VIEWPOINT

# Academic Medicine and Black Lives Matter
## Time for Deep Listening

**Clyde W. Yancy, MD, MSc**
Northwestern University, Feinberg School of Medicine, Division of Cardiology/Department of Medicine, Chicago, Illinois.

**Echoes of** "medicine as the noble profession" continue to resonate, now 35 years since my legendary Chair of Medicine imbued me with this guiding ethos. Nobility in medicine is not obsolete; the selflessness, courage, self-sacrifice, and altruism on gallant display in the response to COVID-19 reassures that at its core, this ethic of egalitarian service remains intact and deeply established in the DNA of physicians worldwide, including the ranks of academic medicine. But now, a new test of this nobility has emerged.

The killings of George Floyd, Breonna Taylor, Ahmaud Arbery, Rayshard Brooks, Tony McDade, and others have placed racism, especially anti-Black racism, as an ever-present painful reality in the collective social conscience and have vigorously galvanized Black Lives Matter. Academic medicine has not been immune from the influence of this intensely spirited movement. #WhiteCoatsforBlackLives and #ShutdownSTEM are highly visible exhortations to raise awareness of racism on the campuses of academic medical centers. Accompanying statements acknowledge that science needs to "look in the mirror" and make space for people of color to lead laboratories that publish great science and produce influential scientists.[1] As one accomplished Black scientist queried: "How much creativity are we leaving on the table?"[1] These symbolic efforts and pensive statements have recently been joined by poignant student-generated protestation statements received by leadership of major academic medical centers with the expectation of explicit action focused on racial equity in academic medicine. This groundswell chorus arguing for change cannot be quieted. Leaders in academic medicine are committed to respond; as a former Black medical student 38 years prior, I am emboldened to applaud.

> All physicians, and particularly those in academic medicine, can and should address racial equality and engage with Black Lives Matter because atonement matters; culture matters; evidence matters; and leadership deeply matters.

These statements and actions mirror what is noted in the broader society: today's protests are unlike those of the 1960s or any prior moment of remonstration; *not a race but a generation is expressing concern* and seeking both a response and a set of intentional actions to expunge racism from medicine. Yet, before proceeding, important questions are necessary; is focusing on academic medical centers an indirect consequence of the universality of concerns in US society? Has academic medicine been caught up in the fury of the moment? Or is there a pressing question of racism in academic medicine?

As Cooper has asserted, health care systems that include academic medicine are a microcosm of society. Social movements and questions of social justice permeate discovery science and education.[2] Williams and others have defined racism as "an organized social system in which the dominant racial group, based on an ideology of inferiority, categorizes and ranks people into social groups called 'races' and uses its power to devalue, disempower, and differentially allocate valued societal resources and opportunities to groups defined as inferior."[3] This definition is an eloquent statement but requires a personal firsthand translation. As a child, racism makes you feel lost and afraid; as a young adult, racism leaves you on the outside looking in; as a young aspiring professional, racism makes you start at the back, work twice as hard, for half as much; and as a mature adult, racism makes your soul grieve. Williams and Cooper have strongly suggested that cultural racism leading to disinvestment in marginalized communities drives (adverse) social determinants of health and subsequent health disparities.[4] The multiple dimensions of racism—cultural, institutional, personal—complicate the discussion and obfuscate responses, but the concern is real and the need to respond is compelling. Several truisms confirm this concern and require active engagement of academic medicine in the attainment of racial equity.

The first truism is that racism is present in academic medicine. Consider the biographies and histories of Daniel Hale Williams, the Tuskegee study, Henrietta Lacks, Charles Drew, and many others that highlight contemptible segregation, bias, and racism throughout the history of medicine. These are not regrettable past deeds of only historical consequence, but milestone events that remain consequential. History, per se, defines culture and culture defines behavior. What exists today as the infrastructure for scientific discovery and medicine reflects structural racism that has evolved from a biased, stained, and oppressive history against Black individuals. If for no other reason than atonement, not for the many people who have been affected by racism in academic medicine, but for the many generations that have been aggrieved by structural racism in medicine, addressing racial equity is a just cause for academic medicine. It is absolutely the right thing to do.

**Corresponding Author:** Clyde W. Yancy, MD, MSc, Northwestern University, Feinberg School of Medicine, Department of Medicine/Division of Cardiology, 676 N St Clair, Ste 600, Chicago, IL 60611 (cyancy@nm.org).

The second truism is that academic medical centers exercise an outsized influence in the practice of medicine. The patients cared for in academic centers in the US reflect a disproportionately small percentage of patients receiving care across the nation. Yet the majority of physicians in practice today receive training from academic medical centers or the aligned affiliates. Thus there is a responsibility to provide not only the biology but also the sociology of medicine. Those who argue that the ills of society have no place in medical education are abjectly wrong; for proof, simply walk the corridor of a COVID-19 unit. Medical students and early career physicians inculcate lessons learned both academically and experientially as foundational pillars in the practice of medicine. Nothing will change in the practice of medicine if that change is not initiated, promulgated, and sustained by academic medicine and championed by the leaders of academic medicine. A new rumble needs to be heard in the alcoves of academic medicine.

The third truism is that what works is simply not clear. In the haste to achieve racial equity in medicine, many are rushing to embrace the same strategies: implicit bias testing; bias mitigation seminars; cluster hiring of diverse faculty members; eliminating any evidence of race-based medicine from curricula; hiring of chief diversity officers; no longer reporting race in research reports. Yet, where is the evidence that such strategies achieve the desired goal? What is the cost to already stressed budgets, and overworked faculty, and are these efforts sustainable? If there were guidelines to inform how best to achieve racial equity in academic medicine, what would be the class of recommendation and the level of evidence? The evidentiary basis for effective strategies to attain racial equity is disappointingly thin arguing for pause before widespread implementation.

But it is precisely because of the paucity of data that academic medicine must be responsive. Academic medicine owns the responsibility of evidence generation, but in this domain has failed miserably. As Carnethon et al have asserted, academic medicine has also failed the investigators who intend to study disparities and racial equity.[5] Considering the health-related consequences of racism in medicine, number of lives lost, and annual health care expenditures, how can this persistent evidence void be allowed to continue? The absence of evidence to achieve racial equity should not be bemoaned and the absence of talented Black clinicians and scientists to diversify faculties should not be cited if academic medicine has been unwilling to execute the science and commit to the training.

The fourth truism is that within the ranks of academic medicine new leaders are identified, mentored, and then vested in new roles of leadership for hospitals, medical schools, and large health care entities. Leadership matters. Culture change, especially of this magnitude, is a top-down process. Budgets, as authenticated and established by leadership, represent a moral contract with the communities that institutions serve. Policy, as it directly affects education, research, and health care delivery, determines how high-priority functions are actualized. Mission, as the guardian of purpose of an academic medical center, establishes the rules of engagement and the metrics of success. When Black persons are not in leadership positions, not in the C-suite, and not even candidates to enter leadership training, the likelihood that budgets, policy, or mission will ever fully embrace racial equity becomes nil; history will continue to dictate the future.

Given these 4 truisms, an argument evolves validating the engagement of academic medicine in the attainment of racial justice. Academic medicine, and especially the leaders of academic medicine, should harken the construct of Polite et al[6] targeting cancer injustice: "...What should no longer be tolerated is the misguided belief that the problem is too difficult to solve, cannot be solved, or that it is due to the affected person's genes or inaction. Public health evidence to the contrary is too compelling, and condoning such excuses violates fundamental principles of equality."

I concur; the fundamentals of equality should be respected; the problem is solvable. Listen deeply to the plaintive calls for change; to heed these petitions could be among the finest moments in medicine. All physicians, and particularly those in academic medicine, can and should address racial equality and engage with Black Lives Matter because atonement matters; culture matters; evidence matters; and leadership deeply matters. This is how the problem will be solved.

Medicine is the noble profession but now, perhaps more than ever before, that nobility will be put to the test.


## ARTICLE INFORMATION

**Published Online:** June 30, 2020. doi:10.1001/jama.2020.12532

**Conflict of Interest Disclosures:** None reported.


## REFERENCES


1. Thorp HH. Time to look in the mirror. *Science*. 2020;368(6496):1161. doi:10.1126/science.abd1896

2. Cooper LA, Beach MC, Williams DR. Confronting bias and discrimination in health care: when silence is not golden. *JAMA Intern Med*. 2019;179(12):1686-1687. doi:10.1001/jamainternmed.2019.4100

3. Williams DR, Lawrence JA, Davis BA. Racism and health: evidence and needed research. *Annu Rev Public Health*. 2019;40(40):105-125. doi:10.1146/annurev-publhealth-040218-043750

4. Williams DR, Cooper LA. COVID-19 and health equity—a new kind of "herd immunity". *JAMA*. 2020;323(24):2478-2480. doi:10.1001/jama.2020.8051

5. Carnethon MR, Kershaw KN, Kandula NR. Disparities research, disparities researchers, and health equity. *JAMA*. 2019;323(3):211-212. doi:10.1001/jama.2019.19329

6. Polite BN, Gluck AR, Brawley OW. Ensuring equity and justice in the care and outcomes of patients with cancer. *JAMA*. 2019;321(17):1663-1664. doi:10.1001/jama.2019.4266