

Advancing Equity in Academic Medicine

As one measure among many to address race- and gender-based discrimination in academic medicine, the Association of American Medical Colleges (AAMC) renamed its most prestigious medical educator award in November 2020.¹ The new name is the AAMC Award for Excellence in Medical Education. The previous name referenced Abraham Flexner, the author of a consequential report² commissioned by the Carnegie Foundation for the Advancement of Teaching and published in 1910. The Flexner Report led to greater emphasis on scientific knowledge and the pursuit of science in medical school curricula. Forsaking the role of clinician mentors who oversaw trainee-apprentices, full-time faculty researchers in academic settings were identified as the correct teachers of medicine.^{3,4} Commended for its focus on standardization and rigor and criticized for its narrowness and clinical detachment,⁴ the report also included Flexner's own opinions on suitability to service as a physician, elevating the role and assumed abilities of White men and disparaging those of others.⁵

Skepticism regarding the prevailing methods of medical training in the early 20th century, as articulated by Flexner, contributed to the reduction in the number of medical schools in the United States. By the 1930s, more than half of the medical schools in the country had closed their doors. Many medical schools who admitted people of color, female applicants, and religious minority applicants folded. Eight of 10 medical schools dedicated to training Black physicians closed,^{6,7} as did 6 of 7 women's medical colleges.⁸ Many medical schools, both rural and urban, serving poor and marginalized communities, were shuttered as well.⁹

Flexner's recommendations influenced which schools survived and how schools evaluated applicants. Flexner stated that White women might acceptably receive their medical training alongside White

men, for instance, but supported racial segregation of medical education and medical practice. He recommended that Black medical schools be closed or their funding lessened and their curricula adjusted to focus on "hygiene rather than surgery, for example."⁵ In addition to delimiting opportunities for physicians who were Black men, Flexner stated that the future of Black women in medicine was only to be as nurses assisting Black male doctors.⁵ Flexner's logic for constraining the number and composition of medical school graduates was subsequently used for justifying medical schools' maximum recruitment numbers, or quotas, for religious minority individuals.¹⁰

Flexner's point of view met with considerable objections by influential medical leaders of the time.^{3,4} The debate largely reflected differing views of training methods rather than social justice concerns. Sir William Osler, beloved clinician and mentor, lamented Flexner's science-weighted approach, stating that he could not imagine anything "more subversive to the highest ideal of the clinical school" than to have medical students trained by full-time researchers who are "out of touch" with the realities of life as physicians.³ However, Ludmerer¹¹ reminds us that, according to Flexner

science ... was "inadequate" to provide the basis of professional practice. The practitioner needs "insights and sympathy," and here specific preparation is "much more difficult."^{12(p26)} In later years, Flexner felt the medical course had become overwhelmed with science to the exclusion of the humanistic aspect of medicine, and he seemed frustrated that such a system of medical education had come to be identified with his name.¹¹

The curricular model proposed by Flexner, an educator and nonphysician, nevertheless took hold. And, as warned by Tauber⁴ 30 years ago, medicine fell prey to the "hubris of our ... forefathers, who so confidently bequeathed their own prejudices to us."

With the unfolding of the past century has come phenomenal progress in the field of medicine and biomedical sciences,

with remarkable achievements in the prevention, diagnosis, treatment, and cure of conditions that have threatened human health for generations. Medical education has evolved to embrace its foundations in science, clinical medicine, and humanistic values.

Still, we have also seen uneven results in terms of representation for nonmajority individuals in medicine.¹²⁻¹⁶ For example, in 1915, 2.9% of medical school graduates were women⁸; in contrast, today, more than half of all U.S. medical students are women.¹⁵ On the other hand, only 5% of the total physician population is Black or African American,¹⁷ while Black or African American people make up 13.4% of the U.S. population.¹⁸ Howard University and Meharry Medical College, the 2 historically Black medical schools that survived the Flexner era, have graduated the majority of Black physicians in the United States, and only 13 U.S. medical schools each graduated 150 or more Black or African American physicians between the graduating classes of 2010 through 2019.¹⁹ In another example of underrepresentation in medicine, individuals identifying as Hispanic compose 18% of the population in the United States, yet fewer than 6% of physicians and 5% of medical school graduates identify as Hispanic.²⁰ Underrepresentation in medicine of individuals who identify as belonging to other, and sometimes multiple, ethnic, racial, religious, gender, and sexual minority groups is increasingly recognized, as are the additional challenges these individuals encounter in training and throughout their careers.^{14,15,21-23} As institutions of public trust, medical schools' failure to produce a representative workforce is a vital social justice concern and, furthermore, has been shown to contribute to differential health outcomes and health disparities.¹⁴

This issue of the journal includes several articles that call for greater equity in medicine. Berwick et al²⁴ discuss the frequency of gender-based role misidentification, documenting that 100% of the 85 women they surveyed had been misidentified as nonphysicians.

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Rabinowitz and Rabinowitz,²⁵ Lewiss and Jagsi,²⁶ and Woitowich et al²⁷ characterize nonequitable experiences of female health care workers during the COVID-19 pandemic. Maurana et al²⁸ describe the IWill campaign at the Medical College of Wisconsin, aimed at promoting gender equity through changes in systems and social norms. Streed et al²⁹ call for academic medical centers to improve patient care, education, and research involving sexual and gender minority people. Pregnall et al³⁰ echo the call for LGBTQ-health-related residency requirements.

Addressing ethnic and racial fairness considerations in medicine, Argueza et al³¹ offer 9 recommendations for advancing equity within medical training institutions, including systematically assessing institutional policies and norms and intentionally sharing and yielding decision-making power. Afolabi et al³² describe a student-led effort to advance antiracist curricula at the University of California, San Francisco, School of Medicine. Fernández et al²⁰ speak about the importance of diversity within Hispanic identity, noting that “academic medicine risks ignoring the distinctive struggles of different minority groups if antiracism efforts are solely aimed at racial categories or an amalgamate ‘people of color.’”

“A more inclusive future for academic medicine,” as noted by members of our journal’s editorial board,¹⁶ “will be enacted not through sentiment, but by means of individual, structural, and symbolic action.” Our authors are advancing this vision through their attention and scholarship in examining issues of equity in academic medicine. The renaming of the AAMC’s award that honors excellence and contributions in medical education is a symbolic act that, while overdue, signifies a welcome step on the long path bending toward justice.³³

Laura Weiss Roberts, MD, MA

Editor-in-chief, *Academic Medicine*

Editor’s Note: The opinions expressed in this editorial do not necessarily reflect the opinions of the AAMC or its members.

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