. Concerted efforts to ensure that the workforce reflects our community and to expand health care for the underserved are critical and require investment. For example, at several sites, the health system funds county programs and provides millions of dollars in unfunded care. The health system also supports specific shelters and clinics that care for underinsured persons. Methods to build trustworthiness and the trust of URG communities and communities of limited resources must include transparent strategies to provide quality and equality of care, including an investment of service in local communities. We must commit to speaking up and to encouraging our departmental leaders to speak up regarding the importance of racial, gender, and religious equity. We can measure our progress by creating dashboards so that progress can be followed, with solutions and strategies that are all-encompassing. Institutions can recognize and celebrate progress of teams that promote health equity by annually awarding a culturally responsive health care award delivered during a public lecture during Human Rights Week. A diverse organization is a high-performing organization.

The COVID-19 pandemic has highlighted longstanding inequities in health care in communities of color.[10] These issues extend beyond medical schools and teaching hospitals into the domains of government and health care policy. Notably, we stress that the leaders of our institutions should voice our concern about these issues and publicly advocate for support to address these disparities. Although the causes of disparate health outcomes are only partly related to disparate health care, university-based departments are often ideally positioned to address the root causes of health

Table Recommendations for Promoting Diversity, Equity, and Inclusion in Departments of Medicine

Diversity
- Use diversity dashboards to track performance ("inspect what you expect")
- Establish diversity goals for the department, section, or unit
- Allocate resources to support diverse candidates (e.g., training stipends, recruitment packages, and endowed professorships)
- Proactively recruit URG faculty, staff, and trainees by allocating resources to this endeavor
- Bias training for search committees
- Search committees comprised of members from diverse backgrounds and perspectives
- Develop early-stage pipeline programs for high school and college URG students
- Utilize mixed methods (e.g., climate surveys and qualitative interviews) to evaluate the culture in the department
- Empower departmental leaders (e.g., vice chair for faculty development and diversity, chair of diversity, and inclusion council) to develop an array of programs to support and develop faculty from URGs
- Develop longitudinal mentoring programs targeted to the needs of diverse groups
- Ensure sponsorship is effectively conducted on behalf of URGs
- Include activities and accomplishments in promoting DEI on CVs in the promotion process
- Carefully review communications to ensure that terminology and descriptions are welcoming to individuals of diverse backgrounds

Equity
- Conduct bias reduction and bystander training for faculty, staff, and trainees
- Systematically review faculty salaries and compensation plans for causes and evidence of inequity or bias
- Create safe and anonymous reporting mechanisms to identify discrimination
- Review academic promotion process to broaden standards of excellence and to minimize bias
- Advertise all administrative and leadership positions to internal and external groups to ensure equal access

Inclusion
- Enhance skills of majority to be effective and consistent allies of URGs through training
- Create awards for faculty, staff, and trainees that recognize outstanding contributions to DEI
- Social networking events (e.g., dinners and outings) to build community among URG faculty, staff, and residents
- Peer mentoring or "buddy" systems to engage with new URG faculty to help them integrate into the departmental community

CVs = curricula vitae; DEI = diversity, equity, and inclusion; URG = underrepresented groups.

disparities and to deploy implementation science and novel models of care delivery to modify systems of care to reduce inequitable health outcomes. For example, several programs have utilized community health workers to improve access to care and health care cancer screening in URGs. The COVID-19 pandemic has engendered unique opportunities to address health inequity in the delivery of vital care.

As leaders, we are responsible for establishing and promoting basic discussions of how we want to lead and communicate our values. We have learned from each other in this time of a pandemic and racial reckoning. Diversity, inclusion, and anti-racist efforts are health care issues that are in our lane (Table). It is now time for DOMs within medical schools and teaching hospitals to embrace inclusive excellence for comprehensive organizational change.[11]

References

1. Association of American Medical Colleges. *Department chairs by department, sex, and race/ethnicity*. 2019. Available at: https://www.aamc.org/media/41546/download. Accessed January 21, 2021.
2. Smith-Doerr L, Alegria SN, Sacco T. How diversity matters in the US science and engineering workforce: a critical review considering integration in teams, fields, and organizational contexts. *Engaging Sci Tech Soc* 2017;3:139–53.
3. Gomez LE,, Bernet P. Diversity improves performance and outcomes. *J Natl Med Assoc* 2019;111:383–92.
4. Bernstein RS, Bulger M, Salipante P, Weisinger JY. From diversity to inclusion to equity: a theory of generative interactions. *J Bus Ethics.* 2020;167:395–410.
5. Chapman EN, Kaatz A, Carnes M. Physicians and implicit bias: how doctors may unwittingly perpetuate health care disparities. *J Gen Intern Med* 2013;28(11):1504–10.
6. Tedesco LA. The role of diversity in the training of health professionals. In: Smedley BD, Stith AY, Colburn L, Evans CH, eds. *The Right Thing to Do, The Smart Thing to Do: Enhancing Diversity in the Health Professions: Summary of the Symposium on Diversity in Health Professions in Honor of Herbert W. Nickens, MD.* Washington, DC: National Academies Press (US); 2001. Available at: https://www.ncbi.nlm.nih.gov/books/NBK223627/Accessed. Accessed January 21, 2021.
7. Raphael JL. The role of sponsorship in achieving workforce diversity in academic pediatrics. *Pediatrics.* 2019;144(2):e20191532.
8. Carethers JM. Toward realizing diversity in academic medicine. *J Clin Invest.* 2020;130:5626–8.
9. Dover TL, Kaiser CR, Major B. Mixed signals: the unintended effects of diversity initiatives. *Soc Issues Policy Rev* 2020;14:152–81.
10. Newman LA, Winn RA, Carethers JM. Similarities in risk for COVID-19 and cancer disparities. *Clin Cancer Res* 2021;27:24–7.
11. Williams DA, Berger JB, McClendon SA. *Toward a Model of Inclusive Excellence and Change in Postsecondary Institutions*. Washington, DC: Association of American Colleges and Universities; 2005.