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Report to the Faculty on Social Justice Initiatives at the Feinberg School of Medicine

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Introduction

In the late Spring of 2020 the Feinberg School of Medicine received ardent inquiries from students, residents, and faculty about the social injustice of institutional racism. Medical schools of a certain age harbor gloomy memories of racial, religious, and gender bias in spite of purging many former inequities from admissions, graduate training, state licensing, and hospital privileging once part of that checkered past[1]. Academic medical centers everywhere are making time to reflect on these painful issues, particularly in light of widespread reports of racial insensitivity and violence to Blacks and other minority communities across the country. A fresh look at our ecosystem now feels urgent and prudent.

Learning organizations like schools of medicine create more equity by fully comprehending the holistic determinants of human health, identifying behaviors that foster unfairness, teaching critical principles of social justice in the classroom and bedside, and ensuring local culture is thoughtfully committed to change. Feinberg must join in this work to be a place where all students, trainees, faculty, and staff can thrive and evolve. This evolution depends on continuous quality improvement. Mitigating lingering vestiges of institutional racism means addressing things previously overlooked in the busyness of our everyday lives.

For purposes of this commentary, one can think of institutional racism as Camara Jones at Harvard defines it—as a problem of differential access to society's goods, services, and opportunities by race[2]. More specifically, for a school of medicine whose principal function is to professionally train the next generation of physicians, scientists, and allied health care professionals, have we unintentionally maintained barriers to fair access and advancement by race? These barriers might encompass perceptions of implicit bias, insensitivity in the way we refer to race in our clinical work and teaching, making insentient judgements during the evaluation of students and trainees, providing less than optimal attention to community needs, or ignoring lagging representation of diversity across the school.

Diversity refers to the composition of our trainees and workforce and inclusion is about culture. Are we aiming to approximate a workforce that reflects the populations we serve? Are we able to leverage a diversity of thought that comes from a myriad of opinions around various decision tables? Is our culture welcoming and inclusive for all? Have we listened to the quiet voices that are marginalized in our community? And do we unintentionally create an environment that makes members of our own workforce feel disaffected and unable to thrive?

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[1] *The Social Transformation of American Medicine*, Paul Starr, Basic Books, 1982

[2] C. P. Jones, Levels of racism: A theoretic framework and a Gardener's tale. *American Journal of Public Health*, 90:1212-1216, 2000.

Professionalism requires we take an introspective lens to who we are and respond appropriately. Although change is an iterative process, we can evolve our culture to a more representative, aware, and inclusive space. To that end, four advisory groups comprising faculty, staff, student, and residents were formed this Summer to deliberate on how we might move forward; I am especially grateful to all those who participated in this effort[3]. These advisory groups included:

- Advisory group on microaggressions, use of race in lectures, clinical presentations, and laboratory algorithms
- Advisory group on evaluation bias
- Advisory group on strengthening our community engagement
- Advisory group on faculty recruitment

Snapshot of Current State

As part of level setting, the school of medicine annually reviews a set of metrics and programs related to diversity and inclusion, and already has systems to track a wide variety of data related to programs for those under-represented in medicine (URM). We also have a website for our programs creating opportunities for communities of need in Chicago.

The number of self-identified URM faculty has increased by 219% in the last nine years (currently 177 faculty). The school of medicine currently requires, prior to beginning a search for a new faculty member, that an equity representative is identified on the search committee by the chair; submission of a Chair Recommendation for new faculty appointments must identify that individual. Twenty-three URM faculty hold 29 leadership positions in the school, including 8 who hold 9 decanal titles. Medical student diversity in the class of 2024 is 23% with 8% LGBTQ. Twenty-one percent of our entering residents are also URM. The percentage of domestic URM students in The Graduate School is 22%; 15% if one includes international students in the denominator. The percentage of staff at Feinberg that self-identify as URM is also 22%.

Feinberg established an Office of Diversity and Inclusion (ODI) for students many years ago

[3] Sarki Abba Abdulkadir, Ronald Ackermann, Jennifer Ann Adrissi, Precious Akanyirige, Luisa Iruela-Arispe, Juana Ballesteros, Daniel Jay Brat, Jen Brown, Oluwateniola Brown, Serdar Bulun, Mercedes R Carnethon, Heather L Campbell, James Carr, Howard Chrisman, James Chandler, Rex L Chisholm, Howard Chrisman, Deborah Clements, Elsy Compres, Zachary Meyer Cross, Matthew Davis, Matthew Davis, Brigid Dolan, John E. Franklin MD, Patricia Garcia, Alfred George, Cybele Ghossein, Maya Jackson-Gibson, Joshua L Goldstein, Marianne Green, Ruchi Gupta, Khalilah Gates-Hill, Namratha Kandula, Kiarri N. Kershaw, Dimitri Krainc, William Lowe, Kelly Michelson, Nicole M Mladic, Linda Rae Murray, Brian Mustanski, Muhammad Yazid Mutawakkil, Nonye Nadia Ogbuefi, Ramael Osasogie Ohiomoba, Ike Okwuosa, Amy Paller, Minoli Perera, Matias Evaristo Pollevick, Susan Quaggin, Ana Marie Reyes, Sandra Maria Sanguino, Ted Schaeffer, Christine Schaeffer, Melissa Simon, Dinee Simpson, Farzaneh Sorond, Linda Suleiman, Dalton James Surmeier, Jacob I Sznajder, Darius Tandon, Linda A Teplin, Melvin Thompson, Oanh Hoang Truong, Grant Upson , Douglas Vaughan, Nicholas Volpe, Diane Bronstein Wayne, Clyde Yancy, Betina R Yanez, Quentin Youmans, Phyllis C Zee, Inger Burnett-Zeigler.

as an early commitment to equity. Since 2015 it has been led by a Vice Dean for Diversity and Inclusion with a broader charge recognizing a variety of needs across Feinberg. This highly effective office has done a superb job in advancing the mission of social justice through new program offerings.

An arc of engagement from secondary school to professional life is supported by ODI's Diversity & Inclusion Council, informative Lyceum Speakers, interactive Town Hall meetings, vibrant website, and quarterly newsletter. Importantly, ODI is the purveyor of the Sustained Dialogue® resource which creates a safe space for students and, most recently, staff. There is close alignment between the Augusta Webster Office of Medical Education (AWOME) and ODI on these pro-diversity & inclusion strategies.

Through the interest of many faculty and staff, the school of medicine has sponsored or assisted the launch of a number of new pipeline programs. For the last three and a half years, Feinberg has served as an internship site for the Chicago Year Up program to train and mentor minority or low socioeconomic background high school graduates to enter our administrative workforce in finance, research administration, or information technology; so far, nine interns have been hired into full-time positions. The school of medicine also sponsors space for the national alumni office of the National Medical Fellowship program providing URM scholarships.

For high school students, we are entering the 11th year of the Northwestern Memorial HealthCare (NMHC) pipeline program with George Westinghouse College Prep, a Chicago Public School. The Cancer Center, Pulmonary and Nephrology Divisions, and the Women's Health Research Institute all run summer pipeline programs as well. Our NUDOCS program is designed for our own Northwestern undergraduates with an interest in medicine who are then invited to spend the spring quarter break in active Feinberg faculty-led mentoring programs on the Chicago campus, mirror course work experienced by M1 students, and MCAT preparatory work.

Similarly, faculty participate in NMHC/Feinberg engagement programs for college premedical students, and separately, ChicagoCHEC (Chicago Cancer Health Equity Collaborative) brings students from the Chicago network of community colleges into an active career preparation mentoring program. The Northwestern University Clinical and Translational Sciences (NUCATS) Institute provides a summer research program for graduate students from two minority serving institutions, Northeastern Illinois University and Chicago State University; many of these students have successfully initiated PhD programs. The school of medicine also supports the Student to Resident Institutional Vehicle for Excellence (STRIVE) program that mentors URM students to become strong residents and fellows; six individuals now have faculty positions at Feinberg.

For residents and fellows, the Northwestern Underrepresented Minority Residents and Fellows Forum provides an excellent resource for professional and social networking. The recently launched Daniel Hale Williams Society supports URM recruitment and retention and the school has developed a pathway with the Northwestern Medical Group (NMG) for talented URM residents and fellows to receive early offers to join the clinical faculty. Through ODI, the school of medicine also has a strong working relationship with the Medical

Organization for Latino Advancement (MOLA). The newly established Minority Faculty Association offers yet another arc of networking for our URM faculty.

In parallel initiatives, Feinberg has active programs to support community engagement under the umbrella of the Institute for Public Health and Medicine (IPHAM), and now has joined a Chicago campus-wide program that encompasses the extensive network of community-based initiatives sponsored by NMHC and Lurie Children's Hospital. Examples include several initiatives combating homelessness emanating from the Department of Emergency Medicine, and strong partnerships with leading congregations on the South Side fueling new anti-violence initiatives and greater disease awareness. Finally, the recent announcement of a planned NMHC outpatient facility in the Bronzeville area of Chicago will provide another new touch point.

Advisory Group Recommendations

So, what else can we do to mitigate unexplored remnants of institutional racism to improve the lives of our core community of students, scholars, faculty and staff? The intention in establishing four advisory groups was to broadly engage the Feinberg community and provide the school of medicine with a menu of new practical interventions suitable for implementation. This menu of recommendations has been considered and categorized as Tier 1 or Tier 2 initiatives (see Appendix), based on those that could be implemented with available resources and infrastructure to make immediate impact. This report focuses on plans to implement Tier 1 recommendations (**bolded below**) as pilot programs to improve our environment and culture; a few scattered overlapping Tier 2 ideas are incorporated into the Tier 1 recommendations. When fully developed through experience, they can be expanded where needed:

- ***Remove race from all clinical presentations and lectures across all levels of trainee education and clinical practice. This includes all rounding, daily progress notes and case conferences***.

Our understanding of race as a proxy for genetic variation and its use in medical education, research, and clinical practice continues to receive widespread scrutiny. Self-reported race is a social construct without clear biological meaning; its improper use encourages the transmission of misinformation[4]. Since the welcome demise of anti-miscegenation laws in this country some five decades ago, the residual prevalence of genetic variants based on assortative mating within races will almost certainly lose predictive value for any individual over time. Reliance on race as a surrogate marker of genetic ancestry or unsubstantiated differences in physiology and disease is quickly becoming a *non sequitur* and should be minimized in teaching and the practice of medicine. Self-reported race, on the other hand, is still a useful social construct for studying the prevalence of adverse determinants of population health or socioeconomic disparities until better methodology evolves.

[4] Yudell, Roberts, DeSalle, and Tishkoff, Taking race out of human genetics, *Science* 351:564-565, 2016.

In terms of general guidance, we should thoughtfully care for patients, as they present, without using race to infer social judgements that risk treatment bias. The same applies to our conferences and presentations. When preparing presentations to students and trainees, all faculty, residents, and fellows must use the Inclusive and Bias Free Curriculum Checklist. When the mention of race adds awareness to a discussion in the undergraduate medical education (UME), physician assistant, physical therapy, or graduate medical education (GME) curricula, it should be well explained from an epidemiologic or socioeconomic perspective. The school will work with various educational units to achieve full assurance.

- ***Create a campus wide bias reporting portal for all staff, students, residents, fellows and faculty that is reviewed by a Bias Incident Response and Education Team that will report to the Vice Dean for Academic Affairs.***

Decanal faculty, department chairs, institute directors, clerkship directors, and residency program directors have already received implicit bias training. Later this year, all faculty and staff will receive similar training. Educational bias reporting in UME occurs currently through a student portal where a concern about implicit bias can be reported in real time during lectures, small group sessions, clinical experiences, and other presentations. These reports are reviewed currently by the Task Force for Inclusion and Bias in AWOME. Educational bias reporting in GME occurs through an anonymous McGaw portal and is reviewed currently by the Senior Associate Dean for GME and the Graduate Medical Education Committee (GMEC). The school of medicine will expand educational bias reporting to the physician assistant, physical therapy, prosthetics/orthotics, and graduate programs, and establish a common mechanism for reviewing this bias reporting using a small group comprising the Vice Deans for Diversity and Inclusion, Education, and Academic Affairs. The school of medicine will also identify, train, and support a faculty member to be a content expert on implicit bias. This individual will provide annual training in implicit bias to new faculty, students, residents, and fellows. Unconscious Bias training is available to staff through Human Resources.

- ***Review all algorithms based on race used in laboratory reporting. For example, providing a range for estimated GFR (eGFR) reporting, one of many race-based clinical algorithms, and offer education in its use and interpretation until the recommendations of the national task force on this metric are available. We recommend each department review and reassess all race based clinical algorithms and report recommendations to the Dean.***

Embedding race into clinical algorithms is potentially fraught with inadvertent errors, as they may propagate unintended race-based medical attitudes or direct uneven attention or resources to a specific racial or ethnic group. eGFR, for example, is potentially one of the most visible elements of racial distinctions in medicine and has received much attention nationally. Use of eGFR is currently under review by the American Society of Nephrology and National Kidney Foundation with plans for a national recommendation later this year, and the school will await their consensus view. The school will also ask each department to identify all race-based algorithms in current use for teaching or clinical purposes and ask for

concrete justification of their applicability based on broadly accepted evidence or consensus nationally.

- ***Support a deeper focus on community centering in the curricula of all student, resident, and fellowship (clinical and non-clinical) training programs***

The school will ask those responsible for curriculum in our many programs and the Institute for Public Health and Medicine (IPHAM) to look at ways to expand emphasis on disparities in health care or service learning within underserved communities.

The school will also ask IPHAM to build on the structure of the Alliance for Research in Chicagoland Communities (ARCC) by using its steering committee as an advisory council to make other recommendations as opportunities arise. Community-centered curricular elements should be designed and implemented with community participation to ensure they reflect benefit for community residents, organizations, and neighborhoods. Community experts will be contracted to provide some course content in areas such as the history of structural racism in Chicago and its relationship with the health profession, healthcare access, and outcomes. The 1619 education project is one example of curriculum that could be embedded throughout student and trainee programs.

AWOME will arrange to make resources in conversational medical Spanish available to those students and McGaw residents who want second language skills. Students and trainees that provide clinical service should have opportunities to spend time learning from and working in communities that are disadvantaged. Forty percent of our student outpatient clinical experiences through Education-Centered Medical Homes (ECMH) attend underserved patients and Feinberg will work with NMG to create more of these clinics where we can. Some community opportunities also exist through Area of Scholarly Concentration (AOSC) activities; these can be expanded using IPHAM as a resource. Students who organize or meaningfully participate in volunteer activities in underserved communities will be recognized annually at Founders Day.

- ***Identify, cultivate, promote, and recruit URM McGaw/FSM residents and clinical and research fellows to the faculty. This effort will be accompanied by the development and implementation of an early career recruitment/career development program.***

- ***Establish an interdepartmental URM recruiting and mentorship-to-leadership program***

- ***Targeted recruitment of senior URM faculty, which will be aided by the development of the capacity for expedient, nimble approach to identifying candidates and extending offers.***

The number of additional URM faculty we can recruit is somewhat hampered nationally by a historically stagnant pipeline of basic science-oriented post-docs or clinical residents and

fellows finishing their GME training, wide interest in retaining such individuals at their home institutions across the country, and the many career choices available that do not include academic medicine. Nevertheless, the strength of our institution and the city of Chicago should leverage our ability to recruit junior URM candidates to join the faculty. For senior faculty candidates outside Northwestern Medicine, we will ensure quality offers are made to attract new faculty where identified.

Although there already is a pathway within the Northwestern Medical Group (NMG) for talented URM residents and fellows to join the clinical faculty early, the investigator track has seen less growth in URM physician-scientist faculty. To address this latter issue, the school of medicine will offer two annually funded positions through the Starzl Academy to support URM clinical fellows for three years beyond ACGME training in order to immerse themselves in a well-funded research program to develop skills and sufficient data to successfully compete for a K-award followed by appointment to the investigator track at the school of medicine.

The school will also ask the ODI to sponsor a meeting every year for two years, and then every other year, for diversity representatives from each department to share interdepartmental initiatives regarding URM hiring and retention or special department programs that have been effective in encouraging diversification.

- ***FSM faculty development resources must be expanded and supported to include content expertise on diversity, equity and inclusion with specific attention to training on strategies for elimination of implicit bias during assessment and evaluation. Leadership must foster a culture where participation in these efforts is expected.***
- ***Require and support a deeper focus and increased expectations for community engagement across Departments and their faculty. Increase recognition and rewards for community and health equity scholarship across every FSM faculty track and department.***

The issue of implicit bias has already been addressed above. The school has also launched two new program through the Office of Academic Affairs called NU-AIMES for mentoring department-based faculty who are Clinician-Educators and LEAP@Feinberg to help equip junior faculty with leadership skills including those surrounding culture and diversity. The school of medicine will encourage departments to develop their own or, in the case of small departments, collaborative inter-departmental diversity programs for faculty career development. We understand this training must be ongoing and ODI and the Office of Faculty Affairs will provide convenient resources that can be used by each department to facilitate this effort.

The Clinician-Educator Track for faculty promotion currently requires faculty to select two of four available domains (Clinical, Education, Health Services and Management, or Research) to model activity justifying promotion. The Appointment, Promotion, and Tenure Committee in the school of medicine has added a fifth domain for Community Engagement. Faculty in the Investigator Track or Team-Scientist Track, whose scholarly work already focuses on

community/health services research, will be judged for promotion based on that scholarly work.

- ***Data Gathering and Dissemination - Expansion of the Office of Diversity and Inclusion with personnel and resources to serve as central oversight and coordination of the DEI activities including gathering data from departments and programs to assess progress and focus efforts on mitigation of evaluation bias across Feinberg campus. These data should be shared with leadership in an ongoing fashion to encourage continuous improvement.***

Given the necessity to assess the implementation and impact of the new initiatives mentioned above, it is clear that an additional staff person in ODI will be needed for managing and reporting. Periodic reporting to the Dean's Office, Executive Committee of the Faculty, The Graduate School, Allied Health programs, McGaw and student committees within AWOME will provide additional review, assessment and recalibration as needed.

Summary

We are a leading academic medical center that educates physicians, scientists, and allied health professionals. Feinberg must ensure its core mission while simultaneously advancing equity as it impacts human health. Cultural change is a predictable stepwise function because it gambles with many moving pieces across a school. We are confident our campus can embrace needed changes such that equity becomes a stronger pillar by which we define our excellence.

More questions regarding social justice will certainly surface over time and so the process goes on. Issues like the role of the police department in university life or the fate of honorific societies such as *Alpha Omega Alpha* are undergoing independent review by the university and the school, respectively.

We acknowledge there are a range of emotions surrounding the urgency to tackle the menu of recommendations identified in this document. But there also is a need to act thoughtfully and carefully, highlighting where and how we intend to move forward responsibly. Feinberg launches this journey with the goal of advancing cultural awareness. Thank you for your self-agency and thoughtful participation as we begin to assimilate new measures of quality improvement.