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Academic medical centers need to go beyond statements condemning racism

By Wari Allison April 22, 2021

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As predictable as mushrooms popping up after rain, condemnation of racism from leaders at academic medical centers and acknowledging it as a public health crisis began emerging almost moments after a Minneapolis jury found former police officer Derek Chauvin guilty of murdering George Floyd on Tuesday.

There's no doubt that speaking out against racism is valuable. But it often isn't backed up by effective leadership to enact policy changes that will actually combat institutional racism.

I'm Black, a woman, an immigrant, an academic, a scientist, and a physician. The world of academic medical centers is one in which personally mediated racism, internalized racism, and institutional racism thrive[2]. It is an environment in which I and others like me are not only subject to racism but witness the consequences of it for the patients we serve.

Antiracism statements by academic leaders often include links to resources such as counseling programs, microaggression training, and platforms for reporting discrimination. While important, these put the onus to act on the victims and the witnesses — get counseling to cope, report it, intervene. While helpful, those are the wrong groups to target. Department chairs, division heads, deans, program directors, and C-suite executives are the ones who need to be involved in driving institutional change.

To counter institutional racism at academic medical centers, leaders must do far more than make antiracism statements. Action is needed at the institutional policy level. Borrowing an acronym[4] usually used for goal-setting, antiracism actions should be SMART (specific, measurable, attainable, realistic, and time-bound), I have four practical recommendations for academic leaders seeking change.

First, make sure your antiracism statements include definitive actions that have been taken or will be taken to combat racism at the policy level at your organization. These include, but aren't limited to, antiracism plans developed by every department; mitigation of barriers to recruitment[5] of not just minority faculty, but of minority faculty to executive leadership positions; implicit bias assessment and workshops[6] for every individual participating in medical student, intern, resident, fellow, and faculty selection processes; and committing significant financial resources[7] to racial equity and justice research.

Second, compensate, reward, and recognize[8] the diversity, equity, and inclusion work done by minority faculty members. That work consumes our time and often our emotions. We do it because we feel responsibility as minorities in predominantly white spaces to make things better and easier for the next generation. We do it because we are asked to and because if we don't, often no one else will. We do it in addition to our other academic responsibilities and we do not get recognized for it when it comes to promotion and tenure[9]. That should change.

Third, stratify deidentified patient outcome data available regarding the clinical services the medical center provides not just by race and ethnicity but by ZIP code within the institution's catchment area. ZIP codes predict life expectancy[10] and health. Use this information to pinpoint where institutional resources are needed to combat racial inequity[11], which is inextricably intertwined with health inequity. This information does not have to be made publicly available, but it should be discussed when major financial decisions regarding clinical services are made and should influence those decisions.

Fourth, send an anonymous survey to every trainee and employee to gather information that will be used to start conversations about their experiences in relation to racism and diversity. You may find that as an institution you are not doing as well as you think you are. Be ready to have hard conversations based on what you find.

Being an antiracist organization takes more than having a diversity officer, an Office of Diversity, Equity, and Inclusion, mandatory microaggression or cultural sensitivity training, and statements of condemnation after a Black person is killed by the police or an Asian American person is assaulted or verbally attacked[12] by someone spewing hateful rhetoric. Without action that leads to institutional policy change such as recruiting and supporting minority faculty and the use of health outcome data to geographically target clinical services, antiracism statements from leaders in academia are just window dressing.

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