Academic Medicine and Black Lives Matter
Time for Deep Listening

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 ing, important questions are necessary; is focusing on to expunge racism from medicine. Yet, before proceed-seeking both a response and a set of intentional actions not a race but a generation is expressing concern in the broader society: today's protests are unlike those

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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 affiliated affiliates. Thus there is a responsibility to provide not only the biology but also the sociology of medicine. Those who argue that the IIs 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 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, promoted, 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. 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 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 condemning 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
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REFERENCES